Improving the treatment of depression in primary care: problems and prospects

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SUMMARY

Previous work has succeeded in improving the recognition of depression by general practitioners. This is likely to be of most benefit when it results in effective treatment. Factors compromising the effectiveness of pharmacological treatments include non-compliance, non-response, and relapse of depression. Psychological therapies, such as cognitive therapy, are effective and may prevent relapse, but are not available to the majority of depressed patients seen in primary care. Existing evidence demonstrates that primary care staff can be trained in effective psychological interventions for depression, but interventions need to be developed which are sufficiently brief to be incorporated into routine treatment. Consistent provision of information about depression, coping strategies, and sources of support may improve compliance with treatment and subsequent outcome.

Keywords: depression, management of disease, coping strategies.

Depression in general practice

MANY studies have documented the high prevalence of depressive symptoms in the general population where the lifetime risk of major depression is between 10% and 20%.[1] Between 5% and 10% of patients in general practice samples meet diagnostic criteria for major depression (i.e. have a depression with at least six significant symptoms present over a minimum two-week period). A similar number can be diagnosed with minor depressive disorder (i.e. similar mood disturbance, but with fewer other significant symptoms than are present in major depression).[2,3] Although the outcome for the majority is good, a substantial minority do not fare well, leading to calls for improvements in the diagnosis and treatment of depression in general practice.[4]

The effects of detection of depression on outcome

Some patients who meet objective criteria for depressive disorders are not diagnosed as depressed by their general practitioners (GPs). Rates of apparent non-detection of depressive disorder may be as high as 30–50% for patients attending single consultations. Thus, many depressed patients, particularly those presenting with somatic symptoms[5] or less severe disorders[6], may be going undiagnosed and untreated. The consequences of non-recognition of depression on outcome have been examined in a number of studies.

Naturalistic studies have identified patients meeting criteria for depression, which was either detected or not by their GP, and have examined the subsequent course of the disorder. Results have been mixed, with some studies finding better[5], some equivalent,[3,7] and some worse[8] outcomes for recognized compared with unrecognized cases. These studies suggest that those with more severe or chronic depressions are more likely to be detected and treated, but are also more likely to have worse outcomes. Other studies have identified samples of patients whose depression was initially missed and then examined the effects of informing the GP of the presence of depression. Although some studies found better outcomes for patients whose GPs were notified of their depression,[9,10] others have found no benefit.[8] Beneficial effects may be confined to those who receive antidepressant medication as a result of being diagnosed as depressed.[10]

Overall, these studies suggest that diagnosis of depression through spontaneous recognition or subsequent notification does not always improve subsequent outcome. Improving detection of depression in primary care is most likely to be of benefit when it permits more effective treatment strategies to be followed. Diagnosis is most important for major depressions or chronic minor depressions, which are least likely to improve without treatment.

The effectiveness of pharmacological treatment in primary care

A range of pharmacological treatments have been shown to be effective for major depression in double-blind, placebo-controlled trials, most often carried out in psychiatric samples.[11] Under these optimum conditions, approximately 40–60% of patients achieve full remission over a 2–4 month treatment period.[12] A small number of controlled trials have provided evidence that medications at therapeutic doses are effective in patients with major depression in general practice.[13] However, the demonstrated efficacy of medication under controlled conditions does not always transfer into clinical practice,[14] and a number of factors may work against achieving response to medication in general practice.

First, medication may be less effective in the kinds of depressed patients typically seen in primary care. The advantage of medication over placebo in patients with less severe major depression[15] or with minor depression[13] has not been established. Such patients are likely to comprise a large proportion of those seen in primary care. Although remission rates are higher for less severe depressions even without treatment, a substantial minority of cases may persist or worsen, particularly where there are co-morbid psychological or physical conditions.[16]

Secondly, the rigour with which treatment is applied in trials may not always be feasible in general practice. Doses of tricyclic medications prescribed in general practice have often been found to be below the therapeutic threshold, even in the face of non-response.[17,18] Inadequate knowledge about antidepressant medication may contribute to this: in one survey of GPs, 26% confessed an inability to make an informed choice of antidepressant.[19] Non-compliance by patients is also a problem. In one study, more than two-thirds of patients had stopped their medication within four weeks of prescription.[18] The reason most commonly given for not complying with treatment was the occurrence of side-effects, particularly dry mouth and sedation. Such a high degree of non-compliance clearly limits the effectiveness of pharmacological approaches to depression in general practice.

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Finally, although many depressed patients make a full and sustained recovery, approximately 30% of treatment responders relapse within one year in both psychiatric and general practice samples.[20] Studies within psychiatric samples have found that patients with residual symptoms are the most likely to relapse[21] and this is likely to apply equally to general practice samples. A significant minority of patients with depressive symptoms seen in general practice will follow a course of partial response to treatment followed by relapse.

In summary, the problems of lower efficacy of medication in less severe depression, prescribing of inadequate doses by doctors, and non-compliance by patients undermine the effectiveness of pharmacological treatment in primary care. Even where pharmacological treatment is successful, subsequent relapse is common. Other forms of treatment must also be considered.

The effectiveness of psychological treatments in primary care

A range of psychological approaches to the treatment of depression can complement drug treatment. Whereas there is little evidence for the efficacy of counselling[22] or interpersonal therapy[23] in treating depression in general practice settings, cognitive therapy has been more extensively researched. A number of controlled trials have demonstrated the effectiveness of cognitive therapy in the treatment of major depression in psychiatric samples.[24] Three studies have investigated the efficacy of individual cognitive therapy in general practice settings. In one study, cognitive therapy alone was more effective than medication alone;[25] in a second study, cognitive therapy combined with treatment as usual from a GP was superior to treatment as usual alone[26]; but in a third study, cognitive behaviour therapy was not significantly more effective in the short-term than routine GP care.[27] There is encouraging evidence that relapse rates are significantly lower following acute treatment with cognitive therapy than following medication.[28-30] Thus, cognitive therapy can be an effective treatment for depression in general practice and could help to tackle the problem of continuing morbidity.

However, cognitive therapy is time-consuming, usually consisting of between 12 and 20 sessions of an hour each. In addition, its effectiveness has only been tested with mental health professionals who have had further specialist training, generally of at least a year's duration, in cognitive therapy. Therefore, the availability of cognitive therapy is limited and the majority of patients with depressive disorders in general practice are unlikely to have access to it directly after initial presentation. Thus, despite its potential effectiveness, cognitive therapy in itself is not a viable routine treatment for depression in primary care.

A number of approaches have been explored to make similar psychological approaches available to more patients. Group cognitive therapy has been developed as an effective alternative to individual therapy.[31,32] In primary care, group cognitive therapy combined with treatment as usual by the GP was significantly more effective than treatment as usual alone.[33] Abbreviated versions of individual cognitive therapy have also been developed. Preliminary data have suggested the effectiveness of 'two-plus-one' sessions of a cognitive approach[34] and of brief cognitive therapy involving six sessions of half an hour (Scott C, Scott J, Tacchi M, Jones R, in preparation). Together these studies suggest that it might be possible to deliver cognitive therapy effectively in formats which are less time-consuming than the usual 16 sessions of individual treatment. However, implementation of these approaches probably requires levels of specialist skill even greater than those required for traditional cognitive therapy. The use in general practice of even these more efficient approaches will be limited by the availability of suitably highly trained specialists.

It is an important question whether effective psychological interventions can be implemented by staff with little specialist training in mental health or specific psychological treatments. Problem-solving therapy from GPs with some additional training has been found to be as effective as antidepressant medication in depression in general practice.[35] Although additional counselling has not generally been found to improve outcomes compared with usual treatment,[22] one study found higher rates of recovery in women who received counselling for post-natal depression from health visitors than in those who did not.[36] In this study, the health visitors received six hours of training in counselling for post-natal depression. These studies suggest that primary care staff can apply effective psychological interventions, and that training in a specific treatment package is more likely to be of benefit than improving general counselling skills. More attention needs to be paid to how such findings might be implemented on a larger scale.

Improving the treatment of depression in primary care

Although it has been suggested that more use should be made of specialist services in treating depression,[37] a review comparing treatment by mental health specialists with that by GPs revealed only a 10% greater success rate for the specialists.[38] Such a modest increase in effectiveness is unlikely to justify making available specialist services to all depressed patients seen in general practice. The potential for improving the treatments routinely available to depressed patients within primary care must be explored. A number of steps might be taken to improve the adequacy of and compliance with pharmacological treatments. There are also a number of ways in which psychological approaches might be made routinely available: through GPs' own use of psychological techniques; through the use of other members of the primary care team; through the provision of materials for individuals to help themselves; and through coordination with support groups in the voluntary sector.

The possibility that failure to detect cases of depression may deny people access to effective treatments was reviewed earlier. Training courses designed to improve interviewing skills have been shown to improve detection of emotional disorders.[10,39] Such approaches are now incorporated into the initial training of GPs and continuing medical education programmes. This is a welcome development and similar steps may be helpful in addressing problems of inadequate treatment and poor compliance.

Although adequate doses of antidepressant medication are not universally effective, they are certainly more effective than inadequate doses. To the extent that prescription of inadequate doses results from lack of knowledge, GPs need to be informed about adequate doses of common antidepressant medications. This needs to be highlighted both in initial training and in continuing education on new medications that become available. Concerns about side-effects may also prevent the prescription of adequate doses. Use of selective serotonin reuptake inhibitors may improve compliance, as these medications typically produce fewer side-effects than tricyclic antidepressants.[40] However, no medications are free from side-effects and many patients have reservations about taking medication at all, so other strategies for improving compliance must also be considered.

There is evidence in bipolar disorder that provision of information about the disorder and its treatment improves compliance with medication[41]. Furthermore, the suggestion of cogni-

tive and behavioural strategies by GPs when prescribing antidepressant medication was associated with improved compliance.[42] As patients are unlikely spontaneously to express doubts about complying with treatment, the provision of information about depression and its treatment that is likely to improve compliance should become part of the routine of prescribing.

As well as improving compliance, information on depression and self-help strategies may directly enhance outcome. Provision of self-help materials in addition to usual GP care to patients suffering from depression or other stress-related problems has been shown to result in lower levels of symptoms[44,45] and fewer consultations over a three-month period[44] compared with treatment as usual alone.

There is evidence that GPs frequently suggest certain changes to thinking and behaviour that patients might make.[42] Little is known about the impact on treatment effectiveness of the use of isolated psychological techniques by GPs. General practitioners have been trained to apply treatment packages, such as problem solving and cognitive therapy, with some success. However, most GPs do not have time either to train in or practise such approaches. Existing evidence suggests that other primary care staff without specialist mental health training can implement some forms of effective psychological intervention. It has been shown that practice nurses can usefully provide support as an adjunct to usual GP treatment,[43] and that counselling from health visitors is effective in post-natal depression.[36] Intervention packages that are sufficiently brief to be implemented on a wide scale have yet to be developed and evaluated, but have the potential to improve the effectiveness of routine care.

The emphasis given so far on interventions for depression by health care professionals should not obscure the importance of social factors in depression. On the contrary, there is much useful work to be done in combating the adverse effects of poverty, unemployment, and social isolation that have been shown to be important in depression. Although the social and political mechanisms for accomplishing such changes are beyond the scope of this paper, GPs may help patients to establish contact with sources of support in the community. Patients may benefit from being put in touch with self-help groups specifically concerned with depression (e.g. Depression Alliance, telephone 0171-721 7411) or with those bodies concerned with associated problems (e.g. single-parent groups, housing associations).

Conclusions

Treatment of depression in primary care can be compromised by limitations on the efficacy, acceptability, and availability of existing treatments. Improvements in treatment may stem from the actions of individual GPs and from the provision of new forms of treatment. Individual GPs can ensure the adequacy of standard treatment by maintaining an awareness of depression, its recognition, and current prescribing recommendations through training events, discussions with colleagues, and reading. Individuals may also be able to enhance compliance and outcomes by providing information about depression and self-help strategies, preferably in verbal and written form, and by directing patients to sources of support. Within the primary care system, provision of simplified psychological treatments by other members of the team needs to be instigated and evaluated. GPs can support such moves locally in their management of their staff team, and on a wider scale through their influence on agencies that commission health care provision and health service research. Specialist services may need to increase the provision of training and consultancy to workers in primary care, as well as treating more resistant cases. In view of the great burden that depression places on stretched resources in primary care, even modest improvements to existing treatments could result in considerable overall benefit.

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