

## Key Messages

- Depression is common in primary care and is a major cause of disability
- Routine psychosocial assessment is the key to improving the recognition of depression. The use of simple, verbal 2 – 3 question screening tools is recommended when targeting adults at high risk for depression
- Assessment should include identification of key stresses contributing to the presentation so that these can be addressed in the management plan
- A high index of suspicion is needed for substance use disorder as it is often harder to recognise than other mental disorders
- K10 and PHQ-9 are useful assessment and monitoring tools
- Most people can be managed within primary care using a stepped care approach
- Use of self-management strategies, including e-therapy, should be encouraged and supported by practitioners
- Psychological and pharmacological therapies are equally effective for treating adults with moderate depression
- Where antidepressant therapy is planned, SSRIs are first-line treatment, with few exceptions
- Planned treatment for depression should reflect the individual's values and preferences and the risks and benefits of different treatment options

# Introduction

Mental disorders are extremely common with over one third of adults who attend primary care likely to have met the criteria for a DSM-IV diagnosis within the past year.<sup>1</sup>

It is probable that a significant number of people with mental disorders are not identified. This can be due to time and resource constraints and relatively low priority placed on patients with minimal functional impairment, especially if they have more urgent medical problems. On the other hand, many people with a diagnosis of depression will be prescribed antidepressants when psychological therapy alone would have been effective treatment. Adjunctive psychological therapy with antidepressants is often neglected due to lack of available services, cost or time constraints.

## **Epidemiology of Mental Disorders in New Zealand.<sup>1</sup>**

Mental disorders are very common in the New Zealand population. A survey conducted between 2003 and 2004, in 13,000 people aged 16 years and over, identified a 40% self-reported lifetime prevalence of a mental disorder. Overall, anxiety disorders were the most frequently reported (lifetime prevalence rate of 25%), followed by depression

and other mood disorders (20%) and substance use disorders -predominantly alcohol (12%).

Other New Zealand studies have shown that half or more of all people who develop a serious mental disorder had experienced the disorder by age 18 years. However, a first episode of depression can occur at any time of life with about a quarter of first episodes reported in people aged 50 years and older. Women have a higher lifetime prevalence rate of disorder than men, particularly major depressive disorder.

New Zealand research has also shown that people with mental disorders do use primary care services although they may not present with these as their main problem. Primary care is well placed to provide effective management of these treatable disorders.

## **Cultural Issues**

There is an inextricable link between health and culture. Cultural identity is an essential component of good health and effective services must reflect all dimensions of wellness. Central to this is recognition of whānau ora, building on the strengths of whānau and encouraging their

involvement in the process of recovery. Services will improve when models of practice incorporate a better understanding of the importance of whānau, and the interface between culture and clinical practices.<sup>7</sup>

Traditional Māori and Pacific perspectives challenge some commonly held assumptions, such as the focus on developing individuality and self advocacy. There is speculation that therapies that focus on the individual may be less relevant and less acceptable for Māori and Pacific patients, who place more emphasis on relationships beyond the individual.<sup>1</sup>

Key cultural issues that need to be addressed in the care of all patients include: <sup>1</sup>

- acknowledgement of environmental factors such as the role of the wider whānau
- awareness of different belief systems and lifestyles
- knowledge of existing support systems such as kaiatawhai (Māori health workers), whānau, kaumatua (elders), ministers, consumer advisers and other specialist service providers

Kaupapa Māori Mental Health Services have wide networks and diverse expertise including the assessment of patients with culturally specific syndromes. Similarly for Pacific peoples input from cultural advisors, leaders, healers or ministers of religion may be needed.<sup>1</sup>

 see BPJ 14 – “Māori Mental Health” for more information on culturally specific syndromes

The primary care sector is the logical place for the delivery of mental health care to Māori, Pacific Peoples and other ethnic groups. It offers better prospects for early intervention and the management of comorbidities.

# Depression in Māori and other ethnicities

## Tangata Whenua

Māori have higher prevalence rates of mental health disorders overall than the rest of the population and experience greater severity, burden and impact.<sup>2-7</sup> Te Rau Hinengaro, the New Zealand Mental Health Survey, reported that 3 in 5 Māori are predicted to experience a mental illness sometime in their lifetime.<sup>6</sup> Major depression was the most common mood disorder among Māori with almost 1 in 3 experiencing major depression at some point in their lives.<sup>3</sup>

## Poorer access to services

There is significant unmet need among Māori with mental illness. Research has shown that less than a third of Māori with a mental health need had any contact with mental health services and most Maori with serious or moderate disorders had no contact with any services. For those Māori with mental health needs that did have contact, general practice services were the services most often used. Māori tend to access mental health services at a later stage of illness, with more severe symptoms and get less health care than others for their mental health issues relative to need (Table 1).<sup>2</sup>

When Māori access services they tend to use mainstream providers. Therefore, it is important to ensure mainstream services are responsive and effective in working.<sup>5</sup> Primary health care and early intervention can reduce the impact and severity of mental illness and addiction-related issues among Māori.<sup>2</sup>

**Table 1:** Severity of mental health disorder, ethnicity, access to services for mental health needs.<sup>2</sup>

Severity	Māori		Non-Māori	
	Prevalence	Access	Prevalence	Access
Serious	9%	48%	4%	64%
Moderate	13%	25%	9%	39%
Mild	8%	16%	6%	19%

### Rangatahi

Rangatahi (youth) are likely to be experiencing higher rates of mental illness than previous generations. Alcohol and other substance-use disorders have contributed to this increase.<sup>6</sup> A higher proportion of Māori are in the age groups where mental disorders are likely to first occur, therefore the impact of unmet mental health need among rangatahi will have a significant impact on Māori as a population.<sup>2</sup>

### Pasifika

Pacific peoples have a high prevalence of mental disorders and suicidal behaviour, compounded by significant underutilisation of health services. Pacific peoples frequently present late to services, and report difficulty accessing culturally appropriate care and information.<sup>1</sup>

### Asian

Although diverse as a group, the New Zealand Asian population shares a range of risk factors for mental disorders, such as social isolation, language barriers and unemployment. There is a strong stigma associated with mental disorders which may delay presentation and treatment. Somatisation (the physical manifestation of mental distress) is more common in this population than in Western societies.<sup>1</sup>

The Mental Health Commission report on Asian mental health highlighted, in particular, the high mental health needs of women and refugees within smaller migrant communities (e.g. Vietnamese, Indonesian), and of older migrants and refugees suffering from pre-migration trauma, combined with the stress of adapting to a new culture. There is general recognition of the need for general practitioners to develop skills in interacting with Asian patients and to increase their awareness of how cultural factors influence the presentation and treatment of mental disorders in this population.<sup>1</sup>

## Etiology of depression and risk factors.<sup>1</sup>

The cause of depression is multifactorial and complex. It involves the interaction of individual vulnerability with exposure to stressors. Genetic, developmental, nutritional, endocrine, psychosocial and life stress factors can all contribute. This complexity may explain the wide variation in clinical presentation and response to treatment.

A number of risk factors (vulnerability) and resilience factors (protective) have been described (Table 2). For example, a history of depression in one or both parents puts their children at a three-fold increased risk of depression, whereas good parenting (emotional warmth, cognitive stimulation) is viewed as protective in the presence of risk factors.

These concepts fit well in to the “stress vulnerability model” whereby stressful situations may trigger depression in susceptible (vulnerable) people, but not in others who display protective traits or resilience. The concept of resilience was once considered to be a personal trait but is now viewed as more of dynamic development process which can be used as part of intervention and prevention programs.

Although depression can present spontaneously, there is usually an underlying factor such as work stress, job

loss, grief or relationship breakdown that can precipitate depression, especially if the person is vulnerable and has low resilience (see below).

Alcohol, cannabis and other recreational drug use are all associated with depression. Although low socioeconomic status alone does not appear to be predictive for development of depression, people in low socio-economic groups may be less likely to access services and receive effective treatment.

## Analysis of antidepressant use in New Zealand

Antidepressants are a mainstay of the treatment of moderate to severe depression (see page 18).

In this analysis of prescribing data (Figure 1) we have looked at the SSRIs (Selective Serotonin Reuptake Inhibitors) and venlafaxine but not TCAs (Tricyclic Antidepressants) as data for the latter are confounded by their significant use for other indications such as pain.

This analysis estimates the number of patients using one of the available SSRIs or venlafaxine. Two consecutive 12 month periods have been considered (August 2006 to July 2007 and August 2007 to July 2008). The volume of venlafaxine prescribing is influenced by its special

**Table 2:** Risk factors and resilience factors for depression

<b>Common risk factors</b> (which could lead to vulnerability)	<b>Resilience factors</b> (protective in the presence of risk factors)
Parental history of depression	Good parenting
Difficult temperament as a child	Easy temperament as a child
Attachment difficulties/parental neglect	Good peer relationships
Family discord	Stability in love relationships
Previous depression/anxiety in adulthood	Has coped with past difficulties well
Ruminating over negative circumstances	

authority status and the current restrictions on its use. However, venlafaxine use has been steadily increasing over the last two years since vocationally trained general practitioners were given authority to prescribe it.

**Notes:**

- The data are not exclusive for the treatment of depression.
- The number of patients has been estimated over the two consecutive twelve month periods analysed.

At a national level citalopram and fluoxetine are the most commonly used SSRIs whilst paroxetine appears to be the least favoured SSRI.

Although all SSRIs are generally accepted to be similar in effectiveness, certain SSRIs may be preferred in specific patient groups. Paroxetine has not been shown to be effective in adolescents and is linked with a higher rate of suicidal ideation. Fluoxetine is the preferred SSRI for adolescents although this is not a licensed indication in New Zealand. In the elderly, citalopram may be preferred due to its lower potential for interactions. Paroxetine should be avoided in pregnancy because of reported higher rates of congenital malformations.

**Fig 1:** New Zealanders receiving an SSRI or an SNRI (August 06 – July 07 and August 07 – July 08)

