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# What prevents GPs from using outside resources for women experiencing depression? A New Zealand study

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**Background.** GPs, often the 'gatekeepers' to mental health and related support services, have been found to refer on less often than seems desirable.

**Objectives.** The aim of this study was to explore what issues GPs would discuss with, and which treatments and support services they would consider for, depressed women; and to investigate barriers to referrals to other resources.

**Methods.** All (217) GPs in one region of Auckland received questionnaires with a vignette and quantitative and qualitative questions concerning their responses to women experiencing depression. Twelve of the 86 respondents were interviewed.

**Results.** GPs wanted to know about a range of medical, psychological and social issues. The solutions valued were biological and psychological, with some also favouring social interventions, such as assistance with childcare. However, the GPs reported limited referrals to outside resources, and frequent use of medication, because of the high cost and limited availability of psychological treatment, and difficulties accessing practical help.

**Conclusions.** This sample of GPs support improved accessibility, availability and affordability of psychological treatments and support services.

**Keywords.** Depression, GPs, referral, women.

## Introduction

Women experiencing depression frequently approach GPs,[1] who become gatekeepers between women and solutions to their distress. A literature review concluded that "psychological interventions . . . are at least as effective as medication in the treatment of depression, even if severe".[2] However, GPs seem reluctant to refer 'depressed' cases to psychologists, social workers or other agencies.[3] A British study found that although GPs were "in favour of non-drug therapy" for depression, they "mainly practised drug therapy due to time pressure and limited availability of resources".[4]

The solutions GPs offer depressed women might be expected to reflect both their beliefs about the causes of depression,[5] and availability of resources. Depression is defined commonly as a disorder[1] and diagnosed by counting symptoms. This 'illness' model can ignore context and encourage symptom-focused solutions. GPs working from this model may overlook risk factors such as social isolation, childhood abuse,[6] current violence or poverty.

This study[7] explores three questions about 'depressed' women:

1. What do GPs want to know?
2. What would GPs do?
3. What factors intervene between assessment and solutions offered?

## Method

All 217 GPs in one area of Auckland were surveyed. Data were gathered from responses to: (i) a case study vignette; (ii) a questionnaire; and (iii) a semi-structured interview to allow elaboration.

The case study presented a woman with depressive symptoms but no risk of suicide. Two open-ended questions asked GPs to list three issues they would discuss

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before considering treatment, and three treatment approaches they might consider. The questionnaire used open-ended questions and Likert scales to explore the three research questions.

## Results

*Response rates*

Eighty-six (39.6%) GPs completed the case study, 55 also completed the questionnaire. Twelve were interviewed.

*What do GPs want to know?*

First, case study responses indicated that GPs would discuss a diversity of issues, including: history of depression (37%), precipitating factors (35%), support networks (33%) and family situation (32%).[7] Among the least cited issues was abuse history including domestic violence, rape, etc. (5%).

Secondly, prompted responses about the relevance of 35 listed risk factors are shown in Table 1. Factor analysis identified a psycho/social/political factor accounting for most variance (30.3%), highly loaded for 'substance abuse' and 'unemployment', and including 'isolation', 'sexual identity', 'poverty' and 'rape'.

Thirdly, statements about causes included four biomedical, four individual/psychological and four social/political beliefs.[7] The strongest agreement (84%) was with the 'social/political' statement that "Poverty contributes to the development of depressive disorders". The greatest agreement in the other groups was with: "People in supportive relationships are less likely to get depressive disorders"(79%, 'individual/psychological') and: "There is an underlying biological cause for most depressive disorders" (62%, 'biomedical').

Interviews also revealed a multifaceted view; a representative statement being:

> "I don't think anybody knows what causes depression . . . there are certain biological theories, and there are . . . certain nurture type theories that are going round. I believe it's in the middle . . ."

*What do GPs do?*

The case study showed that most GPs consider both counselling (92%) and antidepressant medication (94%). However, their reported practice did not reflect this valuing of counselling. Only 55% said they 'often' referred to counsellors. Other significant referrals were to community mental health centres (40%), clinical psychologists (31%) and recreational activities (31%). Less than 15% of GPs referred 'often' to any of the other 26 listed resources.

TABLE 1 *Relevance of 35 risk factors for depression (*n = *55)*

| Risk factor | Mean relevance[a] | % Highly relevant | Risk factor | Mean relevance | % Highly relevant |
|---|---|---|---|---|---|
| Recent divorce | 1.38 | 69% | Negative self-talk | 1.87 | 38% |
| Rape | 1.40 | 65% | Young children to care for | 1.91 | 28% |
| Domestic violence | 1.42 | 64% | Retirement | 2.00 | 25% |
| Child sexual abuse | 1.42 | 66% | Genetic factors | 2.02 | 30% |
| Child emotional abuse | 1.44 | 65% | Illness | 2.04 | 24% |
| Recent childbirth | 1.51 | 57% | Sexual identity issues | 2.08 | 21% |
| Grief | 1.55 | 53% | Poverty | 2.19 | 13% |
| Stressful life events | 1.58 | 54% | Physical disabilities | 2.25 | 13% |
| Child physical abuse | 1.58 | 53% | Menopause | 2.42 | 11% |
| Lack of social support | 1.58 | 51% | Neuroticism | 2.44 | 17% |
| Lack of intimate relations | 1.60 | 51% | Menstrual cycle | 2.48 | 10% |
| Isolation | 1.62 | 47% | Getting older | 2.48 | 11% |
| Biochemical factors | 1.65 | 51% | Neurological dysfunction | 2.50 | 8% |
| Substance abuse | 1.70 | 45% | Brain damage | 2.58 | 14% |
| Unemployment | 1.77 | 32% | Gender | 2.72 | 7% |
| Present family factors | 1.79 | 40% | Racism | 2.90 | 2% |
| Personality factors | 1.85 | 38% | Homophobia | 3.23 | 4% |
| Depressed family members | 1.85 | 32% | | | |

[a] 1 = highly relevant, 2 = moderately relevant, 3 = mildly relevant, 4 = not relevant.

TABLE 2 *Services for depressed Pakeha (European) women that GPs believe should be more available in their area*

| | *n* | % |
|---|---|---|
| Counselling or psychotherapy | 38 | 69 |
| Childcare and home help | 13 | 24 |
| Psychiatrist | 10 | 18 |
| Community mental health services | 8 | 15 |
| Support groups | 7 | 13 |

The figures given are the number of GPs mentioning each service ($n = 55$).

*What factors intervene between assessment and solutions?*

Availability, accessibility and affordability of resources were all matters of concern. Table 2 shows responses concerning availability, which were reinforced by responses about accessibility. Thirty-seven (67%) GPs were concerned about waiting times in the public mental health system, and 24 (44%) about the cost of private therapy.

Ninety-two per cent of the GPs agreed that "psychological therapy should be as affordable as GP treatment". One commented, "I would use an awful lot more counselling if it were freely available, but the people who most need it can't afford it".

## Discussion

If we can assume a relationship between self-report and actual behaviour,[8] this study suggests that GPs are aware of the many risk factors involved with depression, including medical, psychological, interpersonal and social/political issues. Nevertheless although violence and child abuse were considered highly relevant risk factors when presented in the list of possible factors, they were rarely (5%) mentioned spontaneously.[7] This discrepancy is of concern given the documented relationship between child abuse and depression and suicidality.[6] One interviewee commented:

> "I was here about two years before I found someone willing . . . before I was willing to ask about sexual abuse. Now I have so many. I couldn't believe the number who disclosed with sexual abuse".

Whilst theoretically favouring multimodal treatment, the GPs prescribe medication much more frequently than they refer for counselling. This is of concern when considered alongside the findings that 52% of depressed people on medication only either drop out of treatment, or show no response, while only 30% of psychotherapy patients and 34% of 'combined' patients have such negative results.[2]

The discrepancy between GPs' beliefs and behaviours is explained by the lack of availability and affordability of psychological treatment. A report on the treatment of depression in primary care[1] confirms this view of the availability of public mental health services in New Zealand. This concurs with the English finding that GPs "favour non-drug therapy in treating depression" but "mainly practise drug therapy due to time pressure and limited availability of resources".[4] A New Zealand survey of GPs[9] (with similar results to those of an earlier UK study[10]) found that while GPs considered clinical psychologists, counsellors and social workers to be 'helpful', all three professions were considered inaccessible.

This study[7] suggests that when women consult GPs, they may receive short-term solutions, but will often not be helped to address psychological, social or political causes of their depression. This may have little to do with GPs, and much to do with the constraints within which GPs work. GPs are in the unenviable position of acting as gatekeepers to scarce or unaffordable, but highly relevant, solutions.

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