



Depression

- an evidence-based first consultation

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Key messages

(each message matches a heading in the sections below)

1. Depression is common in primary care.
2. Most patients with depression present with somatic symptoms.
3. Open the consultation by including mental health.
4. Differentiating psychological distress from depression can be very challenging particularly on the first visit.
5. Why doctors don't make a mental health diagnosis.
6. How important is it to have a diagnosis of depression versus anxiety versus something else such as being heard and understood?
7. A quick way to rule out depression is by using two questions.
8. A positive response to either "screening" questions warrants further exploration.
9. High depression inventory scores do not necessarily signify depression and will likely be lower at the next visit.
10. Consider empathic listening and non-drug therapies first.
11. Should anti-depressants be prescribed on the first visit?
12. Be aware of the risks of early antidepressant prescription.
13. Consider a phone call to the patient between visits- they are effective.
14. See the patient again in one week or negotiate the interval.

1. Depression is common in primary care

Depression, is commonly understood as a mental disorder characterized by at least two weeks of low mood that is present across most situations. It is often accompanied by low self-esteem, loss of interest in normally enjoyable activities, low energy, and pain without a clear cause.

The 14-country World Health Organisation Collaborative Study on Psychological Problems in General Health Care (WHO PPGHC) estimated that about 14% (range 2.6%-15.9%) of individuals in primary health care facilities suffered from major depression.¹ The Longitudinal Investigation of Depressive Outcomes (LIDO) in Primary Care study reported a similar prevalence for depression in primary care of 13% (range 4 -23%).²

2. Most patients with depression present with somatic symptoms.

45% to 95% of patients with depression present with somatic symptoms and 11% do not report any psychological symptoms.³

It may be easier to screen for the “somatic” symptoms of depression such as sleep, energy, appetite, movement and perhaps concentration before checking the mood, pleasure, guilt and suicidal feelings.⁴

If you think there may be a mood problem you can ask if they have been under any stress lately – as most people have been under some stress they are likely to answer yes. Filling out a depression inventory instrument (e.g. patient health questionnaire 9 [PHQ-9], Hospital Anxiety and Depression Scale – Depression [HAD-D], Beck Depression Inventory [BDI]) can be very useful.⁵

3. Open the consultation by including mental health.

Given that most consultations start with a physical presentation clinicians need to raise the possibility of a mental health cause as well a physical cause especially when the symptoms are not clearly leading to a physical diagnosis.

- Do this directly: how has your mood or spirits been lately?
- Indirectly: ask about sleep, energy, concentration, enjoyment of life and if getting lots of positives then ask directly about depression.

This is not screening for depression but case finding, as the clinician is now dealing with a patient with symptoms that could mean there is a mood component to the consultation. Screening for depression is controversial.⁶

If unsure then you can ask the patient if they would mind filling out a depression inventory (e.g. PHQ-9). If it is normal, pursue the physical health aspects. If positive, you can broach the subject by

saying “this questionnaire suggests you may be having problems with your mood – what do you think?” Many patients will be quite open to the doctor exploring their psychological concerns further. However, some patients can be very somatically oriented (i.e. not psychologically oriented) and may not accept a mental health diagnosis. It is important not to become adversarial at this point, but raising it will allow the patient to discuss psychological matters at a later time.

4. Differentiating psychological distress from depression can be very challenging particularly on the first visit

Making a mental health diagnosis in the primary care setting is challenging. As summed up by one GP “we actually risk manage and live in this glorious twilight zone of uncertainty”.⁷ A diagnosis of depression may be more safely made over more than one visit.⁸

A key challenge encountered is in case definition and deciding where the cut-off lies between psychological distress and clinical depression. Primary care doctors are usually able to recognise patients experiencing distress as a result of problems in their lives, but find it more difficult to decide whether the issues are clinically significant and whether or not to make an explicit mental health diagnosis.⁸ A meta-analysis undertaken by Mitchell *et al.* found that we are 50% more likely to diagnose depression when it is not present, than to identify a case correctly, or miss a case when it is present.⁹

The issue of distress is acknowledged in primary care but there has been limited work on how to measure it. A questionnaire from the Netherlands has been validated and measures distress, anxiety, depression and somatisation and is known as the 4-DSQ.^{10 11} Its main limitation is it has 50 questions which make it less useful in regular short primary care consultations.

5. Why doctors don't make a mental health diagnosis

There are many reasons why doctors may not make a mental health diagnosis even if they are aware that the patient is experiencing psychological distress.

Doctors are usually trained to explore the physical aspects first based on the premise that it is bad practice to miss a physical diagnosis but less problematic to miss a mental health diagnosis.⁷ Family doctors tend to think in terms of problems rather than diagnoses, and may not label a patient with depression unless they plan to treat it.^{12 13}

In some countries, family doctors may not be allowed to make a mental health diagnosis, and are expected to refer all suspected cases to a psychiatrist.

Some doctors don't like dealing with mental health issues.⁷ Some are reluctant to explore psychosocial issues in case they open up Pandora's Box.⁷ Ironically at the bottom of Pandora's Box lies hope. Some avoid doing so due to a lack of confidence or feeling under skilled in raising mental health issues.¹⁴ There may be issues related to the clinician's own emotional fragility – as described in a poem by GP poet Glenn Colquhoun, "I saw a young woman for a repeat prescription. Her story was so large I knew not to ask about it in the morning when the day is fragile with need." Here the clinician is not feeling emotionally able to deal with the anticipated complex issues being presented by a distressed patient.¹⁵

Some doctors have concerns about stigma for the patient⁷ whilst others are concerned about the impact on future insurance claims if a diagnosis of depression is recorded in the medical records.⁷

Some doctors may take the view that many conditions currently diagnosed as major depressive disorder, especially those related to other forms of loss, are better understood within a model of grief that does not assume drug treatment.^{16 17}

6. How important is it to have a diagnosis of depression versus anxiety versus something else such as being heard and understood?

There is considerable overlap in symptoms between depression and anxiety disorders. The Magpie study from Wellington, New Zealand found 18.1% of primary care patients met the criteria for depression over the past 12 months but 56% of them had a co-existing DSM IV level anxiety and 20% a substance use and dependence disorder.¹⁸ Some people with medically unexplained symptoms may be anxious or depressed. There will be a new term in the ICD-11 called anxious depression which includes mixed anxiety depression.¹⁹

Diagnostic accuracy improves over a period of observation and doctors are more able to make a diagnosis of depression in patients who they have seen several times.⁸

Shared understanding of the patient's problems is important. This may include understanding the cultural aspects that are relevant for the patient. Establishing patient rapport, obtaining patient trust, allowing patients to tell their stories, show respect, and allow a healing partnership.²⁰ There are structured approaches to enhancing the clinicians communication skills, such as asking five questions (BATHE approach): what is going on in your life, how do you feel about that, what troubles you most about this, how are you handling that, that must be difficult for you.²⁰

Active listening is recommended.²¹ The late Professor Ian McWhinney said "the greatest single problem in clinical interviewing is the failure to let the patient tell their story."²² The patient's context is also important and in addition to the mental health concerns, consideration of loneliness, co-morbid physical conditions, family violence, sexual and physical abuse, crime, war, migration and homelessness may be needed.

7. A quick way to rule out depression is by using two questions.

We are not recommending screening here. This is for the patient where the presenting symptom is somatic and the physical diagnosis is elusive. The probability of a mental disorder/distress will be much higher than seen in a screening population as the more physical symptoms there are, the more likely there is to be mental health diagnosis. The prevalence in such a clinical setting will be higher than in a screening population and the activity is thus considered to be case finding.²³

1. Have you felt depressed down or hopeless for all or most of the past month?
2. Have you lost interest or pleasure in all or most activities over the past month?

A negative score on both almost always rules out depression.²⁴

8. A positive response to either screening questions warrants further exploration.

If patients answer yes to either question they may be depressed. A PHQ- 9 or other depression inventory will assist in giving a measure of severity.²⁵

Family doctors should always consider suicide risk and the patient's functional ability. The PHQ-9 has questions on suicide and functioning. Among those in the general population who commit suicide, up to 41% may have contact with psychiatric inpatient care in the year prior to death and up to 9% may commit suicide within one day of discharge. The corresponding figures are 83% and 20% for general practitioners. Among those who die by suicide, contact with health services is common before death.²⁶ The National Institute for Health Care Excellence [NICE] (UK guidelines group) recommends "Always ask people with depression directly about suicidal ideation and intent if there is a risk of self-harm or suicide."²⁷

An informal assessment of function can be made by asking the patient about difficulties experienced in social, occupational and family situations.

At this point it is important to check for any past history of mania as about 10% of the primary care population prescribed antidepressant medication actually have undetected bipolar disorder.²⁸ Assessment is also recommended for alcohol and drug use.

9. High depression inventory scores do not necessarily signify depression and will likely be lower at the next visit.

The PHQ-9 gives a measure of distress and patients can have very high scores and not be depressed.²⁹ Research undertaken in the UK suggests that a score of 12 or more on the PHQ-9 (the maximum score is 27) may be a better cut-off to use when deciding whether or not to offer active treatment (usually non-drug first) as this score demonstrated greater specificity, and the same sensitivity than a score of 10 for major depression in a UK population.³⁰

There is evidence that 60% of primary care patients will have a resolution of their depressive symptoms over one year even if the depressive symptoms were not recognised at the first visit.³¹ Many patients' scores are already lower in the following week– due either to regression to the mean or having discussed their symptoms with a clinician (Dr Michael Balint called this 'the doctor as the drug').

10. Consider empathic listening and non-drug therapies first

We would encourage you to begin with non-drug therapies for most patients. NICE guidelines recommend not starting medication at lower levels of severity but to use non-drug therapies.³²

Consider trying low intensity psychosocial interventions first. These may include:

- sleep hygiene,
- individualised self-help principles of CBT,
- computerised CBT (e.g. moodgym.com) with or without a facilitator,
- problem solving therapy,
- behavioural activation,
- physical activity (recommended in groups),
- psychoeducation – explaining the causes of depression can normalize the diagnosis and reduce self-stigma and reduce blame,³³
- group therapy has been shown to be effective in developing countries.³⁴

A Cochrane review found that exercise is moderately more effective than a control intervention for reducing symptoms of depression, but no more effective than psychological or pharmacological treatments.³⁵ In a 2016 RCT, Hallgren found that exercise is beneficial for depression even when it is light (yoga and stretching) as opposed to moderate and vigorous and when conducted once per week.³⁶ Furthermore, there can be cardiovascular and metabolic benefits for patients with depression.

Acceptance and commitment therapy (ACT) is a third wave cognitive behavioural therapy that includes a mindfulness component. It uses a trans-diagnostic approach and patients are considered

to be “stuck” rather than depressed or anxious.³⁷ Limited time is spent on diagnosis when used in primary care with the emphasis being on getting on with therapy as many patients do not return for a second visit.³⁸

11. Should anti-depressants be prescribed on the first visit?

There is currently an absence of evidence on what treatment to start at the first visit. What is known is that the magnitude of benefit of antidepressant medication increases with severity of depression symptoms and may be minimal or non-existent, on average, in patients with mild or moderate symptoms. For patients with very severe depression, the benefit of medications over placebo is much more substantial.³⁹ As most patients in primary care are in the mild to moderate range and many of those in the severe range will become mild to moderate fairly quickly, most patients will not benefit from antidepressants.

12. Be aware of the risks of early antidepressant prescription

There are many risks of early prescribing: the patient may not come back; they may have difficulty in stopping their medication; they may overdose on them and many patients will get adverse effects.⁴⁰

We do not suggest using antidepressants routinely to treat persistent sub-threshold depressive symptoms or mild depression because the risk-benefit ratio is poor. Most people do not benefit from antidepressants, and improvements are more likely to be a placebo response rather than a medication response. For mild to moderate depressive symptoms, the placebo response will be about eight times more likely than a true drug response.³⁹ As most patients are likely to get a placebo response they are likely to give the medication the credit rather than their changed world view. They may demand medications the next time they feel distressed, thereby medicalising their suffering.⁴¹

Problems associated with withdrawal symptoms when trying to stop these medications also need to be considered as it can lead to the unnecessary long term use of antidepressants.⁴⁰

NICE advises avoiding drug treatment unless there is a past history of moderate or severe depression that persists after other interventions, or sub-threshold symptoms that have been present for a long period typically at least two years.³²

13. Consider a phone call to the patient between visits- they are effective

In a randomised controlled trial, nurse-led telehealth care improves clinical outcomes and patient satisfaction.⁴² In each telephone call the clinic’s nurse asked the patient about any concerns

regarding the antidepressant medication, offered suggestions on how to deal with minor side effects, and emphasized the importance of taking the medication regularly. The nurse offered emotional support and helped patients identify activities that they were willing to try to be more active and to find pleasure. Furthermore, the nurse could also address issues about other medical conditions and discuss the patient's overall health.⁴²

In some health services a nurse may not be available. A study in Germany used Health Care assistants for this task.⁴³

14. See the patient again in one week or negotiate the interval

There is no evidence base for choosing such a time interval but we are influenced by the comments of a UK GP in the "Insider's guide to depression" where she says "see us frequently at first, a week is a long time in a Dali landscape. Three weeks are almost unimaginable."⁴⁴

We acknowledge that weekly follow up may not be within the resources of some health services and that factors such as severity may influence the discussion.

Disclaimer.

The authors all work in developed countries and are aware that some of our suggestions may be not be feasible in all countries. Issues of language, war, migration, distance, cultures that prefer verbal rather than written transactions, staffing, translation of questionnaires and limited roles for primary care practitioners in mental health will all modify the ability of some practitioners to follow our suggestions.

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