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# Evidence into practice: the mental health hurdle is high

Ian B Hickie and Grant A Blashki

## *Guidelines for GPs need to tackle the tough issues*

These are interesting times in Australian mental health. On a daily basis, the gap between best practice guidelines and the quality of services delivered widens. Rapid advances in clinical neurosciences give us real enthusiasm for new approaches to treatment. By contrast, national and state-based inquiries highlight fundamental failures in acute and ongoing care. Although major service redevelopments continue, we do not yet provide an integrated health services response. All our governments now concede that a new round of investment, innovation and coordinated reform is essential. Substantial new investments are justified and necessary if we are to see genuine innovation, improved access to care, and better health outcomes in the mental health service environment.

The production of guidelines for bipolar disorder internationally reflects the therapeutic gains that should be available for people with this common and disabling illness.<sup>1,2</sup> However, when guidelines target general practitioners, like the recommendations provided by Mitchell et al in this issue of the *Journal* (page 566),<sup>3</sup> some hard questions need to be asked. Are they relevant to general practice in Australia? Do they connect with the target audience? Are the recommendations achievable in our health care environment?

In recent years, most GPs feel that they have received truck loads of worthy guidelines from their specialist colleagues. Although guidelines are critical to improving health care quality, in the end most fail to recommend strategies that lead to real impacts on clinical practice. The mental health field is no exception. It too is awash with new guidelines.<sup>4</sup> Surprisingly, given that 75% of mental health consultations take place in the primary care environment, few have targeted general practice. A notable exception is the guidelines for the treatment of depression in general practice settings, commissioned by *beyondblue*: the national depression initiative.<sup>5</sup>

From a GP's perspective, most mental health guidelines don't concede basic service limitations. First, GPs are not an unlimited

mental health resource. In fact, recent data indicate a major slowing in the rate of increase in the treatment of common mental disorders in primary care settings.<sup>6</sup> Second, mental health guidelines compete with all other medical guidelines for attention. Simply producing more guidelines for more disorders doesn't increase the likelihood that recommendations will be put into action. Producing more guidelines for closely related topics (eg, bipolar depression,<sup>3</sup> major depression in specialist settings,<sup>7</sup> major depression in primary care,<sup>5</sup> youth depression<sup>8</sup>) also doesn't help. Third, simply extrapolating evidence from studies conducted in patients with severe, chronic or complex disorders encountered in specialist treatment centres may not only be scientifically questionable, but may particularly annoy GPs.<sup>9</sup>

Most importantly, "GP guidelines" for mental disorders should deal explicitly with the key issues: identification of less severe forms of the disorder; management of medical comorbidity; overlap with alcohol and substance misuse; limited geographical and economic access to specialist psychological support; use of alternative treatments for less severe or less complex cases; and implications of poor access to specialist assessment during acute phases of illness. Providing a detailed list of reasons for specialist referral does not assist those GPs who struggle on a daily basis to connect with any specialist support in the private or public sector.

Rather than addressing such issues, specialist psychiatry has a particular knack for creating more disorders, more subcategories and more complex treatment regimens.<sup>1-3</sup> The self-explanatory nature of manic-depressive illness has been replaced by the more opaque terms "bipolar I", "bipolar II", "bipolar depression", "mixed episodes", "rapid cycling", and "cyclothymia". However, if such fine-grained differentiation is not associated with quite specific differences in treatment or prognosis, or is not based on a solid evidence base,<sup>10</sup> then it holds little appeal.

The medical, psychosocial and legal consequences of a GP making a diagnosis of bipolar disorder are potentially consider-

able. To suggest that these can be minimised by having all such decisions reviewed by a specialist is highly optimistic, especially given the decreasing availability and inequitable access to such resources. While recent improved access to psychological therapies through partnerships in general practice,<sup>11</sup> and proposed direct referral mechanisms to clinical psychologists,<sup>12</sup> are most welcome, it is not yet clear whether these developments will increase access for patients with bipolar disorder to the more intensive and targeted therapies they require.

From a primary care perspective, the most useful mental health guidelines tackle the tough issues that cross a GP's desk on a daily basis.<sup>9</sup> Where are the best sources of self-help, self-monitoring, detailed illness descriptions, and family education to be found? Are there high quality e-health resources available?<sup>13</sup> What options are available to a GP when patients become a danger to themselves or their reputations? How should a GP deal with poor compliance? What are the cost implications for patients of particular management plans (eg, costs of travel to specialist appointments)? What should the GP do when specialist services are not available? What are a GP's responsibilities when the patient doesn't return for follow-up appointments and/or medication monitoring? How should a GP document mental health consultations in their medical records? What other clinical or management resources are available? Is additional training required to deliver the therapies recommended in the guidelines?

While the recommendations presented by Mitchell et al,<sup>3</sup> and the related technical summaries, do provide useful clues, insufficient attention to these practice-based issues risks an overall negative rating from the target audience.

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## Sackings at the Canadian Medical Association Journal and editorial independence

Martin B Van Der Weyden

*A clash of purpose between a journal's editors and its owner*

20 February 2006 may well be the day that marked the beginning of the decline of the *CMAJ* (*Canadian Medical Association Journal*) as a widely respected national and international journal. On that day John Hoey, Editor-in-Chief of the *CMAJ* for 10 years, and his Deputy Editor Anne Marie Todkill were summarily dismissed by Graham Morris, the president of CMA Media Inc which publishes the *CMAJ*.<sup>1</sup> As to the reasons for the firings, Morris said, "I felt that after 10 years it was time for a fresh approach."<sup>2</sup> His rationale was greeted with disbelief and derision from leaders in the publishing field. Frank Davidoff, Editor Emeritus of the *Annals of Internal Medicine* was reported as

saying, "Oh, come on! A summary firing without a cause? I mean, how naive do they think people are?", adding, "I think it could be the death knell of this Journal".<sup>3</sup>

The dismissal of Hoey and Todkill provoked editorial comments in the *Lancet*<sup>4</sup> and the *British Medical Journal* (*BMJ*),<sup>5</sup> and condemnations from the Council of Science Editors, the World Association of Medical Editors and the International Committee of Medical Journal Editors — all parties called for the Canadian Medical Association (CMA) to respect editorial independence.<sup>4</sup> Within 3 weeks, the *CMAJ* was reduced to a shell of its former self. The journal's Acting Editor-in-Chief, Stephen Choi,