“Primary Care Mental Health”
Research Program in General Practice

Professor Jane Gunn
Australia (Victoria)

Over 20 million resident population in Australia

Almost 5 million resident population in Victoria
Department of General Practice
Setting up a practice-based research network


Background
The Victorian Primary Care Practice-Based Research Network (VicReN) was established in 2006 by the Primary Care Research Unit at the Department of General Practice, University of Melbourne with funding from the Faculty of Medicine, Dentistry and Health Sciences. This poster aims to explain the process of setting up VicReN over the past year.

What is a practice-based research network (PBRN)?
PBRNs work by bringing primary care practitioners together with academic GPs and other researchers in long-term collaborations to conduct research that matters to practitioners and that makes a difference to the delivery of primary care.

Both sides benefit. Practitioners have the opportunity to develop their research skills and to investigate clinical questions they are interested in, while academic GPs and researchers can access practitioners’ expertise and experience, as well as a practice base.

PBRNs make possible research of a scale and quality that would otherwise be beyond the individual practitioner, and help ensure that it is firmly grounded in the reality of day-to-day primary care.

Key lessons from the literature
Lessons learned from establishing and sustaining PBRNs both in Australia and overseas:
1. Find the ‘champions’ – only work with practices with a genuine interest in and enthusiasm for research.
2. Make research relevant to the everyday concerns of practitioners by ensuring they have input from the earliest stages.
3. PBRNs are not a magic bullet for the problem of recruitment – they can assist but are much more than a list of practices to be contacted by researchers.
4. Building a high degree of trust among network members is critical.
5. When sourcing funding and measuring research impact, think outside the academic box.
6. Stakeholders include the Australian General Practice Network, Divisions, RACGP, government (all levels), patients, advocacy groups, and universities.
7. The core business of the network will be to use research methods to answer questions or solve problems (not to simply “do research”).
8. Setting up an effective PBRN takes time – be realistic and patient.

VicReN’s Development: A Timeline

<table>
<thead>
<tr>
<th>2006</th>
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<tr>
<td>July</td>
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<tr>
<td>Foundation Dinner</td>
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What’s in it... For clinicians?
Research gives me the opportunity to be an ‘agent of change’. It allows me to better understand my patients and their health, shows me the strengths and weaknesses of current interventions, and allows me to direct limited resources more efficiently.

Dr Chris Hogan, Family Medical Centre, Sunbury

What’s in it... For patients?
Our patients like our involvement in research because it gives them the sense that their doctor is linked with state-of-the-art academic findings.

Dr Thomas Mclerney, Pediatric Research in Office Settings (PROS), US

What’s in it... For academics?
Even though VicReN is in its infancy it has already brought a new vitality to our research within the Department. Engaging with a variety of exceptional GPs is inspiring.

Professor Jane Gunn, Primary Care Research Unit, Department of General Practice, University of Melbourne

Being involved in research has energized my commitment to general practice by giving me confidence in evidence-based medicine. It provides a welcome, and worthwhile, variation in my day to day general practice work.

Dr Cathy Hutton, Margaret Street Medical Clinic, Mocinee Ponds

VicReN is supported by the Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne and the Australian Government Department of Health and Ageding, Primary Health Care Research, Evaluation and Development Strategy.
A brief history of the problem of depression

(Ref: Healy 1997; Dowrick 2004; Callahan & Berrios 2005)
What do we mean by depression?

Depressive symptoms

Minor Depression

Dysthymia

Major depression (mild)

Moderate

Severe

The ecology of medical care

Adult population at risk: 1000

Adults reporting one or more illnesses or injuries per month: 750

Adults consulting a physician one or more times a month: 250

Adults admitted to hospital per month: 9

Referred: 5

Tertiary: 1

(Ref: White, 1961; Green 2001)
Australian General Practice

Vague, undifferentiated

100 people visit a GP for 150 reasons

GP records 146 problems

GP institutes 214 management activities

Prescribe, investigate, advise, educate counsel, refer

Ref: Australia’s Health 2006, AIHW
Research Program in Depression

Re-organising care for depression and related disorders in the Australian primary health care setting.

Our vision: ‘A primary care system that promotes emotional well-being and provides people experiencing depression with accessible, responsive and effective management options to assist recovery and maintain well-being.’
30 GPs recruited (randomly selected)

790 patients followed for 3 years

Stakeholder Consultation

Data Syntheses

Practice based phase
• Review of system interventions
• Review of longitudinal studies
• Review of guidelines for primary care
• Lay concepts of depression
• Resilience
1. Data synthesis & literature reviews
2. Cohort study & Stakeholder input
3. Putting complexity into practice
4. Analysis and dissemination
DIAGnosis, Management and Outcomes of Depression in Primary Care
AIMS

1. Map the pathways of care experienced by patients with depressive symptoms in primary care

2. Describe the relationship between health outcomes and
   - GP characteristics
   - Patient characteristics
   - System factors

3. Describe the impact of phase and severity of depression and treatment factors on health outcomes

4. Investigate the facilitators and barriers to management and recovery of patients

5. Assess costs of managing depression in primary care
Recruitment locations

Total Km Travelled

3 3 1 7
30 GPs recruited (randomly selected)

7668 patients (aged 18-75 years) screened

790 patients with depressive symptoms recruited

FOLLOW UP

3 mth 6 mth 9 mth Yearly
Change in depression scores at baseline

Depressive symptoms

- Major Depression: 49%
- Depressive Symptoms: 35%
- No Depressive Symptoms: 16%
Social and lifestyle factors

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

MDD, Depressive Symptoms, Transient
Psychiatric and physical problems

- Substance abuse/dependence
- Panic disorder
- Binge eating
- Back problem
- Arthritis
- Hypertension
- Asthma
- High cholesterol
- Diabetes
- Cancer

Graph showing the percentage of MDD, Depressive Symptoms, and Transient for each condition.
Forms of help received from GP for emotional well-being

- Provided reassurance, encouragement and explanation: 83.2%
- Gave me chance to talk about how I was feeling: 80.7%
- Prescribed medication for depression, stress or worries: 48%
- Encouraged me to exercise: 45%
- Helped me to talk through my problems: 44.7%
- Advice on getting good night's sleep: 28%
- Advice about diet: 32.8%
- Gave me information about depression, stress or worries: 24.6%
- Suggested see another health professional: 22.8%
- Referred me to a health professional: 19.9%
Mental health service provision

- Psychiatrist (n=123)
  - 64

- Counsellor (n=125)
  - 69

- Psychologist (n=136)
  - 72

- GP (n=787)
  - 504 (64%)
Helpfulness of health professional in addressing emotional well-being in past 12 months
Uptake of the Better Access Program

MBS Items Count

Month

Nov-06  Dec-06  Jan-07  Feb-07  Mar-07  Apr-07  May-07
Antidepressant use

790 people screened +ve for probable depression

317 had taken antidepressants in past year (40%)

242 (76%) had a DSM depressive or anxiety disorder

8 (2.5%) had other depressive disorder on PHQ

67 (21%) none of above conditions
Antidepressant use by psychiatric diagnosis

- Major Depressive Disorder in past year: 61.8%
- Current Major Depressive Syndrome: 61.3%
- Dysthymic Disorder: 62.7%
- Alcohol/Drug Dependence: 60.3%
- Panic Disorder: 61.3%
- Anxiety: 60.3%
- Other Current Depressive Disorder: 39.4%
- Alcohol/Drug Dependence: 49%
Antidepressant use by psychiatric diagnostic hierarchy

- Major Depressive Disorder in past year: 61.8%
- Current Major Depressive Syndrome: 43.9%
- Dysthymic Disorder: 42.9%
- Panic Disorder: 38.5%
- Anxiety: 15%
- Other Current Depressive Disorder: 25%
67 participants taking antidepressants without DSM diagnosis

- 3 said depression never been a problem
- 7 met criteria for somatoform disorder
- 8 reported substance dependence
- 21 said depression had been problem in past
- 35 said depression currently a problem
- 38 had persistent depressive symptoms
Antidepressant use

- MAOIs
- RIMAs
- SSRIs
- S-NRIs
- Tetra
- TCAs
Length of antidepressant use (1 antidepressant group)
Helpfulness of antidepressants (1 antidepressant group)

- Not helpful
- Slightly
- Moderately
- Very
- Extremely

% distribution:
- Not helpful: 5%
- Slightly: 10%
- Moderately: 30%
- Very: 35%
- Extremely: 20%
What should GPs be doing for depression care?

RE-ORDER Stakeholder Consultation

Re-organising care for depression and related disorders in the Australian primary health care setting.
STAKEHOLDER CONSULTATION

Database Development

Authors of relevant papers & reports

Web based searching

Networks

Modified Delphi Technique

Choice of Method
WHO IS A STAKEHOLDER?

Consumers

Gov’t & related organisations

Non-gov’t and related organisations

Health sector

Academics

DEPRESSION CARE IN GENERAL PRACTICE AND PRIMARY CARE
CONSULTING NON CONSUMER GROUPS

ROUND 1:
Primer, Survey, Reminder

1172 stakeholders identified
313 responded (313/952, 33% response rate)

220 ‘problematic’ email addresses

ROUND 2:
Primer, Survey, Reminder (x2)

313 responded
276 responded (276/877, 32% response rate)

75 ‘problematic’ email addresses

Modified Delphi Method
### Table 1: Response rate by stakeholder sector

<table>
<thead>
<tr>
<th>Sector</th>
<th>n</th>
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<tbody>
<tr>
<td>Government</td>
<td>62</td>
</tr>
<tr>
<td>NGO</td>
<td>80</td>
</tr>
<tr>
<td>Health and allied health professional</td>
<td>65</td>
</tr>
<tr>
<td>Academic</td>
<td>103</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>310</strong></td>
</tr>
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</table>
Q. How should general practice/primary care respond to people experiencing depression?

Q. What are the barriers for best practice in general practice/primary care when faced with people experiencing depression?

Q. How would we know if general practice/primary care is meeting the needs of people experiencing depression?
Q. How should general practice/primary care respond to people experiencing depression?

Table 2. Ten most frequently nominated items

<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
<th>n = responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Listening</td>
<td>147</td>
</tr>
<tr>
<td>2</td>
<td>Undertaking a thorough diagnostic assessment</td>
<td>136</td>
</tr>
<tr>
<td>3</td>
<td>Developing a plan with the patient</td>
<td>120</td>
</tr>
<tr>
<td>4</td>
<td>Undertaking an assessment of severity and suicide risk</td>
<td>113</td>
</tr>
<tr>
<td>5</td>
<td>Being well trained in depression care</td>
<td>95</td>
</tr>
<tr>
<td>6</td>
<td>Tailoring care to individual needs*</td>
<td>92</td>
</tr>
<tr>
<td>7</td>
<td>Taking into account social factors*</td>
<td>77</td>
</tr>
<tr>
<td>8</td>
<td>Being empathetic*</td>
<td>67</td>
</tr>
<tr>
<td>9</td>
<td>Providing longer consultations*</td>
<td>65</td>
</tr>
<tr>
<td>10</td>
<td>Offering a range of treatment options*</td>
<td>65</td>
</tr>
</tbody>
</table>
Computer assisted telephone interview (CATI)

Q. What do you think are the most important things that general practitioners can do for people experiencing depression, stress or worries?
Q. How should general practice/primary care respond to people experiencing depression?

Ten most frequently nominated items by consumers

<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
<th>n = responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Listen / time to talk</td>
<td>197</td>
</tr>
<tr>
<td>2</td>
<td>Appropriate referral</td>
<td>172</td>
</tr>
<tr>
<td>3</td>
<td>Follow-up / monitoring</td>
<td>83</td>
</tr>
<tr>
<td>4</td>
<td>Guidance</td>
<td>67</td>
</tr>
<tr>
<td>5</td>
<td>Give time</td>
<td>63</td>
</tr>
<tr>
<td>6</td>
<td>Understanding / empathy</td>
<td>48</td>
</tr>
<tr>
<td>7</td>
<td>Support</td>
<td>43</td>
</tr>
<tr>
<td>8</td>
<td>Recognition</td>
<td>38</td>
</tr>
<tr>
<td>9</td>
<td>Information</td>
<td>37</td>
</tr>
<tr>
<td>10</td>
<td>Medication</td>
<td>34</td>
</tr>
</tbody>
</table>
Practice Phase

- Audit, observation,
- Discussion and reflection
- Practice re-organisation
- Review

Underway in Tasmania and Victoria (2007-2008)
Key elements for model for RCT (2009?)
Publications to date


Pierce D, Gunn J.- Using Problem Solving Therapy in General Practice. *Australian Family Physician* 2007: 36; (4) 193-288

Hutton C, Gunn J. Do longer consultations improve the management of psychological problems in general practice? A systematic literature review. *BMC Health Services Research* 2007, 7:71


Hegarty K, Brown S, Gunn J, Forster D, Nagle C, Grant B, Lumley J. Women’s views and outcomes of an educational intervention designed to enhance psychosocial support for women during pregnancy. *BIRTH* 2006, 34:2, 155-163

