Continuing to defeat depression

IN 1991 an editorial in the *Journal* reported a new initiative on depression supported by the Royal College of Psychiatrists and the Royal College of General Practitioners.[1] This defeat depression campaign aimed to raise the medical profession's awareness of the illness and to embark on an ambitious project to educate the general public.

The vast majority of people with depression present to their general practitioners, not necessarily complaining of depression, and about 90% are managed without referral to a psychiatrist.[2,3] However, many sufferers from this painful and distressing disorder do not consult a doctor and many who do consult are not recognized as being depressed, often because they describe physical symptoms rather than mental distress. We know that modern treatment is effective and that approximately 70% of recognized patients respond promptly to the first course of therapy,[4,5] which may be antidepressant therapy, psychological treatment or both. Efforts to encourage depressed patients to seek help and for general practitioners to improve their recognition of the illness through continuing medical education are clearly worthwhile.

A major barrier to patients approaching their doctor is the stigma still associated with mental disorder. Lack of public awareness contributes to this continued stigma, and the fear of being labelled as 'depressed' causes unnecessary suffering.[6] A poll conducted at the start of the defeat depression campaign showed a general lack of knowledge and understanding of mental disorders among the general public.[7] Most people felt that is was easier to sympathize with sufferers of physical illness than those with mental disorders because physical illness is easier to see and understand.

The first step of the defeat depression campaign was to establish an effective working relationship between the two royal colleges in order to foster the best possible care for depressed patients. A joint venture examining the research evidence, together with the clinical experience, of both specialists and general practitioners led to a consensus statement on diagnosis and management. This has been disseminated both as a formal paper[8] and as simplified guidelines. It is recognized that distinct groups of patients have somewhat different needs, requiring different approaches and communication skills. The shared care of patients with depressive illness is an important feature of the campaign.[9] There has been a high level of cooperation and involvement, not only of doctors and nurses, but other health professionals and representives of patient organizations.

What is general practice doing to improve the opportunities for continuing education about patients with depression that will be as relevant as possible to the practical problems that general practitioners, nurses and other members of the primary health care team have to face? The RCGP has established a fellowship in mental health funded by the Department of Health, the Mental Health Foundation and the Gatsby charitable foundation. As a result the national mental health fellow is able to set up regional fellowships, and to work with the national nurse facilitator to train up to 400 nurses facilitators who will provide support at a practice level. This cascade approach should ensure that educational opportunities are spread evenly.

Research from general practice has covered such topics as recognition of depression by general practitioners[10] and a comparison of antidepressant prescribing between general practitioners and psychiatrists.[11] It has already been shown that group training can increase the psychiatric skills of both vocational trainees[12] and established general practitioners.[13] The scientific foundation board of the RCGP has supported a pilot study making a controlled assessment of whether general practitioner trainees can be taught to use brief cognitive therapy in the treatment of their depressed patients. The increased use by general practitioners and the primary health care team of questionnaire testing for depression has been advocated[14] and a brief screening instrument for use among elderly patients evaluated.[15,16] Recently, an exploration of the attitudes of general practitioners and psychiatrists to managing depressed patients has been published.[17]

It is not easy for depressed patients to seek medical help. The illness causes feelings of unworthiness and guilt. Patients often volunteer physical symptoms rather than saying they feel miserable. This can make it more difficult for the general practitioner to help appropriately, so improving interviewing skills and perceptive listening can be of great benefit. As most identified depressed patients are treated exclusively in primary care, it is there that improvements in diagnosis and management will do most good. The new classification of mental disorders, discussed in this issue of the *Journal*,[18] offers great potential for enhancing patient care. The classification is accompanied by flipcards showing diagnostic and management guidelines for common mental disorders such as depression. A great quantity of educational material has been produced as part of the defeat depression campaign, from a sophisticated videotape training package for professionals to translations of a depression leaflet into four Asian languages.

The defeat depression campaign was partly modelled on an educational programme for general practitioners on the Swedish island of Gotland. The island population was relatively isolated from mainland Sweden, simplifying evaluation of the effects of the programme. Following the Gotland campaign hospital admission rates and rates of sick leave from work as a result of depression were lowered, prescribing of antidepressants increased and the suicide rate lowered,[19] though the number of cases suicide was too small for statistical significance. Unfortunately, these beneficial effects were short lived, perhaps because there was no reinforcement or repetition of the initiative.[20]

Compared with a local campaign, evaluating a national campaign presents much greater challenges. Before-and-after evaluation may be confounded by other changes taking place nationally, for example the effects of general practitioner fundholding or the highlighting of suicide prevention as a *Health of the nation* target. Indirect indicators, reflecting changes in general practitioner behaviour, might be an increase in the quantity of antidepressants prescribed or changes in dosage and length of treatment. Better recognition might be inferred if national morbidity survey data show a rise in rates for recognized depression with a fall in rates of alternative diagnoses. A second public opinion poll may show softening of public attitudes to sufferers from depression.

Much remains to be done and there is a clear need to maintain the momentum of educational activities and the interest and involvement of other health professionals, the primary care team and the general public. We are already familiar with increased collaborative working between general practice and community mental health teams. There are continuing opportunities to help reduce the suffering of millions of people by seeking to improve recognition and treatment of depression, reducing associated stigma and encouraging patients to seek help more readily. The lesson from the Gotland experience is that initiatives must be

repeated or reinforced if there is to be continuing benefit. Depressive illness remains one of the major health problems facing society: its monetary cost in the United Kingdom has been estimated at £240 million annually.[21] Its cost in terms of human misery and blighted lives through suicide is probably incalculable. General practice can respond not only in terms of better recognition and treatment but by raising awareness in the whole primary care team. The message must be reinforced that depression is common, recognizable and, above all, treatable.

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What should be the general practitioner's role in early management of acute myocardial infarction?

ACUTE myocardial infarction has a 28-day fatality rate of about 50%,[1] and half the deaths occur in the first two hours after the onset of symptoms;[2] about two thirds of deaths occur in the community.[3] Hospital care starting several hours after the onset of symptoms can therefore have little impact on overall mortality from acute myocardial infarction. The patient's needs for medical care are immediate; there is no 'golden hour'— a period of time during which an injury may go untreated without harmful effects — within which appropriate medical help can be organized. Ideally, the first doctor summoned should be able to administer all three essential elements of coronary care — resuscitation from ventricular fibrillation, pain relief with opiates, and thrombolysis.

Administration of thrombolytic therapy in hospital between four and five hours after the onset of symptoms saves between 20 and 30 lives per 1000 cases of myocardial infarction within a month.[4] Analysis of the three largest trials of prehospital thrombolysis suggests that the additional benefit within a month of prehospital thrombolysis is about 20 lives saved per 1000 cases of myocardial infarction per hour of earlier treatment.[5] Follow up of the Grampian region early anistreplase trial shows that there are further substantial mortality benefits after the first month because patients with small first infarcts are better able to survive subsequent reinfarction.[6] The true benefit of prehospital thrombolysis may be as much as between 60 and 70 additional lives saved per 1000 cases of myocardial infarction per hour of earlier treatment; at least one in 10 lives will be saved by prehospital thrombolysis.

Giving thrombolytic therapy at the first opportunity is thus a matter of the utmost urgency; in terms of potential lives saved, it is more urgent even than resuscitation from cardiac arrest. More lives are likely to be lost by deferring thrombolysis until the patient enters hospital than would be lost by a similar delay in initiating treatment for ventricular fibrillation.[7]

Recognizing the importance of early thrombolysis, a British Heart Foundation working party on the early management of myocardial infarction considered that, ideally, patients should receive thrombolytic therapy within 60 minutes of making contact with the medical/paramedical services.[8] A 90-minute target 'call to needle' time was adopted as being attainable.

Patients with chest pain who dial 999 arrive in hospital sooner than those who call their family doctor.[9,10] This has been used as an argument for encouraging patients with chest pain to bypass their doctors. This policy discounts the possibility of general