Family Practice 2012; **29**:1–2
doi:10.1093/fampra/cmr131

Recognition of distress and depression in primary care: how far should we go?

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This issue has a mental health theme. Three very different research reports and a discussion paper examine the limits and core principles of mental health in family medicine. However much we claim that Descartes was wrong and that the mind and the body should be considered together, psychological issues have a way of making themselves distinct. Mental illness is invisible, silent and denied, but also, when services and support are not there, the part of our work that causes family doctors to become most agitated. In the first paper Kamphuis *et al.*[1] show the value of epidemiological studies using well-defined criteria and high quality methods of measurement; it is probably the highest quality long-term study of recognized and unrecognized depression and course over time. It provides further evidence about the chronicity of many cases of depressive disorder, but while showing greater improvement for those who are recognized, does not provide definitive evidence that those who were not recognized would be better if they had been; it is possible that an unmeasured confounder such as expression of emotions is responsible for improved outcome.

The next two papers raise very different issues about the theoretical and practical limits of primary care mental health. Moscrop *et al.*[2] report an intriguing analysis of young adult non-attenders within a family medicine setting. Using a careful follow-up of records and matched controls, they show that individuals between 15 and 35 who miss appointments are more likely to have had mental health problems in the past and more likely to present mental health problems in the future. The practical implications of this finding are not immediately obvious for the busy practitioner. Personal correspondence with the lead author has revealed that the predictive value of this finding is increased by considering both characteristics together: 69% of those with previous mental health problems as well as non-attendance go on to have a further mental health presentation, compared to 49% of those with previous mental health problems who manage to attend their appointment. This raises the question as to whether practitioners should act on this and contact such individuals and how proactive services should be to wider indicators of mental health problems. Our response to this dilemma may depend not only on further evidence of potential effectiveness but also on how much we think primary care should present itself as capable of addressing mental health problems rather than leaving individuals to look after themselves until they request help.

The third paper provides an exploratory evaluation of an intervention that attempts both to enhance individuals' personal response to distress and to provide a proactive primary care response to psychosocial problems, which are not classified as psychiatric disorders. Collings *et al.*[3] show that a brief intervention, directed at those with subthreshold mental health syndromes and targeting patients' identified goals, was regarded positively by both clinicians and patients. The intervention included several facets not normally seen in primary care mental health research: selection took account of practitioners' judgement of distress; the 'coaching' was provided by generalist practitioners and it deliberately sought to identify individuals' strengths. This contrasts with guidelines for depression and anxiety that emphasize the need to select according to diagnosis and onward 'disposal' with a prescription or for therapy and raises a number of important questions for research in this area. Beyond concerns about its time-limited nature, one potential weakness in the intervention was the relevance of the written material: it is hard to develop a protocolized brief intervention for such a heterogeneous group of individuals. And relatedly, while performed by generalists, the coaching was not explicitly based around the current heterogeneous practice: how far should psychological interventions be adapted according to context? Proving effectiveness will probably require a cluster randomized controlled trial; decisions about inclusion criteria, appropriate outcomes, how far the intervention can be flexed and what effect size would make such a low-intensity intervention cost effective make research into the benefits of the consultation's contribution challenging.

The issues raised by these papers go to the heart of concerns about the commodification of primary care mental health. They are both philosophical—'how

much should mental well-being be incorporated into the realm of health care?'—and epistemological—'what kind of evidence should be incorporated into our decision making?' The discussion paper in this issue of *Family Practice* examines how evidence about diagnosis, stigma, personal strengths and the social aspects of mental illness should influence both diagnostic formulation and service design.[4]

Declaration

Funding: My post is supported by funding from the National Institute for Health Research's Collaboration for Leadership in Applied Health Research and Care for the South West Peninsula. The views expressed in this editorial are mine and not necessarily those of the NHS, the NIHR or the Department of Health.
Ethical approval: none.
Conflict of interest: none.

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