Mood disorders in primary care

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The majority of patients with mental health problems, especially mood disorders, are treated in primary care. Primary care professionals, such as GPs, practice nurses, primary care counsellors and primary care mental health workers are usually the first, and often the only, medical professionals to manage people with mental health problems. The GP is unique among medical professionals in having direct access to the patient's medical history and social background, and his or her assessment is often influenced by many years of contact with the patient.

Epidemiology of mood disorders in primary care

Depressive disorders in primary care are common and are a major public health problem, affecting 5–10% of the population annually. About 16% of people aged 16–64 suffer from a neurotic disorder in any one week.

The World Health Organization collaborative study estimated that 10% of consecutive GP attendees suffer from major depression.[1] It also found that 26% of attendees had at least one psychiatric disorder, according to ICD-10 criteria. In a GP list of 2000 people, 60–100 would be suffering from depression, 70–80 with anxiety and 50–60 with a situational disturbance. In the elderly, a prevalence rate of 11–16% for depression among those over aged over 65 and living at home in the UK has been described. In children, 23% of consecutive attendees aged 7–12 years were found to have psychiatric morbidity (consisting of about 50% emotional disorders and 50% conduct or mixed disorders). Around one-third of adolescents had a psychiatric disorder.[1] Dysthymia is also common in primary care patients, affecting 3–5% of GP attenders. The prevalence of mood disorders in primary care is 2–3 times higher in women than men.

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Affective psychoses are much rarer, with an incidence in primary care estimated at 3 per 1000. A GP with a list of 2000 patients could therefore expect to have 6–7 patients with an affective psychosis.

The burden of mood disorders

Depression is important both from the point of view of the individual and its socioeconomic impact. It causes great individual suffering with significant disability, leads to the breakdown of relationships and families and can result in suicide – worldwide, about 1000 people kill themselves every day (the same as the number of deaths from malaria). Depression causes greater levels of disability than any other common chronic physical illness (apart from coronary artery disease) treated in primary care. The WHO study found that 55% of patients with an ICD-10-defined psychiatric disorder had moderate-to-severe disability.[1] It is predicted that by 2020 depression will be the world's second most disabling condition after ischaemic heart disease. The level of disability is directly related to the number of depressive symptoms the person is suffering and can vary with time.

Socioeconomic impact: depression poses a significant burden on society. The WHO estimated that in primary care, 6 disability days per month are due to depression. The number of disability-adjusted life years lost due to depression has been estimated at 1,500,000 per year.

In primary care, up to 25% of high healthcare-utilizers suffer from depression and 75% have a history of depression. Adequate treatment of depression in this group not only improves symptoms but reduces service use. Dysthymia is also associated with significant disability and increased healthcare utilization and costs.

Issues in diagnosis

The detection of psychological disorders by GPs varies between places and disorders. In the WHO study the overall detection rate was about 50%.[1] The 'Pathways to Care' model helps explain the discrepancy between conspicuous mental illness and what has been termed 'hidden' mental illness (see Figure 1).[2]

Mood disorders can be difficult to diagnose in the primary care setting. Patients rarely present with symptoms that fit neatly into diagnostic taxonomies, but rather with a combination of physical, psychological and social problems. Somatic symptoms are often the first to be presented. The generalist faces the difficult problem of having to tease out a depressive illness from comorbid physical illness and identifying underlying mood disorders in patients who present with somatic problems that lack an organic cause. However, GPs are good at diagnosing severe mood disorders and anxious depression, and over 90% of patients with severe depression are accurately diagnosed. Those with undetected mood disorders tend to have less severe illness, and evidence suggests that failure to recognize them does not have an adverse effect on outcome.

Recognition of mood disorders in primary care

Both patient and doctor factors are important in determining whether or not a mood disorder is recognized.

Patient factors – the mode of presentation is important, and patients who present with somatic complaints are less likely to be correctly diagnosed as depressed. Patients with less severe

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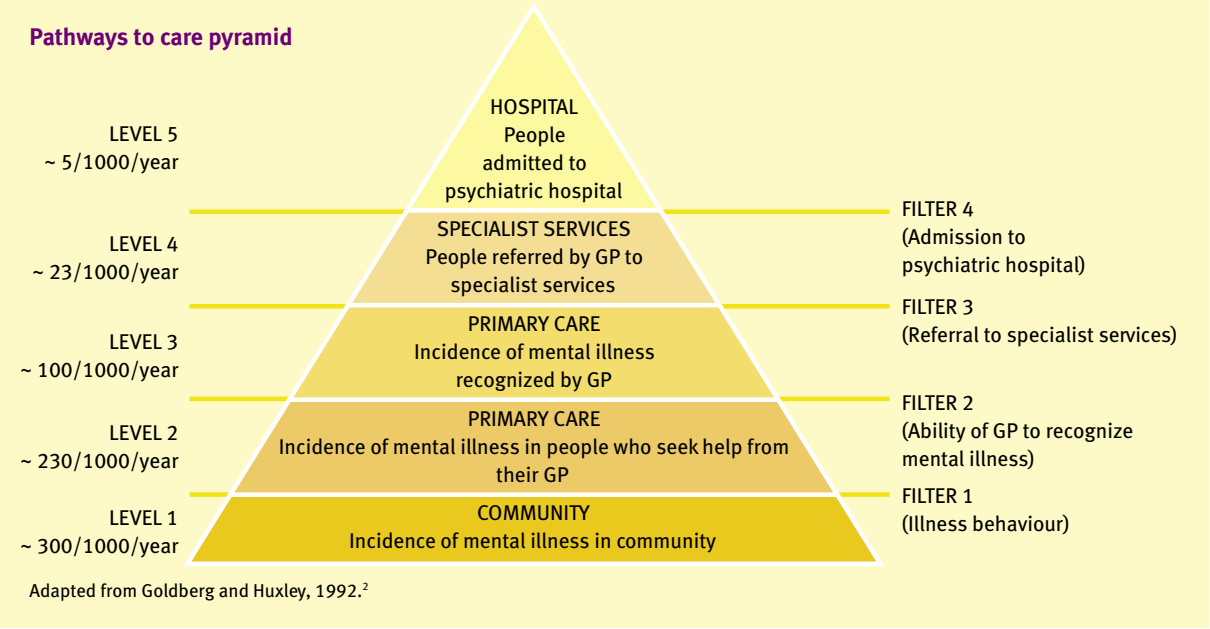

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depression are more likely to be missed and patients with psychiatric histories or high consultation rates are more likely to be correctly identified. Other patient factors that affect recognition include stigma and ignorance of depression. Mood disorders are also more likely to be acknowledged if patients mention psychological problems in the first four symptoms presented, and less likely if they are mentioned towards the end of the consultation.

Doctor factors – GPs who have a positive attitude towards and an interest in mental health problems are more likely to diagnose depression accurately. Consultation styles are also important: GPs who ask open questions initially, give more time, are more empathic, make more eye contact and interrupt less have been shown to detect depression more often. These skills have been successfully taught in interview skills training using video feedback.

Somatization

Somatization is the expression of psychological distress through physical symptoms. Up to 80% of patients with anxiety or depression will initially present in the primary care setting exclusively with somatic complaints. Somatization is a universal phenomenon and probably an integral part of depression as it presents in primary care. However, it can make the diagnosis of a mood disorder more difficult as psychiatric classifications fail to account for somatic presentations. The ability to diagnose depression when presented with somatic complaints relies on the GP's interview style (see above), an awareness of depression, and a high index of suspicion of depression as a possible cause.

Somatizers have been divided into two groups:

- facultative somatizers, who present with physical symptoms but can express their psychological symptoms if appropriately interviewed
- pure somatizers, who deny any psychological symptoms even in the face of an appropriate interview.

A teaching package has been developed by the World Psychiatric Association specifically for use in primary care to help GPs manage patients who somatize.

Suicide in primary care

A GP with a caseload of 2000 patients can therefore expect approximately one suicide every 4 years. While this means it is a rare occurrence, up to 22% of people who commit suicide will have seen their GP in the week before their death, and up to 40% will have seen their GP in the month preceding their death. It is therefore important that GPs enquire about suicidal ideation in all depressed patients and appropriately assess risk factors for suicide.

Screening for depression in primary care

Screening for depression, or more correctly case-finding in primary care, has been controversial. Currently it is recommended in high-risk groups only (e.g. patients with a past history of depression, diabetes, myocardial infarction, disabling physical illness, or other mental health problems). There are a number of simple and relatively quick screening tools that have been used in primary care. These include the Hospital Anxiety and Depression Scale, the Beck Depression Inventory and the Patient Health Questionnaire-9 (PHQ9). These tools provide the GP with an assessment of whether depression is mild, moderate or severe and can be used for assessing the level of depression once a couple of screening questions have been answered:

- during the last month, have you often been bothered by feeling down, hopeless or depressed?
- during the last month have you often been bothered by little interest or pleasure in doing things?

These questions are sensitive (96%) but less specific (57%).[3] The Edinburgh Postnatal Depression Scale is a useful screening tool for postnatal depression in post-partum women and can be used by health visitors.

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