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Mood disorders in primary care

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Abstract
The majority of patients with mental health problems are treated solely within primary care. This article discusses the epidemiology, diagnosis, and management of mood disorders in primary care. Factors influencing recognition, the use of screening instruments, and somatization are discussed. The article also outlines the latest recommendations for the management of depression in primary care using a stepped care model.

Keywords depression; mood disorder; primary care; recognition; screening; somatization; stepped care; suicide

What's new?

- There is increasing recognition that long-term care approaches are required for a significant proportion of depressed patients in primary care
- Case management, medication management, and telephone support are important factors in improving outcomes
- Patients with coexisting depression and physical illness have particular risks and needs, which are being addressed by a specific NICE guideline to be published in 2009
- The Improving Access to Psychological Therapies (IAPT) programme, together with computer- and web-based delivery systems, is assisting access to psychological therapy
- A stepped care model should be used for the management of depression in primary care
- Antidepressants remain the recommended treatment for moderate-to-severe depression

The majority of patients with mental health problems, especially mood disorders, are treated in primary care. Primary care professionals such as general practitioners (GPs) and primary care team members are usually the first and often the only health professionals who manage people with mental health problems. The GP and primary care team are unique among health professionals in having direct access to the medical history and social background, and their assessment and management is often influenced by many years of contact with the patient.

Epidemiology of mood disorders in primary care

Depressive disorders are common within the general population, affecting around 10% of people at any one time, with mixed depression and anxiety the most frequently occurring presentation.[1] Mental health problems are likewise among the most frequent problems seen in primary care in the UK and elsewhere: a World Health Organization 15-centre study identified that a quarter of primary care

attendees worldwide suffer from some psychiatric disorder.[2] Within this setting, the most common problem is depression, identified in 10% of consecutive attendees.[3]

At least half of those people who experience depression will have further episodes, and depression and other common mental disorders are increasingly viewed as long-term illnesses involving sustained impairment and high rates of symptom recurrence. Further, these problems are often seen as part of a more complex presentation that coexists with such conditions as cardiovascular disease, stroke, diabetes, chronic pain, and hypertension, and the course and prognosis of these physical and mental illnesses is greatly worsened by their co-morbidity.

Similar rates of depression have been identified in older people. However, in the elderly, diagnostic and methodological difficulties may disguise the extent and severity of disabling psychological symptoms as many older patients with symptoms of depression do not meet full criteria for major depression.

Among children and young people in the UK, mental disorders exhibit a prevalence of around 10%, with conduct disorders the most common condition among 5–15 year olds and emotional disorders (anxiety and depression) affecting 4%.[4] These problems are a source of suffering and impaired function, which typically disrupt educational and social development and limit achievements. Depression, in particular, is linked to poor academic performance, social dysfunction, substance misuse, and suicide. These problems in childhood often persist, increasing the risk of mental illness in adult life: around half of adults with mental health problems are likely to have met criteria for a disorder by the age of 15 years.

Although depressive and anxiety disorders occur nearly twice as commonly in adult women as in men, these sex differences may be exaggerated in this setting owing to differential consulting rates.

Dysthymia is also common in primary care patients, affecting 3–5% of GP attendees. Affective psychoses are much rarer. The prevalence of any psychotic illness in primary care identified by the Quality and Outcomes Framework (QOF) measures for 2007/08 is 0.7%, and comprises patients with schizophrenia, schizo-affective disorder, bipolar affective disorder and psychotic depression, identified within primary care.[5]

The burden of mood disorders

Depression impacts not only on the individual but also on families and carers, health services, and society in general. Mental health problems as a whole are a leading cause of disability burden in the world: the Global Burden of Disease project analyses for 2001 revealed that 37% of healthy years lost due to disability (YLD) were attributable to neuropsychiatric conditions, and that mental disorders accounted for 4 of the 10 leading causes of disability worldwide.[6] Depression alone accounts for more disability (YLD) than any other cause globally, amounting to almost 12% in high-income countries.

In the UK, nearly 40% of incapacity benefit claimants have mental health problems as their main disability, and these problems are a secondary factor for a further 10% or more[7]; for England this amounts to more than 900,000 adults claiming sickness and disability benefits for mental health conditions, of which a large proportion involves depression.

Depression is associated with higher rates of health service use and increased costs; studies in the USA and Europe have shown medical costs up to two-fold higher for primary care patients with depression compared with controls. Among patients who are frequent primary care attendees, depression appears to be at least twice as common as in the base population.

Depression confers an increased risk of death from a broad range of physical conditions, and, together with the high risk of suicide, underlines the fact that mood disorders are potentially fatal diseases. Pooled data from community studies of older people with a mood disorder have identified a 1.75-fold increased all-cause mortality rate.[8] The effect of depression on mortality appears to be modified by sex, with excess mortality risk conferred by male sex; this may be because men have more cardiovascular pathology, the course of which is strongly affected by depression, as well as the increased likelihood of suicide among men. The causes of suicide are complex, with socio-economic factors, access to firearms and toxic substances, and alcohol consumption all associated with the rate

of suicide.[9] However, depression seems to be the most important disease risk factor for suicidal ideation and behaviour, and is present in at least two-thirds of completed cases.[10]

Issues in diagnosis

Psychological disorders are inadequately recognized in primary care, a problem that is not restricted by national boundaries, with studies in many countries revealing misdiagnosis rates for depression in primary care of 30–50%.[11] Nor does this inadequate recognition appear to be limited to setting or type of staff, being noted in primary care centres, residential and nursing homes, and medical in-patient settings, and in relation to the practice of GPs, nurses, and other health-care professionals. The pathways to care model of Goldberg and Huxley[12] helps to explain the discrepancy between conspicuous mental illness and what has been termed hidden mental illness (Figure 1).

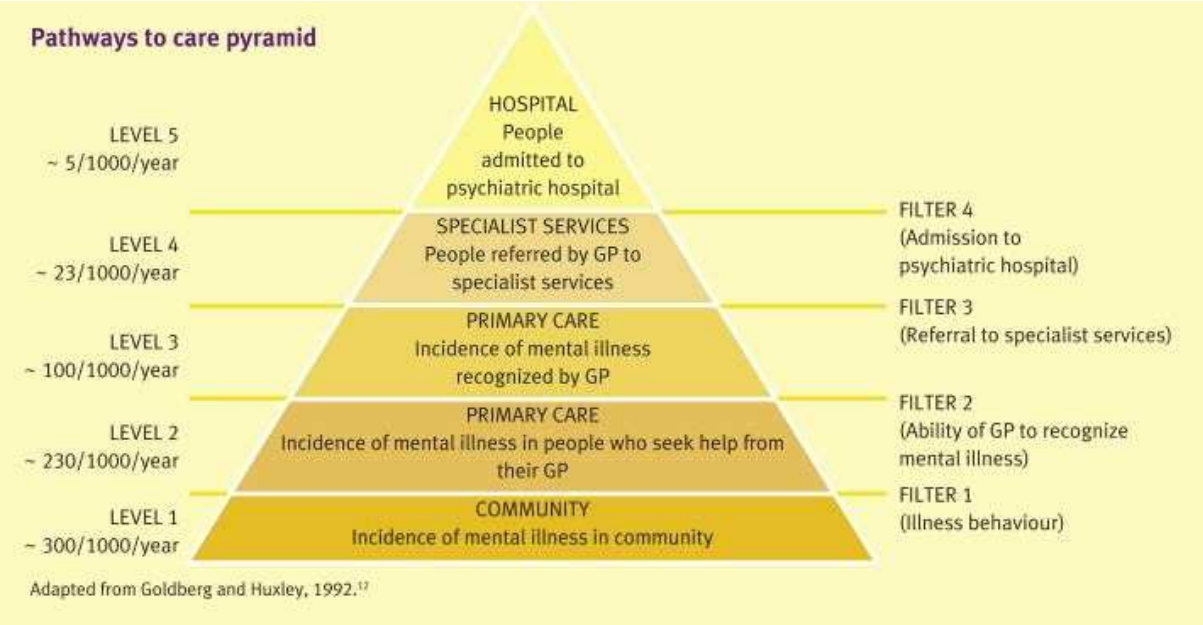

Figure 1: Pathways to care pyramid

Mood disorders can be difficult to diagnose in the primary care setting. Patients rarely present with symptoms that fit neatly into diagnostic taxonomies. Patients in primary care usually present with a combination of physical, psychological, and social problems. Somatic symptoms are often presented first. The generalist faces the difficult problem not only of having to tease out a depressive illness from co-morbid physical illness but also of identifying underlying mood disorders in patients who present with somatic problems that lack an obvious organic cause.

However, GPs are good at diagnosing severe mood disorders and anxious depression. More than 90% of patients with severe depression are accurately diagnosed by GPs. Those with undetected mood disorders tend to have less severe illness, and case recognition rates increase with subsequent consultations.

Recognition of mood disorders in primary care

Recognition of depression appears to be a function of both patient and professional factors.

***Patient factors* –** the mode of presentation is important and patients who present with somatic complaints are less likely to be diagnosed correctly as depressed. Patients with less severe depression are more likely to be missed, whereas those with psychiatric histories or high consultation rates are more likely to be identified correctly. Other patient factors that impede recognition include stigma and an ignorance of depression.

***Clinician factors* –** GPs who have a positive attitude towards and interest in mental health problems are more likely to diagnose depression accurately. Consultation styles are important. GPs who ask open questions initially, give more time, are more empathic, make more eye contact, and interrupt less have been shown to detect depression more often. These skills have been taught successfully in interview skills training using video feedback.

Mood disorders are also more likely to be acknowledged if patients mention psychological problems in the first four symptoms they present, and less likely if they are mentioned towards the end of the consultation.

Somatization

Somatization is the process whereby psychological distress is expressed through physical symptoms. Up to 80% of patients with anxiety or depression initially present in the primary care setting exclusively with somatic complaints. Somatization is a universal phenomenon and probably an integral part of depression as it presents in primary care. However, it can make the diagnosis of a mood disorder more difficult as psychiatric classifications fail to take somatic presentations into account. The ability to diagnose depression when presented with somatic complaints relies on the interview style of the GP, awareness, and a high index of suspicion of depression as a possible cause.

Somatizers have been divided into two groups:

- facultative somatizers, who present with physical symptoms but can express their psychological symptoms if interviewed appropriately
- pure somatizers, who deny any psychological symptoms even in the face of an appropriate interview.

A teaching package has been developed by the World Psychiatric Association specifically for use in primary care to help GPs manage patients who somatize.

Screening for depression in primary care

Screening, or more correctly case finding, for depression in primary care has been controversial. This use of case-finding tools is appealing as these are easy to administer and score, psychometrically robust, and acceptable to patients.[14] However, contradictory results have been obtained, and reviewers have provided differing recommendations, with more conservative approaches holding sway in the UK (compared with conclusions of the preventive health taskforces in the USA and Canada), with systematic case identification restricted to high-risk groups alone, such as patients with a past history of depression or disabling physical illness. The national QOF practice payments are currently allocated for the implementation of case finding among patients with diabetes and coronary heart disease, using a standardized two-question screen:[15 and 16]

During the last month, have you often been bothered by feeling down, hopeless, or depressed?
During the last month, have you often been bothered by little interest or pleasure in doing things?

Additional incentives drive the use of validated tools for the measurement of depression severity at the outset of treatment, and at a further assessment between 5 and 12 weeks after this baseline assessment (http://www.bma.org.uk/ap.nsf/Content/QoFChangesOct08). The instruments identified for this purpose within NHS primary care are the nine-item Patient Health Questionnaire, the Beck Depression Inventory, and the Hospital Anxiety and Depression Scale.

Management of mood disorders in primary care

In the UK, National Institute for Health and Clinical Excellence (NICE) guidelines for the management of depression in primary and secondary care[17] recommend a stepped care model that guides management by matching resources to the severity of the illness (Figure 2). Like Goldberg and Huxley's pathways to care model (see Figure 1), it has five steps; patients can enter the system at any level depending on the level of symptom severity, risk, and available support.

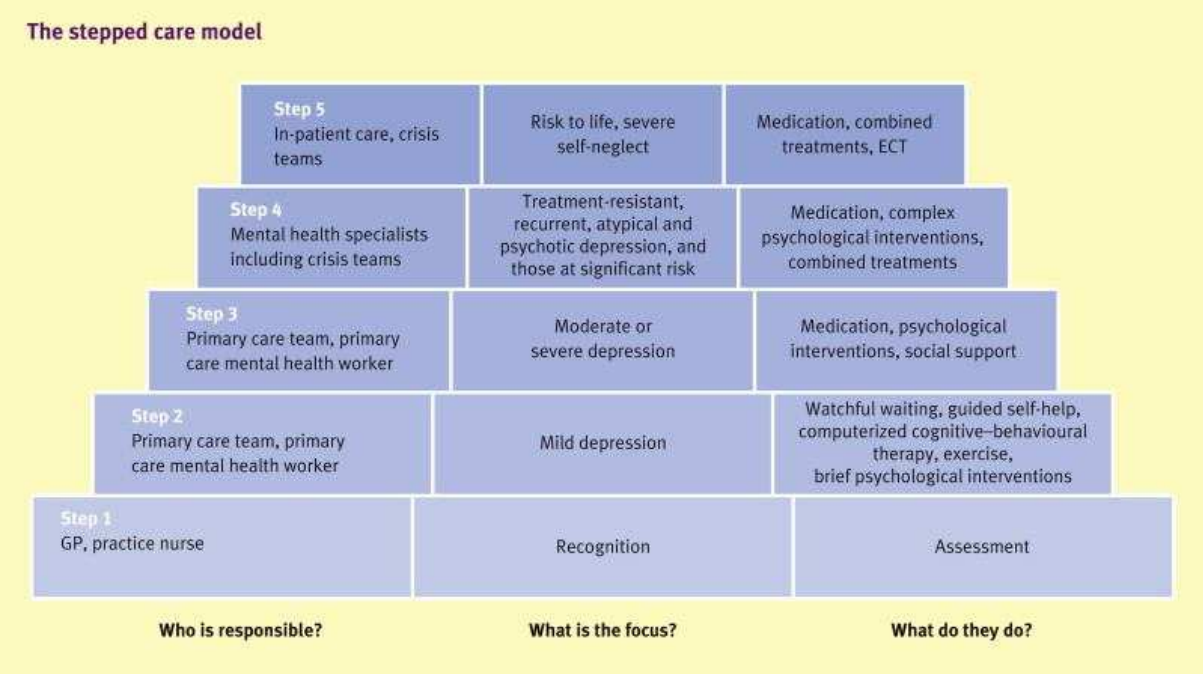

Figure 2: The stepped care model.

Management of mild depression in primary care: for mild depression, 'watchful waiting' is recommended in the first instance as these patients are likely to have higher rates of recovery without formal intervention. They should be reviewed within 2 weeks and re-assessed. Treatment strategies beneficial for patients with mild depression include exercise, guided self-help and bibliotherapy, computerized cognitive behavioural therapy (CBT), problem-solving therapy, brief CBT, and counselling. Antidepressants are not recommended in the initial treatment of patients with mild depression.

Exercise should follow a structured and supervised programme; increasingly this is becoming available 'on prescription' in the UK. Guided self-help is the process whereby limited contact with professionals, usually over 6–9 weeks, is used to facilitate and support the patient in their use of self-help literature. The self-help literature often uses a CBT approach to treatment. Availability of psychological therapies in primary care varies widely and is often limited by lack of staff trained to deliver them. One way to increase access to psychological therapy is the use of computerized CBT such as Beating the Blues® or the freely available package MoodGYM (http://moodgym.anu.edu.au). These have been found to be effective for the treatment of depression and anxiety in primary care, and are well received by patients.

Management of moderate-to-severe depression in primary care: antidepressant medications are the mainstay of treatment for moderate-to-severe depression. The NICE guidelines recommend a selective serotonin-reuptake inhibitor as a first-line antidepressant because they are less likely to cause side effects and are safer in overdose than the tricyclic antidepressants. A recently reported systematic review of antidepressant efficacy[18] attracted considerable media and professional attention because of the authors' conclusion that these medicines are effective only for the most severely depressed patients. However, although most expert commentary affirms that the drug–placebo difference decreases with decreasing severity of baseline illness, there is likely to be clinically significant benefit for patients with moderate-to-severe depression.

CBT is the psychological treatment of choice in patients with moderate-to-severe depression. This usually consists of 16 to 20 sessions over 6–9 months. For the treatment of severe depression, the guidelines recommend a combination of antidepressant medication and CBT. The Improving Access to Psychological Therapies (IAPT) programme commenced in 2006 and involves training psychological therapists and developing delivery and supervision systems to enable greater access to this treatment for people with depression and anxiety. More than £170 million has been committed to this programme, and developments are linked to the results of pilot evaluations in initial sites.

Enhanced care and the role of primary care nurses
Current primary care for mood disorders should involve the whole team within a stepped care approach, and for patients with more serious conditions chronic care principles will enhance overall care. These principles have been used effectively with a range of physical conditions, and involve a combination of service organization with information systems for effective recall and monitoring, health education, protocol-guided care, and use of community supports.

Collaborative care has been identified as the most effective organisation level strategy for depression management in primary care. The central aspect of this approach is case management delivered by practice nurses or allied health professionals, who provide regular patient follow-up (often by telephone), medication counselling to assist adherence and improved feedback to the GP. Brief training for this role and supervision are necessary and, although much of the evidence for this approach derives from US primary care,[19] encouraging results have been obtained from a recent UK study, in which case managers, as part of their role, employed a brief CBT-based psychological approach, behavioural activation that seems to have similar efficacy to more complex psychotherapies.[20] Further trials of collaborative care are underway in the UK, Europe and elsewhere.

Management of bipolar affective disorder
Bipolar affective disorder and psychotic depression are relatively uncommon in primary care. However, primary care has an important role in the management of patients with these more severe mental illnesses, usually in shared care with specialist services. GPs are well placed to monitor the physical health and treatment compliance in these patients, as well as playing an important role in monitoring progress and liaising with family members. This activity forms part of the QOF service measures for primary care management of severe mental illness in England.

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