



Treating depression in the primary care setting

The Centers for Disease Prevention and Control (CDC) has reported that 7.6 percent of Americans age 12 years and older had depression (moderate or severe depressive symptoms in the past two weeks) during 2009 – 2012. The National Survey on Drug Use and Health reported that 6.9 percent of adults 18 or older in the U.S. had at least one major depressive episode in the past year. In the U.S., major depressive disorder affects nearly 20 percent of adults at least once during their lifetimes. Although depression can be a devastating illness, the majority of those diagnosed with major depression can benefit from treatment. However, many people suffering from depression do not realize they have a treatable illness or do not believe that treatment will be effective.

Research has shown that a majority of Americans who seek help for depression, or symptoms of depression, will initiate care with their primary care physician (PCP) rather than a mental health professional. Effective collaboration of care between PCPs and behavioral health providers is a key element in the successful treatment of depression.

Co-occurrence with medical illnesses

The risk of depression is often higher in individuals with serious medical conditions. For example, depression occurs in up to 33 percent of patients who have experienced a heart attack; affects 12 to 24 percent of people with diabetes; occurs in about 15 to 25 percent of people with cancer, depending on the type; and impacts almost half of stroke survivors. Treatment of depression may have a beneficial effect on the overall functioning and recovery and rehabilitation process of the physically ill individual.


Treatment

About two-thirds of people who suffer from major depression can achieve a full remission of symptoms. However, this may require from one to four treatment steps, i.e., specific episodes of treatment. Also, the chances of reaching remission are higher for the first and second treatment steps than for subsequent steps. The most common treatments are

antidepressant medication, psychotherapy or a combination of the two. As with many illnesses, early treatment is more effective and helps prevent the likelihood of serious recurrences.

According to the American Psychiatric Association (APA) *Practice Guideline for the Treatment of Patients with Major Depressive Disorder, Third Edition*:

- Factors to consider in choosing a first-line antidepressant medication include: anticipated side effects and their safety or tolerability, a history of prior response in patient or family member, patient preference, cost, potential drug interactions, co-occurring psychiatric or general medical conditions, relative efficacy and effectiveness, and half-life.
- Monoamine Oxidase Inhibitors (MAOIs) are generally reserved for patients who do not respond to other treatments. Also, the guideline notes that Selective Serotonin Reuptake Inhibitors (SSRIs) or MAOIs may be considered for patients with atypical symptoms.
- Improvement with pharmacotherapy can be observed after four to eight weeks of treatment. If at least moderate improvement is not noted after four to eight weeks of pharmacotherapy, a reappraisal of the treatment regimen should be done.

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- The goals of acute phase treatment for major depressive disorder are to induce remission of symptoms and to achieve a full return to the patient's baseline levels of symptomatic and functional status.
 - During 16 to 20 weeks following remission, patients treated with antidepressant medications in the acute phase should be maintained with these agents to prevent relapse. During the continuation phase, the treatment should be at the same dose, intensity and frequency as in the acute phase. Both the APA Guideline and the Institute for Clinical Systems Improvement (ICSI) Health Care Guideline: *Major Depression in Adults in Primary Care, Thirteenth Edition*, recommend long-term maintenance treatment with antidepressants in order to prevent relapse

and recurrence of depression. The APA Guideline states that the treatment that was effective in the acute and continuation phases should be used in the maintenance phase. The ICSI Guideline specifies that the dosage of antidepressant drug resulting in a therapeutic response should be the dose that is used for the maintenance phase, i.e., six to 12 months for the first depressive episode, three years for the second episode, and indefinitely for a second episode with complicating factors or for a third/ subsequent episode. Complicating factors for depression may include rapid recurrence of episodes, advanced age (over 60 years) at onset of major depressive episode, severity and family history.


Antidepressants and suicide

Clinical evidence strongly supports the use and effectiveness of antidepressant medications in the treatment of depression in all age groups. However, concerns have surfaced about the safety of such usage in children and adolescents. In 2004, after reviewing reports of clinical trials, the Food and Drug Administration (FDA) concluded that more children and teens taking antidepressant medications reported that they spontaneously thought about suicide or made a suicide attempt than those in that age group receiving placebos. As a result, the FDA directed manufacturers to include a warning on all antidepressants and expanded warning statements to clinicians.

After the issuance of the black box warning for all antidepressants for patients under 18 years of age, there was a precipitous drop of 25 percent in rates of both diagnosis and treatment of depression by pediatric and non-pediatric primary care physicians. A later meta-analysis, conducted by an FDA committee, of 24 clinical trials including nine antidepressants (n=4,400) in the pediatric population found a very small increase (0.7 percent) in risk of suicidal thinking/behavior, but no increase in completed suicides. More data showed that apprehension about the use of antidepressants in the pediatric population created a barrier to treatment, resulting in a corresponding 25 percent increase in completed suicide rate in children.

The American Academy of Child and Adolescent Psychiatry (AACAP) currently recommends that “through careful monitoring, the development of a safety plan and the combination of medication with psychotherapy, the risks for increased suicidal thoughts can be managed. For moderate to severe depression, there is benefit in the use of medication because of a higher rate of relief, and more complete relief, from depressive symptoms than not using any medication.” The AACAP considered the available evidence from other studies and concluded that, while spontaneously reported suicide events are more common with SSRI treatment, the benefits of SSRI use in pediatric depression outweigh the risks if carefully monitored. The AACAP also acknowledges that further study is required.

Physicians involved in the care of children and adolescents taking antidepressants should be alert to warning signs of possible increased suicidality and take prompt action if any adverse effects are observed. When the patient has a history of suicidality, such monitoring should occur at every session—and patients who miss appointments should be contacted by the clinician. Further, clinicians should inform patients and their families about specific risks and warning signs.



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

Switching antidepressants to non-monoamine oxidase inhibitor antidepressants, i.e., tricyclic or tetracyclic, selective serotonin reuptake inhibitor, dopamine-norepinephrine reuptake inhibitor, serotonin-norepinephrine reuptake inhibitor, serotonin modulator, or norepinephrine-serotonin modulator antidepressants, within the same class or to another class is usually done when patient improvement is not seen after an adequate trial. After this, combination and augmentation strategies may be attempted with a non-monoamine oxidase inhibitor antidepressant or another adjuvant agent, e.g., lithium, atypical antipsychotics, thyroid hormone, anticonvulsants, psychostimulants. Beginning psychotherapy, changing the type of psychotherapy or increasing the frequency of the psychotherapy sessions may also be considered for these patients.

Referral

In most situations, the PCP's best decision may be to refer the treatment-resistant patient to a psychiatrist for specialized psychopharmacologic treatment and/or psychotherapy. Patients also may be referred to a behavioral health practitioner or facility, e.g., suicide or homicide risk, psychotic or severe unipolar/bipolar depression, specialized therapy.

Getting help

Call the behavioral health telephone number on the member's health insurance card.

More information

For references and more extensive information on the etiology and treatment of major depression, see Magellan's *Clinical Practice Guideline on the Assessment and Treatment of Patients with Depressive Disorders* available at www.MagellanHealth.com/provider under Providing Care/Clinical Guidelines.

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. Health care practitioners using these guidelines are responsible for considering their patients' particular situation 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.