The Management of Anxious Depression in Primary Care

David Goldberg, D.M., F.R.C.P.

Patients with combinations of anxiety and depressive symptoms form the largest group in both community and primary care, yet many remain undetected by primary care physicians and relatively few are referred to mental health professionals. This review deals with 4 issues: (1) the natural history of undetected depression, showing that, although patients have a generally good outcome, there is considerable residual disability; (2) the best management for recognized cases, with evidence that patients with more severe depression benefit from antidepressant therapy and should be followed up more systematically; (3) the indications for specialist referral—suggesting that these are dependent on the skills available in the primary care team and the ease of access to mental health professionals; (4) possible roles for psychiatrists in the management of anxious depression in primary care, concluding that in the United Kingdom link workers could act as coordinators between the psychiatrist and the primary care team, thus improving the care of severely ill patients and improving access for those thought to need specialized care. *(J Clin Psychiatry 1999;60[suppl 7]:39–42)*

Patients with combinations of anxiety and depressive symptoms form the largest group in both community[1] and primary care,[2] and relatively few are referred to mental health professionals.[3] Since a substantial minority of these disorders (45%) is not detected by primary care physicians, it becomes important to know whether the nonrecognition of some of these disorders has adverse consequences and to identify the best management for those disorders that are known to the primary care physician. Therefore, this review deals with 4 issues: whether nondetection of some of these disorders matters, the best management for recognized cases, the indications for specialist referral, and possible roles for psychiatrists in the management of anxious depression in primary care.

DOES FAILURE TO DETECT DISORDERS HAVE ADVERSE CONSEQUENCES?

In the World Health Organization (WHO) study of psychological disorders in primary health care,[3] 640 patients who satisfied International Classification of Diseases, 10th edition (ICD-10) criteria for major depressive disorder were identified and were followed up on at least 1 occasion 3 months and 12 months later. Of these cases, the primary care physicians had detected 317 and missed 323.[4] The undetected patients had less severe illnesses in every way: they had fewer symptoms as assessed by both General Health Questionnaire (GHQ) scores[5] and Composite International Diagnostic Interview (CIDI).[6] Patients had, on average, 2 depressive symptoms fewer on the CIDI ($p < .001$); they were approximately 4 years younger ($p < .004$) and had experienced their first onset of depression 4 years more recently ($p < .003$); and fewer of them had experienced episodes of depression lasting longer than 1 year. The outcome at 1 year was similar in the 2 groups: the undetected patients had fewer symptoms in proportion to their baseline levels (analysis of covariance not significant). However, the outcome for the whole group at 1 year was not particularly favorable, with 28% still clinically depressed and 48% having an ICD-10 diagnosis of a mental disorder. It is possible that an active program of detection and treatment might produce a better outcome than this, but the effect is unlikely to be a large one.

WHAT IS THE OPTIMUM TREATMENT FOR ANXIOUS DEPRESSION IN PRIMARY CARE?

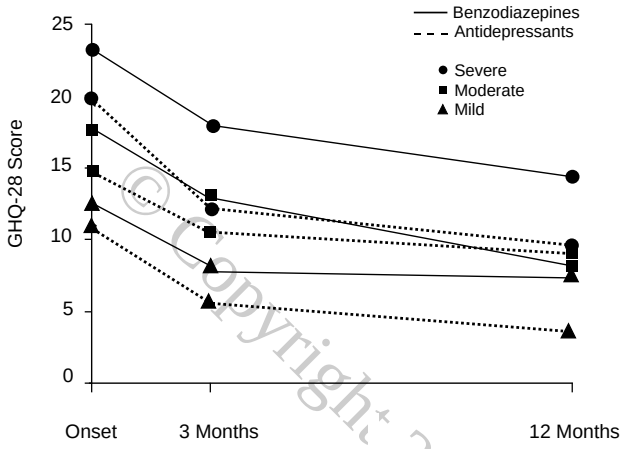
The differences in outcome between active drug and placebo are less in primary care depressions than among the more severe depressions treated in hospital by psychiatrists (those treated by psychiatrists as ambulant patients are intermediate in this respect).[7] The newer antidepressants do not produce better outcomes than the older ones,

From the Institute of Psychiatry, King's College, London, United Kingdom.

The International Consensus Group on Depression and Anxiety held the meeting "Focus on Primary Care Management of Depression," October 15–16, 1998, in Charleston, S.C. The Consensus Meeting was supported by an unrestricted educational grant from SmithKline Beecham Pharmaceuticals.

Reprint requests to: Professor Sir David Goldberg, Institute of Psychiatry, King's College, London SE5 8AF, United Kingdom.

Figure 1. Outcome of Depression Measured by the 28-Item General Health Questionnaire (GHQ-28) at 3 Time Points by Initial Severity of Depression for Those Depressions Treated With Antidepressants and Benzodiazepines[a]



[a]Data from reference 4. Mild depression = 6–9 symptoms, moderate depression = 9–12 symptoms, severe depression = 13 or more symptoms. Differences at 3 months were significant by analysis of covariance.

but side effects are fewer and compliance with recommended medication therefore better.[8] On the other hand, *Hypericum*—a drug extracted from the herb St. John's wort—also has an effect comparable to conventional antidepressants, and it also has significantly fewer side effects.[9] The Cochrane collaboration has published a number of meta-analyses of antidepressant treatment, from which it emerges that antidepressants do have significant advantages over inactive placebo and that their effect is evident not only in depressive episodes but also in dysthymia and depression accompanying physical disease.[10–12]

Recent drug trials have tended to compare active drugs either with inactive placebos or with alternative antidepressants. A meta-analysis of older trials, in which antidepressants were compared with active placebos containing small doses of atropine, failed to demonstrate efficacy of antidepressant drugs.[13] Although it seems certain that more recent trials using inert placebos exaggerate the magnitude of the antidepressant effect, it seems likely that there is still an effect with the more severe depressions. To test this possibility, the data in the WHO study were stratified by severity, and the outcome of those prescribed antidepressants was compared with the outcome of those prescribed sedatives (usually benzodiazepines).[4] This sort of natural comparison does not possess the power of a randomized, controlled trial to determine the effects of different treatments, but it is not without interest. Furthermore, there are fewer patient refusals and no exclusions (as there usually are in a randomized, controlled trial), allowing one to gain a sense of how patients respond to treatments in day-to-day clinical practice. In the WHO study, both groups of patients were exactly comparable at baseline with respect to both sociodemographic features and clinical characteristics. At 3 months, those taking antidepressants had significantly fewer symptoms on the GHQ ($F = 4.6$, $p = .04$) and on a suicide scale ($F = 4.6$, $p = .033$), but differences between the 2 groups of drugs did not persist at 1 year (analysis of covariance not significant). The latter finding is disappointing, but since the drugs were taken for only relatively short periods of time (average 10.7 weeks for antidepressants, 9.2 weeks for sedatives), the null results might be expected. When the case material was stratified by severity of depression, there was very little effect in those with milder depressions (6 to 9 depressive symptoms on the CIDI), and the greatest effect was seen in those with severe depression (> 12 symptoms) initially (Figure 1).

At 1-year follow-up, approximately 60% of both groups treated with drugs still had an ICD-10 diagnosis of a mental disorder, and a massive 50% of each group still satisfied the research diagnostic criteria for depression. From other studies, it would appear that far better results than these might have been obtained with more sustained treatment of the depression.

Psychological Treatments in Primary Care

A number of studies have reported effects comparable to those obtained with antidepressants for various kinds of psychotherapy: interpersonal psychotherapy,[14] problem solving,[15] and cognitive behavioral therapy.[16] It is noteworthy that, just as agents that have very different effects on neurotransmitters are claimed to be equally effective, psychotherapies with totally different rationales have also been shown to be effective. The psychotherapies share an important characteristic with the drugs: they are not administered against an active placebo, so the design is essentially "single blind." However, if counseling is regarded as an "active placebo" (since a number of studies [e.g., Friedli et al.[17]] have failed to show its superiority to "usual care" by the general practitioner), then Scott and Freeman[16] have shown in a small study that effects produced by antidepressants or cognitive behavioral therapy are not superior to counseling. One study has claimed that the combination of drugs and 1 form of psychotherapy—interpersonal psychotherapy—produces better outcomes at greater cost.[18]

The main drawback to any form of psychotherapy in primary care is that staff are not available to administer it in most places. Of the 3 forms that have been systematically evaluated in primary care, problem solving is the easiest to teach and has been shown to be effective when administered by practice nurses or by interested general practitioners themselves. Both other types of psychotherapy require more detailed training and are usually administered by relatively expensive mental health professionals. Computer-administered treatments are now available for depression

in primary care,[19] and several versions either are under development or are currently being evaluated (J. Proudfoot, Ph.D., oral communication, 1998).

Having said this, there are many patients who are unwilling to take drugs for their depression, who will not persist with them because of side effects, or who relapse despite drug treatment. There is also a large group who do not respond at all to drugs. All these patients may benefit from a psychological approach, provided that staff have been trained in its administration. Otherwise, referral to an appropriate mental health professional will be necessary. Patients seen in primary care often have better social support than those seen by the mental health services and may therefore be expected to recover from the episode of depression more quickly than those seen by psychiatrists.[2]

Need for Assessment of the Severity of Depression

General practitioners are often not skilled in assessing the severity of depression and may prescribe subtherapeutic doses of antidepressants for mild depressive episodes that would have remitted spontaneously. We have seen that, in general, the more severely depressed the patient, the better the evidence that antidepressants have a therapeutic effect. In mild depressions, restoration of sleep combined with the offer of supportive help with current life problems may be sufficient, with antidepressant therapy being reserved for those with depressions of moderate and severe intensity. Computer-assisted aids are available to assist the general practitioner in this task.

If antidepressants are prescribed, the patient should be given adequate dosage and, in view of the poor long-term outlook for depressed patients, should be followed up systematically. Where available, practice nurses can assist the general practitioner with this important aspect of care, as well as improve compliance with antidepressant therapy.

APPROPRIATE REFERRAL TO PSYCHIATRIC SERVICES

There is no invariable rule to determine appropriate referral to psychiatric services; it depends upon the availability of mental health professionals in a particular location, the ease of access to these professionals, and the skills available in the primary care team. In many parts of the world, primary care services are the only medical services available, meaning that primary care teams must necessarily deal with all problems. In large cities of industrialized nations, where there are typically many suitable professionals available, referral will depend on whether the patient is able to pay for any necessary treatment and if the indicated treatment cannot be supplied by the primary care team.

Treatment-resistant patients can be loosely defined as those patients who fail to respond to the best treatment available in primary care. It is usual to refer such patients, including those with a severe risk of self-harm, to a mental health professional. Patients with psychotic forms of depression, as well as those with agitated depression and bipolar illness, will also usually be referred to the mental health services, at least for initial assessment. The other indication for specialized psychological treatment is a relapse of depressive illness when the general practitioner wishes to try a treatment that may reduce the risk of subsequent relapses. Cognitive behavioral therapy has been claimed to be effective in this respect.[8,20,21]

THE ROLE OF THE PSYCHIATRIST IN PRIMARY CARE

In view of the burden that common mental disorders place upon primary care and the data which suggest that most needs associated with these disorders remain unmet,[22] it may be asked whether psychiatrists should not play a greater role in primary care. Numerous reports are available from psychiatrists who provide outpatient clinics in primary care—a practice so widespread in the United Kingdom that it has been described as "the silent growth of a new service."[23] Most patients greatly prefer being seen in such clinics than having to go to a psychiatric outpatient department, and the nonattendance rates are correspondingly much lower. Community psychiatric nurses who are caring for patients in the community commonly use these clinics to obtain a psychiatric opinion of a patient or visit the clinic's psychiatrist to report progress with other patients.

Before such a model for service could be generally adopted, there are some searching questions to be answered: first, are there enough psychiatrists to provide this service to all general practices; second, do better clinical results justify the service; and third, is this a cost-effective way of organizing psychiatric services?

There is no single answer to the first question. Even within countries, there is often great variation in the distribution of psychiatrists across the country, and differences between countries are huge.[24] In England and Wales, as there are approximately 12 general practitioners to each general psychiatrist, it would be difficult to provide even a relatively infrequent clinic in each general practice and still have time for work in the inpatient unit or community mental health center. To the extent that these clinics would provide new clinical work, this would be added to a burden that most community psychiatrists in the United Kingdom already find sufficiently heavy.

There is some doubt about whether psychiatrists can add significantly to the routine work of the general practitioner. A study by Katon et al.[25] with "distressed high utilizers" did not show an improved outcome when psychiatrists were directly involved with these patients, while a

later study by Katon et al.[26] showed that only severe depressions benefited from extra joint sessions with both psychiatrist and general practitioner.

There is no doubt that costs are greatly increased when mental health professionals are involved in the routine treatment of depressions in primary care. Scott and Freeman[16] showed that costs of antidepressant therapy from a psychiatrist, cognitive behavioral therapy from a psychologist, or counseling from a social worker were all very much greater than "usual care" exemplified by short sessions with a general practitioner using a tricyclic antidepressant. Only the social worker produced better outcomes than the other 3 treatments, but numbers were small.

In view of these considerations, Goldberg and Gournay[27] have suggested that there should be link workers between community mental health teams and primary care teams, and that these workers should be looking after all patients known to that particular practice who have severe mental disorders (psychotic illnesses and dementias). In this way, coordination between the 2 teams in the care of severely ill patients could be improved, and the link worker could improve access to care from other members of the team for those thought to need specialized care. There is no reason why psychiatrists should not continue to offer clinics in primary care settings—seeing patients who have been selected by general practitioners because their specialist advice is required—but we have yet to demonstrate that psychiatrists have much to offer cases of mild anxious depression.

REFERENCES

1. Office of Population Censuses and Surveys (OPCS). The Prevalence of Psychiatric Morbidity Among Adults Living in Private Households. Report 1. London, England: HMSO; 1995
2. Goldberg DP, Huxley PJ. Common Mental Disorders: A Biosocial Model. London, England: Routledge; 1992:23
3. Üstün TB, Sartorius N, eds. Mental Illness in General Health Care. An International Study. Chichester, England: John Wiley & Sons; 1995
4. Goldberg DP, Privett M, Üstün TB, et al. The effects of detection and treatment on the outcome of major depression in primary care: a naturalistic study in 15 cities. Br J Gen Pract 1998;48:1840–1844
5. Goldberg DP, Williams P. A User's Guide to the GHQ. Windsor, England: NFER; 1988
6. Robins LN, Wing JK, Wittchen H-U, et al. The Composite International Diagnostic Interview: an epidemiological instrument suitable for use in conjunction with different diagnostic systems and in different cultures. Arch Gen Psychiatry 1988;45:1068–1077
7. Clinical Practice Guideline Number 5: Depression in Primary Care. Treatment of Major Depression. Rockville, Md: US Dept Health Human Services, Agency for Health Care Policy and Research; 1993. AHCPR publication 93-0551
8. Simon GE, VonKorff M, Heiligenstein JH, et al. Initial antidepressant choice in primary care: effectiveness and cost of fluoxetine vs tricyclic antidepressants. JAMA 1996;275:1897–1902
9. Linde K, Ramirez G, Mulrow CD, et al. St John's wort for depression: an overview and meta-analysis of randomised clinical trials. BMJ 1996;313: 253–258
10. Song F, Freemantle N, Sheldon TA, et al. Selective serotonin reuptake inhibitors: a meta-analysis of efficacy and acceptability. BMJ 1993;306: 683–687
11. Hazell P, O'Connell D, Heathcote D, et al. Efficacy of tricyclic drugs in treating child and adolescent depression: a meta-analysis. BMJ 1995;310: 897–901
12. Hotopf M, Lewis G, Normand C. Putting trials on trial: the costs and consequences of small trials in depression: a systematic review of methodology. J Epidemiol Public Health 1997;51:354–358
13. Moncrieff J, Wessely S, Hardy R. Meta-analysis of trials comparing antidepressants with active placebos. Br J Psychiatry 1998;172:227–231
14. Schulberg HC, Block MR, Madonia MJ, et al. Treating major depression in primary care practice: eight-month clinical outcomes. Arch Gen Psychiatry 1996;53:913–919
15. Mynors-Wallis L, Gath D. Predictors of treatment outcome for major depression in primary care. Psychol Med 1997;27:731–736
16. Scott A, Freeman C. Edinburgh primary care depression study. BMJ 1991; 304:883–887
17. Friedli K, King MB, Lloyd M, et al. Randomised controlled assessment of non-directive psychotherapy versus routine general practitioner care. Lancet 1997;350:1662–1665
18. Sturm R, Wells KB. How can care for depression become more cost-effective? JAMA 1995;273:51–58
19. Selmi PM, Klein MH, Greist JH, et al. Computer-administered cognitive-behavioral therapy for depression. Am J Psychiatry 1990;147: 51–56
20. Blackburn I, Bishop S, Glen AI, et al. A two year naturalistic study of depressed patients treated with cognitive therapy and pharmacotherapy; each alone and in combination. J Affect Disord 1986;10:181–189
21. Evans MD, Hollon SD, DeRubeis RJ, et al. Differential relapse following therapy and pharmacotherapy for depression. Arch Gen Psychiatry 1992; 49:802–808
22. Bebbington P, Marsden L, Brewin CR. The need for psychiatric treatment in the general population: the Camberwell Needs for Care Survey. Psychol Med 1997;27:821–834
23. Strathdee G, Williams P. A survey of psychiatrists in primary care: the silent growth of a new service. J R Coll Gen Pract 1984;34:615–618
24. Goldberg DP, Thornicroft G. Mental Health Services in Our Future Cities. Maudsley Monograph No 42. Hove, England: Psychology Press; 1998:273
25. Katon W, Von Korff M, Lin E, et al. Distressed high-utilizers of medical care: DSM-III-R diagnoses and treatment needs. Gen Hosp Psychiatry 1990;12:355–362
26. Katon W, Robinson P, Von Korff M, et al. A multifaceted intervention to improve treatment of depression in primary care. Arch Gen Psychiatry 1996;53:924–932
27. Goldberg DP, Gournay K. The General Practitioner, The Psychiatrist and the Burden of Mental Health Care. London, England: Institute of Psychiatry; Maudsley Discussion Paper No 1; 1998