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A Guide for Treating Depression in the Primary Care Setting

Oftentimes, patients who suffer from depression do not complain of a depressed mood but instead report multiple unexplained physical ailments such as fatigue, pain, sleep disruptions, or eating disturbances. The risk of depression is higher in individuals with serious medical conditions, such as diabetes, cancer, and survivors of heart attacks and strokes. Routine depression screening is recommended for all seniors, adults, and adolescents at the time of their medical office visits. Annual depression screening is recommended unless there are clinical indications that additional screenings are necessary.

Clinicians can use a variety of tools to screen patients for depression. One such tool is the **PHQ-2**, a two-question, first step in screening for depression. If a patient answers "yes" to one or both questions on the PHQ-2, the **PHQ-9** patient health questionnaire is recommended to further assess the patient's risk for depression. The PHQ-9 screener can be used to determine the severity of depression, which helps determine next steps for treatment.

Other longer depression screening tools, such as the **Beck Depression Inventory (BDI)** and the **Center for Epidemiological Studies Depression Scale (CES-D)**, can also be used. For screening depression in seniors, the **Geriatric Depression Scale (GDS)** can also be used.

Initial Visit

The following describes the recommended next steps after obtaining a patient's PHQ-9 score during the initial visit.

A score of 5-9 on the PHQ-9 signifies that the patient is experiencing mild depression.

- Consider follow up with the patient in 2-3 weeks without prescribing any medication.
- Consider referral to a behavioral health provider for talk therapy, especially if the patient is expressing suicidal ideation and/or has a history of self-harming behaviors.

A score of 10-19 signifies that the patient is experiencing moderate to moderately severe depression.

- Consider referral to a behavioral health provider for talk therapy, especially if the patient is expressing suicidal ideation and/or has a history of self-harming behaviors.

Providers are encouraged to refer to the Harvard Pilgrim Health Care and Tufts Health Plan guidelines on medication tiers and prior authorization.

Follow-Up Visit #1 (2-3 weeks)

Recommended next steps: **Repeat the PHQ-9 and inquire about symptoms, especially suicidal thoughts.**

- For a patient who has been on medication, encourage them to remain on medication, as benefits will outweigh side effects over time. Benefits may be seen in 2-3 weeks, but more likely will be seen in 4-6 weeks.
- If the medication is making the person worse, stop it and try another medication.
- For those patients who were previously experiencing mild depression:
  - if depression has worsened, begin the patient on an antidepressant medication and follow the steps above.
  - if depression continues but has remained mild, consider referral to a behavioral health specialist for talk therapy, if a referral has not already been made.

Follow-Up Visit #2 (2-3 weeks)

Recommended next steps: **Repeat the PHQ-9.**

- Some positive changes should be seen by this time. If not, and there are no adverse side effects to the medication, consider doubling the dosage.
- If the patient has experienced a partial response to the medication, increase the dose.
- If the patient is continuing to experience multiple side effects, stop the initial medication and switch to a different SSRI.

Follow-Up Visit #3 (2-3 weeks)

Recommended next steps: **Repeat the PHQ-9.**

- If the patient has made improvements, continue to titrate the dosage until the medication has achieved the desired effect.

Through the first year following a depression diagnosis, regular follow-up visits and use of the PHQ-9 at least once a month are recommended until the patient's symptoms have improved for a period of one year.

Follow-Up Visit in One Year

Recommended next steps: **Repeat the PHQ-9.**

- If symptoms have not improved at one year, refer to a behavioral health specialist.
- If the patient has not improved, consider that they may be using other drugs or alcohol that could be interfering with benefits of medication.
- If symptoms have improved at one year, consider starting to taper the medication unless:
  - the patient has had history of three or more major depressive events.
  - the patient has had two major depressive events with a family history of bipolar disorder or major depression.

Other things to consider

For some patients, antidepressant medication in combination with psychotherapy is the most effective treatment.

- There is a risk of under-medicating by keeping patients on a starting dose of medication.
- There is a risk that patients may discontinue medication too soon. Throughout the time you are treating patients for depression, consider telephonic nurse case management in between office visits for ongoing education and to ensure medication compliance. Nurses can also assist patients with setting up reminders to take their medication.
- There is a risk of patients discontinuing medication too soon because they start to feel better. Patients need to be educated that even if they are feeling better, they need to remain on the medication for nine months to one year to prevent a relapse of the depression.

If you need help finding a behavioral health clinician for your Harvard Pilgrim Health Care patients, call Harvard Pilgrim's Provider Service Center at 800-708-4414. To assist your Tufts Health Plan patients, call the appropriate plan number.

For treatment intervention and resource recommendations, refer to the American Psychological Association's Clinical Practice Guideline for the Treatment of Depression.

For more information on depression screening tools, refer to the American Psychological Association's Depression Assessment Instruments.