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The Treatment of Depression in General Practice

A Randomised Controlled Trial

Case Management for Depression in Primary Care:

A Practitioners Guide

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Introduction

This protocol contains guidelines for delivering the case management element to patients with depression treated as part of the Enhanced Care for Depression clinical trial.

Section A describes the research trial and details the overall principles of case management.

Section B outlines a session by session overview.

Section C describes the case management interventions (including education about depression, medication management and behavioural activation) and provides patient information leaflets.

Section D provides resource materials for use by case managers.

Section A

Principles and Practice of Case Management

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Explaining the Trial

This trial is funded by a project grant from the Medical Research Council. It is a randomised controlled trial where patients are allocated to either the 'experimental condition', in this instance case management, or 'usual care' which in this study is care which would be offered in normal circumstances to patients with depression by the GP.

Eligible patients are patients from 18 years onwards with a diagnosis of at least moderate depression who are not suicidal and who would normally be treated by GPs in primary care. Patients with very severe depression who would be referred to local psychiatric services are excluded from the trial. In essence, the trial is trying to find out what impact case management can have on the usual care of patients with depression in primary care.

Although case management has a strong evidence base internationally, its application has not been studied in the UK. The trial is a 'trial platform'. This means that we want to understand the fine details of case management. For example, we do not know who would be the best person to act as a case manager in a UK primary care setting. In order to answer this and other questions, we are conducting the trial in four PCT sites across the North of England and deliberately varying the background of people who are acting as case managers. We are very interested in the outcomes of patients with depression who are assisted by a case manager but we are equally interested in the experiences of case managers themselves and in how the process of case management unfolds.

Hopefully, by the time the trial is complete in March 2006, we will have tested this protocol and will understand more about the process and outcomes of case management for depression in primary care. We will use this information to make recommendations for both clinical practice and further research if this is indicated. Your help in this process is very much appreciated and we thank you for becoming involved.

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Questions and Answers

What is Case Management?

Case management involves one health worker in primary care making proactive contact with patients. It includes regular, scheduled contacts (usually by telephone but may include some face to face contact). Case managers take responsibility for:

1 assessing patients' views of depression, their attitudes to and concordance with psychosocial and pharmacological treatments

2 negotiating shared treatment decisions with patients

3 assisting patients with managing antidepressant medication

4 delivering brief guided self-help psychosocial interventions

5 feeding back of information about treatment and progress to the GP and mental health specialist to assist in treatment decision making

How is Case Management Different from Other Forms of Community Mental Health Care?

In a few areas, case management will be very similar to current practice. However, case management contacts are generally shorter than traditional community mental health care and start as soon as a patient is diagnosed with depression by a GP. The telephone is the most likely mode of contact in case management. Contacts with patients are structured around medication concordance and self-help psychosocial interventions. Psychosocial interventions are less intensive, less dependant on professional delivery and focussed more around self-help interventions. Contact frequency is explicitly organised around the phenomenology of depression and the response and side effect profiles of antidepressant medication and psychosocial interventions.

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Who is Case Management Indicated for?

Case management is suitable for all patients with moderate depression who a) have been prescribed antidepressant medication or b) have chosen not to take medication.

How are Case Managers Supported?

Case managers are part of a system of 'collaborative care'. They do not work alone, but receive support from a specialist mental health professional and share information with the GP. Case managers operate to provide an extension of the GP's work and are in regular contact with the GP. Case managers are also supported by a specialist mental health professional who provides weekly supervision of cases together with advice and support.

How long will Case Management Last?

For the purposes of the trial, the duration of Case Management will be for 12 weeks and include a maximum of 10 contacts per patient.

What is the desired frequency of Contact Sessions?

The minimum frequency should be weeks 1, 2, 4, 8, 12. Additional session frequency should be negotiated with individual patients. Negotiation of contact frequency should take into account patient preference, response to treatment, PHQ9 scores, the requirements of the psychosocial support programme and the amount of GP-patient contact. However, in general, weekly sessions are good practice during the first month of contacts, reducing to fortnightly in the second and third months. Where treatment is progressing satisfactorily, contacts may be less frequent than for patients who are struggling to overcome their depression.

How often should Case Managers try to Contact Patients?

Most case management contacts will be by telephone. Case managers should try to contact patients until they are successful in reaching the patient. The most successful strategy is to arrange a time when patients will be expecting a telephone call from the case manager. However, if patients cannot be reached, case managers should persist in trying to get through to the patient. In some cases, this may require very many attempted calls or calls to be made in the evenings or at weekends where this is possible. Clinical experience tells us that patients are overwhelmingly positive when case managers are persistent. We know of no cases where this has been regarded negatively by patients.

What happens at the End of the Trial?

After the period of case management comes to an end, case managers should discuss options with the patient's GP and their local mental health services. For some patients whose condition has substantially improved, no more assistance will be required aside from regular GP review. In other cases it may be appropriate for the GP to organise a referral to specialist mental health services, where these are available locally. In some cases, following discussion with service managers locally, case managers may wish to maintain further ongoing support to patients. Trial supervisors will be available to advise case managers on next steps; however, all decisions should be taken in consultation with GPs and local service managers.

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Summary: Who Does What in the Trial.

The GP

The GP is responsible for identifying patients with depression and referring them into the trial. They retain all medical responsibility for the treatment of trial patients.

The Case Manager

The case manager is responsible for supporting patients in their treatment choices for depression. They help the patient manage pharmacological treatments where these have been initiated and are also responsible for delivering a programme of self-help psychosocial support to patients. Case managers are responsible for communicating with the GP and supervisors on the progress of patients in the trial.

The Supervisors

Supervisors are responsible for providing support to case managers on the process of case management and on specific pharmacological and psychosocial interventions. They will initiate regular, scheduled reviews of patients and help case managers problem solve any difficulties. They will assist case managers in their communications with GPs.

The Researchers

Researchers are responsible for assessing GP referrals for suitability for the trial. They will interview suitable patients at the beginning and end of the trial to collect clinical outcome measures. The research trial unit is responsible for the random allocation of patients to each arm of the trial and for informing case managers of patient contact details once randomisation has taken place.

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GP identifies patient and initiates treatment	Patient consents to trial	Case manager receives notification of patient participation in trial	Case manager makes 1st appointment with patient (face to face or telephone)	Case manager makes weekly follow up appointments (face to face or telephone). Medication management and behavioural activation.	Case manager makes fortnightly follow up appointments (face to face or telephone). Medication management and behavioural activation.
Week 1	Week 1 or 2			Weeks 2-5	Weeks 5-12
Month 1					Months 2 and 3

Case Management: timetable of possible contact frequency. As a minimum, contacts should be made at 1, 2, 4, 8, 12 weeks.

Arranging Contacts with Patients

The First Contact

It is extremely important that patients are contacted by a case manager as soon as they consent to be involved in the trial, within 24-48 hours of allocation to a case manager. Case management should start as soon as possible after a patient is diagnosed. This is particularly important for patients who have chosen to take antidepressants so that they can be helped through the early stages where side-effects of treatment are common. The case manager should interview all patients within a few days of diagnosis, preferably within the first week following their diagnosis by a GP.

Ideally, the first contact should be face to face unless this is difficult to arrange from the patient's perspective, in which case telephone contact is acceptable. Initial contact appointments should be arranged by telephone, not a letter.

Subsequent Contacts

Most case management contacts should be conducted on the telephone. Time and day for each contact should be negotiated with the patient. Face to face contacts can be arranged if the patient and case manager think that this is desirable but the first option should always be using the telephone.

Contact Frequency

Contacts should be titrated against the patient's needs. However, weekly contacts are recommended for the first five weeks of case management, followed by fortnightly contacts thereafter. More frequent sessions can be arranged if the patient and case manager think that this is desirable. In most cases the maximum number of sessions will be ten. Short but frequent sessions are more important than lengthy individual sessions.

Contact Duration

The initial session should take no more than 30-40 minutes. Subsequent sessions should be timed at 15-20 minutes. Sessions can be shorter. Case managers should strive to keep sessions brief and focussed.

Contact Timing

Unless case managers normally work in the evenings as part of their contract of employment, contacts should be scheduled for between 9.00am and 6.00pm. However, we know that many patients prefer to be contacted out of hours and case managers should try to accommodate patient preferences if at all possible.

Patient-Initiated Contacts

Although the timetable for all scheduled contacts should be negotiated with the patient, some patients may want to be able to contact the case manager between sessions. If a patient specifically requests this, case managers should inform patients of times when they may be available for such patient-initiated contacts.

The Contact Log

All contacts with patients should be recorded on the contact log contained in section D. It is essential that the research team are able to measure the frequency, duration and mode of contact between case managers and patients. This will also be useful in supervision and should be kept up to date at all times. It is a separate record from standard clinical records which case managers would have to fill in under the policies and procedures of their organisations. Please keep a log for each patient in the special study folder, adding extra pages per patient as these are required.

Assessing and Managing Risk

Patients who are actively suicidal are not eligible for inclusion in the trial. However, some patients may experience a deterioration in their mental state during the trial. Each contact, therefore, should always include a risk assessment. No case manager should be managing patients at significant risk of suicide, self-harm or harm to others. Where patients express such ideas and where clear plans are evident, case managers should inform the GP immediately and make use of the local psychiatric service's arrangements for handling patients who present a risk to themselves or others.

Communicating with GPs.

Regular communication with GPs is an essential aspect of case management. There are three levels of communication:

Level 1: A statement of the patient's main problem and treatment plan should be entered into record systems held at the practice level after the first patient contact using the guidelines in Section D. Thereafter, a brief record of each contact should be entered into the general practice notes where the patient is progressing satisfactorily and/or willing to engage in the treatment plan.

Level 2: Where the case manager wishes to alert the GP to changes that may need to be made to the treatment plan, for example in response to lack of progress or changes in patient preference, a specific note should be sent to the patient's GP. Where the case manager has suggested to the patient that s/he should arrange an appointment with the GP in the next few days, the case manager should always inform the GP before the patient makes an appointment.

Level 3: Case managers should communicate in person by telephone to the GP when an urgent message needs to be passed on, for example where a patient is experiencing intolerable antidepressant side effects or where there is a significant worsening in a patient's mental health.

Using Supervision

Supervision to case managers for their trial work will be provided weekly by psychiatrists and psychological therapists working in the trial team. Case managers are expected to report their activity, results of patient monitoring outcome measures, plans for managing their caseload and any problems they are experiencing with specific cases. Supervisors will guide and advise case managers in their management of pharmacological and psychosocial interventions. They will also help the case manager communicate good practice guidelines (particularly on medication) for individual patients to GPs.

At each supervision session there will be a priority ordering of cases to be discussed:

1. All new patients
2. Patients who have reached a scheduled supervision review point after being in the trial for 4, 8 and 12 weeks
3. Patients who are not improving as expected, for example where an adequate trial of antidepressant medication is not having a therapeutic effect or where patients are not benefiting from or engaging in the psychosocial self-help support programme
4. 'Overdue' patients, i.e. where the case manager has not been able to make contact with patients as previously arranged
5. All other patients

Supervisors will expect to base their supervision on reports of regular PHQ9 scores, risk assessments, concordance information and treatment plans. Most supervision content will concern the process of decision making in overall case management, although some specific clinical supervision will be provided.

Section D contains several copies of a sheet to help you prepare for supervision and provides a structure for each type of supervision discussion, together with the information which will be required by supervisors in their discussions with case managers. Photocopy more as you need them.

Interventions

There are two types of intervention in case management for depression: pharmacological and psychosocial. These reflect the treatment options commonly used in primary care for patients with depression. The case manager's role is to help patients make the best use of the treatment(s) they have decided to opt for. In this trial all patients will be offered psychosocial support by the case manager and some patients will have been prescribed medication by their GP.

Antidepressants are very effective medications for depression. Many patients in primary care will be offered and will accept antidepressant medication. However, for a range of reasons, some patients will take a less than optimum dose and therefore get less benefit from their medication. It is the case manager's role to enable patients make better use of their medicines. Although the GP is in charge of prescribing medication, the case manager should assist the patient by reinforcing the information given to patients by their GP and by helping patients and GP problem solve any difficulties with medication tolerance. Where patients decide not to take - or to stop taking - medication, the case manager should support patients' use of alternative psychosocial strategies.

Psychosocial support is less commonly available in primary care. In this trial of case management, it is provided by the case manager in the form of behavioural activation for all patients. Behavioural activation is an evidence-based treatment that has been shown to have equivalent effects to more complex cognitive treatments of depression. It is simple to explain and use and is, therefore, an ideal psychosocial self-help intervention for use by case managers. Supported by patient information literature, case managers guide patients through a behavioural activation programme which increases the range and frequency of activities undertaken by patients in their daily lives.

Instructions and patient education materials for both medication management and behavioural activation are provided in section C.

Section B

Case Management: A Session by Session Guide

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Case Management Session by Session Guide

General Session Structure

All case management sessions should adopt the following structure:

1. **Assessment**
2. **Education**
3. **Shared Decision Making**
4. **Action Following Contacts: Reporting and Supervision**

1. Assessment

The depth of assessment depends at which stage patients are currently being cared for in the case management process. For example, the first contact requires a more in-depth assessment in order to plan a psychosocial support programme. Later contacts will have a more focussed assessment around progress towards patient goals. However, in all contacts there will be assessment of:

- Patient symptom levels
- Risk
- Depression, using the PHQ 9
- Motivation for engagement in treatment
- Treatment concordance (pharmacological and/or psychosocial)
- Response to interventions

2. Education

Again, the level of educational input will vary from session to session. It is likely that in the early contacts, educational input will be highest. However, education may be required at all stages to help patients take decisions about their treatment. For example, where a patient is considering an early termination of an antidepressant regime, education will be required on the mode of action of antidepressants and relapse rates to help the patient make an informed decision. Behavioural activation information is also likely to be given in more detail during the early contact sessions.

3. Shared Decision Making

Case managers should develop a collaborative relationship with patients. Patients are in charge of their own decisions. The case manager should always ensure these are made in an informed way. Case managers collaborate in these decisions by helping patients weigh up their options. Decisions will be about both medication issues and about behavioural activation activities.

When patients have been prescribed medication by their GPs, case managers should ascertain how closely the patient wishes to follow the GP's prescription. Where a patient does not wish to adhere to the GP's prescription, the case manager should respect the patient's view even if they disagree, and help the patient to weigh up the pros and cons of their decision. Case managers must ensure patients' decisions are informed by accurate educational input on antidepressant action and respect and support decisions. Later, if appropriate, discussions about treatment decisions can be initiated by case managers, for example where symptoms and/or PHQ9 scores do not improve.

Decisions will also have to be made about behavioural activation targets and exercises. Negotiated targets and exercises to assist patients to regain their functioning should be realistic and achievable. Selection of activities should be based on patients' own identification of key deficits in their functional activities.

Other decisions will be about the frequency of case manger/patient contacts, time of next contact etc. During all contacts, case managers need to finish the contact with a clear understanding of what the patient has decided to do between this and subsequent contacts and get feedback from patients on their shared understanding of the next steps.

4. Action Following Contacts

All contacts must be followed by feedback to the GP at levels 1-3 below:

Level 1: A statement of the patient's main problem and treatment plan should be entered into record systems held at the practice level after the first patient contact using the guidelines in Section D. Thereafter, a brief record of each contact should be entered into the general practice notes where the patient is progressing satisfactorily and/or willing to engage in the treatment plan.

Level 2: Where the case manager wishes to alert the GP to changes that may need to be made to the treatment plan, for example in response to lack of progress or changes in patient preference, a specific note should be sent to the patient's GP. Where the case manager has suggested to the patient that s/he should arrange an appointment with the GP in the next few days, the case manager should always inform the GP before the patient makes an appointment.

Level 3: Case managers should communicate in person by telephone to the GP when an urgent message needs to be passed on, for example where a patient is experiencing intolerable antidepressant side effects or where there is a significant worsening in a patient's mental health. No case manager should be managing patients at significant risk of suicide, self-harm or harm to others. Where patients express such ideas and where clear plans are evident, case managers should inform the GP in person immediately and make use of the local psychiatric service's arrangements for handling patients who present a risk to themselves or others.

Case managers should always complete the patient contact log and session record as well as complying with the record keeping requirements of the services that employ them.

Supervision:

At each supervision session there will be a priority ordering of cases to be discussed:

1. All new patients
2. Patients who have reached a scheduled supervision review point after being in the trial for 4, 8 and 12 weeks
3. Patients who are not improving as expected, for example where an adequate trial of antidepressant medication is not having a therapeutic effect or where patients are not benefiting from or engaging in the psychosocial self-help support programme
4. 'Overdue' patients, i.e. where the case manager has not been able to make contact with patients as previously arranged
5. All other patients

Supervisors will expect to base their supervision on reports of regular PHQ9 scores, risk assessments, concordance information and treatment plans. Most supervision content will concern the process of decision making in overall case management, although some specific clinical supervision will be provided.

Case managers should also be aware of how closely patients' medication regimes follow prescribing guidance. Where prescriptions do not follow accepted prescribing guidance, the case manager should discuss this with their supervisor. Action following this might include either the case manager or the supervisor communicating to the GP with suggestions.

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Contact Session 1

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Case Manager's Checklist for Session Number 1

(photocopy additional copies as required)

	Tick when complete
Introduction	
1. Assessment person-centred, 'here and now' problem assessment	
1.1 Assessment of Risk thoughts, plans, actions and prevention	
1.2 Formal symptom assessment **Write score here** PHQ-9	
1.3 Medication review attitude to medication and medication behaviour	
1.4 Medication side-effect assessment unusual effects assessment	
2.0 Education	
depression information	
medication information	
material on behavioural activation	
3.0 Shared Decision Making	
agree action goals for medication and behavioural activation	
hand out medication and behavioural activation materials	
negotiate the next contact session	
Record Keeping and Feedback to GP	
complete patient contact log, session record and any other records	
enter a short record of contact, problem statement and action plan into the GP's record systems	
make a special (level 2) or an urgent (level 3) communication if indicated	

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Contact Session 1

Introduction

The case manager should introduce themselves by full name and job title, confirm the patient's full name, outline the case management role and the objectives of the interview, the confidentiality protocol for note taking and inform the patient that the contact should take no more than 30 minutes.

Assessment

1.1 Problem Assessment

The case manager should conduct a person-centred, 'here and now' problem assessment focussing on those aspects of the patient's problems that are interfering with their day to day activities and which are identified by the patient as priorities for change.

1.2 Assessment of Risk

The case manager should ensure they conduct a risk assessment to identify any risk thoughts, plans or actions and anything that is currently preventing the patient enact such plans if present.

1.3 Formal symptom assessment

The case manager should use the PHQ-9 to confirm symptoms and establish a baseline for symptom change over the next few weeks.

1.4 Medication review

If the patient is on antidepressants the case manager should assess the patient's attitude to their medication, ascertain if the patient has commenced the medication and find out to what extent the patient is taking the prescribed dose.

1.5 Medication side-effect assessment

The case manager should ask the patient about any unusual effects which might be attributed to their antidepressant medication.

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Contact Session 1 Introduction: Example Script

"*Hello, my name is [case manager's name]. I am one of the [**role title**] working with Dr [**GP Name**]. Can I just confirm your full name? It's [**patient's full name**].*

*If you remember, you volunteered to be part of a research project investigating how to improve the way we organise treatment for depression. As part of that research study, my job is to contact you today and then regularly over the next three months to help you with your mood. I'll try to do this by supporting the treatment you are getting from Dr [**GP Name**]. I will also help you by giving you information about depression and your treatment and I will suggest other activities to help lift your mood.*

*The purpose of today is for me to get a better understanding of your main difficulties. Dr [**GP Name**] has given me a short report but no details. I'd like to ask you some questions about your main problems At the end of the interview we'll make a plan for the next few weeks to help you with your difficulties. We have about 40 minutes for the interview.*

*After the interview, what I would normally do is let Dr [**GP Name**] know that we have been in contact with each other and give [**him/her**] a short report. From time to time I may discuss your treatment with Dr [**GP Name**]. Also, as part of the research, I have a supervisor whom I will report to so that I can make sure I am following the guidelines for this project Is this OK?*"

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Contact Session 1 Assessment Details: Example Questions

1.1 Person-centred, 'here and now' problem assessment

- What are your main difficulties at the moment, those that prompted you to visit your GP recently?
- How do these difficulties affect you physically?
- How do they affect what you do with your time?
- What thoughts do you have when you feel like this?
- Are there any particular situations that trigger your feelings?
- What impact is this having on your life?
- Could you detail things that you have stopped doing because of the way you feel?

1.2 Assessment of Risk

- Do you have any thoughts of killing yourself?
- Do you have any plans to kill yourself?
- Have you made any preparations to kill yourself or have you tried to do it in the past?
- Is there anything stopping you killing yourself?
- Are you feeling as if you could hurt or harm anyone around you?
- Are you finding it hard to look after yourself or anyone in your care such as children or older relatives?

Other question areas

- What makes the problem better or worse?
- When did the problem start and how has it fluctuated over time?
- Have you had any previous treatment for this problem now or in the past?
- What is your current treatment?
- What is your alcohol or drug consumption?
- What would you like to change about the problem (magic wand)?

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Contact Session 1 Formal Symptom Assessment: The PHQ9

1.3 Procedure for administering the PHQ9

The PHQ9 (see section D) is a brief instrument which enables practitioners and patients to constantly monitor key symptoms of depression. It should be introduced in the following way. If possible, the patient should have a copy of the PHQ9 in front of them to help them answer the questions.

Tell the patient you will be running through this questionnaire each time you talk to each other to give you both a measure of the patient's progress over time during the next few weeks that you will be in touch with them.

"*I would like to ask you some standard questions from a questionnaire. I will ask you about a series of common symptoms of depression. Could you tell me if you have been feeling these symptoms during the last two weeks: Not at all; Several days; More than half the days; or Nearly every day.*"

- Run through the questions in order.
- Quickly add up the score using the system in section D.
- Give the patient feedback on what the score means in terms of their depression severity. Always give this feedback to the patient. Be honest with the scoring and ask the patient, "*How does this fit for you?*" in terms of the way they are currently feeling.
- Given that in the first interview, their score is likely to be high, remind the patient that this is a baseline to measure their progress against.
- Make sure a spare copy of the PHQ9 is handed out/sent by post to the patient

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Agree an overall problem statement with the patient that describes the patient's mood state, their symptoms and the impact of this mood state on their daily activities. For example:

Your main problem is a lack of interest in undertaking previously enjoyed activities, lethargy, sleep problems, reduced activity and thoughts that you are a failure with the consequence that you are finding it difficult to work, socialise and keep on top of your housework.

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Contact Session 1 Medication Review: Example Questions

1.4 Medication Review

- What medication did the GP prescribe?
- Have you started taking it?
- When and how often are you actually taking the tablets?
- Do you know much about how these tablets work?
- How do you feel about taking the medication?
- Do you plan to continue to take them over the next few weeks?
- Are you planning to take them regularly as advised by your GP?
- Have you noticed any benefits yet?
- How effective do you think these tablets are?

1.5 Medication side-effect assessment

- Have you noticed any unusual physical or mental feelings since you have been taking the tablets?
- Could you describe these in detail?
- What do you feel about these effects?
- Do you know anything about side-effects these tablets might cause?

A list of antidepressant side effects is given in Section C. Most side effects are temporary, mildly unpleasant but not dangerous. Consult Section D for a list of common side-effects as well as a list of those for which it will be necessary to consult the GP. Very occasionally, patients may experience side-effects which require them to stop taking the medication. These are listed in Section C. Facts for patients are given in the educational section on the next pages.

Education

The case manager should provide education to patients verbally using the information given on the next three pages. Wherever possible, this verbal information should be supplemented by written material given to, or posted out to, the patient.

2.1 Depression

Many patients request information about depression. There are many good information sources about depression. Section C provides several including an example published by the Mental Health Foundation. The case manager should provide the patient with these leaflets or other resources on depression.

2.2 Medication

If the patient is taking medication, the case manager should provide the patient with educational information on medication and reinforce information about antidepressants given to the patient by the GP. Facts about antidepressants are given in the next pages. Examples of medication information sheets which can be given to patients are provided in section C.

2.3 Behavioural Activation

The case manager should also introduce material on behavioural activation and provide the patient with a rationale for its use. Facts about behavioural activation are given on the next page. Examples of behavioural activation information sheets which can be given to patients are provided in section C.

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Contact Session 1 Education: Depression Information

Basic facts about depression

- Depression is not a sign of personal weakness
- 15-20% of people will experience clinical depression at some time during their life.
- The best research suggests that depression is caused by a combination of inherited or genetic factors and life events – just like high blood pressure or heart disease.
- There is no one way people experience depression

Common symptoms of depression

Physical feelings such as: disturbed sleep including taking longer to get off to sleep and then waking up early; poor appetite and weight loss, or the reverse with comfort eating and weight gain; exhaustion; poor concentration

Behaviours such as: staying at home and avoiding other people; loss of interest in life and inability to enjoy normal things; restlessness and agitation

Thoughts such as: inadequacy; hopelessness and loss of self-confidence; thoughts or even plans of suicide

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Contact Session 1 Education: Medication Information

Basic facts about the effects of antidepressants

- Antidepressant medication is, on average, effective – regardless of what seems to have caused depression for any particular person
- Antidepressants help to relieve symptoms of depression such as depressed mood, loss of energy, appetite changes, sleep disturbance, loss of interest in things, trouble concentrating, and feelings of guilt or worthlessness.
- Antidepressants will not change your personality or make you a different person.
- Antidepressants will not change the important life problems you face, but they may help you deal with those problems more confidently and effectively.
- Antidepressants may help you to feel less overwhelmed by life problems, but they don't create an artificial "high".

Facts about side-effects of antidepressants

- Side effects are common, but these are usually mild and improve with time.
- All known side effects go away after stopping medication (i.e. none are permanent).
- Antidepressants are not addictive unlike other drugs which can produce dependence (e.g. alcohol, tranquilizers or sleeping pills).
- Side effects are worst early on and usually improve whilst the benefits build slowly over a few weeks.

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Contact Session 1 Education: Behavioural Activation

How to Explain Behavioural Activation

When we are depressed:

- we feel physically unwell,
- we have depressed thoughts
- we change the way we behave.

We behave differently by:

- often stopping doing the important life **routines** that make us comfortable in our surroundings.
- withdrawing from doing **pleasurable** things that make us feel well, for example, talking to other people, going for a walk.
- avoiding important and **necessary** things like paying bills.

By withdrawing in this way, our feelings and thoughts also get worse because all our physical, thinking and doing symptoms of depression are linked.

By setting goals of things we want to do we can '***act our way out***' of depression rather than wait until we are ready to '***think our way out***'.

Behavioural activation is a structured, active self-help intervention. It is focused on:

- re-establishing our daily **routines**
- increasing **pleasurable** activities
- addressing **necessary** issues

The purpose of this is to help us to regain functions which have been lost or reduced during depression.

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How to Start Behavioural Activation

1. The *first* step in behavioural activation is to make a diary of what you are doing now.

2. The *second* step is to make lists of things that you would like to do, based on what you have stopped doing since you became depressed.
- Some of these things will be just **routine** jobs which need to be done, such as housework or cooking.
- Others things will be **pleasurable** activities such as going out and meeting people.
- Some things will be important **necessary** activities that you are avoiding, such as paying bills or dealing with conflict.

3. The *third* step is to order these separate lists into one big list, with the most difficult activities at the top of the list and some easier activities at the bottom, making sure you mix up **routine**, **pleasurable** and **necessary** activities.

4. The *forth* step in behavioural activation is to use a diary sheet to plan out how to start doing these things, starting near the bottom of your list and working upwards.

NB: When choosing activities it is very important to:

- start small and help patients to choose things that they are likely to be successful at achieving

- spell out exactly what the activity is, where it will be done, when it will be done, how it will be done, who it will be done with (if it includes other people) and what steps are needed to complete the activity.

3.0 Shared Decision Making

The case manager should agree action goals with the patient around:

3.1 the use of Medication

When patients have been prescribed medication by their GPs, case managers should ascertain how closely the patient wishes to follow the GP's prescription. Where a patient does not wish to adhere to the GP's prescription, the case manager should respect the patient's view even if they disagree, and help the patient to weigh up the pros and cons of their decision. Case managers must ensure patients' decisions are informed by accurate educational input on antidepressant action and respect and support decisions. Later, if appropriate, discussions about treatment decisions can be initiated by case managers, for example where symptoms and/or PHQ9 scores do not improve.

Case managers should also be aware of how closely the medication regime follows prescribing guidance. Where the prescription does not follow accepted prescribing guidance, the case manager should discuss this with their supervisor at the next supervision session and decide on a communication action plan to assist the GP in their prescribing.

3.2 Behavioural Activation

Decisions will have to be made about behavioural activation targets and exercises. In most instances at contact session 1, this will be reading the patient information leaflet in section C or keeping the diary. Activity diaries should be based on patients' own identification of key deficits in their functional activities. Some patients may wish to start using BA worksheets I and II to initiate activation activities.

3.3 Arranging the Next Contact

The case manager should negotiate the next contact session with the patient. This will normally be within a week of the initial session and be conducted by telephone.

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Contact Session 1 Shared Decision Making

3.1 Depression Action

- Information on depression given verbally and handed out/sent by post

3.2 Medication Action

- Does the patient wish to take the medication?
- Details negotiated regarding timing and dosage according to decision above
- Information on antidepressant effects and side-effects given verbally and handed out/sent by post

3.2 Behavioural Activation Action

- Is there agreement to start a programme of behavioural activation?
- Information on behavioural activation given verbally and handed out/sent by post
- First stage diaries and/or worksheets handed out/sent by post for activity monitoring

3.3 Next Contact Session

- Agreement on next contact time, mode (telephone preferred) and place.

Action Following the Contact

Record Keeping
The case manager should complete the contact log, session record and any other records required of the case manager's employing organisation.

Feedback to GP
Level 1, 2 or 3 feedback should be initiated. All patients require at least level 1 feedback (routine report in practice records). For patients with changed treatment preferences level 2 is required (special communication to GP). Level 3 feedback (personal contact with GP) should be used for patients who have severe side effects or present a risk.

Supervision
Case managers should report the outcome of contact session 1 to their supervisor in the next weekly supervision session using the format:

- Gender, age, previous episodes, onset
- Main problem statement
- Risk assessment
- PHQ9 score
- Treatment plan including medication and behavioural activation
- Case Management Action

Where case managers are concerned that the medication prescription by the GP does not follow prescribing guidelines, s/he should discuss this with the supervisor. Action following this might include either the case manager or the supervisor communicating to the GP with suggestions.

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Contact Session 1 Action Following the Contact

Record Keeping

- complete patient contact log, session record and any other records required by the employing organisation

Feedback to GP

- enter a short (Level 1) record of contact, problem statement and action plan into the GP's record systems
- make a special (Level 2) or an urgent (level 3) communication if indicated

Supervision

- report the outcome of contact session 1 in the next weekly supervision session
- if medication prescription by the GP does not follow prescribing guidelines, discuss with supervisor

Contact Session 2

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Case Manager's Checklist for Session Number 2

(photocopy additional copies as required)

	Tick when complete
Introduction	
1. Assessment review and re-confirmation of problem statements	
1.1 Assessment of Risk thoughts, plan, actions and prevention	
1.2 Formal symptom assessment **Write score here** PHQ-9	
1.3 Medication review assessment of concordance	
1.4 Medication side-effect assessment unusual effects assessment	
1.5 Review of Behavioural Activation Support Programme diaries of negotiated behavioural activation activities	
2.0 Education	
Depression, medication and BA information	
3.0 Shared Decision Making	
agree action goals for medication management	
specific behavioural activation plans	
negotiate the next contact session	
Record Keeping and Feedback to GP	
complete patient contact log, session record and any other records	
enter a short record of contact, problem statement and action plan into the GP's record systems	
make a special (level 2) or an urgent (level 3) communication if indicated	

Contact Session 2

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Introduction

The case manager should confirm that they are speaking to the patient, remind the patient of who they are and describe the objectives and time scale for the contact.

1. Assessment

The case manager should remind the patient about the main problem statement agreed at the last contact and ascertain whether there has been any change in mood and problem impact since the last contact. This is not a new assessment but a review of previous information given.

1.1 Assessment of Risk

The case manager should ensure they conduct a risk assessment to identify any risk thoughts, plans or actions and anything that is currently preventing the patient enact such plans if present.

1.2 Formal symptom assessment

The case manager should use the PHQ-9 to re-measure symptoms and confirm the assessment information.

1.3 Medication review

If the patient is on antidepressants the case manager should assess if the patient is taking the prescribed dose and has experienced any benefits yet.

1.4 Medication side-effect assessment

The case manager should ask the patient about any unusual effects which might be attributed to their antidepressant medication.

1.5 Review of Behavioural Activation Support Programme

The case manager should discuss the previous behavioural activation activities negotiated during the last session. This may be reviewing a diary sheet or asking the patient if they have read educational material on behavioural activation.

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Contact Session 2 Assessment Details: Example Procedure

Assessment

Each case management contact should build on the previous one, in essence a continuation of a conversation between the case manager and the patient. Continuation sessions should be short unless the patient's state has deteriorated markedly. Therefore, after the introduction:

- Feedback previous summary statement of main problems.
- Ascertain from patient that this is still an accurate reflection of their difficulties – if not clarify and adjust the summary with the patient.

Assessment of Risk

It is always essential that case managers assess risk at each contact. This can be approached in the following way:

"*Last time we talked I mentioned that sometimes when people are depressed they can feel so despondent that they feel like taking their own lives. Can you tell me whether you have had any suicidal thoughts since we last talked.*

If an affirmative answer is given then the standard risk assessment questions must be run through, i.e.

- Do you have any plans to kill yourself?
- Have you made any preparations to kill yourself or have you tried to do it in the past?
- Is there anything stopping you killing yourself?

Additionally, harm to others, self- and other-neglect should be excluded.

- Are you feeling as if you could hurt or harm anyone around you?
- Are you finding it hard to look after yourself or anyone in your care such as children or older relatives?

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Contact Session 2 Formal Symptom Assessment: The PHQ9

Procedure for administering the PHQ9

The PHQ9 (see section D) – the brief instrument which enables practitioners and patients to constantly monitor key symptoms of depression – should be rated again in the following way. The patient should have a copy of the PHQ9 in front of them to help them answer the questions.

Remind the patient that you will be running through this questionnaire each time you talk to each other to give you both a measure of the patient's progress over time.

"*I would like to ask you the same standard questions from the questionnaire we went through last time. I will ask you about a series of common symptoms of depression. Could you tell me if you have been feeling these symptoms during the last two weeks: Not at all; Several days; More than half the days; or Nearly every day.*"

- Run through the questions in order.
- Quickly add up the score using the system in section D.
- Give the patient feedback on what the score means in terms of their depression severity. Always give this feedback to the patient. Be honest with the scoring and ask the patient, "*How does this fit for you?*" in terms of the way they are currently feeling. Compare their current score to the baseline score rated in the last contact session.
- If there is any improvement connect this to actions they have taken since the last session

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Contact Session 2 Medication Review: Example Questions

Medication Review

The case manager needs to relate the next section to information gathered at the previous contact. Since side-effects of antidepressant typically appear during the first week to ten days of taking medication, this is likely to be a major feature in this section of the contact. Questions might include:

- Have you been taking your medication?
- When and how often have you actually taken the tablets?
- Have you noticed and benefits?
- How do you feel about continuing to take the medication?

Medication side-effect assessment

- Have you noticed any unusual physical or mental feelings since you have been taking the tablets?
- Could you describe these in detail?

Information review

- Did you read the information on antidepressants I gave/sent you?
- What do you think about the information?
- Do you have any questions for me about it?

A list of antidepressant side effects is given in Section C. Most side effects are temporary, mildly unpleasant but not dangerous. Consult Section C for a list of common side-effects as well as a list of those for which it will be necessary to consult the GP. Very occasionally, patients may experience side-effects which require them to stop taking the medication. These are listed in Section C.

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Contact Session 2 Review of Behavioural Activation

Information

- Ask the patient if they have read the information you sent/gave them at the last contact session.
- Ask the patient what they think about the material.
- Ask the patient if they have made any attempts to list ***routine***, ***pleasurable*** and ***necessary*** things that they would like to do that they have stopped doing since they became depressed.
- Check if the patient has tried to put any of these things into a hierarchy or an ordered list.
- Ask the patient if they have tried any of the activities.

Diary

- Ask the patient if they have filled in the diary sheet for the last week
- If the sheet has been even partially filled in, go through it with them.
- Make sure you praise and reinforce any attempt to make lists or order them.
- If the patient has tried any activities make sure you encourage them and reinforce any progress.
- Help the patient to connect any improvement with behavioural activation actions they have taken.

Next Steps

- Ask the patient if they are prepared to try some behavioural activation exercises

2.0 Education

The case manager should act on the information given in sections 1.1-1.5 of the assessment.

2.1 Medication

Further information on medication may be unnecessary if the patient is happy to take it as prescribed. However, if there are issues regarding medication, the case manager should reiterate the information about antidepressants given in the previous session and in the educational material sent to the patient. The case manager should ensure that the patient is fully informed about the action, effects and side effects of antidepressants. The case manager should also address pros and cons of medication concordance decisions plus discuss barriers to concordance where this has been identified as a problem in the assessment phase of the contact.

2.2 Behavioural Activation

The case manager should reiterate the rationale for behavioural activation and explore how prepared the patient is to embark on a personalised behavioural activation programme.

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Contact Session 2 Education: Medication Information

If patients are ambivalent about antidepressant medication, it may be necessary to again provide the information given in the previous contact:

Basic facts about the effects of antidepressants

- Antidepressant medication is, on average, effective – regardless of what seems to have caused depression for any particular person
- Antidepressants help to relieve symptoms of depression such as depressed mood, loss of energy, appetite changes, sleep disturbance, loss of interest in things, trouble concentrating, and feelings of guilt or worthlessness.
- Antidepressants will not change your personality or make you a different person.
- Antidepressants will not change the important life problems you face, but they may help you deal with those problems more confidently and effectively.
- Antidepressants may help you to feel less overwhelmed by life problems, but they don't create an artificial "high".

Facts about side-effects of antidepressants

- Side effects are common, but these are usually mild and improve with time.
- All known side effects go away after stopping medication (i.e. none are permanent).
- Antidepressants are not addictive unlike other drugs which can produce dependence (e.g. alcohol, tranquilizers or sleeping pills).
- Side effects are worst early on and usually improve whilst the benefits build slowly over a few weeks.

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Contact Session 2 Education: Behavioural Activation

If it is necessary, briefly go through the rationale for Behavioural Activation, i.e.

When we are depressed:

- we feel physically unwell,
- we have depressed thoughts
- we change the way we behave.

We behave differently by:

- often stopping doing the important life routines that make us comfortable in our surroundings.
- withdrawing from doing pleasurable things that make us feel well, for example, talking to other people, going for a walk.
- avoiding important and necessary things like paying bills.

By withdrawing in this way, our feelings and thoughts also get worse because all our physical, thinking and doing symptoms of depression are linked.

By setting goals of things we want to do we can '***act our way out***' of depression rather than wait until we are ready to '***think our way out***'.

Explain the importance of the diary and BA worksheets I and II so that patients can plan their week and also keep a record to look back and see how they have done.

3.0 Shared Decision Making

The case manager should help the patient make decisions about a medication and behavioural activation treatment plan. Behavioural activation plans should be patient-centred, detailed and specific. ***Behavioural Activation Worksheets I and II*** and the ***Behavioural Activation Diary*** should be used and incorporated into behavioural activation treatment planning.

The case manager should negotiate the next contact session with the patient. This will normally be within a week and be conducted by telephone.

Record Keeping and Feedback to GP

The case manager should complete the contact log, session record and any other records required of the case manager's employing organisation. The case manager should enter a level 1 record of contact into the GP's record systems and make any other contact at levels 2 or 3 as necessary.

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Contact Session 2 Shared Decision Making

Medication Action

- Does the patient wish to continue to take the medication?
- Details negotiated regarding timing and dosage according to decision above
- Any further information required on depression, antidepressant effects and side-effects given verbally and handed out/sent by post

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Behavioural Activation Action Plan

Behavioural Activation Step 2:

- if they have not yet thought of activities, help the patient to put their identified **routine**, **pleasurable** and **necessary** activities into a series of lists in BA Worksheet I.
- If necessary, collaboratively fill in one or two activities in the three lists in worksheet I to encourage the patient.

Behavioural Activation Step 3:

- ask the patient to order these separate lists into one big list using BA Worksheet II, with the most difficult activities at the top of the list and some easier activities at the bottom, making sure patients mix up **routine**, **pleasurable** and **necessary** activities

Behavioural Activation Step 4:

- together, choose a few examples of these activities from the bottom of the list
- help the patient schedule these activities into a new diary
- try to schedule at least something once a day, more if the patient wishes it but do not insist on so many activities the patient will not be able to achieve them.

NB: When choosing activities it is very important to:

- start small and help patients to choose things that they are likely to be successful at achieving
- spell out exactly what the activity is, where it will be done, when it will be done, how it will be done, who it will be done with (if it includes other people) and what steps are needed to complete the activity.

Next Contact Session

- Agreement on next contact time, mode (telephone preferred) and place.

Record Keeping and Feedback to GP

The case manager should complete the contact log, session record and any other records required of the case manager's employing organisation. The case manager should enter a level 1 record of contact into the GP's record systems and make any other contact at levels 2 or 3 as necessary.

Contact Sessions 3-10

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Case Manager's Checklist for Session Numbers 3-10 *(photocopy additional copies as required)*	**Tick when complete**
Introduction	
1. Assessment review and re-confirmation of problem statements	
1.1 Assessment of Risk thoughts, plans, actions and prevention	
1.2 Formal symptom assessment **Write score here** PHQ-9	
1.3 Medication review assessment of concordance	
1.4 Medication side-effect assessment unusual effects assessment	
1.5 Review of Behavioural Activation Support Programme diaries of negotiated behavioural activation activities	
2.0 Education	
Depression, medication and BA information	
3.0 Shared Decision Making	
agree action goals for medication management	
specific behavioural activation plans	
negotiate the next contact session	
Record Keeping and Feedback to GP	
complete patient contact log, session record and any other records	
enter a short record of contact, problem statement and action plan into the GP's record systems	
make a special (level 2) or an urgent (level 3) communication if indicated	

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Contact Sessions 3-10

Introduction
The case manager should confirm that they are speaking to the patient, remind the patient of who they are and describe the objectives and time scale for the contact.

1. Assessment
The case manager should remind the patient about the main problem statement agreed at the last contact and ascertain whether there has been any change in mood and problem impact since the last contact. This is not a new assessment but a review of previous information given.

1.1 Assessment of Risk
The case manager should ensure they conduct a risk assessment to identify any risk thoughts, plans or actions and anything that is currently preventing the patient enact such plans if present.

1.2 Formal symptom assessment
The case manager should use the PHQ-9 to re-measure symptoms and confirm the assessment information.

1.3 Medication review
If the patient is on antidepressants the case manager should assess if the patient is taking the prescribed dose and has experienced any benefits yet.

1.4 Medication side-effect assessment
The case manager should ask the patient about any unusual effects which might be attributed to their antidepressant medication.

1.5 Review of Behavioural Activation Support Programme
The case manager should discuss the previous behavioural activation activities negotiated during the last session. This is likely to involve reviewing a diary sheet to assess concordance with negotiated activities.

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Contact Sessions 3-10 Assessment Details: Example Procedure

Assessment

Each case management contact should build on the previous one, in essence a continuation of a conversation between the case manager and the patient. Continuation sessions should be short unless the patient's state has deteriorated markedly. Therefore, after the introduction:

- Feedback previous summary statement of main problems.
- Ascertain from patient that this is still an accurate reflection of their difficulties – if not clarify and adjust the summary with the patient.

Assessment of Risk

It is always essential that case managers assess risk at each contact. This can be approached in the following way:

"*When we have talked previously I have mentioned that sometimes when people are depressed they can feel so despondent that they feel like taking their own lives. Can you tell me whether you have had any suicidal thoughts since we last talked.*

If an affirmative answer is given then the standard risk assessment questions must be run through, i.e.

- Do you have any plans to kill yourself?
- Have you made any preparations to kill yourself or have you tried to do it in the past?
- Is there anything stopping you killing yourself?

Additionally, harm to others, self- and other-neglect should be excluded.

- Are you feeling as if you could hurt or harm anyone around you?
- Are you finding it hard to look after yourself or anyone in your care such as children or older relatives?

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Contact Sessions 3-10 Formal Symptom Assessment: PHQ9

Procedure for administering the PHQ9

The PHQ9 (see section D) – the brief instrument which enables practitioners and patients to constantly monitor key symptoms of depression – should be rated again in the following way. The patient should have a copy of the PHQ9 in front of them to help them answer the questions.

Remind the patient that you will be running through this questionnaire each time you talk to each other to give you both a measure of the patient's progress over time.

"*I would like to ask you the same standard questions from the questionnaire we go through each time. I will ask you about a series of common symptoms of depression. Could you tell me if you have been feeling these symptoms during the last two weeks: Not at all; Several days; More than half the days; or Nearly every day.*"

- Run through the questions in order.
- Quickly add up the score using the system in section D.
- Give the patient feedback on what the score means in terms of their depression severity. Always give this feedback to the patient. Be honest with the scoring and ask the patient, "*How does this fit for you?*" in terms of the way they are currently feeling. Compare their current score to the baseline and subsequent scores rated in previous contact sessions.
- If there is any improvement connect this to actions they have taken since the last session

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Contact Sessions 3-10: Medication Review: Example Questions

Medication Review

The case manager needs to relate the next section to information gathered at the previous contact. Questions might include:

- Have you been taking your medication?
- When and how often have you actually taken the tablets?
- Have you noticed and benefits?
- How do you feel about continuing to take the medication?

Medication side-effect assessment

- Have you noticed any unusual physical or mental feelings since we last talked?
- Could you describe these in detail?

Information review

- Do you need any further information or explanation on antidepressants?

A list of antidepressant side effects is given in Section C. Most side effects are temporary, mildly unpleasant but not dangerous. Consult Section C for a list of common side-effects as well as a list of those for which it will be necessary to consult the GP. Very occasionally, patients may experience side-effects which require them to stop taking the medication. These are listed in Section C.

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Contact Sessions 3-10: Review of Behavioural Activation

Diary

- Ask the patient if they have filled in diary sheets for the period since the last contact.
- In early sessions, BA worksheets I and II may have been the focus of activity between contacts, in which case ask about these – has the patient made any attempt to list ***routine***, ***pleasurable*** and ***necessary*** activities and have they tried to put any of these things into a hierarchy or an ordered list.
- If the diaries and/or worksheets have been even partially filled in, go through them with patients.
- Make sure you praise and reinforce any attempt to make lists, order them, complete diaries or try any activities.
- Help the patient to connect any improvement with behavioural activation actions they have taken.
- Try to elicit any barriers to behavioural activation, together with how the patient feels about the pros and cons of activating.

Next Steps

- Ask the patient if they are prepared to do some behavioural activation exercises

2.0 Education

The case manager should act on the information given in sections 1.1-1.5 of the assessment.

2.1 Medication

If there are issues regarding medication, the case manager should reiterate the information about antidepressants given in previous sessions and in the educational material sent to the patient. The case manager should ensure that the patient is fully informed about the action, effects and side effects of antidepressants.

2.2 Behavioural Activation

If necessary, the case manager should review the patient's understanding of behavioural activation programme, assess its success and refocus the patient's attention to educational material previously given out.

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Contact Sessions 3-10: Education: Medication Information

During later sessions it is unlikely that patients will require much more information on antidepressants. However, it may be necessary to provide information about how long patients should stay taking antidepressants:

Basic facts about the effects of antidepressants

- Antidepressant medication is, on average, effective – regardless of what seems to have caused depression for any particular person
- Antidepressants help to relieve symptoms of depression such as depressed mood, loss of energy, appetite changes, sleep disturbance, loss of interest in things, trouble concentrating, and feelings of guilt or worthlessness.
- Antidepressants will not change your personality or make you a different person.
- Antidepressants will not change the important life problems you face, but they may help you deal with those problems more confidently and effectively.
- Antidepressants may help you to feel less overwhelmed by life problems, but they don't create an artificial "high".
- Current recommendations suggest that in order to avoid a relapse it is beneficial for people to remain taking antidepressants for at least six months.

Facts about side-effects of antidepressants

- Side effects are common, but these are usually mild and improve with time.
- All known side effects go away after stopping medication (i.e. none are permanent).
- Antidepressants are not addictive unlike other drugs which can produce dependence (e.g. alcohol, tranquilizers or sleeping pills).
- Side effects are worst early on and usually improve whilst the benefits build slowly over a few weeks.

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Contact Sessions 3-10: Education: Behavioural Activation

Although in later sessions it is unlikely, if it is necessary, briefly go through the rationale for Behavioural Activation, i.e.

When we are depressed:

- we feel physically unwell,
- we have depressed thoughts
- we change the way we behave.

We behave differently by:

- often stopping doing the important life routines that make us comfortable in our surroundings.
- withdrawing from doing pleasurable things that make us feel well, for example, talking to other people, going for a walk.
- avoiding important and necessary things like paying bills.

By withdrawing in this way, our feelings and thoughts also get worse because all our physical, thinking and doing symptoms of depression are linked.

By setting goals of things we want to do we can '***act our way out***' of depression rather than wait until we are ready to '***think our way out***'.

Explain the importance of the diary and BA worksheets I and II so that patients can plan their week and also keep a record to look back and see how they have done.

3.0 Shared Decision Making

The case manager should help the patient make further decisions about the medication and behavioural activation treatment plan. Behavioural activation plans should continue to be patient-centred, detailed and specific. They should also be progressive and forward looking as the patient becomes better able to determine their own activity programme. Diaries should be used and incorporated into behavioural activation treatment planning.

The case manager should negotiate the next contact session with the patient. This will normally be within a week in the first month or so, becoming more spaced out in the second and third months. Most contacts will be conducted by telephone.

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Contact Sessions 3-10: Shared Decision Making

Medication Action

- Does the patient wish to continue to take the medication?
- Details negotiated regarding timing and dosage according to decision above
- Any further information required on depression, antidepressant effects, ideal duration of treatment and side-effects given verbally and handed out/sent by post

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Behavioural Activation Action Plan

Behavioural Activation Step 4:

- together, choose a few more examples of activities from the bottom of the list in BA Worksheet II
- help the patient schedule these activities into a new diary
- try to schedule at least something once a day, more if the patient wishes it but do not insist on so many activities the patient will not be able to achieve them.

NB: when choosing activities it is very important to:

- start small and help patients to choose things that they are likely to be successful at achieving
- move on to bigger things when the patient feels able to
- spell out exactly what the activity is, where it will be done, when it will be done, how it will be done, who it will be done with (if it includes other people) and what steps are needed to complete the activity.

In addition it may be necessary to revisit steps 2 and 3, i.e.

Behavioural Activation Step 2:

- help the patient to put their identified **routine**, **pleasurable** and **necessary** activities into BA Worksheet I.
- if necessary, collaboratively fill in one or two activities in the three lists in worksheet I to encourage the patient.

Behavioural Activation Step 3:

- ask the patient to order these separate lists into one big list using BA Worksheet II, with the most difficult activities at the top of the list and some easier activities at the bottom, making sure patients mix up **routine**, **pleasurable** and **necessary** activities

Next Contact Session

- Agreement on next contact time, mode (telephone preferred) and place.

Record Keeping and Feedback to GP

The case manager should complete the contact log, session record and any other records required of the case manager's employing organisation. The case manager should enter a level 1 record of contact into the GP's record systems and make any other contact at levels 2 or 3 as necessary.

Section C

Case Management Interventions and Patient Information Leaflets

Educating Patients about Depression

The role of the case manager is to ensure that patients are well informed about their problems and about depression. This should be done both verbally and using back up written material. There are many good resources about depression to give to patients. Several key messages should be imparted:

- Depression is not a sign of personal weakness
- 15-20% of people will experience clinical depression at some time during their life.
- The best research suggests that depression is caused by a combination of inherited or genetic factors and life events – just like high blood pressure or heart disease.
- There is no one way people experience depression
- Common symptoms include:

Physical feelings such as: disturbed sleep including taking longer to get off to sleep and then waking up early; poor appetite and weight loss, or the reverse with comfort eating and weight gain; exhaustion; poor concentration

Behaviours such as: staying at home and avoiding other people; loss of interest in life and inability to enjoy normal things; restlessness and agitation

Thoughts such as: inadequacy; hopelessness and loss of self-confidence; thoughts or even plans of suicide

At the end of this section are a number of patient information resources including authoritative information sources from independent bodies now follow. The booklet from the Mental Health Foundation (MHF) is a particularly good resource. The MHF have given us permission to photocopy this booklet for the purposes of this trial.

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Medication Management

The goal of medication management is to assist patients to make the best decision on antidepressant use by:

- **assessing** attitudes to medication, medication use, clinical outcomes, medication effects and side effects
- imparting **education** regarding appropriate use of antidepressants
- negotiating **shared decisions** on patients' medication usage

Case managers will provide information and will support patients' decision-making. Case managers will not be making independent prescribing decisions (e.g. stopping medication, change in dosage). Mostly, the case manager will support the patient in their decision to follow (or not) the medication recommendation made by the GP, providing information so that this decision is made in an informed manner. The only instance where a case manager should make a different direct recommendation to a patient on medication is if they identify possibly dangerous side effects. In these instances, case managers must:

- advise the patient to temporarily discontinue medication
- inform the GP of the possibility of dangerous side effects being present
- strongly advise the patient to make an urgent appointment with their GP

Where a patient decides not to follow the prescription made by the GP, case managers should ensure that the patient's decision is fully informed by information on the effects and side effects of antidepressants. The pros and cons of their decision and alternative strategies should also be explored. Further discussions between the patient and the GP should be encouraged and non-pharmacological psychosocial support offered in the form of behavioural activation by the case manager.

Where a case manager is aware that a GP's prescription does not follow prescribing guidelines, this should be discussed with the case manager's supervisor and a joint plan devised to assist the GP and the patient make effective use of antidepressant medications.

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Antidepressant Medication

Antidepressants are prescribed by the GP to many patients with depression. They are highly effective. Modern antidepressants from the Selective Serotonin Reuptake Inhibitor (SSRI) and Selective Noradrenalin reuptake Inhibitor (SNRI) classes are now more widely used than earlier antidepressants such as the tricyclics. However, older tricyclic antidepressants are still prescribed where clinically indicated.

The role of the case manager is to enable the patient to maximise the benefits of taking antidepressants. Many patients take antidepressants at a less than optimum dose through misguided beliefs about addiction or mode of action. For example, it is necessary to take antidepressants for a number of weeks at a therapeutic dose before beneficial effects are observed by patients. Unfortunately, unpleasant side effects often appear before these beneficial effects. This combination of delayed action and immediate side effects causes many patients to reconsider or stop taking their antidepressants. Other patients may take antidepressants sporadically when they are feeling particularly low, in the belief that they have an immediate effect. Finally, current recommendations are that patients should continue to take antidepressants for six months following remission of symptoms. Many patients stop taking their medication before this period has elapsed, increasing their chances of relapse.

It is important to state that case managers are there to help patients make informed decisions about taking antidepressant medication. Where that decision is not to take medication, patients' decisions are to be respected and supported. Later, if appropriate, case managers can initiate further discussions about medication decisions made by patients, if for example symptoms and/or PHQ9 scores do not improve.

Medication management is, therefore, essential to help patients get the most benefit from their prescriptions. A combination of education, medication effect and side effect monitoring in collaboration with patients can improve concordance and mental health outcomes.

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Common antidepressant side-effects and actions

Side effect	What happens	What to do about it
COMMON		
Nausea and vomiting	Feeling sick and being sick.	Take your medicine after food. If you are sick for more than a day, contact your doctor. This tends to wear off after a few days or a week or so.
Insomnia	Not being able to get to sleep at night.	Discuss with your doctor. He or she may change the time of your dose, or reduce the dose a little to start with.
Sexual dysfunction	Finding it hard to have an orgasm. No desire for sex.	Discuss with your doctor. See also a separate question in this section.
LESS COMMON		
Drowsiness	Feeling sleepy or sluggish. It can last for a few hours after taking your dose.	Don't drive or use machinery. Ask your doctor if you can take your SSRI at a different time of day.
Headache	Your head is pounding and painful.	Try aspirin or paracetamol. Your pharmacist will be able to advise if these are safe to take with any other drugs you may be taking.
Loss of appetite	Not feeling hungry. You may lose weight.	If this is a problem, contact your doctor or chemist for advice.
Diarrhoea	Going to the toilet more than usual and passing loose, watery stools.	Drink plenty of water. Get advice from your pharmacist. If it lasts for more than a day, contact your doctor.

Common antidepressant side-effects and actions - continued

UNCOMMON		
Restlessness or anxiety	Being more on edge. You may sweat a lot more.	Try and relax by taking deep breaths. Wear loose fitting clothes. This often happens early on in treatment and should gradually ease off over several weeks. A lower starting dose may help sometimes.
RARE		
Rashes and pruritis	Rashes anywhere on the skin. These may be itchy.	Stop taking and contact your doctor now.
Dry mouth	Not much saliva or spit.	Suck sugar-free boiled sweets. If it is bad, your doctor may be able to give you a mouth spray.
Skin rashes	Blotches seen anywhere.	Stop taking and contact your doctor now. This is a particular problem with fluoxetine (Prozac)
Tremors and dystonias	Feeling shaky. You may get a twitch or feel stiff.	It is not dangerous. If it troubles you, contact your doctor.

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Side Effects Which Give Cause For Concern

Below is a list of side effects which should be regarded as of considerable concern. They are rare. For most of these symptoms, patients should be advised to stop their medication and discuss with the GP as soon as possible.

Skin rash – Can be caused by any medication. This is usually not caused by a true allergy, but is usually reason for switching medication.

Akathisia - Subjective symptoms of tension, panic, irritability and impatience together with movements usually taking the form of shuffling of feet while sitting and pacing or rocking while standing. Fidgety leg movements may occur while lying down.

Priapism (prolonged or painful erections) – Can occur with Trazodone.

Jaundice (yellow skin or eyes) – Can indicate liver inflammation (hepatitis) caused by medication.

Manic/Hypomanic symptoms (speeded up, "racy", elevated mood, excessive energy, grandiosity) – Antidepressant medications can precipitate mania (especially in those with family history of bipolar disorder).

Palpitations/Irregular heartbeat – While antidepressants can cause irregular heartbeat, this symptoms will usually be due to anxiety. Should discuss with GP as soon as possible.

Problem Solving Medication Management Difficulties

Patients may stop taking medication completely or take less than the prescribed dose for a range of reasons. Here are some possibilities:

- '***ineffective/not-helpful***'
- '***no longer necessary***'
- '***side effects***'
- '***concerned about safety***'
- '***concerned about addiction***'
- '***believes not appropriate - just a crutch***'
- '***family oppose it, others will find out***'
- '***forgot to renew prescription***'

It is important to:

Assess the true reasons for medication non-concordance
Provide **education** about the way antidepressants work and their side effects
Come to a **shared decision** about what to do next.

Several examples of education materials for patients are provided later in this section. These should be used to help patients come to an informed decision.

The next page highlights key messages about antidepressants and side effects which case managers may find useful in coming to a shared decision with patients.

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Antidepressant Medication: Key Messages

Basic facts about the effects of antidepressants

- Antidepressant medication is, on average, effective – regardless of what seems to have caused depression for any particular person
- Antidepressants help to relieve symptoms of depression such as depressed mood, loss of energy, appetite changes, sleep disturbance, loss of interest in things, trouble concentrating, and feelings of guilt or worthlessness.
- Antidepressants will not change your personality or make you a different person.
- Antidepressants will not change the important life problems you face, but they may help you deal with those problems more confidently and effectively.
- Antidepressants may help you to feel less overwhelmed by life problems, but they don't create an artificial "high".
- Current recommendations suggest that in order to avoid a relapse it is beneficial for people to remain taking antidepressants for at least six months.

Facts about side-effects of antidepressants

- Side effects are common, but these are usually mild and improve with time.
- All known side effects go away after stopping medication (i.e. none are permanent).
- Antidepressants are not addictive unlike other drugs which can produce dependence (e.g. alcohol, tranquilizers or sleeping pills).
- Side effects are worst early on and usually improve whilst the benefits build slowly over a few weeks.

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Behavioural Activation 1

When we are depressed we feel physically unwell, we have negative thoughts and we change the way we behave. These feelings, thoughts and behaviours are all linked. We end up in a vicious circle where the worse we feel physically, the more we think depressed thoughts and the more we withdraw from doing the normal things we used to do. The more we withdraw, the more we feel physically unwell and the more depressed our thoughts become.

- Some of these things we avoid are just ***routine*** activities such as cleaning the house, doing the ironing, washing up. Other routines are disrupted such as the time we go to bed or get up, when we eat and how we cook for ourselves. These are the important life routines that make us comfortable in our surroundings
- Other activities that get disrupted are things we do for ***pleasure*** such as seeing our friends, enjoying a day out with our families or playing games with our children. There are the things that often make us feel well.
- A third area where we avoid activities is in important ***necessary*** things such as paying bills or confronting difficult situations at work.

Behavioural activation is a structured, active self-help intervention. It is focused on activities to help patients:

- re-establish their daily routines
- increase pleasurable positively reinforcing external activities
- address necessary issues such as unpaid bills

Behavioural activation is about helping patients to '***act their way out***' of depression rather than wait until they are ready to '***think their way out***'.

The case manager's role is to support and coach patients in using a range of materials including diaries and information sheets. Case managers are not therapists and the patient retains control of all activities they undertake through a guided support programme from the case manager.

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Behavioural Activation 2

How to Start Behavioural Activation

1. The *first* step in behavioural activation is to make a diary of what people are doing now.

2. The *second* step is to think about things that people would like to do, based on what they have stopped doing since they became depressed.
- Some of these things will be just **routine** jobs which need to be done, such as housework or cooking.
- Others things will be **pleasurable** activities such as going out and meeting people.
- Some things will be important **necessary** activities that people are avoiding, such as paying bills or dealing with conflict.

3. The *third* step is to make a list of these different things, with the most difficult activities at the top of the list and some easier activities at the bottom, making sure people mix up **routine**, **pleasurable** and **necessary** activities.

4. The *forth* step in behavioural activation is to use a diary sheet to plan out how to start doing these things, starting near the bottom of people's list and working upwards.

NB: When choosing activities it is very important to:

- start small and help people to choose things that they are likely to be successful at achieving

- spell out exactly what the activity is, where it will be done, when it will be done, how it will be done, who it will be done with (if it includes other people) and what steps are needed to complete the activity.

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Enhanced Care for Depression

Patient Information Leaflets

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Depression, Your Mental Health Worker and You

Patient Information Leaflet

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Help from your mental health worker

As part of the research trial, your mental health worker, who has had special training in helping people to manage depression, will support you during the next three months. S/he will do this in several different ways:

- Contact you by telephone at regular intervals and at a time arranged between you and her/him.

- Explain about depression and give you information, including leaflets and booklets to read and information on where to get other information.

- Help you make the best use of any medication that your GP has prescribed by giving you information on the medicine, including information on any possible side effects.

- Plan an individual programme of support and self-help activities with you to help you overcome many of your symptoms of depression.

- Work closely with your GP and anyone else involved in your care and treatment.

Please do not be afraid to ask your mental health worker any questions about the system of care we are testing in this research trial. They will try to answer your queries as best they can and if necessary will forward your questions to one of the researchers.

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Depression

What is Depression?

In our lives we use the word 'depression' to describe feelings of low mood which all of us feel from time to time. However, the word is also used to describe a medical illness. When we talk about depression in this medical way it describes a feeling of persistent sadness, involving feelings of helplessness and hopelessness. Depression also affects our bodies and our thoughts and includes feelings of physic illness and of not being able to think clearly.

Depression is a very common problem. Very many adults will at some time experience symptoms of depression. Feeling sad or fed up is a normal reaction to experiences that are upsetting, stressful or difficult. Those feelings will usually pass with time. However, if you are suffering depression, you are not 'just' sad or upset. You have an illness which means that intense feeling of persistent sadness, helplessness and hopelessness are accompanied by physical effects such as sleeplessness, a loss of energy, or physical aches and pains.

How Does Depression Affect People?

When people are depressed they may find it difficult to do even simple things. People stop doing their normal activities such as household routines, getting up at certain times of the day, cooking and eating meals. People also cut themselves off from other people. They may also become inactive, just doing nothing for long periods of time.

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Common Symptoms of Depression

There is no specific way a person who is depressed feels. However, many people have a range of physical and mental symptoms which affect the way they feel, do and think. Some symptoms are listed below.

Physical feelings such as: disturbed sleep including taking longer to get off to sleep and then waking up early; poor appetite and weight loss, or the reverse with comfort eating and weight gain; exhaustion; poor concentration

Behaviours such as: staying at home and avoiding other people; loss of interest in life and inability to enjoy normal things; restlessness and agitation

Thoughts such as: inadequacy; hopelessness and loss of self-confidence; thoughts or even plans of suicide

Depression: the Good News

The good news about depression is that the vast majority of people recover from their depression. Treatments are available which are effective. These include drug treatments and self-help. Your mental health worker will help you get the best out of whatever treatment you have decided to take. S/he will be able to answer your questions about medication and self-help and will support you during your illness. Your mental health worker will also talk to your GP to keep your GP informed as to how you are progressing.

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Antidepressants

Patient Information Leaflets and Booklets

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Behavioural Activation

Patient Information Leaflet

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Behavioural Activation 1

When we are depressed we feel physically unwell, we have negative thoughts and we change the way we behave. These feelings, thoughts and behaviours are all linked. We end up in a vicious circle where the worse we feel physically, the more we think depressed thoughts and the more we withdraw from doing the normal things we used to do. The more we withdraw, the more we feel physically unwell and the more depressed our thoughts become.

On the next page is an example of the vicious circle of depression: 'George'

- Some of these things we avoid are just ***routine*** activities such as cleaning the house, doing the ironing, washing up. Other routines are disrupted such as the time we go to bed or get up, when we eat and how we cook for ourselves. These are the important life routines that make us comfortable in our surroundings
- Other activities that get disrupted are things we do for ***pleasure*** such as seeing our friends, enjoying a day out with our families or playing games with our children. There are the things that often make us feel well.
- A third area where we avoid activities is in important ***necessary*** things such as paying bills or confronting difficult situations at work.

Behavioural activation is a structured, active self-help intervention. It is focused on activities to help us:

- re-establish our daily routines
- increase pleasurable activities
- address necessary issues such as unpaid bills

Many people think that it is necessary to feel completely physically well before starting to do things again. However, research evidence suggests that gradually starting to do more of the things we have been avoiding again can be a very effective way of self-help for depression.

Behavioural activation is about helping us to '***act our way out***' of depression rather than wait until we are ready to '***think our way out***'.

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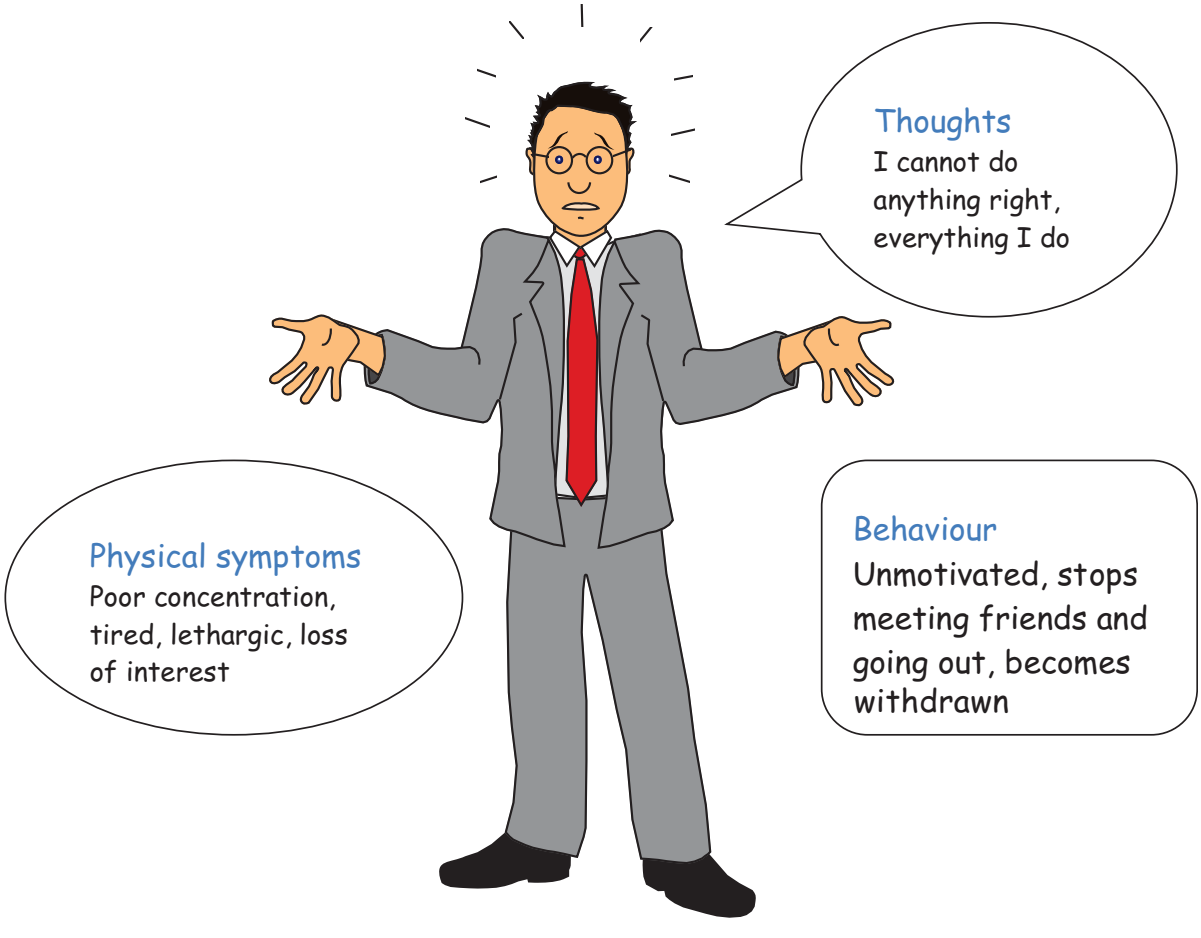
George had been feeling anxious and depressed since he had been made redundant. He had lost his confidence and had a low self-esteem. He had thoughts that he was no good and could do nothing right. He felt tired and lethargic all the time, lost interest in hobbies and interests, and had poor concentration. He became unmotivated and stopped going out or meeting friends or doing the things he had previously enjoyed. He became more and more withdrawn. The more he had these thoughts, physical symptoms and behaviour the more depressed and anxious he became. This 'vicious circle' of thoughts, physical symptoms and changes in behaviour maintain George's depression.



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Behavioural Activation 2

The goal of behavioural activation is to enable you to recommence some of the behaviours which are typically reduced in depression. The purpose of this is to help you to regain some of your lost or reduced activities.

Behavioural Activation – The Four Steps

1. The *first* step in behavioural activation is to make a diary of what you are doing now.

2. The *second* step is to make three lists of the things that you would like to do, based on what you have stopped doing since you became depressed.

- One list will be just **routine** jobs which need to be done, such as housework or cooking.
- The second list will be **pleasurable** activities such as going out and meeting people.
- The final list will be important **necessary** activities that you are avoiding, such as paying bills or dealing with conflict.

3. The *third* step is to combine these different things into a final big list, with the most difficult activities at the top of the list and some easier activities at the bottom, making sure you mix up **routine**, **pleasurable** and **necessary** activities.

4. The *forth* step in behavioural activation is to use a diary sheet to plan out how to start doing these things, starting near the bottom of your list and working upwards.

Behavioural Activation 3

Step 1

Take a blank **diary** sheet.

Each day, fill in what you are doing. Be specific and try to fill in each square. Even if you think you are doing nothing, this is very helpful information

Discuss this list with your depression specialist mental health worker. His or her role is to support and coach you in using the diaries and information sheets. You are in control of all activities you plan to undertake, though you will get guidance and support from the depression specialist mental health worker.

Step 2

Think about things that you would like to do, based on what you have written down in your first diary. Identify things that you have stopped doing since you became depressed.

- Some of these things will be just **routine** jobs which need to be done, such as housework or cooking.
- Others things will be **pleasurable** activities such as going out and meeting people.
- Some things will be important **necessary** activities that you are avoiding, such as paying bills or dealing with conflict.

Use the **Worksheet I** to list all these activities. Put them down in any order you like, as you think of them

Behavioural Activation 4

Step 3

Using **Worksheet II**, organise all these different things into a list, with the most difficult activities at the top of the list and some easier activities at the bottom.

Make sure you mix up **routine**, **pleasurable** and **necessary** activities so that there is a mixture of different types of activities at the bottom, middle and top of the list.

Step 4

Use another clean **diary** sheet to plan out how to start doing these things. Take some examples of **routine**, **pleasurable** and **necessary** activities from near the bottom of your list and plan to do them. Write down at certain times exactly what you will do.

Spell out exactly what the activity is, where it will be done, when it will be done, how it will be done, who it will be done with (if it includes other people) and what steps are needed to complete the activity.

Try to schedule at least something once a day, more if you wish it but do not plan on so many activities that you will not be able to achieve them. Remember to start small and work up to big.

Try it for a week or two!

Behavioural Activation 5

What's Next?

Once you have tried to do some of the activities you have listed, discuss your progress with your mental health worker. He or she will encourage you and give you advice. As you accomplish some activities on your list move on up the list to other more difficult activities. Some activities will give you pleasure but it is more likely you will begin top feel a sense of accomplishment for more successfully completed activities (no one feels pleasure at paying a bill!)

Dealing with Setbacks

Remember that depression affects how you feel, what you do and what you think. It is unlikely you will be 100% successful. Some days will be better than others. If you do not do what you had planned one day, leave it for another day and try again. Complete success is not necessary. The best thing you can do is to keep trying. Compare what you are doing with how you were a few weeks earlier (try comparing your new diary with old ones). If you are really struggling, choose some activities from nearer the bottom of your list, or something different.

Finally, discuss your progress with your mental health worker. He or she will advise you and support you.

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Behavioural Activation

Patient Worksheets and Diaries

Section D

Resource Materials in Case Management

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PHQ-9 monitoring tool

Patient Name _____ **Date** _____

1. Over the last 1-2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.

   a. Little interest or pleasure in doing things
   Not at all **Several days** **More than half the days** **Nearly every day**

   b. Feeling down, depressed, or hopeless
   Not at all **Several days** **More than half the days** **Nearly every day**

   c. Trouble falling asleep, staying asleep, or sleeping too much
   Not at all **Several days** **More than half the days** **Nearly every day**

   d. Feeling tired or having little energy
   Not at all **Several days** **More than half the days** **Nearly every day**

   e. Poor appetite or overeating
   Not at all **Several days** **More than half the days** **Nearly every day**

   f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down
   Not at all **Several days** **More than half the days** **Nearly every day**

   g. Trouble concentrating on things such as reading the newspaper or watching television
   Not at all **Several days** **More than half the days** **Nearly every day**

   h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual
   Not at all **Several days** **More than half the days** **Nearly every day**

   i. Thinking that you would be better off dead or that you want to hurt yourself in some way
   Not at all **Several days** **More than half the days** **Nearly every day**

2. If you ticked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

   Not Difficult at All **Somewhat Difficult** **Very Difficult** **Extremely Difficult**

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Scoring the PHQ-9

The PHQ-9 is a useful monitoring tool to ensure case managers have an objective measure of a patient's mood as well as information gleaned from their assessment contacts. It can be quickly totalled to give confirm mental health state and give patients weekly feedback on the outcomes of their treatment.

Of the 9 items in question 1 count one point for each item ticked 'several days', two points for each ticked 'half the days' and three points for those ticked 'nearly every day'. Sum the total for a severity score.

SCORE	SEVERITY
<10	Mild depression
10-14	Moderate depression
15-19	Moderate to severe depression
>20	Severe depression

Definition of improvement

Improved A reduction of 2 or more points on the baseline score

Not improved Drop of 1 point or no change or increase

Definition of remission

If patients have a score of less than 5 they are considered to be in remission.

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Patient Contact Log

Patient Name_____ GP Name _____ Page___ of ___

Date	Contact Number (1-10)	Contact Duration (mins.)	Face to face or phone?	Medication Management Y/N	Behavioural Activation Y/N	PHQ9 Score	Comments

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Session Record; Summary of Contact

Patient **Date** **Session no**

Assessment (depression, risk, medication, side effects, behavioural activation)

PHQ9 Score

Education

Shared Decision Making

Action Following Contact (Level of GP feedback – 1,2,3)

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Suggested Brief Reporting Format for GP Records Following Session 1

Date and Time of Contact with Patient _____

Main Problem Statement (single sentence summarising the patient's triggers, autonomic, behavioural and cognitive symptoms, impact on life). Risk category.

E.g. ***Jean Smith, part of case management research trial. Main problem is a lack of interest in undertaking previously enjoyed activities, lethargy, sleep problems, reduced activity and thoughts that she is a failure with the consequence that she is finding it difficult to work, socialise and keep on top of her housework. Not at risk of suicide.***

Case Management Plan (outline of contacts planned with patient)

E.g. ***Mrs Smith agreed to be contacted weekly to review her progress with fluoxetine and to commence a programme of behavioural activation. Information on depression, antidepressants and behavioural activation given to Jean.***

Name of Case Manager _____

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Suggested Brief Monthly Reporting Format for GP Records

Number of Contacts with Patient in Last Month _____

Progress report (brief outline of progress)

E.g. *Mrs Smith experienced initial mild nausea which abated after 10 days. Her mood is slightly improved and she continues to take her fluoxetine as prescribed. She has started on a behavioural activation programme and is beginning to re-establish her daily routine. She is not at risk.*

Future Plans

E.g. *Mrs Smith will continue to be contacted weekly for the next two weeks to review her progress, her concordance with her fluoxetine and to support her behavioural activation programme.*

Name of Case Manager _____

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Preparing for Supervision. Date……

In preparation for your supervision session, make a note of patients in the following five categories. Include the detail mentioned to assist you and the supervisor deal with your caseload effectively and efficiently. Use your session records and patient contact log to organise yourself prior to supervision and to refer to during supervision.

1. New Patients: (gender, age, previous episodes, onset, main problem statement, risk, PHQ9 score, treatment, case management action so far).

   Number of patients for discussion…….

2. Patients at 4, 8 or 12 weeks (review point, gender, age, episode, treatment summary, initial PHQ 9 score, risk, case management action, progress including PHQ 9 scores).

   Number of patients for discussion…….

3. Patients who are not improving as expected, (time in study, gender, age, episode, treatment summary, initial PHQ 9 score, risk, case management action, progress including PHQ 9 scores).

   Number of patients for discussion…….

4. Overdue patients (time in study, gender, age, episode, treatment summary, initial PHQ 9 score, risk, case management action including number of attempts made to contact patient).

   Number of patients for discussion…….

5. All other patients (current caseload numbers, number of patients in caseload additional to those already discussed in this supervision session, any other problems).

   Number of patients for discussion…….

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Organising Information For Supervision

1. New Patients

- Gender, age, previous episodes, onset
- Main problem statement, risk
- PHQ9 score
- Treatment plan including medication and behavioural activation
- Case Management Action

2. Patients at 4, 8 or 12 weeks

- Review point, gender, age, episode
- Treatment summary
- Initial PHQ 9 score, risk
- Action so far by case manager
- Progress including PHQ 9 scores

3. Patients who are not improving as expected

- Time in study, gender, age, episode
- Treatment summary
- Initial PHQ 9 score, risk
- Action so far by case manager
- Progress including PHQ 9 scores

4. Overdue patients

- Time in study, gender, age, episode
- Treatment summary
- Initial PHQ 9 score, risk
- Action including number of attempts made to contact patient

5. All other patients

- Current caseload numbers
- Number of patients in caseload additional to those already discussed in this supervision session

Plus…… any other problems not covered above.