Should general practitioners be testing for depression?

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SUMMARY. While most patients with recognized depressive illness are treated by general practitioners without referral, there is evidence that many patients classifiable as depressed after psychiatric interview are not diagnosed as such. Missing depression is of great importance since it is now eminently treatable. This paper explores the use in primary care of questionnaire tests for depression and also their role in case finding in vulnerable groups of patients. The potential of existing validated questionnaires in clinical work and audit is largely unexploited. As yet, however, there is no gold standard for the diagnosis of depression seen in primary care. Clusters of symptoms do not yet accurately predict the course of the illness or response to treatment. More research is needed on the natural history of depression seen in the community, as well as on treatment and outcome.

Keywords: depression; diagnosis; psychiatric assessment by GP; psychiatric screening; questionnaires.

Introduction

DEPRESSION is a potentially life threatening clinical illness and one of the United Kingdom's major health problems, not only because of prolonged work absence and poor work performance but also in terms of human misery. The importance of depression to the health of the nation is recognized in the government white paper for England which targets a reduction in death from suicide, now running at 4000 cases per year in the UK.[1] A national campaign, 'Defeat depression'[2] is underway, sponsored by the Royal College of Psychiatrists in association with the Royal College of General Practitioners, and a consensus statement linked to the campaign, on the identification and management of the disease, has been published.[3]

Most depression is treated in the community by general practitioners without referral to secondary care,[4,5] yet studies have shown that general practitioners may fail to diagnose up to a half of patients presenting at the surgery and classifiable as depressed after interview by a psychiatrist.[6,7] Missing depression is of great importance since it is now eminently treatable, and simple recognition of the illness by a doctor has been shown to be beneficial even when the patient does not comply with treatment.[8]

The aims of this paper are to explore the use in primary care of questionnaire tests for depression and their role in case finding in vulnerable groups of patients. Would wider use of these instruments be an effective way of aiding the diagnosis of depression, of increasing responsiveness to treatment through earlier recognition and thus of enhancing patient care? Should the whole practice population, attending patients or vulnerable groups only be offered screening? Finally, which screening tests are most useful in primary care?

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Improving recognition

The practical problem for the general practitioner is to be able to identify depression in the limited consultation time available and within the context of continuing care for patients of all ages presenting with a variety of problems. The patient may have physical illnesses with symptoms that overlap the presenting somatic symptoms of depression such as tiredness, weight change, abdominal pain or headache. Both patient and doctor are looking for an underlying cause for the patient's symptoms. Most people who seek medical help turn first to their general practitioner; a substantial number do not present directly with psychological symptoms of depression.[9,10]

Even if detection by general practitioners could be enhanced by the promising new training techniques for improving the psychiatric skills of general practitioners,[11] it seems unlikely that the proportion of depressed people discovered by general practitioners could be substantially increased without formal testing.

Research psychiatrists have defined the syndrome of major depressive disorder,[12] and diagnostic instruments based on such definitions have been shown to discriminate responders to antidepressant drugs from non-responders in general practice.[13] The general practitioner deals with a broad range of depressive illness that includes not only major depression but also many less severe but more chronic or intermittent types of depression that are frequently intertwined with chronic physical illness. Depression which does not meet psychiatric criteria for a major depressive episode may still have a considerable impact on the quality of a patient's life. What exactly should general practitioners look for when testing for depression? What should be the operational definition of a case of depression in primary care? As with common medical conditions such as hypertension and peptic ulcers it is important to recognize and manage borderline as well as severe cases.

One disadvantage with research classifications of psychiatric disorder is that they are designed primarily to make highly reliable diagnoses. Diagnostic criteria used by researchers rarely provide a workable taxonomy of clinical problems seen in general practice and seldom relate directly to a distinctive treatment or management. On the other hand, clinical assessment of psychiatric illness by general practitioners is known to be remarkably variable.[14] Diagnostic categories in primary care, and the associated testing should relate to clinical management.

There is already an extensive literature on the development and use of self-rating psychiatric screening questionnaires in the community arising from the work of Shepherd and colleagues[15] and Goldberg.[16] Valid pencil and paper tests are available to help identify psychiatric illness including depression.[17,18] Computerized questionnaires, which patients complete themselves using a keyboard, have been used in research work by psychiatrists[19] and are also suitable for use by the general practice team.[20]

The general health questionnaire[21] and the hospital anxiety depression scale[18] have been used extensively in primary care populations. Both the hospital anxiety depression scale and the shorter versions of the general health questionnaire are constructed to avoid misdiagnosis of true symptoms of physical disease from those somatic symptoms occurring in depression. Use by general practitioners in their practices[22] suggests that they are generally acceptable to patients while providing the general

practitioner with much more detail about psychological symptoms. If the doctor makes appropriate use of the information provided by the general health questionnaire the patient is likely to recover more quickly from psychiatric disorder.[23,24] Thus, a psychiatric screening test may be of value in clinical as well as academic work.

Other screening devices, like the erythrocyte sedimentation rate, are accepted as useful in alerting the clinician to the possibility of serious illness.[25] The validity and reliability of psychiatric research instruments have been substantiated by their authors but not their utility during a busy consulting session: will the result of a test affect the doctor's clinical judgement? These screening questionnaires provide a probability estimate of psychiatric caseness. If patients complete such a questionnaire before seeing the doctor, information will be available to the doctor when the patient is seen on how likely it is the patient would be classified by a psychiatrist as either a probable case or a probable normal. This information in itself would improve the detection of masked depression and influence the appropriateness of referrals to secondary care.

Screening and case finding

For some years psychiatrists have been raising the issue of screening in the community for psychiatric illness.[23,26] In a classic screening programme a test is applied to apparently healthy volunteers in order to identify those individuals at high risk of having otherwise unrecognized disease. Probable cases can then be referred to their own doctor to confirm the diagnosis and for any necessary treatment. It is understood by those screened that they will be followed up and, if the diagnosis is confirmed, they will receive treatments of established efficacy.[27] For the moment, the case for classic population screening in general practice for psychiatric illness is unproven.

In contrast to screening, case finding is a process whereby patients who have sought health care (for example, from their general practitioner) are tested, with their consent, for disorders which may be unrelated to their presenting complaint. This more selective strategy would appear to be more practicable than a classic screening programme to detect clinically significant depression in general practice. After case finding the doctor will need to make follow-up arrangements for the continuing clinical care of the patient whose illness has been identified.

Skuse and Williams have pointed out that two factors determine whether case finding for psychiatric illness in general practice will be beneficial: the number of patients with psychiatric illness being correctly diagnosed and the benefit to cost ratio for the procedure.[28] Cost should be assessed in broad clinical terms and not in the exclusively monetary sense. These authors have developed a method for calculating the probable effect of introducing a case finding procedure into general practice but the data required to determine values for cost and benefit to enter into this model are not readily available. In any service application of case finding, as distinct from research procedures, consideration of whether or not benefits exceed the medical and financial cost should be mandatory.

Selective screening for high risk groups is well established practice for other diseases and may be applicable to high risk groups for depression in general practice. Such a clinical policy might be appropriate, as part of health checks, for those thought to be at risk by reason of lifestyle or social circumstances, physical illness, or family history. A questionnaire for psychological distress ought to be as much a part of the screening clinic for those aged 75 years or more as urinalysis, weight or other conventional measures. Such a policy would provide a second line of defence against missing important psychological problems as well as physical disease.

Clinical applications of questionnaires

There are several clinical situations where questionnaires could be useful.

- They can be used to aid diagnosis when psychiatric disorder is suspected but the presentation is masked by prominent physical symptoms.
- Repeated tests can be used to monitor clinical progress[29] or to assess change in chronic disorder, and tests might be of value in predicting the likely benefit of drug treatment.
- Repeating a test one or two weeks after the initial test can differentiate temporary mood disturbance from true psychiatric disorder.
- In an area of general practice which trainee practitioners often find difficult, questionnaires might be of value in clinical training.
- Self-rating scales could also be used in clinical audit projects as outcome indicators of psychiatric care; their application should be systematically explored.

Personal clinical experience confirms the acceptability to patients of questionnaire testing and suggests that discussing the results during the consultation helps patients to verbalize their feelings, enhancing compliance in patients concerned about psychotropic drug treatment.

Problems with testing

Psychiatric screening questionnaires have been developed for research work which involves groups whereas clinical practice is concerned with individual patients. Therefore, the results of self-rating in individual cases should be interpreted with caution. Some patients are extreme raters and the scores on any kind of ratings scale should not be used as a diagnosis any more than urinalysis, peak expiratory flow rate or sleep diaries should be used alone. It should also be remembered that labelling a patient as psychiatrically ill can do harm in some instances. Existing screening tests for psychiatric illness often yield too many false positives to be suitable for routine use in clinical practice unless higher cutoff scores are used.[22,30] For clinical use a test should have a high positive predictive value, indicating that the patient is really psychiatrically ill in the case of a screening test or that, for example, the patient will respond to antidepressants in the case of a predictive test. Wilkinson and Barczac used both the general health questionnaire and the hospital anxiety depression scale in general practice.[31] Both questionnaires showed good discrimination between cases and non-cases. The general health questionnaire is widely used but may not detect chronic illness as it is sensitive to changing symptoms. The hospital anxiety depression scale is recommended by Wilkinson and Barczac for its ease of completion and constant threshold score. They suggest that the inexperienced general practitioner or those working in non-English speaking communities (the hospital anxiety depression scale is available in different languages) would find results useful before prescribing antidepressants.

General practitioners rarely make false positive diagnoses but do miss a large proportion of cases screened as positive by the general health questionnaire or hospital anxiety depression scale. There is still uncertainty about the true definition of a psychiatric case among patients seen in a general practitioner's surgery so that opinions of generalists and specialists will differ on occasion. A general practitioner's diagnosis will be more clinically appropriate than a positive screening test alone though the general practitioner's diagnosis should take the screening results into account.

The value of a test in clinical work will lie in its ability to help with accurate predictions that contribute to a good clinical de-

cision on diagnosis or treatment. Clinicians will also need to be convinced that using a questionnaire is worth the time it takes. Though patient-completed questionnaires may be expected to assist in diagnosis of psychiatric illness including depression and in monitoring clinical progress they cannot be a substitute for clinical awareness of the possibility of depression. Clinical vigilance involves considering the possibility that every psychologically distressed patient might be depressed. Few patients are put off by questions concerning sleep, energy, unusual irritability or aches and pains. Patients should ideally be asked about their experiences as well as their symptoms, remembering that tact is required if asking about thought disturbance or suicidal ideation.

Further research

Further research is needed before screening for depression could become part of everyday practice. Important questions for the researcher are whether screening tests can also predict outcomes such as response to treatment, social functioning or the possibility of recurrence. Many validation studies of the use of screening questionnaires have been short term often involving single consultations, yet repeating these tests in the course of an illness is probably the best method of measuring the course and outcome of mental illness in the community. Self-administrated computerized assessments have the advantage over pencil and paper tests in that they provide more detailed information by allowing branching more easily so that questions asked can vary in response to the patient's answers. An added clinical bonus is the therapeutic effect of taking a patient's history by computer.[32]

As suggested by Lewis, computerized testing may therefore be of use in providing a standardized assessment from which clinical guidelines could be developed.[33] A basis for the development of such guidelines is provided in the report of the working group of the royal colleges of general practitioners and psychiatrists on shared care.[34] Questionnaire testing could provide extra diagnostic information for the general practitioner without the need for referral. The assessments could be linked eventually to advice on diagnosis and guidance on management. The resulting guidelines should be based on randomized clinical trials which have used the computerized assessment to identify groups who will benefit from treatment.

To date, most research has been done in clinic settings or in special situations so that gaps remain in the knowledge required to teach the recognition of depression and other psychiatric illnesses in health service general practice. Research diagnostic criteria should not be the only benchmark used in deriving a gold standard for the diagnosis of clinically significant depression in the conditions of everyday general practice. General practitioners care continuously for the same few thousand patients through many illnesses and over many years. The exclusive use of research diagnostic criteria undervalues the usefulness of the general practitioner's opportunity to observe, or simply sense, changes in appearance and behaviour. It is surely time, building on sound research work, to widen the debate on this basic issue.

At a time when the resource implications of any new clinical activity are assuming ever greater importance, it will be necessary to estimate with precision the likely outcome of introducing a case finding procedure in general practice. The theoretical model of Skuse and Williams[28] needs to be tested by providing the data from which to derive values for cost and benefit.

Conclusions

Most general practitioners dread missing a case of meningitis, which is relatively rare in general practice, but are less concerned about missing a case of depression which is common and also potentially life threatening. Using screening tests clearly increases recognition of psychiatric illness in the community. Whey are they not more widely used in practice?

One reason for this may be that the general practitioner is unsure how to interpret the results in clinical terms so there is little evidence as yet that they affect what doctors do as measured by increased prescribing or referral. The aim of primary care testing for depressive illness must be improvement in recognition of the disease in attending patients contributing to an improved outcome. The case for a widespread classic screening programme is unproven, certainly on the grounds of cost effectiveness, and should not be introduced at this time.

On a clinical level it is likely that the familiarity gained by regular use of a questionnaire by the doctor would improve awareness and interview skills, helping focus the consultation towards psychological problems especially when the patient preferentially presents somatic symptoms. Applying a test at least once to a representative sample of people attending the surgery would indicate the hidden morbidity in consulting patients. Practice nurses, health visitors and other members of the primary care team are also potential users of these questionnaires.

More research is needed about the natural history of depression seen in the community as well as on treatment and outcome. More answers would already be available if the same resources that have been used to evaluate screening for cancer or heart disease had been applied to the primary care evaluation of questionnaire tests for depression.

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