Down at the Doctor's. How should GPs and their teams help people with mental health problems?

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I'm going to talk to you tonight about some research which I've carried out together with a number of colleagues over the last 20 years or so on mental health problems, but in primary care, in general practice rather than in specialist psychiatric practice. You will see, I hope, that this has been a very rich area to research and I think our research has had an impact on the care patients receive in general practice from GPs and their teams.

Mental health disorders are very common indeed, affecting as many as one in six people at any one time. The 2007 Office for National Statistics (ONS) household survey of adult psychiatric morbidity in England found that 16.2% of working-age adults had an anxiety or depressive disorder. Of these 9.0% had mixed anxiety and depressive disorder, 4.4% were diagnosed with generalised anxiety disorder (GAD), 3.0% with post-traumatic stress disorder (PTSD), 2.3% with major depression, 1.4% with phobias, 1.1% with obsessive-compulsive disorder (OCD), 1.1% with panic disorder, and 0.4% with psychosis including schizophrenia, bipolar or manic-depressive disorder, and other psychoses.

Together with neurological disorders, mental health problems are the leading cause of disability in the UK. This graph from the United Kingdom Clinical Research Collaboration shows estimated disability adjusted life years, which are years of life lost, or spent disabled, due to different conditions. As you can see, the biggest bar here in green of disability adjusted life years is for neurological and mental health problems. Now the darker bars represent the percentage of spend of UK research money on that area and, as you can see, even though neurological and mental health problems are the leading cause of disability, they only get around half the money on research spent on them that cancer gets. Obviously cancer is more commonly fatal, but neurological and mental health problems can give you a lifetime of disability and I would suggest we need more research funding in mental health.

The research that I do can be described in a couple of ways which might help you to think where it fits in the whole spectrum of research. When we think of research, a lot of people think about genetics, or cellular biology, the study of molecules, cells and tissues, and we do conduct that sort of research in our medical school, but we also do quite a lot of research at the level of the person, the population and the community. The sorts of methodologies that we would use include health psychology, qualitative studies (which involve usually interviews of individuals or focus groups), epidemiology (the study of diseases in populations), clinical trials (interventions amongst groups of people), and health services research across the different levels of primary, secondary and tertiary care in the National Health Service.

Another way of looking at this is where along the spectrum of translation from basic research into health care delivery, my research takes place. This is quite a well-known diagram from David

Cooksey's review of UK health research five years ago which pointed out that there were two 'gaps in translation' which needed to be bridged if we were to have more improved health care from research. One is the gap between discovery and design, and getting things into early clinical trials; the other gap though is between getting the results of those trials, having demonstrated an intervention works, and translating them into actual practice. This requires assessment of health technologies with health economics and health services research, and research into knowledge management and delivery of care. So it's the sort of research that's funded by the NHS through the National Institute for Health Research Health Technology and Assessment Programme, the NIHR Service Delivery and Organisation programme, and the National Institute for Health and Clinical Excellence (NICE), rather than the Medical Research Council or Wellcome Trust which might fund more basic science research. My mental health research is definitely to be placed in this second gap in translation, but it's nevertheless as important as basic science research – what's the point of laboratory scientists developing new antidepressants for example if they are not taken up and prescribed appropriately and cost-effectively? Implementation is crucially informed by health services research.

The first study that I'm going to talk about is a randomised control trial of teaching GPs to carry out structured assessments of their long-term mentally ill patients, and this was the main study that I did for my Doctorate, my MD at St George's Medical School, when I was a Mental Health Foundation funded research fellow. We published that 16 years ago in the British Medical Journal and this is an example of research which I think had impact on practice, as I will show you.

This was a man who took part in the research who gave his permission for his photo to be used in teaching about the findings. He was 55 and he lived in South London, and was a patient of one of the general practices that took part in my study. He had a lot of continuing mental health problems. He'd suffered from schizophrenia since his mid-20's, so over 30 years he continued to have symptoms including hallucinations and delusions. He could hear voices of people talking to him from inside the house. He believed that he was the drummer in Madonna's band and that he was being recorded by the BBC. He was also on methadone because he'd been a heroin addict back in his 20's and his use of heroin might have contributed to precipitating his schizophrenia. As well as his mental health problems, I think you can see from this photo that he had a number of physical health problems. He had very poor teeth, very poor dentition, never saw the dentist, he had quite bad skin problems which you can't see very clearly here but he had rather poor personal hygiene, he tended not to change his clothes from one week to the next and rather neglected his personal hygiene and personal care. In addition he smoked 40 cigarettes a day and that caused him to have chronic bronchitis and heart disease, which is ultimately what shortens the life of many people with schizophrenia, rather than their mental health problems.

He lived with his poor old mum who was in her 80s. The reason they've both got their coats on in this picture is not because they're going out but because their heating had broken down. The electricity in fact had failed in their old Victorian house in South London and they were waiting for Social Services to get an electrician along to help get things started again, so they were both wearing several layers of clothes to keep warm. I think you can see the care worn expression on his mother's face. She was actually an auxiliary nurse before she retired, but she'd also been looking after him as his personal nurse for 30 years.

The reason that I undertook the study for my MD was because we were aware from research that I and others had done that GPs' care of the long term mentally ill was not terribly systematic and was often fairly superficial. GPs would tend to treat their patient's physical problems, give them sickness certificates and repeat prescriptions, but they very rarely reviewed their mental state or their psychotropic drugs, the drugs for their mental health problems. Even though people in this group tended to be heavy smokers, often obese, not taking any exercise and not turning up for cervical screening and other health promotion, GPs didn't really take much action about that and there seemed to be an attitude that the patients' mental health problems were such that any healthy lifestyle advice was rather a waste of time. Patients in this group sometimes had physical health problems which went missed, because the open-ended consultation style that we tend to use in general practice, which relies on the patient to come to us, make an appointment, come and tell us what's going wrong with them, doesn't really work in patients with the apathy and social withdrawal which are frequent accompaniments to schizophrenia and other serious mental illnesses.

So this is what I did for my Doctorate, I carried out a randomised controlled trial. I set up case registers and looked at the records of 440 long-term mentally ill patients in 16 practices. Those practices were then randomly allocated to two groups: eight intervention practices in which I taught the GPs to carry out structured assessments of their patients, and eight control practices, which carried on with usual GP care. After 2 years I looked at the records of the patients in all 16 practices again, to see what care they'd received. In the meantime I looked at 101 of the patients selected at random to describe in more detail the problems that they were having and to examine them for physical health problems. The follow-up rate was 373 out of the 440, more than 80%.

Now this bar chart shows the difference between the patients in the control practices, that's the blue bars, and the intervention practices, the yellow bars, where the GPs were taught the structured assessment. This shows the number of referrals following GP surgery assessments in those patients over two years as a percentage of patients in each of the two groups. As you can see around 15% of the control patients were referred to psychiatrists compared to nearly 22% of the intervention patients. More intervention patients were also referred to community psychiatric nurses (CPNs), to social agencies, and for physical problems. This was statistically significant only for the CPN referrals, but you can see the general trend is in the direction of more activity in the intervention practices.

And these are psychotropic drug treatment changes. They include changes in neuroleptics (major tranquillisers), antidepressants, other mental health drugs, and any change in drug treatments including for physical problems. Again, as you can see the general tendency was for more intervention in the practices taught the structured assessment, and overall this was significant at the 5% level.

However, the number of structured assessments carried out by GPs was less than perfect. Only 74% of patients even had a first assessment carried out, so a quarter of patients didn't get that done. That dropped to about half of the patients having two assessments, 30% having three, and only 1 in 6 patients having all four planned assessments over the six months. This was because, when talking to the GPs they found it quite difficult to fit this into their practice, and without extra resource to fund special sessions where they and the practice nurse could get together with these patients, this wasn't going to happen just voluntarily.

I was pleased therefore that, in the 2003 GPs' NHS contract, and the revised GP contract of 2006, performance indicators were put in for setting up registers of patients with severe mental health problems and reviewing them annually. Here you can see that GPs were awarded up to 23 points (out of a total of 1000 for clinical care) for the percentage of patients reviewed within the last 15 months. The extra three months is so that GPs could chase people up that hadn't been along in a year.

The annual review of patients with severe long-term mental health problems incentivised in the GP contract included these elements: health prevention and promotion, a check on alcohol, drugs, and smoking, a check for heart disease and diabetes, and checks on psychiatric medication, community mental health nurse involvement, and what services were actually being received by the patients and their carers. These reviews usually involve the practice nurse as well as the GP. It's important that these reviews are done well, and I was interested to learn recently that Jacquie White and colleagues in the Faculty of Health Sciences here in Hull run a training programme for practice teams in this area.

In the first couple of years after these indicators were introduced, most practices, virtually 100% across the country, set up registers of their patients with severe and enduring mental illness, and at least three-quarters and getting on for 90% in Southern England, where there's probably less deprivation and it might be easier to make these changes and practices are perhaps a little less busy, practices had managed to review more than 90% of their patients in order to earn the full 23 points that they could get. The average completion of reviews earned 21 out of 23 points so at least at the process level, the work that I did, along with research by others in the same area, had an impact. Whether these reviews improve the outcomes for patients is another question, and I am currently a minor member of a team led by Rowena Jacobs, of the Health Sciences Department at York, looking at whether the completeness and quality of regular reviews of these patients is associated with lower rates of admission to hospital.

I'm largely outlining a medical approach to mental health this evening, and the medical model is often criticised as inadequate in this field. I agree, we should think of mental health in terms of a whole range of psychological and social factors too, factors which can affect us positively as well as negatively. The good looking man in the middle of this picture is a long-time colleague and friend of mine, Chris Dowrick, professor of primary medical care at Liverpool medical school. This picture shows us walking together with another colleague Peter Salmon, a health psychologist in Liverpool. Chris invited me to walk with him in the Sierra Nevada in Spain when I was a bit down myself, going through a divorce at the time. Good friends are one of the things that can promote our mental health.

The second study I'm going to talk about is a study that I carried out with two medical students, Fiona King and Louise Albertella, who were doing their year medical student research projects in Southampton, and with Peter Smith, Professor of Statistics. I'd moved to Southampton in 1998 to take up the Chair there and I became interested now in depression. Professor Chris Thompson and others there had carried out the Hampshire Depression Project a large well conducted study that found that teaching GPs how to treat depression better according to guidelines was unsuccessful. Analysis of the study suggested GPs were treating some patients who didn't need treatment, while

not treating others who did need it. So I was interested in looking more closely at how GPs decided which patients needed treatment.

This was a study where the medical students sat in the waiting room of participating general practices and screened patients with a questionnaire, the Hospital Anxiety and Depression Scale depression sub-scale, or HAD-D, before the patients went in to see the doctor. They were looking for new cases of depression that were unknown to the Practice. The doctors then independently rated the presence and severity of depression amongst the patients as they consulted, blind to the scores that the patients had received in the waiting room, and recorded whether they had acknowledged depression with the patients, whether they'd offered them antidepressants, or referred them for psychological or psychiatric treatment.

This table shows that the GPs rated a total of 101 patients out of the 669 as depressed. A positive relationship is seen between the GPs' perceptions of the severity of the patient's depression along the top and offers of antidepressants down the side. As you can see, 71 were thought to have mild depression and 30 moderate depression. The numbers who were offered antidepressants was 4% of the 71 with mild depression, and 37% of those with moderate depression. So there was clearly a relationship between GP perception of severity of depression and whether or not they were offered antidepressants, which is what you would expect.

However, this table shows you the relationship between GP diagnoses of depression and the patients' scores on the HAD-D questionnaire. Where patients score 8 or more on the HAD-D they're rated as a possible case of depression. Across the top here again you can see the GP diagnosis of depression. They thought that 101 were depressed out of 669 and 568 were not. Down the middle there you can see that according to the HAD-D, 97 were rated as depressed and 572 were not. So similar numbers of patients overall were classed as depressed, about 100 out of the 669, but of the 97 who were a case of depression according to the HAD-D, only 31 were diagnosed as depressed by the GP and 66 were missed, which means that the sensitivity of the GPs for diagnosing depression against the HAD-D was only 32%. So GPs are not terribly good at picking up depression in a global way when compared to a questionnaire like the HAD-D, which has been shown in other studies to be a valid indicator of depression diagnosed by a longer psychiatric interview.

This fed through into the offers of antidepressants so as you can see from this table, out of the 14 patients offered antidepressants, only two of them (14%) had scores of 11 or greater on the HAD-D, which equates to probable major depression, six (43%) had scores in the borderline area, possible major depression, and another six, 43%, had scores of less than 8, which means that major depression is unlikely. So 43% of these offers were being made to patients with scores suggesting depression was unlikely.

We recommended better ways to assess depression severity should be used than GP judgement alone, to target treatment more appropriately to patients with more severe depression. This study was considered by the expert group reviewing the GP contract Quality and Outcomes Framework in 2005. Subsequently, in the revised QOF from 2006 onwards, up to 25 points were awarded for a new indicator which rewarded the use of an assessment tool, validated for use in primary care, at the outset of treatment. So that study I think had impact, at least in terms of changing what GPs were asked to do in the Quality and Outcomes Framework in 2006, when depression was included in the framework for the first time.

Music I think can also promote mental health. Certainly I have had huge pleasure from the Rolling Stones over many years. Listen to the words of Mick Jagger and music of Keith Richards from Mother's Little Helper, 1965:

"Kids are different today, I hear every mother say
Mother needs something today to calm her down
And though she's not really ill, there's a little yellow pill,
She goes running for the shelter of a mother's little helper,
And it helps her on her way, gets her through her busy day**"**

The Stones were talking about Valium, which was prescribed widely and fairly indiscriminately in the 1960s and 1970s before a ruling from the Committee on the Safety of Medicines in 1980 warned of its propensity to cause dependence. This brings me onto this increasingly widely prescribed drug, Prozac. Prozac was the first of a new class of antidepressant, the selective serotonin reuptake inhibitors or SSRIs, and was first licensed for use in 1990. Since then the numbers of SSRIs prescribed has increased steadily, year on year.

This is a bar chart of trends in the prescribing of mental health drugs in general practice in England, from the Prescription Pricing Authority which collects together all our GP prescriptions. Now as you can see, the total number of prescriptions rose between 2000 and 2005, from around 10m to around 12m items per quarter. Now the drugs that we're interested in, the SSRIs, the Prozac type drugs, are represented by the dark blue bars, the second lot of bars up, and as you can see they increased from about 5m to over 6m prescriptions per quarter during that period,. Other newer antidepressants, represented by the yellow bars, were also increasing. The red bars at the bottom are the older tricyclic antidepressants, amitriptyline, imipramine, and others. As you can see, the SSRIs and newer antidepressants are being prescribed in addition to a baseline of more than 2m items per quarter of the older antidepressants, which have not reduced, so the newer ones are not replacing the older ones. They are in addition and they're the main reason why the total number of prescriptions is going up and up, year on year. This is a process which is still continuing so we were interested to unpick why the prescribing of antidepressants was increasing.

To look into this increasing prescribing of antidepressants, we carried out a descriptive study using the General Practice Research Database, the GPRD, which is a large database of routinely collected computer data from general practices all up and down the country. This study was carried out with Mike Moore and Nick Dunn, colleagues in Primary Medical Care in Southampton, and Brian Yuen and Mark Mullee in Medical Statistics there. It was funded by the National Institute for Health Research; you remember this sort of research which is over towards the right-hand end of the translational spectrum tends to be funded more by the NHS than the MRC.

The possible causes of year on year rises in antidepressant prescribing in general practice could be an increase in the true incidence of depression; an increase in the diagnosis of depression perhaps due to improved recognition or changing thresholds for diagnosis; an increase in the proportion of cases of depression who are treated with antidepressants; or an increase in the duration of prescribing, so that the average number of prescriptions for a similar number of patients increases overall.

The GPRD is a huge database. At its height in 2001 it had more than 3m patients in it as you can see here and it's currently around 2m patients. The practices that contribute to this resource upload data from their practice computers anonymously to a central database. One of the challenges in using the GP Research Database is that the numbers of practices and the numbers of patients have varied over time as you can see. To get round this problem we selected only practices which were in the GPRD right throughout the period for which we had data, from 1993 to 2005.

So the first question I raised was whether the incidence or diagnosis of depression was increasing. Well this is the incidence of diagnosed depression in the GPRD and as you can see it remains relatively flat between 1993 and 2005, and in fact there might have been an increase during the nineties which then tailed off a bit during the noughties. Overall it's fairly steady at a rate of around 10 per thousand, or 1% per year. Remember these are new cases only, not all cases, which would be around 5 to 10% per year. The lines show the usual situation found in studies of the incidence of depression, which is that women are diagnosed twice as often as men, which I don't think is surprising. After all women do all the caring, they bring up the children, they look after the old people, they have all the hormonal issues to deal with, premenstrual tension, childbirth and the menopause, and women generally get the rawer deal in life so it's not surprising to me that depression is twice as common in women.

This chart shows that diagnosis was most common in young women, particularly in women of aged 18-30, here shown by the orange line, where you can see the rate of diagnosis of depression is around 30 cases per 1000 so that's about one in 30 young women being diagnosed as depressed each year. This is a lot more compared to women in older age groups where there was a slight rise amongst the under-18s, but for the 31-64 year olds and the over 65s, generally the trend was to diagnose less depression between 1993 and 2005, and actually I'm not that surprised about this because generally speaking it was a period of relative affluence and probably reduced deprivation over time.

The second question was whether we were treating more of these new cases with antidepressants and again the answer is no, not really. In fact, if anything, during the 2000's the proportion treated dropped off a bit from around 80% to around 75%. This is rather circular because GPs often only attach a diagnosis of depression to people if they're going to treat them with antidepressants, so it may be that there are other patients that they think are depressed but don't attach a label to because they're not going to treat them. Having a label of depression in your GP records is not always the best thing for a patient because employers, insurance companies, and others can come along afterwards and ask for reports from a GPs' records and, unfortunately these days, although we'd rather it wasn't, depression is still a stigmatised disorder. At any rate, around 80% of those labelled with depression were treated with antidepressants and that stayed much the same during the period 1993 to 2005.

So were people being treated for longer over time? Well our initial analysis suggested not. These bars represent the proportions of patients who had different durations of treatment in the first two years after diagnosis and as you can see in 1993 to 1994 around half (55%) of the patients diagnosed actually had only 30 days or less of treatment prescribed. Around 20% had one to two months of treatment; around 10% had two to three months; around 10% had three to six months, and only around 5% of patients had more than six months worth of prescriptions. This is interesting because

the recommended duration of treatment for a first episode of depression would be more than six months according to NICE guidelines, but only 5% of patients were getting that duration of treatment prescribed. The situation hadn't really changed in 2004 to 2005. You can see here that the sizes of the bars look much the same, and again only about 5% of patients were treated for more than six months.

However, we found that the mean number of prescriptions of antidepressants per patient per year was going up steadily in our sample, so although more people were not being treated, and it looked on the surface that the duration of treatment was staying much the same, the number of prescriptions per patient per year was going up from around three to almost six, nearly doubling during this time period. This rise of course mirrored what was happening at the national level, where prescriptions for antidepressants were going up year-on-year. So how could we explain this? It was a bit of a mystery but we thought to understand better what was going on we had to look at individual patients and what happened to their treatment over some years after diagnosis.

So we split the patients into five groups. Those who received what we call chronic treatment were those who received at least one prescription in the year of diagnosis and in every year after that for five years; those who received intermittent treatment received at least one prescription in the year of diagnosis and in at least one of the five subsequent years; those who received short term treatment received a prescription in the year of diagnosis but not in any of the five subsequent years; delayed treatment meant no prescription was received in the first year of diagnosis but a prescription was given sometime between years two and five; and finally we had a no treatment group where patients were given a label of depression but never received a prescription for an antidepressant.

Now this chart takes a little bit of getting your head round. Over on the right you can see the colour key for patients who received the various patterns of treatment: the chronic treatment group is represented by the blue bars; intermittent treatment by the dark red bars; short term treatment by the pale yellow bars; and delayed treatment by the pale blue bars. You can't see the no treatment group on this chart because this is a chart of prescription days, so everyone on here received some treatment. As you can see in the two long term use groups, the chronic treatment and the intermittent treatment groups, the number of prescription days does increase over time. Amongst the patients receiving short term or delayed treatment it remains much the same. The two longer treatment groups were relatively small, but they were the ones receiving more and more prescriptions year-on-year and their treatment patterns explained the cause of the rise in the average number of prescriptions per patient.

The implications of the findings of this study were that, instead of looking at the initial prescribing decision and trying to improve the targeting of drug treatment to more severe depression, which is what we'd done up until that point, increased attention should focus in the future on appropriate longer-term prescribing in the small number of patients who end up on long term antidepressants. Other research we did led by Gerry Leydon showed that some of those patients were often not being monitored and having their need for medication reviewed regularly. Some wanted to come off their medication but found it hard and needed help to do that. We concluded there is a small but growing number of patients, particularly of young women, who are taking Prozac and other drugs like that for depression year-on-year and really ought to be reviewed so the question can be raised

with them about whether they should come off the drugs. Strictly speaking, the SSRIs are not addictive because, unlike Valium, people taking them don't develop tolerance to their effects and need more and more of them, but they do have withdrawal symptoms associated with them including anxiety symptoms, and need to be tapered off slowly with advice and supervision from the doctor.

Families can obviously be the cause of depression as well as prevent depression through mutual love and support. I am extraordinarily lucky to have two parents still alive and well and enjoying regular cruises, and two lovely kind and successful children, Celia and Patrick, now in their mid-20s. Here's a picture of them altogether on the cliffs between Deal and Dover where I grew up.

The fourth study I'd like to talk about is a study of the management of depression in general practice in relation to scores on the depression severity questionnaires which you will recall we recommended should be introduced and rewarded through the GP contract Quality and Outcomes Framework. We were interested to look at the use of these questionnaires and whether prescribing was influenced by the results obtained using them with patients. I worked with Chris and colleagues from Southampton as well as Amanda Howe's primary care group at East Anglia medical school. This study was funded through unrestricted educational grants from four manufacturers of antidepressants, who were interested in learning more about influences on GPs' prescribing, but they had no say in the questions we asked, the methods we used, or the results we presented.

We were interested in looking at whether rates of antidepressant prescribing and referrals to specialist services varied in line with patients' scores on the QOF severity questionnaires. The two questionnaires that we looked at were the two most commonly used measures, the Patient Health Questionnaire nine item version, or PHQ-9, and the Hospital Anxiety and Depression Scale, depression sub-scale or HAD-D, which I've mentioned we used in the previous study of detection and rating of severity of depression. We realised that it was unlikely to be the scores on these measures alone that would determine rates of antidepressant drug prescribing by GPs, and we looked at other potentially important predictors that the GPs would take into account, including the age of the person, any past history of depression, and any concurrent physical illness, in particular diabetes and coronary heart disease, where GPs might think twice about prescribing antidepressants because of the potential negative side effects of treatment on those conditions.

In 38 general practices between Southampton, Liverpool and Norfolk, we looked at over 2,000 patients who were assessed with the severity questionnaires in the first year of their introduction, 2006-2007, specifically at rates of prescribing of antidepressants and referrals to specialist mental health or social services (you can see the types of mental health worker that were included in those referrals there).

This table shows down the side whether or not patients were prescribed an antidepressant and whether or not they were referred to mental health or social services. Across the top is shown the severity of patients' depression according to their scores on the PHQ-9 questionnaire. As you can see, a total of 1,658 patients were assessed with the PHQ-9, and of those 1,384 were rated as moderate to severely depressed, 189 as mildly depressed and 85 as minimally depressed. The rates of prescribing for these groups of patients do vary in line with the severity according to the questionnaire. You can see in the moderate to severe depression category nearly 87% of patients received a prescription, whereas in the minimal depression category only 27% did. Overall 79%

received a prescription for an antidepressant which was in line with what we found in the GPRD study I mentioned earlier. In terms of referral, again there was a relationship with severity rated by the PHQ-9. Only about one quarter of patients were referred overall, but that varied from 13% of those with minimal depression, through 16% of those with mild depression, to 25% of those with moderate to severe depression.

Now if we look at the HAD-D questionnaire ratings a similar picture emerges. The chances of treatment with an antidepressant and referral are both related to severity of depression according to the HAD-D questionnaire, in a similar fashion to the PHQ-9 results.

However, things are never that simple, and we really had to raise a question mark over whether the scores on the two questionnaires were in reality informing the decision to refer and treat because the classification of patients according to these two different measures revealed quite different profiles. The PHQ-9 was more likely to put people into the moderate to severe depression category than the HAD-D. Here you can see among both men and women, about 80% of those rated with the PHQ-9 were put into the moderate to severe category, whereas amongst the HAD-D it was only about 60%, and yet the proportions of patients rated with either measure who were treated with antidepressants and/or referred were the same. So we thought we had to be sceptical really about whether the scores were informing the GPs' decisions to prescribe or refer.

We put together a logistic regression model, which is a statistical model which includes several factors together which between them might help to explain GPs' prescribing or referral decisions. These factors were the severity of depression, older age, a past history of depression, having diabetes or coronary heart disease, and the location where the practices were based, because there is evidence that practices in some towns are more likely to prescribe than practices in others, because the local prescribing culture varies. We found that Southampton practices had quite a high level of prescribing compared to practices in the other two cities we studied. Here you can see the logistic regression models for the two measures and, even when putting all these factors in together, for both the PHQ-9 and the HAD-D assessed patients, prescribing was very much related to severity (the three pluses there show that receiving a prescription was related to severity). In addition, amongst the HAD-D rated patients, when taking these other factors into account, referral was still also related to severity. Referral was negatively related to being aged over 65 for both groups of patients, so elderly patients were much less likely to be referred, independently of whether they had a past history or diabetes or heart disease. A past history was a predictor of prescribing in PHQ-9 rated patients but not HAD-D rated patients, and having diabetes or heart disease was a negative predictor of both prescribing and referral in the PHQ-9 group, so if you had diabetes or coronary heart disease you were much less likely to be either treated or referred at least among the PHQ-9 rated patients.

To summarise the findings of this study, overall about 80% of patients assessed with either questionnaire received a prescription and about 20% were referred to specialists. Prescriptions and referrals were associated with higher severity measure scores, but the overall rates of treatment or referral were very similar for patients assessed with the two different measures, despite the fact that the PHQ-9 classified more than 80% of patients as moderately or severely depressed and in need of treatment, compared to only about 55% for the HAD-D. Finally, rates of intervention were

lower for older patients and for patients with co-morbid (accompanying) coronary heart disease and diabetes.

To summarise this work that I've shown you on the GP use of antidepressants, the diagnosis of depression and prescribing of antidepressants by GPs has remained remarkably consistent through the nineties and the noughties: about 80% of patients diagnosed are treated with antidepressants, but most patients take them for too short a time compared to guideline recommendations of six months. On the other hand, a small proportion of patients are kept on them long-term which explains the rise in prescribing, but may be too long in some cases. Analysis of patients' records suggests GPs largely decide on drug treatment on the basis of severity but they also take age and physical illness into account. The two most widely-used severity questionnaires perform inconsistently in practice, which has brought them into disrepute and their inclusion in the QOF may actually be discontinued from April 2012, which will be welcomed by many GPs as many don't like using them. Simon Gilbody and I are involved in a multicentre research project to look again at the best predictors of the need for antidepressants, including severity scores on questionnaires, funded by an NIHR programme grant led by Glyn Lewis in Bristol and involving Chris Dowrick in Liverpool. However, future research and policy also needs to focus on the duration of prescribing and follow-up monitoring of people put on these drugs long-term, as well as the initial decision to prescribe.

A sense of community is important to our mental health, a sense of belonging to a wider group, of sharing a common interest and purpose. This is a picture of members of my old running club in Romsey at the end of the annual five mile beer race. All finishers are rewarded with a pint of London Pride which is just what you need after five miles up and down the hills of Hampshire. Alcohol in small amounts can help our mood, but of course too much alcohol too often causes rather than relieves depression.

I want to turn away from drug treatment now. The next study I want to talk about is a qualitative study, an interview based study that we carried out with patients, their carers, and GPs about depression management in primary care. We wanted to identify what were the GPs' goals and the patients' goals when managing depression and what came out strongly in this study was the value to patients of being heard, of being listened to. This was led by Olwyn Johnston, a Health Psychologist; and the team included Satinder Kumar a GP and Anthropologist; Kathy Kendall, a Medical Sociologist; John Gabbay, a Public Health Doctor; and Robert Peveler, a Psychiatrist; so we were very much a multidisciplinary group. It was funded by the Medical Research Council and published in the British Journal of General Practice in 2007.

We interviewed 28 depressed patients and 32 GPs, and we found that patients valued being listened to very much. These were the sorts of benefits which may or may not be immediately obvious. First of all, a sense of connection, helping the patients to feel understood by the doctor. They valued the process of reflection, helping people to clarify or reframe either what was wrong with them, using the medical model, or what was wrong with their situation, adopting more of a social model, to help explain their depression. They valued being listened to for the sense of acceptance, that the doctor would accept them for who they were even when others were condemning them for their behaviour. Sometimes just bearing witness to the suffering that people are going through can be helpful even if you're not actually doing anything to change their situation. Reassurance is important, in particular that people who are depressed are not going mad. Ventilation, catharsis is

helpful obviously, to help people get things off their mind, and the doctor's can be a safe place where they can sound off and talk about things. But encouragement is also very important, because most people, the large majority of people with depression, do get better and people need reassurance about this, because often people feel they are never going to get better and they're going to end up disabled, and on long term treatment. The great majority won't.

Unfortunately, in general practice patients often don't feel very listened to. There's often a perceived lack of time, the doctor seems rushed, and even 10 minute appointments (which have lengthened during my working lifetime from five minutes) aren't long enough for people to describe their feelings and feel they've been heard. Doctors often seem to be preoccupied with the computer or making notes, and not giving the person enough attention. There's sometimes a perceived lack of receptiveness or acknowledgement of their problems as worthy of discussion. The patient feels less worthy than those with physical illness and the doctor may even dismiss the problems as not worthy of medical attention. Or if the doctor does respond, the doctor decides too quickly to reach for the prescription pad and offer antidepressants. However, patients don't mind so much if the GP doesn't do much talking and listening with them if they are being referred on to someone else who will listen, perhaps a counsellor or another professional to give them some sort of talking treatment.

Loving and being loved is also related to our mental health, one way or the other. I'd like to thank my partner Dr Helen Mander, who works in Hull as a clinical psychologist, for all the love and support she gives me. So I have my own personal therapist, how great is that? I think counting your blessings, especially your friends, family and loved ones, is a really important thing to try and do every day. Helen says psychologists call that having a positive data log, and it's part of a cognitive behavioural approach to treating depression. That brings me on to psychological treatments, which is what most patients prefer, although for many years they have been relatively unavailable in most parts of the country, which helps explain why GPs prescribe antidepressants, the lack of an alternative to what many of us realise are very imperfect drugs.

I was delighted to be asked to join a team from the Universities of Sheffield, Manchester and London while I was at Southampton, to look at a new service model of providing talking treatments, the Improving Access to Psychological Therapies (IAPT programme). The IAPT programme was set up in two demonstrations sites and our project helped evaluate them between 2006 and 2009. IAPT is a new service introduced to give much greater access to talking treatments for people with anxiety and depression, who can be referred from general practice or hospitals, from social services, or self-referred. This study was funded by the National Institute for Health Research Service Delivery and Organisation programme, and is very much at the right hand end of that translational spectrum that I showed you at the beginning of the lecture.

The Improving Access to Psychological Therapies programme includes two steps of care, low intensity which includes guided self-help, helping people to help themselves which might be through using books or computer programmes, to help them identify and challenge negative automatic thoughts, and through behavioural activation, helping them to get out more, to increase their daily activities, and face the things that make them anxious, because we know that this graded exposure can be helpful in itself. Often low intensity treatment is delivered over the telephone in four to five sessions of around 45 minutes, which is relatively short. The second step is high intensity treatment,

for those who don't respond to low intensity treatment, which may be 15 to 20 one-hour sessions of cognitive behaviour therapy which is a much more detailed therapy which tackles the person's negative thoughts and behaviours, or interpersonal therapy which looks more at how people deal with their important others. In this study we looked at the effects of the IAPT programme in the two demonstration sites: in Doncaster in the north, and Newham in South East London in the south.

To summarise the main findings of the study, these demonstration sites were very successful. They were able to treat hundreds of patients every month, most patients receiving low intensity therapy delivered over the telephone, lasting 4-5 sessions each. This was so successful that six times as many patients received treatment than previously, which is fantastic, except when you realise that the absolute increase was only from 1%, that's one in a hundred patients, to 6%, six in a hundred of those with some sort of mental health problem actually receiving a talking treatment. Nevertheless, amongst the 6%, their use of accident and emergency was reduced so people were turning up at hospital much less often with problems of anxiety and depression needing help urgently, and 5% more patients in the IAPT group got back to work, than in the usual GP care group. So it was successful to that extent.

There were also a number of problems identified with the IAPT programme. Patients found it quite a problem if they didn't see the same person each time and because of staff turnover there was often a lack of continuity or follow-up for patients. For some people practitioners who contacted them over the phone could be experienced as impersonal when compared to professionals from their own practices. Some patients felt that they didn't really have much choice, they would have preferred more of a counselling approach or some other approach that they were used to from the past, and they felt shoe-horned into this possibly rather restrictive model, the two-step model of the IAPT programme. And although hundreds more patients received treatment, as I've said they were still only a small minority of the total number of patients with anxiety and depression.

This slide summarises some of the work that we've done on talking treatments. People need to feel listened to. There are all sorts of reasons why it's important for them. It may go without saying that that is obvious but it often doesn't happen in practice. GPs often can't or don't listen enough and the same may go for practice nurses who are often busy with practical tasks. Referral for some sort of talking therapy can be very helpful but even with the increased access provided by the IAPT programme, only a minority of patients who might need referral can get it due to the limited funding available, and that's likely to get worse as the NHS makes its 20% efficiency savings over the next few years. Some people anyway find outside therapists rather impersonal and so one of my conclusions is that primary care teams may have to do more themselves. If they do that then the training of people who are offering talking therapies in primary care, together with supervision, some regular feedback on how they're doing, will be essential to maintain the quality of treatment provided.

I have mentioned some other potential treatments for depression in passing, and one of them which is currently under-rated is regular exercise. Exercise has done me a power of good. Over the last few years I have been running marathons, at least two marathons a year and this is a picture of me recently taking part in the Chicago marathon in the States. I think that regular exercise is keeping me sane, I think it really helps me if I find the time to put in long distance runs, I find I think more clearly, and I can take on the daily demands of being the head of a medical school. I'm not sure why

exercise helps you. It has been shown to increase the level of endorphins, those natural morphine-like hormones which can flood into the blood on long runs, when you're really away in the zone, in a meditative like state, and everything around you melts into the background, like in this picture.

On the other hand, maybe you go through so much pain while you're running that the rest of life seems wonderful by comparison, but it doesn't necessarily do wonders for your looks. This is a picture of me running The Grim which is a cross-country run in freezing December through flooded tank traps and deep yellow mud on an army assault course near Aldershot. Does this remind you of anything?

It reminded me of one of those Gremlins from the movie. I think we feel better if we're able to laugh at ourselves, and not take life too seriously sometimes. Humour then is another possible therapy for mental health problems.

I'd like to finish by thanking some of the many people with whom I have had the privilege of working on the projects that I've talked about, and other projects too numerous to include in this talk. From my great late mentor, Paul Freeling, who inspired me to go into general practice, first as a student and then later as a research fellow; through to colleagues at HYMS with whom I'm doing research today, like Simon Gilbody. Some colleagues are here in the audience. I'm really pleased that Chris Dowrick from Liverpool has been able to make it. He's an old mate and we've been involved in several studies together. Research is a business that really engages you with other people and I hope that I've shown that work on mental health problems is all about people. It's work at the level of the person, and the community, so it's not molecular biology but I think you'll agree that it's still very important research. Thank you for listening.

Down at the Doctor's

How should GPs and their teams help people with mental health problems?

Tony Kendrick

Professor of Primary Care and Dean,
Hull York Medical School

November 2011

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Mental health problems: very common

Prevalence among16-64 year olds:

- 9.0% mixed Anxiety and Depression
- 4.4% Generalised Anxiety Disorder
- 3.0% Post-Traumatic Stress Disorder
- 2.3% Major Depressive Disorder
- 1.4% Phobias
- 1.1% Obsessive Compulsive Disorder
- 1.1% Panic Disorder
- 0.4% Psychosis (Schizophrenia, Bipolar Disorder, and other psychoses)

McManus et al, Psychiatric Morbidity Survey
Office for National Statistics, 2007.

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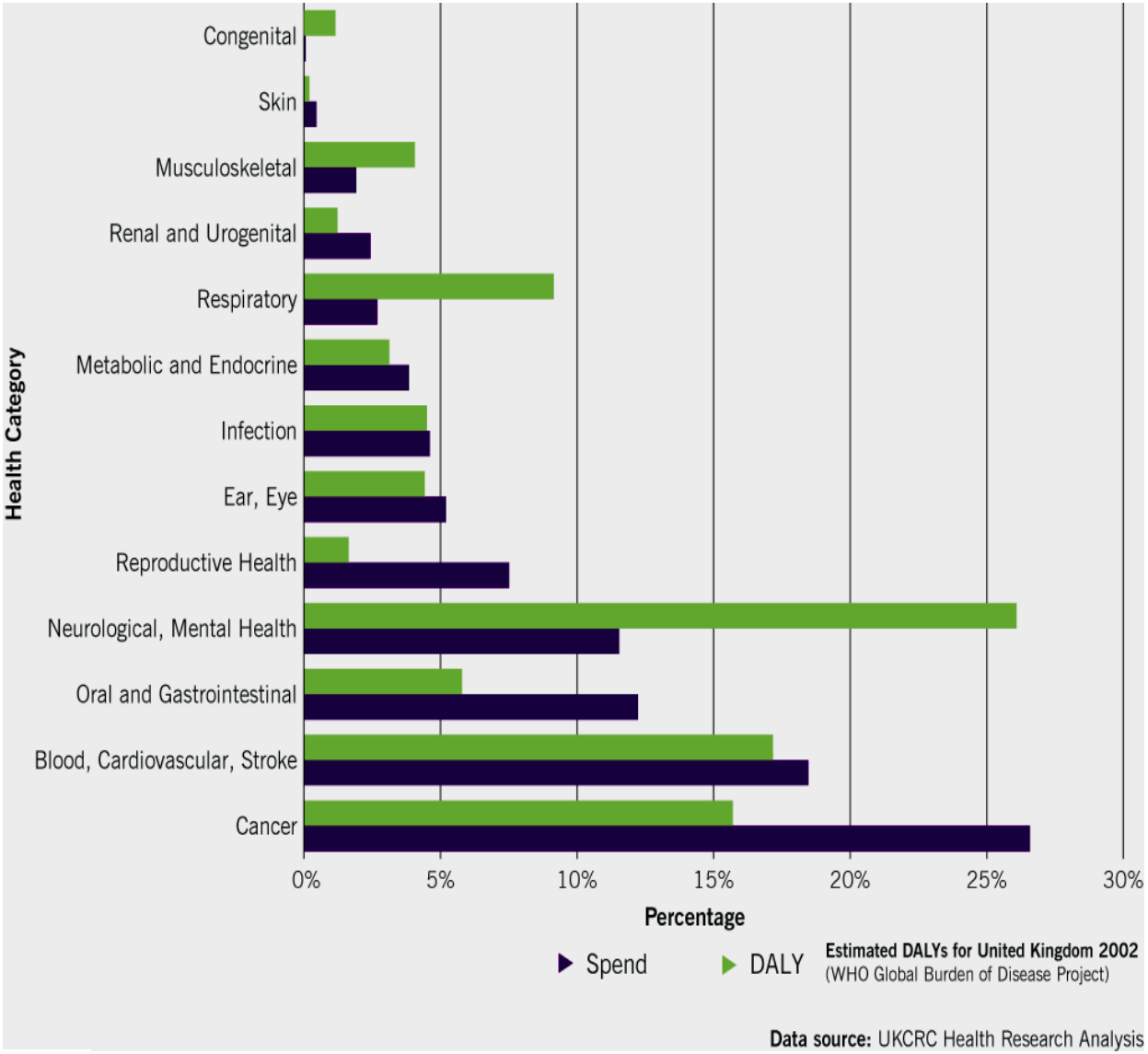

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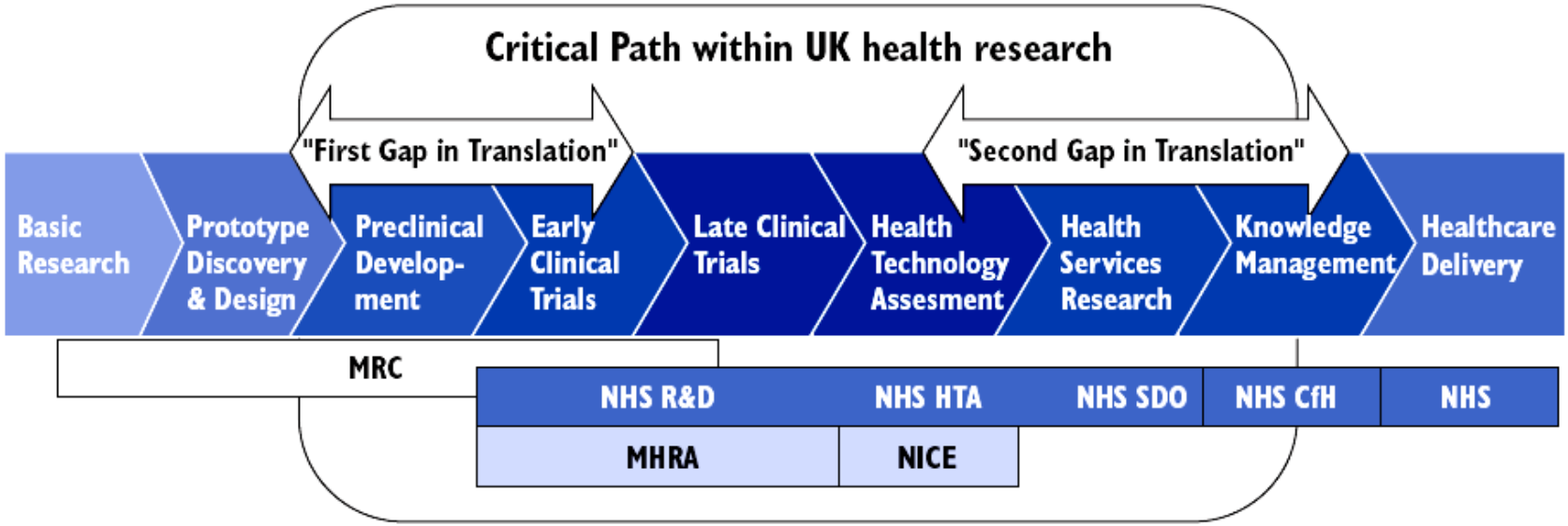
Level in system	Example of research
Atoms	Imaging
Molecules	Genomics, proteomics
Organelles	Mytochondrial biology
Cells	Cellular biology
Tissues	Matrix biology
Organs	Hepatology
Body system	Cardiovascular
Person	**Health psychology, qualitative studies**
Population	**Epidemiology, clinical trials**
Community	**Health services research**
Ecosystem	Ecology
Biosphere	Environmental research

The need for clinical and health services research



Cooksey D. A review of UK health research funding. London: Stationery Office, 2006

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Randomised controlled trial of teaching general practitioners to carry out structured assessments of their long-term mentally ill patients

Tony Kendrick, Tom Burns & Paul Freeling

St George's Hospital Medical School

Funded by the Mental Health Foundation

British Medical Journal 1995, 311, 93-98

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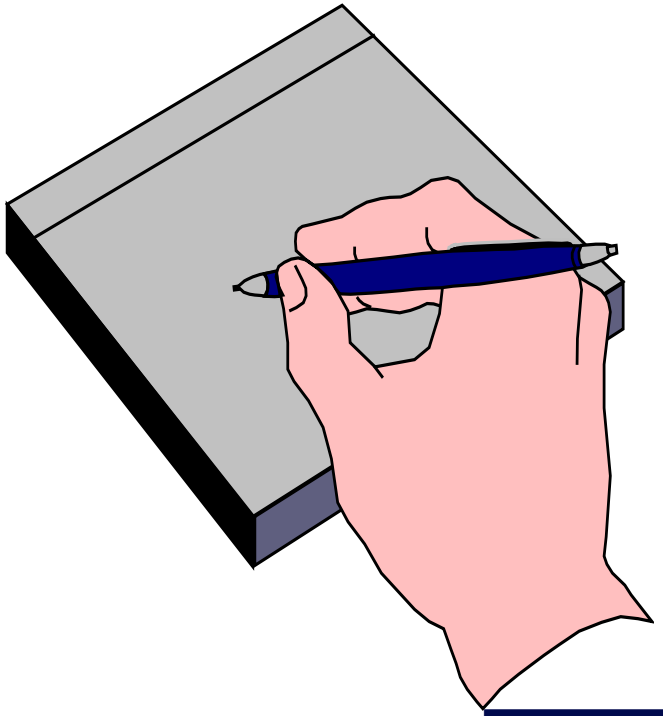
What were GPs doing for their long-term mentally ill patients?

- Treating physical problems and issuing certificates and repeat prescriptions (Parkes et al 1962, Kendrick et al 1994)
- Reviews of mental state and psychotropic medication were relatively uncommon (Nazareth et al 1993, Kendrick et al 1994)
- Health promotion was almost non-existent (Kendrick, 1996)
- Open-ended consultation style tended to miss problems in patients with apathy and withdrawal



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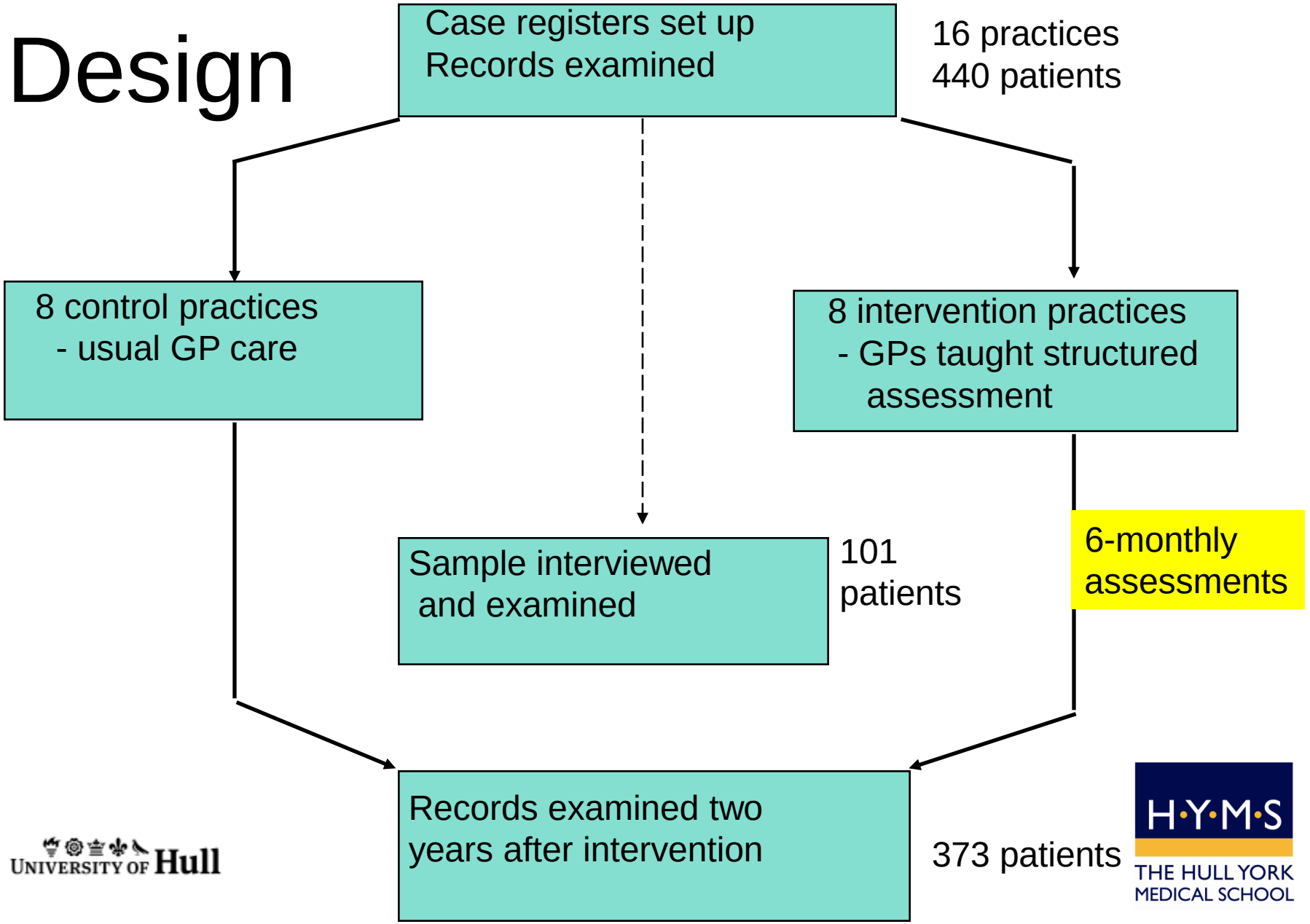
Design



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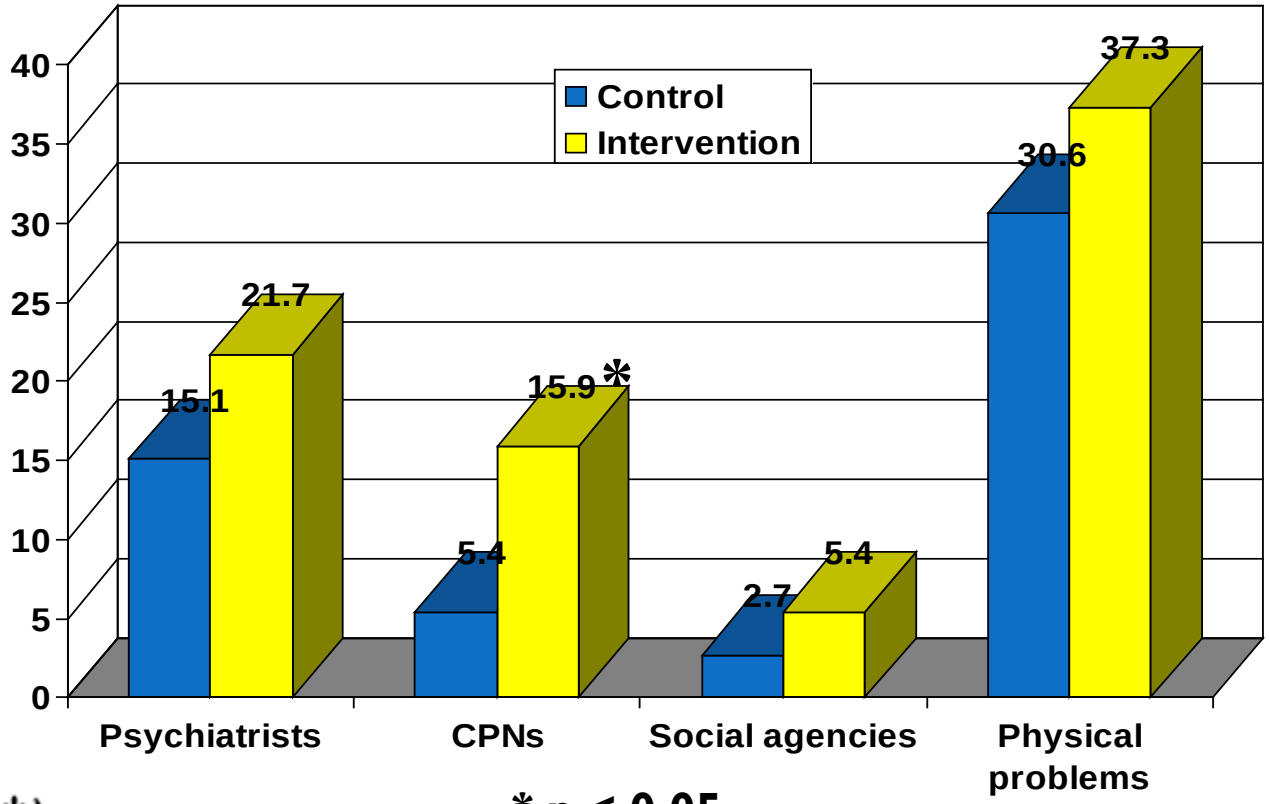
Referrals following GP surgery assessments

(% of patients over two years)



* p < 0.05

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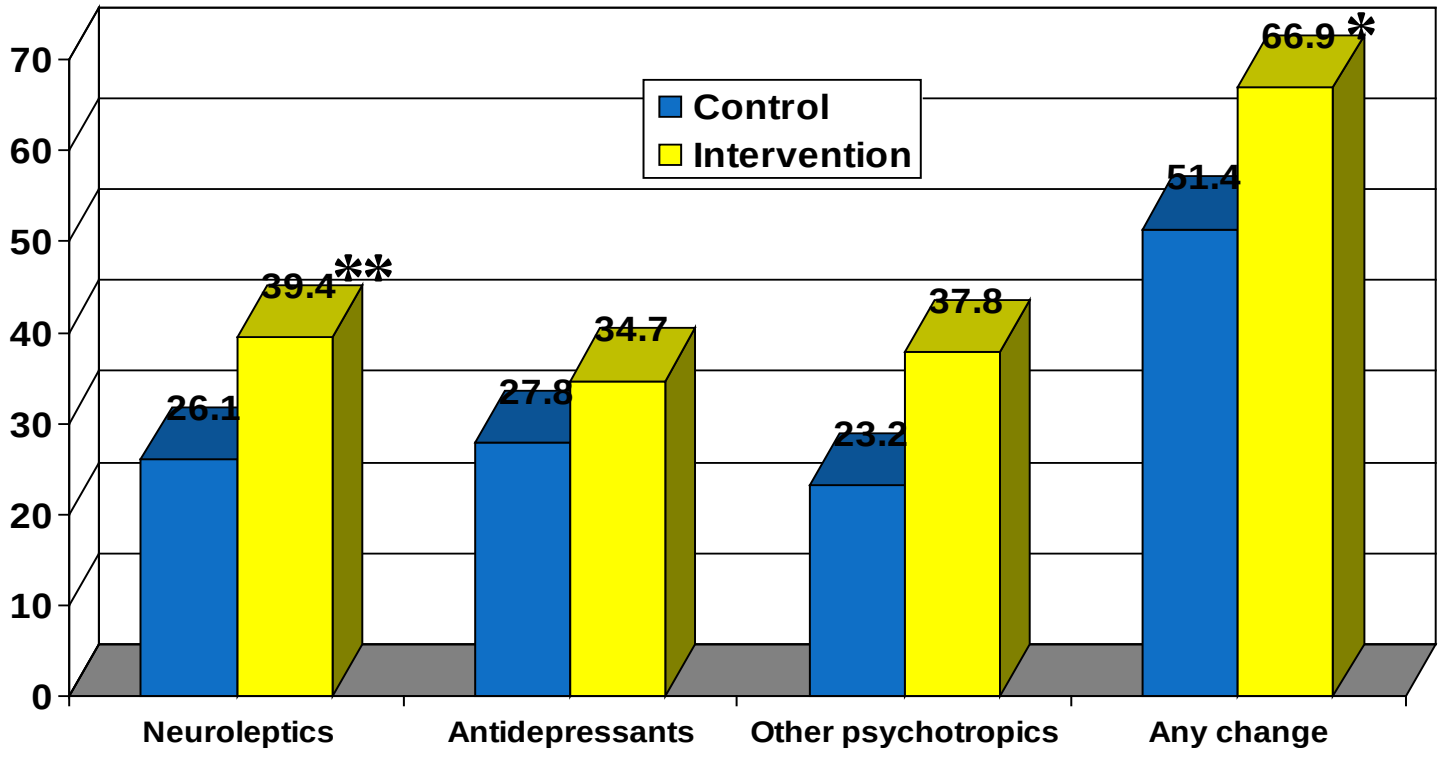
Psychotropic drug treatment changes

(% of patients over two years)



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* p < 0.05 ** p< 0.01

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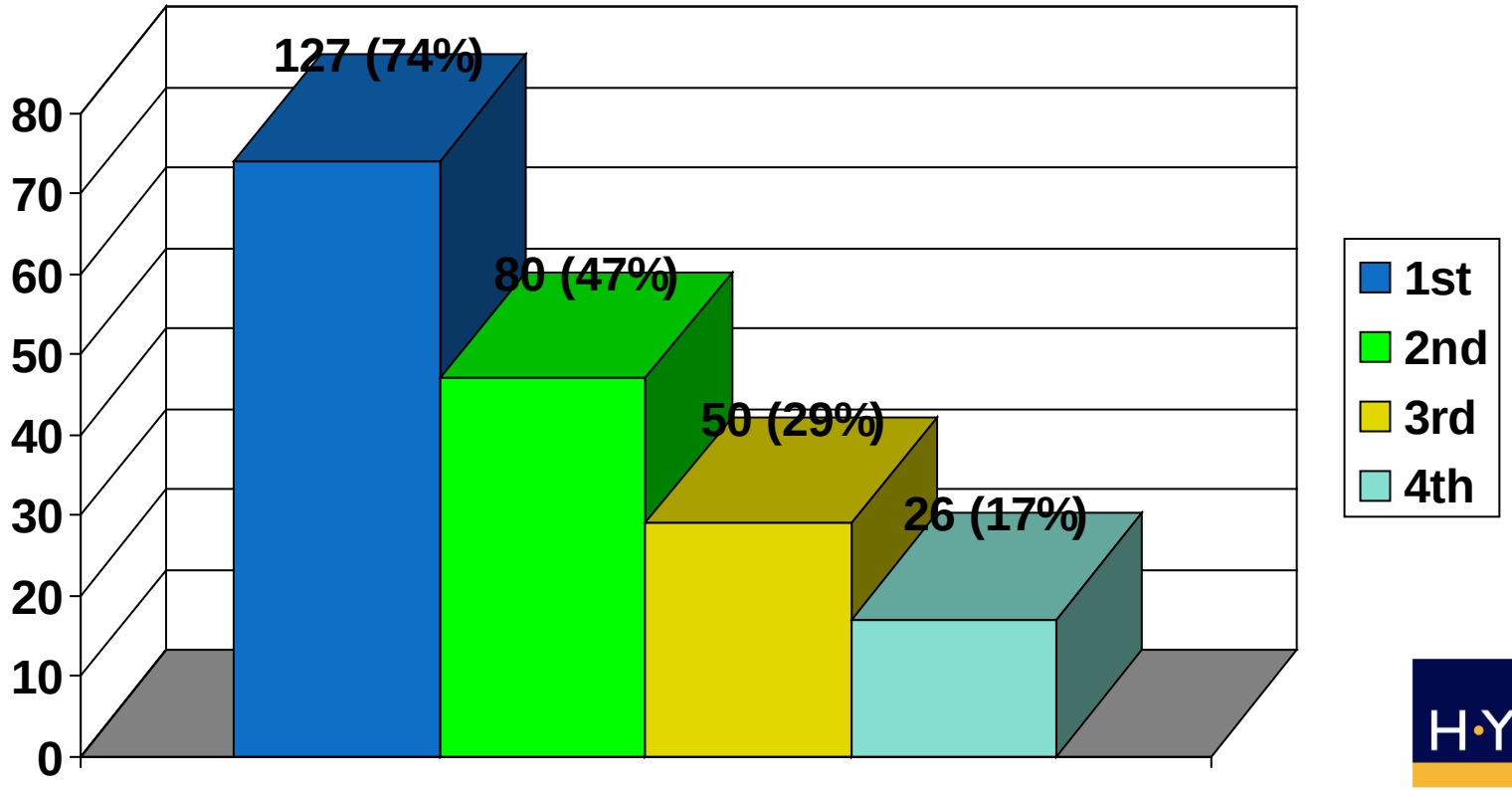
Structured assessments carried out by GPs over 2 years



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New General Medical Services Contract Quality and Outcomes Framework 2003

Indicator	Points	Payment stages
MH1 Register of patients with severe long-term MH problems	7	
MH2 % of patients reviewed within the last 15 months	23	25 – 90%

NHS Confederation/BMA, 2003 and revised 2006.

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Annual review of patients with severe long-term mental health problems

Physical care

- Routine health promotion and prevention
- Alcohol or drug use
- Smoking and heart disease
- Risk of diabetes

Medication

- Accurate, up to date

Coordination of services

- Community mental health nurse involvement
- What services are actually being received by the patients and their carers

General Medical Services Contract Quality and Outcomes Framework
NHS Confederation/BMA, 2003 and revised 2006.

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Quality and Outcomes Framework MH 1 and 2 indicators 2004-5

Region	% of practices with a register of patients with severe mental illness	% of practices which reviewed >90% of patients with SMI
NW England	99.4	76.0
NE England	99.2	77.4
London	99.3	77.0
Eastern England	99.3	85.2
Southern England	100	87.8

Average points for completion of patient reviews = 21 / 23

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GP treatment decisions for patients with depression: an observational study

Tony Kendrick, Fiona King, Louise Albertella & Peter Smith

University of Southampton

British Journal of General Practice 2005;55:280-286.

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Methods

- 669 patients screened in waiting room with Hospital Anxiety and Depression Scale depression sub-scale questionnaire (HAD-D) before seeing the doctor (excluding people with known depression)
- The doctors rated the presence and severity of depression and reported whether they:
  - Acknowledged depression
  - Offered antidepressants
  - Referred for psychological treatment
  - Referred for psychiatric opinion

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Perceived severity and offers of antidepressants

		GP perception of severity of depression		Total
		mild	moderate	
Whether or not patient was offered anti-depressants	No	68	19	87
	Yes	3 (4%)	11 (37%)	14
	Total	71	30	101

Fisher's exact test $p < 0.05$

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GP diagnoses of depression compared to the HAD-D

		Whether or not a case on the HAD-D (score 8+)		
		Yes	No	Total
GP diagnosis of depression	Yes	31	70	101
	No	66	502	568
	Total	97	572	669

Sensitivity = 32%

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HAD-D scores of 14 patients offered antidepressants

0-7 (major depression unlikely)	6 (43%)
8-10 (possible major depression)	6 (43%)
11+ (probable major depression)	2 (14%)

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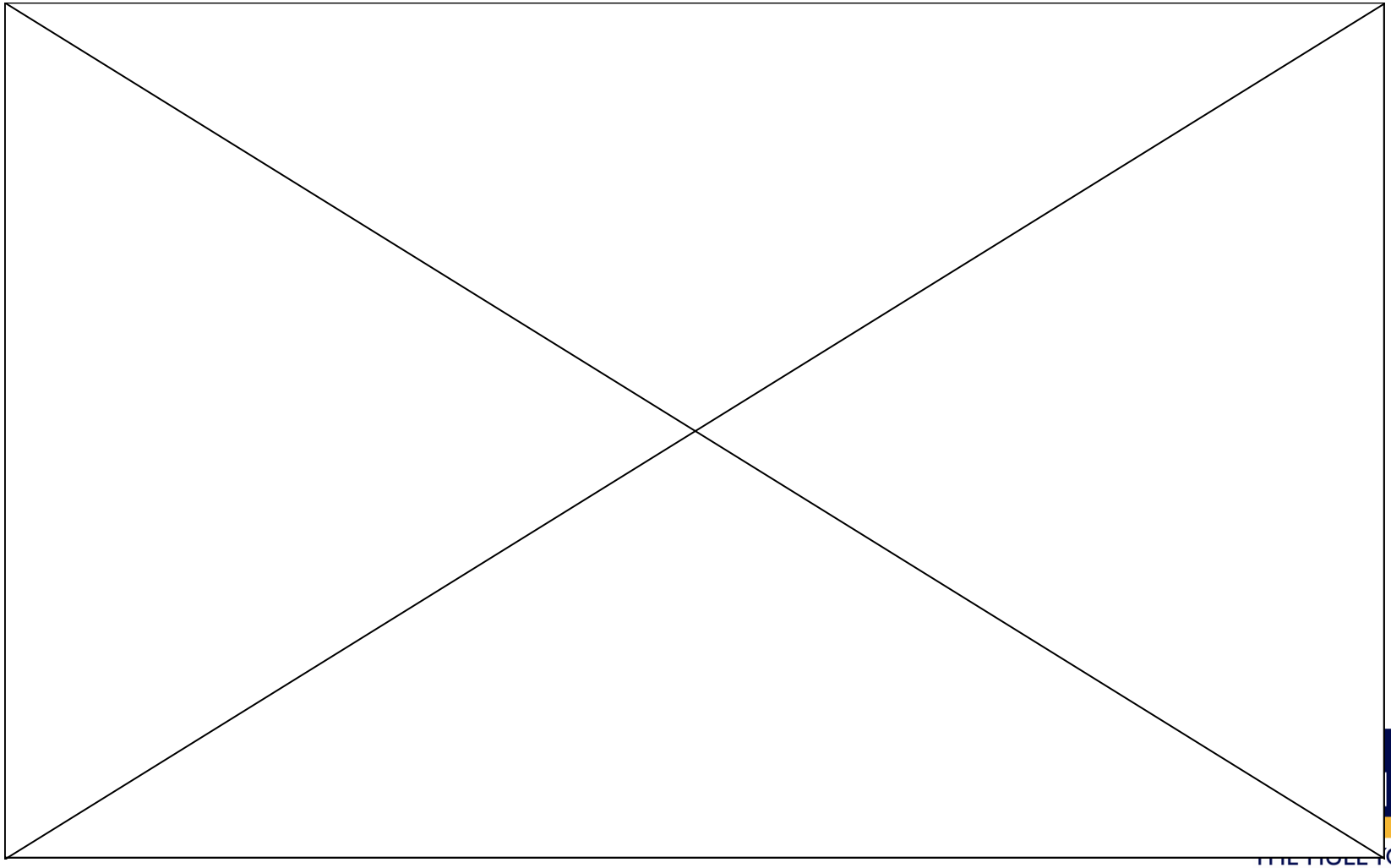
Implications for practice

- Better ways to assess depression severity are needed in order to target treatment more appropriately
- Fed into expert group reviewing the QOF
- In the revised QOF from April 2006, up to 25 points were awarded for a new indicator:
  - In those patients with a diagnosis of depression, the percentage of patients who have an assessment of severity, using an assessment tool validated for use in primary care, at the outset of treatment



Music

"Kids are different today, I hear every mother say
Mother needs something today to calm her down
And though she's not really ill, there's a little yellow pill,
She goes running for the shelter of a mother's little helper,
And it helps her on her way, gets her through her busy day"

Jagger M, Richards K. Mother's little helper. 1965.

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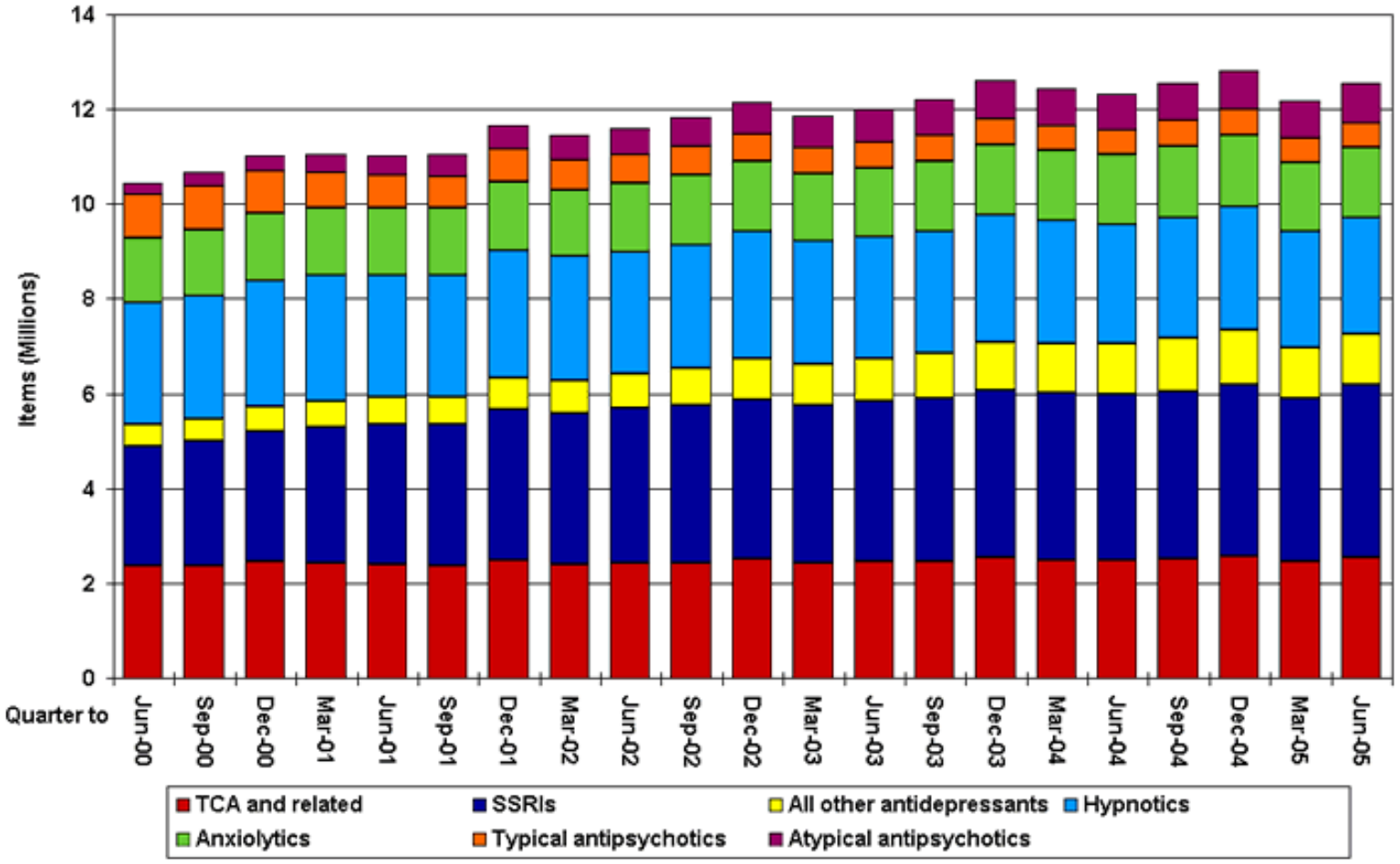
The new Valium?

Trends in Prescribing of Mental Health Drugs in General Practice in England (Chart 1)



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Explaining the rise in antidepressant prescribing: a descriptive study using the General Practice Research Database

Mike Moore, Ho Ming (Brian) Yuen, Nick Dunn, Mark Mullee &Tony Kendrick

Primary Medical Care and Medical Statistics,
University of Southampton

Funded by the National Institute for Health Research

British Medical Journal 2009;Oct 15;339:b3999

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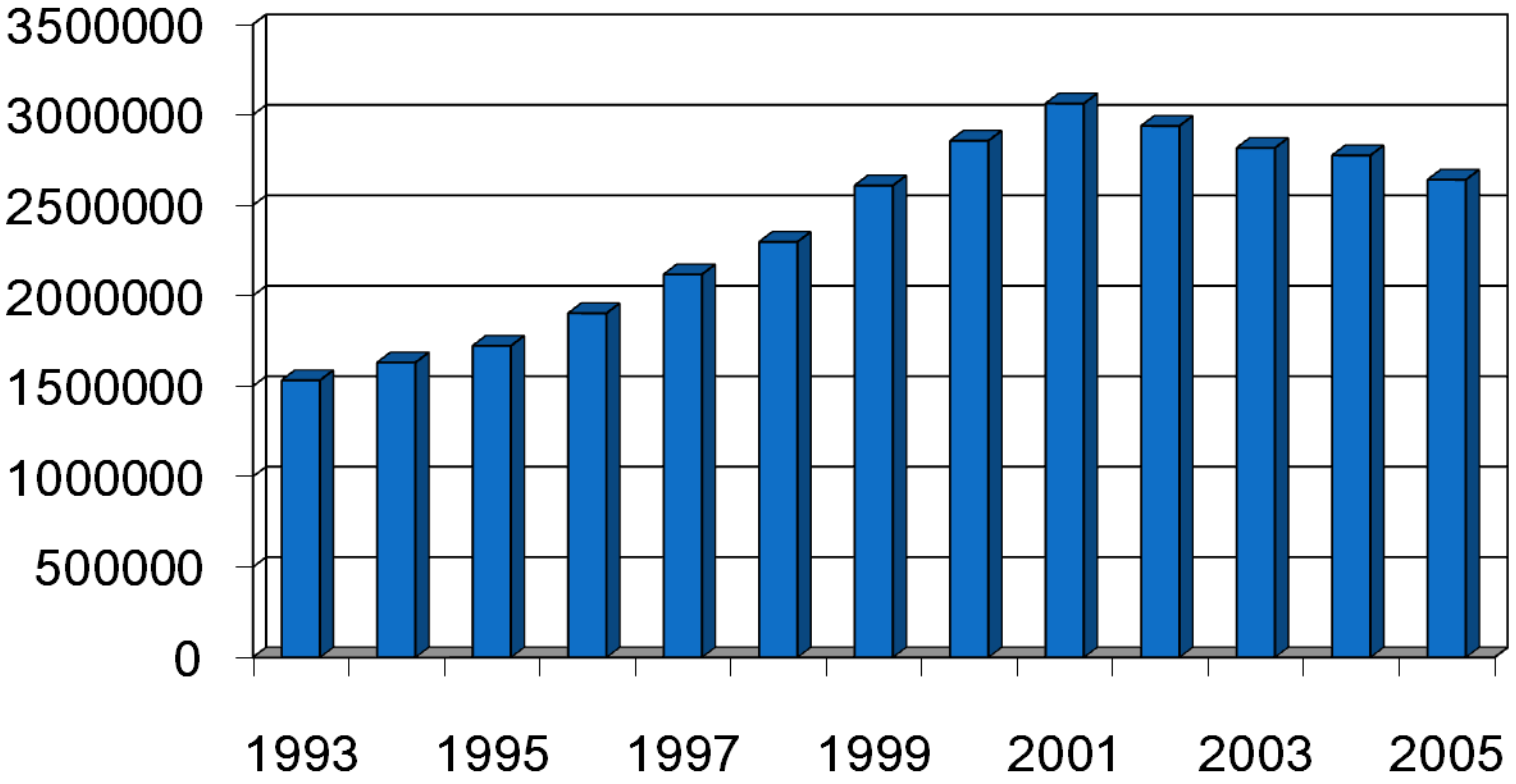
Possible causes of increased prescribing

- An increase in the incidence of depression
- An increase in the diagnosis of depression
  - Reflecting improved recognition or changing thresholds for diagnosis
- An increase in the proportion of cases treated
- An increase in the duration of prescribing

Number of patients in the GP Research Database



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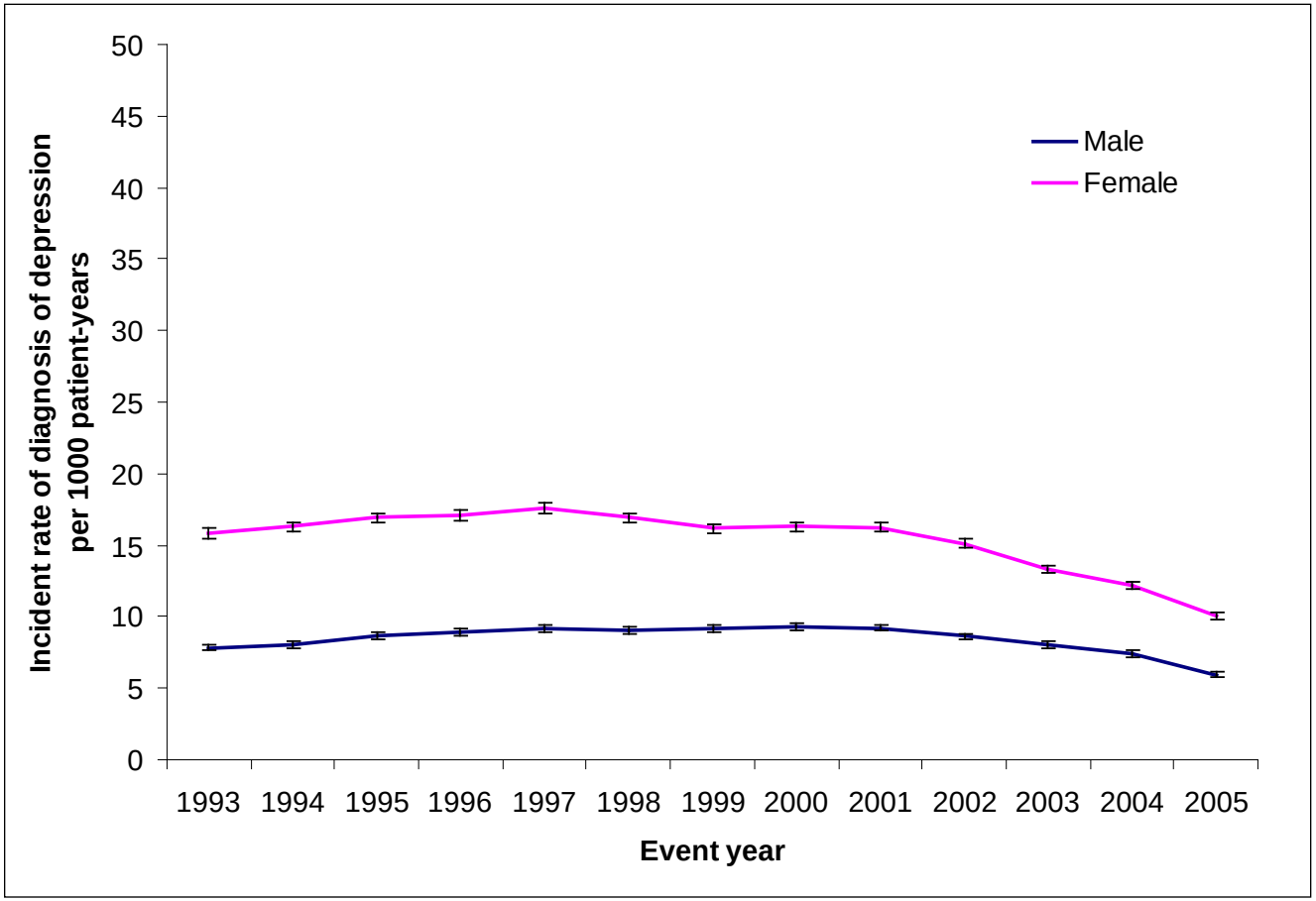
Incidence of first recorded episode of depression (per 1000 patient-years)



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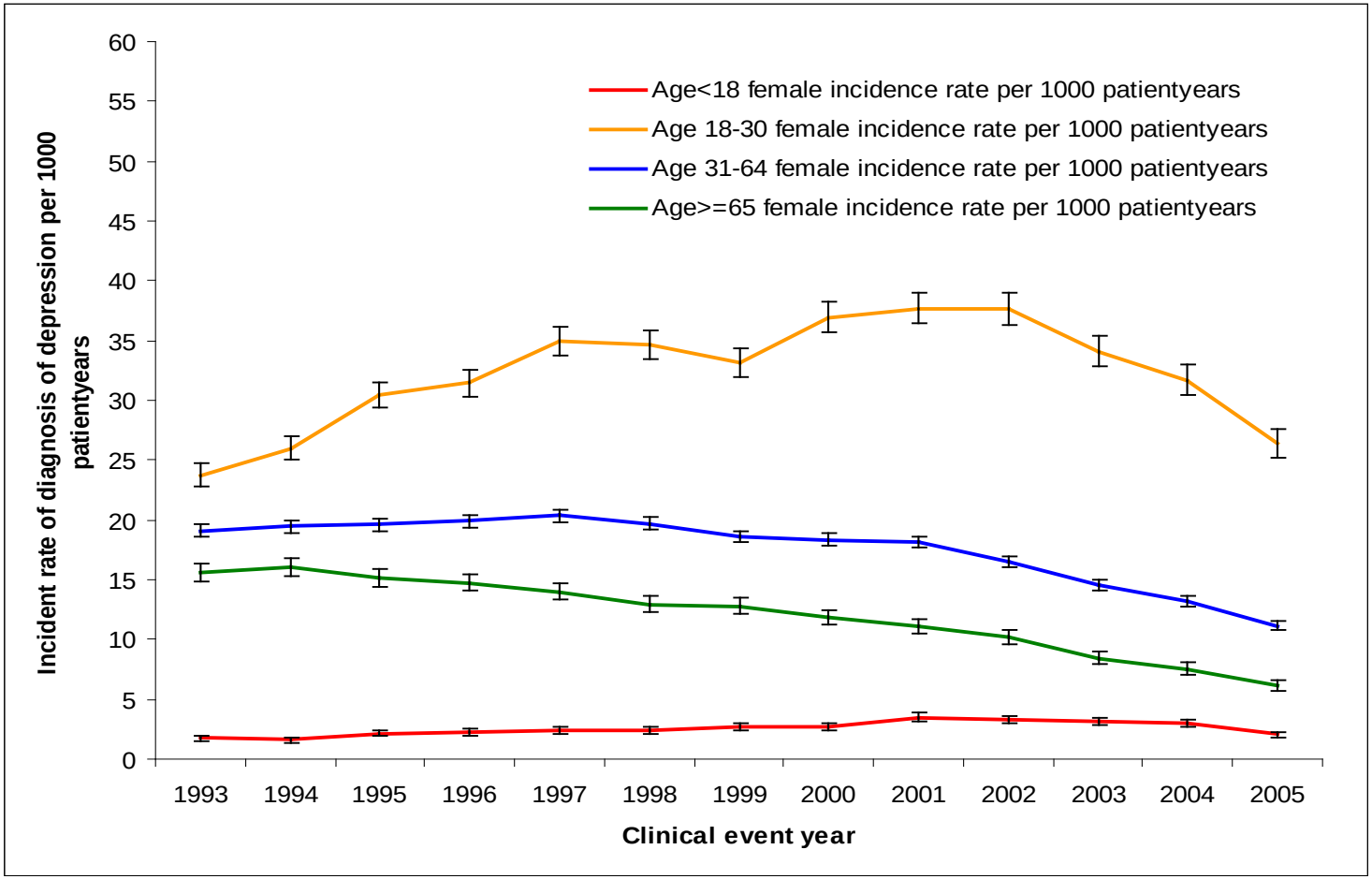
Incidence of first episode depression in women by four age bands



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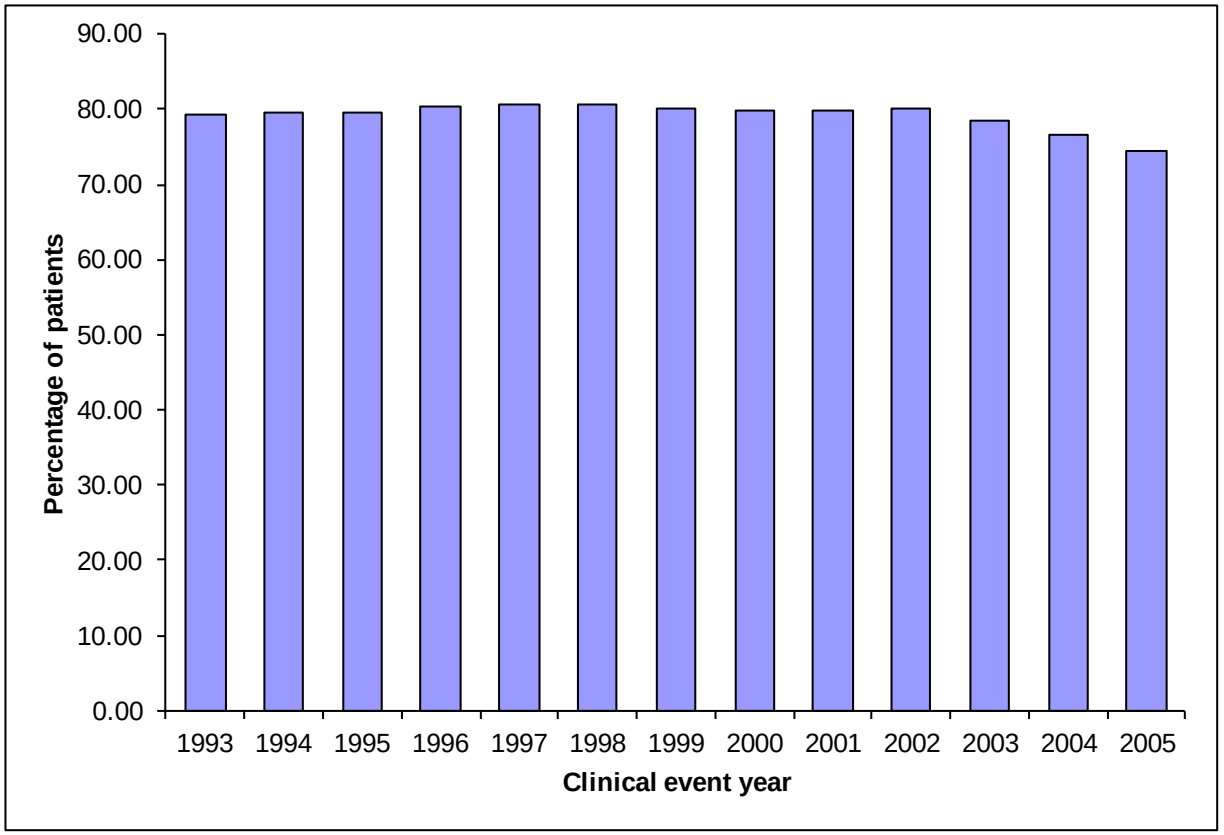
Percentage of new cases treated with antidepressants



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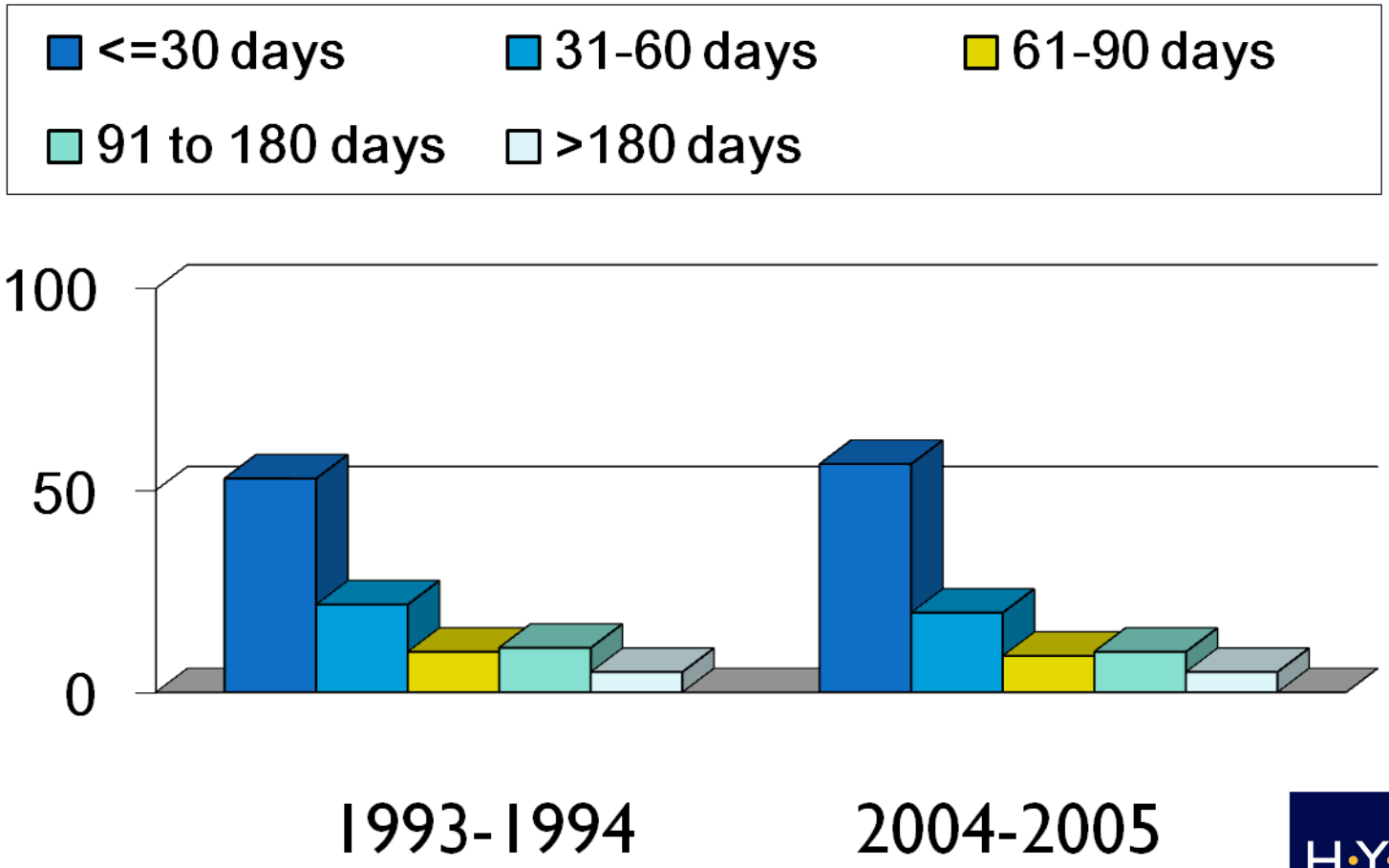
Duration of initial treatment



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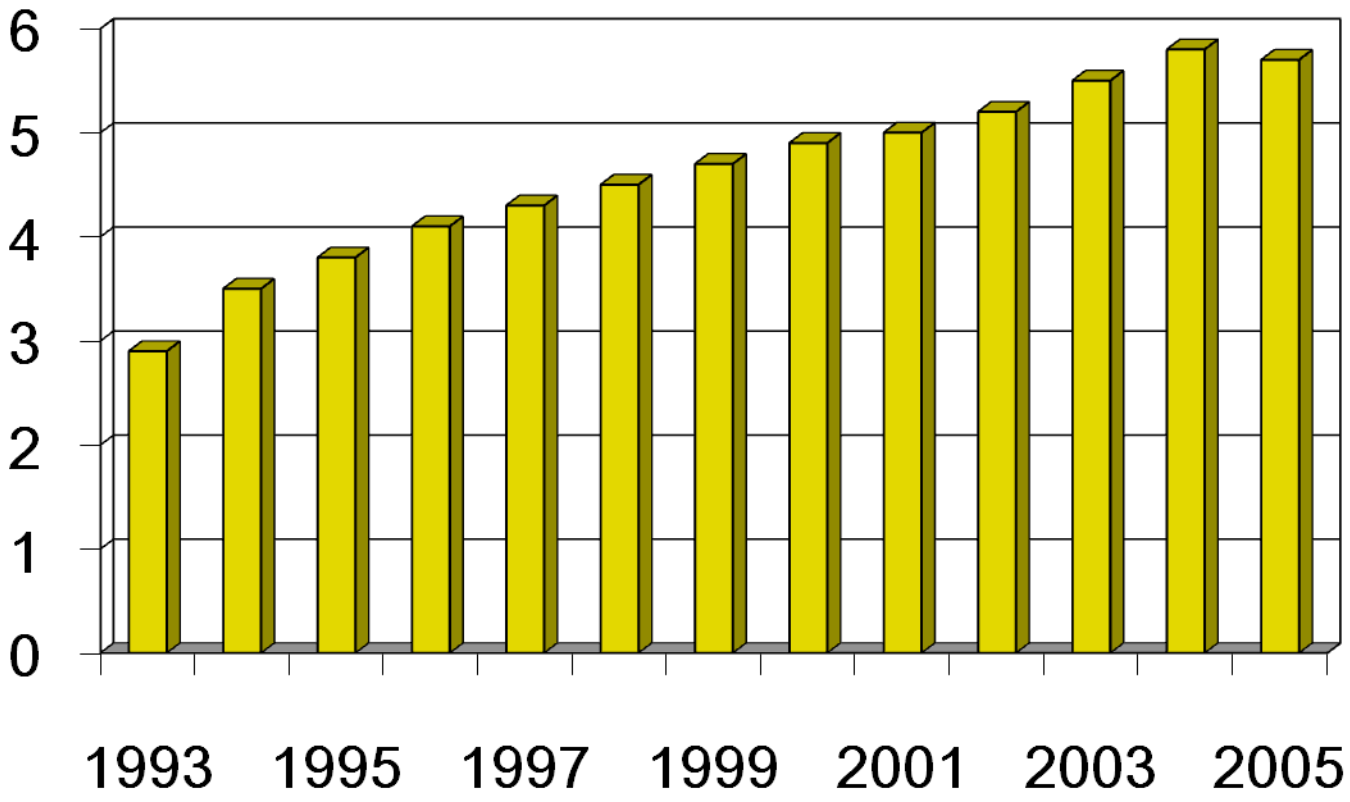
Mean number of prescriptions of antidepressants per patient per year



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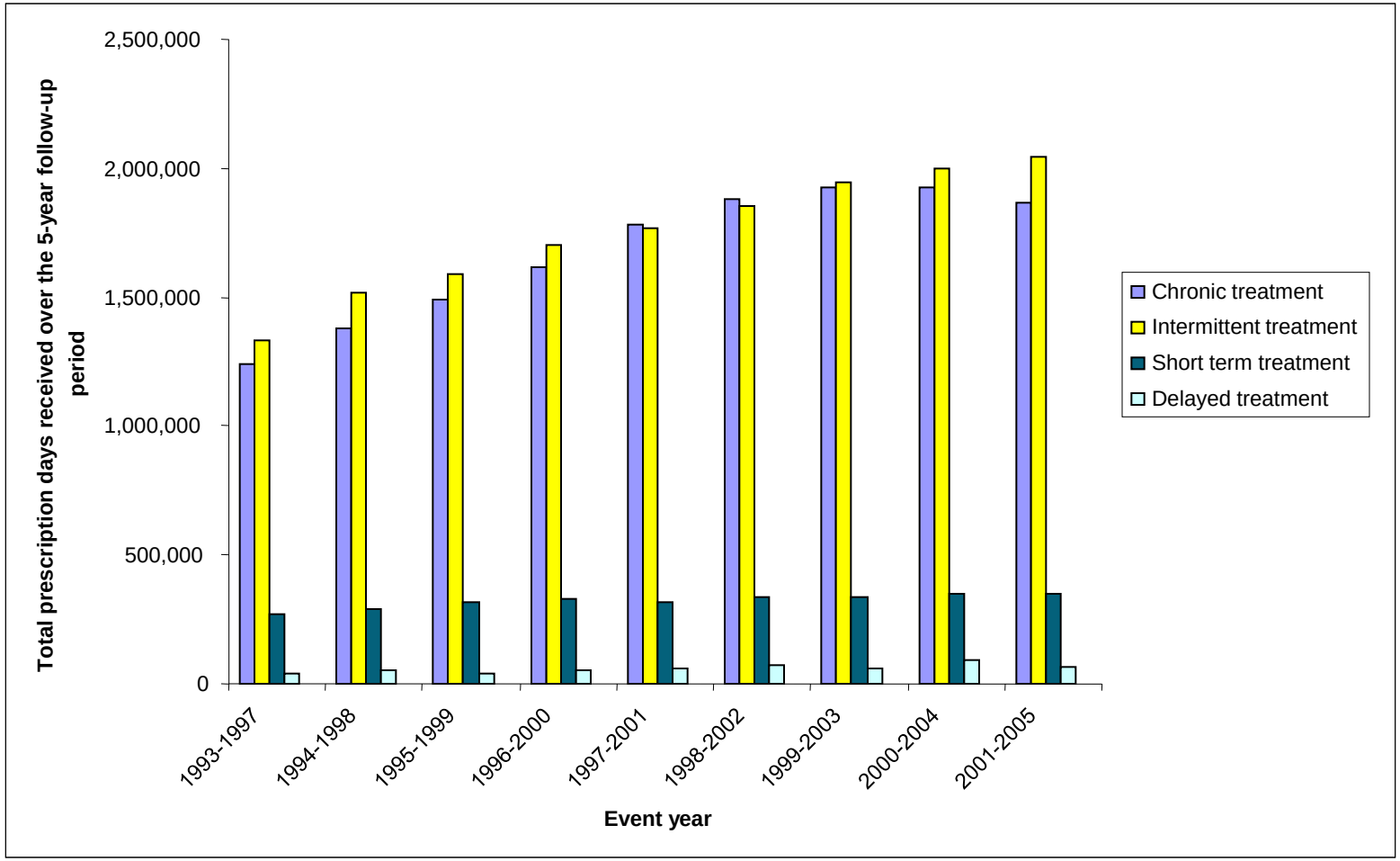
Five treatment patterns over five years

- **Chronic treatment:** a prescription in the year of diagnosis and every year after that, for five years
- **Intermittent treatment:** a prescription in the year of diagnosis and at least one of five subsequent years
- **Short term treatment:** a prescription in the year of diagnosis, but not in any of five subsequent years
- **Delayed treatment:** no prescription in the year of diagnosis, but a prescription in years 2-5
- **No treatment:** never received a prescription

Prescription-days over five years by group



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Implications

- Research and policy has largely focussed on the initial prescribing decision and targeting of antidepressant drug treatment to more severe depression

- Increased attention should focus on appropriate longer term prescribing, monitoring, and medication review

- Some patients on long-term treatment find it hard to come off and need active review to help them do that

Leydon GM, Rodgers L, Kendrick T. A qualitative study of patient views on discontinuing selective serotonin reuptake inhibitors. *Family Practice* 2007 doi: 10.1093/fampra/cmm069.

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Family

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Management of depression in UK general practice in relation to scores on depression severity questionnaires: analysis of medical record data

Tony Kendrick, Chris Dowrick, Anita McBride, Amanda Howe, Pam Clarke, Sue Maisey, Mike Moore & Peter Smith

Universities of Southampton, Liverpool and East Anglia

Funded by Lilly, Lundbeck, Servier and Wyeth pharmaceuticals

British Medical Journal 2009;338:b750.

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Aim

To determine if rates of antidepressant drug prescribing and referrals to specialist services varied in line with patients' scores on the QOF depression severity questionnaires (PHQ-9 and HAD-D)

Other potentially important predictors taken into account:

- Demographic factors
- Past history of depression
- Concurrent physical illness, including diabetes and coronary heart disease

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Methods

- Analysis of anonymised medical record data
- 38 general practices in Southampton, Liverpool, and Norfolk
- 2294 patients assessed with severity questionnaires between April 2006 and March 2007 inclusively (first year of their introduction)
- Outcome measures:
  - Rates of prescribing of antidepressants
  - Referrals to specialist mental health or social services (Counsellor, Primary Care Mental Health Worker, Psychologist, Psychiatrist, or Social Worker)

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Intervention and severity on PHQ-9

Item of management received	Number (%) of patients in receipt of item by PHQ-9 severity category			
	Minimal (N = 85)	Mild (N = 189)	Moderate to severe (N = 1384)	Total (N = 1658)
Prescription for an antidepressant	23 (27.1)	92 (48.7)	1195 (86.7)	1310 (79.0)***
Any referral to mental health/ social services	11 (12.9)	31 (16.4)	351 (25.36)	393 (23.7)**

Significance of differences between severity categories ($\chi 2$ test, with an adjustment to allow for clustering): **p<0.01; ***p<0.001

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Intervention and severity on HAD-D

Item of management received	Number (%) of patients in receipt of item by HAD-D severity category: Minimal (N = 121)	Mild (N = 138)	Moderate to severe (N = 325)	Total (N = 584)
Prescription for an antidepressant	64 (52.9)	108 (78.3)	292 (89.9)	464 (79.5)***
Any referral to mental health/ social services	16 (13.2)	23 (16.7)	80 (24.6)	119 (20.4)

Significance of differences between severity categories ($\chi 2$ test, with an adjustment to allow for clustering): ***p<0.001

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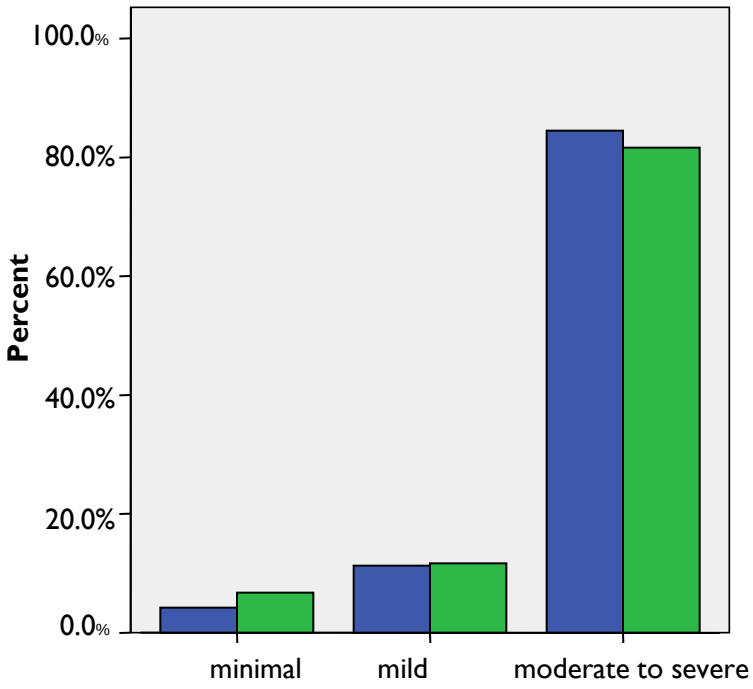
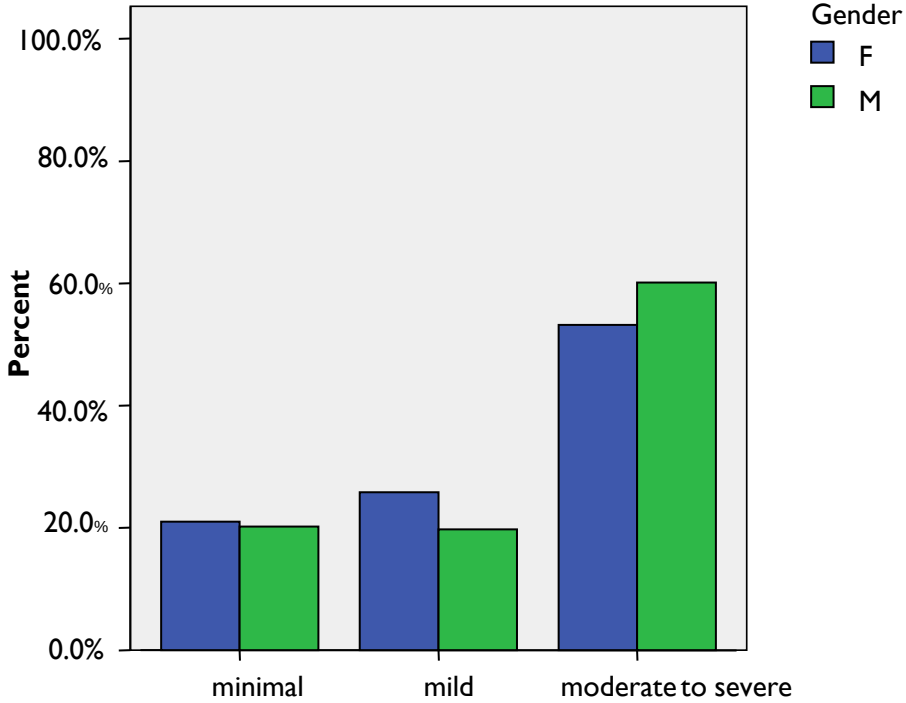
Classification: differences between measures



PHQ-9 Severity



HAD-D Severity

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Logistic regression models

Item of management	Severity	Age 65+	Past history of depression	Diabetes mellitus	Coronary heart disease	Southampton v Liverpool and Norfolk
PHQ-9 patients						
Prescription	+ + +		+ + +	_ _	_ _	+ + +
Referral		_ _ _		_ _	_ _	
HAD-D patients						
Prescription	+ + +					+ +
Referral	+ + +	_ _ _				

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Main findings

- Overall ~ 80% of patients assessed received a prescription for an antidepressant, and ~ 20% were referred to specialist services
- Prescriptions and referrals were significantly associated with higher severity measure scores
- However, overall rates of treatment and referral were very similar for patients assessed with different measures, despite the fact that the PHQ-9 classified > 80% of patients as moderately to severely depressed and in need of treatment, compared to only ~ 55% for the HAD-D
- Rates of intervention were lower for older patients, and for patients with comorbid physical illness including coronary heart disease and diabetes

Summary: GP use of antidepressants

- Diagnosis and prescribing of antidepressants by GPs has remained remarkably consistent through the 1990s and 2000s
  - Approximately 80% of patients diagnosed are treated
  - Most patients take them for too short a time
  - A small proportion may be kept on them for too long
- Analysis of records suggests GPs largely decide on drug treatment on the basis of perceived severity
  - Age and physical illness are also taken into account
- The two most widely used severity questionnaires perform inconsistently in practice, which brings them into disrepute
- Future research and policy needs to focus on the duration of prescribing, and follow-up monitoring, as well as the initial decision to prescribe

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Qualitative study of depression management in primary care: GP and patient goals, and the value of listening

Olwyn Johnston, Satinder Kumar,
Kathy Kendall, John Gabbay, Robert Peveler, & Tony Kendrick

University of Southampton

Funded by the Medical Research Council

British Journal of General Practice 2007;57:872-879.

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Patients value being listened to

- Connection: helping them to feel understood
- Reflection: helping them to clarify or reframe
  - What's wrong with them (medical model)
  - What's wrong with their situation (social model)
- Acceptance: when others are condemning them
- Bearing witness: helping them feel they are not alone
- Reassurance: that they are not going mad
- Ventilation: to help them get things off their mind
- Encouragement: that they will get better

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Patients often don't feel listened to

- Lack of time
  - The doctor seems rushed
  - Ten minute appointments aren't long enough
- Inattention
  - The doctor is preoccupied with the computer, or making notes
- Perceived lack of receptiveness/acknowledgement
  - The patient feels less worthy than physically ill patients
  - The doctor dismisses the problem
- Superficial response
  - The doctor decides too quickly to prescribe antidepressants
- OK if GP refers on to someone who will listen
  - Counsellor, other professional

Love

An evaluation of a new service model: Improving Access to Psychological Therapies demonstration sites 2006-2009

Glenys Parry, Michael Barkham, John Brazier, Kim Dent-Brown, Gillian Hardy, Tony Kendrick, Jo Rick, Pete Bower, Karina Lovell & Stephen Walters.

Universities of Sheffield, Manchester, Southampton, and London

Funded by the National Institute for Health Research

NIHR Service Delivery & Organisation Report, 08/1610/154,

June 2011.

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IAPT programme

- Low intensity
  - Guided self-help
  - Behavioural activation
- High intensity
  - Cognitive Behaviour Therapy
  - Interpersonal Therapy

- Demonstration sites
  - Doncaster
  - Newham

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Main Findings

- The demonstration sites were able to treat hundreds of patients per month
- Most therapy was low intensity, delivered by the telephone, lasting 4-5 sessions
- The proportion of patients with mental health problems who received treatment increased six-fold from 1% to 6%
- Use of Accident & Emergency was reduced
- 5% more patients got back to work

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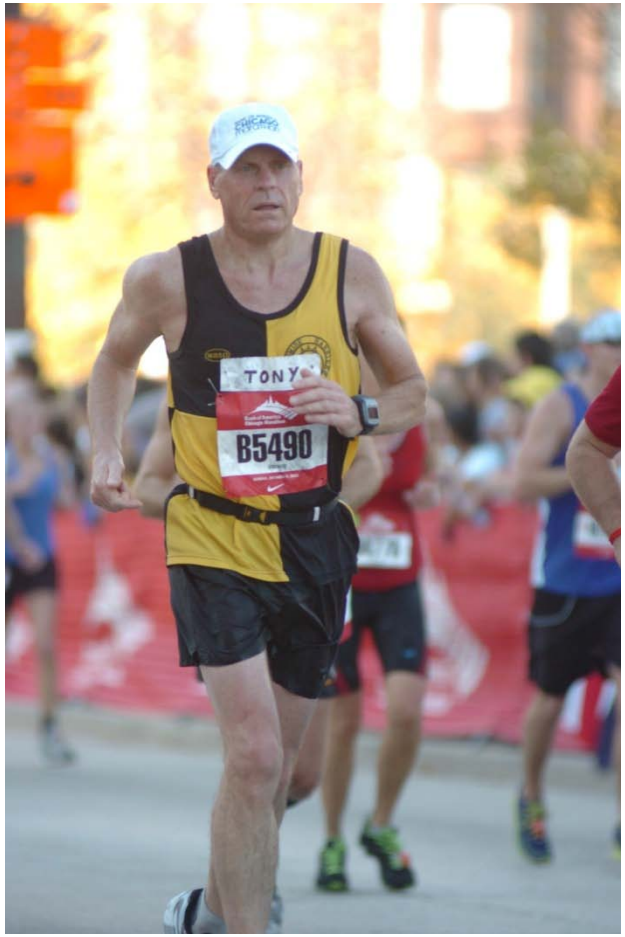
Problems with IAPT

- Lack of continuity (due to staff turnover) or follow up problematic for patients
- For some people practitioners could be experienced as impersonal
- Some experienced little or no choice in referral or treatment options
- Although hundreds more patients received treatment, they were still only a small minority of the total with anxiety and depression

Summary: talking treatments

- People need to feel listened to
- GPs often can't or don't listen enough
- Referral for therapy is associated with improved outcomes and less use of non-mental health care
- However only a minority of patients who need referral can get it, due to limited funding
- Some find outside therapists impersonal
- Primary care teams may have to do more themselves
- Training and supervision are essential

Exercise



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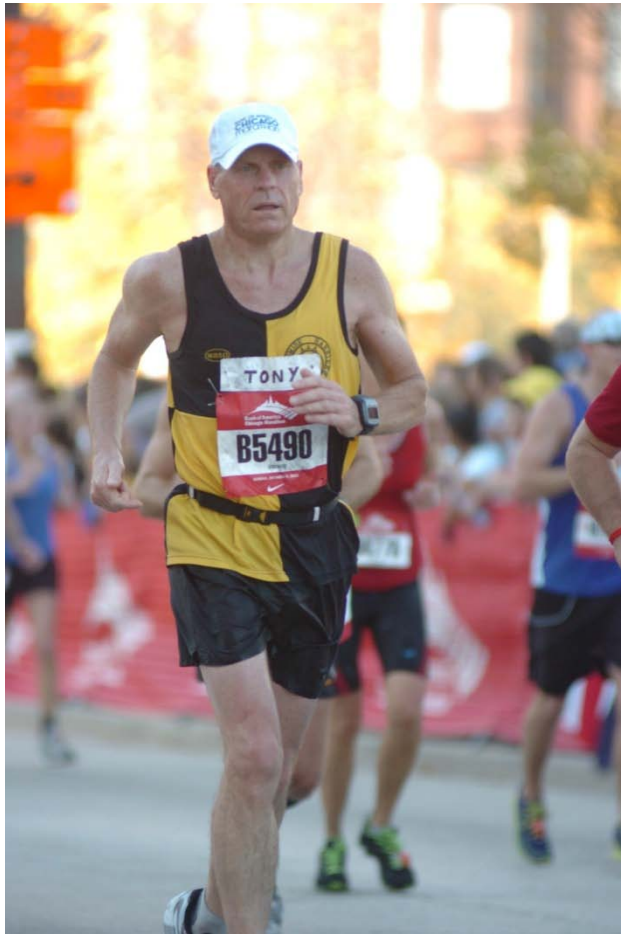

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Humour

Separated at birth?


Paul Freeling


Bonnie Sibbald


Tom Burns


Sean Hilton


Andre Tylee


Roger Jones


Pali Hungin


Tess Harris


Chris Thompson


Rob Peveler


Lucy Simons


Judith Lathlean


Jon Birtwistle


Lisa Sturdy

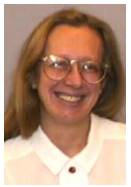

Karen White


Martina Dorward


Kathy Kendall


Satinder Kumar


John Gabbay


Helen Smith


Hazel Everitt


Judy Chatwin


Helen Mander


Mike Moore


Judy Rhodes


Peter Smith


Julia Berry


Lucy Yardley


Ian Williamson


Paul Little


Chris Dowrick


Hazel Inskip


Cyrus Cooper


Rona Moss-Morris


Felicity Bishop


Gerry Leydon


George Lewith


Peter Croft


Jenny McSharry


Hannah Burgess

Christelle Blunden

Pete Bower

Glenys Parry

Simon Gilbody

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THANKS A MILLION!

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