

## A Guide for Treating Depression in the Primary Care Setting

Many patients who suffer from depression do not often complain of a depressed mood, but complain instead of multiple unexplained physical ailments such as fatigue, pain, sleep disturbances 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 visit. In general, yearly 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 screener that can be the start of screening for depression. If a patient answers "yes" to one or both of the questions on the PHQ-2, then the recommendation is that it should be followed by use of the **PHQ-9** questionnaire to further assess patient's risk for depression. The PHQ-9 screener can be used to determine the severity of depression, which will help to decide the next steps for treatment. Other longer depression screening tools, such as the **Beck Depression Inventory** and the **Center for Epidemiologic Studies Depression Scale (CES-D)**, may also be used.

For screening depression in seniors, the **Geriatric Depression Scale (GDS)** may also be used.

### INITIAL VISIT

The following describes the recommended next steps after obtaining a patient's score on the PHQ-9 on 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 at this time.
- Consider a referral to a behavioral health provider for talk therapy, especially if the patient is expressing suicidal ideation and/or has a past history of self-harming behaviors.

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

- Consider a referral to a behavioral health provider for talk therapy, especially if the patient is expressing suicidal ideation and/or has a past history of self-harming behaviors.
- Consider starting the patient on antidepressant medication (1/2 dose for the first four days, then increase to starting dosage) and follow up in 2-3 weeks. See starting dosages on the chart below.
- Consider also prescribing anti-anxiety medication for the first 4-6 weeks if the patient complains of severe anxiety or insomnia.

#### A score of over 19 signifies that the patient is experiences severe depression.

- Consider referring the patient to a behavioral health specialist for further evaluation and consultation, especially if the patient is expressing suicidal ideation and/or has a past history of self-harming behaviors.
- Consider starting the patient on antidepressant medication (1/2 does for the first four days, then increase to starting dosage) and follow up in 2-3 weeks.
- Consider also prescribing anti-anxiety medication for the first 4-6 weeks if the patient complains of severe anxiety or insomnia.

#### SSRI Starting Dosages

Medication	Starting Dosage
fluoxetine	20 mg qd
paroxetine	20 mg qd
citalopram	20 mg qd
fluvoxamine	50 mg qd
bupropion	150 mg qd

**Begin with the following two only if they have worked well in the past:**

Medication	Starting Dosage
sertraline	50 mg qd
escitalopram	10 mg qd

**It is important to refer to the Tufts Health Plan formulary for 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 him or her to remain on medication, as benefits will outweigh the 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 at this time and follow the steps above.
  - If depression continues but has remained mild, consider referral to a behavioral 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, 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 many 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.
- If the patient hasn't improved at least 50 percent, it is time to switch antidepressants. The new antidepressants may be another SSRI or it may be an SNRI listed below

**SSRI Starting Dosages**

Medication	Starting Dosage
venlafaxine	37.5mg qd maximum dose 225mg qd
duloxetine	20mg-30mg qd; maximum dose 60mg qd
desvenlafaxine	50mg qd; no benefit has been seen at doses greater than 50 mg qd

**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 OFFICE 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
- Also, if patient has not improved, consider that they may be using other drugs or alcohol that may 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 THE patient on a starting dose of medication.

- There is a risk that your patient may discontinue medication too soon. Throughout the time you are treating your patient for depression, consider telephonic nurse case management in between office visits for ongoing education and to ensure medication compliance. Nurses may also assist the patient to set reminders that help the patient to remember to take medication.
- There is also a risk of the patient's discontinuing medication too soon because he or she starts to feel better. Patients need to be educated to understand 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 with finding a behavioral health clinician for your Tufts Health Plan patients, call the Tufts Health Plan Behavioral Health Department at 800.208.9565.

For further information regarding the treatment of depression, refer to the American Psychiatric Association's *Practice Guidelines for the Treatment of Patients with Major Depressive Disorder, Third Edition*. A link to these guidelines can be found in the Clinical Guidelines section on the Tufts Health Plan website at [tuftshealthplan.com](http://tuftshealthplan.com).