How can general practice tackle Australia’s depression epidemic?

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Overview

The problems

The research

Some ideas for discussion
The problems

• Depression is very common
  • the single largest cause of disability burden
• Depression is a driver of health care use
  • GPs prescribe 85% of the 12 million antidepressant scripts (2006-2007; AIHW)
  • 1.5 million psychological services provided in the first 14 months of Better Access
• GPs seen to miss cases yet...
  • 1 in 4 adults attending a GP satisfy criteria for depression
  • Depression is one of the most common diagnoses in GP
DRIVERS OF DEPRESSION CARE IN GENERAL PRACTICE – who is responsible?
The place of generalism?

Health care costs are rising
Ageing population with multiple long-term conditions
Health care inequities are growing
Health workforce shortages
Pressure for primary care reform
Focus on health care teams and new ways of working
Research underway

**EXEMPLARY MODEL OF DEPRESSION CARE IN GENERAL PRACTICE**

PHASE I & II

- Voice of Patients [diamond Study]
- Voice of Non-patients [re-order Study]
- Review of Guidelines

PHASE III

- Voice of primary care Providers [re-order]

- Observation of practices
- Audit of medical records
- Survey of GPs
- Practice meetings (x5)
- Interviews: GPs Patient & Carer (PhD Study)
THE DIAMOND STUDY
DIAgnosis, Management and Outcomes of Depression in Primary Care
• Commenced in 2005
• 4 year follow-up underway

Baseline: Postal survey & telephone interview
12 MONTH Postal survey & telephone interview
24 MONTH Postal survey & telephone interview
36, 48, 60 MONTH Postal survey & telephone interview
DIAMOND RECRUITMENT LOCATIONS

Total Km Travelled

3 3 1 7
A view of depression from community practice

• Blurry boundaries

• General practice is a good place for depression care to occur

• Depression care should combine physical and mental health care

• Depression care should be tailored and take account of social context
Phase & severity demand different response

Depressive symptoms

Minor Depression

Dysthymia

Major depression (mild)

Moderate

Severe

Do GPs miss depression?

Who are we designing depression care for?

Findings from the diamond study
GP recruitment

30 GPs recruited (randomly selected)

Screening

7,667 patients (aged 18-75 years) screened

Baseline

789/1793 patients with CES-D ≥ 16

FOLLOW UP

3 mth → 6 mth → 9 mth → Yearly
Percentage with probable depression (CESD≥16) by physical condition at screening

- None*: n=2142
- Hypertension n=1258
- Cancer n=192
- Other n=559
- Lipid disorder n=820
- Arthritis n=1357
- Heart disease n=239
- Asthma n=774
- Back problems n=2125
- Chronic sinusitis n=401
- Diabetes n=400
- Emphysema n=167
- Dermatitis n=521
- Stroke n=59
Odds of probable depression by number of physical conditions
## Cohort characteristics

<table>
<thead>
<tr>
<th>Variable</th>
<th>Cohort</th>
<th>Eligible</th>
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<tbody>
<tr>
<td></td>
<td>n=789 (%)</td>
<td>n=1004 (%)</td>
</tr>
<tr>
<td>Female</td>
<td>563 (71.4)</td>
<td>689 (68.8)</td>
</tr>
<tr>
<td>Age M (SD)</td>
<td>48.0 (13.1)</td>
<td>47.1 (15.1)</td>
</tr>
<tr>
<td>Live alone</td>
<td>167 (21.3)</td>
<td>184 (18.5)</td>
</tr>
<tr>
<td>Unable to work</td>
<td>115 (14.6)</td>
<td>131 (13.1)</td>
</tr>
<tr>
<td>Left school before year 10</td>
<td>134 (17.0)</td>
<td>185 (18.6)</td>
</tr>
<tr>
<td>Smoker *</td>
<td>249 (31.7)</td>
<td>273 (27.4)</td>
</tr>
<tr>
<td>Self-reported depression in past year *</td>
<td>424 (53.8)</td>
<td>389 (39.0)</td>
</tr>
<tr>
<td>Ever told by a doctor had depression *</td>
<td>530 (70.5)</td>
<td>473 (51.1)</td>
</tr>
<tr>
<td>Taking antidepressants *</td>
<td>307 (39.3)</td>
<td>252 (25.3)</td>
</tr>
<tr>
<td>Chronic physical condition in past year *</td>
<td>542 (68.8)</td>
<td>591 (59.3)</td>
</tr>
<tr>
<td>Long term illness/health problem/disability *</td>
<td>405 (52.5)</td>
<td>442 (45.4)</td>
</tr>
<tr>
<td>Ever afraid of partner *</td>
<td>278 (36.8)</td>
<td>258 (26.9)</td>
</tr>
<tr>
<td>Rated health as excellent</td>
<td>28 (3.6)</td>
<td>27 (2.7)</td>
</tr>
</tbody>
</table>
Some cohort facts

• Half first spoke to GP more than 5 years ago
• 3 in 5 said the first thing they had done was to speak with a professional (most commonly the GP)
• 1 in 3 try to manage it themselves
• Most people feel they are caring for their depression, then a family member then the GP
• They seek help when unable to cope, suicidal thoughts, can’t sleep, crying too much, physical symptoms, others prompt
• Stigma still prominent
• Majority happy with general practice as setting for care
• One third not happy about the idea of waiting room screening
• Like the idea of written plans
• Happy with idea of seeing a well trained practice nurse or psychologist
• Want information, self-help resources, group support, targeted services, social interaction, more affordable
Diamond cohort

Depressive Symptoms
CES-D ≥ 16
N=1793 (23.9%)

diamond Cohort
N = 789

Major Depressive Syndrome
( PHQ-MDS)
N = 211 (26.7%)

Depressive Symptoms
(CES-D≥16, no PHQ-MDS)
N = 408 (51.7%)

Transient Depressive Symptoms
(CES-D<16, no PHQ-MDS)
N = 170 (21.5%)
Mental and physical problems

![Graph showing prevalence of various health conditions including anxiety, substance abuse, panic disorder, binge eating, back problems, arthritis, hypertension, asthma, high cholesterol, diabetes, and cancer.]
Social and lifestyle factors

- Unable to work
- Difficulty with money
- Pension or benefit
- Alcohol
- Smoker
- Ch. sex abuse
- Ch. phys abuse
- Partner violence

Chart showing the prevalence of MDD, Depressive Symptoms, and Transient in various social and lifestyle factors.
What do people do for depression?

Depressive symptoms, coping alone

Seeking help from family and friends

Seeking help from primary care & community

Specialist care

Patients seen in general practice

Inpatient care
What should GPs do for patients?

Listen to them. Don’t push pills down their throat and send them to something they can afford because if they don’t, it’ll only .. The money pressure only adds to the pressure of depression.

Well I can only say what mine has done, which is to treat me to the best of his knowledge and then when he believes he can’t treat me anymore is to refer me to someone who can.
## What Non-consumer and Consumer’s want

<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Listening</td>
<td>1</td>
<td>Listen / time to talk</td>
</tr>
<tr>
<td>2</td>
<td>Undertaking a thorough diagnostic assessment</td>
<td>2</td>
<td>Appropriate referral</td>
</tr>
<tr>
<td>3</td>
<td>Developing a plan with the patient</td>
<td>3</td>
<td>Follow-up / monitoring</td>
</tr>
<tr>
<td>4</td>
<td>Undertaking an assessment of severity and suicide risk</td>
<td>4</td>
<td>Guidance</td>
</tr>
<tr>
<td>5</td>
<td>Being well trained in depression care</td>
<td>5</td>
<td>Give time</td>
</tr>
<tr>
<td>6</td>
<td>Tailoring care to individual needs</td>
<td>6</td>
<td>Understanding / empathy</td>
</tr>
<tr>
<td>7</td>
<td>Taking into account social factors</td>
<td>7</td>
<td>Support</td>
</tr>
<tr>
<td>8</td>
<td>Being empathetic</td>
<td>8</td>
<td>Recognition</td>
</tr>
<tr>
<td>9</td>
<td>Providing longer consultations</td>
<td>9</td>
<td>Information</td>
</tr>
<tr>
<td>10</td>
<td>Offering a range of treatment options</td>
<td>10</td>
<td>Medication</td>
</tr>
</tbody>
</table>
What do GPs offer?

- Provided reassurance, encouragement and explanation: 83%
- Gave me chance to talk about how I was feeling: 81%
- Prescribed medication for depression, stress or worries: 48%
- Encouraged me to exercise: 45%
- Helped me to talk through my problems: 45%
- Advice about diet: 33%
- Advice on getting good night's sleep: 28%
- Gave me information about depression, stress or worries: 25%
- Suggested see another health professional: 23%
- Referred me to a health professional: 20%
Re-order key findings

• Depression care is highly individualised;
• There is a sense that depression care is burdensome;
• Problems with physical & technological infrastructure;
• Limited time to talk about depression as a practice;
• In spite of access to social workers, psychologists remain primary referral pathway;
• Monitoring for depression occurs at the level of individual practitioner.
Re-order key findings

Technological infrastructure – practice staff have varied understanding of how to search software;

DSM-IV classification of major and minor not used;

Difficulties sorting distress from depression;

Depression is not episodic so much as everyday.
Developing Principles for exemplary care

**NPT PRINCIPLES**

- COHERENCE

- COGNITIVE PARTICIPATION

- COLLECTIVE ACTION

- REFLEXIVE MONITORING
Principles for an exemplary practice

• Develop understanding and agreement about who is depressed and who is not; (achieve coherence)

• Agree upon techniques to decide on who is depressed and who is not; (joining in; cognitive participation)

• Agree on who does depression work, how it is allocated and organised; (collective action)

• Identify ways for practices to know that they are doing good work; (reflexive monitoring)
Principles for exemplary depression care in the primary care setting

Coherence
A shared understanding of what constitutes depression.

Cognitive Participation

Collective action
Agreement about how care is organised

Exogenous Factors

Endogenous Factors

Reflexive Monitoring
Coherence

• Agreed techniques for dealing with the diffuseness of depression

• Agreed boundaries to sort ‘distress’ from ‘depression’
Cognitive Participation

- Agreement that depression care is legitimate work.

- Agreement upon the sets of techniques required to do the work.
Endogenous Factors

*Interactional workability:*
- Develop agreements about the conduct of work.
- Provide support (IT, templates, guides, clinical discussions, peer support).
- Make explicit values around cooperation, goals and meaning of the work and acknowledge the informal rules that influence depression work.
- Provide support for integrating/separating physical health from depression work as required.

*Relational Integration:*
- Agreement on who does the work & why?
- Enable processes for information sharing, communication, cooperation and conflict resolution.
Exogenous Factors

**Skill set workability:**
- Practice policies for practice team skill set and allocation of work that optimises the skill set within available funding mechanisms.
- Practice structure and organisation that keeps abreast of policy & funding changes.

**Contextual Integration:**
- Physical infrastructure, structural and policy mechanisms that enable practice adoption and adaptation of available funding & programs.
- Structural mechanisms to support the value of depression work.
- Policies and procedures for diagnosis, clinical records, prescribing, referral, follow-up and how these are communicated and shared.
Reflexive Monitoring

• Agreement about how depression work will be monitored at patient and practice level using qualitative and routinely collected quantitative measures.

• Provide the information systems, training and required infrastructure.

• Agree upon frequency and mode of patient follow-up.
The balancing act of dealing with the “wicked problem”

• Agree a philosophy of practice but also take action
• Avoid the blame game but ensure responsibility
• Invest in infrastructure but don’t forget the relationship
• Build teams but ensure there is space for ongoing personal relationship
• Measure outcomes but be aware that the most important things may be impossible to measure (so value & $)
• Deliver effective mental health care but don’t ignore the physical and social
What could we do today?

Congruent service boundaries/catchment
Identify a practice population
Shared health records (esp for severe)
Practice based forum for dialogue and exchange (clinical relevance)
Just in time access to advice (co-location and distant)
Recognition of the expertise of the GP (trust and respect)
Agree a shared philosophy
Begin to join up social, physical and mental health services
Focus on student and vocational training & practice nurse training
Provide accessible tools for common problems
Provide access to practical help as well as psychological services
Begin a campaign to explain how physical/mental/social is linked
Reduce focus on single disease solutions
Begin trials of stepped care, shared care, collaborative care ...............the UK??
What should underpin health care?
### A generalist philosophy

<table>
<thead>
<tr>
<th>Ways of Being (Ontological Frame)</th>
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<tbody>
<tr>
<td><strong>Virtuous character:</strong> holds ethical character traits of compassion, tolerance, trust, empathy and respect</td>
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<tr>
<td><strong>Reflexive:</strong> interdependent, reflects on judgments and biases, lifelong learner</td>
</tr>
<tr>
<td><strong>Interpretive:</strong> processes of interpretation are used to understand patient with an emphasis on the contextual factors, use of multiple health systems languages, active listener, autonomous decision-maker, good communication skills</td>
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<th>Ways of Knowing (Epistemological Frame)</th>
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<tr>
<td><strong>Biotechnical:</strong> uses scientific and rational evidence, high index of suspicion, bio-medically driven, technically focused, uses advanced information systems</td>
</tr>
<tr>
<td><strong>Biographical:</strong> concentrates on lived-experience and life-story, family, carers, community and social knowledge all provide evidence</td>
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<th>Ways of Doing (Practical Frame)</th>
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<td><strong>Access:</strong> accessible, first-contact point, gatekeeper, provides referral</td>
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<tr>
<td><strong>Approach:</strong> balances individual versus population needs, consultation-based, holistic, comprehensive, flexible, adaptable, acts across clinical boundaries, provides early diagnosis, interdisciplinary team approach, negotiates and coordinates services, integrates knowledge, promotes health through education, prevents disease, is culturally sensitive, provides patient-centered care, minimizes service inequities, reduces service fragmentation</td>
</tr>
<tr>
<td><strong>Time:</strong> provides continuity of care over whole of life cycle (longitudinal)</td>
</tr>
<tr>
<td><strong>Context:</strong> community-based, uncertain, complex, deals with undifferentiated multiple problems of patients, acute and chronic care</td>
</tr>
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The key

Relationships

Responsibility

Reflexivity
Your questions

What mechanisms could be put in place to promote better coordination of the range of care needs (clinical and non-clinical) for people with mental illness (generally, and including for people with depression) to prevent people from falling through the gaps, and what role could GPs and other health professionals play in this?

What are some of the barriers to effective communication/collaboration in ensuring a multi-disciplinary team approach to the delivery of primary mental health care?

The life expectancy and quality of life of people with severe and persistent mental illness is significantly reduced due to untreated co-occurring physical illness. Primary mental health care services have an important role in prevention and early intervention and addressing these poor outcomes among this population group. In what ways could the primary care system be better placed to respond to the health care needs of people with co-occurring mental and physical disorders?

Taking an holistic view of depression care in the primary care setting, what does Professor Gunn perceive as the main reasons many people who have depression (and anxiety) fail to discuss it with their doctor; and in what ways could the primary care setting be re-orientated to address this?