



Treating Depression in the Primary Care Setting

The Centers for Disease Prevention and Control (CDC) estimates that five percent of Americans older than age 11 may have depression. Although depression can be a devastating illness, the majority of those diagnosed with major depression can be effectively treated. However, many people suffering from depression either do not realize they have an illness that can be treated or do not believe that treatment works.

Research has shown that nearly 71 percent 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 one in three patients who have experienced a heart attack; affects at least 15 percent of people with diabetes; occurs in about 23 to 60 percent of people with cancer, depending on the type; and impacts nearly 40 percent 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, Second 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, quantity and quality of clinical trial data. (*Note: Along with reported observations of weight gain, emerging research findings affirm that long-term use of antidepressants in moderate to high daily doses is associated with a significant increased risk of diabetes.*)
- 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.
- The goal of acute phase treatment for major depressive disorder is to return patients to their baseline levels of symptomatic and functional status.
- During 16 to 20 weeks following remission, patients who have been treated with antidepressant medications in the acute phase should be maintained with these agents to prevent relapse. In general, the dose used in the acute phase also is used in the continuation phase.

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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.

Since the FDA warning, studies have been conducted to review the relationship between antidepressant use and suicide. The American Academy of Child and Adolescent Psychiatry (AACAP) considered the available evidence 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.

Both the APA Guideline *Watch for the Practice Guideline for the Treatment of Patients with Major Depressive Disorder, Second Edition* and the Institute for Clinical Systems Improvement (ICSI) Health Care Guideline: *Major Depression in Adults in Primary Care, Twelfth Edition*, recommend long-term maintenance treatment with antidepressants in order to prevent relapse and recurrence of depression. 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.

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.

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.

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. Other referrals may be made 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.