



National Study into the Management of Depression in General Practice: Results and Implications

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Study 1: Research Questions

- What do GPs consider to be significant barriers to the effective management of depression in general practice?
- What relationships do practice location and GPs' gender have to their management of depression and related disorders?
- What relationship does prior mental health education have to GPs' management of depression and related disorders?

Procedures

- GP Reference Group - development of questionnaire
- All 123 Divisions of General Practice invited to participate
- 52 Divisions participated:
 - urban GPs: 54%
 - rural/regional GPs: 46%
- 608 survey forms distributed through Divisions
- 420 (69%) survey forms returned
- Recompense per completed form : \$40 - GP, \$10 - Division

Participants

Gender: males – 46.4% females – 53.6%

Age: 35 – 64 yrs: 70%

Consult in languages in addition to English: 17.5%

Qualifications:

- FRACGP – 37.1%
- FACRRM – 11.2%
- formal P/G Mental Health (MH) qualifications – 8.3%
- other family medicine qualifications – 25.2%
- other post-graduate qualifications – 41%
- completed MH training in last 5 years – 43.6%
- training in non-pharmacological therapy (NPT) for dep/anx – 34.0%

Measures

- **Demographics**
(e.g. age, years in practice, training, education in MH, practice type)
- **Current clinical experience**
(e.g. presentation, treated with new antidepressants)
- **Barriers to care** (e.g. lack of time)
- **Confidence in skills** (e.g. treating depression with counselling)
- **Health Attitudes about depression**
- **Depression Attitude Questionnaire (DAQ)**
- **Education in depression & related disorders**

Main barriers to management of depression

Lack of access to mental health specialists:	51.4%
Usual consultation time prevents adequate assessment of dep'n:	50.6%
Poor reimbursement for time spent managing dep'n:	50.4%
Management of presenting problems limits time spent on dep'n	39.4%
Patient reluctant to be referred to a mental health provider:	37.3%
Inadequate time to provide appropriate treatment:	36.8%
Practice workload prevents adequate attention to dep'n:	32.3%
Patient or family reluctance to accept diagnosis of dep'n:	21.7%
Patient inability/unwillingness to discuss depressive symptoms:	16.2%
Lack of accessible assessment tools for dep'n:	15.9%

N.B.: *Proportion of GPs who said the factors affected their management A FAIR AMOUNT or A GREAT DEAL*

Results: Current clinical practice

- GPs did not identify an overly high percentage of their depressed patients as presenting primarily with somatic symptoms
- GPs who reported better knowledge of, & confidence in the use of assessment & NPT estimated they saw more depressed patients
- GPs who identified more practice barriers to care of depressed patients reported they saw more depressed patients
- Use of NPT related to confidence in diagnosis & treatment of suicide, & liaising with MH specialists
- GPs who believed little they could do, lacked knowledge & comfort in the assess & treatment, depressed patients resistant to treatment, more likely to refer to psychiatrists
- GPs who believed management of depressed patients is hard work & are confident in liaising with MH specialists more likely refer to psychologists

Results: Location of Practice

- **No significant differences between urban/rural:**
 - attitudes to depressed patients
 - identification of barriers to care
- **Rural GPs:** > prescribe medication
> confidence in liaising with MH professionals
- **Urban GPs:** > confidence in use of NPT

Results: GP Gender

- **Female GPs:**
 - > likely to provide MH treatments
 - > offer NPT
 - > believe depression a biochemical abnormality that responds well to medication
- **Female GPs:**
 - > with no MH training lacked most confidence in delivering NPT
- **Male GPs:**
 - > believe little can be done for depressed patients
 - > believe depressed patients should not be encouraged to consult their GP
 - > prescribe medication

Results: Effects of MH training

- Education in assessment & treatment of MH disorder related to GPs' positive attitudes about depressed patients
- GPs with training or P/G MH:
 - less likely to identify lack of knowledge of diagnostic criteria, assessment & treatment methods for depression as barriers to care
 - more often used NPT for dep'n/anxiety
 - more confident in use of NPT for dep'n/anxiety
- GPs with P/G MH more confident diagnosing & treating suicidal patients

Conclusions from Study 1:

- MH training/education influences
 - GP attitudes towards depressed patients,
 - identification of barriers to care of depressed patients,
 - confidence in assessing & managing depression
- Depression attitudes influence diagnostic rates
- Rural GPs are particularly in need of training in depression assessment & treatment
- MH training strong impact on female GPs' confidence, although it would also impact on the practice of male GPs

Study 2: Research Questions

Does Mental Health (MH) training & education undertaken by GPs:

- impact on knowledge of NPT?
- affect the specific delivery of cognitive, behavioural, and structured problem solving treatments by GPs?

Procedures

- Australian Divisions of General Practice (ADGP) mailed questionnaire packages to 200 GPs
- Questionnaire packages contained explanatory statement, anonymous survey, & reply paid envelope
- GPs who completed and returned the survey were paid \$40 and her/his division \$10

Participants

88 GPs returned surveys

56 Females; 32 Males; 54% aged 45-54 yrs

GPs who participated in the **'National Study into the Management of Depression in General Practice'** and who

- reported they used 'a fair amount' or 'a great deal':
 - cognitive/and or behaviour therapy and/or
 - structured problem solving



Measures

Survey with questions on:

- GPs' training in non-pharmacological treatments (NPT)
- how often GPs use specific CBS
- GPs' confidence in using specific CBS
- how GPs implement CBS
- GPs' knowledge of CBS techniques

Results: NPT Techniques

Most used:

- provide patient with diagnosis, verbal info on disorder, rationale for use of NPT, sleep hygiene education
- ask patient to complete pleasurable activities records
- explain reason to patient for pursuing topic during sessions

Least used:

- structured clinical interviews
- instruct patient to keep written sleep-wake diary
- written script for progressive muscle relaxation
- written records to identify anger patterns

Results: Effects of MH Education on NPT

GPs with PG MH *more often* than GPs with 20- hrs:

- Implement cognitive therapy
 - provide rationale emphasising changing inaccurate beliefs to alleviate depression
 - guide patient to consider whether maintaining a specific belief is helpful
- Teach progressive muscle relaxation during the session
- Review written records/materials
 - review during session patient's written record of activity completed, thought record, & out of session use of problem solving
- Graded Exposure
 - develop with the patient a hierarchy of feared situations and plan for exposure
 - practice with the patient coping statements
 - review patient's out of session experience of graded exposure

Results: Effects of MH Education on NPT

GPs with PG MH *more often* than GPs with 20+ hrs

- Review patient's out of session experience of graded exposure
- Review patient's written activity record during session

GPs with 20+ hrs *more often* than GPs with 20- hrs

Provide patient with:

- a written script for progressive muscle relaxation
- education regarding the sleep-wake cycle



Results: Confidence in use of NPT

GPs with PG MH *more confident* than all GPs:

- Cognitive therapy
 - provide rationale that emphasises the importance of changing inaccurate beliefs to alleviate depression
 - encourage patient to view thoughts as beliefs rather than as facts
 - guide the patient to consider whether maintaining specific belief is helpful
- Written Records
 - review during session the patient's written activity record, anger patterns records, record of their out of session use of problem solving
- Graded Exposure
 - develop with the patient a hierarchy of feared situations & plan for exposure
 - review patient's out of session experience of graded exposure

Results: Confidence in use of NPT

(cont'd)

GPs with PG MH *more confident* than GPs with 20- hrs:

- Formally review progress after an agreed number of sessions
- Encourage patient to use written problem solving techniques on problems that arise between sessions/consultations
- Teach the patient controlled breathing techniques during the session
- Cognitive therapy
 - practice with the patient coping statements for use in feared situations
 - explore the relationship between the patient's negative beliefs and their underlying belief system

Implementation Issues

GPs with PG MH *more likely* than all GPs:

- To take only emergency phone calls or interruptions when conducting CBS sessions

GPs with PG MH *more likely* than GPs with 20- hrs:

- To allocate specific times in week to offer NPT for depression/anxiety
- To schedule a fixed number of sessions for treatment
- *Less likely* to be concerned that if they use CBS, they will lose control of consultations

Conclusions

1. Specific MH training appears to contribute little to GPs' knowledge of NPT
2. MH education affects the range and types of CBSs implemented by GPs
3. MH education affects GPs' confidence in use of CBSs and how the consultation is structured
4. MH PG > 20+ hrs > 20-hrs