Depression in primary care: expanding the evidence base for diagnosis and treatment

Harvey A Whiteford

Primary care has the lead role in reducing the burden of common mental disorders in Australia. This supplement adds to the evidence base needed to achieve it

The National Survey of Mental Health and Wellbeing, conducted by the Australian Bureau of Statistics (ABS) in 1997,[1] and the Australian Burden of Disease Study, conducted by the Australian Institute of Health and Welfare (AIHW) in 1998–1999,[2] greatly influenced mental health policy in Australia. Until that time, the major focus of the National Mental Health Strategy had been on providing services for those individuals discharged from (or who in the past would have been admitted to) psychiatric hospitals. While the service reforms for such individuals remain incomplete,[3,4] the information provided by the ABS and AIHW studies significantly expanded the mental health policy agenda in Australia.

The AIHW Australian Burden of Disease Study found that mental disorders and substance misuse accounted for nearly 30% of all health-related disability, and that depression was the leading cause of disability among all health conditions for both sexes.[2] While already suspected from smaller epidemiological studies, a major finding from the ABS National Survey of Mental Health and Wellbeing was the low treated prevalence of depression, anxiety and substance misuse in Australia. Of all those surveyed who met the diagnostic criteria for a mental or substance use disorder, 65% had not used any form of health service in the previous 12 months.[1] The 12-month treated prevalence for substance use disorders was 14%, for anxiety disorders, 28%, and for depressive disorders, 40%.

Another major finding of the ABS survey was its confirmation that general practitioners were the most common providers of mental health care, with 76% of people who were receiving any mental health care reporting using this type of service (often in conjunction with another health service).[5]

The policy response to these findings was to expand the population health scope of the National Mental Health Strategy and to develop a focus on primary mental health care, with the aim of increasing the treated prevalence for common mental disorders. In June 1999, the Commonwealth Government established a national primary mental health care initiative to provide education and skills-based training in mental health for GPs. In July 2001, the federal government then introduced Better Outcomes in Mental Health Care,[6] a program that provided access to psychological services through the use of locally negotiated service contracts between Divisions of General Practice and psychologists. One hundred and fourteen Divisions participated in the program, and it is generally considered to be effective.[7,8]

In November 2006, the Australian Government introduced the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule (MBS) initiative (the "Better Access" program), providing new MBS items for services provided by GPs and psychiatrists, and access to the MBS (on referral by a GP, psychiatrist or paediatrician) for psychologists and appropriately qualified social workers and occupational therapists. In the first year of this program, more than half a million Medicare items for GP Mental Health Care Plans were claimed by more than 20 000 GPs, and the number of allied mental health consultations greatly exceeded expectations.[9]

In this supplement, Fletcher and colleagues (*page S107*) report that, despite the dramatic uptake of the Better Access program in its first 5 months of operation, the demand for psychological services provided through the Access to Allied Psychological Services (ATAPS) component of the Better Outcomes in Mental Health Care program was not reduced.[10]

With the large number of services being provided under the Better Access and Better Outcomes in Mental Health Care programs, a significant increase in treated prevalence of mental disorders in Australia is expected to be seen when the data from the Second National Survey of Mental Health and Wellbeing (conducted by the ABS in late 2007) are analysed. However, what is less clear is the quality of care being provided to the patients who are now accessing treatment. Several articles in this supplement address this critical issue.

A longstanding concern has been whether GPs are able to detect common mental disorders in their patients. Clarke and colleagues (*page S110*) examined the way distress and depression are perceived by GPs, and developed a taxonomy that may be useful in general practice settings.[11] Wilhelm and colleagues (*page S114*) discuss the value of screening tools to increase recognition of patients with mental disorders.[12]

Given that the requirement for mandatory training (present in the Better Outcomes in Mental Health Care program) was removed in the Better Access program, the issue of training GPs is critical. Blashki and colleagues (*page S129*) demonstrate that competency in cognitive behavioural strategies, at least in highly motivated GPs, can be improved with relatively brief training sessions.[13] In a report of an innovative program, Parker and colleagues from the Black Dog Institute in Sydney (*page S126*) describe their computerised assessment and diagnostic program, developed to assist GPs with diagnostic subtyping and management of mood disorders.[14] Their work suggests that the Mood Assessment Program (MAP) allows the practitioner to shape a management plan in conjunction with broad treatment guidelines. Further evaluation of the MAP is both necessary and proposed.

Even when common mental health problems such as depression are detected and treated, there is still a need to address relapse prevention. Research into this area in primary care is sparse. Howell and colleagues (*page S138*) trialled a depression relapse prevention program in South Australia and found it to have promise, especially for older patients.[15]

Primary care is an ideal setting in which to address the high comorbidity between mental and physical disorders.[16] Baseline

findings from a prospective cohort study, reported by Gunn and colleagues (*page S119*), confirm the substantial psychiatric, physical and social comorbidities in patients with depression.[17] This emphasises the importance of integrated clinical care for these people. Articles by Pols and Battersby (*page S133*)[18] and Pier and colleagues (*page S142*)[19] also examine aspects of this important area.

Given that the evaluation of many new programs is mostly funded by government, the outcomes are often in the "grey literature". Christensen and colleagues (*page S103*) reviewed the literature on anxiety and depression programs in Australia and found that many programs did not publish patient outcomes in the formal literature, were difficult to identify, had poorly disseminated results, and gave little information about their effectiveness.[20] They propose a clearinghouse as one solution for getting this information to researchers, practitioners, consumers and policymakers.

It is clear that the main focus of activity aimed at reducing the burden of common mental disorders in Australia is in primary care. Specialist mental health services play a supporting, but not central, role. Ensuring the primary mental health care sector can reduce the burden of common mental disorders by increasing the number of patients receiving evidence-based interventions remains the challenge. The articles in this supplement contribute to the evidence base necessary to achieve this outcome.

Competing interests

I am engaged as a consultant to the Australian Government Department of Health and Ageing.

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