Towards a practical solution for depression in general practice

Professor Jane Gunn MBBS FRACGP DRANZCOG PhD, Primary Care Research Unit, Department of General Practice, The University of Melbourne

Correspondence to: j.gunn@unimelb.edu.au

***Jane Gunn** is a GP and Associate Professor, Deputy Head and Research Director in the Department of General Practice, University of Melbourne. Jane completed her PhD on postnatal care in the early 90s and is actively involved in primary care research and part-time general practice. In developing a focus on understanding and managing depression in general practice Jane led the development of a consortium for improving the management of depression in primary care (www.diamond.unimelb.edu.au) which is investigating several innovative approaches to management.*

Depression as an illness is rising to the top of the disability charts and The World Health Organization predicts that by 2020 it will be the second leading cause of disability in developed countries. There is an extraordinary amount of medical literature devoted to the topic of depression. A search of 'PubMed' or 'Google' returns thousands of 'hits'. My own interest in depression has been fuelled through my doctoral studies into postnatal problems, recent work on depressive symptoms in the adult primary care population and my clinical work as a general practitioner. In this article I use these experiences, research and practice, to explore key issues that must be addressed if we are to find practical solutions for this common, often disabling condition. Firstly, we must agree upon the concept of depression that is useful for general practitioners and secondly we must decide upon the most practical solutions, although the word 'solution' is probably better replaced by 'response'.

What concept of depression is useful for general practice?

It may seem disheartening to return to definitional issues around depression, but recent research highlights our need to do so. There is confusion in the way that terminology is being used. What form/s of depression are we talking about? Depression is a term in everyday use. Football supporters become 'depressed' when their team loses, fans become 'depressed' when they miss out on concert tickets. General practitioners use the term to refer to depressed mood, depressive symptoms, depressive syndrome and depressive illness. Dr Heather McGarry, from our Department at The University of Melbourne, has led an important survey of general practitioners that has demonstrated that few general practitioners routinely or purposively apply the DSM IV criteria when assessing a patient with probable depression. We know from other research that whilst 'major depression' is a severe and incapacitating illness, 'minor depression' accounts for more use of general practice services.[1] How important is it to distinguish between the type and severity of depression, according to traditional psychiatric definitions? The literature suggests that we should seriously consider doing so. Antidepressant therapy is superior to placebo in major depression but not minor depression; for which psychological therapies alone are the preferred treatment. This evidence suggests that it is important to make the distinction between major and minor depression. Yet it appears that few GPs actually bother with this distinction.[2] Is this a short-coming of general practitioners, or is the distinction of little practical use?

There is a growing debate about the use of a categorical versus dimensional approach to depression in the primary care setting.[3] People experiencing depressive symptoms in primary care usually have co-morbid physical and psychological problems; yet the research which informs

our practice is often undertaken on people experiencing a 'pure' form of major depression, the co-morbid varieties deliberately excluded from the studies.

General practice needs to know whether using formal psychiatric diagnostic criteria are helpful, or not, in the management of depression in primary care; or whether specific primary care criteria are more appropriate. Emerging research from groups with a good understanding of the discipline of general practice is shedding light on this topic. In New Zealand, the MaGPIe study,[4] has demonstrated that there is an association between the level of psychological problem and the treatment that someone receives; indicating that general practitioners are using specific criteria to decide upon treatment.

In Australia, we are currently undertaking a longitudinal study, called *diamond* (diagnosis and management of depression), where we are following a group of people experiencing depressive symptoms and documenting the co-morbidities (physical, mental and social), treatments and service use over time. We will explore whether there are important differences (physical, mental and social) between people experiencing major depressive disorder and other depressive syndromes from a group of primary care patients. Our inclusion of measures of the doctor-patient relationship, social participation, social support, partner abuse and substance abuse will shed light on previously ignored factors in the development and persistence of depression (www.diamond.unimelb.edu.au). General practice needs to document the general practice response to the common general practice presentations (see Box); we need to articulate it in order to ensure that we can document how well it is occurring and determine whether our response is the most helpful it can be. General practice is a discipline based on a biopsychosocial approach, one that expects physical, emotional and social aspects to every presentation and one that is adept at dealing with uncertainty and diagnostic confusion. This understanding needs to be reflected in the way we research, report and practice.

Do practical solutions exist already?

The mismatch between practice and evidence

Over the years a number of papers report research that highlights the deficits of general practice to identify and correctly manage the ever-growing problem of depression.[5] The argument has been waged that if GPs did their job better (by diagnosing depression and applying evidence-based therapies) the ever-growing burden of depression could be quelled. This is a rather simplistic approach and yet it went relatively unchallenged by general practice for some years; despite the fact that in casual conversation, general practitioners would express alarm at the concept that depression is being missed so often and so obviously, when all they seemed to be faced with day in, day out, were people experiencing various degrees of depressive symptoms.

There is no doubt that anyone wanting to work as a general practitioner needs to have the knowledge and skills required to deal with mental health problems, as these form an integral part of general practice

The assumption that a knowledge and skill deficit of general practitioners is a major contributor to the ongoing problem of depression appears to have been ill-guided. A number of cross-sectional studies using depression screening tools have shown that general practitioners miss cases of 'possible' depression. Yet when a more sophisticated analysis is undertaken it appears that general practitioners do better than first thought. In fact they are very good at picking up a serious depression, as Thomson and colleagues have shown.[3] This finding has been supported by research undertaken in New Zealand by the MaGPIe group[4] who have found that GPs rarely miss depression in people that they see over time. This being the case it is unlikely that interventions that focus largely on training GPs in identification will make much of a difference to the diagnosis and management of depression.

In Australia, GP training in depression care has been seen as an important part of the solution to the 'depression' problem, where it forms an integral part of the 2001 *Better Outcomes in Mental Health Care* initiative (BOMHC). The BOMHC has provided education and training for GPs, financial incentives and enhanced access to support from psychiatrists and psychologists to address the delivery of care for high prevalence mental health disorders. As with all continuing medical education and professional development there is a tendency for training to 'preach to the converted'. Whether this has occurred in Australia is hard to judge as, to date, there is no formal published evaluation of the effect of this training on GPs or health outcomes for people experiencing depression.

There is no doubt that anyone wanting to work as a general practitioner needs to have the knowledge and skills required to deal with mental health problems, as these form an integral part of general practice. What is not clear to me is the evidence supporting the lack of these skills in our current general practice workforce. An interesting feature of the training component of the BOMHC was that it was implemented as a 'hurdle' requirement for GPs in order for them to access the new special mental health fee-for-

service items. This has caused controversy, as it has implied (to some) that a general practitioner per se is not adequately trained to provide mental health care. In Australia, there has been a dedicated postgraduate training programme for general practice for more than thirty years. The patient-centred clinical method and a biopsychosocial approach have been cornerstones of this programme. Underlying mental health and emotional issues are a regular part of the cases presented in the final clinical examinations. There is debate in general practice circles in Australia as to the need for 'extra' training for particular conditions in order for GPs to access higher payments for managing those conditions. Interestingly, many GPs who have undertaken the training do not bother with using the newer item numbers, preferring instead to continue their usual billing patterns. It will be very interesting to follow the outcomes of the BOMHC in Australia. Anecdotally, the enhanced access to psychiatrists for complex cases and to allied health for intensive psychological therapies has been particularly welcomed by Australian GPs. Whether it has made a difference to health outcomes for patients is not clear at this stage.

Towards practical solutions

Australia and New Zealand have well-trained general practice workforces. The focus on potential short-comings of general practitioners, in my mind, has allowed us to side-step the more challenging problem of actually being able to assist people to recover from depression. Whilst we have access to newer antidepressants with fewer serious side-effects we know, from research and practice, that is not enough. Perusing the Cochrane systematic reviews relevant to depression one finds that whilst pharmacological and psychological treatments have been shown in randomised controlled trials to be superior to placebo treatments, the trials included in the reviews have usually been short-term and we lack primary care data on the long-term effectiveness of even the most widely used treatments.

When devising practical solutions for general practice we must remember that much of the research is conducted in secondary and tertiary care settings and may not be relevant to our primary care setting. Firstly, our case-load is likely to include far more people with minor depression, distress and sub-syndromal depression for whom antidepressants are no better than placebo. Secondly, our case-load is likely to include people experiencing co-morbidities which make the job of managing things far more complicated. Thirdly, our clinical experience has highlighted that

Depression in general practice

Depression in practice could be the young woman, so full of life and potential who, when faced with the collapse of her young marriage, sinks into the depths of despair. Suicidal thoughts fill her nights, agitation and lack of concentration fill her days, overeating and purging, muscle aches, pains of unknown origin, sadness, tears and hopelessness. She has the full hand of a sudden, major depression. I met this woman more than five years ago and she has received intensive psychiatric care along with my own care as a general practitioner. She experienced 'treatment resistant' depression and tried many antidepressants and mood medications. Recently, her depression lifted as quickly as it had descended. She made a special visit to tell me of the news – it had gone. She was living again; after many years of her life hanging in the balance.

Depression in general practice could be the highly creative person with a recurring major depressive illness that responds each time to respite, antidepressants and gentle exercise.

These stories will be familiar, yet they are not the commonest way that depression presents to a general practitioner; nor are they the most challenging cases to treat. As a part-time GP who has been in practice for 15 years, I can think of no more than half a dozen patients for whom depression has conformed to the classic hand of major depressive disorder, with the diagnosis and management plan clear for all to see; albeit a harsh, demanding, unknown road for the sufferer, their family and friends. Far more often depression presents to me as a mixture of low mood, personality traits, anxiety, lack of motivation, negative thinking and a mixture of somatic complaints and physical illness. It walks into the consulting room tied up in a web of physical symptoms, emotional distress, relationship and social issues. The tangle is so tight that it can take many consultations to work out where to begin; indeed it can be a task of trial and error in which doctor and patient gingerly feel the way. To me this is the stuff of general practice – the biopsychosocial in full flight. To me this is the exact presentation that the Fellowship of the learned Colleges of General Practitioners prepares general practitioners for. Yet, when I read the published literature and the policy statements I find a familiar lament – general practitioners get it wrong too often. General practitioners miss and mistreat depression. What is going on?

for a significant number of people their struggle with depression will persist beyond their course of cognitive behavioural therapy (should they be able to access it) or antidepressants. None of the existing guidelines have been developed to deal with the complexity of the cases of depression that general practice has to manage.[6] Even the promising collaborative care models used in the USA (a health care setting that bears little resemblance to Australia or New Zealand) have been tested on patients with major depression (co-morbidities excluded) who are willing to take antidepressants;[7] this is only the tip of the iceberg of depression that general practitioners actually manage.

The voice of general practice research is being raised to debate the now widely held belief that a major problem confronting better depression care is that general practitioners miss and mismanage depression. The time has arrived for general practice to call loudly for acknowledgement of the role it already plays, to articulate how it defines the problem that 'depression' presents and to establish interventions that are proven to work, having been rigorously tested on people who resemble the patients cared for in the setting of general practice.

Competing interests

None declared.

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