Diagnosing and treating depression

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The 2001 annual world health report from the World Health Organization (WHO) focussed on mental health in all countries and societies. One of the 10 recommendations made by the report was to bring the management and treatment of mental disorders into primary care to maximise service provision and reach the greatest number of people. The WHO recognised that mental healthcare is already being provided within primary care, but it identified a continued need for training to improve the effectiveness of the management of mental disorders in general practice.[1]

In 2002, the Sainsbury Centre for Mental Health undertook an independent policy review into the development of primary care mental health services. It found that although 90% of people with mental health problems are cared for in primary care, their care accounts for less than 10% of the total expenditure on mental health.[2]

In 2005, a report for the Government identified further scope for improvement in primary care services for most patients with depression and anxiety disorders.[3] The emphasis on mental health and depression within the Quality and Outcomes Framework (QOF) has ensured appropriate disease registers are in place. There is active depression case finding in individuals with diabetes or ischaemic heart disease. Validated depression assessment tools are now used, and for those with severe and enduring mental illness, management plans as well as structured review and monitoring systems are in place.[4]

LEARNING OBJECTIVES

After working through this article you will be able to:

- Identify the advantages and disadvantages of using screening tools in the diagnosis of depression
- Discuss the most appropriate treatment for people with mild, moderate or severe depression
- Identify effective models of structured care for patients with depression
- Discuss the importance of adherence to antidepressant therapy in relation to depression outcomes

ACTIVITY

Look at your practice QOF registers and identify how many people have a diagnosis of ischaemic heart disease and/or diabetes.

- What percentage of these patients have been involved in active case finding for depression?
- Identify how many patients have had a new diagnosis of depression in the previous 12 months.
- What percentage of these patients have had their diagnosis confirmed using a screening tool?

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This series is for primary care nurses working in advanced practice. It aims to encourage you to question practice, and consider and implement changes to improve care provision.

Module 09.7 Depression in primary care

Part 1. Understanding the impact

Part 2. Diagnosis and treatment

ANTIDEPRESSANTS

Within primary care, patients with depression are usually treated with antidepressants.[5-7] In its 2004 depression management guidelines, NICE does not recommend antidepressants for the initial treatment of mild depression because of a poor risk/benefit ratio.[8] Individuals with mild symptoms of depression should be offered psychosocial therapy or a psychological therapy as a first-line intervention.

NICE does recommend antidepressants for the treatment of moderate or severe depression. (selective serotonin reuptake inhibitors) are the first-line choice, preferably in combination with a psychological therapy.[8] This advice was supported by *The Depression Report*.[9] The lack of both trained therapists and NHS funding to employ them poses a significant obstacle to developing psychological therapies. Consequently, treatment for all individuals with depression, irrespective of its severity, continues to be predominantly with antidepressants.

FAILURE TO DIAGNOSE AND TREAT

There is evidence to support the view that if depression is detected early, patients get better more quickly.[10] Despite this, there are a number of challenges to the detection and management of depression. Like hypertension,[11] depression is subject to the rule of halves:

- just under half of depressed patients seek help from a doctor
- about half of those who present to primary care have their depression detected
- only half of those who are diagnosed receive treatment for depression
- only half of those who are prescribed treatment complete it.

Therefore fewer than 10% of patients actually finish a therapeutic course of treatment.[12]

The diversity of the problems associated with the diagnosis and treatment of depression in primary care are summarised in Boxes 1 and 2. These may be attributed to the absence of depression care systems.[13] In general, patients are passive receivers of care with little evidence of structured arrangements for ongoing care and support.[14,15] The results of a 2003 qualitative study, utilising semi-structured interviews to explore the perceptions of 23 patients about the quality of depression care in general practice, advocate a model of care within which patients are followed up systematically.[16] Several structured models of care for patients with depression have been implemented and evaluated within primary care. Some have been more successful than others, but these results are not necessarily generalisable from one practice to another.[17-21]

ACTIVITY

Identify the number of patients in your practice with a diagnosis of mild, moderate or severe depression.

- What treatment/s do each of these subgroups normally receive?
- How many patients have had access to a psychological therapy?
- How do your findings compare with recommendations from the NICE depression management guidelines?

BOX 1. PROBLEMS WITH THE DIAGNOSIS OF DEPRESSION

- Fear, stigma or ignorance may prevent people from seeking help from their GP[3]
- Failure to identify patients with depression; 50% remain undiagnosed[12,48-51]
- 80% of patients with depression present with non-specific physical symptoms and avoid mentioning any emotional or psychological symptoms[13,47,51-53]
- Misdiagnosis on initial presentation, although detection of depression does improve with additional visits to the GP[3]

BOX 2. POTENTIAL PROBLEMS IN THE TREATMENT OF DEPRESSION

- Variability of the threshold at which GPs will prescribe treatment[54]
- Most depressed patients treated in general practice receive less than the doses and duration of antidepressant treatment recommended in clinical practice guidelines[19]
- Adherence to antidepressant medication is poor and is associated with a recurrence of symptoms in about 50% of patients who stop their prescription as soon as they feel better[24,55-58]
- Patients may decline treatment for their depression[3]
- Patients are reluctant to take or stop their antidepressant medication because of concerns about dependence and addiction[59-63]
- Many patients discontinue antidepressant medication because of the risk of adverse drug effects or inefficacy[64]
- Inadequate follow-up of patients[13,65]
- Patients are often reluctant to accept medication and think counselling should be offered[66]
- Lack of availability of psychological therapies because of a lack appropriately trained therapists[9,67]

ADHERENCE TO MEDICATION

The Drug and Therapeutics Bulletin states that 30% of patients remain depressed despite antidepressant therapy.[22] This may be attributable to various factors, including non-adherence to the prescribed treatment following presumed recovery, side-effects, and patient beliefs and attitudes towards the antidepressant prescription.[7]

One study reported an estimated 50% non-adherence rate to antidepressant therapy, matching non-adherence rates for other medications.[23] A systematic review of 32 studies, whose primary outcome was the assessment of factors that influence adherence to all classes of antidepressants, concluded that adherence is a major problem, with about 33% of patients dropping out of treatment for reasons including:[24]

- illness characteristics – chronic illness frequently results in poorer compliance
- patient's characteristics – social isolation, polypharmacy, female sex, substance misuse and paranoid ideation can lead to poorer compliance

- side-effects
- time taken to improve
- patient-doctor relationship.

Adherence has rarely been the subject of specific research, but the few studies that have been undertaken have not provided consistent or reliable evidence to indicate the efficacy of specific interventions. However, they do consistently indicate that adherence can be improved through interventions supporting the prescription of antidepressants.[24]

Comprehensive interventions combining cognitive, behavioural and affective components are more effective than single-focus interventions. Patients with chronic illness, including those with mental health problems, benefit but there are no magic bullets in terms of best interventions. The following, however, have all been shown to have an impact on adherence:[25,26]

- patient education about depression and the need for antidepressants
- group processes
- family support and education
- behavioural modalities
- provider interventions.

EFFICACY OF MEDICATION

Over the past few years the effectiveness of antidepressant medications has been increasingly questioned. Three meta-analyses of randomised, placebo-controlled, short-term efficacy trials data held by the US Food and Drug Administration (FDA) have been undertaken by one group of researchers in the past 10 years.[27-29] The data referred to all SSRIs, the most commonly prescribed antidepressants.

ACTIVITY

Identify the number of prescriptions for antidepressants that have been issued in the past year in your practice.

- What proportion were for SSRIs and what proportion were for tricyclic antidepressants?
- How many patients have collected a regular repeat prescription of their antidepressant medication for a 6-month period?
- How many patients have only ever received one prescription for an antidepressant?

BOX 3. EFFICACY OF SSRI DRUGS: RESULTS OF A META-ANALYSIS[29]

- The overall effect of the new generation of SSRI antidepressants was below the recommended criteria for clinical significance
- There was virtually no difference in the improvement scores for drug and placebo in patients with moderate depression
- There was only a small and clinically insignificant difference among patients with severe depression
- The difference in improvement between the antidepressant and placebo did reach clinical significance but only in the most severely depressed patients
- Additional analyses indicated that the apparent clinical effectiveness of antidepressants in the most severely depressed patients reflected a decreased responsiveness to placebo rather than an increased responsiveness to antidepressants

In more than half of the trials, the drug failed to outperform placebo. On average, placebo was found to duplicate 82% of the active drug response. The most positive trial results showed that active drug elicits an improvement in only one-third more patients than placebo, with the placebo response appearing to be greater in cases of less severe depression;[30] this is the group of patients most likely to be treated in primary care.

The 2008 meta-analysis was undertaken to identify whether there is a link between initial depression severity and antidepressant benefit.[29] The researchers obtained data on all the clinical trials submitted to the FDA for the licensing of four SSRIs – fluoxetine, venlafaxine, nefazodone and paroxetine. See Box 3 for a summary of the findings.

The researchers concluded that there is little reason to prescribe new generation antidepressant medications to any but the most severely depressed patients, unless alternative treatments have been ineffective. However, it is those patients with less severe depression who are most likely to receive their care in primary care. These meta-analyses[28,29] raise important questions. What do patients actually benefit from? Is it the SSRI effect or a placebo effect? Does it matter as long as there is a positive response to treatment, with the trend towards recovery?

RECOGNISING DEPRESSION

The recognition of depression is essential if it is to be treated effectively. NICE recommends that screening for depression should be undertaken in primary care in high-risk groups.[8] This includes individuals with:

- a medical history of depression
- significant physical illness causing disability
- existing chronic disease
- other mental health problems, such as dementia, personality disorders.

Potential physical causes of depression and the possibility that depression may be caused by other medications the patient is taking should always be considered.

Screening questions should be asked when patients present with symptoms suggestive of depression, or if they belong to one of the high-risk groups. People suspected of having depression should be assessed for major depression according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria (Table 1). Assessment should include evaluation of suicide risk (Table 2), with an awareness that suicide ideation can develop at any time during treatment.

SCREENING AND ASSESSMENT TOOLS

Two-question screen plus help question

The two-question screen plus help question has a high sensitivity and specificity for diagnosing depression.[31] The questions are as follows:

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

The help question is:

- Is this something you would like help with?

TABLE 1. DSM-IV DEPRESSION SCREENING QUESTIONS

1. Has your depression been interfering with your life for the past 2 weeks?
2. Have you lost interest in things?
3. Do you feel tired or lacking in energy?
4. Have you lost confidence in yourself?
5. Do you find it difficult to concentrate?
6. Do you find you are not sleeping well?
7. Have you lost your appetite or lost weight?
8. Do you feel guilty about things?
9. Do you feel you are being punished?
10. Do you feel that life is not worth living?
11. Have you ever thought about ending it all?

Duration

- For how long have you felt like this?
- Does it last for most of the day?
- Do you feel like this most days?

Interpretation

Mild depression	Positive response to two questions from 1–3, plus two others from 4–11
Moderate depression	Positive response to two questions from 1–3, plus three or more from 4–11
Severe depression	Positive response to most questions, especially 8 and 10

TABLE 2. ASSESSMENT OF SUICIDE RISK

1. Do you feel life is not worth living?	1
2. Have you felt like acting on this?	2
3. Have you made any plans?	3
4. Have you tried to end your life before?	4

1 = Yes	Treat depression, assess suicide risk at each visit, arrange follow up appointment
1 and 2 = Yes	Treat, give patient contact details for Samaritans, refer
1, 2, 3, 4 = Yes	Urgent referral to crisis team

If the patient answers 'yes' to either of the two screening questions and would like help, consider asking more detailed questions using the DSM-IV diagnostic criteria for depression (Table 1), plus the assessment of suicide risk (Table 2).

Some of the more detailed screening tools not only diagnose depression, but also provide a severity score. This is useful because it facilitates a measure of initial severity and ongoing progress. Three depression severity scales commonly recommended for primary care patients under the age of 65 years are the:

- Hospital Anxiety and Depression Scale (HADS)[32,33]
- Patient Health Questionnaire–9 (PHQ-9)[34,35]
- Becks Depression Inventory (BDI).[36,37]

Pregnant women and elderly people are at increased risk of depression. The Edinburgh Postnatal Depression Scale (EPDS) and the Geriatric Depression Scale (GDS) are recommended for use in these two vulnerable groups.[38]

Hospital Anxiety and Depression Scale

HADS[32] has been validated for use in primary and community care settings.[33,39] It is self-administered and takes up to 5 minutes to complete. An online version is available via Mentor, a diagnostic decision-support tool available in the UK via general practice clinical systems, such as EMIS. The anxiety and depression subscales within HADS each comprise seven questions that score 0–3, depending on the severity of the problem described in each question. The total anxiety and depression scores are categorised as normal (0–7), mild (8–10), moderate (11–14) or severe (15–21).

Anxiety and depression are independent measures, but the advantage of HADS is that it facilitates the measurement of the severity of both simultaneously. The HADS depression subscale has a 90% sensitivity and 86% specificity for depression, compared to the gold standard of a structured diagnostic interview.

Patient Health Questionnaire–9

The PHQ-9 is a nine question self-report measure of severity that takes about 3 minutes to complete.[34] It was developed in the US and has been validated for the measurement of depression severity with a sensitivity of 88% and a specificity of 88% for major depression.[35] It is available free to download and is also available for use during consultations via Mentor.

PHQ-9 uses DSM-IV criteria and scores are categorised as minimal (1–4), mild (5–9), moderate (10–14), moderately severe (15–19) or severe (20–27). The key difference between the PHQ-9 and HADS is that PHQ-9 does not measure anxiety in conjunction with depression. This may be a disadvantage as many individuals seen in primary care present with mixed anxiety and depression.

Becks Depression Inventory

The BDI was first introduced in 1961.[36] The BDI-II is the 1996 revision, developed in response to the American Psychiatric Association's publication of the DSM-IV,

which changed many of the diagnostic criteria for major depressive disorder.[37] The BDI-II is a 21-item self-report instrument, which takes about 5 minutes to complete. A total score of 0–13 is considered minimal, 14–19 is mild, 20–28 is moderate, and 29–63 is severe.

The BDI is designed to reflect the depth of depression, to monitor changes over time, and to provide an objective measure of improvement and the effectiveness, or otherwise, of therapy. Unfortunately it is not available via Mentor.

Geriatric Depression Scale

The GDS was developed in 1982 specifically for rating depression in elderly people – individuals aged 65 and over.[38] The 30 questions represent a reliable and valid self-rating depression screening scale for elderly people. A short, 15-question version of the GDS has been developed and validated[40] and can be accessed via Mentor for use in consultations. The GDS is ideal for evaluating the clinical severity of depression and for monitoring treatment.

Edinburgh Postnatal Depression Scale

Postnatal depression occurs during the first year after childbirth, usually within the first 3 months, and often with gradual onset. Many women with postnatal depression do not recognise the symptoms themselves and will hide them for fear of being seen as a failure for not coping well during this difficult time.

The EPDS is a 10-item self-report scale,[41] validated on a community sample of women at 6 weeks post-partum.[42] It has been shown to have satisfactory sensitivity and specificity, and is also sensitive to change in the severity of depression over time. The EPDS can be completed in about 5 minutes and uses a simple method of scoring. Many health visitors use it as a screening method for new mothers, usually at 6–8 weeks post partum.

DISADVANTAGES OF SCREENING TOOLS

All self-report screening tools are subject to similar problems; the scores can easily be exaggerated or minimised by the person completing them. As with all questionnaires, the way in which the tool is administered can have an effect on the final score. If a patient is asked to fill out the form in front of other people in a clinical environment, social expectations might elicit a different response to the one they may give via a postal survey, for example.[43]

IMPROVING MANAGEMENT

The involvement of service users is an important part of NHS strategy to improve service quality. Therefore, planning for improvement needs to start from the perspective of the user. Patients' views about service quality may differ from those of healthcare professionals, managers and policy makers. Involving users helps to avoid the development of inappropriate services and may result in innovative and imaginative approaches to managing depression in primary care.[44]

Improving outcomes for patients with mild, moderate or severe depression is not just a case of prescribing an SSRI. It has been suggested that the whole process of care could be enhanced if depression in primary care were included with other chronic conditions, such as diabetes, asthma and hypertension, and subject to systematic, nurse-led management.[15,45] Suggested changes are summarised in Box 4.[15]

BOX 4. IMPROVING THE ORGANISATION OF DEPRESSION CARE[15]

- Align efforts to improve depression care with broader strategies for improving care in other chronic conditions
- Increase the availability of depression case management services in primary care
- Develop registries and reminder systems to ensure active follow-up of depressed patients
- Achieve agreement on how depression outcomes should be measured to provide outcome-based performance standards
- Initiate greater support from mental health specialists for management of depressed patients by primary care providers
- Campaign to reduce the stigma associated with treatment of depressive illness
- Increase the dissemination of interventions that activate and empower patients managing a depressive illness
- Redefine the lack of time of primary care providers for high-quality depression care as an issue in organisation of care and in provider training
- Develop incentives (organisational or financial) for high-quality depression care

ACTIVITY

- Find out which depression screening tools you have access to in your practice.
- Gain experience using each of them by selecting appropriate patients.
- Identify your experience of using each tool, in particular ease of use for you and the patient. Was there anything unexpected in the results?
- What are the advantages and disadvantages of each of the screening tools?

Answers to self-assessment, p48

1 Less than 10% of total NHS expenditure on mental health is spent on patients with mental health problems in primary care. **2** NICE recommends psychosocial therapy or psychological therapy as the first-line treatment for people with mild depression. **3** The lack of trained therapists and the lack of funding to employ therapists are delaying the development of psychological therapies. **4** Any five of the following: variable diagnostic thresholds; subtherapeutic prescribing of antidepressants; poor compliance with antidepressant therapy; patients decline or stop antidepressant therapy; patient preference is for counselling; poor follow-up of patients on treatment; lack of availability of psychological therapies. **5** Any four of the following: past medical history of depression; significant physical illness causing disability; existing chronic disease; other mental health problems, such as dementia, personality disorder. **6** Do you feel life is not worth living? Have you felt like acting on this? Have you made any plans? Have you tried before? **7** The Hospital Anxiety and Depression Scale scores for anxiety as well as depression. **8** The Geriatric Depression Scale detects depression in people aged 65 years and over; the Edinburgh Postnatal Depression Scale detects depression in postnatal women. **9** Choose any four of the nine factors identified in Box 4. **10** The patient needs to give a positive response to five questions; questions 1-3 plus three more positive answers to questions 4-11.

CONCLUSION

Nurse-led chronic disease management is part of the everyday workload for many nurses working in general practice and is a proven, effective, management tool for chronic disease.[46,47] Practice nurses have both the skills and the knowledge to manage chronic disease and are ideally placed to give structured, systematic care. The evidence indicates that providing such care for patients with depression will help to alleviate some of the current problems with its primary care management. For this to happen there will need to be a shift in the current perspective. Depression will need to recognised as a chronic disease and nurse-led care become the norm within primary care. Appropriate training, so that practice nurses are able to undertake a pro-active role, should also be made available.[17] ●

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SELF-ASSESSMENT

1 What percentage of the total NHS expenditure on mental health is spent on people with mental health problems in primary care?

2 What does NICE recommend as the first-line treatment for people with mild depression?

3 What obstacles are delaying the development of psychological therapies for patients with depression in primary care?

4 Identify five problems that have an impact on the current treatment of depression

5 Identify four groups of patients who are at high risk of developing depression

6 Which four key questions are asked to establish the level of suicide risk?

7 Which of the depression screening tools gives a score for anxiety as well as for depression?

8 Name the two groups of people for whom there is a specialised screening tool for the detection of depression

9 Identify four factors that might improve the organisation of depression care

10 How many positive responses to the DSM-IV depression screening questions does a patient need to give to confirm a diagnosis of moderate depression?

RESOURCES

- **Management of Depression in Primary and Secondary Care.** NICE Clinical Guideline 23. www.nice.org.uk/guidance/CG23
- **Depression in Primary Care** www.depression-primarycare.co.uk
- **The World Health Report 2001**
  Mental Health: new understanding, new hope. Geneva: WHO, 2001.
- **Withdrawing patients from antidepressants** Drug Ther Bull 1999; 37(7): 49-52.
- **The Depression Report**: a new deal for depression and anxiety disorders. The Centre for Economic Performance Mental Health Policy Group. London: London School of Economics, 2006.