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Untreated depression in the community

AIMS AND METHOD

Reaching into the community to treat people with anxiety and depressive disorders raises the spectre of wrongful use of scarce resources at best, and of disease mongering at worst. We recruited for an internet-based treatment for social phobia.

RESULTS

Applications were received from 789 people, and 205 were rejected because of severe depression or suicidal thoughts. Many were excluded because they had another disorder or were in treatment. Some dropped out, only 7 were subthreshold cases and 291 people with social phobia were treated.

CLINICAL IMPLICATIONS

Despite easy access to clinicians, the burden of untreated serious mental disorder in the community remains considerable.

The *British Journal of Psychiatry* recently published a debate between Summerfield and Veale entitled 'Proposals for massive expansion of psychological therapies would be counterproductive across society.'[1] The reason for this was the Layard proposal to train therapists in cognitive–behavioural therapy (CBT) so that 800 000 more people could be treated. Summerfield, arguing in the affirmative, labelled this disease mongering and doubted there was evidence for effectiveness.[1] Veale arguing in the negative, noted that 800 000 was 1.5% of the population, a small part of the 12% of the adult population that met criteria for a depressive or anxiety disorder in the UK psychiatric morbidity survey and were untreated. [1] He thought that, with proper safeguards, effective therapy could be delivered.

The concern, as always, is that people will present with trivial disorders and use resources needed for those with disabling chronic conditions. We now report the results of recruiting for an internet-based programme for people with social phobia that revealed surprising unmet need.

Method

In June 2007 we began recruiting participants for randomised controlled trials to evaluate the effectiveness of an internet-based programme for treating social phobia.[2,3] Applicants to www.climateclinic.tv were self-referred members of the public who had seen or heard print and radio reports about the programme. We received enquiries from more than 1000 people and applications from 789 people over a period of 27 weeks. Exclusion criteria were severe depression, suicidal ideation, substance use, currently being treated for a mental disorder, and not meeting criteria for social phobia. We used a telephone interview to confirm the diagnosis of social phobia as the principal complaint. We used the Patient Health Questionnaire – 9 item (PHQ–9) to screen for depression: 82% of the 580 primary care patients in the initial study[4] had a PHQ–9 score of less than 10, indicating no depressive disorder. In a comparable data-set of 599 patients attending general practitioners (GPs) in Auckland, New Zealand (B. Arroll, personal communication, 2009), a similar number scored less than 10, and only 2% scored in the severe range of 20 to 27.

Results

The severity of social phobia in the 291 people treated in the programme was considerable and comparable with that in individuals seeking face-to-face treatment at our specialised clinic. Adherence and progress in treatment were also comparable.[3] The rates of comorbid depression were considerable (Table 1) and considerably more severe than among a sample of GP attenders. Applicants were excluded if severely depressed ($n = 81$, 14.5%), had any current suicidal ideation ($n = 184$, 33%) or because of substance misuse ($n = 9$, 1.6%). People already in treatment elsewhere were excluded, as were people who, during a structured telephone interview, identified another anxiety disorder as their principal complaint. In that diagnostic interview only 7 of the 364 who reported social phobia as their principal complaint were excluded because their symptoms were below threshold, and 66 dropped out before treatment began, leaving the 291 to be treated.

Discussion

The second Australian Burden of Disease report found that mental disorders accounted for 13% of the burden of disease and that anxiety and depressive disorders contributed 50% of this.[5] In the 1997 Australian National Mental Health Survey, 6.3% met criteria for a comorbidity adjusted current depressive or anxiety disorder. Only 45% reported seeing a health professional and only 24% reported treatment with medication or CBT. Treatment with selective serotonin reuptake inhibitors and/or CBT are very cost-effective[6] and it was a serious public health issue that the majority of people with these disorders went untreated when 80% of people with comparable physical disorders received effective treatment.[7]

Several Australian government initiatives have sought to address this unmet need. In 2001, the Better Outcomes in Mental Health Care programme[8] improved GPs' ability to detect and treat common mental disorders, and within 15 months of that initiative commencing, more than 3000 GPs had been trained. The government has also encouraged web-based services for people with anxiety and depressive disorders. In 2006, Better Access to Mental Health Care[8] resulted in new health

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Table 1. Distribution of levels of depression severity in a sample of patients attending New Zealand general practitioner (GP) clinics and applicants to an online social phobia treatment programme

Patient Health Questionnaire – 9 item score	Severity	New Zealand GP data[a] ($n = 599$), %	Shyness programme applicants ($n = 557$),[b] %
0–9	Nil	86	45
10–19	Moderate	13	40
20+	Severe	2	15

a. Unpublished data from patients attending GPs in New Zealand (B. Arroll, personal communication, 2009).

b. Original sample 789; however, 232 applicants were excluded or dropped out before completing the Patient Health Questionnaire – 9 item.

insurance items including, for the first time, direct fee for service reimbursement for psychologists following GP-prescribed mental healthcare plans. Early figures indicated a huge response with some 600 000 services rebated through Medicare for psychologists in the first 8 months (November 2006 to June 2007) of the Better Access scheme.[8]

We expected that the unmet need in the community for treatment for anxiety and depressive disorders would be lessening, yet people applying for internet therapy for social phobia were seven times more likely to have a severe depression than the average person attending their primary care physician. Our internet social phobia programme was not appropriate for severe depression, so we excluded applicants scoring in the severe range on the PHQ–9 and applicants indicating suicidal ideation. They were sent links to websites providing information about depression and treatment, advised to contact their local doctor and invited to contact us for advice. Only one person did. These data are sobering and indicate that despite the improved access to mental health services resulting from the recent fee support for psychologists in Australia, a serious amount of unmet need remains. Virtually no one with a trivial disorder applied for treatment.

The capacity of any healthcare system will never meet the entire need or desires of the community. Veale[1] reported that the mean duration of disorder in people presenting to the UK pilot psychological therapy sites was 6 years and concluded that these people were not complaining of transitory life stresses. Our data indicate that a very considerable need continues to exist in the Australian community from consumers with severe depression and, presumably, with other mental disorders as well. There is a clear need for new initiatives in service delivery models. We argue that the application of computer technology to this problem is a logical option worthy of serious exploration.[9] Programmes such as Moodgym[10] and the Shyness programme[2,3] are effective treatments. They have demonstrated the potential to reach consumers who are not able or willing to access face-to-face treatment but who still experience considerable burden. Conceivably, such programmes could provide a practical first step in stepped care models of service provision, providing effective treatments to consumers with mild to moderate symptoms. Additionally, they might motivate consumers with severe symptoms to participate and, gaining some benefit, finally seek face-to-face treatment. Consumers are seeking information and treatment online. We must recognise this and provide them with a choice of credentialed and effective internet-based treatment programmes. Reliance on better access by subsidising fees for face-to-face therapy, although helpful, does not appear to be sufficient.

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Declaration of interest

None.

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