Chapter 3

Stepped Care for Depression in Primary Care: What Should Be Offered and How?

Abstract

- Stepped care approaches may offer a solution to delivering accessible, effective and efficient services for individuals with depression. In stepped care all patients commence with a low intensity, low cost, treatment. Treatment results are monitored systematically and patients move to a higher intensity only if necessary.

- We deliver a stepped care model to target patients with depression. The first step consists of psycho-education and ‘watchful waiting’ since half of all depressions recover spontaneously within a limited period of time. The second step, guided self-help, is the key element of the stepped care model. Guided self-help especially when offered through the Internet, is effective and cost efficient. As a third step, brief face-to-face psychotherapy is proposed. Finally, longer-term face-to-face psychotherapy and anti-depressant medication might be considered.

- Patients are monitored by one person, a care manager, who is responsible for the decision to step up to a next treatment and for the continuity of care.

- The different treatments within the stepped care model are evidence-based. Data on cost-effectiveness of the full model are still scarce but recently we demonstrated that introducing stepped care could halve the incidence of new cases.

- Effects of guided web-based self-help could be enhanced by incorporating them in a stepped care model.
Introduction

Currently, major depression is one of the most debilitating disorders in western countries due to its high prevalence and burden of disease.[1,2] Although effective treatments and clinical guidelines are available in most Western countries a number of obstacles exist with respect to accessibility, effectiveness, and efficiency in the management of depression. First, a large number of patients are not treated at all. It is estimated that about a third to half of all depressions, both mild and severe cases, are not recognized as such.[3-5] Second, even when depression is recognized, treatment is not always based on evidence. Although precise estimates are lacking, it has been suggested that this is true for as much as 50% of all cases.[6]

The recognition of these and other obstacles in depression management have led to alternative ways of treatment delivery. Most well-known service models are based on the constructs of collaborative care, disease management and stepped care.[7,8] These models usually include a number of different evidence-based interventions, the close involvement of non-medical specialists, the monitoring of outcomes and the use of care managers. In many collaborative care and disease management programs assignment of the available treatment options is based on interdisciplinary discussions of the patient's needs. As a result different patients start with different treatments. In stepped care models, all patients start with the same low intensity intervention. Progress is monitored and only those patients who do not respond adequately, step-up to a subsequent intervention of higher intensity. The assumption of stepped care is that many patients benefit from low intensity treatments and do not need further treatment. In theory, this means that stepped care is the most cost-efficient model of care delivery. It might be a way to meet increasing care demands and to improve allocation of scarce resources. Stepped care models have been described for other disorders such as weight control, eating disorders, generalized anxiety disorder, panic disorder, and alcohol problems.[9-14] Although the first results seems promising, large scale, good quality randomized trials into (cost) effectiveness of full stepped care models are still lacking.[15]

Within a stepped care model all patients start with a low intensity treatment. Therefore, guided self-help fits very well within stepped care. In recent years, self-help has been increasingly offered through the Internet and it has been convincingly demonstrated that it is effective in reducing mental health problems in the general population.[16-19] Evidence about effectiveness in primary care patients is also starting to emerge (see also Hickie et al., this supplement).[20] However, not all patients want to start with (web-based) self-help and neither will every patient benefit from it. Therefore, it is not recommended to offer (web-based) self-help as a stand-alone therapy but to include it within a more comprehensive care model such as the stepped care model.

In the remainder of this paper we will describe the development and evaluation of a stepped care model implemented in the Netherlands. We will illustrate this using knowledge gained from two randomized trials, the first of which was aimed at elderly patients (75 years or older) with subthreshold depression and anxiety disorders, and the second of which, targeted younger adults (18-65 years) with subthreshold and major depression and anxiety disorders.[21-22] Both projects were performed in primary care settings and had stepped care interventions in which guided self-help was one of the main care elements.
**Stepped Care: General Layout**

In establishing a stepped care project one first has to determine which health care professionals need to contribute to the service. In both our research projects we included psychiatric nurses who were used to working within a primary care clinic. Normally they assist the general practitioner (GP) in diagnosing mental health problems and they perform brief psychological interventions.[23] In the context of our stepped care projects, they were appointed as care managers and were responsible for: the monitoring of the patients, to make sure patients were invited for the next intervention, and to carry out part of the interventions. They were trained for two days and we organized weekly supervision sessions.

An important feature of stepped care is the monitoring of the improvements of patients after each intervention. The duration of each of the interventions needs to be long enough to enable change but it should not be too long. In case the intervention does not lead to recovery, the patient needs to proceed to the next step as quickly as possible. We regard 6 to 8 weeks as the minimum time interval (this was used in the project with adults) and 12 weeks as the maximum (this was used in the project with the elderly). Monitoring could be based on clinical assessments but in both our research projects standardized questionnaires were used because they are quick to complete and they provide standardized measures of recovery. Several well validated depression questionnaires are available for this purpose.[24] We used the Inventory of Depressive Symptomatology (IDS) in one project and the Center for Epidemiological studies - Depression scale (CES-D) in the other.[25-28]

**Patients in the Stepped Care Model**

In the trial on the elderly only patients with subthreshold disorders were included. In the stepped care trial with adults all patients were included, from subthreshold to severe depression. We think that psychological disorders, such as depressive disorders, exist on a continuum rather than in separate categories. Treating subthreshold depression is important on its own because it causes a substantial loss of quality of life.[29] Furthermore, treating subthreshold depression might prevent the disorder becoming full-blown.[30] This way of thinking of mental disorders as being on a continuum, and about optimal treatment in different phases of the disease, can also be seen in other disorders.[31]

However, patients with a severe depression were referred directly to the fourth step. The depression was considered to be severe when the patient had a major depressive episode and was unable to function adequately in daily life. Functioning was assessed with the Work and Social Adjustment Scale (WSAS).[32] This is a simple four-items scale measuring impairments regarding work, home management, leisure activities, and relationships with others. Patients who performed poorly on at least three domains were referred to the fourth step. In our trials this assessment of depression severity was performed by the researchers. In regular care, the general practitioner should be the one to assess this.

**First Step: Watchful Waiting**

It is estimated that about 50% of all patients with a depressive episode recover spontaneously within 3 months.[33] Therefore, in most clinical guidelines for depression (e.g., Dutch and
English)\textsuperscript{34,35} watchful waiting is recommend as a first step in depression care. In concordance with these guidelines we included watchful waiting as the first step in both our stepped care projects. This step was of the same duration as the other steps, 6-8 weeks and 12 weeks in our trials with adults and elderly respectively.

**Second Step: Guided Self-Help and Internet Based Interventions**

Self-help therapies are often based on cognitive-behavioral therapy (CBT). In the Netherlands the CBT-based course ‘Coping With Depression’ is converted into a self-help version.\textsuperscript{36} The self-help version is available in book and web-based format which consists of 8 weekly lessons.\textsuperscript{37,38} It aims to improve social skills, to increase pleasant activities, to challenge depressogenic and anxiogenic thinking, and to improve coping with problems. This self-help course was offered in book format in the stepped care trial with elderly people.

In the stepped care trial with adults we used a self-help course based on problem solving therapy (PST) that consisted of 5 weekly lessons. In an earlier trial we demonstrated its effectiveness for people in the general population.\textsuperscript{39} The general idea of PST is that participants learn to regain control over their lives by determining what really matters to them and by learning a systematic approach to solving their problems. The advantage of PST is that it is a generic approach that means that it is suitable for patients with different types of psychological problems and for patients with co-morbidity. In our trial, participants could choose between a book and a web-based format of the course.

When delivering (web-based) self-help interventions, it is recommended to offer some type of support in order to prevent dropout. This support should be aimed at motivating patients and in assisting them to master the self-help techniques. Support can be delivered face-to-face, through telephone, or on-line. It takes about 15 minutes a week to deliver web-based feedback for one participant and is provided by the care manager.

**Third Step: Brief Face-to-Face Therapy**

The care manager working with the GP provided a brief face-to-face therapy as a third step. Problem-solving therapy (PST), the therapy which was also used for one of our self-help interventions, is the most suitable form of face-to-face therapy since it is short (5 to 7 sessions of 30 to 45 minutes each), easy to understand (focuses on daily problems) and can be administered by non-mental health specialists such as nurses. It is specifically developed for use in busy and time-constrained primary care settings.\textsuperscript{40} The literature shows that PST can be an effective treatment for depression although the varying results warrant more research to ascertain the conditions and subjects in which these positive effects are realized.\textsuperscript{41,42} Face-to-face PST was applied in both our stepped care projects as a third step.

**Fourth Step: Longer Term Face-to-Face Therapy and/or Antidepressants**

Patients who do not recover after web-based self-help and brief face-to-face therapy need to step up to the next level of care: antidepressants, longer-term evidence-based face-to-face therapy or a combination of both. In this phase it is important that a more detailed diagnostic interview is performed in order to determine why the former interventions did not work and what is needed. Patients might be referred to the GP (as was done in our stepped care project
with the elderly) or directly to a specialized mental health specialist (as was done in our stepped care project with adults).

**Effects of Our Stepped Care Trials**

The stepped care project on adults is still in progress with the results expected to be available in 2010. The stepped care project for older adults with subthreshold depressions demonstrated large preventive effects: the 12-month incidence of depression and anxiety was 24% in the control group and 12% in the stepped care group (relative risk, 0.49; 95% confidence interval (CI) = 0.24 to 0.98).

**Discussion**

Stepped care models might be a cost-effective way to improve depression management. In this paper we propose a stepped care model which we used in two research projects and which consists of four steps: (1) watchful waiting, (2) guided (web-based) self-help, (3) brief problem solving treatment, and (4) longer-term face-to-face treatment and/or antidepressants. Nurses working as care managers monitored the progress of the patients.

Many general practitioners already implicitly work according to stepped care principles. After all, they try to provide the least burdensome treatment that is most likely to induce significant health gains. However, there are a number of differences between this practice and the stepped care model we propose. First, a mental health worker (such as a nurse) needs to be introduced in primary care. A recent review demonstrates beneficial effects of on-site mental health workers regardless of their background or the way care is organized.[43] Secondly, minimal interventions such as guided self-help and Internet-based interventions need to be introduced. The evidence on effectiveness for depression and anxiety disorders is so compelling that it is recommended in the UK by the National Institute for Clinical Excellence (NICE) for administering within the National Health Service (NHS).[44] Particularly in the treatment of depression and anxiety, many excellent Internet-based interventions have been developed[17,39,45], and there is no doubt that this type of intervention will become an important way of delivering minimal interventions to depressed and anxious patients.

New models of care delivery can only be implemented successfully when providers and patients benefit from it. Results from the IMPACT study, a large trial on collaborative disease management for late-life depression in primary care, has shown that 93% of the physicians were very or somewhat satisfied with the new care delivery model compared to 61% of the physicians in the care as usual group.[46] They identified proactive patient follow-up and patient education as the most helpful components of the new model. In the UK stepped care evidence-based psychological treatments are implemented in routine care through the Improving Access to Psychology Therapies (IAPT) project. Observational studies on large number of patients show considerable effects on depression and anxiety for low-intensity stepped care treatments within a collaborative care system.[47]

One element of debate with respect to stepped care focuses on which patients to include. There seems to be a general perception that minimal interventions should only be offered only to patients with subthreshold depressions or mild major depressions.[40,49] However, research on
patients with more severe symptoms is lacking. One solution is to supplement guided web-based self-help with medication for those severe cases. More research is needed to determine the effects of self-help in more severe cases and to establish optimal cut-offs. Another point of consideration is whether to include patients with co-morbid disorders. Since about 60% of all patients with a major depressive disorder also suffer from an anxiety disorder, and because it is difficult to distinguish the two disorders without an extensive diagnostic interview, we think it is worthwhile to aim the stepped care program and the web-based self-help therapy at both disorders. Our problem-solving web-based self-help course is very useful for this purpose because it is generic.

There are also some potential drawbacks in offering interventions according to stepped care principals. When people do not respond adequately to the self-help intervention they might experience a sense of failure. This might demotivate them to start with another treatment. Moreover, especially in the case when the self-help treatment is based on the same principles as the brief face-to-face treatment (e.g. PST), they might experience it as being 'more of the same'. When they did not respond to self-help they might not respond to this brief face-to-face intervention either. To minimize this risk it is important to acknowledge that the stepped care model should be seen similarly as a treatment guideline. When patients indicate that they are really not motivated for a specific type of treatment, or they feel that it is not helping them, it might be wise to step up more quickly.

Current problems in depression management call for alternative ways of treatment delivery. Stepped care with web-based guided self-help as a first step, might be a useful and cost-efficient new way of doing this. Our first results on stepped care for elderly patients with subthreshold depression are very promising. More results on younger adults and costs will become available in 2010.
References


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