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An evidence-based first consultation for depression:

nine key messages

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1. DEPRESSION IS COMMON IN PRIMARY CARE BUT MANY PATIENTS MAY NOT RECEIVE A MENTAL HEALTH DIAGNOSIS

Depression is commonly understood as a psychological condition characterised by ≥2 weeks of low mood often accompanied by low self-esteem, loss of interest in normally enjoyable activities, low energy, and pain without a clear cause. The prevalence of major depression in primary care is estimated to be about 13% (range 4–23%).

Because doctors are usually trained to focus on physical aspects first, some may perceive that it is less problematic to miss a mental health diagnosis[1] or may even evade enquiring about psychosocial issues to avoid opening Pandora's Box (ironically in which lies hope).[1] Some perceive that low mood related to loss may be better understood within a model of grief, choosing not to diagnose depression. Others have concerns about stigma or the impact on insurance claims if 'depression' is documented.[2]

2. HOW IMPORTANT IS IT TO HAVE A DIAGNOSIS OF DEPRESSION OR ANXIETY VERSUS 'BEING HEARD AND UNDERSTOOD'?

Empathic listening is key to gaining a shared understanding of the patient's problems, including relevant cultural aspects. Actively listening shows respect, enhances rapport, builds trust, and enables a healing partnership. In addition to mental health concerns, there may be loneliness, comorbid physical conditions, family violence, sexual and physical abuse, crime, war, migration, or homelessness. Although there are reasons to avoid official labelling in primary care, it is important to identify psychological distress with or without the label.

3. DIFFERENTIATING PSYCHOLOGICAL DISTRESS FROM DEPRESSION CAN BE VERY CHALLENGING, PARTICULARLY ON THE FIRST VISIT

Making a mental health diagnosis for clinicians in primary care is challenging, and a depression diagnosis may be more accurate if made over more than one visit.[3] A key challenge is deciding where the cut-off lies between psychological distress and clinical depression, and may not be therapeutically important initially or at all. There is also considerable overlap between depression and anxiety disorders, and a new term in the ICD-11 will include mixed anxiety and depression. The Magpie study found that 18.1% of primary care patients met the criteria for depression over the past 12 months and that 56% of them had a coexisting anxiety at the DSM-IV level and 20% a substance use and dependence disorder.[3]

4. MOST PATIENTS WITH DEPRESSION PRESENT WITH SOMATIC SYMPTOMS, SO OPEN THE CONSULTATION BY INCLUDING MENTAL ALONGSIDE PHYSICAL HEALTH

Most consultations start with a physical presentation. Forty-five to 95% of patients with depression present with somatic symptoms and 11% do not report any psychological symptoms.[4] Clinicians can raise the possibility of psychological health alongside physical health, especially when symptoms do not clearly lead to a physical diagnosis. It should also be remembered that, the more physical symptoms present, the higher the likelihood of a mental health diagnosis.

If unsure, you can suggest the patient completes a depression inventory (for example, the Patient Health Questionnaire 9 [PHQ-9]). If it is negative, pursue the physical health aspects but be cognizant of poor functioning in those with sub-threshold conditions. If positive, you can broach the subject by saying, *'This questionnaire suggests you may be having problems with your mood — what do you think?'* Some patients can be very somatically oriented. It is important to recognise this and it may be better to maintain the relationship by inviting the patient to discuss psychological matters at a later time.

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5. RULE OUT DEPRESSION BY USING TWO QUESTIONS AND EXPLORE FURTHER IF THERE IS A POSITIVE RESPONSE

You may choose to ask:

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. A positive score to either signals possible depression, and a depression inventory can assist in assessing severity. The positive predictive value of a positive score on either the depression or interest/pleasure questions is around 18–20%.[5] If there is any risk of self-harm or suicide, always ask directly about suicidal ideation and intent. Always assess for alcohol and drug use, and check for a past history of mania. About 10% of the primary care population prescribed antidepressants have undetected bipolar disorder.

6. ONE-OFF HIGH DEPRESSION SCORES DO NOT NECESSARILY SIGNIFY MAJOR DEPRESSION AND ARE LIKELY TO BE LOWER AT THE NEXT VISIT

The PHQ-9 gives a measure of distress and some patients can have very high scores and not be depressed.[6] Research undertaken in the UK suggests that a score of ≥12 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).

There is evidence that 60% of primary care patients will have a resolution of their depressive symptoms over 1 year even if the depressive symptoms were not recognised at the first visit.[7] 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'*.

7. CONSIDER NON-DRUG INTERVENTIONS FIRST

National Institute for Health and Care Excellence guidelines recommend a stepped care approach by starting with non-drug interventions (NDIs) for mild-to-moderate depressive symptoms.

Evidence-based NDIs include:

- sleep hygiene;
- individualised self-help principles of cognitive behavioural therapy (CBT);
- computerised CBT with or without a facilitator;
- problem-solving therapy;
- behavioural activation;
- psychoeducation;
- group therapy; and
- physical activity.

8. THINK VERY CAREFULLY BEFORE COMMENCING ANTIDEPRESSANT MEDICATION ON THE FIRST VISIT

There is currently an absence of evidence on what treatment to start at the first visit, but there are many known risks of early prescribing (the patient may not come back, adverse effects, or overdose). Problems associated with withdrawal symptoms when stopping medication need to be considered as they can lead to unnecessary long-term use of antidepressants.

What is known is that the magnitude of benefit of antidepressants increases with severity of depression 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 more substantial but still a response is more likely to be a placebo than an active drug effect.[8] As most patients in primary care are in the mild-to-moderate range, and many of those in the severe range become mild to moderate fairly quickly, most will not benefit from antidepressants. For mild-to-moderate depressive symptoms, the placebo response will be about eight times more likely than a true drug response.[8] Patients may credit the medication for their recovery rather than their changed world view, and may demand medications the next time they feel distressed, thereby medicalising their suffering.[9]

The National Institute for Health and Care Excellence advises avoiding drug treatment unless there is a past history of moderate or severe depression that persists after other interventions have been tried, or sub-threshold symptoms that have been present for a long period, typically at least 2 years.

9. SEE THE PATIENT AGAIN IN 1 WEEK (IF POSSIBLE) AND CONSIDER PHONING THEM BETWEEN VISITS

In a randomised controlled trial, nurse-led telehealth care improved clinical outcomes and patient satisfaction.[10] Early follow-up for depression is essential, as emphasised by the comments of a UK GP in 'An insider's guide to depression': *'See us frequently at first. A week is a long time in a Dali landscape. Three weeks are almost unimaginable.'*