Treating patients with anxiety and depression: who will help the GP?

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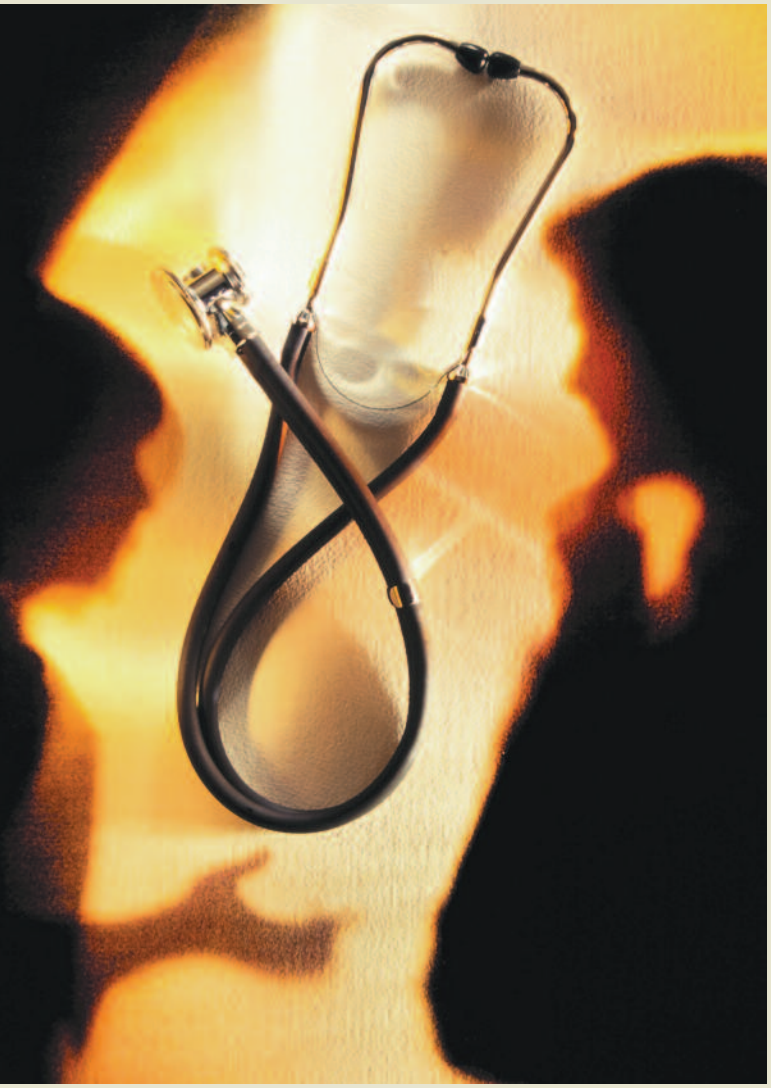

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In Australia, general practitioners manage much of the anxiety and depression experienced by members of the community. SPHERE is a national depression project which aims to provide GPs with the opportunity to receive ongoing education and support in the identification, treatment and management of common mental disorders in primary care. SPHERE was launched in early 1998, as a collaborative enterprise between academic and clinical psychiatrists and GPs, and more than one thousand GPs have participated.[1] The first training components of the project were provided free of charge to GPs.

This paper explains the need for mental health initiatives such as the SPHERE project, describes what SPHERE has found about how common anxiety and depressive disorders are managed in general practice, and outlines the way in which SPHERE supports GPs.

Who needs care?

In Australia, we are now faced with the obvious gap between the prevalence of mental disorders in our community and the capacity of our health care system to provide high quality treatments. The 1997 National Survey of Mental Health and Wellbeing indicated that 18% of adults had suffered a mental disorder in the 12 months previous to being surveyed.[2] Less than half of those with a disorder consulted a doctor.

Who provides care?

Australia does not devote a large degree of its health care spending to mental disorders and has only just started to focus attention on significant public health problems such as major depression and suicide.

The specialist sector

In the current mental health care system, the specialist sector deals largely with those patients suffering psychotic disorders (e.g. schizophrenia, bipolar disorder) or severe nonpsychotic disorders. Additionally, those with the most severe personality and substance abuse disorders are likely to find their way into specialist care. Only a minor proportion of those with the common anxiety, depressive and substance abuse disorders ever consult a psychiatrist or clinical psychologist.

The GP setting

When people do decide to seek medical help they prefer to consult their GP.[3] In the current mental health care system, treatment of the common forms of anxiety and depression has been left largely to the family GP. Consequently, over 75% of all mental health contacts occur between patients and their GP.

Why do GPs need support?

In the last decade, we have seen marked improvements in the quality of drug and non-drug treatments available for the treatment of the common anxiety and depressive disorders.[4] Major advances include the new selective serotonin reuptake inhibitors (SSRIs) and cognitive behavioural therapies. Only the more complex cases require specialised interventions so at least 60 to 70% of anxiety and depressive disorders can now be managed in the GP setting.

Unfortunately, our medical system is struggling to provide either the educational support or the necessary incentives that would result in rapid uptake of these treatments in general practice. Traditionally, little support has been provided to the GP by the specialist sector, educational institutions or government initiatives. Undergraduate and postgraduate training in the discipline of mental health has been inadequate,[5] and the current time and fee constraints in primary care discourage practitioners from expanding their mental health skills.

Further, the classification systems promoted by specialist psychiatry do not translate readily to the primary care sector,[6] and may have only discouraged GPs from providing effective treatments. Moreover, most patients with mental disorders that are seen in primary care will present with somatic symptoms and/or have a concurrent medical disorder. Treatment in primary care will often involve provision of both medical and psychotropic agents as well as sound behavioural interventions, such as increased social and physical activity, reduction of harmful substance use and conflict resolution with key others.

What happens in general practice?

As part of the SPHERE project, a range of data has been collected from clinical audits conducted by over 400 GPs. These clinical audits consist of self-report questionnaires from patients as well as their doctor's individual diagnoses and the treatments they provided. This allows us to examine the relationships between a patient's current psychological state and their doctor's response.[7]

Too much medicine?

GPs are often criticised for inappropriately prescribing psychotropic drugs to patients who present with mood, anxiety or other psychological problems. The media has been quick in attacking pharmaceutical companies associated with the development and the marketing of the new antidepressant agents.[8] Similarly, those who highlight the current lack of treatment of psychological disorders – including the SPHERE project, which has received financial support from a pharmaceutical company – have also been subject to this same style of criticism.[8] Interestingly, such attacks ignore the evidence of the disability due to common mental disorders,[9] the very poor long term medical and psychological welfare of these patients,[10] and the continuing rise of the youth suicide rate in Australia.

Clinical audit data from the SPHERE project clearly demonstrate that Australian GPs are still very conservative in their volume of prescribing antidepressant compounds. For example, of those patients identified as having an anxiety or depressive disorder who received treatment, only 8% received antidepressant therapy alone and 10% any combination of pharmacological and non-pharmacological approaches; 18% received non-pharmacological therapy alone.[11]

Treatments used

Drug treatment

With regard to the types of antidepressants prescribed, there has been a significant shift towards the prescription of the newer and safer agents such as the SSRIs for those patients clearly identified as having depressive disorders. For a wide range of other disorders, however, including anxiety, sleep disturbance, headaches and other vague somatic symptoms and chronic pain, tricyclic antidepressants continue to be popular.[11] Interestingly, an age bias was operative, with older patients continuing to receive the older drugs. This may be due largely to the continuation of low dose tricyclic antidepressants for sleep disturbance. Clearly, ceasing these medications in older patients, particularly after many years of continuous use, is a challenging task for both the patient and the practitioner.

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Non-drug treatment

With respect to non-pharmacological therapies, due to the severe lack of postgraduate training in their use, and the absence of rewards for their provision, the most effective therapies are rarely provided – for example, only 4% of GPs provided cognitive behavioural therapy, while 86% provided simple counselling and support.[11]

Who gets treated?

From a patient perspective, older patients are more likely to be identified as having psychological disorders. Presumably this reflects their more frequent attendance for care and the consequent capacity of the doctor to better understand their

difficulties. Younger patients are less likely to receive treatment, even though they have a higher prevalence of disorders of 59% compared with 38% for older patients.[12] Those from non-English speaking backgrounds and those who report somatic rather than psychological symptoms are also less likely to receive treatments.[12]

Who treats?

From the doctor perspective, female doctors, older doctors and those with some mental health training provide more treatments. Interestingly, older doctors seem to pick up mental disorders more effectively and often respond appropriately. Female doctors generally take on more than their fair share of the mental health burden in primary care. Those with mental health training clearly attract patients who will benefit from their extra skills. For example, doctors with some mental health training correctly identified 33% of patients with psychological problems compared with 24% for doctors without any mental health training.[12]

From a practice perspective, those who see fewer patients per week, those who work in more traditional family practice settings and those in regional, rather than urban or rural centres are also better at identifying problems.[12] When it comes to prescription of the newer antidepressant drugs and the provision of the newer non-drug treatments, similar trends emerge.

How does SPHERE support GPs?

The SPHERE Project has developed educational materials, training seminars and ongoing disease management programmes designed to increase the likelihood that GPs will provide high quality treatments. For example, the case identification system incorporates a self-report screening system for psychological and somatic forms of distress, individual reports for doctors and an analysis of practice characteristics and diagnostic decisions.

This year, interactive computer technology will permit us to bring these services directly to participating practitioners.

As participants in SPHERE have become more interested in acquiring mental health skills, the project has developed an agenda for their ongoing educational needs.[13] We provide a pyramidal structure so that those GPs who make the most practical contributions to the provision of mental health services can receive ongoing additional education. This education may involve the acquisition of cognitive behavioural therapy skills, or imparting knowledge about treating geriatric depression, chronic fatigue and chronic pain. Divisions of General Practice, Area mental health services and private psychiatrists are involved in programme delivery, as are universities. Practice support, particularly via interactive technologies, is a key goal.

For more information, GPs can telephone the SPHERE Hotline on 1300 651 344.

Conclusion

A better primary mental health care system needs to support education and practice initiatives, such as the SPHERE Project, which are known to be associated with higher identification and treatment rates.[14] There is an urgent need for the federal government to put in place real practice and training incentives so that GPs are not penalised professionally or financially for playing their key role in the mental health care system. MT

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