

How do Victorian GPs manage patients with depression?



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BACKGROUND

Depression is common, yet management in general practice is poorly described, especially the relationship between medication use and focussed psychological strategies. Government initiatives are targeting general practitioners' provision of mental health care.

METHODS

Postal survey of a random sample of 350 Victorian GPs between November 2001 and April 2002.

RESULTS

Forty-eight percent response rate. Most GPs reported prescribing medication (82%) or providing supportive counselling (87%) to most patients with mild to moderate major depression, while few (<20%) reported frequently using focussed psychological strategies. Training in psychiatry or focussed psychological strategies was associated with use of psychological therapies.

DISCUSSION

Future education programs that support GPs to overcome barriers to using focussed psychological strategies may provide more effective care.

Depression is frequently managed by Australian general practitioners.¹ In 2002, the Australian government introduced initiatives aimed at improving community mental health care.² These initiatives focussed on high prevalence mental illnesses such as depression. They included financial incentives for GPs to undertake further mental health training, particularly in focussed psychological strategies (for which there is evidence of effectiveness) such as cognitive behaviour therapy (CBT)^{3,4} and problem solving therapy (PST).^{5,6} How Australian GPs approach management of depression is described in only a few studies, with estimates of the frequency of prescribing medication differing.⁷⁻⁹ Counselling is more frequently used for depression, but GPs predominantly use nonspecific counselling rather than focussed psychological strategies.⁸

Previous studies suffer from limitations in their methods, including using nonrandom samples of GPs and small geographic areas. Our study addresses these. As it was conducted before the Better Outcomes in Mental Health Care Initiative,² it provides baseline data for future comparisons.

Methods

We designed a questionnaire to investigate GPs' management of mild to moderate

depression in adult patients. It included Diagnostic and Statistical Manual IV (DSM-IV) criteria¹⁰ for major depression, minor depression and dysthymia. Questions included methods used in the previous 6 months for managing patients with depression, GPs' use of DSM-IV criteria, and GP demographic details and training. The questionnaire was pilot tested with a convenience sample of 11 GPs (only minor changes were necessary). It was then sent to study GPs with an explanatory letter and reply paid envelope. Reminder letters and two further copies of the questionnaire were sent to nonresponders. Any remaining nonresponders were followed up by telephone.

Our power calculation assumed a sample size of 340 GPs, giving a 5% margin of error and confidence interval of 95%. Allowing for a 50% response rate, a random sample of 700 GPs was requested from the General Practice Branch of the Commonwealth Department of Health and Ageing. However, they only provided a sample of 350 Victorian GPs (representing a 7% margin of error).

We analysed cross tabulation of selected variables to compare GP characteristics with their methods of managing patients with depression. Qualitative data were coded and categorised by themes.

The Human Research Ethics Committee

of The University of Melbourne approved the study.

Results

Completed questionnaires were received from 153 (48%) of the eligible GPs ($n=319$). Thirty-one GPs were excluded (because they were seriously ill, no longer working in general practice, or had left the practice without leaving a forwarding address). Participants' characteristics were similar to the national GP population in gender balance, average age, place of graduation, and practice size. However, GPs from remote centres were under-represented

and participants reported working fewer hours per week than the national average (*Table 1*).

Prescription of medication

Participants reported strategies used to manage mild to moderate depression in the previous 6 months (*Table 2*). Most (82%, 124/151) participants reported using medication with at least half of patients with mild to moderate major depression in the previous 6 months. Only one participant reported not prescribing medication to any such patients during that period. Selective serotonin reuptake inhibitors (SSRIs)

were the most frequently prescribed class (97%, 149/153).

Nonpharmacological management

Most participants (87%, 131/150) reported providing supportive counselling to at least half of patients with mild to moderate major depression in the previous 6 months. Two-thirds (61%, 91/150) reported its use with all such patients. Three-quarters (73%, 106/146) reported recommending exercise to at least half of patients to manage depression in that time.

In contrast, only 18% (27/149) of participants reported using PST with at least half of patients with mild to moderate depression. Similarly, 15% (22/149) of participants reported using CBT with at least half of these patients in the previous 6 months. Provision of drug and alcohol or family and marital counselling was reported for smaller proportions of patients.

Impact of formal training

Associations were found between participants' reported formal training (ie. had undertaken a degree, diploma, certificate, short course or work in a psychiatric service at registrar level or above) in psychiatry or focussed psychological strategies and use of psychological therapies in the previous 6 months.

Formal training in psychiatry was associated with CBT use for patients with mild to moderate major depression, as was formal training in CBT and PST (*Table 3*). Formal training in CBT and PST was also associated with use of PST. No association was found between the participants' gender or age and frequency of using these strategies.

As virtually all GPs reported prescribing medication, comparison was made between those reporting high rates of prescribing (ie. three-quarters or more of patients) and those reporting less frequent use. There was a nonsignificant trend toward greater use of medication by older and male GPs. There was also no association

Table 1. Characteristics of responders compared with nonresponders, Victorian and Australian GP characteristics

GP characteristic	Responders n=153 n (%)	Nonresponders n=166 n (%)	Victoria ¹⁷ n=5296 n (%)	National ^{17,18} n=20 983* n (%)
Sex				
Male	103 (67)	127 (77)	3414 (65)	14 024 (67)
Average age (years)				
Males	49	51	N/A **	50
Females	46	44	N/A	42
Place of graduation				
Overseas	37 (24)	31 (19)	N/A	4717 (23)
Practice size				
Solo	25 (17)***	N/A	927 (18)	4076 (19)
2-4	69 (48)	N/A	2137 (40)	8665 (41)
5+	51 (35)	N/A	2232 (42)	8225 (39)
Hours per week in clinical practice				
Males	43	N/A	48	48
Females	32	N/A	31	32
Practice location				
Capital city	110 (72)	125 (75)	4082 (77)	16512 (68)
Other metropolitan centre	6 (4)	6 (3)	174 (3)	1709 (7)
Large rural centre	11 (7)	6 (4)	237 (5)	1375 (6)
Small rural centre	8 (5)	9 (5)	274 (5)	1374 (6)
Other rural area	18 (12)	19 (11)	518 (10)	2426 (10)
Remote centre	0 (0)	0 (0)	11 (<1)	295 (1)
Other remote centre	0 (0)	1 (1)	0 (0)	485 (2)

*National practice location data, $n=24\ 176$ (head counts of 1998-1999 Medicare primary care providers)

**N/A = not available

***Denominator may vary due to missing data

Table 2. Reported frequency of use of management strategies for mild to moderate depression in the past 6 months (n=151)*

Method	No patients n (%)	Very few patients n (%)	Quarter of patients n (%)	Half of patients n (%)	Three-quarters of patients n (%)	All patients n (%)
Medication	1 (1)	5 (3)	21 (14)	53 (35)	58 (38)	13 (9)
Supportive counselling	4 (3)	5 (3)	10 (7)	14 (9)	26 (17)	91 (61)
Exercise	9 (6)	11 (8)	20 (14)	27 (19)	23 (16)	56 (38)**
Drug and alcohol counselling	25 (17)	65 (43)	42 (28)	9 (6)	5 (3)	4 (3)
Family or marital counselling	38 (26)	60 (41)	27 (18)	9 (6)	9 (6)	5 (3)
Meditation or relaxation techniques	60 (41)	53 (36)	22 (15)	8 (5)	3 (2)	2 (1)
Problem solving therapy	75 (50)	33 (22)	14 (9)	19 (13)	3 (2)	5 (3)
Cognitive behaviour therapy**	76 (51)	36 (24)	15 (10)	12 (8)	4 (3)	6 (4)

*Denominator may vary due to missing data

**Percentages may not equal 100 due to rounding

Table 3. Use of CBT, PST and medication in the past 6 months compared with participants' sex, age or level of training (n=151)*

GP characteristic	CBT		PST		Medication	
	Odds ratio	95% CI	Odds ratio	95% CI	Odds ratio	95% CI
Gender						
Male	0.94	0.48–1.86	1.08	0.55–2.15	0.51	0.25–1.02
Age group years						
<35	1.0		1.0		1.0	
36–54	0.75	0.26–2.16	0.38	0.12–1.17	3.06	0.92–10.13
55+	0.65	0.19–2.16	0.51	0.15–1.79	2.67	0.71–9.95
Formal training in: Psychiatry						
Yes	3.35	1.63–6.89	1.76	0.88–3.52	1.11	0.56–2.20
Cognitive behavioural therapy						
Yes	7.82	2.98–20.51	3.06	1.36–6.93	0.74	0.34–1.60
Problem solving therapy						
Yes	3.34	1.13–9.89	3.46	1.17–10.24	0.84	0.31–2.23

*Denominator may vary due to missing data

found between rates of prescribing and participants' level of training (Table 3).

Discussion

Despite drawing on a random sample, there are limitations to this study. First, it relies upon self report, which introduces possible recall bias. Second, we achieved less than 50% response rate, which means there may have been a response bias. Some GPs may not routinely use the DSM-IV criteria provided. Only certain focussed psychological strategies were included and definitions of these were not provided.

Individual GPs may have interpreted these terms differently, perhaps altering estimation of their use. This study was limited to Victoria. The small sample size may limit the ability to detect differences between subgroups.

More than 80% of respondents reported using antidepressant medication and supportive counselling to treat most patients with mild to moderate major depression. This contrasts with a recent Australian study of volunteers, which found pharmacological treatments are not widely used by GPs.¹¹ However, it is consistent with

a Sydney (New South Wales) study⁷ which found 67% of patients with depression were prescribed medication by GPs, and a retrospective case note audit which found 94% of patients with depression had received antidepressants during a 5 year period.⁹ In Australia, SSRIs are the most commonly prescribed antidepressants,^{1,12,13} and our findings are consistent with this. Despite recommendations that focussed psychological strategies are a first line treatment of mild to moderate depression,¹⁴ in this study GPs continue to use them infrequently. As found previously,⁸ formal

training in psychological therapies is associated with more frequent use.

We found an association between formal training in psychiatry or focussed psychological strategies and the use of CBT and PST. However, its causal direction is unclear. The literature is mixed. Mental health training can improve GP knowledge and skills¹⁵ or have no such impact.¹⁶ Perhaps research using randomised controlled trials and larger sample groups is needed to resolve this. Additionally, research that identifies barriers to using focussed psychological strategies in general practice will guide education which can support GPs to overcome such barriers and allow more effective patient care.

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Implications of this study for general practice

What we already know

- CBT and PST, as well as antidepressant medication, are effective for the treatment of mild to moderate depression.

What this study shows

- GPs frequently prescribe medication and use supportive counselling for mild to moderate depression, but use focussed psychological strategies infrequently.
- Mental health training was associated with increased use of focussed psychological strategies.

Conflict of interest: none declared.

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