EUR/ICP/QCPH 05 01 03
ENGLISH ONLY
UNEDITED
E60246

WHO

REGIONAL OFFICE FOR EUROPE

WELLBEING MEASURES IN PRIMARY HEALTH CARE/ THE DEPCARE PROJECT

Report on a WHO Meeting

Stockholm, Sweden
12–13 February 1998

SCHERFIGSVEJ 8
DK-2100 COPENHAGEN Ø
DENMARK
TEL: +45 39 17 12 55
TELEFAX: +45 39 17 18 64
TELEX: 12000
E-MAIL: HVR@WHO.DK
WEB SITE: HTTP://WWW.WHO.DK

1998

EUR/HFA targets 12, 31

TARGET 12

REDUCING MENTAL DISORDERS AND SUICIDE

By the year 2000, there should be a sustained and continuing reduction in the prevalence of mental disorders, an improvement in the quality of life of all people with such disorders, and a reversal of the rising trends in suicide and attempted suicide.

TARGET 31

QUALITY OF CARE AND APPROPRIATE TECHNOLOGY

By the year 2000, there should be structures and processes in all Member States to ensure continuous improvement in the quality of health care and appropriate development and use of health technologies.

ABSTRACT

People with depression are often not treated optimally or treated at all. Many depressed people do not seek help and, in most countries, only a few general practitioners are well equipped to diagnose and measure outcome for people who seek treatment. The WHO Regional Office for Europe held a meeting on quality assurance for mental health in 1993, as part of a broader project supported by the European Forum of Medical Associations; it looked at indicators for acute depression care. The Regional Office held a meeting on patient outcome measures in mental health in 1995 to review the results of studies made since the first meeting and to recommend further application and dissemination of indicators for long-term, acute and community care. The objective of the Meeting on the Use of Wellbeing Measures in Primary Health Care – the DepCare Project was to discuss guidelines for carrying out a range of studies in several European countries, and the use of screening tools to identification and manage depression and psychological problems and stress-related disorders, with a focus on quality of care. The participants decided to set up a common database hosted by the Regional Office.

Keywords

MENTAL HEALTH
DEPRESSIVE DISEASE – prevention and control
QUALITY OF LIFE
QUALITY OF HEALTH CARE
PRIMARY HEALTH CARE
EUROPE

This document was text processed in Health Documentation Services
WHO Regional Office for Europe, Copenhagen

CONTENTS

Page

IMPLEMENTATION OF DEPCARE

DISSEMINATION

DepCare will participate in the European Association of Psychiatrists (EAP) meeting in Copenhagen during September 1998, presenting an abstract and poster.
Responsible: Professor Per Bech

An article based on the three Consensus Meetings will be prepared.
Responsible: Professor I. Philp

A home page on the WorldWideWeb for DepCare will be developed on the Internet.
Responsible: Mr John Donoghue

A draft of the InfoKit (see Plan 5) will be prepared as part of a marketing package.
Responsible: Mr John Donoghue

Establish a link to the pharmacists in order to include DepCare in their next meeting.
Responsible: Mr John Donoghue

IMPLEMENTATION AT COUNTRY LEVEL

The CARMEN project (mental health in central Asian republics) will support centres where needs are identified in this region.

Albania, Georgia and Slovenia will collect data on pre- and post-partum depression based on the WHO (five) Well-Being Index, and make relevant interventions, in collaboration with obstetricians.

A study of the cases with a wellbeing score <6, either previously[1] or identified during current studies, will be reviewed. Violence against women during pregnancy will be part of this study.
Responsible: Professor Bülent Coskun (CARMEN), Dr Vuksan Kola (Albania), Dr George Naneishvilli (Georgia), Dr Vislava Veliknoja (Slovenia)

Testing of PROGRESSOR, DepRelief and other instruments.
Responsible: Professor Jørn Halberg Beckman (PROGRESSOR) Professor Ian Philp (DepRelief)

1. Set up common database hosted at WHO/EURO.
Responsible: Professor Per Bech, Dr Kirsten Staehr Johansen

[1] Through pilots I and II of the OBSQID project on obstetrical care.

CONCLUSIONS OF THE 3RD CONSENSUS MEETING

Recognition and measuring depression in PHC and prevention of suicide

The WHO (five) Well-Being Index and EASY-Care should be linked to other existing WHO programmes and eventually to either electronic or paper-based patient records.

Compliance in continuation of therapy in depression

One way of identifying and following up patients to ensure that they do not fall out of the system would be through the use of pharmacists' computer systems. (This may not be legal in some countries.) Positive reinforcement of compliance is important throughout the treatment phase, where family members could be engaged as allies. A checklist could be developed so that the GP can know when and why patients drop out of treatment; once the cause of non-compliance is identified, the GP should work with the patient to resume and complete treatment.

Recognition and measurement of depression in PHC and prevention of suicide

A programme for postgraduate courses for GPs should be structured, after reviewing existing options in order to select the best solution.

Stress or stress-related disorders

A psychological profile questionnaire, focusing on stress-related problems (PROGRESSOR) was thought to be of interest in further validation and applicability studies.

Compliance in continuation of therapy in depression

An information pack for GPs *(Infopack)* should be developed to assist GPs in achieving patient compliance with drug therapy treatment.

Main points relating to non-compliance:

- dose and length of treatment
- non-compliance is standard
- always ask about concordance – offer support
- importance of giving the patient consistent information
- use of the five-point scale.

1 Introduction

Within the frame of clinical psychiatry, it is well known that a major proportion of patients with depression are most often not treated optimally or not treated at all, despite the existence of a large amount of clinical literature for optimal medical treatment on handling depression and reducing the suicide rate. The problem is partly that a significant number of patients who suffer from depression do not consult a doctor. Also, few general practitioners (GPs) are well equipped to diagnose and measure outcome of treatment of this large heterogeneous group of patients.

Non-compliance by patients is a further problem,both at the beginning of treatment, when many patients suffer from side effects, and at a later stage when symptoms start to disappear and the patients no longer feel ill. At both points, a significant number of patients drop out of treatment. If treatment is interrupted during the latter phase, patients often have a relapse within a short time, resulting in loss of the ability to work, reduced quality of life and leading, in some cases, to suicide.

An effective tool to diagnose and monitor the course of depression can increase patients' compliance with prescribed treatment, if used systematically by the GP. To reduce relapse of depression symptoms and the rate of suicide (target 12 of the health for all policy),[i] the DepCare Project is based on the WHO (five) Well-Being Index,[2] [ii] (Annex 1), together with the Major (ICD10) Depression Inventory (Annex 2), WHO/ICD 10 Depressive Episode (Annex 3), WHO/ICD 10 Depression Diagnosis and DSM-IV Depression (Annex 4) and its Rating Scale (Annex 5). The WHO/EURO (five) Well-Being Index is available in 20 languages.

1.1 The 1st consensus meeting[iii]

A meeting on quality assurance for mental health (1st consensus meeting) was held in August 1993 in Stockholm, Sweden, hosted by the Swedish Medical Association, as part of a broader project supported by the European Forum of Medical Associations (EFMA).[iv] Twenty-three experts were present from 11 countries. The meeting included working groups with the task of identifying quality indicators at various levels.

One group looked at indicators for acute depression care, including:

- *diagnostic precision*, e.g. variables such as proportion of cases assessed by severity of the condition;
- *symptom reduction*, e.g. through the use of an appropriate scale;
- *adverse drug reaction*, e.g. proportion of newly diagnosed patients who have interrupted treatment; and
- *premature discontinuation of treatment*, e.g. by proportion of early drop-outs.

A second group identified the following five major indicators for suicide prevention:

- the availability of a local programme for the care of suicidal patients;
- the proportion of people who attempt suicide that are examined by a specialist in psychiatry (emergency units);

---

[2] Incorporated in the Elderly Assessment Sytems (EASY-Care) for older people.

- the proportion of patients seen at a clinic or contacted by telephone within a week of a suicide attempt;
- the frequency of psychiatric autopsy of suicide victims; and
- the availability of epidemiological data at the regional or national level.

The participants recommended that the proposed indicators and instruments be tested in a selected number of areas in various Member States of the WHO European Region and that a further meeting should be held on the same theme one year after the start of the testing period.

1.2 The 2nd consensus meeting[v]

The meeting on patient outcome measures in mental health (2nd consensus meeting), also held in Stockholm, Sweden in November 1995, was called to review the results of studies undertaken since the 1st consensus meeting and to make recommendations regarding the further application and dissemination of the quality indicators. This meeting was divided into separate parts.

1.2.1 Patient outcome for long-term care

The participants discussed the importance of determining which domains were relevant for the particular individual concerned as regards wellbeing and satisfaction. The instruments they recommended included the WHO (28) Well-Being Index as a generic tool and the Diabetes Treatment Satisfaction Questionnaire as a disease-specific tool for diabetes mellitus. For use in schizophrenia, they recommended the QLI (Quality of Life Interview), for clinical trials the SF-36 (Medical Outcomes Study, Short-Form 36), and for subjective measurement of quality of life the Lancashire Quality of Life Profile. The Quality of Life self-report and the QLS (Quality of Life Scale, developed by Heinrichs and Carpenter) were deemed to be useful disease-specific instruments. Although different from quality of life, the Family Burden Questionnaire was recommended as a relevant outcome indicator set.

1.2.2 Patient outcome of acute care

The meeting made the following recommendations:

- Both a global/single item instrument (ACSA-Anamnestic Comparative Self-Assessment) and a multidimensional instrument (WHO/EURO 28-item Well-Being Index or subscales thereof) were useful and were recommended, particularly with a view to comparing scores over time and between groups. Alongside these, a disease-specific questionnaire or a satisfaction questionnaire could also be used.
- The weights of the different items and dimensations in multidimensional instruments should be determined, in order to obtain an empirical basis for identification and prioritization of QOL (quality of life) in which interventions are likely to be most effective. Weights could be calculated from data using a simultaneously applied global and multidimensional instrument.

1.2.3 Patient outcomes in community care

The SF-36[vi vii] instrument is a compromise as a generic measurement at the community level, and possible applications include: health screening in the community; comparison of different diagnoses of patient burden, clinical trials and patient monitoring in clinical trials. When interest is focused on specific diagnoses and/or symptoms, the SF-36 should be complemented with a diagnosis-specific instrument or symptom checklist. The advantage of SF-36 as an international

screening tool is, on the one hand, that translation procedures for European languages are strict[6] and, on the other, that each sub-scale is transferred to a 0 to 100 percentage measure in which 0% = worst possible and 100% = best possible. However, the WHO translation procedures[viii] are the ideal approach.

For older people, the Elderly Assessment System (EASY-Care) was under development for multidimensional assessment of health status and wellbeing.

1.2.4 Conclusions and recommendations

- The instruments recommended should continue to be applied through a range of studies in several European countries.
- Many of the instruments require further investigation and refinement, including translation procedures.
- In any study, both a generic and a disease-specific instrument should be included.
- A common database of studies should be set up, although it would be necessary to consider matters such as the confidentiality of patient data, copyright of questionnaires, and the checking, validation and interpretation of data.
- A further meeting should be held to take forward this project.

1.3 The 3rd consensus meeting

The Meeting on use of Wellbeing Measures in Primary Health Care/The DepCare Project (the 3rd consensus meeting) was held in Stockholm in February 1998, and brought together 24 experts from 12 countries. The objective was to set guidelines for carrying out a range of studies in several European countries, using screening tools for identification of depression cases. On this basis, the tools can be further investigated and refined. Generic and disease-specific tools should be matched and studies on their suitability carried out. Also, in order to set up a common database, items such as confidentiality of patient data, copyright of screening tools, validation and interpretation of data need to be established.

The DepCare Project was introduced: its aim is to ensure that GPs use a questionnaire such as the WHO (five) Well-Being Index[ix] to screen all patients showing signs of depression. The symptoms should be rated by using the WHO/ICD 10 Major Depression Inventory.[x]

It should be emphasized that there are two versions of the WHO (five) Well-Being Index. The original version is that from the 2nd Consensus Meeting (1995), in which the first item is negatively worded: *"I feel downhearted and sad"* (Annex 1A). The second version is that presented at the 3rd Consensus Meeting (1998), in which the first item is positively worded (Annex 1B). Furthermore, the WHO (five) Well-Being Index (1995) has four answer categories (from 0 to 3), while the WHO (five) Well-Being Index (1998) has six answer categories (from 0 to 5). In both versions, higher scores mean better wellbeing.

The WHO (five) Well-Being questionnaire (1998) has been based on the results of Professor Guelfi's European study, comparing the WHO 22-item version with the 22-item Psychological General Well-Being Index (see 2.4.2 below), which supported categories from 0 to 5.

Until now the WHO (five) Well-Being questionnaire (1995) has mostly been used for the identification of depression cases. A score of 5 or less means risk of depression, which should be further examined.

The WHO (five) version (1998) can easily be used both as case identifier and as outcome measure parallel to SF-36 (i.e. the scores are converted to 0% to 100%, where 0% means lowest possible wellbeing and 100% means highest possible wellbeing). Thus, the score variation from 0 to 25 is the theoretical score range of the WHO (five) version (1998). Multiplication with factor 4 gives the 0% to 100% score analogue to SF-36.

1.4 The DepCare Project

The aim of the DepCare project is to promote and enable GPs to screen and diagnose patients for signs of depression. The goal is to diagnose at least 85% of patients in need of treatment and 80% of depressed patients, following the Kupfer (91) symptom curve[xi] (Annex 6) as a sign for monitoring adequate treatment. Depression would be screened, diagnosed and rated by using the WHO (five) Well-Being Index together with the Major Depression Inventory. Screening of older people would be undertaken using EASY-Care to obtain a broader picture of the health status and wellbeing of the person.

In the pilot phase, it is envisaged that 100 centres (10 GPs in 10 ten countries) will participate. Data will be case-based and aggregated to the national level.

2 Opening, introduction and approval of agenda

(Chairperson: Mr U. Scholdström)

Mr U. Scholdström welcomed participants on behalf of the Swedish Medical Association. The meeting then elected Professor Per Bech as Chairperson and Dr Dan Rost Rapporteur.

Professor Per Bech took the chair and in his turn welcomed participants. He said that at this third meeting of the group activities would focus on more practical aspects, moving closer to the patient and to the naturalistic setting in which the patient is normally treated. He introduced Dr Kirsten Staehr Johansen of the WHO Regional Office (WHO/EURO) Quality of Care of Technologies programme, who had been instrumental in "pushing" participants of this group towards identifying viable solutions in the area of mental health.

Dr Staehr Johansen said that the policy for continuous quality of care development (QCD), a joint activity of the European Federation of Medical Associations (EFMA) and WHO/EURO, issued recommendations[xii] based on the moral and ethical components of the professions, considered as the "bible" for quality of care. Initially, many physicians had had difficulties in accepting the QCD concept that degrees or levels of quality exist or that one provider may be better than another, and that identification and dissemination of best practice should be a tool for promoting QCD.

A founding principle of the World Health Organization had been the realization that different outcomes of health care treatment were not necessarily based on genetic, social or economic factors[xiii] but should be optimal for the entire world population, i.e. the moral and ethical right of every human being. Cost–effectiveness was, however, increasingly being sought by health care authorities and needed to be considered as an essential component of health care services.

Dr Staehr Johansen invited participants to introduce themselves and state their specific fields of interest within the area of mental health. It became apparent that there was a good mix of professions represented, covering administrators, primary and secondary health care providers.

3 The use of wellbeing measures in primary health care /The DepCare Project

(DR KIRSTEN STAEHR JOHANSEN)

In 1980, WHO's Member States agreed on a common health policy: health for all by the year 2000 (HFA2000). In 1984, a total of 38 targets[i] were endorsed based on this policy, of which one – target 12: *reducing mental disorders and suicide* – is directly linked to the present activities. The text of this target reads:

> *By the year 2000, there should be sustained and continuing reduction in the prevalence of mental disorders, an improvement in the quality of life of all people with such disorders, and a reversal of the rising trends in suicide and attempted suicide.*

Among the recommendations for achieving this target are:

- improved access to measures that support people and equip them to cope with distressing or distressful events and conditions;
- development of comprehensive community-based mental health services with a greater involvement of primary health care (PHC); and
- development and implementation of programmes for suicide prevention.

It is obvious that PHC is central to a successful programme for the improvement of mental health, because it is the GP who, as a rule, will be the first health care provider a person with depression and/or mental disorders will meet. Therefore, it is essential that the GP should be able to recognize and diagnose these conditions.

The conscious recognition by health professionals of the *"moral and ethical"* obligations of their profession is evidenced by EFMA through their advocacy of a QCD policy, which recommends that *"…national medical associations should take a leading role in quality of care development with the overall aim of benefiting patient care. […] QCD is therefore both an* ***ethical, educational and a professional responsibility*** *that is inherent to the independence of the profession."*

Health care management, in the concept of WHO/EURO, is the merger of QCD with the tools necessary for its implementation which would allow monitoring and assessment of quality and outcome (health status and cost) of health care services. This approach is known as QualiCare and is now being adapted to various diseases and conditions (diabetes mellitus – DiabCare, oral health care – OralCare, perinatal and obstetrical care – ObsCare/OBSQID).

QCD is in many ways based on achieving changes in the behaviour of health care authorities, industry, financers, health care providers and patients. QCD works primarily by appealing to the health care provider's professional ethics or pride in a way that has personal meaning. If the provider knows how his/her patients fare when compared to those of colleagues, experience has shown that he/she will be motivated, by concern for the patients' wellbeing and his or her professional satisfaction, to change his/her behaviour so as to improve the outcome of the care he/she provides.[xiv xv xvi xvii xviii xix]

In accordance with the WHO/EFMA QCD strategy and policy, the initial steps in any QCD programme are: i) to define the problem; and ii) to develop relevant quality indicators (variables whose values indicate the level of the quality of health care and/or health services). Ideally, indicators are related to the final (true) outcome of care, but in some cases intermediate indicators of outcome need to be employed. Differing from other methods of evaluating care, the use of true outcome indicators, intermediate outcome indicators and validated structure and process indicators in the form of quality core data sets focus on the patient as the key to the successful outcome of care. An important driving force which has shown to be very useful for QCD is measuring the resources used which often increase because of poor quality of care and can result in health complications.

It is important that the professional bodies are involved throughout the development of quality indicators, so that there is consensus on the final selection. Without their involvement, quality indicators will have little credibility or acceptability. It is easy to see why: if health care providers are to be motivated by their professional pride and satisfaction to improve their quality of care, quality indicators will provide the basis for data collection and comparison between outcomes of care. Providers must therefore view the indicators as being relevant, valid and reliable.

The quality indicators developed for mental health have been tested and validated since the 1st consensus meeting in 1993 over two years of trials until the 2nd consensus meeting in 1995. Structures and plans for implementation of QCD in mental health were developed at the 3rd consensus meeting and are included in this document. A successful QCD programme involves the following steps:

- problem identification and development of indicators
- situation analysis
- comparison of results leading to setting of realistic targets
- identification of best practice and intervention activities
- monitoring and evaluation
- sustainability.

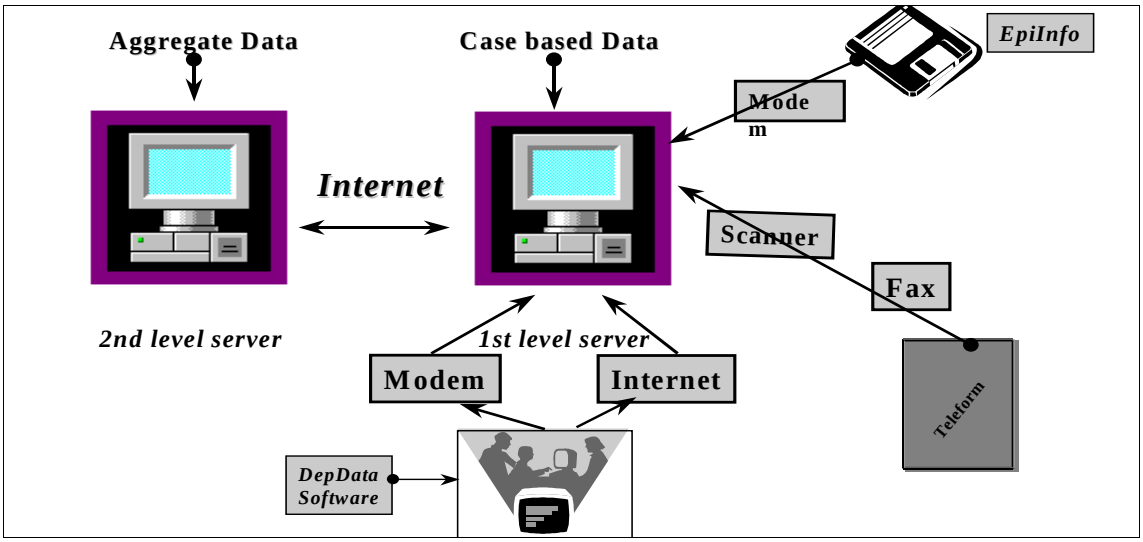
The areas of oral health and diabetes mellitus are the most advanced in the implementation of QCD. Based on the concept of QCD, and to enable the evaluation and monitoring of the results of health care, a number of indicators were developed: in the case of oral health, WHO and the Fédération Dentaire Internationale (WHO/FDI) agreed in 1969 on a basic outcome indicator (the number of decayed, missing or filled teeth – DMFT index). In 1981, WHO/FDI set up oral health national goals for the year 2000[xx] covering the groups aged 5–6 years, 12 years, 35–44 years and 65 years and over. Thirty-five European Member States have set up national programmes in oral health, and a number have reported achieving the target of ≤ 3 DMFT at age 12[xxi] (Albania, Belgium, Bulgaria, the Czech Republic, Denmark, Finland, France, Iceland, Ireland, Italy, the Netherlands, Norway, Slovenia, Spain, Sweden, Switzerland, Turkey and the United Kingdom).

Similarly, in 1989 WHO/EURO and the International Diabetes Federation (WHO/IDF) agreed on goals for the management of diabetes care[xxii] (reduction of new blindness, renal failure, and limb amputations; cut morbidity and mortality from coronary heart disease; and achieve pregnancy outcomes which approximate those of non-diabetic women). As a consequence, a total of 36 European Member States had national programmes for diabetes mellitus in 1997. One or more of the St Vincent goals[xxiii] have been achieved at the local, regional or national levels in Belarus, the Czech Republic, Denmark, Finland, France, Germany, Hungary, Iceland, Israel, Italy, Lithuania, the Netherlands, Norway, Poland, the Russian Federation, Spain, Sweden, Switzerland and the United Kingdom.

Monitoring a QCD programme such as DepCare requires the use of the WHO (five) Well-Being Index to screen people with suspected depression, linked to core data sets for other diseases and conditions. Quality indicators from a variety of such sources should be included in as many health care and/or electronic patient record packages as possible, so that data can become comparable across communities, regions and between countries.

On the other hand, for data collection to become possible, it is not necessary to develop a new information tool. A generic software tool developed by WHO/CDC known as Epi-Info can be adapted to the needs of the user. WHO/EURO has incorporated some of the wellbeing quality indicators into versions of this software for management of diabetes mellitus, perinatal and obstetric care and orthodontics. The resulting data files can be sent over the Internet for incorporation into the relevant databases hosted on the QualiCare server at WHO/EURO. Where information technology is non-existent or its use not feasible, core data sets can be printed, completed by hand and either faxed or scanned into the databases. (Fig. 1.)

Fig. 1. DepCare – Quality development in depression through the use of information technology



It could be argued that the most important factor for sustaining and developing a QCD programme is the involvement, commitment and enthusiasm of providers, patients, health authorities, financers, industry and other related sectors. Knowledge about own and peer results becomes indispensable in furthering personal and professional goals at the provider level and overall improvement of health at the patient level, lowering costs of treatment (possibly including insurance premiums) which reflect financer costs, and, at the public health level, decreasing the overall burden of health care.

Preliminary trials have shown that the wellbeing quality indicators are transnational, i.e. they are relevant in various countries and different cultures. It is now time to test them with different age groups, and ascertain how the measurement of wellbeing can be included as routine within general practice as a component of GPs' daily activities.

Finally, Dr Staehr Johansen spoke of the importance of networking, an essential part of this type of QCD activities. It is crucial that there is a close link between network participants at meetings

or via telephone, e-mail and correspondence, in order to exchange experience and disseminate successes.

4 Naturalistic studies in depression in PHC

(DR J. DONOGHUE, DEPARTMENT OF COMMUNITY PSYCHIATRY, WIRRAL HOSPITAL, UNITED KINGDOM)

Guidance on the effective treatment of depression has been issued at both international and national levels.[xxiv xxv] Two important recommendations have been made regarding the use of antidepressants in the primary care setting: antidepressants should be used at doses which have been shown to be effective for the treatment of depression, and treatment should continue for 4–6 months after a response has been obtained.

Recent large database studies have found that antidepressants are seldom used effectively in the primary care setting.[xxvi xxvii xxviii xxix] In Denmark, Rosholm and colleagues found that in a population of over 200 000 patients, average doses of tricyclic antidepressants **never** achieved levels of 100 mg daily.[20] In two studies in the United Kingdom in a population of over 750 000 patients, Donoghue and Tylee found that only **one in eight** tricyclic treated patients received a dose of 125 mg daily or more. In contrast, over 99% of prescriptions for SSRI antidepressants were at adequate treatment doses.[28 29] A further study in Scotland by McDonald et al in a population of about 400 000 patients found that **72% of prescriptions** for tricyclic antidepressants were considered to be **sub-therapeutic**. Moreover, they also found that **only 32%** of patients received more than 90 days treatment with antidepressants.[30]

An as yet unpublished study by Donoghue of SSRI on prescribing in primary care found that, although these medicines were prescribed in adequate doses, length of treatment was often short and that, with fluoxetine, paroxetine, and sertraline, **only 31.1%, 29.9% and 23.9%** of patients respectively completed three months' treatment and entered a fourth month of treatment.

The conclusion is that treatment with antidepressants is often sub-optimal in primary care, and does not reach the standards of care recommended by national and international guidelines.

5 Practical use of the WHO (five) Well-Being Index

5.1 In relation to pregnancy (Ms Dawn Fowler, Consultant, WHO/EURO)

The purpose of Ms Fowler's presentation was to show how assessment of outcomes of clinical symptoms, medical processes that include psychological and physical wellbeing is possible, using experience gained in the OBSQID[xxx] Project. The objective of OBSQID was to identify quality indicators to measure and compare outcomes of obstetrical and perinatal care to identify and disseminate best clinical practices. Quality indicators are tools for monitoring and evaluating the outcome of care and its process, and providing information on the degrees and levels of quality by focusing on QCD.

The quality indicators for collection of aggregated data for obstetrical care were agreed at the European Consensus Conference on Quality Indicators for Perinatal Care (Tübingen, Germany, October 1993). A total of 21 indicators were identified as essential and feasible for monitoring, comparing and evaluating perinatal care and the appropriate use of technology. At the 1st Workshop on QCD for Perinatal care (Hillerød, Denmark, September 1994), a critical review resulted in a final number of 23 essential indicators.

The 2nd Workshop on Quality Development in Perinatal Care (Trieste, Italy, October 1995) developed various tools, including a core data set for collection of case-based data, as well as a one-page data collection form with indicator definitions. This form can be completed by hand, faxed to a regional/national node and then scanned into the database. It was also decided to conduct a first pilot using this form.

Pilot 1 (September 1996) involved 11 clinics in 8 Member States. Data were collected on over 1200 births, including the WHO/EURO (five) Well-Being Index (Annex 1A) scores, and sent to WHO/EURO for analysis, evaluation and feedback. The results demonstrated how the core data set could be used to establish baseline data and analysis of trends. The benefits of this system were the setting of common standards and definitions for systematic data collection, analysis, evaluation and feedback, and comparisons of outcomes between local, regional and national data, thus identifying areas for interventions.

The 3rd Workshop on QCD in Perinatal Care (October 1996, Trieste, Italy) discussed experience gained from Pilot I. As a result, modifications to the indicators and alterations to the data collection form were agreed. It was also decided that the Epi-Info generic software tool would be adapted to OBSQID for data entry, and to carry out a second Pilot to test the changes proposed by Pilot I.

The 4th Workshop on QCD in Perinatal Care (Poznan, Poland, October 1997) analysed the results from Pilot II carried out during spring/summer 1997 at 27 clinics in 17 EURO Member States covering a total of over 5278 births.

In the central Asian republics and Kazakhstan (CARAK), a special version of the OBSQID core data set (including the WHO (five) Well-Being Index) was designed to measure results and outcomes in these specific settings. CARAK Pilot 1 was carried out in January–February 1997 in 13 clinics in 6 countries, resulting in data on 1249 births.

Analyses of data results are used in the following manner: in public presentations they are reported anonymously; in the database itself, each centre is assigned a unique bar code identifier for self recognition and WHO/EURO works directly with each centre to report back its own results. In particular, when carrying out analysis WHO/EURO looks for outliers, especially centres or countries with high scores so that such centres of best clinical practice can be twinned with centres having poorer outcomes.

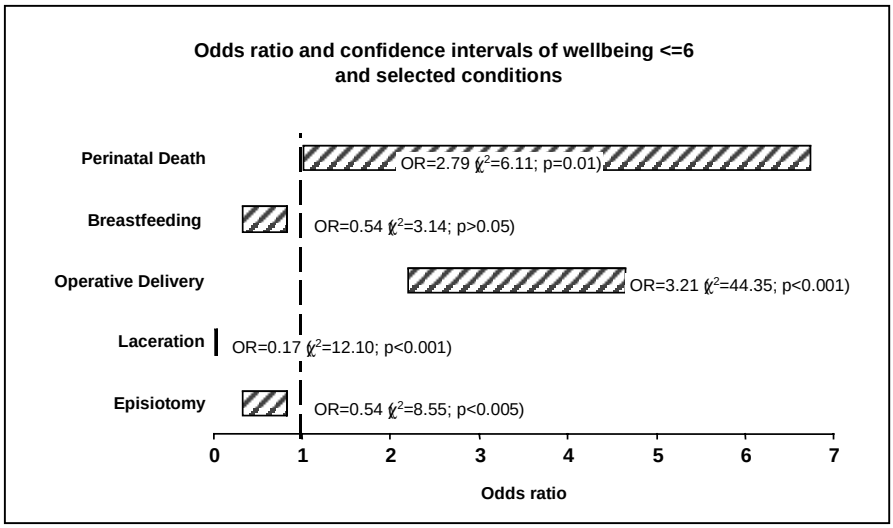
Centralization of data collection, data analysis and dissemination of results ensure consistency in the data, timely feedback, opportunities to link centres to ensure constant QCD activities and appropriate use of technologies. However, it is vital that providers have ready access to their own results for carrying out timely interventions.

The database can also be used as an “appetiser” for intervention programmes, for focusing on actual use of resources, and for identifying other areas requiring further investigation. In this way, centres not originally involved become interested in participating, resulting in a snowball effect.

For the OBSQID pilots, the WHO (five) Well-Being Index was administered at three different times during the pregnancy: 4–6 weeks before expected delivery; within 48 hours of delivery; and 4–6 weeks after delivery.

5.1.1 Results of the WHO (five) Well-Being Index from OBSQID Pilots 1 and 2

Fig. 2 Average wellbeing



The average wellbeing score of women from 13 participating centres was 9.6±1.8 six weeks before delivery, 9.9±2.0 at delivery and 10.1±1.0 six weeks after delivery. The overall percentage of low wellbeing scores (<=6) was 7.3% and 2.1%, respectively. Although there is confounding by centres, having in mind the percentage of pregnant women in the overall population, the low wellbeing score may pose a significant problem. There is clearly need for further investigation.

The analysis of data also indicates increased occurrence of low wellbeing scores (<=6) at birth in relation to adverse outcome of pregnancy and operative delivery. Women who undergo an operative delivery are three times more likely to have a low wellbeing score at time of birth. Women experiencing an adverse outcome of term delivery (stillbirth, fetal intrapartum death, early neonatal death) are three times more likely to have a low wellbeing score, with a confidence interval for odds ratio lying between 1.1 and 6.8 times. Although no increased odds ratio for episiotomy and a low wellbeing score was established during the pilot study, the low wellbeing score in the episiotomy versus no episiotomy groups was 4.5% and 1.6%, respectively. Having in mind the frequency of this intervention, the wellbeing assessment, appropriate clinical management and prenatal support for pregnant women can be said to be of paramount importance.

5.2 In relation to psychiatric patients (Professor P. Bech for Dr J. Guelfi)

After the 1st consensus meeting, Professor Guelfi organized a study in psychiatric patients comparing the WHO (22) Well-Being Index with the Psychological General Well-Being Scale (PGWB). In total, 437 patients were included: from Paris (Professor Guelfi) 143 patients; from Düsseldorf (Professor Gaebel) 55 patients; from London (Professor Tyrer) 105 patients, and from Lisbon (Professor Paes de Sousa) 134 patients. The results showed that the WHO (five) Well-Being Index and the corresponding five-item PGWB correlated significantly with each other as well as with the total scales.

The two items in the PGWB in which mood or spirit is measured in both a positive and a negative way correlated around 0.8. On the basis of Professor Guelfi's findings, it has been suggested that the WHO (five) Well-Being Index should be revised to ask only in a positive way (measuring positive wellbeing), and with answer categories from 0 to 5 (instead of 0 to 3). That means that the second version of the WHO (five) Well-Being Index has a raw score range from 0 (worst possible wellbeing) to 25 (best possible wellbeing). Multiplication by 4 gives the SF-36 percentage scale from 0% (worst possible) to 100% (best possible).

A Danish population study has shown that normal individuals (without major depression) have a mean score of 75 (0–100 scale). People with current major depression have a mean score of 37.5. Therefore, the cut-off score on the WHO (five) Well-Being Index (1998) with theoretical a (percentage) score range of 0–100 is 50.

The WHO (five) Well-Being Index (1995) has a theoretical raw score range from 0 to 15. The cut-off score here is ≤5.

The WHO (five) Well-Being Index (1998) is measured in six categories (Annex 1B). When scored on the four categories of the WHO Well-Being Index (1995) (Annex 1A), the categories of "all the time" and "most of the time" are combined, as are the categories of "some of the time" and "none of the time". Thus, it is always possible to convert the 1998 version to the 1995 version.

5.3 In relation to the elderly (Dr R. Heun)

The validity of the WHO (five) Well-Being Index (1995) was evaluated in a sample from the elderly population.

A sample of 254 elderly subjects completed the WHO (22) Well-Being Index which includes the five-item version. All the subjects were interviewed with the Composite International Diagnostic Interview and various neuropsychological tests for current and lifetime psychiatric disorders.[3]

The internal validity or consistency of the self-rating scale showed that the short version of the WHO (five) Well-Being Index was as valid as the full 22-item Index. The external validity showed that the sub-scales were as valid as the full indexes as to predicting subjects with acute psychiatric disorders. Living conditions were at least equally important in comparison with psychiatric disorders for explaining the variance of the Well-Being Index scores.

The WHO (five) Well-Being Index has adequate internal and external validity in a study of elderly persons from the general population. Decreased wellbeing seems to reflect poor living conditions or the presence of a psychiatric disorder. Threshold scores have to be adapted for different purposes.

6 Recognition of depression in the elderly
(PROFESSOR I. PHILP)

The need to improve the awareness, recognition and management of depression in old age will require the adoption of standardized methods of assessment for use in routine practice in primary health care, and the development of educational programmes for training primary health care physicians. Professor Philp described two projects which address these needs.

---

[3] Huen, R. et al. Internal and external validity of the WHO well-being scales in the elderly general population. *Acta psychiatrica Scandinavica*, (1998) (in press).

6.1 Standardized assessment of older people in primary health care in Europe

A major European Commission project, SCOPE (1966–1969) has established the value of EASY-Care, a standardized quality of life assessment instrument for multiprofessional use with older people in primary care settings. The specification of EASY-Care was agreed at a European Consensus meeting, co-sponsored by WHO/EURO in November 1993. Its broad coverage includes the assessment of depression and wellbeing that maps to the WHO (five) Well-Being Index.

Trials have confirmed the acceptability, usefulness, reliability and validity of EASY-Care for first-stage assessment of older people in primary care settings, usually administered by a nurse, social worker, therapist or care assistant.

EASY-Care should become widely used in the primary health care of older people in Europe. Secondary data analysis will allow measurement, comparison; benchmarking and target setting for key indicators of quality of life of older people in Europe, using the WHO QualiCare server. To avoid duplication with use of the WHO (five) Well-Being Index, and to ensure that the assessment of wellbeing and depression is embedded within the assessment of the functioning and quality of life of the older person, EASY-Care[4] (incorporating the WHO (five) Well-Being Index) should be the instrument of first choice for first stage assessment of wellbeing and depression in people aged 65 and over.

Deprelief[5] is a CD-ROM-based programme for educating primary health care physicians in the awareness, recognition and management of depression in older people. *Deprelief* is intended for use in small groups with facilitation from a moderator, who will usually be a specialist in the psychiatry of old age. With over 1000 assets to choose from, the moderator can adapt the programme to the needs of the group. All statements are supported by up-to-date references and have been reviewed by leaders in the psychiatry of old age in Europe.

Advanced educational principles are used to promote active learning, leading to changes in participants' knowledge and skills. Participants will construct a care pathway for best practice in the identification and management of depression in their patients, based on the circumstances and resources available to them and the knowledge and skills developed through participation in the *Deprelief* programme. The success of the programme will be evaluated according to whether participants are able to implement change in their practice.[6]

7 Quality development in depression care and prevention of suicide, with special emphasis on pregnancy

(JAN ØYSTEIN BERLE MD, INSTITUTE OF PSYCHIATRY, UNIVERSITY OF BERGEN, NORWAY)

Well intentioned efforts to prevent suicide have been seen through the last decades. A fact that has often been overlooked is that an affective disorder is the single most important risk factor for actual completed suicide.[xxxi] The prevalence of depression is greater than previously thought: a

[4] EASY-Care was developed by Professor Ian Philp on behalf of WHO/EURO. Further information can be obtained from Professor Philp (for contact information, see participants' list).
[5] Developed by the Lundbeck International Neuroscience Foundation.
[6] Further information on Deprelief : Dr Veronique Narboni, Manager, the Lundbeck International Neuroscience Foundation, Dalbergstroget 5, 2630 Taastrup, Denmark.Tel: +45 4371 4373, Fax: +45 4371 4273, e-mail: vna@lundbeck.dk.

12-month prevalence of major depressive episode is reported at 10.3% (men 7.7% and women 12.9%).[xxxii] Clinical tools and instruments for better and earlier detection of depression in general practice will be an important factor in preventing suicide. Clinical guidelines and better clinical practice in treating depression are other factors.

Most studies indicate that depression is more frequent in women than in men, but far more men than women commit suicide. We should be aware of this paradoxical fact, and look for possible sex-specific affective syndromes and different patterns of help-seeking activity between men and women.[xxxiii] Women are increasingly vulnerable to depression and other psychopathologies during their childbearing years. The risk of a psychotic episode in the post-partum period is therefore increased. This illness is often related to bipolar disorder.[xxxiv]

Few studies have been conducted on depression during pregnancy. The recognition of pregnancy as a period of emotional wellbeing might be a myth.[xxxiv] Antenatal maternal stress or anxiety might influence the unborn child in various ways, but we know relatively little about the long-term effects on the developing foetus and more research is needed.[xxxv] A programme to improve women's mental health and reduce maternal stress or anxiety during pregnancy might be relatively easy to implement.

Within the first year after birth post-partum depression is seen with a prevalence of 10–20%.[xxxvi] For 60% of women, post-partum depression represents their first episode of depression.[xxxvii] This is an illness with a good prognosis when recognized and treated. Illness in this period will often have greater consequences to the woman and to her family. Long-lasting depression might have negative effects on the mother–baby interaction and might disturb mother–infant attachment and could lead to cognitive and emotional disturbances in children.[xxxviii] Untreated illness gives a risk of chronicity and an increased suicidal risk.

A simple self-rated measure developed in England, the Edinburgh Postnatal Depression Scale (EPDS), was introduced in 1987 by Jon Cox and colleagues. EPDS correlates wellbeing with physician-rated scales and a depressive disorder diagnosis. EPDS is easy to use as a screening instrument, and has in later years been translated into a number of languages. The test is commonly used in several countries and is a valuable screening instrument for depression. A slightly modified version has been tried out successfully during pregnancy.

8 Recognition of depression in general practice and prevention of suicide

(DR D. ROST, GP, DENMARK)

Dr Rost is a Danish GP with his own practice, which means that he alone knows what is best for his patients and what kind of treatment each one needs. Dr Rost admitted that he has no in-depth knowledge of psychiatry because GPs do not receive much training. It is, however, undoubted that patients with depression are as much a part of a GP's practice as those with medical complaints.

Psychiatrists claim that GPs overlook 50% of depressed patients. To remedy this situation, the GP needs to screen his/her patients for depression. Dr Rost recommended the following as a guide to those most likely to suffer from this complaint:

- people aged over 70 years;

- patients with constant physical complaints;
- patients with physical symptoms from various organs;
- patients with discrepancy between their own health status evaluation and the observations of the GP; and
- whenever the GP doubts his/her own diagnosis.

Once screening is complete, Dr Rost uses a diagnostic tool developed in the United States by Professor Robert Spitzer, in cooperation with GPs, known as PRIME-MD,[xxxix] which covers five groups of the mental disorders most commonly encountered in primary care: mood, anxiety, alcohol, eating, somatoform. Many GPs in Denmark use this tool.

Once depression has been diagnosed and treatment initiated, experience has shown that the response rate will be 70% and the outcome good. However, the patient needs to be followed to the end of his/her depressive episode, ideally lasting one year. The GP will see the patient every week until it is certain that medication is working and to identify side effects, if any. After a treatment period of 4–6 weeks, the GP sees the patient once a month. This routine is important to ensure patient compliance with treatment.

Suicide is frequently the result of a major depression.

8.1 Conclusion

In order to treat depression in primary care, it will be necessary to educate GPs in screening and diagnosis. Once diagnosis has been carried out, treatment needs to be continued until the patient is well, with continuous follow-up during treatment.

9 Compliance in depression

(PROFESSOR KOEN DEMYTTENAERE, UNIVERSITY HOSPITAL LEUVEN, BELGIUM)

Professor Demyttenaere focused on data resulting from studies of the drop-out rate of patients who are identified as suffering from depression. Professor Demyttenaere said the main reasons for dropouts are side-effects from drug therapy and lack of efficacy of the therapy.
During a trial carried out over nine weeks, a total of 40% of patients dropped out of treatment. The study further looked at parameters such as gender, age, educational level, job category, initial HAM-D and CGI, or some severe adverse event. After 10 weeks, 50% of patients had dropped out for various reasons including the fact that they felt better or had experienced side effects from drug therapy, a fear of dependence on drugs, inappropriate treatment, doctors' orders, or lack of efficacy of treatment. Early drop-outs were linked to lack of efficacy (3.2 weeks) and side effects (4.5 weeks). Drop-out because of improvement in the patient's condition or fear of dependence on drugs occurs later.

A very interesting result from Professor Demyttenaere's compliance trials is that, after the doctor tells the patient that there will be an interval of three weeks before the antidepressant drugs will appear, the patient will take three times the recommended dose to ensure an antidepressant effect in one week. Thus the patient may "overdose" on the new generation of antidepressants to obtain an earlier onset of effects but may, in consequence, develop side effects, which can lead to discontinuance of the treatment.

There is no strict coherence in antecedent causes to drop-out. These can include public perception of mental depression, a patient's emotional weaknesses, or bad parenting. In 45% of the cases, the patient feels he/she should will away the symptoms. There should be a clear relationship between compliance and positive outcomes. This is not always the case, however; the reasons can include a patient's feeling that his/her body needs a rest from medication, or that medication is only needed when he/she is actually experiencing symptoms. An important parameter is the interconnection between patient, family, health care provider and pharmacist.

It is possible to predict early dropouts; impossible to do so with later ones. In 63% of drop-out cases in the study, the health care provider was not aware that there was a problem

10 Structured psychotherapy

(DR J. BECKMANN AND MS HANNE DREISIG, ODENSE UNIVERSITY HOSPITAL, DENMARK)

The term "structural" refers to the profile obtained for each individual patient on the basis of his or her response to the items in the psychological profile questionnaire PROGRESSOR. The brief psychotherapy will focus on the patient's profile problems. The questionnaire has mainly been used in the general practice setting and both patients and GPs have found it applicable. The first scientific pilot study has been carried out in patients with Parkinson's disease. This type of psychotherapy is a mixture of behavioural and cognitive therapy.

A study to combine the WHO (five) Well-Being questionnaire as well as the Major (ICD-10) Depression Inventory (MDI) with PROGRESSOR has recently been initiated.

There are many short forms of psychotherapy that have been found effective in mild to moderate depression. Thus, the best documented form of brief psychotherapy is cognitive therapy (Bech et al 1979). However, the interpersonal psychotherapy (Klerman et al 1984) and the so-called behavioural therapy (Lewinson et al 1974) have also been shown to have effects. All these short forms of psychotherapy have been developed in the United States on physically healthy subjects in a population of middle-class and well educated adults. It is therefore important to evaluate structural psychotherapy in medically ill patients.

11 Quality of life and health economics

(DR J.N. YFANTOPOULOS, HEALTH ECONOMIST, ATHENS UNIVERSITY)

Dr Yfantopoulos spoke about a study on the cost–effectiveness of optimizing wellbeing based on a population of 1500. This involved issue, analysis and evaluation of responses to a questionnaire that included the following dimensional fields: mobility, self-care, level of activities, level of discomfort, anxiety and depression. Also included were three levels of rating and understanding, identification of the best imaginable situation, and test instruments for different types of health status. In this study, the patient classified him/herself.

As an example, partial results in Greece showed that problems with mobility increase with age and can become severe after the age of 55. Self-care is higher in young people but this ability decreases with age, as does the ability to carry out everyday activities. Pain and discomfort also increase with age. Anxiety and depression have shown a U-turn curve: they are high in young people, decrease in the group aged 45–54, and increase again after age 55. As the population ages, the increase becomes almost exponential.

When comparing the results on an international basis, the rating variation in health status is very small.

11.1 Conclusion

Cost and resource utilization should be included routinely in evaluations. Data cost utility indicator(s) should be identified taking into account various levels of variable including time perspectives, whether short-, medium- or long-term. The age of the subjects being evaluated is also very important.

12 The DepCare Project

(PROFESSOR P. BECH AND DR T. SCHÜTZE, FREDERIKSBORG GENERAL HOSPITAL, DENMARK)

With reference to the modified response curve after Kupfer (1991) (Annex 6), Professor Bech made the following suggestion for the DepCare Project.

1. The first stage for the recognition of major depression is the use of the WHO (five) Well-Being Index (see Annexes 1A and 1B).
2. The second stage for recognition is the Major Depression (ICD-10) Inventory (Annex 2). This questionnaire is designed as an analogue to the WHO (five) Well-Being Index. In principle, the WHO (five) Well-Being Index measures positive wellbeing, while the Major Depression Inventory measures negative wellbeing or the symptoms of depression. The total score of this inventory can be used to indicate the response curve when used in acute therapy for depression.
3. In naturalistic observation studies such as DepCare, the setting is the family doctors treating depressed patients without randomization of treatments, i.e. in open realistic trials. In this situation, it has been shown that there is a considerable number of drop-outs in the continuation therapy. The standard criteria for the treatment of depression with antidepressants in DepCare might be:

- at the end of active therapy (first eight weeks), at least 70% of the patients should still be in treatment;
- at the end of continuation therapy (six months later), at least 50% of the patients should still be in treatment;
- the relapse rate during continuation therapy should be below 20%; and
- the rate of patients who have responded during acute therapy should be 70%.

Dr Schütze described briefly a new instrument that exists in both an ICD-10 version and a DSB-IV version. This structural intervention has its major importance in detecting depressed patients with previous hypomanic or manic states (bipolar patients). In principle, bipolar patients should be excluded from the DepCare project.

12.1 Conclusion

A quality criterion for treatment of major depression in primary health care was recommended, with the following targets:

Percentage of patients completing the acute phase (first six weeks)	70%
Degree of remission (in percentage) after 6 weeks treatment	70%
Percentage of patients completing the continuation phase (first 6 months)	50%
Percentage of relapse in the continuation phase	20%

13 Group workshops

The first day of the meeting was devoted to setting the scene. The second day was concerned with the implementation of programmes and how the structure should be developed and results measured.

The participants were divided into working groups, based on their specific fields of interest, with the objective of identifying common tools and drawing up recommendations for their use as well as timeframes for achieving common targets. It is important to recognize and use windows of opportunity during the implementation process. Permanent working groups should also have decentralized leadership.

13.1 *Group 1:* Recognition and measuring depression in PHC and prevention of suicide

(Convenor: Dr D. Rost)

Who should be screened for depression: (a) Selected groups (elderly, somatic symptoms, others); (b) all patients over time.

All patients should be invited to answer the WHO (five) Well-Being Index (using EASY-Care for older patients); if the score is > 6–7, the GP can proceed with a diagnostic tool to detect depression (not necessarily on the same day). If depression is detected, the GP should decide what type of treatment to offer the patient including, if appropriate, cognitive therapy (not necessarily undertaken by the GP). If the PROGRESSOR is validated positively, this would be a treatment option. Other tools available on the market need to be identified and validated before being recommended by DepCare.

The group recommended that all patients should be invited to answer the WHO (five) Well-Being Index (with EASY-Care used for older people) at least once a year, or within whatever timeframe the GP finds convenient or necessary. The GP should put at least one of the five questions to patients who do not wish to answer the WHO (five) Well-Being Index.

Suicide rates are difficult to measure either within a single practice or in a group of practices. Can other indicators/parameters be used for monitoring purposes?

A local centre participating in DepCare may not be able to measure suicide within its specific area. Suicide rates should, therefore, be pooled in communities and/or regions for statistical purposes as part of a wellbeing database, which will monitor and perform quality tests. A cost measurement study by professional health economists should be carried out, if possible.

13.1.1 Conclusion

The WHO (five) Well-Being Index and EASY-Care should be linked to other existing WHO programmes and eventually to electronic or paper-based patient records.

13.2 *Group 2:* Stress and structured psychotherapy

(Convenors: Dr J. Beckmann and Ms Hanne Dreisig)

The group concluded that the ongoing trials with the PROGRESSOR are positive. The focus on the patient's profile of current problems should be evaluated in relation to the outcome measures both on PROGRESSOR itself and on the WHO (five) Well-Being Questionnaire.

13.2.1 Conclusion

PROGRESSOR is a psychological profile questionnaire for designing the most appropriate form of psychotherapy. Although the results of the validation study are still lacking, the applicability is rather positive.

13.3 *Group 3:* Compliance in continuation of therapy in depression disorders

(Convenor: Dr K. Demyttenaere)

Compliance is best understood as an indicator of the concordance between the patient and the treatment recommended by the doctor. However, the doctor is not always the treating health care provider. For example, concordance is often the result of interaction between patient and nurse or pharmacist.

Compliance is the issue of poor concordance by the patient with recommended treatment, and can sometimes be linked to the contact level between the patient, GP, therapist, nurse, pharmacist or other health care provider. Compliance is not only linked to depression but to medication for various diseases and conditions, for example hypertension, diabetes and asthma. It is always best to assume that non-concordance by patients is the normal behaviour and most GPs will wait for a poor outcome before raising the question with the patient. It should be noted that GPs' attitude towards non-concordance is often negative.

The average GP does not normally have much direct experience regarding treatment dosages for antidepressants and related drugs. This can result in over-prescription, which is an important parameter. There is a clear need for GPs to be educated about pharmacological therapy related to depression. The Kupfer curve (Annex 6) should be used to help the GP identify a patient's position regarding response to medication and outcome.

It is important that multidisciplinary teams working with patients speak the same language and convey identical messages to the patient. An acutely depressed patient often has trouble retaining a lot of information. At this stage, information should be simple and direct; it can be increased later. Written information is also helpful. Although the primary focus should be on the benefit of treatment, special attention should also be given to side effects of drugs. It is important for the health care giver to acknowledge the existence of side effects, to allow an open discussion of the issue and encourage the patient to return with other questions he or she may have.

13.3.1 Conclusion

The group suggested that one way to identify patients in the non-compliance stage is through the pharmacists' computer system, although this might not be legal in some countries.

Positive reinforcement for compliance is important throughout the treatment and it can be useful to engage parents and family members as allies. It could be useful to develop a checklist to learn

why patients drop out of treatment; once the reason has been identified, the GP should work with the patient to resume and complete treatment.

13.4 General discussion

During the discussion which followed, participants agreed that the modified response curve after Kupfer (1991) (Annex 6) is of major importance in promoting patient compliance with treatment. In order to identify and treat patients with depression, it is essential that GPs should systematically screen their patients using a tool that has been validated and has proved to be both effective and patient-friendly. The most appropriate screening tool is the WHO (five) Well-Being Index for younger people and EASY-Care (incorporating the WHO (five) Well-Being Index) for older people.

Such a screening tool must obey strict standards in, for example, translation and validation procedures. Participants also recommended that there should be a two-stage evaluation for quality of life and depression. Suggested criteria for treatment of major depression in primary health care could be:

- control of disease – identification of symptoms and side effects resulting from drug therapy, and follow-up to support compliance;
- the GP's view of the patient as a whole person, taking into consideration such items as independence, occupation, ability for self-care and quality of life;
- patients' interpersonal relationships with family, co-workers, friends and others, and how they function within society; and
- the availability of support within the family and the burden of a depressed person on a family.

First Stage	Second Stage
WHO Positive Wellbeing	**Major Depression (ICD-10) Negative Wellbeing**
1. In good spirits	1. In low spirits
2. Active and vigorous	2. Lack of energy
3. Interested in things	3. Lack of interests
4. Fresh and rested	4. Sleep disturbances
5. Calm and relaxed	5. Restless/subdued
	6. Difficulty in concentration
	7. Lacking self-confidence
	8. Guilt feelings
	9. Suicidal thoughts
	10. Decreased/increased appetite

14 Working Groups on Implementation

14.1 *Group 1*: Recognition and measuring depression in PHC and prevention of suicide (Convenor: Dr D. Rost)

How can the DepCare project be made more interesting for the GP?

The group considered that GPs could best be interested in the DepCare project through local professional associations, the creation of groups of twelve members, or other (yet to be identified) means.

They suggested that the project name be revised as *Dep* has a negative connotation; *wellbeing,* on the other hand, has a positive connotation.

In order to encourage patients to ask to be screened for depression, participants suggested that big companies should encourage their employees to be tested. WHO and pharmaceutical companies should also encourage testing. WHO rules should be followed at all testing sessions.

How can a good and valid postgraduate course for physicians be planned?

Several levels of postgraduate training should be available, as follows.

- ***Level 1***: once this course is completed, GPs would be capable of teaching others. The certificate of completion could be at either national or international level. Duration of training can be up to one week.
- ***Level 2:*** GPs who do not have time to attend the full course could choose to take only the most important sessions. In its abbreviated form, this course can be held nationally and last for 1–2 days.
- ***Level 3***: for those GPs interested in DepCare but unable to invest the time needed for levels 1 and 2. This could be an "appetiser" once the GP is able to use it in practice immediately. Duration: evening courses. Can be held locally.

  When planning levels 2 or 3, it is important to identify GPs' specific needs according to the requirements at country level. There are several programmes available that can be used as a basis for this type of postgraduate education. It will be necessary to identify these and find the one that is most suitable, tailoring the curriculum to meet DepCare requirements.
- ***Level 4:*** multidisciplinary training for nurses and other health care providers who are in contact with patients in general practice so that there is consistency in the messages given to patients by health care providers.

Specific country models (resulting from requirements identified at levels 2 or 3) might be implemented with the support of the pharmaceutical industry, as long as the WHO guidelines for collaboration with industry are followed**.** To interest GPs and (later) patients in DepCare, it will be important not to focus on depression but to stress that DepCare is about wellbeing and quality of life. It may be possible to increase patients' interest in being tested for wellbeing by their GPs through the mass media (TV, newspapers, Internet, etc.); in turn, this would automatically arouse GPs' interest in this service. Local, national and European scientific societies should be informed of DepCare and its objectives.

All documents on DepCare should carry the WHO logo.

How can other professions (e.g. pharmacists) become effectively involved with DepCare?

The European Community Leonardo programme might be a means of financing courses for GPs in wellbeing and quality of life, as well as supporting vocational training. To improve health care providers' skills and knowledge, it will be necessary to prove that DepCare is relevant to the European region. A current system for training GPs in management of depression (*Deprelief*) should be explored to see whether the WHO (five) Well-Being index and *EasyCare* (for older people) could be included.

14.1.1 Conclusion

After review of what exists in the field, structure a postgraduate training programme for GPs.

14.2 *Group 2:* Stress and structured psychotherapy

(Convenor: Dr J. Beckmann)

PROGRESSOR provides a highly nuanced psychological profile of the patient, through which the GP learns that he/she cannot rely solely on the patient's *symptoms* and adjust treatment accordingly, but must understand the patient's *experience* and specific language for communicating personal health problems.

The background for cognitive therapy has proven efficacy and could provide motivation for both patient and doctor through close interaction between the parties. It is important to make the protocol available to the patient so that the patient can structure his or her steps during diagnosis and treatment. It is here that the PROGRESSOR system is useful.

14.2.1 Recommendations

1. A module of PROGRESSOR should be produced for DepCare**.**
2. A design for an outcome acceptance study based on PROGRESSOR, as a kind of intervention/drug intended to make the person change him or herself, should be developed.
3. A demonstration of the PROGRESSOR method should be carried out and made available to GPs as an option of treatment, as part of DepCare**.**

14.2.2 Conclusion

The PROGRESSOR system could be a valuable clinical tool for structured discussion of a broad spectrum of emotional and psychological issues and overall improvement of the doctor–patient relationship. The PROGRESSOR is ready for testing and validation. DepCare needs to be able to offer a tool capable of handling cognitive therapy (although not necessarily at a high level).

14.3 *Group 3:* Compliance in continuation of therapy in depression

(Convenor: Mr J. Donoghue)

The group suggested that the following plan should be developed to assist GPs achieve patient compliance with drug therapy (Plan 5).

A. Information pack for GPs (Infopack)

1. Dose and length of treatment
2. Non-compliance is standard
3. Always ask about concordance – offer support
4. Importance of giving consistent information
5. Five-point scale.

B, C, D. Information for patients

	Phase I	**Phase II**	**Phase III**
a.	AD's do what	AD's do what	Doing well
b.	Likelihood of resp.	Feeling better (keep going)	Long term
c.	Keep dose	Look forward	Addictions
d.	Length	Length	Length
e.	Side effects	Questions?	Questions

14.3.1 Timetable for Plan 5

Two-stage strategy for Plan 5 DepCare

- Small scale

Comparing	Intervention
10 GPs are given Infopack, 10 are not	
Patient satisfaction	Simple measuring of pick-up-improvement

- Grand scale

Partnership
Delivery of Infopack to GPs

- Integration of three groups.

14.4 General discussion

Participants agreed on the importance of collaboration with industry, whose input would be especially important as there should be consensus on priorities for activities. International companies should contribute to a set of minimum core activities to be agreed. To ensure financing of local activities in WHO Member States, it is essential that each participating centre or working group identify its own funds.

When implementing data collection activities, it is important to focus on locally available technology in order to make data collection activities as broad as possible and to keep costs down. WHO/EURO should provide secretarial support as needed. The QualiCare server in Copenhagen will host aggregate data during the pilot phase.

15 Implementation of DepCare

The meeting decided that the representative of the CARMEN project (on mental health in central Asian republics) would support centres where intervention programmes have been identified. As well as the CARMEN project, Albania, Slovenia and Georgia will collect data based on the WHO (five) Well-Being Index, as a first step in activities based on pre- and post-partum depression, in collaboration with local obstetricians. Cases with a score of > 6 identified in previous studies should also be followed up. Identification of violence against women during pregnancy will be part of this study.

Responsible: Professor Bülent Coskun (CARMEN), Dr Vuksan Kola (Albania), Dr George Naneishvilli (Georgia), Dr Vislava Veliknoja (Slovenia).

15.1 General

Participants decided that the group should participate in the European Psychiatrists Association meeting scheduled to be held in Copenhagen during September 1998. The group will present an abstract and a poster; the production of these will be the responsibility of Professor Bech.

An article based on the proceedings from the 1st, 2nd and 3rd consensus meetings should be prepared. This will be the responsibility of Professor Philp. Those present at the 3rd meeting will review the article; however, a specific timeframe for comments will be set up so that there is no delay in publication.

Participants decided to create a web site on the Internet for DepCare based on Plan 5 as developed by Working Group 3 on *compliance in continuation of therapy in depression*. This will be the responsibility of Mr Donoghue.

With regard to Plan 5, it was also decided to prepare a draft of the *InfoKit* as part of a marketing package. This will be the responsibility of Mr Donoghue.

A link should also be established with the pharmacists in order to have DepCare included in their next meeting. This will be the responsibility of Mr Donoghue.

16 Future events

The following meetings would be held:

- European Association of Psychiatrists – September 1998 (Copenhagen)
- European College of Neuro-Psycho-Pharmacology – June 1999 (London)
- St Vincent Declaration Working Group on Primary Care – May 1998 (Brussels)
- Meeting on Western European GPs – September 1998.

17 Closure of the meeting

Closing the meeting, Dr Kirsten Staehr Johansen said that, in summary, three main decisions had been taken:

- that activities identified at the meeting should be given priority;

- that the DepCare project was ready to go European; and
- that DepCare should link up with other activities, such as the meetings set out above.

Dr Staehr Johansen thanked participants for attending and said she looked forward to working with them during implementation of DepCare**.** On behalf of the participants, she also thanked the Swedish Medical Association for their support in making the consensus meetings on mental health possible.

For his part, Mr Scholdström of the Swedish Medical Association expressed his pleasure in being able to cooperate with this initiative. He was sure that the implementation phase of the DepCare would be successful.

Annex 1

WHO (FIVE) WELL-BEING QUESTIONNAIRE

Please put a circle on each of the five statements which is closest to how you have been feeling over the last two weeks. Notice that higher numbers mean better wellbeing.

Over the last two weeks	All the time	Most of the time	More than half of the time	Less than half of the time	Some of the time	At no time
I feel cheerful and in good spirits	5	4	3	2	1	0
I feel calm and relaxed	5	4	3	2	1	0
I feel active and vigorous	5	4	3	2	1	0
I wake up feeling fresh and rested	5	4	3	2	1	0
My daily life is filled with things that interest me	5	4	3	2	1	0

Scoring:

The **raw score** is calculated by totalling the figures of the five answers. The raw score ranges from 0 to 25, 0 representing worst possible and 25 representing best possible quality of life.

To obtain a **standardized percentage score** ranging from 0 to 100, the raw score is multiplied by 4. A standardized score of 0 represents worst possible whereas a score of 100 represents best possible quality of life.

Interpretation:

Is it recommended to administer the Major Depression (ICD-10) Inventory (Annex 2) if the raw score is below 13 or if the patient has answered 0 or 1 to any of the 5 items.
A score below 13 indicates poor wellbeing and is an indication for testing for depression using ICD-10

Monitoring change:

In order to monitor possible changes in wellbeing, the standardized percentage score is used. A 10% difference indicates a significant change (ref. John Ware, 1995).

Annex 2

MAJOR (ICD-10) DEPRESSION INVENTORY

The following questions are to do with how you have been feeling over the last two weeks. Please put a tick in the box ☐ which is closest to how you have been feeling.

How much of the time	All the time	Most of the time	Slightly more than half the time	Slightly less than half the time	Some of the time	At no time
1. Have you felt low in spirits or sad?	☐	☐	☐	☐	☐	☐
2. Have you lost interest in your daily activities?	☐	☐	☐	☐	☐	☐
3. Have you felt lacking in energy and strength?	☐	☐	☐	☐	☐	☐
4. Have you felt less self-confident?	☐	☐	☐	☐	☐	☐
5. Have you had a bad conscience or feelings of guilt?	☐	☐	☐	☐	☐	☐
6. Have you felt that life wasn't worth living?	☐	☐	☐	☐	☐	☐
7. Have you had difficulty in concentrating, e.g. when reading the newspaper or watching television?	☐	☐	☐	☐	☐	☐
8a. Have you felt very restless?	☐	☐	☐	☐	☐	☐
8b. Have you felt subdued?	☐	☐	☐	☐	☐	☐
9. Have you had trouble sleeping at night?	☐	☐	☐	☐	☐	☐
10a. Have you suffered from reduced appetite?	☐	☐	☐	☐	☐	☐
10b. Have you suffered from increased appetite?	☐	☐	☐	☐	☐	☐

Name: ..... Date: .....

Scoring of Major (ICD-10) Depression Inventory

Each item is scored on a Likert scale from 0 to 5, with the following possibilities:

	All the time	Most of the time	Slightly more than half the time	Slightly less than half the time	Some of the time	At no time
Item 1	5	4	3	2	1	0
Item 2	5	4	3	2	1	0
Item 3	5	4	3	2	1	0
Item 4	5	4	3	2	1	0
Item 5	5	4	3	2	1	0
Item 6	5	4	3	2	1	0
Item 7	5	4	3	2	1	0
Item 8a[a]	5	4	3	2	1	0
Item 8b[a]	5	4	3	2	1	0
Item 9	5	4	3	2	1	0
Item 10a[a]	5	4	3	2	1	0
Item 10b[a]	5	4	3	2	1	0

[a] At items 8 and 10, choose the sub-item (a or b) with the highest score.

When measuring treatment outcome, the sum of the ten items is used. A higher score signifies deeper depression.

When using the scale in the diagnosis of depression according to ICD-10, there are the following possibilities:

mild depression: a score of 4 or 5 in two of the first items, plus a score of 4 or 5 in at least four of the last seven items;

moderate depression: a score of 4 or 5 in two of the first three items, plus a score of 4 or 5 in at least four of the last seven items;

severe depression: a score of 4 or 5 in all of the first three items, plus a score of 4 or 5 in at least five of the last seven items;

major depression: the number of items is reduced to nine, as item 4 is a part of item 5. The item (4 or 5) with the highest score is included. There must be a score of 4 or 5 in at least five of the nine items, of which one must be either item 1 or 2.

Annex 3

WHO/ICD-10 DEPRESSIVE EPISODE

Criterion A

The statements or symptoms (see Criteria B and C) should have lasted at least two weeks most of the time, e.g. a score of 5 or less on the WHO (five) Well-Being Index.

Criterion B

Includes three symptoms (B1 Depressed mood; B2 Decreased energy; B3 Loss of interest). With reference to the WHO (five) Well-Being Questionnaire (1995 version), the procedure is:

- *In the WHO questionnaire you said that … "*

If the patient has scored 0 to 1 on item 1: "*That means that most of the time you have been depressed"?*

B1	Depressed mood	☐ Yes	☐ No

If the patient has scored 0 to 1 on either item 3 or 4: "*That means that most of the time you have low energy*"?

B2	Decreased energy	☐ Yes	☐ No

If the patient has scored 0 to 1 on item 5: "*That means that most of the time you have no interest in things*"?

B1	Loss of interest	☐ Yes	☐ No

- *If at least two boxes with "yes", go to Criterion C.*

Criterion C

Covers the following C symptoms

- *For the last two weeks, have you had any of the following symptoms most of the time?*

		Yes	**No**
C1	Poor appetite and/or weight loss?	☐	☐
C2	Trouble sleeping every night?	☐	☐
C3	Talk or move more slowly than normal, or more restless than usual?	☐	☐
C4	Low self-confidence or worthlessness?	☐	☐
C5	Feelings of self-reproach or guilt?	☐	☐
C6	Diminished ability to concentrate?	☐	☐
C8	Recurrent thoughts of death?	☐	☐

Annex 4

WHO/ICD-10 DEPRESSION DIAGNOSIS AND DSM-IV MAJOR DEPRESSION

Symptoms		Yes = 1 No = 0	F 32.0 Mild depression	F 32.1 Moderate depression	F 32.2 Severe depression
B1 B2 B3	Depressed mood Decreased energy Loss of interest	■ ■ ■	Two boxes with “yes”	Two boxes with “yes”	Three boxes with “yes”
C1 C2 C3 C4 C5 C6 C7	Poor appetite or weight loss Insomnia Psychomotor retardation or agitation Worthlessness Guilt Diminished ability to concentrate Suicidal thoughts	■ ■ ■ ■ ■ ■ ■	Two boxes with “yes”	Four boxes with “yes”	Five boxes with “yes”
Total B1-C7 – Major depression			Five boxes with “yes”	Five boxes with “yes”	Five boxes with “yes”

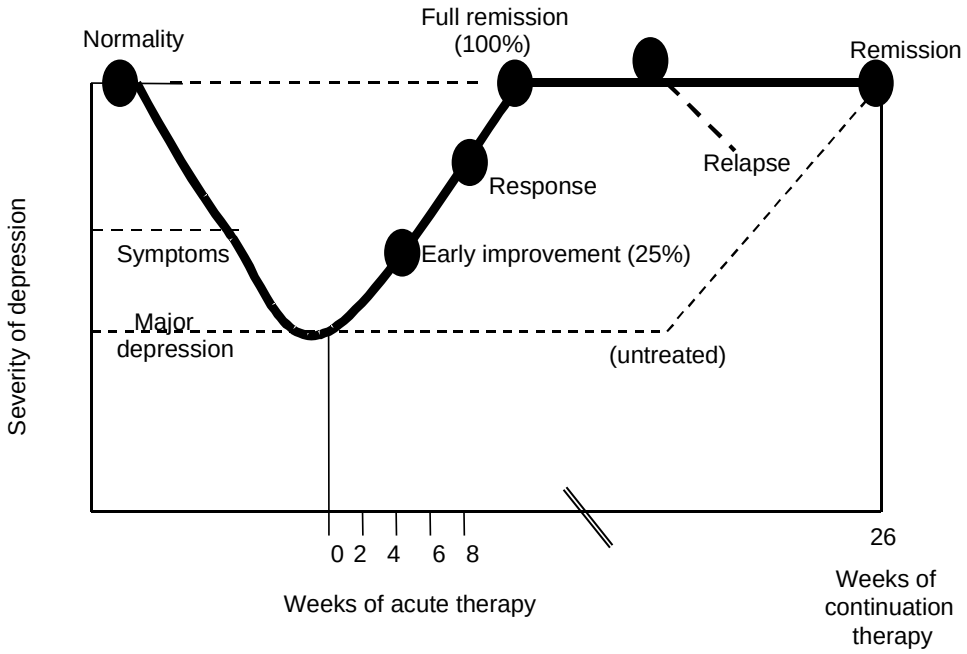
Annex 5

MAJOR DEPRESSION RATING SCALE
ICD-10 VERSION

No	Items – Score range		Score
1	Depressed mood	(0–4)	
2	Diminished interest in social activities	(0–4)	
3	Decreased appetite and/or significant weight loss (sum of 3a or 3b):		
3a	Decreased appetite	(0–2)	
3b	Weight loss	(0–2)	
4	Insomnia	(0–4)	
5	Psychomotor retardation and/or agitation (highest score on 5a or 5b):		
5a	Retardation	(0–4)	
5b	Agitation	(0–4)	
6	Fatigue or loss of energy	(0–4)	
7	Feelings of worthlessness and/or guilt (highest score on 7a or 7b):		
7a	Loss of self-esteem	(0–4)	
7b	Guilt	(0–4)	
8	Diminished ability to concentrate	(0–4)	
9	Recurrent thoughts of death, suicide ideation or plans	(0–4)	
	Total	(0–36)	

Annex 6

MODIFIED RESPONSE CURVE AFTER KUPFER (1991)



Annex 7

SCOPE AND PURPOSE

The meeting on quality assurance for mental health (1st Consensus meeting) held in August 1993 in Stockholm recommended that the proposed indicators and instruments be tested in a selected number of areas in various WHO European Member States and that a further meeting should be organized on the same theme after the start of the testing period.

The meeting on patient outcome measures in mental health (2nd consensus meeting), also held in Stockholm in November 1995, made recommendations regarding the further application and dissemination of the proposed indicators.

The meeting on use of wellbeing measures in primary health Care/the DepCare Project (3rd consensus meeting), will be held in Stockholm in February 1998 and will set up guidelines for carrying out a range of studies, using the tools for mental health in several European countries. On this basis, the tools will be further investigated and refined. Generic tools should be matched to disease-specific tools and studies on their suitability carried out. Also in order to set up a common database, confidentiality of patient data, copyright, checking validation and interpretation data need to be identified.

The DepCare Project will be introduced: its aim is to ensure that general practitioners will use the WHO five items Well-Being Questionnaire for screening all patients for depression. The depression symptoms will be rated by using the WHO five items Well-Being Questionnaire together with the Major Depression Inventory.

Annex 8

PROGRAMME

Thursday, 12 February

08.00–09.00	Registration
09.00–09.30	Opening, introduction and approval of agenda (Chairperson, Mr U. Scholdström)
	Election of Chairperson and Rapporteur
	Adoption of agenda and programme
09.30–09.45	The use of wellbeing measures in primary health care/The DepCare Project (Dr Kirsten Staehr Johansen)
09.45–10.15	Naturalistic studies in depression in PHC (Dr J. Donoghue)
10.15–10.45	Coffee break
10.45–11.30	The WHO Five well-being scale :
10.45–11.00	– In relation to pregnancy (Ms Dawn Fowler)
11.00–11.15	– In relation to psychiatric patients (Dr J. Guelfi)
11.15–11.30	– In relation to the elderly (Dr R. Heun)
11.30–11.45	Recognition of depression in the elderly (Dr I. Philp)
11.45–12.00	Quality development in depression care and prevention of suicide, with special emphasis on pregnancy (Dr J. Berle)
12.00–12.15	Recognition of depression in general practice and prevention of suicide (Dr D. Rost)
12.15–12.30	General discussion
12.30–13.30	*Lunch*
13.30–13.45	Compliance in depression (Dr K. Demyttenaere)
13.45–14.00	Structured psychotherapy (Dr J. Beckmann)
14.00–14.15	Quality of life and health economics (Dr J.N. Yfantopoulos)
14.15–14.30	The DepCare project (Dr P. Bech & T. Schütze)
14.30–16.00	Group workshops
	Group 1: Recognition and measuring depression in PHC and prevention of suicide (Dr D. Rost)
	Group 2: Stress and structured psychotherapy (Dr J. Beckmann)
	Group 3 Compliance in continuation of therapy in depression (Dr K. Demyttenaere)
16.00–16.15	Coffee break
16.15–16.45	Report of the Working Groups
16.45–17.30	General discussion

Friday, 13 February

09.00–10.00	Working groups on implementation
	Group 1: Recognition and measuring depression in PHC and prevention of suicide (Dr D. Rost)
	Group 2: Stress and structured psychotherapy (Dr J. Beckmann)
	Group 3 Compliance in continuation of therapy in depression (Dr K. Demyttenaere)
10.00–10.30	Reports from working groups
10.30–11.00	Coffee break
11.00–12.00	General discussion
12.00–12.45	Implementation of DepCare
12.45–13.00	Closure of the meeting

Annex 9

PARTICIPANTS

Ms J. de Backer
Meerstraat 54
1840 Londerzeel
Belgium
representing Dr Leo Pas, St Vincent Declaration Primary Health Care Working Group
Flemish Institute of General Practitioners
St Hubertusstraat 48
2600 Berchem
Belgium

Professor Jørn Halberg Beckmann
Director, Department of Clinical Psychology
Odense University Hospital
Kløvervænget 16–18
DK-5000 Odense C
Denmark
Tel: +45 6541 4225
Fax: +45 6613 4440

Dr Jan Øystein Berle
Institute of Psychiatry
University of Bergen
N-5021 Bergen
Norway
Tel: +47 55 97 44 22
Fax: +47 55 97 44 19

Professor Bülent Coskun
Kocaeli University
Faculty of Medicine
Psychiatry Department
Kocoali
Turkey
Tel: +90 262 311 31 37
Fax: +90 262 239 57 00

Professor Koen Demyttenaere
Department of Psychiatry
University Hospital
Herestraat 49
3000 Leuven
Belgium
Tel: +32 16 34 87 01
Fax: +32 16 34 87 00

Dr John Donoghue
4 Wrenfield Grove
Liverpool L179Qd
United Kingdom
Tel: +44 151 72 75276

Ms Hanne Dreisig
Director of Psychotherapy
Department of Clinical Psychology
Odense University Hospital
Kloevervaenget 16–18
DK-5000 Odense C
Denmark
Tel: +45 6541 4225
Fax: +45 6613 4440

Ms Tina Fisher
Pharmaco-economic Affairs
Krogshøjvej 31
2880 Bagsvaerd
Denmark
Tel: +45 44 42 13 24
Fax: +45 44 42 16 30

Professor J.-D. Guelfi
Chef du service psychiatrie
Groupe hospitalier Paul Brousse
12 Av. P.V. Coutirier
94804 Villejuif
France
Tel: +33 1 45 49 30 87
Fax: +31 1 45 59 3424

Dr Reinhard Heun
Department of Psychiatry
Rheinische Friedrich-Wilhelms-University
Sigmund-Freud-Str. 25
D-53105 Bonn
Germany
Tel: +49 228 287 5712
Fax: +49 228 2876097

Mr Thomas Ibsen
P.O. Box 48
Skovlunde
Denmark
Tel: +45 42 84 68 00
Fax: +45 42 84 6181

Dr Vuksan Kola
Psychiatry Service
University Hospital Centre “Mother Teresa”
Tirana
Albania
Tel: +355 42 647 03
Fax: +355 42 21 877

Dr Bertrand de Lavenne
International Project Leader
6, place des Pléiades
F-92415 Courbevoie Cédex
France
Tel: +33 1 46 41 22 29
Fax: +33 1 46 41 69 95

Ms Annette Lunde
Vestre Gade 18
DK-2650 Hvidøvre
Denmark
Tel: +45 36 38 05 05
Fax: +45 36 38 05 01

Dr George Naneishvili
Director, Research Institute of Psychiatry
Asatiani str. 10
Tbilisi, 380077
Georgia
Tel: +(995 32) 39 47 65
Fax: +(995 32) 94 36 73

Professor Ian Philp
Head, Department of Health Care for Elderly People
University of Sheffield
Northern General Hospital
Brearley Wing, Floor C., Herries Rd
UK-S5 7AU Sheffield
United Kingdom
Tel: +44 114 271 5124
Fax: +44 114 271 5771

Dr T. Schütze
Psychiatric Institute, Frederiksborg General Hospital
Dyrehavevej 48
DK-3400 Hillerød
Denmark
Tel: +45 48 29 32 52
Fax: +45 42 26 38 77

Dr Vislava Velikonja
Assistant Professor, Department of Obstetrics and Gynaecology
University Medical Centre
Slajmerjeva 3
SL-Ljubljana
Slovenia
Tel: +386
Fax: +386 61 315 328

Professor Börje Wistedt
DWO Psychiatric Clinic
Karolinska Institute
Danderyd Hospital
S-182 88 Danderyd
Sweden
Tel: +46 8 655 50 00
Fax: +46 8 753 34 21

Professor J.N. Yfantopoulos
Professor of Health Economics
University of Athens
12, Sachtouri Street, Halandri
GR-152 32 Athens
Greece
Tel: +30 1 360 9037
Fax: +30 1 684 0212
e-mail: y.fa@otenet.gr

Temporary Advisers

Professor Per Bech *(Chairperson)*
Psychiatric Institute
Frederiksborg General Hospital
Dyrehavevej 48
DK-3400 Hillerød
Denmark
Tel: +45 48 29 32 52
Fax: +45 42 26 38 77

Dr Dan Rost *(Rapporteur)*
Praestegaardsvej 5
DK-6070 Christiansfeld
Denmark
Tel: +45 74 56 11 07
Fax: +45 74 56 33 11

Mr U. Scholdström
The Swedish Medical Association
Villagatan 5
S-114 86 Stockholm
Sweden
Tel: +46 8 790 3300
Fax: +46 8 20 5718

WHO Regional Office for Europe

Dr Kirsten Stæhr Johansen
Quality of Care and Technologies

Ms Dawn Fowler
STC, Quality of Care and Technologies

Ms Helle Rink
Technical Assistant, Quality of Care and Technologies

Dr Toma Tomov
Mental Health Unit

References

[i] WHO Regional Office for Europe. *Health for all targets. The health policy for Europe* (1984, updated edition 1991). Copenhagen, WHO Regional Office for Europe, 1991 (European Health for All Series, No. 4).

[ii] Bech, P. et al. The WHO (Ten) Well-Being Index: Validation in Diabetes. *Psychotherapy and psychosomatics*, **65**: 183–190 (1996).

[iii] *Quality assurance indicators in mental health care:* report on a WHO meeting. Copenhagen, WHO Regional Office for Europe, 1993 (EUR/ICP/CLR 062 01344).

[iv] *Collaborative project between the European Forum of Medical Associations and WHO: Policy of medical associations regarding quality of care development.* Copenhagen, WHO Regional Office for Europe, 1993 (EUR/ICP/HSC 021(C)/BD/01/A/Rev.1).

[v] *Patient outcome measures in mental health. Consultation on financing incentives for quality of care – the model of oral health care*: report on a WHO meeting. Copenhagen, WHO Regional Office for Europe, 1995 (EUR/ICP QCPH 05 03 03).

[vi] Ware, J.E., Gandek, B. and the IQ OLA Project Group. The SF-36 health survey. *International journal of mental health*, **5**: 49–73 (1994).

[vii] Ware, J.E. & Davies, A.R. *Monitoring health outcomes from the patient's point of view: a primer*. Kenilwork, New Jersey, Integrated Therapeutic Group, 1995.

[viii] Sartorius, N. & Knyken, W. Translation of health status instruments. Orley, J. & Kuykens, W. ed. *Quality of life assessment; international perspectives*. Berlin, Heidelberg, Springer-Verlag, 1994.

[ix] *The Bech, Hamilton and Zung Scales for Mood Disorders*, 2nd ed. Berlin, Springer-Verlag, 1996.

[x] Bech, P. & Wermuth, L. Applicability and validity of the Major Depression Inventory in patients with Parkinson's Disease. *Nordisk journal of psychiatry*, 1998 (in press).

[xi] Kupfer, D.J. Long-term treatment of depression. *Journal of clinical psychiatry*, **52**(Suppl): 24–34 (1991).

[xii] Recommendations for national medical associations regarding quality of care development (QCD). *Medisch Contact*, **6**:48 (1993).

[xiii] Evang, K. Det internasjonale helsearbeid. *Nordisk medicin*, **36**: 2171–2182 (1947).

[xiv] Petersen, P.E. Effectiveness of Oral Health Care – some Danish experiences. *Proceedings of the Finnish Dental Society*, **88**: 1–2 (1992).

[xv] Jensen, L.P. et al. Fire års erfaringer med Karbase. Et redskab til kvalitetsudvikling i karkirugi. *Ugeskrift for Læger*, **156**(47): 7032–7035 (1994).

[xvi] Andreasen, A.H. et al. Equity and improvement in outcome of breast cancer in Denmark. *In*: Roger France, F.H. et al., ed. *Case-based telematic systems*. Amsterdam, IOS Press, 1994.

[xvii] "Miraculous" development from health services research. *British medical journal*, **312** (1996).

[xviii] Gillis, C.R. & Hole, D.J. Survival outcome of care by specialist surgeons in breast cancer: a study of 3786 patients in the west of Scotland. *British medical journal*, **312**: 145–148 (1996).

[xix] Staehr Johansen, K. WHOCARE: Hospital infection surveillance and feedback programme. *Healthcare computing*, **859**: 366 (1992).

[xx] International Dental Federation and World Health Organization. Global goals for oral health in the year 2000. *International dental journal*, **32**: 74–77 (1982).

[xxi] World Health Organization. *Health for all: list of indicators.* Copenhagen, WHO Regional Office for Europe, 1993.

[xxii] *Diabetes mellitus in Europe: a problem at all ages in all countries. A model for prevention and self care.* A meeting organized by the World Health Organization, Regional Office for Europe, and the International Diabetes Federation, Europe. October 1989. *Giornale italiano di diabetologia*, **10**(Suppl) (1990).

[xxiii] Staehr Johansen, K. et al., ed. Improving health of people with diabetes: the "end of the beginning". *Diabetes nutrition and metabolism*, **10**:3 (1997).

[xxiv] WHO mental health collaborating centres. Pharmacotherapy of depressive disorders: a consensus statement. *Journal of affective disorders*, **17**: 197–198 (1989).

[xxv] Paykel, E.S. & Priest, R.G. Recognition and management of depression in general practice: Consensus Statement. *British medical journal*, **305:** 1198–1202 (1992).

[xxvi] Rosholm, J-U. et al. Outpatient utilisation of antidepressants: a prescription database analysis. *Journal of affective disorders*, **27**: 21–28 (1993).

[xxvii] Donoghue, J.M. & Tylee, A. The treatment of depression: prescribing patterns of antidepressants in primary care in the United Kingdom. *British journal of psychiatry*, **168**: 164–168 (1994).

[xxviii] Donoghue, J.M. et al. Cross sectional database analysis of antidepressant prescribing in general practice in the United Kingdom, 1993–5. *British medical journal*, **313**: 861–622 (1996).

[xxix] MacDonald, T.M. et al. Antidepressant drug use in primary care: a record linkage study in Tayside, Scotland. *British medical journal*, **313:** 860–861 (1996).

[xxx] Staehr-Johansen, K. The OBSQID Project: obstetrical quality development through integrated use of telematics. *Studies in health technology and informatics,* **14**: 59–62 (1994).

[xxxi] Goodwin, F.K. & Jamison, K.R. Manic-depressive illness. New York, Oxford University Press, 1990.

[xxxii] Kessler, R.C. et al. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the National Comorbidity Survey. *Archives of general psychiatry*, **51**: 8–19 (1994).

[xxxiii] Rutz, W. Prevention of suicide and depression. *Nordic journal of psychiatry*, **50**(Suppl 37): 61–67 (1996).

[xxxiv] Glover, V. Maternal stress or anxiety in pregnancy and emotional development of the child. *British journal of psychiatry*, **171**: 105–106 (1997).

[xxxv] Brockington, I.F. *Motherhood and mental health*. Oxford, Oxford University Press, 1996.

[xxxvi] Llewellyn, A.M. et al. Depression during pregnancy and the puerperium. *Journal of clinical psychiatry*, **58(**Suppl 15): 26–32 (1997).

[xxxvii] Murray, L. & Cooper, P.J., ed. *Postpartum depression and child development.* New York, The Guilford Press, 1997.

[xxxviii] Cox, J.L. et al. Detection of postnatal depression. *British journal of psychiatry,* **150**: 782–786 (1987).

[xxxix] Spitzer, R.L. et al. Utility of a new procedure for diagnosing mental disorders in primary care. *Journal of the American Medical Association*, **272**: 1749–1756 (1994).