The effects of depression awareness seminars on general practitioners knowledge of depressive illness

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SUMMARY
The Royal Colleges of Psychiatry and General Practice wish to improve knowledge of depressive illness among patients and professionals. This study reports the results of a series of depression education seminars in a Health Board in Northern Ireland. Seminars lasted 2½ hours and included didactic teaching and interactive case management vignettes. 88 general practitioners took part (39% of those eligible). Seminars increased knowledge as measured by questionnaire immediately, but this did not appear to be sustained at one year, when compared to a group of general practitioners with no access to such seminars. Educational programmes as described do not appear to have a sustained effect on general practitioners’ knowledge of depressive illness.

INTRODUCTION
The Defeat Depression Campaign is being organized in the UK by the Royal College of Psychiatrists in association with the Royal College of General Practitioners. Its aim is to improve knowledge of depressive illness and its treatment among patients and professionals. There is evidence (on a small scale) that such campaigns can lead to increased detection, treatment and reduced disability from depression. There has been limited published evaluation in the UK, with some work suggesting little impact on general practitioners’ clinical practice in particular. In the USA intensive programmes of education have been evaluated by questionnaire with positive and substantial results. The aim of the present study was to assess whether a series of depression awareness seminars made available across a specific area to general practitioners would increase knowledge of depressive illness, and whether this was sustained at one year.

SUBJECTS AND METHODS
The Northern Health and Social Services Board (NHSSB) has a population of 406,000 served by 245 GPs. A series of eight seminars was held throughout the Health Board. As many general practitioners as possible were contacted and invited to seminars in their area. Twenty general practitioners were not canvassed as they had recently received teaching on depression.

Each seminar lasted 2½ hours, comprising 1 hour of didactic teaching based on the consensus statement from the Royal Colleges and 1½ hours of interactive case vignettes discussing common diagnostic and management problems.

Knowledge of depressive illness and its management was assessed by a twelve item true or false questionnaire given before the seminar (Table) and repeated afterwards. General practitioners who took part in the original seminars were contacted at one year and a second twelve item questionnaire was used (to avoid practice effects, but covering the same areas). The results, at one year, were compared to a group of general practitioners from outside the area with no exposure to such seminars. This second group were also seeking to attend an educational meeting on depression and therefore showed a similar level of motivation to the study group. To ensure compliance all questionnaires were completed anonymously. Scoring was +1 for correct answers and 0 for incorrect; missing replies were treated as incorrect. Scores were normally distributed and the unpaired t-test was applied (all results two tailed).

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Table
First GP Questionnaire

1. Depressive illness can be diagnosed if mood and associated changes have been present for 1 week. 
   YES/NO
2. When depressive illness is triggered by life difficulties antidepressants have no place in management. 
   YES/NO
3. Depressive illness always presents with marked lowering of mood as the main symptom. 
   YES/NO
4. Asking about suicidal ideas may be dangerous and precipitate suicidal actions. 
   YES/NO
5. People who commit suicide do not tell others. 
   YES/NO
6. Depressive illness when treated usually does not recur. 
   YES/NO
7. Antidepressants should be used for 2 months after the patient recovers. 
   YES/NO
8. If two antidepressants fail there is little point in trying other treatments. 
   YES/NO
9. Compliance with antidepressant treatment is usually very good. 
   YES/NO
10. Most people who commit suicide have personality difficulties and are not depressed. 
    YES/NO
11. Antidepressants, when used, should always be combined with supportive counselling. 
    YES/NO
12. Suicide is most common in middle aged females. 
    YES/NO

Correct Answers
YES = 11
NO = 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 12.

RESULTS

Of the 225 general practitioners eligible for inclusion, 88 took part in one seminar (39.1%). The mean (SD) score was 9.9(1.4) before and 10.9 (1.2) after. The range was 5-12 on both occasions. The increase was statistically significant (t = -3.1, df = 174, p<0.002).

44 general practitioners were contacted at one year (50% of original sample, 20% of eligible general practitioners in Health Board) and completed the second questionnaire. They were compared with 30 general practitioners not exposed to a local defeat depression seminar. There was no difference in scoring between those exposed 9.5 (1.3) and not exposed 9.5 (1.5) (t = 0.1, df = 72, p = 0.9) at one year follow-up.

DISCUSSION

This study attempts to recruit general practitioners into educational seminars and assess the outcome. Informal discussion suggested they would be unlikely to attend longer sessions devoted to one disorder. The findings suggest little evidence of sustained benefit from seminars as described above. The Iowa Study demonstrated protracted benefits from their educational programme. This may be related to the duration of educational input (two days), or that their audience was primarily mental health professionals. The Iowa study also demonstrated a substantial attrition rate (41% were unable to be contacted or did not reply) at long term follow-up (6 months). Non-responders in this study were not significantly different on several key demographic variables from those who did reply, suggesting the high attrition rate did not bias the study.

A Swedish study,\(^1\) carried out on the island of Gotland, did not look at knowledge gains but found intensive education on depression and suicide for general practitioners (over several days), did reduce suicide rate and days lost from work related to depression. The study was relatively small and it is unlikely the methodology could be repeated on a larger scale. Despite this it has been a major theoretical and practical underpinning of the Defeat Depression Campaign.

There are several limitations to the present study which assesses accumulation of knowledge. This may be a marker towards outcome of care but does not necessarily reflect what happens in the surgery. However it is unlikely care can be improved without knowledge gains.

There was no active randomization process as the aim was to capture as many general practitioners as possible. With regard to the immediate effects of the seminars, the general practitioners acted as their own controls. At one year a group of equally motivated general practitioners were available for comparison.

The questionnaires were answered anonymously to encourage forthright replies; this prevents any
sub-analysis with regard to age, psychiatric experience etc.

The questionnaire has been used with other mental health practitioners and can discriminate between different groups. The questions are based on Royal College recommendations and related documents. The author was involved in training at all seminars. On certain occasions this was shared with colleagues. Training material, slides etc, were standard at all meetings, and based on national recommendations.

It is unclear how questionnaire assessment relates to clinical practice. However, the scores in this study do suggest scope for improvement in knowledge of depressive illness. The questions posed should not be considered esoteric. Most general practitioners' education follows a format similar to the seminars provided; reassessment of this method may be necessary.

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