Treating depression in the primary care setting

Major depression is a common and treatable mental disorder that manifests as changes in mood, cognition and physical symptoms lasting for two weeks or longer.

According to the Centers for Disease Control and Prevention (CDC):

- Depression is responsible for significant disability, with more chronic impairment than arthritis or diabetes.
- The lifetime risk for depression in the U.S. is approaching 30%.
- 8.1% of Americans age 20 and older has major depression, with women twice as likely as men (10.4% vs 5.5%) across all age groups (2013–2016).
- It carries a significant risk of suicide, the 10th leading cause of death in the U.S.
- 80% of those with depression reported some impairments in functioning, either at home, work or social activities.
- One out of 37 children age 6 to 17 suffer from depression, and only one out of five receive treatment (CDC 2011–2012).

The importance of PCPs in depression care

Considering the shortage of behavioral health providers and because depression is a common illness, primary care providers (PCPs) play a critical role in recognizing and treating depression.

It is estimated that PCPs provide 60% of mental healthcare and prescribe almost 80% of antidepressants. PCPs also provide an opportunity to identify suicide risk and prevent death, as many patients who have attempted suicide visited their PCP within weeks of the attempt.[1]

Recommendations for addressing depression in the primary care setting

SCREENING

Since 2016, the U.S. Preventative Services Task Force has **recommended screening for depression in the general adult population, including pregnant and postpartum women.** They also recommend having adequate systems in place to **ensure accurate diagnosis, effective treatment, and appropriate follow-up.**

Commonly used **depression screening instruments** include:

- Patient Health Questionnaire (PHQ) in various forms. (A brief form of the PHQ-9—the two question PHQ-2—should be used for all adults, to be followed by the PHQ-9 if a positive response occurs).
- Hospital Anxiety and Depression Scales in adults.
- Geriatric Depression Scale in older adults.
- Edinburgh Postnatal Depression Scale (EPDS) in postpartum and pregnant women.

All positive screens should lead to additional assessment that considers severity of depression and comorbid psychiatric problems (e.g., anxiety, panic attacks, or substance abuse), alternate diagnoses, and medical conditions.

When treating a depressed patient in the primary care setting, it is critical to monitor patients closely over time to ensure an adequate medication trial and to prevent treatment drop-out.

ASSESSMENT

When an individual screens positive for depression, it is critical to confirm the diagnosis and to evaluate for medical comorbidities, as they are common with major depression.

Depressive symptoms can be generated by prescribed medications or by substance use disorders, and can be secondary to an array of medical conditions such as thyroid disorders, cancers, infectious diseases, vitamin deficiencies, and dementias.

It is also important to **rule out a bipolar depression** by exploring a history of mania or hypomania, as treating bipolar depression with just an antidepressant can be both ineffective and exacerbate the illness course. **Exploring for acute suicidality and psychotic symptoms is critical** and, if present, may require immediate referral to a behavioral health provider, including hospitalization.

TREATMENT OPTIONS

Always consider psychotherapy for all degrees of depression; psychotherapy alone may be sufficient to treat mild and at times moderate depression. **Pharmacotherapy is almost always indicated for severe depression and usually for moderate depression.**

First-line medications usually include selective serotonin-reuptake inhibitors (e.g., citalopram, fluoxetine, paroxetine, sertraline), serotonin-norepinephrine reuptake inhibitors (venlafaxine, duloxetine), or bupropion or mirtazapine. Initial drug selection can be based on side-effect profile, effectiveness of previous trial in the patient and family members, cost, and patient preference.

Initial trials should involve starting at a low dose with gradual increases as the patient is observed every two weeks. It may take two to eight weeks to see a full effect, but if there is no change within the first few weeks, consider an antidepressant of a different class. Partial responses, even when at full dose, may require augmentation strategies.

Both newer and older classes of antidepressants are available. Use of newer antidepressants has not yet been addressed by treatment guidelines, and older classes of medications—including tricyclic antidepressants and monoamine oxidase inhibitors—should be reserved for use by psychiatrists in treatment refractory cases, as they carry a higher risk profile.

Concerns about suicidality caused by antidepressants

In 2004, the FDA raised concerns of increased risk of suicidality in individuals younger than age 24, which resulted in the creation of a black box warning. However, since then, this potential side effect has not been confirmed by other reviews. Either way, not prescribing an antidepressant to an acutely depressed individual creates significant risk. Therefore, if adequate follow up and monitoring (especially for suicidality) occurs, physicians should not hesitate to consider these medications.

Again, for more complex cases, including patients with bipolar depression, acute suicidality, psychosis or pregnancy, we recommend psychiatric consultation and referral.

Once an effective medication or combination is found, it is essential that the patient continue the medication for at least six months, if this is their first episode. Those with two or more episodes may continue the medication for years, and often indefinitely.

Help patients get the depression care they need

In summary, PCPs play a critical role in identifying and treating depression, and it behooves PCP practices to implement screening tools, be familiar with depression assessment, and become comfortable with prescribing antidepressants.

This document is designed to provide an overview on the importance of this work and basic recommendations. Please refer to other resources as needed, such as the Magellan PCP toolkit—www.MagellanPCPtoolkit.com—and the APA Practice Guideline for the Treatment of Patients with Major Depression, Depression in the Primary Care Setting.[2] You also may call the number on the back of the member's benefits card to arrange a referral to a behavioral health provider or to consult with a Magellan medical director.

These guidelines are not intended to replace a practitioner's clinical judgment. They are designed to provide information and to assist practitioners with decisions regarding care. The guidelines are not intended to define a standard of care or exclusive course of treatment. Healthcare practitioners using these guidelines are responsible for considering their patients' particular situations in evaluating the appropriateness of these guidelines. This information is not a statement of benefits. Benefits may vary and individual coverage will need to be verified by the plan.

1. *Barkil-Oteo A. Collaborative care for depression in primary care: how psychiatry could "troubleshoot" current treatments and practices. Yale J Biol Med. 2013;86(2):139–146. Published 2013 Jun 13.*
2. *LT Park and CA Zarate, 2019, NEJM 380;6:559-568, and Assessing and treating Depression in Primary Care Medicine, by AJ Gelenberg and HS Hopkins, AMJMED (2007) 120:105-108*

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