The Management of Anxious Depression in Primary Care

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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.
but side effects are fewer and compliance with recommended medication therefore better. 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. 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.

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. 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). 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, problem solving, and cognitive behavioral therapy. 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 Freeman16 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.

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, 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.

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.

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, 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.” 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. 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., 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. 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 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 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