Underrecognition of Anxiety and Mood Disorders in Primary Care: Why Does the Problem Exist and What Can Be Done?

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Despite current debate on the methodology of existing research into depression and anxiety disorders, there is still general agreement that recognition rates of these conditions in primary care could be improved. This review examines the factors that influence recognition of these disorders from both the patients' perspective and the primary care givers' perspective. Approaches and methods for improving recognition in primary care, including guidelines, mental health skills training, screening, and increasing public awareness, are considered in detail. *(J Clin Psychiatry 2007;68[suppl 2]:27–30)*

Primary care physicians (PCPs) are at the forefront in dealing with patients with mental health problems: it has been reported that > 90% of patients with mental health problems are treated solely in primary care.[1,2] The World Health Organization study on Psychological Problems in General Health Care (PPGHC), which was standardized across 14 countries, found that 26% of individuals visiting their PCP had at least 1 psychiatric disorder as defined by the *International Classification of Diseases*, Tenth Revision (ICD-10) criteria.[3] Moreover, 17% of these patients had current depression. Depression affects between 5% and 15% of consecutive attenders in primary care.[4–6] Recent published data from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project estimated that 13.4% of primary care patients suffered from major depression across 6 European countries.[7,8]

After depression, generalized anxiety disorder (GAD) is the most common mental health problem in primary care.[9] Data from the PPGHC study showed that GAD had a prevalence of 8.5% in primary care, with 44% of cases having associated depression.[10,11] Agoraphobia and panic disorder were less common, with prevalence of 1.5% and 2.2%, respectively.[10,11] Further ESEMeD data showed a lifetime prevalence of 2.8% for GAD, 0.8% for agoraphobia, and 1.6% for panic disorder.[7] The proportion of individuals with GAD in the previous 12 months having a comorbid disorder was 76.0% in the ESEMeD survey.[8,12]

LACK OF RECOGNITION OF DEPRESSION AND ANXIETY IN PRIMARY CARE

The PPGHC study found that 49% of patients who were identified as having major depression on the basis of research diagnostic instruments had not been recognized by PCPs.[3] Other cross-sectional studies have found similar results of between 30% and 50% of people with depression being recognized by PCPs.[5,6,13–19]

Low recognition rates have also been found for anxiety disorders in primary health care. Wittchen et al.[20] found recognition rates of GAD by PCPs of 34.4% for pure GAD and 43% for GAD with comorbid depression. Similarly, only 24% of patients with social phobia were diagnosed with an anxiety disorder by their PCPs. However, 60% of people with social phobia seen in primary health care were actively receiving psychotropic medication, mostly in the context of comorbid depression.[20]

Interestingly, ESEMeD data show that of those patients consulting any type of formal health service in the previous 12 months, 15.1% with a mood disorder and 23.2% with any anxiety disorder did not receive either psychotropic drugs or psychological treatment.[7]

EXPLAINING THE UNDERRECOGNITION OF ANXIETY AND DEPRESSION IN PRIMARY CARE

A number of factors may help explain the apparent underrecognition of anxiety and depressive disorders in

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primary care. Does research accurately reflect and model the complexities of recognition in primary care? Many PCPs think it does not and feel unjustly criticized. Taking a cross-sectional "snapshot" of the prevalence of unrecognized depression and anxiety may indeed overestimate the prevalence, as cross-sectional studies fail to reflect the longitudinal nature of primary care that allows patients to be diagnosed on subsequent visits.[21,22] Indeed, when a longitudinal perspective is taken, 30% remain undetected at 1 year and 14% at the end of 3 years.[23,24] Also, depression that is unrecognized by PCPs is often at the milder end of the spectrum and may be more likely to improve spontaneously.[18,19,25–27] Despite these disclaimers, there remains general agreement that recognition rates of anxiety and depression in primary care can be improved. Both patient and PCP factors are important in determining whether depression or anxiety is correctly recognized.

Particular patient characteristics have been found to impact the recognition of depression in primary care. Women are more likely to be assessed as having mental health problems by male PCPs[28]; however, this may have more to do with the PCP than the patient, and, more recently, Gater et al.[29] found that sex did not affect the likelihood of depression or anxiety being detected. Marks et al.[28] also found that being middle-aged, unemployed, bereaved, separated, or white increased the likelihood of depression being recognized. Men with depression may be underrecognized because, although being functionally impaired, they often have fewer classical symptoms than women with depression.[30] Other factors that have been found to increase the likelihood of recognition are a past history of depression, older age groups, patients who present with psychological and social problems, and patients who suffer from other psychiatric illnesses.[26,31]

Another factor that complicates the recognition of depression and anxiety in primary care is somatization.[32] Patients often present with physical symptoms rather than psychological complaints and are less likely to be recognized as depressed or anxious.[14] Over 70% of patients with depression and anxiety have somatic presentations.[33] How patients attribute the cause of depression or anxiety also affects recognition; people who attribute a psychological cause are more likely to be recognized. Patients who normalize or minimize their symptoms are less likely to be identified.[34] Stigma, too, may be associated with underrecognition and may account for up to 45% of people failing to report emotional problems to their doctor.[35]

There is a wide variation in the ability of PCPs to diagnose mental health problems, due largely to differences in knowledge, skills, and attitudes.[13,36] Lengthening the consultation does not appear to improve recognition, probably because it does not affect these factors.[28,37] However, empathy, an interest in psychiatry, and asking about family and problems at home increase recognition of mental illness, while preoccupation with organic illness decreases it.[38] PCPs' attitudes toward depression do not seem to affect recognition, although they do affect perceived ease of management by the PCP.[39]

IMPROVING DETECTION RATES

Improving the recognition of depression and anxiety in primary care has been the focus of a substantial amount of research. A wide variety of approaches has been tried, ranging from national campaigns, educational strategies, clinical guideline introduction, screening, and local "bottom-up" initiatives.

It appears that national campaigns have limited impact on detection and recognition rates. A 5-year national campaign in the United Kingdom, run jointly by the Royal College of Psychiatrists and Royal College of General Practitioners, achieved modest gains, with only 40% of PCPs having made a difference to their practice as a result of the campaign and no changes in the public's perception of antidepressant medication as addictive and less therapeutic than counseling.[40,41]

Mental health skills training has been effective in improving recognition and management of somatizing and depressed patients by PCPs, but it remains uncertain whether this translates into improved clinical outcomes.[42–44] Clinical guidelines, often combined with educational initiatives, have received increasing interest as a way of improving recognition and outcome. Initially, there was optimism for this approach, as Rutz et al.[45] showed that suicide rates decreased and antidepressant prescription increased after an educational program for PCPs consisting of a 2-day course delivered by psychiatrists. However, the study was flawed and the results have not been replicable, while efforts to improve recognition using clinical guidelines alone have also failed.[46] In the United Kingdom, the Hampshire Depression Project was designed to assess whether a combination of training and clinical guidelines would improve recognition and clinical outcomes for depressed primary care patients.[47] Despite an extensive educational program, there was no effect on detection or clinical outcomes.

Screening patients in primary care for depression and anxiety is a possible method of improving recognition and clinical outcomes. Feeding back the results of screening to PCPs appears to improve recognition and management of depression, but there is wide variation in improvement between studies. Screening appears to work best when implemented as part of a multifaceted system of depression care, and immediate feedback seems more effective than delayed feedback.[48] In contrast, a prospective study in the United Kingdom found that disclosing to the PCP the identity of those who screened positive for depression led to a worse outcome for this group than for those who remained unrecognized.[25] A systematic review of screening and feedback on recognition and outcome of

depression found that only feedback of high risk cases increased the rate of recognition.[49] Despite this, both the United States Preventive Services Task Force[50] and, in the United Kingdom, the National Institute for Clinical Excellence[27] have recommended that PCPs screen patients for depression. Screening is, however, likely to be of benefit only when used as part of a systematic approach to the management of depression.[51]

WHAT WORKS IN PRIMARY CARE?

Collaborative Care

A number of studies have demonstrated improved recognition and clinical outcomes by enhancing the whole process of depression management in primary care.[52–56] Katon et al.[52] used a collaborative-care model that consisted of an extensive educational campaign and training in the implementation of treatment guidelines over a 1-year period, comanagement of patients by the PCP and psychiatrist, and reorganized service structures to enhance the role of PCPs. They demonstrated an increased adequacy of antidepressant prescribing, improved clinical outcomes, enhanced patient satisfaction, and an increased sense of effectiveness and satisfaction among PCPs in treating depression. However, the educational effect did not persist after the program was discontinued, suggesting that organizational restructuring is a vital part of improving outcomes.[57] Although there is less evidence for similar approaches to anxiety management, a collaborative-care model was shown to enhance outcomes for patients suffering from panic disorder with no increase in costs.[58,59]

Other Approaches

It is likely that a combination of "top-down" and "bottom-up" approaches is needed to adequately address the problem of low detection of depression and anxiety in primary care. Initiatives must be tailored to meet local needs and this may be best accomplished within a stepped-care model. The National Institute for Mental Health in England, as part of the Modernisation Agency of the Department of Health, has developed a Primary Care Program that may help.[60,61] The programs include staff development (core skills training and mental health "champion" development), commissioning and developing effective partnerships, and empowering primary care users. As part of this program, "Trailblazer" courses are being run to develop local mental health "champions."[62,63] More than 600 participants have already been through these courses in the United Kingdom, and similar courses are being developed in New Zealand, Australia, and the United States. The modular courses are designed to elicit learning needs and provide mental health skills training. They are multiprofessional, and participants attend in pairs: 1 participant from primary care, their course partner from secondary care. This design fosters close collaborative relationships between primary and secondary care and helps to develop innovative services that best meet the needs of the patient population.

A potentially important part of improving recognition of depression and anxiety is increasing public awareness. Patients with GAD, for instance, frequently fail to associate their symptoms with a psychological disorder.[20] Although large national campaigns have been disappointing in changing public perception of mental health problems, at a local level, primary care services may play an important part by implementing mental health awareness programs. "Expert patients" can help define the most useful strategies for improving mental health awareness within their community and encourage people to seek help.

CONCLUSION

The problem of improving recognition of depression and anxiety in primary care is unlikely to be solved by a single intervention. Indeed, the extent to which underrecognition is a problem remains controversial and it has been argued that efforts to improve recognition have to ensure that they do not increase the number of false-positive diagnoses and lead to unnecessary treatment.[64] To improve the overall care of people with depression and anxiety, multifaceted interventions are necessary that combine "bottom-up" approaches, such as mental health skills training as part of a needs-led multidisciplinary teaching program, adapting nationally derived guidelines to meet local service needs, and local practice-based mental health awareness initiatives, with "top-down" approaches, including the development of national guidelines, educational campaigns to decrease stigma and raise awareness, and the dissemination of evidence-based best practice. Ultimately, efforts to improve recognition must be addressed within the wider context of enhanced care processes for the management of anxiety and depression.[65]

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