Identifying and Managing Depression in Primary Care in the United Kingdom

Andre Tylee, M.D., F.R.C.G.P., M.R.C.Psych.

The Depression Guideline Panel for the National Institute for Clinical Excellence (NICE) in England has developed a stepped-care model for the recognition and treatment of depression in primary care. The first 3 steps of the model apply to primary care settings and were developed to help primary care professionals overcome barriers to recognizing depression. The somatic symptoms of depression present the most significant barrier to recognition because patients who somatize their symptoms will often lead their physician to think there is a physical reason for the symptoms. This preoccupation with physical illness often delays or prevents diagnosis. Step 1 of the care model focuses on recognizing depression by initially assessing patient mood and interest. Step 2 suggests nonpharmacologic therapies for patients who have mild depression, and step 3 suggests pharmacologic and nonpharmacologic therapies for patients who have moderate-to-severe depression. Improving awareness of the symptoms of depression and physician core skills through guideline-driven practice will hopefully increase the recognition rates for depression in England.

(J Clin Psychiatry 2006;67[suppl 6]:41–45)

Recently, the Depression Guideline Panel for the National Institute for Clinical Excellence (NICE) recommended that the recently updated NICE guidelines[1] include clear guidance to help primary care physicians in England recognize and treat depression. The panel advocated a stepped-care model, where the first 3 steps are specific to the primary care setting (Table 1).[1] The first step is to recognize the presence of depression and to assess its severity. The second step makes recommendations about the treatment of mild depression utilizing a care team, and the third step makes recommendations about the treatment of moderate-to-severe depression. The panel used the ICD-10 criteria to define *depression* in the guidelines and outline factors in addition to symptom counts that need to be assessed to formulate a plan.

This article will focus on the NICE guidelines recommendations for recognizing and treating depression in primary care in the United Kingdom and the various reasons why depression is often not recognized.

BARRIERS TO RECOGNITION

Multitude of Presentations

Patients who present with somatic symptoms are less likely to have their concurrent depression recognized. Since approximately three fourths of patients with depression present with somatic symptoms,[2] these symptoms represent a major obstacle to recognizing depression if they become the focus of the evaluation. Patients with concurrent physical illness are approximately 5 times less likely to have their major depression recognized.[3] This lack of recognition is mostly patient driven because patient attributions have a considerable impact on the hypotheses that physicians draw. Physical symptoms that are normalized or somatized by the patient can mislead physicians.[4] Presentations of concurrent lethargy and pain, for instance, make it difficult for physicians to recognize depression, yet patient complaints of fatigue and excessive sleepiness should raise the index of suspicion for depression. Conversely, patients who psychologize their symptoms make recognition much easier for the physician.[4,5] However, if complaints of somatic symptoms for which there is no apparent physical cause are viewed as the patient's passive attempt to communicate psychological symptoms, this obstacle may be overcome, especially when the patient becomes comfortable enough with his or her primary care physician to give nonverbal, paraverbal, or verbal clues to the depression.

Clinical observation[6] showed that when patients mentioned symptoms of major depression within the first 4 symptoms, they were approximately 10 times more likely

Table 1. NICE Stepped-Care Model for Treatment of Depression[a]

Step Number	Description	Care Setting or Clinician Type	Severity/Type of Depression	Action or Treatment
1	Recognition of depression in primary care and general hospital settings	General practitioner, nurse	Recognition of depression	Assessment
2	Managing recognized depression in primary care	Primary care team, primary care mental health worker	Mild depression	Watchful waiting, guided self-help, computerized CBT, exercise, brief psychological interventions
3	Managing recognized depression in primary care	Primary care team, primary care mental health worker	Moderate or severe depression	Medication, psychological interventions, social support
4	Involvement of specialist mental health services	Mental health specialists including crisis teams	Treatment-resistant, recurrent, atypical, or psychotic depression	Medication, complex psychological interventions, combined treatments
5	Depression needing inpatient care	Hospital setting, crisis teams	Risk to life, severe self-neglect	Medication, combined treatments, ECT

[a]Data from the National Institute for Clinical Excellence (NICE).[1]
Abbreviations: CBT = cognitive-behavioral therapy, ECT = electroconvulsive therapy.

Figure 1. Subtypes of Patients With Depression Delineated in the Depression Research in European Society Study[a]
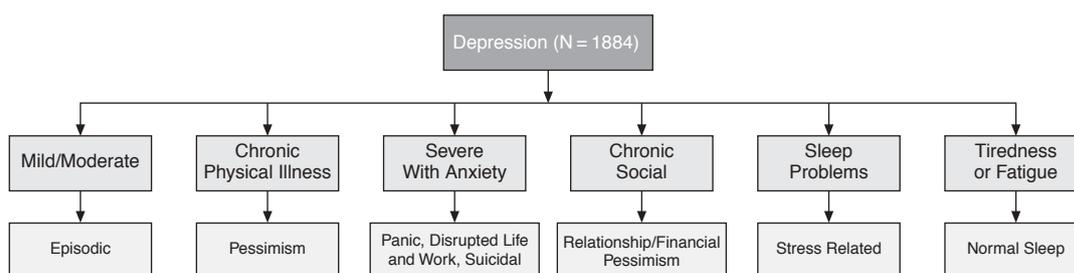
[a]Data from Tylee et al.[9]

to have the depression recognized. Conversely, if patients mentioned a symptom of depression at the end of the consultation or late in the consultation, they were less likely to have their depression recognized.[6] Likewise, a correlation was found between the severity of depression and recognition. That is, symptoms of mild depression were more likely to be missed than symptoms of severe depression.[7]

Patients presenting with comorbid mental health conditions, such as anxiety, are often not diagnosed with concurrent depression. Certainly substance misuse, alcohol problems, and also insomnia and fatigue are often obstacles to a depression diagnosis. In the 6 to 10 minutes that a primary care physician in the United Kingdom has available to spend with a patient, these issues dominate the physician's thoughts, and it is often difficult for the physician to redirect his or her thinking to depression.

The European Study of the Epidemiology of Mental Disorders project found that few people actually seek help for their depression.[8] Patient lack of knowledge about depression, lack of knowledge about the efficacy of treatments for depression, and the fear of becoming addicted to pharmacologic treatments hinder diagnosis and certainly do not motivate patients to seek help. Likewise, access to primary care physicians is a problem for patients who

work, because the physician's office hours often conflict with the patient's working hours. These issues coupled with the defeatist attitudes of many patients and the stigma attached to a psychological condition present major obstacles to recognizing and then effectively treating depression. Despite the 5-year Defeat Depression campaign and a subsequent 5-year campaign that have tried to address this stigma, attitudes appear to have changed little, especially among employers, such that physicians and patients may be reluctant to document depression in sick notes that document an employee's reason for missing work.

In the Depression Research in European Society (DEPRES) study, my colleagues and I[9] have shown that patients with depression generally fall into 6 subtypes according to symptoms (Figure 1): mild-to-moderate depression, chronic physical illness, severe anxiety and depression including suicidality and panic, chronic social problems, sleep problems, and tiredness or fatigue/lethargy. Interestingly, this categorization may suggest that certain patients present with lethargy rather than depression, but lethargy was also present in patients from all other categories. Therefore, complaints of lethargy or excessive sleepiness should raise the index of suspicion of depression.

Figure 2. Gender Effects of Depression: Number of Symptoms Present in Depression With Significant Impairment[a]
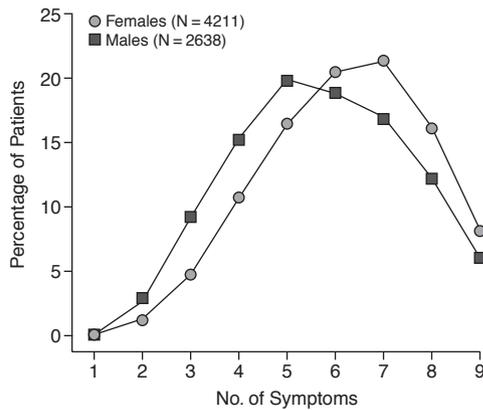
[a]Data from Angst et al.[10]

Angst et al.[10] have analyzed gender differences within the DEPRES study and found that among patients with depression who had significant functional impairment, men had fewer of the core symptoms of major depression than women (Figure 2). This study suggests that men have either fewer or different symptoms than women.

Physician Factors

Primary care physicians in the United Kingdom report preoccupation with physical illness among the major reasons for not recognizing depression.[11] Short consultation times are also recognized among the major obstacles to diagnosis, and there is some evidence suggesting that an extra 2 or 3 minutes can make a difference in terms of a physician's ability to elicit psychosocial problems.[12] Unfortunately, poor consulting skills and lack of knowledge about the symptoms of depression on the part of the physician still remain among the obstacles to diagnosis.[13] The current situation is perhaps due to the lack of systematic training for primary care professionals, who often go into practice with very little opportunity for mental health training.

Doctors are just as likely as, or more likely than, their patients to have depression.[14] Symptoms of professional burnout will also decrease the likelihood of appropriate diagnosis and treatment for illnesses, such as depression, that have potentially complex presentations.

SCREENING AND TREATMENT

The NICE guidelines have graded levels of recommended interventions within the stepped-care model for treating depression presented in Table 1. Level A recommendations are supported by at least 1 randomized, controlled, blinded trial. Level B recommendations are supported by well-designed clinical trials. Level C recommendations are supported by expert opinion. Finally, good practice points (GPP) are recommendations developed by the Guideline Development Group. Of the 5 steps of the NICE guidelines, only the first 3 apply to the primary care setting.

Step 1

The NICE guidelines suggest that primary care professionals who suspect that a patient has depression should assess the patient's mood and interest (Level B). If either of these areas suggests the presence of depression, physicians should further assess the patient using a DSM- or ICD-based tool. Patients who are at high risk for depression, such as postnatal patients, the elderly, the chronically ill, the disabled, the socially isolated, those with diabetes, and post–myocardial infarction patients, should receive further assessment even in the absence of obvious symptoms of depression.

Step 2

The NICE guidelines suggest that exercise improves mild depression (Level C). Although more research is needed in this area, it is reasonable to suggest that patients with lethargy and energy management problems consider graded exercise. Guided self-help interventions are Level B recommendations and include cognitive-behavioral therapy (CBT)–based written material that is introduced to the patient and then reviewed after 6 to 8 weeks. Psychological interventions are Level B recommendations for the mildest depression and include 6 to 8 sessions over 10 to 12 weeks focusing on problem-solving, brief CBT, and brief counseling. Recently, computerized CBT has been developed, and the "Beating the Blues" program has been recommended by a NICE technology appraisal. The computerized CBT "Beating the Blues"' provides weekly, 1-hour sessions for 8 weeks with minimal staff supervision. This method improves depression, negative attributional style, and work and social adjustment. Improvement is independent of drug treatments, length of illness, and severity of illness.[15] In addition, computerized CBT appears to be cost-effective.[16]

Patients with sleep and anxiety problems should be advised on sleep hygiene and anxiety management (Level C). Patients who have mild depression but do not want an intervention should be monitored to ensure their condition does not deteriorate. Mild depression is, however, often situational and may be resolved by CBT problem-solving therapy. It is often not necessary to medicalize mild depression in patients with situational problems, especially when the label *depression* may be detrimental. Antidepressant therapy is not recommended for patients with mild depression unless their symptoms persist or if the patient has a history of moderate-to-severe depression that initially presents as mild depression (Level C). St. John's wort can help mild-to-moderate depression, but even though it is pre-

scribed in some countries, it comes in varying formulations and carries the risk of drug interactions (Level C), so it is not available by prescription in the United Kingdom.

Step 3

The NICE guidelines recommend that antidepressants should be routinely offered to patients with moderate-to-severe depression (Level A). Most selective serotonin reuptake inhibitors (SSRIs) are recommended as first-line agents because of their favorable side effect profile and the depth and breadth of their efficacy data. No recommendations for targeting symptoms such as lethargy via certain antidepressants have been made. NICE recommends continuing antidepressant therapy for at least 6 months after signs of effect (Level A). Depression had been excluded from the primary care physicians' contract in England, but starting on April 1, 2006, primary care physicians will be rewarded for screening their patients with diabetes and coronary artery disease for depression and for baseline assessment of depression severity.

Antidepressants that are not recommended as first-line treatment include the following: escitalopram because of a lack of clinical efficacy at the time of guideline preparation, although this exclusion is based on early clinical data; reboxetine because of a lack of convincing efficacy; moclobemide because of the need for a washout period; and mirtazapine because of associated sedation and weight gain. Venlafaxine is recommended only for primary care physicians with a special interest in mental health, in line with concurrent regulatory guidelines, although there is no definition of *special interest in mental health* given. Duloxetine was not considered because the guidelines were drafted before this product was launched.

For patients with chronic depression, the NICE guidelines recommend antidepressants in combination with CBT (Level A). Befriending can also help people with social isolation, and work advice may help people cope with their work environment while also receiving treatment for depression (Level C). According to the guidelines, some evidence shows that telephone support from either medical or nonmedical staff can improve depression, and multifaceted care programs, in which primary care professionals and secondary care professionals work together, can provide benefit as well (Level C). However, these interventions need further study in the United Kingdom setting. The NICE guidelines recommend psychological treatments at 16 to 20 sessions of CBT or interpersonal psychotherapy with or without concurrent medication (Level B). Additionally, couples therapy may serve as a good alternative to individual psychological therapy (Level C).

CONCLUSION

In the United Kingdom, the recognition of depression is still not optimal. However, the larger public health prob-

lem in primary care may be that when people with mild depression are recognized and then medicalized, given prescriptions, and given sick notes for their employers, it can often be to their detriment. The challenge is to make sure that primary care physicians are better at initial assessment and targeting of treatments so that they can discern between mild, moderate, and severe depression and be able to give the right levels of and the right types of treatment.

Patients often add to the burden of providing appropriate care by somatizing their depression symptoms. Many patients with depression do not have an organic reason for their physical complaints. However, the somatic presentation causes the physician to focus on organic causes rather than psychological status. Missed or delayed diagnoses due to somatic presentations underscore the need to train primary care physicians to help patients reattribute their symptoms and accept treatment for them. Primary Care Programme of The National Institute for Mental Health in England (NIMHE) is currently trying to address the lack of systematic training for primary care professionals. Patient outcome will probably benefit from systematic baseline assessment for patients with depression and advice on how to target treatments.

Although patients often want psychological treatments, there is a serious shortage of them. Unfortunately, primary care physicians do not often have an alternative to writing prescriptions because the funding for alternative services is not available. At present, we can improve the recognition and treatment of depression by improving core skills and providing incentives for primary care physicians. Increasing consultation times and promoting imaginative approaches to mental health care will no doubt play a large role in depression management in primary care.

REVIEW QUESTION

What are some of the barriers to depression diagnosis and treatment that you see in your community, both in primary care in general and in your own practice? Do treatment guidelines help in overcoming those barriers and improving diagnosis and treatment? Why or why not?

REFERENCES

1. National Institute for Clinical Excellence. Quick Reference Guide: Depression: the management of depression in primary and secondary care

(Clinical Guideline 23). Dec 2004. Available at: http://www.nice.org.uk/pdf/CG023quickrefguide.pdf. Accessed January 20, 2006

 2. Simon GE, VonKorff M, Piccinelli M, et al. An international study of the relation between somatic symptoms and depression. N Engl J Med 1999;341:1329–1335

 3. Tylee A, Freeling P, Kerry S. Why do general practitioners recognize major depression in one woman patient yet miss it in another? Br J Gen Pract 1993;43:327–330

 4. Kessler D, Lloyd K, Lewis G, et al. Cross sectional study of symptom attribution and recognition of depression and anxiety in primary care. BMJ 1999;318:436–439

 5. Bower P, West R, Tylee A, et al. Symptom attribution and the recognition of psychiatric morbidity. J Psychosom Res 2000;48:157–160

 6. Tylee A, Freeling P, Kerry S, et al. How does the content of consultations affect the recognition by general practitioners of major depression in women? Br J Gen Pract 1995;45:575–578

 7. Thompson C, Ostler K, Peveler RC, et al. Dimensional perspective on the recognition of depressive symptoms in primary care: the Hampshire Depression Project 3. Br J Psychiatry 2001;179:317–323

 8. Alonso J, Angermeyer MC, Bernert S. Prevalence of mental disorders in Europe: results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project. Acta Psychiatr Scand Suppl 2004;420:21–27

 9. Tylee A, Gastpar M, Lepine JP, et al, for the DEPRES Steering Committee. Identification of depressed patient types in the community and their treatment needs: findings from the DEPRES II (Depression Research in European Society II) survey. Int Clin Psychopharmacol 1999;14:153–165

10. Angst J, Gamma A, Gastpar M, et al. Gender differences in depression: epidemiological findings from the European DEPRES I and II studies. Eur Arch Psychiatry Clin Neurosci 2002;252:201–209

11. Freeling P, Rao BM, Paykel ES, et al. Unrecognised depression in general practice. Br Med J (Clin Res Ed) 1985;290:1880–1883

12. Howie JG, Porter AM, Heaney DJ, et al. Long to short consultation ratio: a measure of quality of care for general practice. Br J Gen Pract 1991;41:48–54

13. Marks JN, Goldberg DP, Hillier VF. Determinants of the ability of general practitioners to detect psychiatric illness. Psychol Med 1979;9:337–353

14. Caplan RP. Stress, anxiety, and depression in hospital consultants, general practitioners, and senior health service managers. BMJ 1994;309:1261–1263

15. Proudfoot J, Ryden C, Everitt B, et al. Clinical efficacy of computerised cognitive-behavioural therapy for anxiety and depression in primary care: randomised controlled trial. Br J Psychiatry 2004;185:46–54

16. McCrone P, Knapp M, Proudfoot J, et al. Cost-effectiveness of computerised cognitive-behavioural therapy for anxiety and depression in primary care: randomised controlled trial. Br J Psychiatry 2004;185:55–62