Depression in primary health care: from evidence to policy

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> General practitioners cannot, should not, and do not carry alone the burden of averting or treating all mental health disorders in the community.[1]

Depression is a common mental disorder and the primary cause of disability in Australia.[2] It is often managed in general practice and community settings, rather than in specialist services. Although there is good evidence for the efficacy of specific treatments for depression, less is known about the best models and mechanisms for delivering depression services in primary care. The aim of our article is to discuss the implications for policy of a recent synthesis of the literature on the effectiveness of different models for the delivery of depression interventions in primary care.[3]

Current national mental health policy is guided by the Council of Australian Governments (COAG) National Action Plan on Mental Health 2006–2011[4] and the Australian Health Ministers' National Mental Health Plan 2003–2008.[5] The COAG-endorsed plan is supported by federal funding of 1.9 billion dollars over 5 years. Its stated aims are to reduce the prevalence of mental illness and its risk factors and to increase access to appropriate health care and engagement, employment, education, and accommodation in the community. Key areas of action include the support of mental health promotion, prevention and early intervention programs; and the integration and improvement of the care system for people with mental health problems. The latter incorporates the institution of Medicare rebates for psychologist consultations, a commitment to funding telephone counselling and self-help and web-based support services, and a commitment to increasing mental health services in rural and remote areas. The National Mental Health Plan 2003–2008 states that mental health programs should be based on evidence of effectiveness, and that approaches that "are not based in evidence should not continue to be supported".[5]

ABSTRACT

Objective: To consider the implications for mental health policy of a recent synthesis of the literature on the effectiveness of different service delivery models for depression in primary care.

Methods: A discussion based on the results of several systematic reviews of primary care models for depression management. Primary care was defined broadly within a prevention, early-intervention, treatment and recovery/support framework, and incorporated both community and general practice settings.

Results: There were promising effective models for depression interventions both in the broader community and in general practice settings.

Conclusions: There is a need to support evidence-based models for depression care, including innovative new technologies for facilitating consumer self-management of depression. The ability of practitioner training and guideline implementation to improve consumer outcomes for depression is limited. Policies and incentives are required to facilitate the reorganisation of general practice and, in particular, the implementation of care management as well as enhanced care and guided self-help in these settings.

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Methods

Framework and scope

Discourse about depression services in primary care often focuses on management in general practice settings. Here, consistent with the current national mental health policy environment, we define primary care more broadly within a prevention, early-intervention, treatment and recovery/support framework. Within this framework, primary care interventions are provided in a range of settings (eg, practitioner's office, school, home) by a range of practitioners (eg, general practitioners, mental health practitioners) and using a variety of media (eg, face-to-face contact, print, the Internet and telephone).

We also focus specifically on the evidence base relating to the effect of services on depression outcomes rather than on proxy or intermediate process variables such as rates of treatment or referral by GPs, which may or may not be associated with individual consumer outcomes.

Models of care: the evidence

In order to compile an evidence base for policy discussion, we conducted a series of six reviews, the details of which are described elsewhere.[3,6] To be included in a review, studies were required to report a depression outcome and to be either a randomised controlled trial or a quality controlled trial.

Our article focuses mainly on the primary review, which covered community interventions, telephone interventions, collaborative care, shared care and single practitioner models. Our review was based on a search of the PubMed database using the MeSH term "delivery of health care", other keywords arising from trial searches, and previous systematic reviews. The majority of the retrieved articles related to general practice and particularly to collaborative care and related models. However, the term "collaborative care" was not used consistently in the empirical literature and the composition of the interventions employed in the trials varied across studies. We therefore focused on the efficacy of the *components* of care (eg, care management, enhanced care, provider training, provider feedback, patient education, decision aids). The remaining five reviews were syntheses of findings for specific types of intervention, including Australian school-based programs, Internet applications delivering automated cognitive behavioural therapy, Internet peer-to-peer support groups, telephone interventions and passive education interventions.

Results

The key findings from these reviews are summarised in the Box.

On synthesis, within the general practice context, care management, enhanced care and guided self-help led to better outcomes than treatment-as-usual or control, with the evidence for care management being strongest. Revising professional roles and the

Key findings from systematic reviews of the effectiveness of models in general practice and community settings for improving depression outcomes

General practice context

Improvement in depression outcomes relative to treatment-as-usual or control condition

- Care management: assistance within the practice in managing patient care (eg, the use of care managers such as a nurse to monitor and manage patients)
- Enhanced/extended care: the use of specialist practitioners or the direct provision of enhanced therapy within the practice (eg, cognitive behaviour therapy provided by a health professional)
- Guided self-help in general practice: the use of computer-based programs or other self-help materials supervised by a practitioner (eg, a nurse)
- Systematic tracking by a non-doctor: monitoring of patient progress and/or provision of enhanced care (eg, by a nurse or psychologist)
- Revision of professional roles: for example, a nurse assumes the role of case manager. Role shifting often involves greater involvement of non-health professionals in care delivery
- Incorporation of patient preferences into care

No improvement in depression outcomes relative to treatment-as-usual or control

- General practitioner training and feedback: interventions designed to improve outcomes by improving GP skills, including education and the provision of clinical practice guidelines
- Pharmacist interventions: tracking by a pharmacist over time (eg, of prescribed antidepressants)

Community context

Improvement in depression outcomes

- Community treatment interventions: depression treatment in organisations based in the community (eg, interpersonal therapy in school-based clinics)
- Automated Internet applications (eg, automated cognitive behaviour therapy)
- School-based interventions (eg, cognitive behavioural interventions)

More evidence of effectiveness required

- Telephone interventions
- Internet support groups: peer-to-peer support (eg, bulletin boards)
- Passive education (eg, brochures, lectures, Internet) ◆

use of a non-GP to track patients — as, for example, when a nurse assumes the role of case manager and contacts patients regularly (particularly in cases in which a behavioural treatment is provided) — is effective in general practice. Incorporating patient preferences into care is also associated with better outcomes.

The mechanisms underlying the efficacy of these models and components have not been systematically investigated. However, care management may work by increasing adherence,[7] by providing evidence-based psychological therapy rather than no therapy or generic counselling,[8] and by detecting early any changes in mental health status or barriers (eg, side effects) that require a change in treatment regime or level. Incorporating consumer preferences may improve outcomes by increasing therapeutic alliance[9] and averting non-adherence.[10]

By contrast, and consistent with previous reviews,[7] GP training and feedback did not improve depression outcomes. The reasons for this are unclear. It is possible that time constraints associated with the demands of a busy general practice militate against the optimal management of depression, even when the GP is well trained. Alternatively, the nature or level of training provided to the GPs may have been insufficient.

Finally, the reviews revealed that incorporating patient preferences into care was helpful and that early interventions, treatments and prevention programs can effectively improve depression outcomes within non-GP-based community settings, including schools and the Internet (Box).

Discussion

Most high-quality trials of the effectiveness of intervention models in general practice have been undertaken in the United Kingdom and the United States. Thus, some caution must be exercised in generalising the results of our synthesis of general practice trials to the Australian context. However, the data suggest that there would be value in incorporating a mental health care manager into general practices. The role of the care manager would be to maintain contact with patients, to track their progress (either through face-to-face contact or by telephone), to provide feedback to the GP, to facilitate or arrange contact between the patient and GP as needed, to encourage adherence to medication, and to provide or organise evidence-based psychological interventions. These interventions could be face to face, via telephone, or in the form of guided self-help (for example, by means of a hard copy manual or computer program). Funding models and practical methods of accommodating mental health care managers in general practice settings are required, including models that involve the possibility of sharing managers across smaller practices.

In addition, there is a need to invest in existing evidence-based community interventions for depression. An example of a COAG-supported area of intervention is in schools. Currently, mental health programs are delivered by the federal government-funded MindMatters program. Although we specifically reviewed sources of evidence concerning Australian school programs, we found little outcome evidence concerning MindMatters at the time of our review. Nevertheless, we believe that MindMatters would provide an excellent platform for the delivery of programs that are of demonstrated efficacy (such as the Australian-based FRIENDS program developed at the University of Queensland).

Similarly, evidence-based community self-help interventions, including those accessible on the Internet,[11,12] are currently available for reducing depression symptoms.

Thus our findings provide evidence to support, in principle, the COAG initiative to fund web-based services. Such initiatives have the potential to reduce the pressure on recently introduced Medicare-funded psychologist services and to provide a service to those who would opt not to receive face-to-face services or to whom such services are inaccessible. Overall, the uptake of Medicare-funded access to psychologists has been considerably in excess of that anticipated.[13] However, at the time of writing, no published data were available reporting on the uptake of the Medicare-funded psychologist care in rural areas or of the federal government-funded services delivered through rural Australian Divisions of General Practice. However, given the paucity of psychologists in rural areas[14] and the difficulty of attracting and retaining them in rural settings,[15] it is unlikely that the allocation of funding for local psychologists will by itself solve rural care access issues, particularly for consumers who are located a long distance from larger rural centres. Moreover, there is evidence that

people living in rural areas value self-sufficiency in health.[16] Thus, alternative service models are required. Given that the government currently subsidises access to broadband Internet services in rural areas, Internet applications have the potential to address some of the unmet need in rural areas. Bibliotherapy interventions may also be a feasible approach.

Serious consideration should be given by Australian policymakers to facilitating and prioritising funding for research on *models* of depression care in primary practice, particularly those with the potential for increasing accessibility to care at an affordable price. As care management in general practice and Internet self-help are effective models of depression care, there may be merit in researching the benefits of combining these components of care.

We have been exploring in principle the concept of an e-clinic model in which GPs refer clients to a service that is embedded within a call-centre structure and delivers evidence-based Internet information and automated therapy. This could be linked to tracking by a care manager and supervised by a psychologist, with input from a psychiatrist. In the e-clinic model, the GP would retain overall responsibility for the patient, but tracking functions would be undertaken by telephone and in virtual space. Models such as these could offer particular advantages if implemented in a rural context or in other situations in which local specialist mental health input is either not available or not favoured by the consumer.

Conclusion

The evidence indicates that care management and consumer-centred models that emphasise guided self-management and consumer empowerment are likely to benefit people with depression. Such approaches may also benefit the overburdened GP and mental health practitioner and are consistent with the aims of policy makers concerned with delivering better public health outcomes at an affordable cost. However, translating this evidence into practice requires a willingness at all levels to further reorganise current systems of delivery in primary care. It also requires the development of implementation strategies and the institution of funding models to make it happen.

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Competing interests

None identified.

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