

October 1, 2022

Depression: Screening and treatment in the primary care setting

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Mental health disorders affect well-being.

Mental health includes physical, biological and emotional factors that relate to an individual's well-being and sense of self.



Major depression is very common

- One of the most common mental health disorders
- Affects 17.3 million people
 - 8.44% of adults
 - 17% of adolescents, including 25% of adolescent girls
 - According to 2020 data from the Substance Abuse and Mental Health Services Administration (SAMHSA)
- 40% increased risk for medical illness
- #1 cause of disability

RISK FACTORS

- Alcohol use disorder
- Comorbid chronic medical conditions
- Being female
- Recent pregnancy or childbirth
- Recent stressful event
- Personal or family history of depression

Starting in the primary care setting

- There are many reasons why patients do not seek help for depression. Stigma plays a significant role.
- The fact remains that many individuals that suffer from depression go undetected and undiagnosed.
- Screening can be done using validated survey tools that are highly sensitive to identify patients for assessment and intervention.

The national guideline

U.S. Preventive Services Task Force (USPSTF) recommendations

SCREENING

- The USPSTF recommends screening for depression in the general adult population, including adolescents and pregnant and postpartum women.
- Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up.

ACCURATE IDENTIFICATION

- The USPSTF found convincing evidence that screening improves the accurate identification of adult patients and adolescents with depression in primary care settings, including pregnant and postpartum women.

Routine screening is considered a best practice.

The signs and symptoms

Depression affects the mind and body.

Physical

- Fatigue
- Lack of energy
- Sleeping too much, too little
- Overeating or loss of appetite, constipation, weight loss or gain
- Headaches
- Irregular menstrual cycle
- Loss of sexual desire
- Unexplained aches, pains

Behavioral

- Crying spells
- Withdrawing from others
- Neglecting responsibilities
- Loss of interest in personal appearance
- Loss of motivation
- Slow movement
- Use of drugs and alcohol

Psychological

- Sadness, anxiety, guilt, anger, mood swings, lack of emotional responsiveness, feelings of helplessness, hopelessness, irritability
- Frequent self-criticism, self-blame, pessimism, impaired memory and concentration, indecisiveness and confusion, tendency to believe others see one in a negative light, thoughts of death and suicide

DSM-5 diagnosis for major depression

- Five or more of the following must be present for two weeks with a change from baseline functioning
- One of the first two criteria must be present

<input type="checkbox"/> Depressed mood most of the day, nearly every day as self-reported or observed by others	<input type="checkbox"/> Insomnia or hypersomnia nearly every day	<input type="checkbox"/> Feelings of worthlessness or excessive or inappropriate guilt nearly every day
<input type="checkbox"/> Diminished interest or pleasure in all or almost all activities most of the day, nearly every day	<input type="checkbox"/> Psychomotor agitation or retardation nearly every day	<input type="checkbox"/> Diminished ability to think or concentrate nearly every day
<input type="checkbox"/> Significant weight loss when not dieting, or weight gain; or decrease or increase in appetite nearly every day	<input type="checkbox"/> Fatigue or loss of energy nearly every day	<input type="checkbox"/> Recurrent thoughts of death, recurrent suicidal ideation without a specific plan

DSM-5 diagnosis for major depression

All of the following standardized criteria must apply:

- ✓ Symptoms cause clinically significant distress or impairment in social, occupational, other areas of functioning.
- ✓ Symptoms are not attributable to the direct physiologic effects of a substance or a general medical condition.
- ✓ Occurrence of the major depressive disorder is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder or other specified or unspecified schizophrenia spectrum and other psychotic disorders.
- ✓ Patient has never been a manic or had a hypomanic episode.

Initial screening with the PHQ-2

A positive PHQ-2 is helpful but insufficient. For example, it doesn't address suicidality; a negative PHQ-2 does not mean the patient isn't suicidal.

The PHQ-2 consists of two items:

- Over the past 2 weeks, have you felt down, depressed or hopeless?
 - Over the past 2 weeks, have you felt little interest or pleasure in doing things?
- The PHQ-2 is highly sensitive for depression but not very specific. It is generally used only as a preliminary screening tool.
 - Oftentimes, if neither item is endorsed, then no further assessment is indicated.
 - Endorsing one or both items should prompt further assessment prior to diagnosis or clinical intervention.

Screening with the PHQ-9

A positive PHQ-9 is helpful but not sufficient for diagnosing depression.

- The PHQ-9 consists of 9 objective items rated on a scale of 0 to 3.
- This survey tool is both highly sensitive and specific for depression.
 - It can be used to screen and diagnose depression.
 - It can be used to measure the severity of depression, as well as response to treatment.

PHQ-9 score	Depression severity
0-4	None or minimal
5-9	Mild
10-14	Moderate
15-19	Moderately severe
20-27	Severe

The PHQ-9 is open-sourced and free to use.

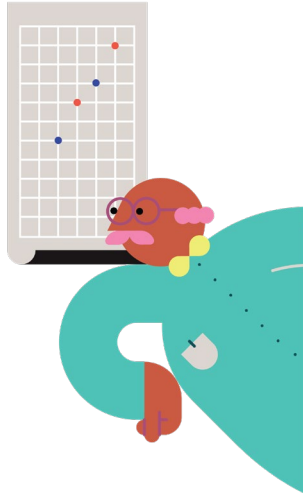
Limitations of the PHQ-9

Always address positive responses to item 9 (suicidality, self-harm).

- The PHQ-9 is a self-report tool; all positive responses should be reviewed with the patient to ensure the survey tool was understood.
- The PHQ-9 is validated to aid in the diagnosis of depression. A positive screen has a high likelihood of corresponding to the diagnosis of major depression, but other mood disorders or conditions should be considered.
- The diagnosis of major depression requires impairment of social, occupational and/or other important areas of functioning.
- The 10th item (about difficulty) was added to help guide assessment and treatment; it does not require numerical scoring.

Psychiatric consultation

- Despite a positive PHQ-9 for depression, there may be circumstances when a PCP should consider psychiatric consultation prior to treatment:
 - Uncertainty about the diagnosis
 - Presence of comorbid psychiatric disorders
 - Risk of suicide
 - Need for hospitalization
- In other cases, informal, “curbside” consultation may be sufficient.



Outpatient treatment options

Maximize shared decision-making by discussing options with your patients.

The majority of patients suffering from depression can be treated in the outpatient setting with:

- Psychotherapy (counseling)
- Medication management
- A combination of both

Selection factors to consider:

- Patient preference
- Prior treatment experience and/or response
- Severity of depression
- Available resources

Primary care integration

Some mild to moderate depression can be treated in a primary care home with behavioral health integration (behavioral health professionals and/or psychiatric consultants working as part of the primary care team).

Planning treatment

Treatment intensity should match depression severity.

SEVERITY OF DEPRESSION

MILD

Generally responds very well to short-term focused psychotherapy, avoiding the risks associated with medication side effects.

MODERATE

Generally responds similarly to either psychotherapy or medication. Combined therapy is best practice and may be especially helpful for patients with psychosocial and interpersonal problems, intrapsychic conflict, recurrent depression and/or co-occurring disorders.

Note: Mild or moderate depression can sometimes be treated in the primary care home depending on resources.

SEVERE

Generally responds best to both psychotherapy and medication. Severe symptoms are an indication that medication should be recommended.

Severe depression that does not respond to medication and therapy may require a referral to transcranial magnetic stimulation (TMS), electroconvulsive therapy (ECT) and novel treatments like esketamine.

Treatment options based on PHQ-9 results

Combination therapy is best but not always necessary.

PHQ-9 score	Depression severity	General guidelines (may differ based on clinical presentation)	
0-4	None or minimal	<ul style="list-style-type: none">No treatment.	For scores 5 and higher, engage a behavioral health consultant if one is part of the primary care team.
5-9	Mild	<ul style="list-style-type: none">Watchful waiting.Repeat the PHQ-9 at a follow-up appointment in 4-6 weeks.	
10-14	Moderate	<ul style="list-style-type: none">Recommend psychotherapy and/or antidepressant medication.Follow-up every 4 weeks or sooner.	
15-19	Moderately severe	<ul style="list-style-type: none">Encourage psychotherapy and antidepressant medication.Follow-up every 2-4 weeks.	
20-27	Severe	<ul style="list-style-type: none">Consider expedited referral to a mental health specialist.	

Psychotherapy (counseling)

Some patients are reluctant to pursue psychotherapy, but most will respond if engaged.

PCPs aren't typically trained to provide psychotherapy, but they can play an important role in the referral process, helping patients overcome personal stigma. Many psychotherapeutic modalities exist, but the primary techniques include:

COGNITIVE BEHAVIORAL THERAPY (CBT)

Helps patient identify faulty or inaccurate thoughts so that they can change their behavioral responses

INTERPERSONAL THERAPY

Focuses on conflicts and role transitions to help improve relationships

PROBLEM-SOLVING THERAPY

Helps build practical approaches to handle problems and stress

Medication management (antidepressants)

Patients can vary in their willingness to consider medication. Discussing options and addressing concerns will help the decision-making process and enhance medication adherence. Keep in mind the following about antidepressants:

Improve emotional and physical symptoms

Selection should be based on targeting specific symptoms for improvement.

Have a broad range of side effects that often resolve

Patients are more likely to be compliant with treatment if they are aware of potential side effects ahead of time.

Have a variable onset, work best over time

Patients should be cautioned not to expect immediate improvement and be encouraged to allow sufficient time before changing or stopping medication. Best practice recommendations for acute phase trial of an antidepressant is 12 weeks, while continuation phase prior to consideration of discontinuation is six to 12 months.

Medication selection

Allow adequate time for a treatment response.

Antidepressant effectiveness is generally comparable between and within drug classes.

SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors) and a few atypical antidepressants are first-line medications that have variable adverse effects. Atypical antipsychotics can be used for refractory depression but only in consultation with a psychiatric consultant.

Selection should be based on the patient's clinical features, family history, anticipated side effects and safety considerations, accounting for other medical conditions and potential medication interactions.

Medication dose should be maximized for partial response prior to considering a medication change. The dose may be increased every 2-4 weeks until the desired effect is achieved, the maximum FDA-recommended dose is reached or the medication is not tolerated.

There can be up to a 1- to 6-week delay prior to improvement of symptoms at the therapeutic dose. Allow at least two months for an adequate trial.

If partial response continues, consider changing to an antidepressant from a different drug class. Augmentation with a second agent may also be reasonable to treat select side effects in consultation with a psychiatric consultant.

Select common antidepressants

Discuss potential side effects with patients and encourage compliance.

	Initial dose	Typical range	Notes
SSRIs			
citalopram (Celexa)	20 mg	20-40 mg	Fewer side effects overall
escitalopram (Lexapro)	10 mg	10-20 mg	Can initially increase anxiety; approved for pediatric ages
fluoxetine (Prozac)	20 mg	20-60 mg	Can be activating (energy); approved for pediatric ages
paroxetine (Paxil)	20 mg	20-60 mg	More side effects overall – contraindicated in children < 18
sertraline (Zoloft)	50 mg	50-200 mg	Approved for anxiety in youth
SNRIs			
duloxetine (Cymbalta)	60 mg	60-120 mg	Can help chronic pain; approved for anxiety in adolescents
venlafaxine (Effexor)	37.5 mg	75-375 mg	Rapid clearance (good for elderly)
desvenlafaxine (Pristiq)	50 mg	50 mg	Rapid clearance (good for elderly)
Atypical antidepressants			
bupropion (Wellbutrin)	150 mg	150-450 mg	2nd line medication for ADHD
mirtazepine (Remeron)	15 mg	15-45 mg	Can be sedating

Medication treatment approach

Treat for nine to 12 months with close follow-up.

- See patients within 1 to 2 weeks of starting therapy.
- Modify treatment every 2 to 4 weeks as indicated. “Start low, go slow—but go.”
- Monitor closely for suicidal ideation in first few months.

PHASES OF TREATMENT

ACUTE

1-3 months

Remission with return to baseline level

CONTINUATION

4-9 months

Relapse prevention

DISCONTINUATION

9 to 12 months

Tapered withdrawal avoiding premature discontinuation

Note: Consider maintenance for patients who have had two or more recurrent episodes of depression or who have risk factors for recurrence.

Measuring improvement

Correlate changes with full clinical presentation.

The PHQ-9 can be re-administered as needed to track treatment response. Although there is no strict guideline, a common recommendation for monitoring and adjusting treatment at 4-6 weeks is as follows:

PHQ-9 change	Treatment response	Treatment plan
No change or drop of 1 point	Inadequate	<ul style="list-style-type: none">• ↑ antidepressant dose.• Follow-up in 1-2 weeks.
Drop of 2-4 points	Possibly inadequate	<ul style="list-style-type: none">• Consider ↑ antidepressant dose.• Follow-up in 2-4 weeks.
Drop of 5 points or more	Adequate	<ul style="list-style-type: none">• No change in antidepressant dose.• Follow-up in 4-6 weeks.• Target is remission (PHQ-9=\leq 5).

Coding and billing

Screening with the PHQ-9 is reimbursable.

- Use of the PHQ-9 improves the care of patients with depression but also requires additional work on the part of the PCP.
- CPT 96127 (*brief emotional/behavioral assessment*) can be submitted under the general medical benefit. Medical documentation should reflect that the survey tool was administered, scored and discussed/used for treatment. The appointment visit should correlate to an appropriate diagnosis of depression.
- HCPCS G0444 can also be used for annual screening of depression under preventive care services. The medical documentation must demonstrate that the PHQ-9 was performed, scored and reviewed. This code doesn't need to be tied to a specific diagnosis.

Final considerations

Depression is highly treatable, but treatment takes time.

- Collaborate and share information with treating psychotherapists to best manage a patient's depression. A release of information form is not required for coordinating mental health (e.g. depression) care with a therapist.
- Encourage the development of a supportive network of family members and significant others.
- Consult with a psychiatric specialist if the patient:
 - Has severe side effects that cannot be managed
 - Does not respond to treatment
 - Suffers repeated relapse of symptoms
- Consider referral for hospitalization if there is significant concern of potential self-harm, harm to others or an inability to care for self.





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