Consensus Statement on the Benefit to the Community of ESEMeD (European Study of the Epidemiology of Mental Disorders) Survey Data on Depression and Anxiety

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Objective: To provide an overview of the importance of the data generated by the European Study of the Epidemiology of Mental Disorders (ESEMeD), which found that prevalence and burden of mood and anxiety disorders were high and that care of individuals with mental disorders was suboptimal. Thus, ESEMeD data, based on 21,425 noninstitutionalized adults from Belgium, France, Germany, Italy, the Netherlands, and Spain who underwent computer-assisted personal interviews, confirmed previous findings from epidemiologic studies performed in other locations. In addition, how this large and unique dataset may be utilized for maximum benefit to patients is outlined. ***Participants:*** The co-chairmen David J. Nutt, M.D., Ph.D., and Ronald C. Kessler, Ph.D., invited 6 faculty members to participate: Jordi Alonso, M.D., Ph.D.; Alastair Benbow, M.B., M.R.C.P.I.; Yves Lecrubier, M.D.; Jean-Pierre Lépine, M.D.; David Mechanic, Ph.D.; and André Tylee, M.D. ***Evidence:*** The consensus statement is based on the 6 review articles published in this supplement, which include ESEMeD data and data from pertinent scientific literature. ***Consensus Process:*** The faculty met over a 2-day period: day 1 included discussion of the review articles, during which the chairmen identified issues for further debate; day 2 included discussion of key issues to arrive at a consensus view. The consensus view was drafted by the chairmen and approved by all attendees. ***Conclusions:*** ESEMeD provides a very important opportunity to improve knowledge on the epidemiology of mood and anxiety disorders. Despite a decade of educational initiatives, the diagnosis and treatment of mood and anxiety disorders remain suboptimal. Lack of awareness and stigma surrounding mental illness, variations in physicians' ability to diagnose and treat psychiatric conditions, and physician time pressures all contribute to the problem. Future education initiatives should include patients, primary care physicians, employers, and health policy influencers. Patients with mood and anxiety disorders may benefit from targeted antidepressant treatment, which should optimize the chance of patients' receiving appropriate therapy. In addition, depending on the patients' circumstances, psychotherapy, counseling, or social support may also be initiated.

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Mood and anxiety disorders represent a serious health care problem due to their high prevalence in the community and high costs to both individuals and society. Although important insights into the prevalence and burden of these psychiatric conditions can be derived from large-scale general population epidemiology surveys, any potential benefit of such studies to patients or society can be realized only if the data are easily understood, practically applied, and widely disseminated. Unfortunately, previous studies have failed to provide this information. For example, the World Health Organization (WHO) Psychological Problems in General Health Care (PPGHC) study focused only on primary care,[1] whereas the Depression Research in European Society (DEPRES) study explored only a limited diagnosis range in a nonrepresentative population sample.[2]

The European Study of the Epidemiology of Mental Disorders (ESEMeD) project was designed to collect important data on the prevalence and burden of, and care of

Table 1. ESEMeD—A Unique Epidemiology Survey

Features Unique to ESEMeD
Use of DSM-IV diagnostic criteria
Expanded set of disorders, including PTSD, Axis II disorders, and separation anxiety
Data on severity (clinical severity measures for each disorder, eg, HAM-D score for depression, YBOCS score for OCD)
Data on impairment (functional disability and impairment assessed using the SF-12 and the WHO-DAS-II)
Data on duration of disorder and treatment
Data on quality of treatment and treatment barriers
Other Features Studied
Age (data in the elderly)
Sex
Country
Treatment
Comorbidity with medical and psychiatric conditions

Abbreviations: ESEMeD = European Study of the Epidemiology of Mental Disorders, HAM-D = Hamilton Rating Scale for Depression, OCD = obsessive-compulsive disorder, PTSD = posttraumatic stress disorder, SF-12 = 12-item Short Form Health Survey, WHO-DAS-II = World Health Organization Disablement Assessment Schedule II, YBOCS = Yale-Brown Obsessive Compulsive Scale.

individuals with, mental disorders across Europe.[3] Data were collected from representative samples of the adult population in 6 countries: Belgium, France, Germany, Italy, the Netherlands, and Spain. If the sample size (> 21,400 individuals), the range of mental disorders assessed, and the comprehensiveness of the data collected are considered, ESEMeD is one of the largest population-based epidemiologic studies in mental health conducted to date. The ESEMeD project was the result of the joint effort of investigators from several European countries and the WHO and was funded by the European Union Commission and GlaxoSmithKline Pharmaceuticals (Research Triangle Park, N.C.).

In September 2003, a roundtable meeting of experts in the fields of psychiatry and epidemiology, including ESEMeD Scientific Committee members, was held to discuss the first data set generated by ESEMeD and its relevance to primary care physicians, psychiatrists, patients, caregivers, health care policy makers, and employers. This article represents the consensus of the panel on the state of current knowledge on the prevalence and burden of mood and anxiety disorders and their recognition and treatment. The role of ESEMeD in addressing the unmet need in terms of the underrecognition and undertreatment of mood and anxiety disorders was also discussed. Finally, various education and health care initiatives were proposed to improve the diagnosis and care of patients with depression and anxiety.

EPIDEMIOLOGIC SURVEYS

Epidemiologic surveys of psychiatric disorders have been undertaken in one form or another since the middle of the 19th century. Early surveys combined clinical and screening interviews, but there was little consensus on the true prevalence of a specific mental disorder due to the lack of standardized diagnostic criteria. The introduction of the *International Statistical Classification of Diseases and Related Health Problems*, Tenth Revision (ICD-10)[4] and *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition (DSM-III) criteria[5] provided the consistency needed to collect rigorous epidemiologic data. However, most epidemiologic studies were conducted in isolated countries, with differences in methodologies making comparisons difficult. For example, some European studies used ICD-10 criteria for diagnosis, whereas studies in the United States tended to use DSM criteria. International studies have concentrated on particular disorders and thus have not involved a comprehensive collection of data but rather have tended to focus mainly on prevalence data.

ESEMeD

ESEMeD has a number of unique features that make it a valuable source of epidemiologic data (Table 1). It is the first European survey to use DSM-IV criteria[6]; simultaneous inclusion of the ICD-10 enables direct comparison between the 2 diagnostic instruments. Another innovation was the fact that this survey assessed a wider spectrum of disorders than previous studies because it also included posttraumatic stress disorder (PTSD), Axis II disorders, and separation anxiety. Moreover, in addition to measures included in previous surveys (data on comorbidity, gender, age, and country), ESEMeD also collected data that had not previously been assessed, including data on severity, impairment, duration, quality of treatment, and barriers to treatment.

Also, in contrast to most previous studies, data were collected on the entire adult population, including those aged 65 years and over. The sampling methodologies, comprehensive psychiatric instruments, and quality control procedures used rendered the ESEMeD database a unique and important source of information.[7] The ESEMeD prevalence estimates are generally lower than those found previously, perhaps due to the fact that ESEMeD data were based on DSM-IV and a revised version of the Composite International Diagnostic Interview and thus yield better estimates.[8] However, Carta and Angst[9] stated that the prevalence rate may be underestimated in studies in which epidemiologic data are derived from interviews performed by lay staff since these data reflect only the patients' point of view; thus, Carta and Angst believe that the diagnostic gold standard should not be determined by data obtained by interview alone. Furthermore, although the ESEMeD sample was restricted to only the noninstitutionalized population, the institutionalized population would be insignificant among such a large sample.

The first data from ESEMeD show that, of subjects surveyed (N = 21,425), 14.7% had a lifetime history of any mood disorder and 14.5% had a lifetime history of any anxiety disorder.[10,11] National surveys in the United States,[10,12]

Australia,[13] and the Netherlands[14] have also found the prevalence of psychiatric disorders in the general population to be high. For example, in 2001–2002, the U.S. National Comorbidity Survey Replication study (NCS-R) found the lifetime prevalence of major depressive disorder (using DSM-IV criteria) to be 16.2%.[10] A high degree of comorbidity of depression with other psychiatric disorders was apparent from these surveys.[10,13,14] ESEMeD also found high levels of psychiatric comorbidity; for example, 54.2% of subjects with major depression experienced at least 1 other mental disorder within the past year.[11,15] In addition, in the NCS-R, the majority (72.1%) of patients with lifetime major depression also had a comorbid psychiatric disorder.[10]

UNDERRECOGNITION OF DEPRESSION AND ANXIETY IN PRIMARY CARE

Despite the high prevalence of mood and anxiety disorders, studies have found poor levels of recognition of these disorders in primary care. For example, the WHO study on psychological problems in general health care found that 49% of patients identified as suffering from major depression had not been diagnosed by their primary care physician.[16] Similarly low recognition rates have also been found for anxiety disorders.

Barriers to the Recognition of Depression and Anxiety in Primary Care

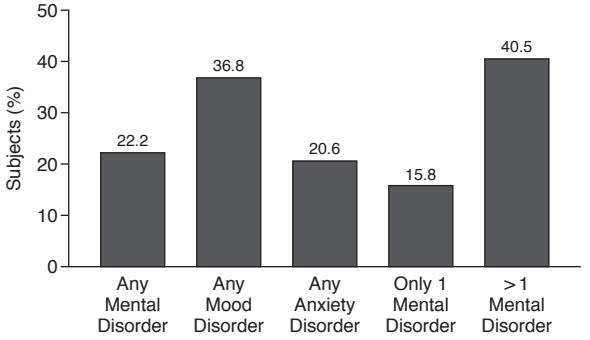
The reasons for the low rates of recognition of mood and anxiety orders in primary care are complex and can be broadly classified as those pertaining to the patient and those pertaining to the physician.

It is well known that patients who do not complain of psychological symptoms or severe functional impairment are much less likely to be diagnosed as having a psychiatric disorder than those who present with psychological or functional problems.[17–20] However, lack of awareness and the high level of stigma surrounding mental health problems among the general population mitigate against their presenting to primary care with psychological symptoms. Some patients are in denial of the presence of psychological symptoms, and many either do not report them or assume that what they are experiencing is normal given their life experiences. Indeed, ESEMeD data show that 63.2% of patients with mood disorders and 79.4% of patients with anxiety disorders did not seek help from formal health care services in the previous 12 months (Figure 1).[11,21]

Physical symptoms are the most common presenting symptoms at the onset of a psychiatric disorder, and the physician is faced with the challenge of distinguishing physical and psychological symptoms in order to make a diagnosis. Although the presence of multiple (more than 3 or 4) unexplained somatic symptoms is likely to be indicative of a psychiatric disorder, it has an adverse effect on the recognition of depression,[22] probably because emotional symptoms are low on the list of reported symptoms of patients who are somatizers.[23] Patients reporting pain and fatigue and patients who are frequent attenders are also likely to have a psychiatric condition. Physicians should consider impairment, symptom severity, and duration of symptoms while making their diagnosis. Men who are functionally impaired by depression have fewer depressive symptoms than women, which could have a negative impact on the detection of depression in men.[24] Comorbid psychiatric conditions or physical illness may further confound the diagnosis of mood and anxiety disorders. Moreover, patients frequently believe that depression is a normal mood fluctuation and often attempt to normalize their symptoms, complicating the diagnosis.[25]

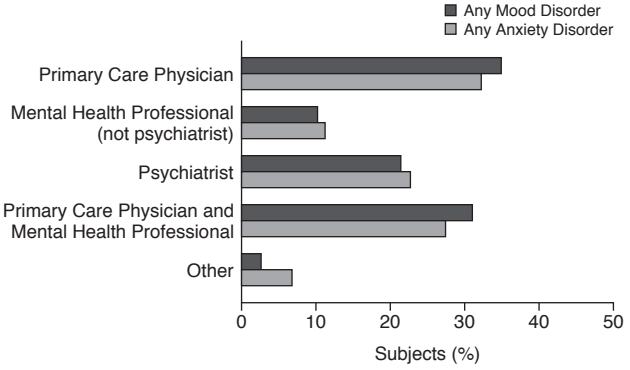
There is considerable variation in the ability of primary care physicians to diagnose mental health problems, which relates to differences in knowledge about, skills concerning, and attitudes toward mental illness. Primary care physicians are also under considerable time constraints, which may increase the likelihood of misdiagnosis of a psychiatric condition since these conditions may take relatively longer to diagnose. Some physicians also lack confidence in managing psychiatric disorders, often due to the limited training received in this area, and so may be averse to diagnosing a disorder they feel unable to treat adequately. Primary care physicians also appear to be reluctant to diagnose young people with a potentially chronic disorder such as depression. In addition, once a diagnosis is made, comorbidities tend not to be probed for. However, the prescription of an appropriate antidepressant agent may minimize the effect of this problem, although the recent concerns regarding the adverse effects of antidepressant treatment of patients with undetected bipolar disorder indicate that care must be taken. While ESEMeD did not assess bipolar disorder, clinicians must inquire about personal and family history regarding bipolar disorder prior to prescribing an antidepressant without a mood stabilizer. In addition, both cognitive-behavioral and interpersonal

Figure 1. Proportion of Individuals, by Illness Group, Consulting Any Type of Formal Health Care Service in the Previous 12 Months (Part II sample N = 8796)[a]



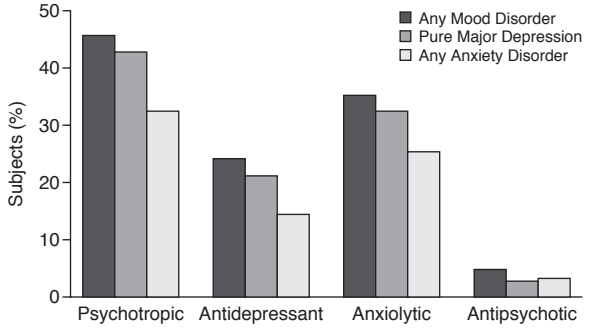
[a]Data from Alonso et al.[11,21]

Figure 2. Subjects With Any Mood or Anxiety Disorder Who Consulted Any Formal Health Care Services in the Previous 12 Months by Service Type (total N = 21,425)[a]



[a]Data from Alonso et al.[11,21]

Figure 3. Proportion of Patients With Any Mood Disorder, Pure Major Depression, or Any Anxiety Disorder Treated With Any Psychotropic, Antidepressant, Anxiolytic, or Antipsychotic Drug in the Last 12 Months (total N = 21,425)[a]



[a]Data from Alonso et al.[28]

psychotherapies are effective in treating anxiety and mood disorders and in some cases when used in combination with medication are more efficacious than either medication or psychotherapy alone.[26,27]

UNDERTREATMENT OF MOOD AND ANXIETY DISORDERS

Data from ESEMeD indicate that mood and anxiety disorders are still undertreated,[28] supporting data from previous worldwide epidemiologic studies. Only a small proportion (22.2%) of individuals with mood, anxiety, or alcohol disorders surveyed in ESEMeD had sought help, and this help was mostly from a primary care physician or a mental health professional (Figure 2).[11,21] The percentage of patients with mood or anxiety disorders who presented to a health care professional but then did not receive any treatment was surprisingly high at 20.7%.[11,21] Further, patients were often not prescribed appropriate therapy; for example, only 21.2% of patients with pure major depression received an antidepressant drug (Figure 3).[28] (See also the article by Alonso and Lépine,[11] this supplement.) Even when pharmacologic treatment was prescribed, many patients received inappropriate treatment, such as an anxiolytic agent alone for major depression (18.4%).[28]

Noncompliance is a further potential barrier to patients' receiving appropriate therapy for the required duration. Patients may stop taking medication if they think that it is causing even a mild side effect, such as constipation or diarrhea, even though these usually will resolve quickly if treated. In addition, many patients stop their treatment as soon as they start to feel better, thus maximizing the risk of relapse. The need to continue treatment to prevent relapse must therefore be communicated at diagnosis.

CONSEQUENCES OF UNDERRECOGNITION AND UNDERTREATMENT OF MOOD AND ANXIETY DISORDERS

Mood and anxiety disorders are associated with high levels of morbidity and increased mortality. Patients with mood and anxiety disorders experience significant impairment in their daily functioning,[29] which means they often have poorer social and physical functioning than patients with chronic physical illnesses, such as diabetes and congestive heart failure.[30,31] Indeed, it is predicted that by 2020, major depression will become the second most disabling medical condition worldwide (after ischemic heart disease).[32] In addition, depression and anxiety are frequently comorbid with, and may exacerbate, physical illnesses.

ESEMeD data confirm that psychiatric disorders are associated with a significant level of functional disability.[33] The disorders found to be associated with the highest disability risk (as measured by the mean work lost days score during 30 days) were agoraphobia, PTSD, panic disorder, and generalized anxiety disorder (Figure 4). Major depression, specific phobia, and social anxiety disorder were also associated with high functional disability (Figure 4). Furthermore, the mean work lost days (WLDs) for any mood disorder (23) and any anxiety disorder (19) were greater than those for chronic physical conditions, such as heart disease (18) and diabetes (12). ESEMeD also found that the more comorbid psychiatric disorders that are present, the greater the disability experienced by the individual. Furthermore, disability for an individual with major depression and comorbid agoraphobia was greater than for an individual with major depression and comorbid arthritis.[11,33]

The burden associated with depression and anxiety disorders not only significantly affects the quality of life of patients, but also has a huge impact on society, including economic costs (discussed in more detail below). Thus, it is important to address the underrecognition and undertreatment of these disorders.

THE ROLE OF ESEMED IN ADDRESSING THE UNMET NEED

Despite more than a decade of education initiatives, data from ESEMeD show that the diagnosis and treatment of mood and anxiety disorders are still suboptimal. Some progress has been made in the care of these patients, largely due to the availability of improved treatment options. The selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs) are recommended as first-line treatment since they are effective and well tolerated and are consequently increasingly prescribed. In addition, the SSRIs and SNRIs are effective against some of the comorbid psychiatric disorders as well as the primary diagnosis. However, depending on the severity, duration, patient behavior, and preferences, counseling may also be an appropriate first-line treatment.

ESEMeD provides an unprecedented amount of data on mood and anxiety disorders in the European general population. Data from ESEMeD on the prevalence, underrecognition, and undertreatment of these disorders agree with previous studies conducted worldwide. Therefore, findings derived from ESEMeD may also be applicable worldwide. Following review of the ESEMeD data and discussion of the reasons for the suboptimal diagnosis and treatment of mood and anxiety disorders, we identified 4 key areas in which the vast ESEMeD database could be used to provide a greater understanding of the problems relating to diagnosis and treatment (Table 2). However, it should be noted that the criteria used in ESEMeD differ from those used in assessing patients for treatment, for in the latter case factors including duration, associated disability, and presence of stressor all need to be determined.

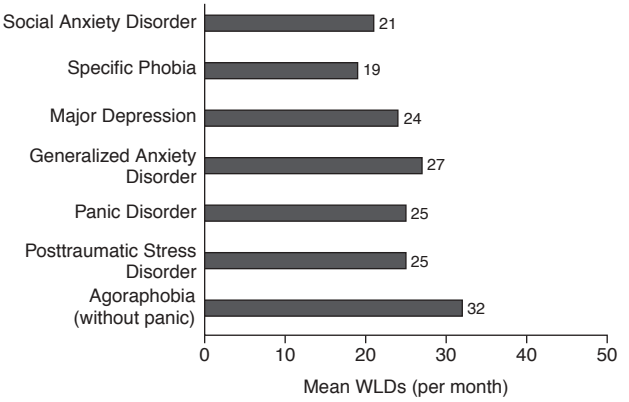
Identification of Types of Patients That Would Most Benefit From Diagnosis and Intervention

Data could be provided from ESEMeD on the severity of illness and associated impairment to identify the type of patients it is most important to treat. Identification of these patients would release the health care team—particularly primary care physicians—from feeling that every patient should be questioned about his or her mental health. Data showing the benefit for individuals and society of appropriately treating patients with severe depression and/or anxiety would also be of value.

Prevention of Dropout

Society and patients need to understand that effective treatments for mood and anxiety disorders are available. It would therefore be of interest to discover how much "inappropriate" treatment of depression and anxiety across the ESEMeD database was a result of patients' stopping treatment. Analysis of what treatment was prescribed and for how long compared with what was taken by patients would be of value, as would an assessment of the comorbidity of mood and anxiety disorders with physical illness and the extent that this affects severity of illness and impairment.

Figure 4. Mean Work Lost Days (WLDs) Per 30-Day Period Due to Mental Disorder During 12 Months (Part II sample N = 8796)[a]



[a]Data from Alonso et al.[11,33]

Table 2. Key Areas in Which ESEMeD Can Increase Understanding of the Unmet Need for Improved Recognition and Treatment of Depression and Anxiety Disorders

Key Area	Target Audience
Identification of patients	Health care team (including primary care physicians, other physicians, psychiatrists, and nurses)
Prevention of dropout	Patients, media
Appropriate treatment	Health care team (including primary care physicians, other physicians, psychiatrists, and nurses), patients, media
Economic issues	Large employers, health policy influencers, media

Abbreviation: ESEMeD = European Study of the Epidemiology of Mental Disorders.

Appropriate Treatment

Education of both physicians and patients is important to ensure that the most appropriate treatment is received. Physicians should be aware that the sole use of benzodiazepines for depression is not appropriate, while education of patients will help them to expect good quality of care. Reasons for inadequacy of treatment across ESEMeD, such as prescription of inappropriate medication (including inadequate dose or duration), noncompliance, and taking nonprescribed medication, need to be explored further. Breakdown of prescribed treatment items by health care setting, i.e., primary care physician versus psychiatrist, would show whether differences in prescribing patterns exist.

Economic Issues

Failure to accurately diagnose and appropriately treat and manage mood and anxiety disorders has enormous economic impact. Depression is associated with increased accidents at work; for example, depressive symptoms have been found to be a risk factor for accidents among agricul-

tural workers.[34] Psychiatric disorders are also associated with high levels of absenteeism, loss of productivity when at work, and a high workforce turnover (early retirement, leaving, being dismissed). These issues can also have adverse effects on the work performance of others. In the United States, mental disorders are the fastest growing cause of disability, with depression being the number one cause of work disability.[35]

The number of subjects affected by depression and anxiety disorders and the number of disability days due to these conditions across ESEMeD could be used to calculate the overall cost in disability days. These data would be of great interest to a wide audience including large employers, health policy influencers, and the media.

EDUCATION AND HEALTH CARE INITIATIVES

Education of the general population about depression and anxiety may help affected individuals to understand that they have a treatable condition and reduce the stigma associated with mental illness. This increased understanding and reduced stigma would increase the number of individuals seeking help and may allow patients to more readily express that they feel low or need help, facilitating initial diagnosis. The stigma associated with mental illness, which can affect health care professionals as well as patients and caregivers, is partly due to ignorance within society and the negative imagery reinforced by the media. Balanced documentaries or television story lines monitored by professional bodies may help to alleviate misconceptions and highlight the truth about mental illness. However, media-communication is a vast industry, and so this may have little impact; it therefore may be more sensible to work around stigma and direct limited resources elsewhere. The development of social networks—sharing knowledge and experience with peers—may be a more powerful tool in improving understanding of psychiatric conditions and treatment possibilities for both health care providers and patients. Demand management—a relatively new concept developed in the United States—involves educating patients about their illness prior to consultation with their doctor. It is thought that this will empower patients to get the best care from their doctor. Patient advocacy or "self-help" groups have the same aim and are common across Europe and the United States.

Other barriers to patients' seeking help, such as surgery waiting times, access to health care services, and the need to take time off work to visit the doctor, are harder to overcome and may require government initiatives. The U.K. Department of Health, for example, is currently conducting a consultation exercise to reduce waiting time and improve access. In the United States, disease management companies are being employed by clinics to help reduce waiting times by using strategies such as phone triage systems, the allocation of nurses to high utilizers, or the identification of high-use/high-cost patients with whose care the management companies can assist. Other health care initiatives could involve publicizing online screening tools, the use of screening as part of a multifaceted program, evaluation of the economic impact, the promotion of disease management approaches for primary care, depression awareness days, and encouraging the increased use of well-trained counselors. However, even with the diverse differences globally, none of these health care systems is proving to be more beneficial in the treatment of patients with mood and anxiety disorders. In view of the huge impact of depression and anxiety on economic productivity, occupational health service providers must be fully aware of the best practices in diagnosis and especially treatment of these disorders. One option to improve outcomes is for companies to pay for caseworkers to assist recovery of staff.

As primary care physicians vary in their interest and knowledge of psychiatric conditions, education is key to improving the care of patients with mood and anxiety disorders. Mental health skills training, adapting nationally derived guidelines on the detection and treatment of mood and anxiety disorders to meet local circumstances, is important for primary care physicians. Training in mental health should also be improved for medical students to avoid physicians' developing negative attitudes toward mental health later in their career. Multidisciplinary team working and the use of physician extenders (such as, in some instances, chiropractors, acupuncturists, and counselors) should be encouraged to share the burden of patient management. Given the relatively longer time needed to make a psychiatric diagnosis, physicians should be encouraged, rather than discouraged, to have more than one consultation with their patient before making a diagnosis.

CONCLUSIONS

ESEMeD is a unique survey that provides an opportunity to find out more about the epidemiology of depression and anxiety disorders than has been known before. This knowledge can be used to promote change, which will potentially benefit both patients and society. Further, these data can be used in the prioritization of resource allocation according to need rather than demand.

Review of the ESEMeD data shows that, despite a decade of education initiatives, the diagnosis and treatment of mood and anxiety disorders remain suboptimal. Lack of awareness and the high level of stigma surrounding mental health problems have resulted in a widespread patient reluctance to present to primary care with psychological symptoms. Moreover, considerable variation exists in the ability of primary care physicians to diagnose and treat mental health problems; this variation is related to differences in knowledge about, skills regarding, and attitudes toward mental illness. Further, primary care physicians often feel that they do not have the time needed to make an accurate

psychiatric diagnosis. Education of the general population about the prevalence of mood and anxiety disorders and that effective treatment is available may reduce stigma surrounding mental health issues and ultimately increase the number of individuals who seek help. Graduate and postgraduate training is also needed to improve the diagnosis and treatment of mood and anxiety disorders in primary care, while multidisciplinary team working should be encouraged to share the burden of patient management. Physicians should also be encouraged to take the time needed to make an accurate psychiatric diagnosis.

In addition, during discussion, some cross-cultural epidemiology, interpretation, symptom reporting, and cross-country comparison difficulties were debated. These problems highlight the requirement for further methodological studies to improve the reliability, validity, and cross-cultural comparability of this type of data.

Patients with mood and anxiety disorders may benefit from treatment with an appropriate antidepressant, psychotherapy, counseling, or social support. This recommendation should optimize the chances that patients will receive appropriate therapy in terms of both the prescribed therapy's being effective and increased patient compliance.

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