Managing depression in primary health care

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***John Cosgriff** is a GP who works part-time for Counties Manukau DHB mental health services in a GP liaison capacity. He has a long-standing interest in mental health, particularly depressive disorders, and improving the interface between primary health care and secondary mental health services. He firmly believes that high quality primary mental health care can significantly reduce the impact of mental illness and that to develop this quality service is a current challenge for GPs and their teams.*

Introduction

The primary care team has the central role in the identification, assessment and management of this common health problem.

Depression causes significant distress and disability in our communities. By 2020 it will be responsible for the greatest burden of disability from any disease.[1] Primary health care needs to increase its knowledge and develop the necessary systems if we want to reduce the potential impact on society.

Depression is a common illness. Lifetime prevalence rates approach 20% with females having double the rates of males. There is some thought that the prevalence is increasing.

Identification

For the GP, identification is the initial step towards better outcomes. Traditionally we have believed that GPs did not recognise much of the mental health issues that presented in their practices. However the results of the MaGPIe study strongly discounts this view. This study showed that GPs recognise the presence of significant mental health concerns in over 50% of consultations.[2]

My view is that the GP needs to have a low threshold when considering whether a patient has a depressive illness. Some patients seem to be at increased risk including those with pre-existing chronic physical problems, women in the post-partum period, those who have suffered recent bereavement, patients with a previous episode of depression, and people with recurrent somatic presentations of distress.

Often I am asked whether or not there is any value in screening patients. The US Taskforce on Screening has recommended that all adults be screened for depression. They recommend using a simple two question method:

- In the last two weeks have you felt sad most of the time? and
- In the last two weeks have you lost interest in things that give you pleasure and enjoyment most of the time?[3]

If the answer is yes to either of the questions then the taskforce recommends that the person is more fully assessed for a possible current depressive illness. There is, however, no recommendation on how often adults should be screened.

Increasingly the GP is using tools to confirm the diagnosis of depression. A comprehensive review of these tools is beyond the scope of this article.[4] My view is that tools are useful to quantify the severity and to monitor objectively the response to treatment but should not replace a comprehensive and thorough assessment.

Although depression is starting to be classified as mild, moderate and severe, there is no agreed classification system. It is important that the number of symptoms is considered along with past history, family history and degree of associated impairment in functioning. NICE Guideline recommendations provide a useful start (Figure 1).[5]

The comprehensive assessment

The important features to consider in a comprehensive assessment include

1. **Current symptoms** – the traditional symptoms of depression are well known and listed in Figure 1. The GP needs to ascertain the time span the symptoms have been present and their persistence through the day. For moderate and severe depression, symptoms need to be present for at least two weeks and persist through most of each day. Symptoms that have been present even at a low grade for many months or even years would suggest the possibility of dysthymia – a chronic depressive illness.
2. **Assessment of risk of harm to self or others** – the GP must feel comfortable in asking about suicide and assessing the risk. If the primary care team thinks that the risk to the person themselves or to a significant other (e.g. a young baby in the post-partum period)

is high then discussion with secondary mental health services is strongly recommended.

3. **Precipitating events** – it is important to identify and clarify the influence of any precipitating factors preceding the onset of the illness. I particularly ask about recent change or loss, e.g. intimate relationships, family situation, work, and physical health as well as asking about their support systems and how they usually cope with stress.
4. **Level of functioning** – a depressive illness always causes impairment in the person's usual level of functioning and disruption to their usual lifestyle. Therefore the GP needs to understand the potential interference with the person's usual level of functioning. A useful question to assess this is 'how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?'
5. **Concurrent other mental health issues**, particularly anxiety disorders, alcohol and recreational drug use. From the MaGPIe study we know that there is a significant overlap in these diagnostic categories.
6. **Past history of similar episodes** and the duration of the previous episode, its precipitants and how the person responded to interventions particularly those which benefited them.
7. **Past and current medical history** including any recent physical symptoms with an examination if indicated. Laboratory investigations are generally unhelpful if there is no indication of a physical health problem from the history and examination. I also enquire about drugs that are associated with depression particularly anabolic steroids, oral contraceptives, and beta blockers though the list of potential drugs is long.[6]
8. **Family history** of psychological problems particularly depression.

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Patient management plans

Once the GP is certain of the diagnosis of depression a management plan needs to be formulated with the patient. A core component of this is to form a strong therapeutic alliance with the patient. Like many other health issues the role of the practice team is to support a patient-centred approach to management providing support to the patient so that they can self-manage their illness. This begins with education about the diagnosis of depression including providing written information for them to read afterwards. Usually I try to discuss how common depression is, the possible causes, the treatment options and the optimistic prognosis. When someone is depressed their sense of hope is diminished so that a crucial role for the GP is to offer hope and the clear expectation that the depressive symptoms will improve.

There are four general measures that I discuss with all patients regardless of the severity of depression.

- **Sleep hygiene** – often people's sleep patterns are significantly disturbed so that attention to ensuring a usual sleep pattern is essential.
- **Exercise** – there is a small amount of evidence that regular aerobic exercise for 30–40 minutes three times a week is beneficial.[5]
- **Activity scheduling** – having fun is an essential part of life. Encouraging and planning an activity that is relaxing and enjoyable is helpful.
- **Mobilising social and cultural supports** – confiding in a friend, family member or employer helps to reduce the sense of isolation.

Together with the patient I then consider the specific treatments available. These depend on the severity of the symptoms and the degree of functional impairment. Regardless of what treatment option is chosen, active follow-up with the patient is essential. It is the active follow-up and

Figure 1. Symptoms of depression (from ICD 10)

Mild depression

- Four or less symptoms
- No past or family history
- Social supports available
- Symptoms intermittent or present for less than two weeks
- Not actively suicidal
- Little associated impairment

Moderate depression

- Five or more symptoms
- Past or family history of depression
- Low social supports
- Suicidal thoughts
- Associated social disability

Severe depression

- Seven or more symptoms
- Presence of melancholia or psychotic symptoms
- Persistent sadness or low mood and/or
- Loss of interest

plus

- Fatigue or low energy
- Disturbed sleep
- Poor concentration
- Low self confidence
- Poor or increased appetite
- Suicidal thoughts or acts
- Agitation or slowing of movements
- Guilt or self-blame

Source: NICE guidelines

ongoing monitoring with the patient of their progress that is crucial if the burden of disability that depression confers on individuals and communities is to be reduced.

For ***mild depression*** the treatment options beyond the strategies described above is essentially watchful waiting and regular active follow-up over a month or so to check that the person's symptoms are improving. I organise two weekly appointments with the person to monitor that their symptoms are not increasing and that they therefore do not require the more specific treatments described below.

For ***moderate depression*** I discuss with the person anti-depressant medication and psychotherapy. There is good evidence that antidepressants and cognitive behavioural (CBT) and interpersonal psychotherapy (IPT) are equally effective.[7] The latter two therapies need to be undertaken by experienced and competent practitioners if they are to be recommended. However, access to these psychological therapies is limited for those who cannot afford private therapy. Pragmatically I usually advise a trial of a serotonin re-uptake inhibitor (SSRI). There is little difference in efficacy between the three commonly available SSRIs in New Zealand though their side-effect profiles are slightly different. All should be started at 20mg daily in the morning with a discussion about common side-effects namely increased agitation, sexual dysfunction and weight loss. It is also important to address the common concerns that patients express about antidepressant medication namely that it is addictive as well as discussing that a discontinuation syndrome, particularly with paroxetine, is possible.

I follow people up regularly at two weekly intervals and often part of this can be done by phone. There is good evidence that active telephone follow-up by the practice nurse improves patient outcomes and is cost-effective.[8] If at six weeks there is no response to the SSRI, I double the dose to 40mg and continue to encourage the patient to implement the self-help techniques described above. It is important to promote an optimistic outlook and encourage the patient to believe that they will return to their usual level of functioning.

In ***severe depression*** I consider using an SSRI or tricyclic antidepressant.

Tricyclic antidepressants have been successfully used to treat depression for over 40 years. However I believe that their use today, due to their side-effects and poor safety profile in overdose, is limited to the following situations:

- Good response in a prior depressive episode (preferably the same drug should be used and the dosage quickly titrated upwards to the dosage that the patient responded to in the last episode).
- Severe depression with features of melancholia though the benefit needs to balanced against any known cardiovascular risk.
- Failure to respond to a trial of at least one SSRI at up to 40mg daily for six weeks.

Tricyclics have traditionally been recommended in dosages up to at least 150mg daily (apart from nortriptyline where dosages up to 100mg are usual). However there is some research suggesting that they are as effective in moderate depression in lower dosages. In practice I think that if people are responding at a lower dose then that is the dosage they should stay on, but non-response at 25–50 mg of tricyclics is common. In this situation the dosage should be increased slowly towards the usual recommended dose.

Unusual presentations

1. **Melancholic depression** is a severe form of depression with the distinguishing features of psychomotor disturbance as well as commonly non-reactive mood, loss of pleasure and mood worse in the mornings. It is more likely to have a genetic loading and is highly likely to respond to drug therapy.
2. **Atypical depression** presents with mood reactivity, over-eating and over sleeping and is associated with long standing sensitivity to interpersonal rejection. This responds best in primary care to SSRIs.
3. **Psychotic depression** is a severe form characterised by hallucinations, delusions and guilty ruminations. It only responds to physical treatments and prompt referral to secondary mental health services is recommended.
4. **Chronic depression** is when symptoms have been present for two years and often patients need a combination of drug and psychological treatments. Often there are social issues that need to be resolved.

Management of non response patients

Management of non response to an initial trial of medication at six weeks at full dosage namely 40mg of SSRI:

- Check medication compliance and address issues around non compliance
- Review diagnosis
- Review with the patient any factors that may be perpetuating the mood disorder and, if identified, address management towards them
- Change treatment – there is debate about a trial of a different SSRI though this is commonly done in practice. The other option is a trial of tricyclic medication.
- If available add CBT or IPT to the management plan.

Who to refer to secondary services

The GP needs to feel able to ask advice and know how to access this advice from a secondary mental health professional if they are concerned or feel uncertain of their management. Typically I referred patients to secondary services when they ex-

hibited any of the following behaviours or symptoms

- Poor or incomplete response to two interventions
- Active suicidal thoughts or plans
- Psychotic symptoms
- Severe agitation or self neglect
- Recurrent episodes particularly with an episode within one year of the last.
- Severe symptoms that the GP does not feel competent to manage.

Relapse prevention

Depression is an illness that relapses in at least 70% of people. Maintaining people on the antidepressant at the dose they responded to for nine to 12 months after a first episode reduces the chance of a recurrence.

If a person has had two or more depressive episodes antidepressants should be continued for at least two years. The use of CBT or IPT when there are residual symptoms has been associated with lower rates of relapse and should be considered in these patients.[7]

Summary

For GPs the challenge is to identify those people who are depressed by having a high index of suspicion and undertaking a comprehensive assessment. Treatment depends on severity, patient preference, identified stressors and the availability of different treatment options. Active follow-up and monitoring of improvement is critical.[9,10,11] The final challenge is for structural change within primary care to allow GPs the time for assessment and follow-up, providing better access to non-pharmacological management options, and improving the liaison with secondary care so that easy advice/referral is possible. Only then will primary care be able to lessen the burden from this illness.

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