

Putting prevention into practice:

an education module

PARTICIPANT WORKBOOK



THE ROYAL AUSTRALIAN
COLLEGE OF
GENERAL PRACTITIONERS

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Participant workbook

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A significant proportion of death, illness and injury in Australia is preventable. General practitioners (GPs) and general practice team members play an essential role in promoting health and preventing disease.

More than any other area of medicine, general practice is the specialty that helps patients work toward being the healthiest they can be. It is personalised care based on an ongoing relationship with patients in the context of their family, friends and community.

The second edition of The Royal Australian College of General Practitioners (RACGP) *Putting prevention into practice: guidelines for the implementation of prevention in the general practice setting* ('green book') was distributed to all Australian general practices in late 2006. The green book outlines strategies that GPs can use in the consultation and that practices can implement, as well as how to use community resources effectively.

The RACGP has developed this education module to support the use of the green book. The module provides a practical and inspirational guide to successful prevention activities in practices. It outlines the theory behind prevention and provides practical case studies, activities and strategies that can be used to implement prevention in your own practice. It also helps teams identify what prevention activities to focus on, develop a systematic approach to prevention, and identify and address any barriers that may arise. By implementing strategies that are known to work, I hope that much time and effort will be saved.

The module can be used as a small group learning activity, in larger formal training workshops or by individual practitioners. Acknowledging the importance of the entire practice team in prevention, the module has been designed for use by GPs, practice nurses, practice managers and others in the general practice team.

I would like to thank the Australian Government Department of Health and Ageing for providing the funding for the development of this module. The RACGP also greatly appreciates the input of the Australian Association of Practice Managers, the Australian General Practice Network, and Australian Practice Nurse Association who have provided advice and direction. Dr John Litt, green book medical editor, has been an important contributor. The RACGP Quality Care Unit initiated this project and oversaw its development. A number of GPs, practice nurses, practice managers and division of general practice staff reviewed the materials and provided advice and suggestions.

The RACGP is proud to play a significant role in building the capacity of GPs to provide preventive health care and in working with national organisations to ensure a sustainable general practice role in prevention.

I hope you find this module interesting and that it stimulates prevention activity in your practice. I encourage your participation and commend your efforts to improve preventive care in general practice.



Dr Vasantha Preetham
RACGP President

Welcome to Putting prevention into PRACTICE – an education module designed to help GPs and practice staff increase their knowledge and understanding of how prevention strategies can be introduced into their practices.

As implementing prevention activities into practices takes a team approach, the module has been designed for the whole practice team: general practitioners (GPs), general practice registrars, practice managers, practice nurses, other practice staff as well as divisions of general practice.

This participant workbook contains an overview of the materials covered in the Putting Prevention into Practice Program and outlines the key learning objectives of the program.

Use this workbook in conjunction with the workshop to record your answers to discussion and case study questions.

The aims of this module are to:

- provide an overview of the guidelines for the implementation of prevention in general practice (the 'green book')
- raise awareness of the value of evidence based strategies for the implementation of prevention in the general practice setting
- create opportunities to exchange ideas
- incorporate this information into clinical practice.

The vital role of the GP and practice staff in implementing prevention strategies at all levels of the health care system is highlighted by interactive case studies.

Module development

The RACGP Quality Care Unit developed this module with funding from the Australian Government Department of Health and Ageing. An advisory committee comprising the key stakeholders oversaw the development to ensure that the module is applicable and accessible to all target groups.

Quality assurance and continuing professional development

This module has been designed as an RACGP Category 1 QA&CPD activity. The Australian Practice Nurse Association will provide 6 hours of CPD points as a Group A activity, and practice managers are eligible for 6 points through the Australian Association of Practice Managers.

Module structure

The module is divided into a number of separate but related components:

- pre-course activity
- an outline of preventive strategies and the PRACTICE framework
- applying the PRACTICE framework at various levels: the consultation, the practice, and community and health care system, and
- post-course activity.

Participants should complete the pre-course activity before completing the module. The post-course activity, which builds on the pre-course activity and brings together learning from the module, should be completed after the module.

Learning objectives

Upon completion of the putting prevention into PRACTICE module, participants should be able to demonstrate:

Behaviour

- Proactively and systematically review patients for relevant preventive care and focus on those who will benefit most from preventive care.
- Display increased confidence in implementing prevention in general practice.

Attitude

- Appreciate the pivotal role of general practice in the implementation of effective preventive strategies.
- Value evidence based strategies in the implementation of prevention in the general practice setting.

Skills

- Confidently use motivational interviewing and behavioural counselling.
- Implement practice prevention plans that utilise the PRACTICE prevention framework.
- Improve their performance in the delivery of prevention.

Knowledge

- Understand the principles of effective and efficient prevention strategies.
- Understand how to implement preventive care in health management.

Resources

Resources to be used in conjunction with this module are:

- *Putting prevention into practice: guidelines for the implementation of prevention in the general practice setting* (green book) available at www.racgp.org.au/guidelines/greenbook
- *Guidelines for preventive activities in general practice* (red book) available at www.racgp.org.au/guidelines/redbook
- *Smoking, nutrition, alcohol and physical activity: a population health guide to behavioural risk factors in general practice* (SNAP guide) available at www.racgp.org.au/guidelines/snap
- *National guide to a preventive assessment in Aboriginal and Torres Strait Islander peoples* (National guide) available at www.racgp.org.au/guidelines/nationalguide
- Lifescripts resources for general practice available at www.health.gov.au/lifescrpts or www.adgp.com.au/site/index.cfm?display=5267.

Hard copies of the RACGP publications can be ordered from the RACGP Publications Unit available at www.racgp.org.au/publications/orders.

Suggestions and examples

If you have any suggestions for improving the module or examples of programs that practices have implemented that could be included in the module, please contact the RACGP Quality Care Unit.

Further information

If you have any queries about the program, please contact the RACGP Quality Care Unit on 03 8699 0559 or email qualitycare@racgp.org.au.

Barriers to preventive care

Work pressures, time constraints, limited teamwork and lack of a supportive infrastructure can make it difficult for practices to adopt a preventive approach in their daily practice.

What are the barriers to preventive care in your practice?

What are ways these could be addressed?

Improving prevention in general practice

Improving preventive care should be based on four key components:

- use a clear framework
- effective planning
- use evidence based implementation strategies
- acknowledge difficulties and determining how to overcome them.

Case study – Gumtree Medical Centre

The practice team at Gumtree Medical Centre is concerned that existing services and strategies are not adequately meeting the preventive care needs of their patients. To address this concern, the practice team decides to conduct a needs assessment to identify practice prevention priorities with the aim of improving preventive care services within the practice.

What should the needs assessment involve?

Applying the PDSA cycle

The PDSA cycle consists of a sequence of four repetitive steps: plan, do, study and act.



Outline a plan for implementing a diabetes screening program in general practice.

Objective: _____

Achieve: _____

Actions: _____

Resources: _____

When: _____

Who: _____

How: _____

Possible barriers: _____

Scenario

The program was implemented. The practice team decided to use the Diabetes Australia 'tick test' as an initial screening test. Reception staff flagged patients aged 45 years and over, and asked them to complete the test while waiting to see the GP. The patient then took it with them into the consultation. The receptionist noted on the patient's record that the test had been completed. The GP then reviewed the test and discussed the need for fasting blood sugar tests with the patient where required.

After 1 month, the practice team met to review the program's success, discuss their experience, and whether there has been any improvement. The number of patients screened, diagnosed with diabetes and prediabetes during the month was noted. While the number of diabetes diagnoses was low, there were a number of patients with prediabetes or those with negative screening test but identified risk factors. The patients had generally been receptive to the proactive approach to screening, however, some had not been willing to return for a blood test. The GPs reported that it was often difficult to discuss diabetes due to time constraints, as the patient was presenting for other reasons. In many cases, other risk factors were indicated which required advice (ie. weight loss and physical activity), and although this was a good opportunity to raise it, time was again an issue.

It was also noted that patients aged 35–45 years and considered at high risk were not included in the screening. As the risk for these patients is based on ethnic background, it was not easy to select patients for the screen tick box.

The practice nurse was concerned that they collected useful information that was not always recorded on the patient's health summary and that it would be useful to flag patients for follow up in 12 month or 3 years as necessary.

It was noted that both GPs and practice nurses had experienced an increased workload due to the number of patients who required advice on diet, weight loss and physical activity.

The PRACTICE prevention framework

Implementation of preventive care can be challenging. The 'PRACTICE' prevention framework has been designed to strengthen prevention activities in general practice. The core elements of the PRACTICE prevention framework are: principles, receptivity, ability, coordination, targeting, iterative cycles, collaboration, and effectiveness and efficiency. Consideration of these elements will facilitate improvements in the delivery of preventive care.

<p>P</p>	<p>Principles What underpins the process?</p>	<p>Implementing prevention activities within a structured framework has greater impact than individual activities</p> <p>Implementation strategies should be evidence based and outcomes focused</p> <p>Strategies should address sustainability and maintain a commitment to quality culture</p>
<p>R</p>	<p>Receptivity Why should I do it? What's in it for me?</p>	<p>Implementation is enhanced when patients, GPs and practice staff:</p> <ul style="list-style-type: none"> • believe prevention is important, feasible and realistic • understand the benefits of prevention and see the process as worthwhile • can observe a measurable change in outcome
<p>A</p>	<p>Ability What do I need to do to achieve it?</p>	<p>Implementation is enhanced when GPs have the necessary:</p> <ul style="list-style-type: none"> • knowledge • skills • attitudes/beliefs • organisational infrastructure • time
<p>C</p>	<p>Coordination How will we do it and who will organise it?</p>	<p>Involves the processes and activities that help various groups work together effectively to accomplish a set goal</p> <p>Coordination may be improved by:</p> <ul style="list-style-type: none"> • a facilitator • clarification of roles and responsibilities • good communication • good planning

Principles

Some examples of principles that can be adopted within a prevention program include a patient centred approach and a systematic and whole-of-practice population approach.

What are the guiding principles of your practice?

How does the practice demonstrate these principles?

Has your practice adopted:

- a patient centred approach?
 - a systematic and whole of practice population approach to preventive care?
 - incorporated strategies to identify and address health inequalities and disadvantaged groups?
- Provide examples for each of these.

Receptivity

To enhance the receptivity of the key players involved in preventive care, implementation strategies should:

- be transparent, respectful and supportive
- be consistent with professional and practice goals and values
- build on the knowledge and skills of the participants
- be realistic and reversible
- identify appropriate incentives.

Are patients in your practice receptive to preventive activities?

Have you thought about introducing a preventive care strategy?

What could you do to increase receptivity: for GPs, staff and patients?

Can you routinely incorporate meaningful feedback on performance?

Ability

What preventive activities are you currently doing? What prevents this happening?

What knowledge/skills do GPs and practice staff need in order to adopt preventive care?

Do you provide patient education materials consistently?

Does your IT system prompt you about patients eligible for preventive activities?

Coordination

Who plays a coordinating role in your practice?

Are the various roles and responsibilities within your practice clearly delineated?

T	<p>Targeting</p> <p>Who needs it?</p>	<p>Identify priority prevention areas and the level of need</p> <p>Identify target groups</p> <p>Targeting prevention processes to the correct healthcare levels:</p> <ul style="list-style-type: none"> • individual • group • practice • community and health system
I	<p>Iterative cycles</p> <p>How can I ensure that it happens?</p>	<p>Cyclical planning/learning processes assess the effectiveness of strategies and provide feedback to ensure improvement – PDSA cycle</p> <p>Change the implementation process when necessary</p>
C	<p>Collaboration</p> <p>Who can help me?</p>	<p>Key partnerships include:</p> <ul style="list-style-type: none"> • the GP and the patient • practice staff and the patient • the GP and practice staff • the practice and the community or health promoting organisations <p>Requires teamwork and good communication</p>
E	<p>Effectiveness and Efficiency</p> <p>What works? How can I make it routine?</p>	<p>Focus on preventable diseases, those with a significant burden of morbidity or those that can be influenced by GP or practice nurse interventions</p> <p>Use evidence based and outcomes focused strategies</p> <p>Determine the feasibility of providing preventive care routinely</p> <p>Complement practice prevention activities with effective population/community based prevention strategies</p> <p>Utilise the 'less is more' approach</p>

Collaboration

How would you rate your ability to work as a team with:

- the patients in your practice?
- other members of your practice team?
- the community and community-based health workers and specialists?

Provide examples of good teamwork for each of these. What helps, what hinders?

To what extent do you involve other health care organisations in your patients' care?

Effectiveness and Efficiency

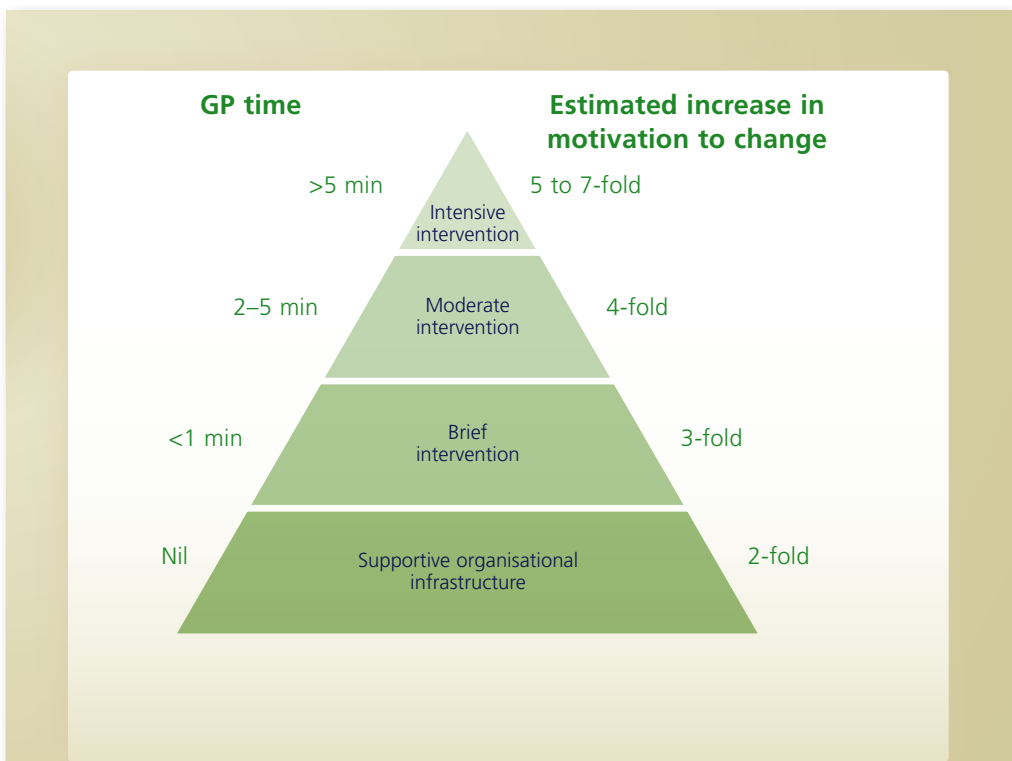
Case Study: Influenza Vaccination

Scenario

Gumtree Medical Centre routinely sends out influenza vaccination reminders to all patients aged over 65 years in February/March each year. Administratively, this is time consuming and postage costs are high. The practice team meets to discuss whether this can be done more efficiently.

How could the practice team make this process more efficient?

'Less is more': the reality pyramid



How/when could you utilise a 'less is more' approach?

What could you include in a 1 minute intervention for smoking cessation?

Exercise: Gumtree Medical Centre

Scenario

Some time after the successful implementation of the diabetes screening program, the Gumtree Medical Centre decides to investigate the possibility of starting a diabetes clinic in order to provide additional services to patients with diabetes.

What would need to be considered at the initial meeting?

Applying the PRACTICE framework

04

Applying the PRACTICE framework at various levels of health care support

Prevention activities can be implemented at each of the following levels:

- consultation
- practice
- community and health care system.

The consultation is a core component of general practice but may be a source of dissatisfaction for both GPs and patients.

GPs believe patients may:

- have unrealistic expectations
- not adhere to advice
- fail to take responsibility for their behaviour.

Patients believe GPs may:

- not provide sufficient information or explanation
- not listen.

Are these factors applicable to your practice?

Discuss some strategies to address/avoid dissatisfaction.

The practice: The implementation of preventive activities at the practice level should be systematic and use a whole-of-practice approach. This involves a shift in perspective away from individual patients to an overall practice population.

The community and the health system: Community and healthcare organisations can provide support for local health prevention activities via:

- publications
- publicity
- other support.

A quick guide to putting prevention into PRACTICE

	Consultation	Practice	Community
Principles What underpins the process?	Adopt a systematic, patient centred approach	Be systematic and use a whole-of-practice approach	Strengthen partnerships and develop collaborative approaches to prevention
Receptivity Why should I do it? What's in it for me?	Receptiveness to change should be considered from both the patient and GP perspective	Ensure all practice staff believe prevention strategies are important and worthwhile	Build partnerships with other health professionals and community organisations
Ability What do I need to do to achieve it?	Assess the abilities of both the patient and the GP; address any deficits	Ensure staff have the knowledge, skills and abilities to undertake preventive care	Build networks and partnerships with other agencies and groups in the community
Coordination How will we do it and who will organise it?	Assess complexity of patient health concerns and the benefits of sharing care	Clarify the roles, tasks and responsibilities of the practice team	Link prevention activities across the practice and the wider community
Targeting Who needs it?	Asking patients to complete a prevention survey is an effective strategy	Assess patient and practice prevention needs and set targets based on need	Identify partner organisations that share an interest in specific target populations
Iterative cycles How can I ensure that it happens?	It is important to periodically review interventions to determine their efficacy	Assess whether the strategies implemented improve the delivery and uptake of preventive care	Use PDSA cycles
Collaboration Who can help me?	Increase patient involvement in their healthcare during the consultation	Building an effective partnership with patients is the responsibility of all practice staff	Maximise the use of other health professionals and agencies
Effectiveness What works? How can I make it routine?	The average consultation is only 15 minutes, therefore it is important to adopt an effective and efficient strategy	Identify barriers and enhancers of preventive activity before launching preventive care in your practice	Determine the best use of your practice's time/contribution in community programs and service delivery

The 5As framework can help formulate lifestyle intervention strategies into activities that can be achieved in less than 1 minute or in 1–5 minutes.

The 5As framework includes:

The 5 step process

Ask	Identify patients with risk factors
Assess	Assess level of risk factor and its relevance to patient's health assess readiness/motivation to change
Advise	Provide brief advice and motivational interviewing provide written information Provide a lifestyle prescription
Assist	Offer pharmacotherapies Offer support for self monitoring
Arrange	Arrange referral to special services Arrange contact with social support groups Arrange follow up with GP

Do you feel confident in motivational interviewing?

What strategies promote better patient adherence?

Have you experienced conflict with your patients in regard to prevention?

How did you manage the conflict? Were you successful?

Exercise: Motivational interviewing – video consultation

What was done well in this consultation? Why did it work?

How would you have handled this differently if Peter had not been motivated to quit?

Scenario

Review of the practice register shows that allergies are not adequately recorded, and that many health summaries are incomplete.

How would you develop and implement a plan to update health summaries? What review processes would you include? What different roles could practice team members take?

Scenario

One of the part time GPs complains that she doesn't have time to check her patient's health summary and record the information.

What strategies would you take to make team members more receptive?

How can updating these health summaries assist in future prevention activities?

Are there systems in place in your practice to enhance preventive care?

What needs to change and what might the barriers to change be?

Exercise: Case study – Elmtree Medical Centre: 45 year old health check

Scenario

The practice team at Elmtree Medical Centre decides to target patients eligible for the 45 year old health check. The team consists of four GPs, two practice nurses, a practice manager and reception staff.

Knowing that patients must be aged 45–49 years inclusive and have an identifiable risk factor for chronic disease, practice nurse, John, looks at the practice database to identify eligible patients. At the next team meeting, John reports that it is not easy to identify eligible patients. Although age, gender and current medications are recorded, weight is only identified in 50% of patients, and many of these do not have height or body mass index recorded. Smoking status and alcohol consumption are recorded less than 50% of the time, and diet is recorded in less than 10% of patients.

What strategies could the practice take to improve their practice database?

What roles could different team members take?

What strategies might a practice with a more complete database use to identify patients?

Scenario

The practice team at Elmtree Medical Centre decides to identify patients eligible for the 45 year old health check as they come into the practice for other reasons. Reception staff flag patients visiting the practice who are within the eligible age range, and a practice nurse then asks them to complete the green book's patient practice prevention survey to identify risk factors. Their responses are later entered into their electronic record. If risk factors are identified, patients are then provided with information on the health check and how it may benefit them, and they are invited to return for the health check on another day. A brief information sheet about the health check is prepared for patients to take home with them.

The practice uses the RACGP checklist as the basis of the health check, and one of the GPs and a practice nurse work together to perform the health check. The practice nurses collect information such as BMI and waist circumference, and assess the SNAP factors and provide advice where required. The GPs undertake the remainder of the assessment, provides further advice and answers any additional questions.

What training could be helpful to enhance the benefits of this health check?

Scenario

One month after the implementation of this program, the practice team meets to discuss any problems. The following problems are identified:

- a number of patients undertaking the health check would benefit from referral to support services in the local area. While staff are aware of these services, it can take some time during the visit to locate the information to give to the patient
- it was noted that some patients who had visited had been asked to complete the survey more than once.

How could these problems be addressed?

The community and health system

What factors might prevent practices from working with community groups and divisions?

How can these issues be minimised?

Exercise: Case study – Gumtree Medical Centre

Scenario

The Gumtree Medical Practice is in an area of low socioeconomic status (SES) and a large proportion of the practice population has low SES. Responses to a prevention survey show that patients see mental health as a priority area. Practice staff are conscious of the fact that patients with low SES are statistically more likely to have depression. Therefore, on the basis of these results, the practice team decides to implement a program to screen for depression.

After reviewing the evidence set out in the RACGP red book,¹ the team decides to focus initially on screening people at increased or high risk of depression, ie:

- people at increased risk of depression (eg. with a family history of depression, recent loss, postpartum women, people with poor social supports, un/under-employed people, young men in rural areas, mothers from low SES groups, people suffering from life stress) should opportunistically be screened for depression, and a high level of clinical awareness of those at high risk of depression should be maintained
- people at high risk of depression (eg. a past history of depression, multiple or unexplained somatic complaints, chronic illness/pain, alcohol and drug abuse, comorbid psychological conditions) should be screened every 12 months, and a high level of clinical awareness should be maintained at every encounter.

A team meeting is organised to discuss how the depression screening program will be implemented. One of the doctors conducts a quick search using the RACGP *MyGeneralPractice* desktop resources which enable quick access to the Cochrane database,² the National Guideline Clearing House³ and Bandolier. Using search terms 'depression', 'screening' and 'primary care', she is able to read papers about this topic and learn more about the issues related to screening for depression. She reports to the team that depression guidelines did generally support case finding or screening for depression, but the literature only supports screening if the practice had a system in place to ensure that people suspected of having depression could be adequately assessed, treated and followed up.³⁻⁵ She also notes that there is evidence that case finding is best focused on patients that have not been seen in the past 12 months.⁶

The team decides to use the PRACTICE framework to highlight areas that are currently being addressed, along with areas that need attention. You draw up a matrix as shown below to assist you in this.

Using the PRACTICE matrix for the implementation of a prevention program to record height and weight of patients as a guide (*Table 2*), complete the PRACTICE matrix to help you identify what may be required to implement a comprehensive prevention program designed to screen for depression. For each element, outline what needs to be done at each level of care.

Note that this matrix can be used as a guide when developing a prevention plan, however, it may not be possible to address every aspect all at once. By considering all the issues, you will be able to prioritise your prevention activities, and develop your plan based on your practice's priorities. Additional activities could be introduced at a later stage.

	Consultation	Practice	Community
P			
R			
A			
C			
T			
I			
C			
E			

Recording height/weight of patients

	Consultation	Practice	Community
P	Engagement with patients to identify their goals	All patients can access care within a specified time	The practice is accessible to the community
R	All GPs in the practice agree that obesity and weight management is important	All practice staff agree that obesity and weight management is important	Community based campaigns promote healthy eating and weight management
A	All consultation rooms have scales, measuring tapes and height charts	Practice staff ensure that scales are regularly calibrated	Body mass index (BMI) and waist circumference measures are used as standard practice in the community
C	GPs understand how to record height/weight consistently	Practice nurse identifies process for entry of height/weight information into clinical systems	If necessary, consult with clinical software supplier and DGP regarding data recording
T	Agree, initial focus will be adults (over 18 years)	Agree, initial focus will be adults (over 18 years)	Those with BMI that records as obese are given information on community weight loss programs
I	Discuss how to raise weight issues. Develop 2–3 intervention ‘scripts’	Practice nurse will measure percentage of patients’ weight/height at regular intervals	Collaborate with community weight loss programs to feed progress information back to practice
C	Have agreed referral list and pamphlets	Have agreed referral list and pamphlets	Identify agencies that can help, eg. community health centre, gym, walking group
E	Aim for timeliness. Measure when patient first enters room, or have PN measure prior to consult	Practice nurses measure patients prior to consult and enter into clinical software	Use external agencies to provide education within the practice or refer patients to external agencies for education

Table 2.

Based on the matrix you have just completed, outline a plan for implementing a depression screening program in general practice:

Objective: _____

Achieve: _____

Actions: _____

Resources: _____

When: _____

Who: _____

How: _____

Possible barriers: _____

Scenario

The program was implemented. Procedures were developed for GPs to ask and record past, social and family history, and reminder systems set up to assist them. GPs asked those patients considered at increased risk of depression two questions: 'Over the past 2 weeks, have you felt down, depressed or hopeless?' and 'Over the past 2 weeks, have you felt little interest or pleasure in doing things?' GPs recorded on the patient's file when they screened for depression, so that they will know at future visits when the patient was last screened. After 1 week, practice nurses reviewed the records of patients seen during that period.

After 1 week, the practice team meets to review the success of the program, discuss their experience, and whether there has been any improvement. The GPs had difficulties in asking and recording all the information due to time constraints. In some cases relevant issues came up in the course of conversation during the consultation, and in other cases it was not always easy to ask. Where GPs assessed patients as being at increased risk of depression, they found that they were generally able to quickly ask the two screening questions, however, in some cases there was not enough time. Patients who answered yes to the depression screening questions required additional time to discuss further. General practitioners suggested a patient information pack would be a helpful resource to give patients. Practice nurses found it difficult to assess whether social and family history had been asked due to a lack of consistency in the reporting by GPs, as it was unclear whether a blank record meant that there were no relevant issues, or whether the patient had not been asked. It was also difficult to determine which of the at risk patients had been screened for depression.

What changes should be made to address the problems or areas for improvement encountered?

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