PHARMAC
Pharmaceutical Management Agency

Depression Treatment in New Zealand

A HealthTracker Research Study

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researchsolutions

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Background

Issues & Objectives

In 2006, PHARMAC is planning work with GPs and Psychiatrists in the area of depression. The key aims identified to us by PHARMAC are….

- To promote evidence prescribing i.e. identify the rationale for selecting one agent over another.
- To create awareness of the safety issues of antidepressant meds.
- To increase the number of patients that respond positively to treatment.
- To create an awareness of the place of non-pharmacological treatment of depression.
- To support clinicians in the identification and treatment of depression.

In order to help PHARMAC with these objectives, Research Solutions was commissioned to undertake a survey with General Practitioners.

PHARMAC identified a number of specific objectives for this survey, which were as follows…

- To identify barriers to identification and treatment of depression in the primary care setting.
- To ascertain the level of confidence in providing advice and treatment in relation to depression.
- To provide feedback on how to support primary care providers to identify and deliver appropriate care to enrolled populations.

- To identify the sources of information utilised by primary care providers to identify and treat depression.
- To identify the basis and rationale for selection of pharmaceutical treatments.
- To identify the level of non-pharmacological interventions used and the evidence behind those interventions.
- To identify any safety concerns associated with the use of antidepressant meds.
- To identify the average duration of treatment with antidepressant meds.

Please note, during this report when we refer to depression, we are specifically referring to patients with mild to moderate depression unless otherwise stated.

Methodology

The methodology chosen for this project was an online survey with 149 General Practitioners recruited nationwide through the GP panel (HealthTracker) hosted by Research Solutions.

The survey was conducted between the 28th June and 3rd July 2006.

A sample size of 149 respondents represents a maximum statistical margin of error of ±7.8% at 95% confidence.

Executive Summary

This report details the findings of an online survey conducted with 149 General Practitioners throughout NZ in June-July 2006. The purpose of the study is to better understand how GPs treat patients with mild to moderate depression, both with pharmaceutical medication as well as non-pharmaceutical alternatives.

Although not an expressed objective, an interesting finding of this research is that there appears to be key differences between GPs trained in NZ and those not trained in NZ approach the treatment of depression.

Also of note is the slight skew towards urban catchments; 74% of the sample described their practices as being *mainly urban*, another 14% described their practice as *mainly rural* and 14% an *equal mix*.

Treatment In General – Confidence

Amongst this sample of GPs, confidence in treating mild to moderate depression is high, on average at 8.1 mean points out of 10. The high confidence seen in the sample appears to be based on first-hand experience and therefore selection of type of treatment seems to be based on a mixture of evidence and experience.

GPs who rated themselves unconfident (7 or below out of 10) did so mainly because of a lack of first-hand experience with depressed patients, with smaller proportions mentioning lack of time to be able to properly diagnose depression, especially given it's multi-factorial nature.

The Treatment Process

GPs were asked to rate a series of factors on importance when prescribing a pharmaceutically based treatment for depression. Above all, GPs cite patients' safety as being the most important. For example rating *likelihood / ease of compliance* 8.6 out of 10, *possible physical side effects* 8.5, *patient safety concerns* 8.4, *potential addictiveness* 8.3 and *sensitivity* 8.3. *Drug availability* is also rated important at 8.2, while GPs are less concerned about the *financial cost to government*, rating it 4.9 out of 10.

Nearly half of all GPs, 44%, indicated that they develop a formal treatment plan for almost **all** of their depression patients. GPs were significantly more likely to almost always use a formal treatment plan if they were trained in NZ, with 52% compared to 35% of those trained overseas saying this. Of all GPs, nearly one quarter (24%) developed a plan for up to a third of their patients, with a further 14% doing so for two thirds of their patients. Some 17% never developed a formal treatment plan, with this figure being significantly higher when treating Indian patients (33%).

On average, GPs would expect a patient to use antidepressants for between 6 months to 20 months. It is noteworthy that the average minimum treatment duration is about the same between GPs trained in NZ or not, however, GPs trained in NZ on average keep their patients on anti-depressants for nearly 3 months longer, 21 months compared to 18 months amongst overseas trained GPs.

The greatest barriers for GPs in diagnosing and treating depressed patients were identified by GPs as follows….

- *Patients' risk of side-effects;*
- *Social stigma* (significantly higher amongst GPs predominantly trained overseas);
- *Social and personal problems;*
- *Patient compliance;*
- *Patients disputing their GP's diagnosis*.

Non-Pharmaceutical Based Treatments

GPs use a high proportion of non-pharmaceutical based treatments to treat their patients. GPs treat, on average, 50% of their depression patients with non-pharmaceutical treatments like exercises, diet or sleeping patterns. Likewise GPs treat 46%, on average, of their depression patients with counselling.

The most common reasons cited as evidence for the use of non-pharmaceutical based treatments are as follows, with first-hand experience being paramount…

- Evidence they had seen from *counselling / CPT;*
- Evidence from *exercising;*
- *Personal experience with patients;*
- *Articles, journals and literature*.

The Use Of Anti-depressants

GPs associated TCAs and SSRIs more closely with having safety concerns than other classes of anti-depressants.

- 61% of GPs indicated that they had safety concerns with **TCAs**, particularly the risk of overdose and physical side-effects.
- **SSRIs** followed with 52% of GPs raising some safety concerns. Specifically, GPs are worried that using the medication could possibly increase the risk of suicide, particularly for teenagers. The possible psychological and physical effects associated with the medication were also associated with SSRIs.

Favourability for SSRIs over other longer established anti-depressants is overwhelming. GPs favour SSRIs in terms of minimising possible *side-effects* at 8.2 out of 10, where 1 = much prefer longer established anti-depressants and 10 = much prefer SSRIs. Likewise with treating *overly sensitive patients* (7.9), *anxiety* (7.5), *treatment resistant patients* (7.3) and the *speed of efficacy* (7). Older anti-depressants are preferred in terms of *Insomnia* (3.2).

When asked to give examples of circumstances in which GPs would prescribe paroxetine instead of fluoxetine, more than half of GPs (58%) talked about the *degree of anxiety* of the patients, followed by the *intolerance to fluoxetine* and lack of *response to fluoxetine*, each mentioned by 24% of GPs. Some 6% of GPs indicated they rarely or never prescribe paroxetine instead of fluoxetine.

Information Source

A significant 84% of all GPs indicated that they use *CME events* to obtain information in order to help them diagnose and treat depressive patients. More than half of them also use *journals* (56%), exchanging information with *colleagues* (53%) or using *MIMS* (50%) for information. Other popular information sources include *Medsafe*, *medical conferences* and *New Ethicals.* Some, 34% of GPs cited *PHARMAC*.

The most commonly used resources for patients are *everybody.co.nz* (36%), *pharmaceutical company information* (26%) and *Medsafe* (20%). Of note, is that more GPs use sources of information biased towards or sponsored by pharmaceutical companies than PHARMAC.

Support

GPs were asked in an open-ended question how they could better be supported in the identification and delivery of appropriate care to their depressed patients. Over one third, some 37%, said that better support could be achieved by having *better access to consulting*. This is followed by suggestions for more *funding* (19% of GPs), *CME* (17%) and more *information and handouts for patients* (13%). Other suggestions include the *ability to prescribe medicine* (9%), *easier access to specialist advice* (8%) and *more understanding of depression* (4%). Only 4% of GPs indicated that they *do not need any additional support*.

Conclusions and Recommendations

- While GP's confidence in treating depression is high, they feel frustrated, claiming that the government / funding agencies are not supporting them.
- Given the constraints they feel they are working under, GPs are reluctant to go outside of what they know and their current behavioural patterns. In particular the use of meds, because they have little faith in patients being able to see a specialist and only a small amount of time in which to diagnose their patients. Anti-depressants are regarded as a relatively safe and easy way of covering the gap between diagnosis and seeing a specialist. Awareness of the **safety issues** surrounding the use of anti-depressants is good, and it is based on experience. GPs regard anti-depressants with respect.
- However, the public need to be better informed, to better / manage patient expectations and increase compliance.
- GPs are **unlikely** to change the class of drugs they are currently prescribing.GPs predictably ask for more accessible specialists and more availability to meds. Some GPs find it insulting and demeaning that they do not have greater access.
- In order to increase evidence based prescribing, it is important to counteract GPs acting out of habit, or being unduly influenced by pharmaceutical company literature, which is more likely to be used than more independent / non-commercial sources.
- We recommend that PHARMAC….
    - Disseminate user friendly resources for GPs and patients alike in order to help facilitate GPs away from the pharmaceutical company information.
    - Educate GPs and patients of the need for a formalised treatment plan. There is a link between those who seldom use a formal treatment plan and do not use non-pharmaceutical based treatments (for about a quarter of the sample).
    - There is potential for a PHARMAC / BPAC website to provide more balanced and comprehensive information than pharmaceutical websites and pamphlets.
- Up to 50% of the sample's patients are not being offered behavioural treatments as an alternative / supplement to medication (although only 1 respondent never used any alternative to anti-depressant in the treatment of depression). This should be seen as an opportunity. To make non-pharmaceutical based alternatives easier and more efficient to access, we recommend that…
    - Local nurses are funded to provide patient follow-up, facilitate exercise, dietary changes and ensure compliance. This will take this "burdensome" activity out of the GPs practice.
    - This will encourage GPs to initiate non-pharmaceutical treatment.
    - Could be supplemented by existing providers such as Maori Health Providers.

Main Findings

GP Profile

This section of the report profiles the General Practitioners who participated in this survey in terms of their gender, training background, ethnic groups that are highly represented amongst their catchments and which DHB they are based in.

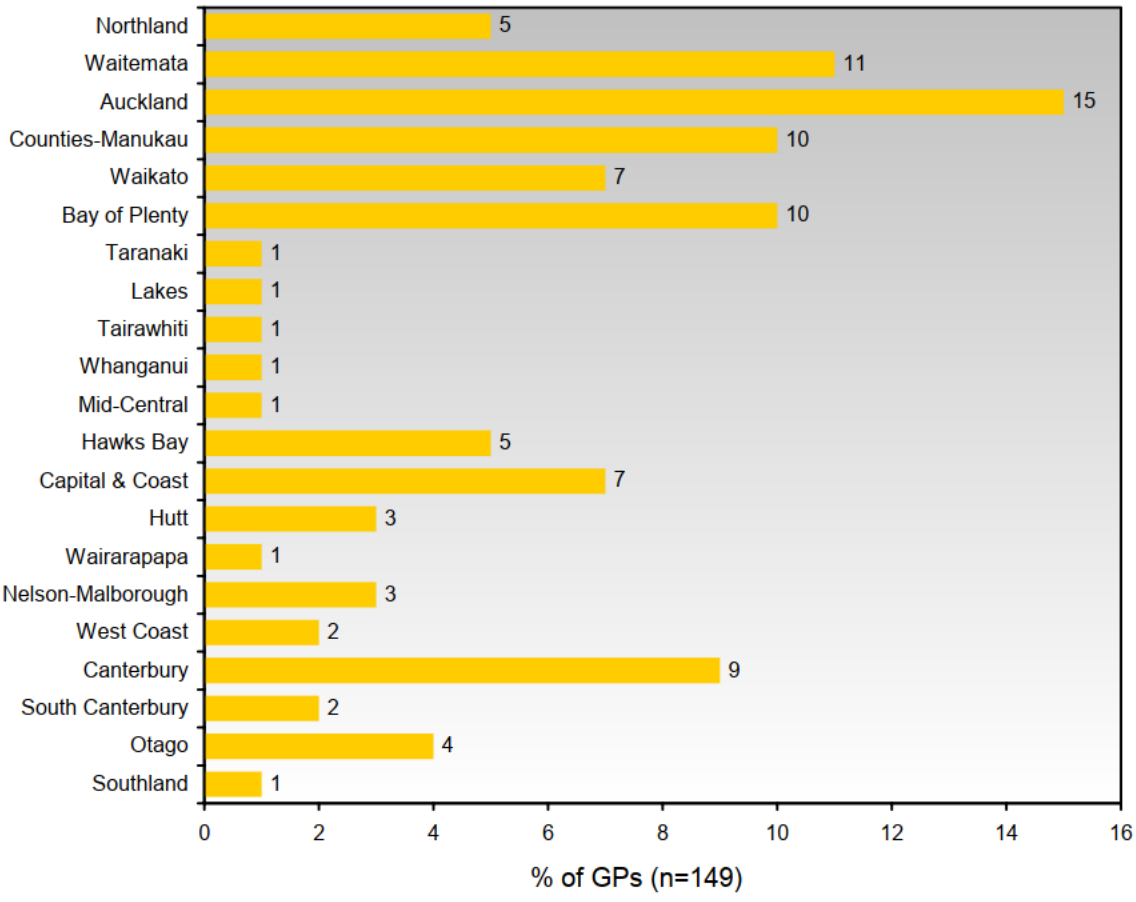
Of the 149 respondents, 58% (n=87) are males, with the remaining 42% (n=62) female.

The chart below shows the DHBs that the GPs' practices are based in. It was pleasing to see a good cross-section of NZ sampled.

Some 15% of all GPs' practices are in Auckland, followed by 11% in Waitemata, 10% each in Counties-Manukau and Bay of Plenty and 9% in Canterbury.

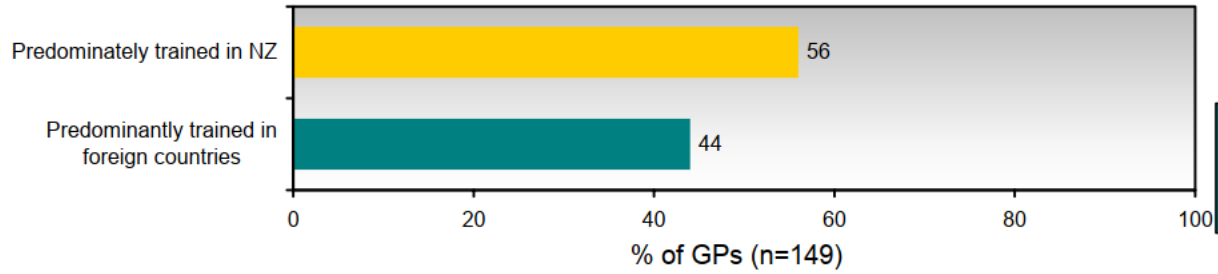
The chart below is ordered from top to bottom, from northern most DHB to southern most DHB.

The sample's DHB



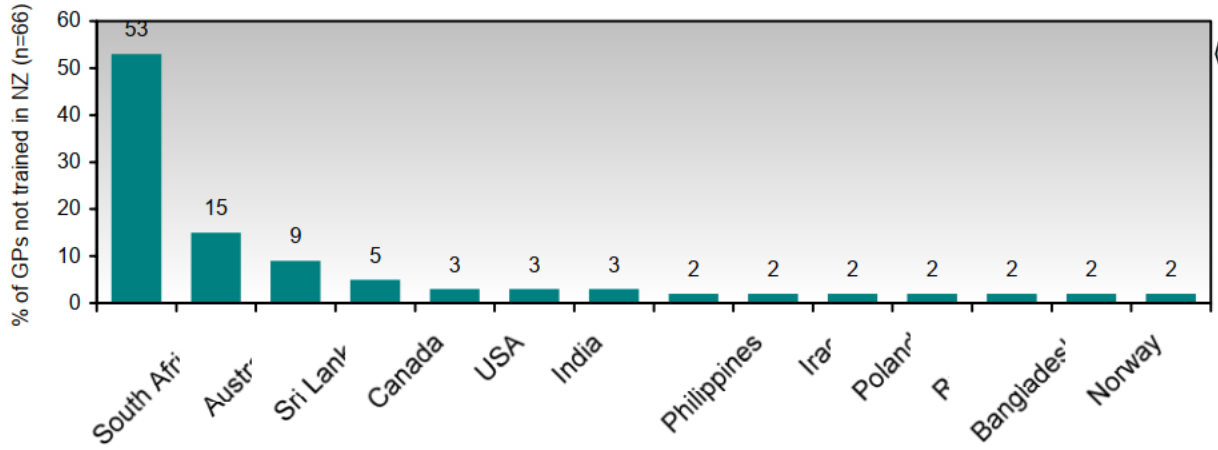
Amongst the 149 GPs who participated in this survey, 56% indicated that they were predominately trained in New Zealand (by which we mean they received most of their formal training here), while the rest, 44%, were predominately trained in other countries.

GPs trained in NZ or elsewhere



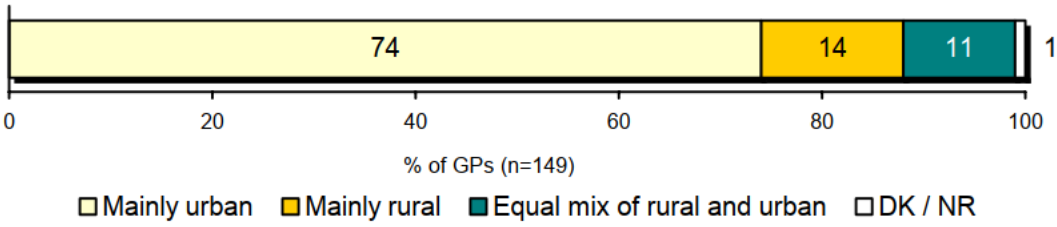
Of the 44% (n=66) of GPs who were predominantly trained overseas, more than half were trained in the UK, some 53%, with a further 15% who were trained in South Africa and 9% in Australia. Other countries which have provided major medical training to these GPs include Sri Lanka (5%), Canada (3%), USA (3%) and India (3%).

Which country GPs were predominantly trained in if not NZ



GPs (n=149) were asked to tell us what best describes their practice catchment, *mainly urban*, *mainly rural* or an *equal mix of rural and urban*.

Nearly three quarters of GPs indicated their practice catchment area is *mainly urban*. Some 14% described their practice catchment as *mainly rural* with a further 11% saying an *equal mixture of rural and urban*.



The Treatment of Depression by GPs in NZ

This section of the report details the key findings of how depression is treated at the primary-care level in NZ. Included is which ethnic groups are highly represented, GPs' confidence in treating depression, why some GPs are not confident, important factors in the treatment process, whether patients are on a formal treatment plan, the duration of meds, barriers to treatment, levels of non-pharmaceutical based treatment, the meds, why SSRIs are preferred, when paroxetine is used instead of fluoxetine, what sources of information GPS use and show their patients and how GPs can be better supported.

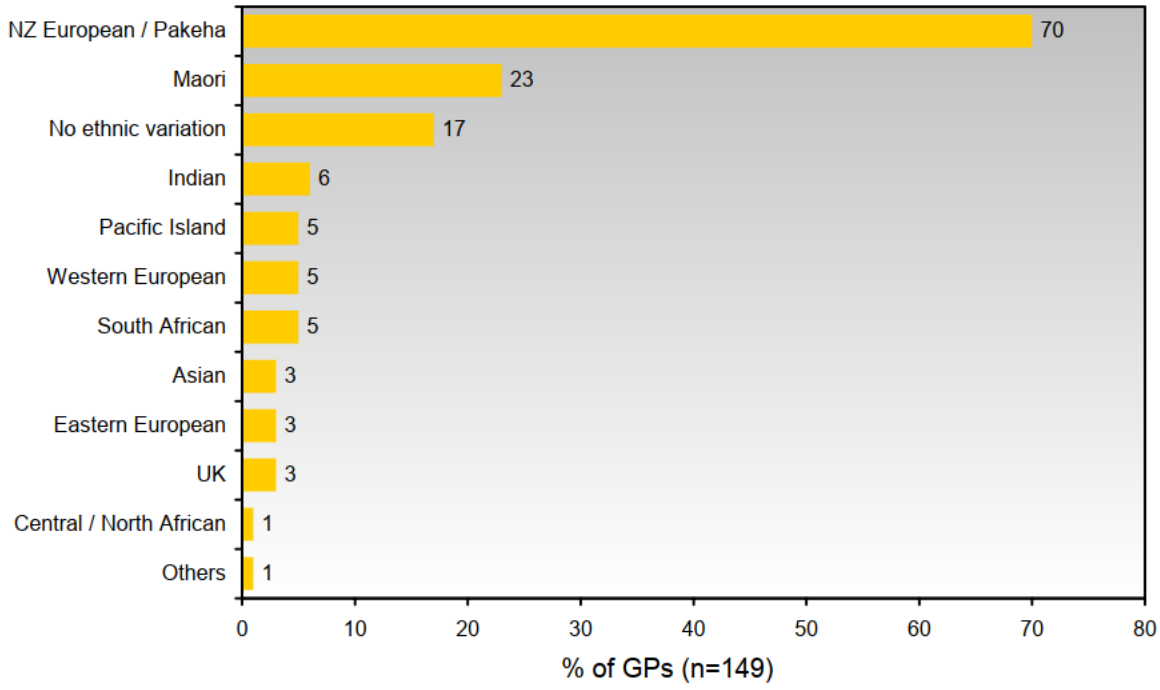
Ethnic groups highly represented amongst GP's practices

When asked to say which, if any, ethnic groups are highly represented amongst their depression patients, 70% of all the GPs surveyed mentioned *NZ Europeans*, followed by 23% who mentioned *Maori*. Some 6% of GPs mentioned *Indian* and 5% each talked about *Pacific Islanders*, *Western Europeans* or *South Africans*.

Smaller proportions of *Asians*, *Eastern Europeans*, *British*, *Central / North Africans* and *other* ethnic groups were mentioned by GPs.

Some 17% of all GPs did not recognise any ethnic variation amongst their catchment.

Ethnic groups that are highly represented amongst depression patients



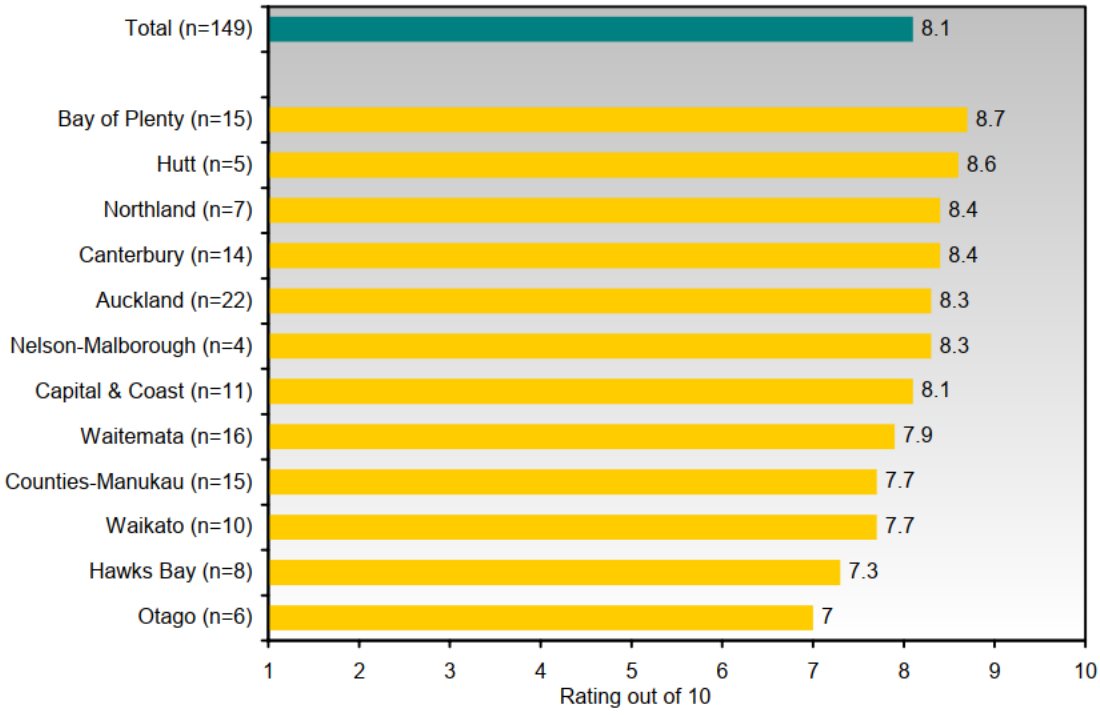
Confidence In Treating Depression

GPs (n=149) were asked to give a rating on how confident they felt in treating depression in their patients using a scale from 1 to 10, where 1 equals 'not very confident' and 10 equals 'extremely confident'. This was then collated into a mean score out of 10. Due to the small base sizes of some of the DHBs, not all are charted.

Overall, the sample of GPs are very confident in treating depressed patients, with an average rating of 8.1 out of 10. This implies that efforts to change their treatment habits may strike some resistance.

By DHB, GPs practising in Bay of Plenty are the most confident group, with an average rating of 8.7, followed by GPs in the Hutt (8.6), Northland (8.4) and in Canterbury (8.4). GPs in Otago are less confident compared to GPs in other DHBs, with a rating of only 7 out of 10.

GPs' confidence in treating depression



Only a very small number of GPs (n=14) described themselves as 'not confident' in treating depression (defined by giving themselves a rating of 7 or lower). We asked these GPs why they rated themselves below 7. This was asked as an open-ended question. The following verbatim comments detail the reasons these 14 GPs are not confident and revolve around the lack of first-hand experience, with smaller proportions mentioning lack of time to be able to properly diagnose depression, especially given it's multi-factorial nature.

"A short consultation often reveals little of what is going on with the patient at first. More than one or two appointments needed to make a proper diagnosis."

"Difficult to establish actual diagnosis and the multi-factorial components that may create it."

"Do not see a lot of patients with depression so do not have a lot of experience with assessing or treating depression. I often refer to our mental health worker for assessment of depression before prescribing medication."

"Don't see many depressed patients, or perhaps I am not recognising them!"

"I deal with this very little, because of the patient group I see. For treatment, I refer to GO"

"I do not feel that I am very good on the counselling side. Treating depression is not just dishing out pills - that is the easy bit"

"I feel that patients often need a lot of time which I cannot give or referral to other services which are expensive privately, or have long waiting times publicly."

"Lack of knowledge and training."

"Limited access to support services to aid my management essentially leaving management to use of medications without counselling etc."

"Many of them have underlying physical illnesses."

"The risk of suicide."

"There is always room for improvement. I never have the time to council patients with mild depression so feel we could do it better (but then we would need 28 hours a day)."

The Treatment Process

Important Factors Influencing Pharmaceutical Based Treatments

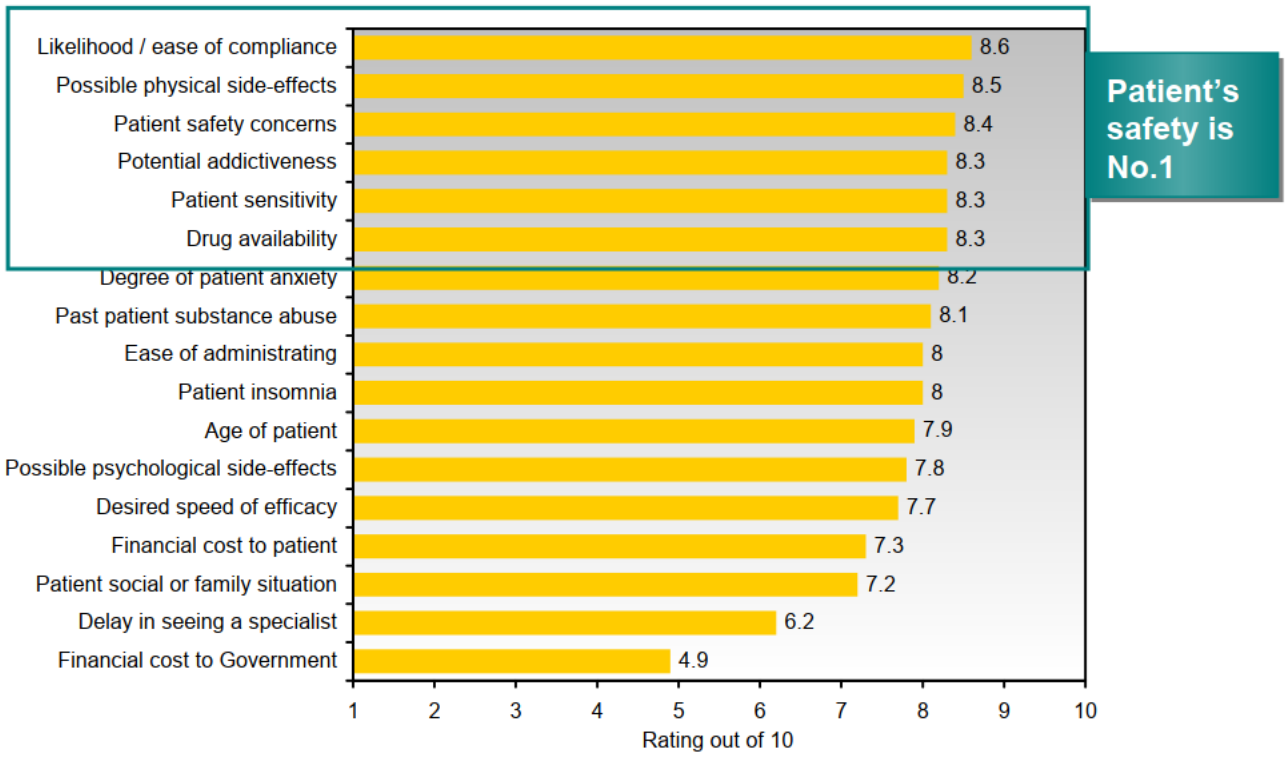
GPs (n=149) were asked to give a rating on how important they felt a series of factors were in prescribing a pharmaceutically based treatment. GPs used a scale from 1 to 10, where 1 equals 'completely unimportant' and 10 equals 'extremely important'. This was then collated into a mean score out of 10.

Overall, most of the factors measured were considered important by GPs.

Above all, the *likelihood / ease of compliance* of the prospective prescription is most important, with a mean score of 8.6 out of 10. The *possible physical side-effects* and *safety of patients* followed at 8.5 and 8.4 respectively. Other factors like *the potential addictiveness*, *patient sensitivity* and the *availability of the drug* were all rated fairly highly in terms of their importance, at 8.3 out of 10. Clearly, GPs make the safety of their patients the most important concern when prescribing treatments. The availability of appropriate medication is also very important to GPs in the treatment of depression.

Of all the aspects, the one that GPs rate least important is *the financial cost to government*, rated at only 4.9 out of 10. This sends a clear message that it is appropriate treatment, not cost, that is paramount to successful treatment in the minds of GPs. Interestingly, *delay in seeing a specialist* was only rated 6.2. We will re-visit this point later in the report as GPs clearly indicated that this was a significant issue. We believe that it is rated as only moderately important in the treatment decision, because the assumption is that there is seldom any likelihood of seeing a specialist within a reasonable time-frame – hence it is a non-issue for GPs.

Importance of factors around pharmaceutical based prescribing



The perception of importance placed on the factors discussed above, vary amongst practice catchments with different ethnic groups highly represented in them.

The table below summaries the **significant** differences with comparison to the overall rating (charted above). Ratings in **green** demonstrate those that are statistically significantly higher than the overall rating and ratings in **red** demonstrate those that are significantly lower than the overall rating.

Factors charted but not included in the table below show no significant differences across the ethnic groups.

	Total (n=149)	Pacific Islands (n=8)	Eastern European (n=4)	Asian (n=4)	UK (n=4)	No ethnic variation (n=25)
Possible physical side-effects	8.5	**9.6**				
Patient safety concerns	8.4			**10.0**		
Patient sensitivity	8.3	**9.5**	**6.8**			
Degree of patient anxiety	8.2					**7.6**
Patient insomnia	8.0	**8.9**				**7.3**
Ease of administrating	8.0				**9.5**	

The table reads: GPs with Pacific Islanders highly represented in their patient pool consider the possible physical side-effects significantly more important than the overall sample, with a rating of 9.6 out of 10, compared to 8.5 by the total sample.

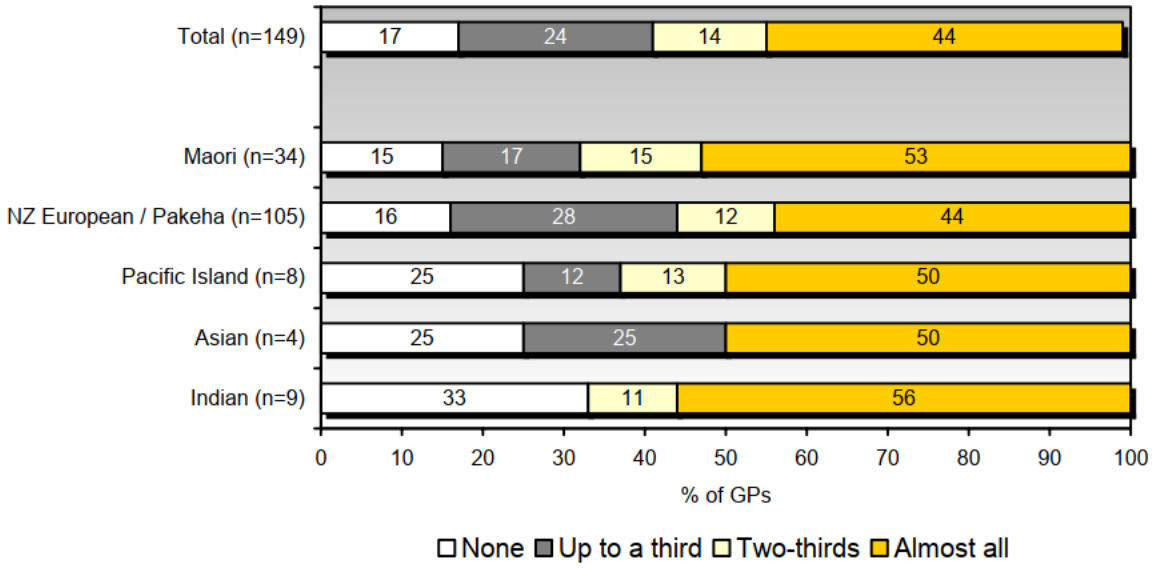
Note: some of the sub-groups have small sample base, therefore the numbers should be treated with caution.

Plan For Treatment

The chart below shows the proportion of patients on a formal treatment plan. Some ethnic groups are charted where interesting results were reported.

Overall, nearly half of all GPs, 44%, said that they developed a formal treatment plan for *almost all* of their patients, with this figure being higher amongst catchments where Indian and Maori are highly represented. A further 38% of the total sample have developed a formal treatment plan for some of their depression patients and 17% report *none* of their patients are on formal plans. Catchments where Indian, Pacific Island and Asian patients (note small base size) are highly represented, are less likely to have a formal treatment plan in place.

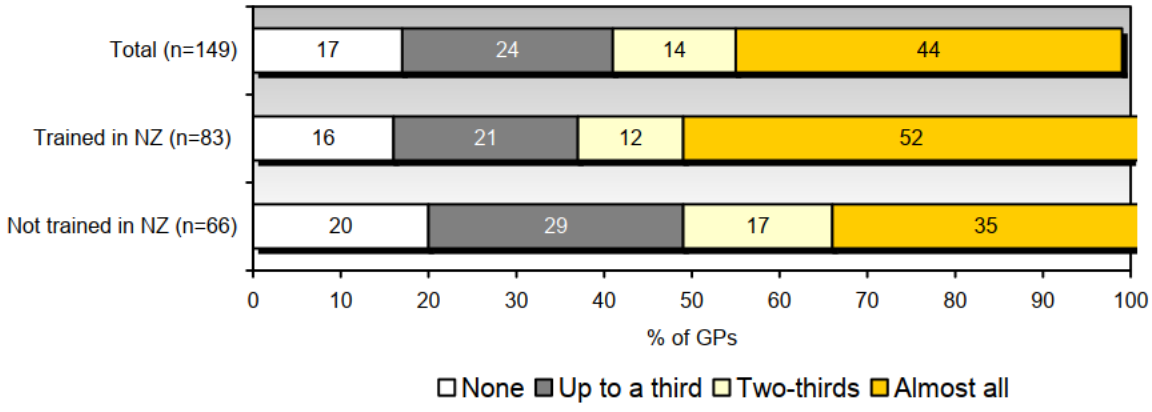
Proportion of patients managed with a formal treatment plan



There is an interesting difference in the use of formal treatment plans between those GPs who were predominantly trained in NZ and those who were not.

GPs were significantly more likely to almost always use a formal treatment plan if they were trained in NZ, with 52% compared to 35% of overseas trained GPs saying this.

Difference between the use of formal treatment plans whether trained in NZ or not



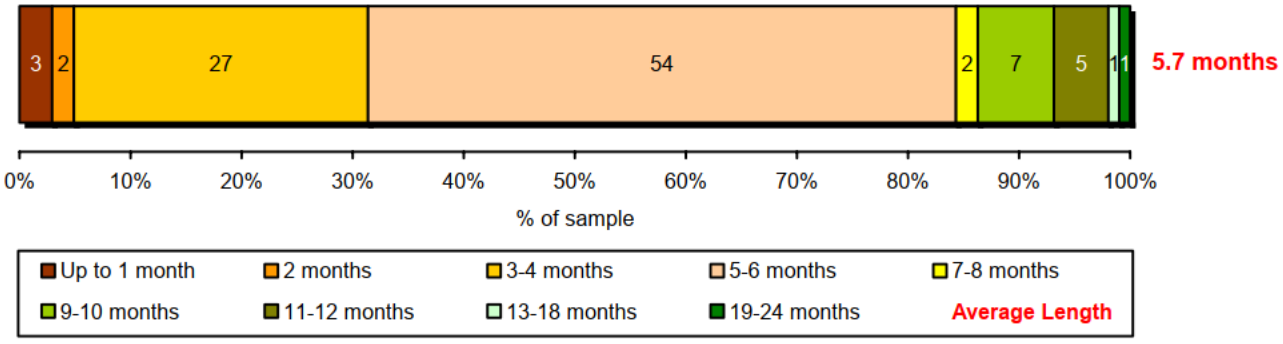
Duration Of Medication

The two charts below show the minimum and maximum duration for which GPs (n=149) expect patients with mild to moderate depression to use antidepressants for.

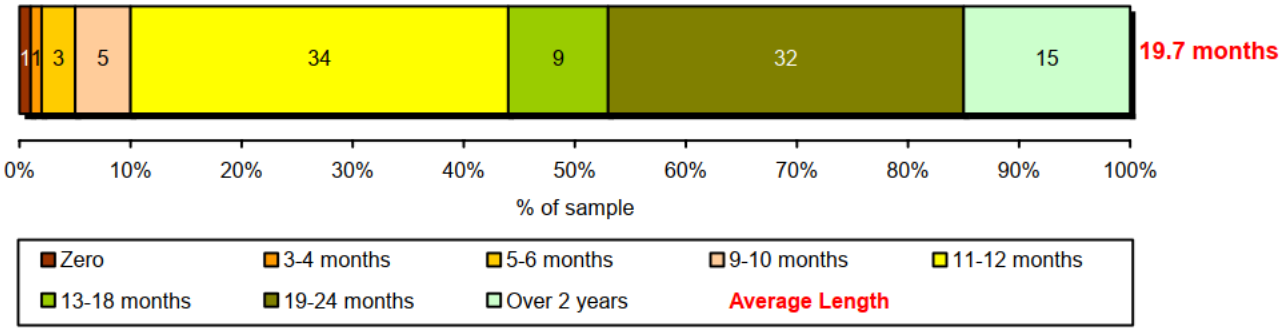
On average, GPs would expect a patient to use antidepressants for between 6 months to 20 months.

It is interesting to note that while the average minimum treatment duration is about the same between GPs trained in NZ and those trained elsewhere, GPs trained in NZ on average keep their patients on anti-depressants for nearly 3 months longer, 18 months compared to 21 months.

Minimum Treatment duration



Maximum Treatment duration



Barriers To Treatment

All the GPs (n=149) in the sample were asked to specify, from a set list, what the biggest barrier(s) they face when diagnosing and treating depression are. This was asked as a multiple response question.

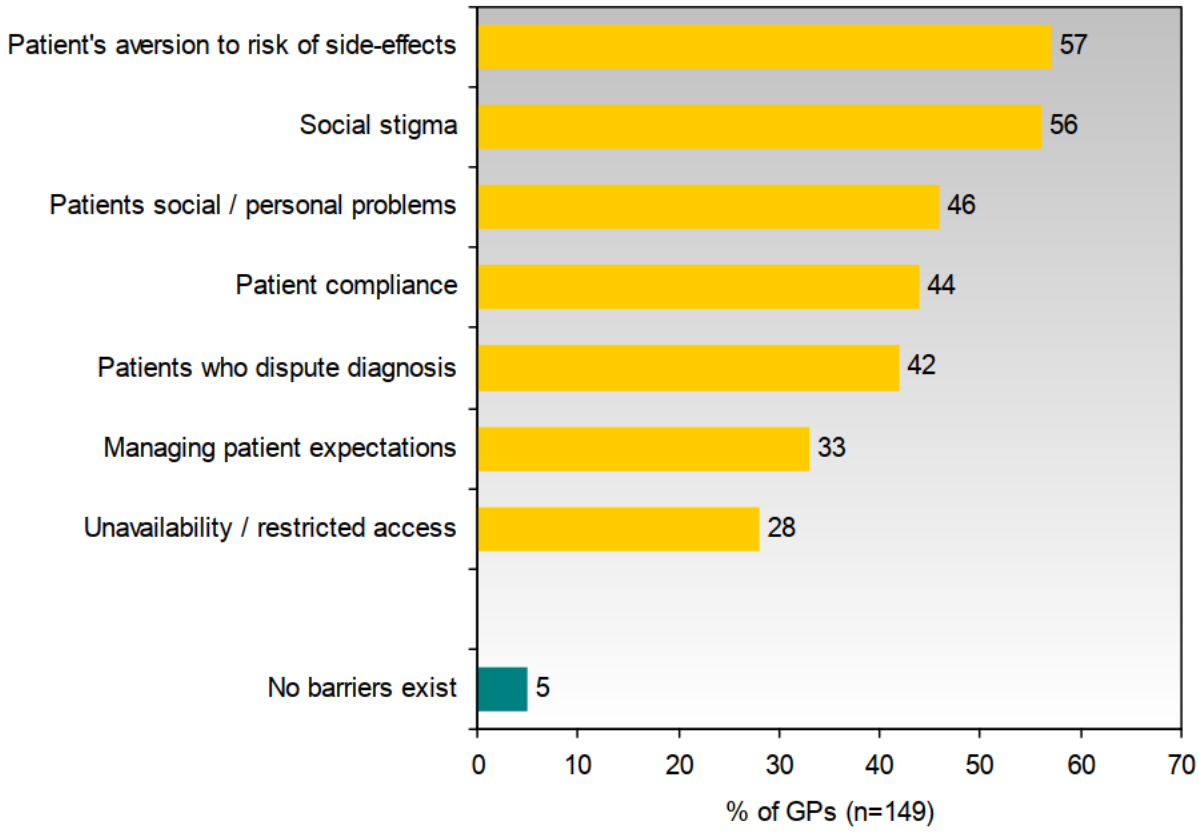
More than half of GPs each talked about the *patient's risk of side-effects* (57%) and the *social stigma* (56%) as being the greatest barrier to successful treatment they face. Of note is that the amount of GPs who mentioned *social stigma* jumped for those who were predominantly trained overseas, 67% compared to 47%. This clearly identifies social stigma as being more of a concern for GPs who were predominantly trained overseas.

A little under half, 46%, talked about the patient's *social and personal problems*, followed by 44% who mentioned *patient compliance* and 42% who cited *patients disputing their GP's diagnosis*.

A further one third felt *managing patients' expectations* was the greatest barrier to treatment and another 28% cited the *unavailability / restricted access* to some medication.

Some 5% did not think any barrier exists for them in diagnosing and treating depression patients.

The biggest barriers faced when diagnosing and treating depression



Non-Pharmaceutical Based Treatment

Now that we better understand how pharmaceutical based treatments work for our respondents, we turn our attention to the other side of the study, non-pharmaceutical based alternatives.

The chart below shows the average proportion of GPs who treat mild to moderate depression patients with non-pharmaceutical treatments such as counselling **and** other behavioural treatments such as exercise, diet and sleeping patterns.

On average, GPs treat a greater proportion of their depression patients with non-pharmaceutical treatments like exercise, diet or sleeping patterns than counselling, 50% compared to 46%. We assume because behavioural changes are easier and cheaper to initiate than counselling.

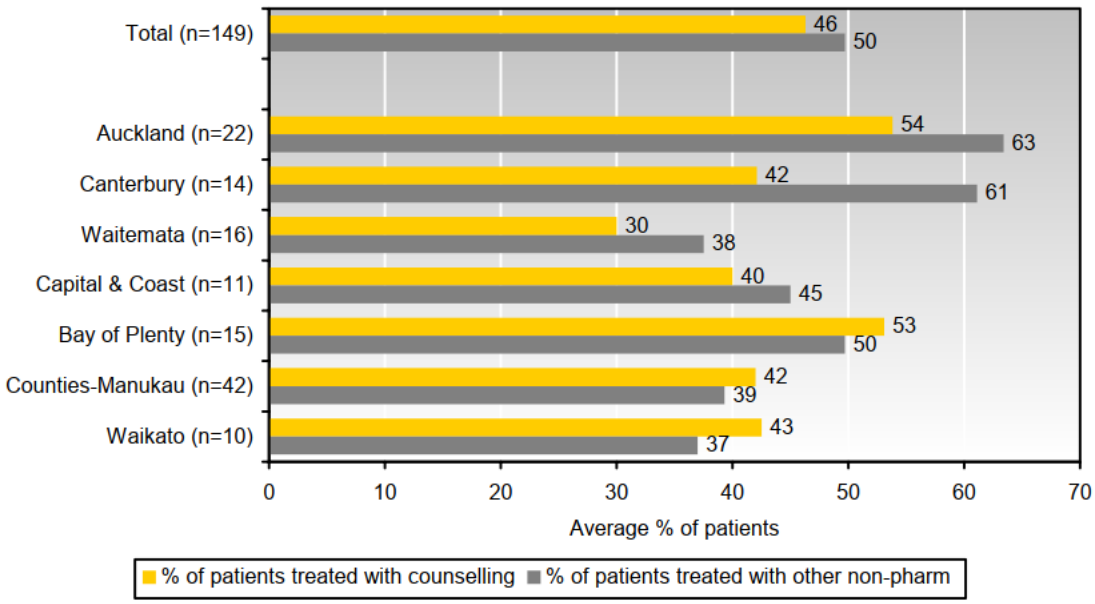
Amongst different DHBs, non-pharmaceutical based treatments such as exercise, diet and sleeping patterns are more commonly used than the average (the Total shown in the chart) in Auckland (63% compared to 50%) and in Canterbury (61% compared to 50%).

Counselling is slightly more commonly used than the average for patients in Auckland (54% compared to 46%) and Bay of Plenty (53% compared to 46%). In Waitemata both forms of treatment are used less than the average.

Amongst patients in catchments where Maori are highly represented (not charted), counselling is significantly more commonly used, with GPs using this treatment for 58% compared to the average of 46%. This could reflect the additional health resources sometimes available to Maori communities.

Also not charted, both forms of non-pharmaceutical based treatments are more common amongst GPs predominantly trained in NZ. Counselling is used for 51% of their patients compared to 41% for GPs not trained in NZ, likewise for other alternatives such as exercise, diet and sleeping patterns, where 54% of their patients are treated this way, compared to 44% for GPs not trained in NZ.

Proportion of patients treated with non-pharmaceutical based treatments

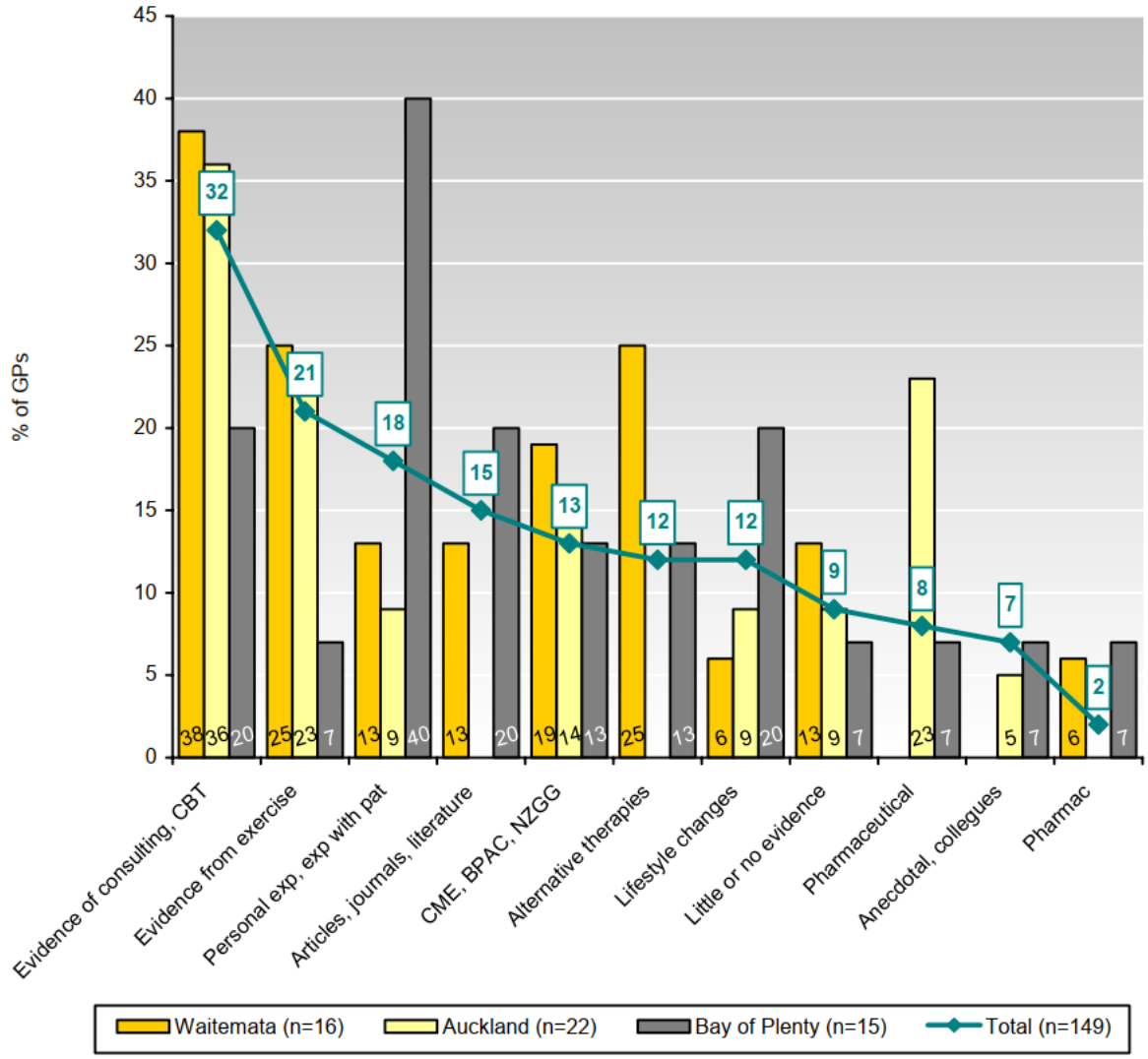


When asked to tell us what evidence GPs have for using non-pharmaceutical alternatives, one third (32%) of GPs mentioned the evidence they had seen from *counselling / CPT*, followed by evidence from *exercising*, mentioned by 21%. Some 18% said the evidence to use non-pharmaceutical treatments came from their *personal experience with patients* and a further 15% named *articles, journals and literature*.

PHARMAC was mentioned by 2% of the sample, and **only** in Waitemata and Bay of Plenty.

First-hand experience of one kind or another was by far the most common reason given.

Evidence for using non-pharmaceutical alternatives



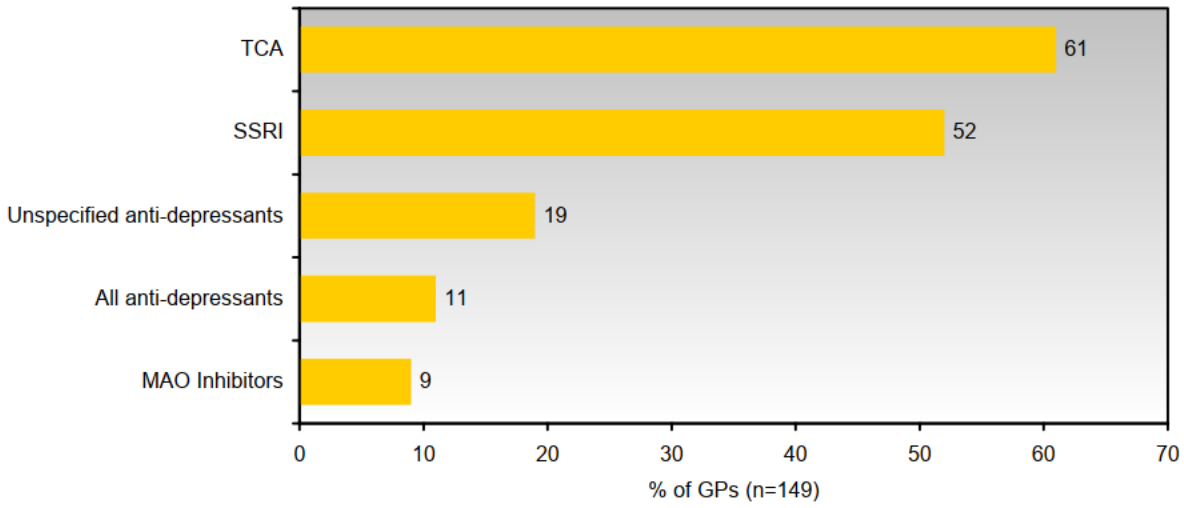
The Medication

Safety Concerns

The following chart shows the percentage of GPs that associated **any** safety concern with a particular class of anti-depressant.

Some 61% of GPs associated some safety concerns with *TCAs*, with 52% associating any safety concern with *SSRIs*, 19% with *unspecified anti-depressants*, 11% with *all anti-depressants* and 9% with *MAO Inhibitors*.

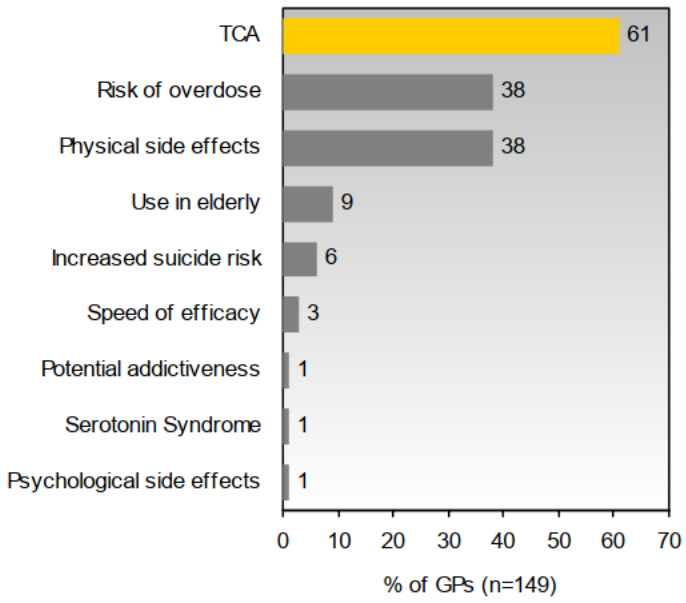
Safety concerns associated with which class of anti-depressant



The following series of charts show **what** specific safety concerns are associated with each class of anti-depressant mentioned by GPs (as charted above). Note that all percentages are of the total sample i.e. 38% of all GPs associated the *risk of overdose* with TCAs.

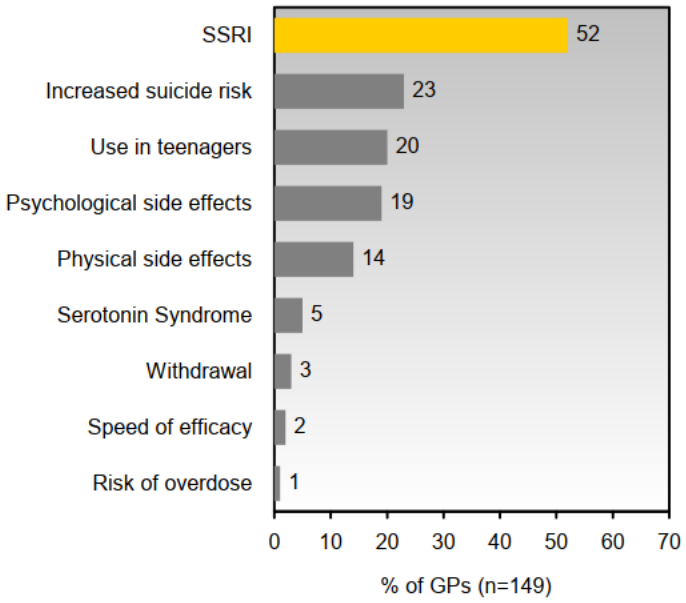
TCA

The chart opposite summarises safety concerns GPs associated with TCAs. Some 38% each mentioned their concern about the *risk of overdose* as well as the *physical side-effects*. A further 9% were cautious when using it in *elderly patients*, 6% mentioned the *risk of suicide*. Other concerns include the *speed of efficacy*, *potential addictiveness*, *Serotonin Syndrome* and *psychological side-effects*.



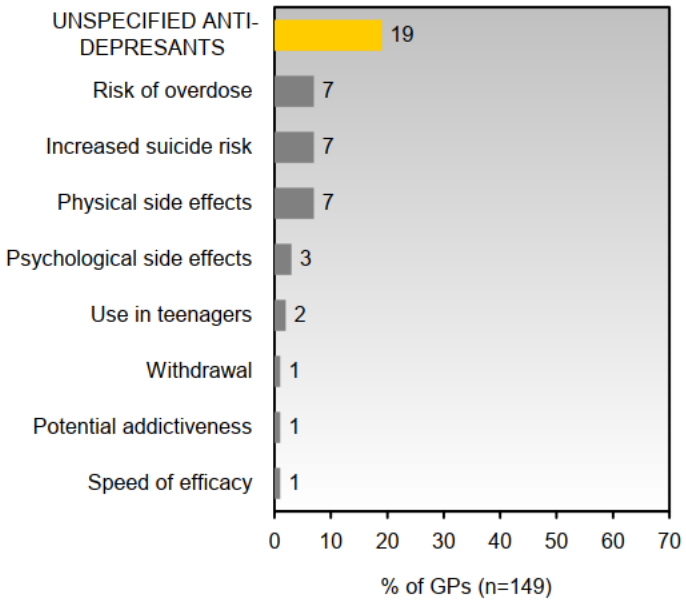
SSRI

The chart opposite summarises safety concerns GPs associated with SSRIs. Some 23% associated SSIRs with the *risk of suicide*. Approximately one in five each mentioned the *use in teenagers* and possible *psychological side-effects*. A further 14% associated SSRIs with *physical side-effects*. Other issues include *Serotonin Syndrome*, *withdrawal*, *speed of efficacy* and *risk of overdose*.



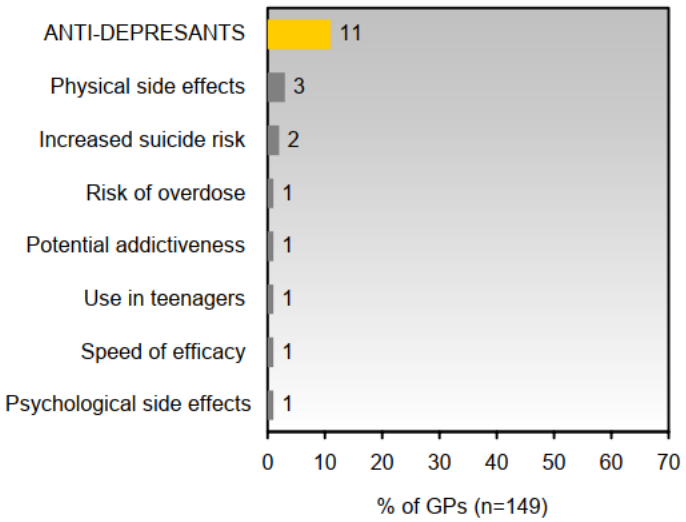
Unspecified Anti-depressants

The chart opposite summarises safety concerns GPs associated with anti-depressants, though they did not specify which. Overall, GPs mostly mentioned the *risk of overdose*, increased *risk of suicide* and *possible physical* and *psychological side-effects*.



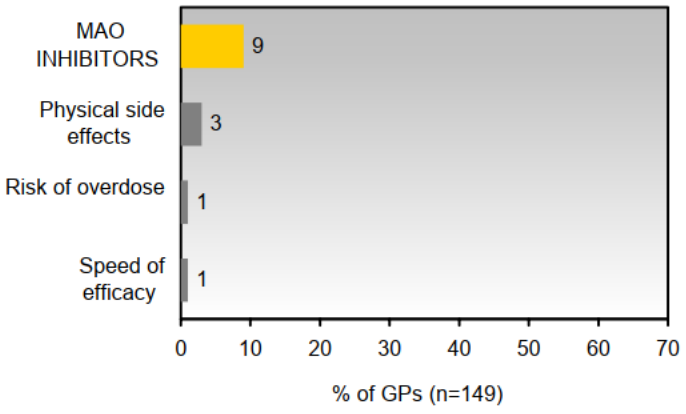
All Anti-depressants

The chart opposite summarises safety concerns GPs associated with **all** anti-depressants. *Physical side-effects*, *risk of suicide* and a host of other general concerns were mentioned.



MAO Inhibitors

As can be seen MAO Inhibitors are mostly associated with *physical side-effects*.



Some verbatim comments from GPs about their safety concerns are shown below:

"Delayed time of onset of action e.g. SSRI's,TCA's."

"Potential of unwanted side-effects contributing to non adherence e.g. dry mouth / constipation with TCAs headache / trembling / indigestion with SSRI."

"INC. risk suicide Waropax in adolescents."

"Aropax in adolescents."

"Toxicity with intentional overdose."

"Interactions with alcohol and other medications."

"Safety with driving."

"These apply to almost all anti-depressants."

"Start of meds in young adults, suicide risk, insomnia."

Preference Of Prescriptions

Given a list of conditions that we know to be important in deciding which medication to use, GPs were asked to give their opinion about whether older established anti-depressants or SSRIs were generally best in regards to each of these factors.

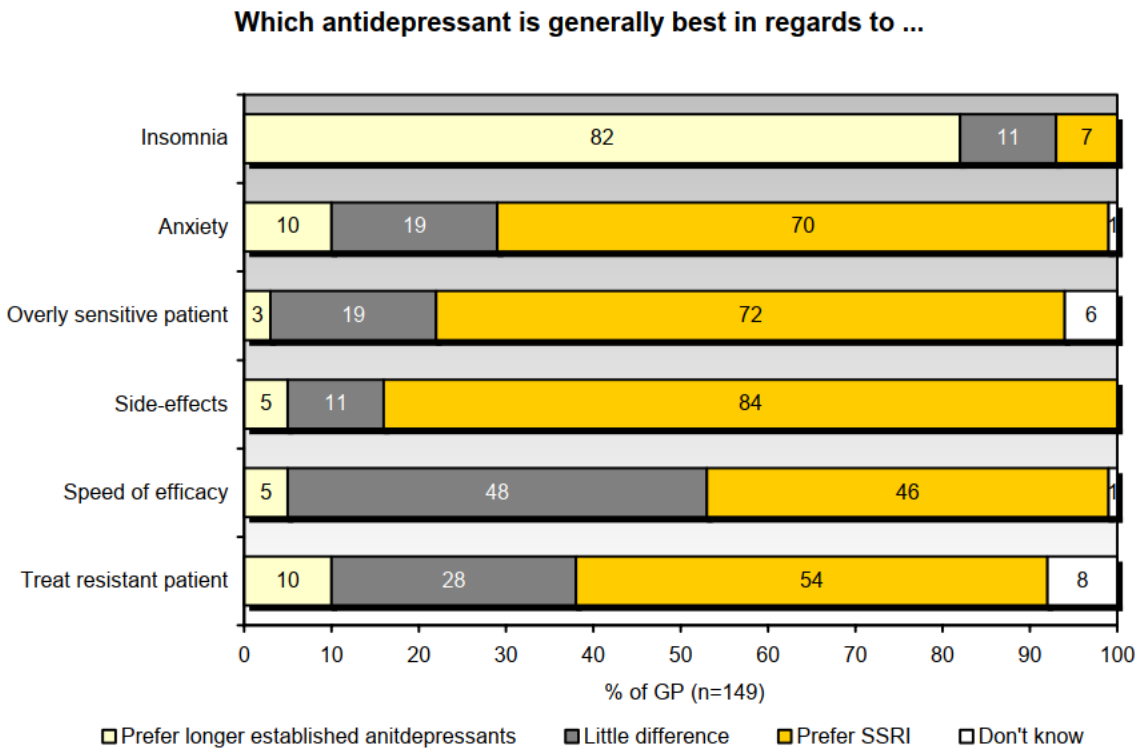
Respondents used a scale of 1 to 10, where 1 was 'much prefer longer established antidepressants' while 10 was 'much prefer SSRIs'. Responses were also collated into a mean score out of 10.

In the chart below percentages are grouped together for ease of interpretation and understanding of the chart.

The only factor where GPs clearly favoured older established anti-depressants for was *insomnia*.

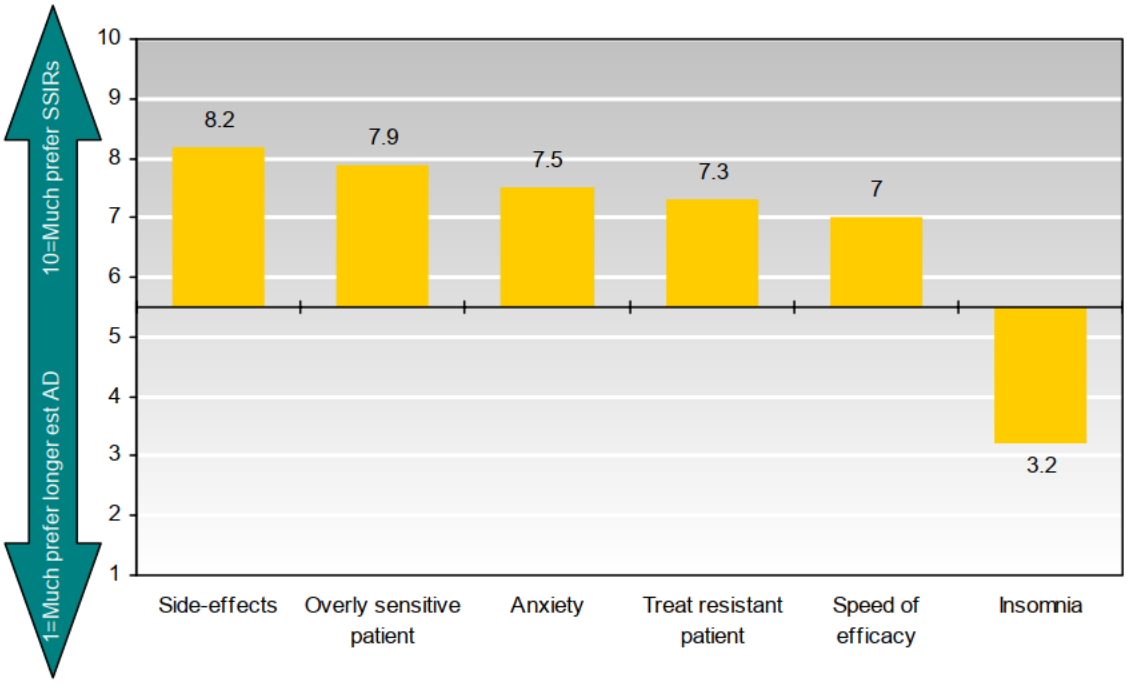
GPs clearly favoured SSRIs in terms of minimising *side effects* (84%), treating *overly sensitive patients* (72%), *anxiety* (70%) and *treating resistant patients* (54%).

Nearly half of all GPs, 46%, believe there is little difference between these drugs in terms of the *speed of efficacy*, a further 46% believe SSRIs are better on this factor, compared to 5% who believe longer established antidepressants are better on this factor.



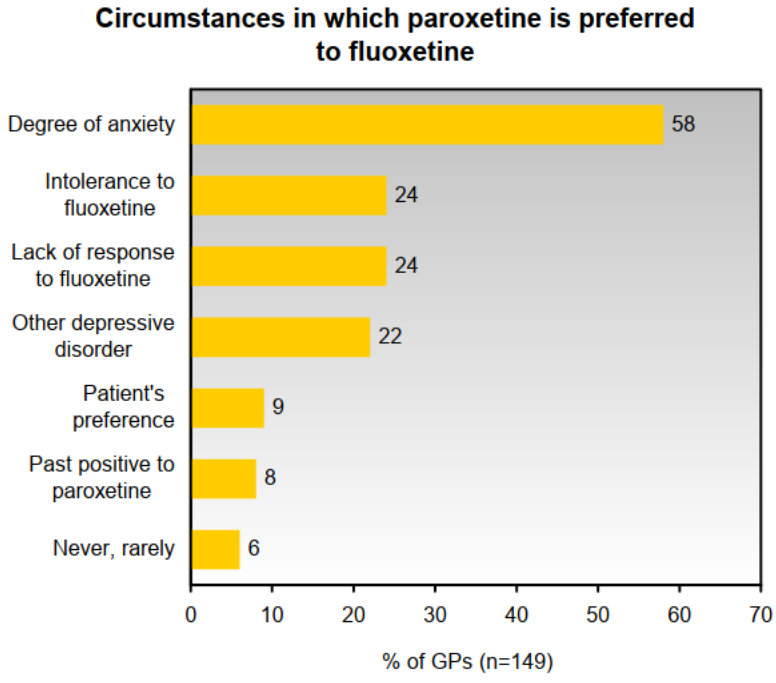
The following chart shows the same set of information as is shown above, but as a mean score out of 10.

On average, GPs clearly prefer SSRIs to older anti-depressants under all the circumstances measured, except when the patient demonstrates *insomnia*. SSRIs are preferred more in terms of minimising *side-effects*, followed by *overly sensitive patients*, *anxiety*, *treating resistant patients* and *speed of efficacy*.



Why paroxetine (Aropax) is preferred to fluoxetine (Fluox)

GPs were asked under what circumstances they prefer prescribing paroxitne to fluoxetine.



The chart below shows that paroxetine is preferred to fluoxetine because of the *degree of anxiety*, with 58% of GPs mentioning this. Some, 24% each said they prescribe paroxetine over fluoxetine when the patient shows a *lack of response* or *intolerance* to fluoxetine. A further 22% talked about *other depressive disorders*.

Six percent of GPs indicated that they *rarely or never* prescribe paroxetine instead of fluoxetine.

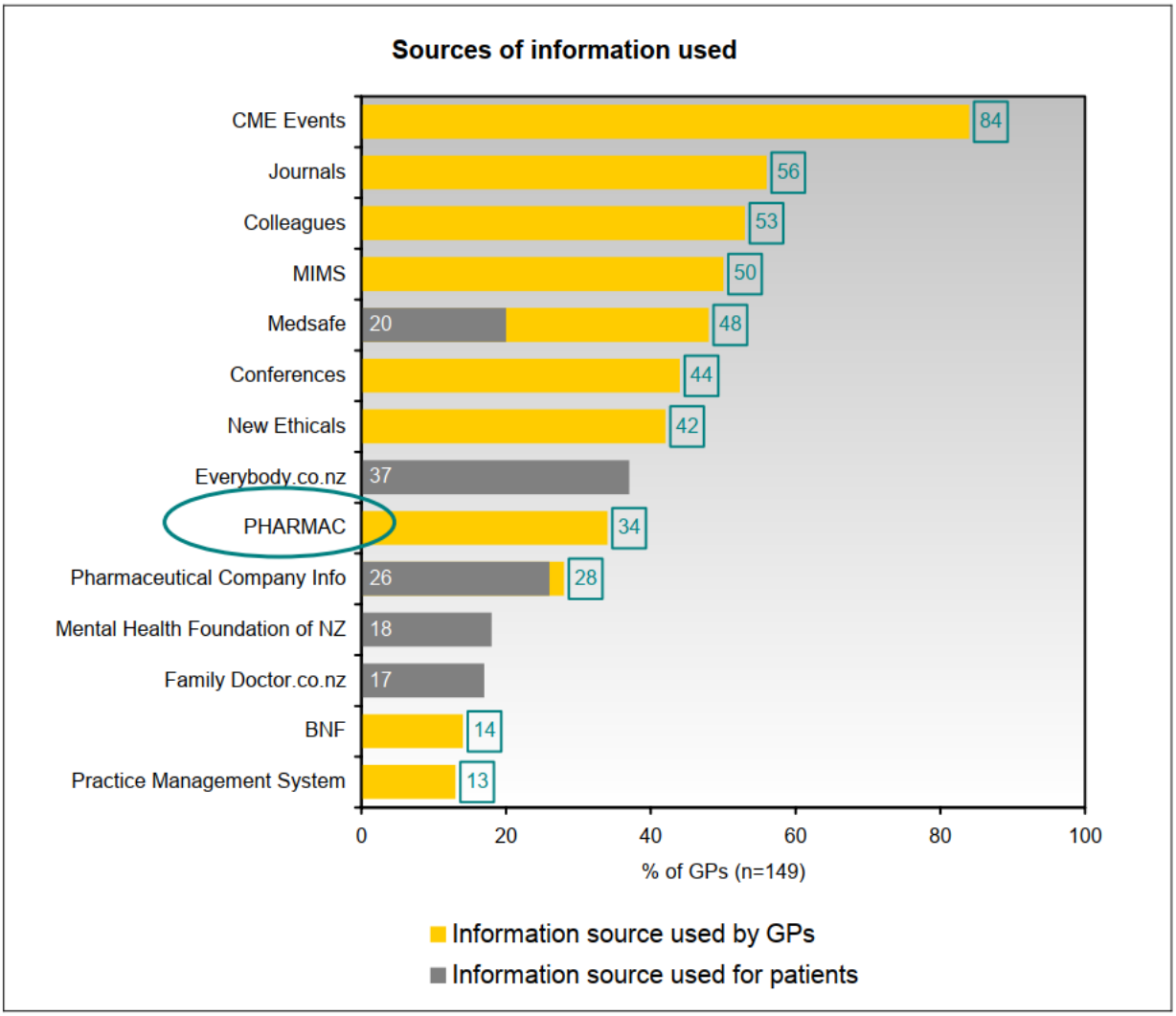
Information Source

GPs were asked to tell us which sources of information they use for **themselves** to identify and treat depression as well as for **patients** to help them understand the treatment.

In the chart below the bars in orange represents the percentage of GPs who use that source of information for **themselves**, while the bars in grey represents the percentage of GPs who use that source of information for **patients**.

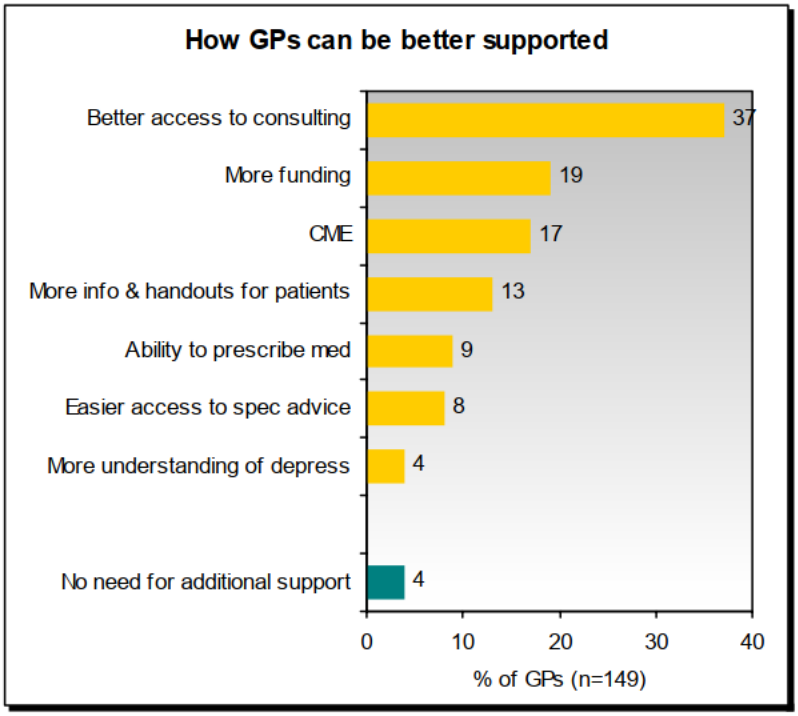
A significant 84% of all GPs indicated that they use *CME Events* to obtain information in order to help them diagnose and treat depressive patients. More than half of them also use *journals* (56%), exchanging information with *colleagues* (53%) or using *MIMS* (50%) for information. Other popular information sources include *Medsafe*, *medical conferences* and *New Ethicals*. Some, 34% of GPs cited *PHARMAC*.

The most commonly used resources for patients are *everybody.co.nz* (36%), *pharmaceutical company information* (26%) and *Medsafe* (20%). Of note, is that more GPs use sources of information biased towards or sponsored by pharmaceutical companies than that provided by PHARMAC.



How GPs can be better supported

The chart below summarises the way GPs told us they could be better supported in order to help them identify and deliver appropriate care to their depression patients.



Over one third, some 37%, said that better support could be achieved by having *better access to consulting specialists*. This is followed by suggestions for more *funding* (19%), *CME* (17%) and more *information and handouts for patients* (13%).

Other suggestions include the *ability to prescribe medicine* (9%), *easier access to specialist advice* (8%) and *more understanding of depression* (4%).

Only 4% of GPs indicated that they *do not need any additional support*.

Responses vary amongst GPs in different DHBs. The percentages shown in the table below are calculated only for DHBs with sufficient sample size. Cells shaded in yellow indicate a notably higher difference when compared to the total sample, and cells shaded in pale green indicate notably lower results.

Funding appears to be more of a significant issue in the Bay of Plenty.

	Total (n=149)	Waitemata (n=16)	Auckland (n=22)	Counties-Manukau (n=15)	Waikato (n=10)	Bay of Plenty (n=15)	Capital & Coast (n=11)	Canterbury (n=14)
Better access to consulting	37%	50%	36%	40%	30%	40%	36%	43%
More funding	19%	31%	18%	7%	10%	40%	18%	21%
CME	17%	19%	32%	20%	0%	7%	18%	14%
More info & handouts for patients	13%	13%	18%	13%	0%	13%	9%	7%
Ability to prescribe med	9%	6%	5%	7%	30%	20%	18%	7%
Easier access to spec advice	8%	6%	5%	13%	10%	7%	0%	14%
More understanding of depression	4%	0%	0%	13%	10%	0%	9%	0%
No need for additional support	4%	6%	0%	0%	0%	0%	9%	14%

The table reads: 50% of GPs based in Waitemata said they expected to have better access to consulting, compared to 37% of the total sample.

The following quotes are verbatim comments by GPs in regards to the types of support they would like in order to help them to identify and deliver better care to depression patients. They have been coded into general themes as follows…

More time for GPs:

"One of the problems is time - Patients do not tell anybody why they are coming and if you are suddenly faced with a depressed patient in the middle of a very busy session it is difficult to spend enough time with them - if I knew that was the reason a patient was coming to see me I would book them as the last patient of the day."

"There should be 3 hour long funded appointments available in the first year of diagnosis initial , first follow-up at 6 weeks and 2nd follow-up at 3 months with patients paying as per usual for the 6, 9 and 12 month reviews and anything else. It is ridiculous that the Government thinks we can treaty any condition let alone mood disorders with 10 minute consultations & expect a decent outcome."

"Initial diagnosis and treatment is not possible effectively in one 10-15 minute appointment. Funding is often an issue for these patients. A source of funding to enable early review or prolonged appointments at no or little cost to patient would help where patient cannot afford usual fees."

"Extra funding mechanisms for extended time consultations and follow up consultations. Patients own trusted GP often the best therapeutic professional seen but cost structure of GP is a barrier."

Access to counselling / support:

"Easy access to a counsellor and support groups."

"GP liaison nurse who could follow up for side effects in first few weeks and help encourage with exercise. Also quicker access to hospital counselling."

"National support for primary care follow up of depressed patients and subsidised psychological treatments as in the Engage programme trailed in the PROCARE PHO."

"Handouts similar to the leaflet I used to get from Mental Health Foundation, more readily available access to CBT, wider access to supported exercise programs."

"Increased subsidy for the consultations as they usually take 30 minutes or longer and decreased charge at private counselling as public counselling is practically non existent or, increase availability of free counselling, and increase social worker man power."

"Early referral to specialist, planned follow up and monitoring."

"More accessible (i.e more affordable) psychological therapies."

"Training information ready access to specialists - psychiatrists and / or counsellors (fully funded via public system or very small part charge payment on patients side)."

"More funding for projects such as local (Hawke's Bay) MHI which fund psychotherapy for newly diagnosed mental illness of mild to mod severity."

"Free trained counselling, extra funding for GP consultations for such depression consults. More help when we need it from mental health services, instead of exclusions and ringing around when phoning for advice."

"It would be really good if we have community workers who can follow up these patients who will never return for a follow up."

"Improve access to Mental Health services."

"Cognitive Behavioural Therapy might be used if it was available."

"Better communication and support form psych services (which I understand are under pressure). Better social support network for patients - sometimes access to MINS team (provide support for the patient in their own environment to tide over period of excess stress or crisis) would be ideal.

"

Easier access to some meds:

"Make the medications more accessible, Moclobemide for example. At last Efexor is more obtainable."

"De-restrict access to newer antidepressants and give me access to first world medications."

"More GP choice of antidepressant without having to refer to specialists. Choice of SSRI without having to try fluoxetine first."

"Written information to give to patients explaining their condition."

"I use the old prozac, citalopram and aropax sheets from the drug companies days to advise patients of their particular drugs side effects, mode of action , possible interactions etc but these are running out and getting dated, There is very little on the TCAs nothing specific I can think of from Pharmac , Aurorix and SNRIs are bureaucratically challenged. Lack of trust in GPs by PHARMAC is a major source of irritation and insult, I would use more low dose clomipramine for mild anxiety depression if it wasn't bureaucratically hindered."

"Help line."

More information for GPs:

"Better education like CBT courses, some funding privately for counselling."

"More widespread understanding of the prevalence and reality of depression as a medical problem."

"GPs with skills in mental health are not recognised by the system, bear the brunt of the mental health needs, and have their treatment options limited by both access to psychiatrists and limitation of medications."

"MedTech now has the ability for 'Smart Forms?' and I have seen one for depression, but it is not available free. It should be standardised and made available across NZ."

"Peer group meetings & discussions with specialist."

"The pamphlets written by the Efexor company have a reasonably informative booklet with each pack, the information needs to be modified a little though - this could be the basis of a support booklet for GPs."

"More exposure to international meetings."

"Web based interactive case studies with web links to other relevant sites."

More patient information:

"Have good resources for patients already, written management plans for patients may be helpful."

"Advertising in the media the symptoms of depression and that treatment is available - see your GP - no product names mentioned. The main problem is time - it is difficult to spend the time needed and almost impossible to charge a reasonable amount."

"Increased information / education in the community to improve understanding, reduce stigma, reduce patient resistance - Wider publication of evidence-based material."

"Good pharmaceutical information at the pharmacy."

"Get PHARMAC to allow free prescribing based on clinical assessment."

"Media attempts to deal with stigma of mental illness are great. Good handout information is available. Less scare mongering concerning anti-depressants."

"Incentives for patients to join gyms or to accept green prescriptions would be also worthwhile."

"Hand-out material to patients especially to help them self monitor their progress."

"I would value a good one page summary of aetiology for patients along with a good one page summary of the NZGG advice."

Other:

"Experience is really the only teacher."

"Good, well constructed, patient friendly web sites."
"Procare is good, public system is non-existent."

Appendix

Research Material

Questionnaires

PHARMAC Depression Treatment Survey

Thank you for taking the time to participate in this survey - your views are valuable to us, and your responses are completely confidential.

This survey will take approximately 10 minutes for you to complete and at the end of it, we will ask you for your address in order to post you a voucher to spend on books, CDs or magazine subscriptions at Fishpond.co.nz – New Zealand's answer to Amazon.

First off, we would like to better understand the process you and your patients go through from diagnosis to the decision of which treatment is best suited to the patient.

Q1a Generally, how confident do you feel in treating moderate to mild depression in your patients?

NOT Very Confident									EXTREMELY Confident
01	02	03	04	05	06	07	08	09	10
		↓					↓		
		CONTINUE TO Q1B					CONTINUE TO Q2		

Q1b You rated your confidence below '7' – why is that?

Q2 Please think about when you have to prescribe a pharmaceutically based treatment for a patient that you have diagnosed as having moderate to mild depression.

Please rate how important, *on average*, each of the following aspects is to you when making a prescription…

	Completely Unimportant									Extremely Important	Don't know
Financial cost to patient	1	2	3	4	5	6	7	8	9	10	11
Patient social or family situation	1	2	3	4	5	6	7	8	9	10	11
Desired speed of efficacy	1	2	3	4	5	6	7	8	9	10	11
Possible physical side-effects	1	2	3	4	5	6	7	8	9	10	11
Financial cost to government	1	2	3	4	5	6	7	8	9	10	11
Degree of patient anxiety	1	2	3	4	5	6	7	8	9	10	11
Patient insomnia	1	2	3	4	5	6	7	8	9	10	11
Likelihood / ease of compliance	1	2	3	4	5	6	7	8	9	10	11
Patient sensitivity	1	2	3	4	5	6	7	8	9	10	11
Possible psychological side-effects	1	2	3	4	5	6	7	8	9	10	11
Potential addictiveness	1	2	3	4	5	6	7	8	9	10	11
Patient safety concerns	1	2	3	4	5	6	7	8	9	10	11
Past patient substance abuse	1	2	3	4	5	6	7	8	9	10	11
Drug availability	1	2	3	4	5	6	7	8	9	10	11
Ease of administering	1	2	3	4	5	6	7	8	9	10	11
Age of patient	1	2	3	4	5	6	7	8	9	10	11
Delay in seeing a specialist	1	2	3	4	5	6	7	8	9	10	11

Q3 Could you identify any safety concerns, if any, you associate with the use of anti-depressant medication?

Write as much as you feel is necessary in the box below, *being sure to indicate which anti-depressants you are referring to.*

Q3 Please indicate which class of antidepressants is generally *best* in regards to each factor shown below…

	Longer-established anti-depressants much preferred				No difference					SSRIs much preferred	Don't know
Insomnia	1	2	3	4	5	6	7	8	9	10	11
Anxiety	1	2	3	4	5	6	7	8	9	10	11
Overly sensitive patients	1	2	3	4	5	6	7	8	9	10	11
Side effects	1	2	3	4	5	6	7	8	9	10	11
Speed of efficacy	1	2	3	4	5	6	7	8	9	10	11
Treatment resistant patients	1	2	3	4	5	6	7	8	9	10	11

Q4 In what circumstances do you prescribe paroxetine (Aropax) instead of fluoxetine (Fluox)?

Q6 Please indicate which sources of information you use in order to identify and treat depression…

Medsafe ---------- 01
PHARMAC ---------- 02
New Ethicals ---------- 03
Journals ---------- 04
Conferences ---------- 05
MIMS ---------- 06
Practice Management System ---------- 07
Colleagues ---------- 08
CME Events ---------- 09
Pharmaceutical Company Info ---------- 10
BNF ---------- 11
Other ---------- 12
None ---------- 98
Don't know ---------- 99

Q7 What, if any, are the biggest barriers you face when diagnosing and treating mild to moderate depression in your patients?

Patients who dispute diagnosis ---------- 01
Social stigma ---------- 02
Patient aversion to risk of side-effects ---------- 03
Managing patient expectations ---------- 04
Patient compliance ---------- 05
Patients' social / personal problems ---------- 06
Unavailability / restricted access to certain drugs ------ 07
Other ---------- 08
No barriers exist ---------- 98
Don't know ---------- 99

Q9 Please indicate which, if any, of the sources of information shown below you use or show to your depression patients in order to help them understand and treat their depression…

Medsafe ---------- 01
Everybody.co.nz ---------- 02
Mental Health Foundation of NZ ---------- 03
Family Doctor.co.nz ---------- 04
Pharmaceutical Company Info ---------- 05
Other ---------- 06
None ---------- 98
Don't know ---------- 99

Q10 On average, what would be the *minimum* and *maximum duration* you would expect a patient with mild to moderate depression to use antidepressants for?

MINIMUM - ENTER APPROXIMATE NUMBER OF MONTHS ➔ | |

MAXIMUM - ENTER APPROXIMATE NUMBER OF MONTHS ➔ | |

Q10b For what proportion of depression patients whom you manage do you develop a formal treatment plan?

None ---------- 1
Up to a third ---------- 2
Two-thirds ---------- 3
Almost all ---------- 4

Q11a What proportion of your mild-moderate depression patients do you treat with non-pharmaceutical treatments such as counseling?

ENTER APPROXIMATE PERCENTAGE ➔ [ ]

Q11b What proportion of your mild-moderate depression patients do you treat with OTHER non-pharmaceutically based treatments aside from counseling i.e. exercise, diet or sleeping patterns?

ENTER APPROXIMATE PERCENTAGE ➔ [ ]

Q12 What evidence do you have for using non-pharmaceutical alternatives in treating mild – moderate depression?

Write as much as you feel is necessary in the box below.

[ ]

Q13 Can you tell us how General Practitioners could be supported better in order to identify and deliver appropriate care to patients with mild to moderate depression?

Write as much as you feel is necessary in the box below.

[ ]

Q14 Which, if any, ethnic groups are highly represented amongst your depression patients?

Maori ---------- 01
NZ European / Pakeha ---------- 02
Pacific Island ---------- 03
Asian (excl. Indian) ---------- 04
Indian ---------- 05
Western European (excl.UK) ---------- 06
Eastern European ---------- 07
Central / North Africans ---------- 08
South African ---------- 09
UK ---------- 10
Other ---------- 11
No ethnic variation ---------- 12
Don't know ---------- 13

Q15a Can you tell us whether you were predominantly trained in NZ?

Yes ---------- 01
No ---------- 02

Q15b <If no in Q15a>, please specify the country where you were predominantly trained_____

Q16 In which DHB is your practice based?

Northland ---------- 01
Waitemata ---------- 02
Auckland ---------- 03
Counties Manukau ---------- 04
Waikato ---------- 05
Bay of Plenty ---------- 06
Taranaki ---------- 07
Lakes ---------- 08
Tairawhiti ---------- 09
Whanganui ---------- 10
Mid Central ---------- 11
Hawkes Bay ---------- 12
Capital & Coast ---------- 13
Hutt ---------- 14
Wairarapa ---------- 15
Nelson Marlborough ---------- 16
West Coast ---------- 17
Canterbury ---------- 18
South Canterbury ---------- 19
Otago ---------- 20
Southland ---------- 21

Q17 Which of the following best describes where your practice's catchment area?

Mainly urban ----------1
Mainly rural ----------2
Equal mix of rural and urban ----------3

Q18 Please indicate your gender…

Male ---------- 1 Female -------3

In order for us to post you a reimbursement for your time could you please enter the postal address you would like this sent to below. Please include your name.

Name:
Postal Address: *Street number and name*
Suburb
City / Region