Depression is the most common psychiatric disorder in the general population and the most common mental health condition in primary care, yet many patients do not recognize or want to discuss symptoms of depression with their medical provider. Many present instead with somatic symptoms (e.g., headache, back problems, fatigue, or chronic pain), which may make diagnosing depression more difficult. Lifetime prevalence of depression in the United States ranges from 8 to 12 percent. Individuals who have suffered from one episode of depression frequently have recurrences, with 72 percent having more than one episode. The average age of onset is around thirty years old. There are multiple types of depression varying in symptoms and severity. The type of depression focused on in this paper is major (unipolar) depression.

Unrecognized and untreated depression can lead to decreased quality of life (QOL), comorbidities with poor outcomes, increased risk of mortality, increased economic burden, and increased risk of suicide. Screening is a key factor in diagnosing and treating depression. It is important to screen patients who may be at risk or exhibit signs of depression and doing so routinely may help patients feel less stigmatized or judged. The US Preventive Services Task Force (USPSTF) recommends screening all patients routinely, and then further evaluating those who score above a specified level.

Major depression presents with five or more of the following symptoms, present most of the day, almost every day for a minimum of two consecutive weeks:

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<tbody>
<tr>
<td>1.</td>
<td>Depressed mood</td>
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<tr>
<td>2.</td>
<td>Loss of interest or pleasure in most or all activities</td>
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<td>3.</td>
<td>Insomnia or hypersomnia</td>
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<tr>
<td>4.</td>
<td>Change in appetite or weight</td>
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<td>5.</td>
<td>Psychomotor retardation or agitation</td>
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<td>6.</td>
<td>Low energy</td>
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<td>7.</td>
<td>Poor concentration</td>
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<td>8.</td>
<td>Thoughts of worthlessness or guilt</td>
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<tr>
<td>9.</td>
<td>Recurrent thoughts about death or suicide</td>
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At least one of the presenting symptoms is **depressed mood** or **loss of interest or pleasure** in doing things. The symptoms lead to substantial distress or impaired psychosocial functioning, and are not the direct result of substance use or a general physical medical disorder.

Persistent depressive disorder (dysthymia) is a form of depression that is characterized by depressive symptoms that last for at least two years, with depressed mood present for most of the day, and for more days than not and the depressed mood is accompanied by **two or more** of the following symptoms:

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<tbody>
<tr>
<td>1.</td>
<td>Decreased or increased appetite</td>
</tr>
<tr>
<td>2.</td>
<td>Insomnia or hypersomnia</td>
</tr>
<tr>
<td>3.</td>
<td>Low energy</td>
</tr>
<tr>
<td>4.</td>
<td>Poor self-esteem</td>
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<tr>
<td>5.</td>
<td>Poor concentration</td>
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<tr>
<td>6.</td>
<td>Hopelessness</td>
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Clinical red flags to initiate targeted screening include:\(^{15}\)
- Insomnia
- Fatigue
- Chronic pain
- Recent life changes or stressors
- Fair or poor self-rated health
- Unexplained physical symptoms

**Subjective Findings and History**
- Risk factors may include genetic, medical, environmental, and social factors:
  - Prior depressive episode
  - Family history
  - Female gender
  - Childbirth (e.g., post-partum depression)
  - Childhood trauma
  - Stressful life events
  - Poor social support
  - Serious medical illness
  - Dementia
  - Elderly
  - Substance abuse
- Symptoms may include mood, cognitive, neurovegetative, or somatic symptoms
  - sadness, emotional distress, emotional numbness, anxiety or irritability
  - loss of energy, changes in sleep, appetite, or weight.
  - headache, abdominal or pelvic pain, back pain, or other physical complaints
a common pneumonic used to help remember common symptoms of depression is SIG E CAPS:

- Sleep disturbance,
- Interest/Pleasure reduction,
- Guilt feelings or thoughts of worthlessness,
- Energy changes/fatigue,
- Concentration/attention impairment,
- Appetite/weight changes,
- Psychomotor disturbance,
- Suicidal thoughts

**Objective Findings**

- Can be non-specific and broad. Of note, the Diagnostic & Statistical Manual (DSM-IV) does not include these physical signs as an integral part of the clinical picture of depression, consequently leaving the diagnosis of depression to subjective criteria and perceptions.

- The Hamilton Depression Rating Scale and the Montgomery-Asberg Depression Rating Scales use certain physical signs as an integral part of their scoring measures. Consider:
  - Retardation of movements and diminished gestures and expressions.
  - The patient may appear tired, self-concerned, bored, inattentive and display a loss of interest in the surroundings.
  - Anxiety which may be expressed by severe restlessness and agitation, muscle tension, or wringing of hands.
  - Frequent weeping, moaning, or sighing.
  - Repeating phrases expressive of misery in a monotonous and stereotyped way.
  - Tachycardia, dry tongue/mouth, sweaty palms and/or bodily extremities, cold clammy skin, pallor, pupillary dilatation, tremor, and the fluctuations in blood pressure with wide pulse pressure.

**Assessment**

- Thorough physical exam (PE).
- Labs to rule out other causes of symptoms: CBC, electrolytes, comprehensive metabolic panel, liver function tests, thyroid panel, EKG, EEG.

There are several short validated depression screening tools that are readily available for practitioners to use and include: the PHQ-9, the PHQ-2, the Beck Depression Inventory for Primary Care, and the WHO-5. All of these can be self-administered by patients during or prior to a visit and are available in multiple languages. The PHQ-9 has shown to be the most accurate and can also be used to monitor response treatment and can be found here[17,18].

(www.uspreventiveservicestaskforce.org/uspstf/uspsaddepr.htm)

An algorithm developed by Maine Health has been developed to help guide treatment based on changing PHQ-9 scores - http://www.mainehealth.org/workfiles/depression/PHQdxtxguideline042910.pdf.
**Diagnosis**

Assessment should be made for co-existing morbidities, including other mental health conditions. Many behavioral health conditions can exist concurrently as well as along with substance abuse issues. Mental health and substance abuse together is considered a “dual diagnosis”. If mental illness is suspected, suicidal ideation should be assessed. Suicide is the 10th leading cause of death in the U.S. More than 90% of those who die by suicide had one or more mental health disorders.\(^{19}\)

**Plan**

Effective treatments for depression include pharmacotherapy and psychotherapy. Chronic depression is associated with poorer treatment response, highlighting the importance of early identification and treatment. Effective treatment requires careful monitoring of treatment adherence and clinical response together with changes in treatment if the clinical response is poor.\(^{20}\) This is no different from the approach to patients with chronic medical conditions.

The primary care and/or CAM provider is often a gateway to expert care and can provide patients with the resources they need to access a specialist. Recognizing and referring patients with serious health conditions is a fundamental role of all medical providers. The recommended treatment of mental and behavioral health conditions is a team based therapeutic model. Team consultation, assessment and management of these patients can provide them with the best possible medical care.

Mental illnesses are treatable. Most people diagnosed with a serious mental illness can experience relief from their symptoms by actively participating in an ongoing individual treatment plan. Patients who are currently under the medical supervision of other licensed providers and are taking medications for behavioral health conditions should be encouraged to remain on these.

*Antidepressants* (monotherapy or combination therapy):\(^{21,22,23,24,25}\)

- Selective serotonin reuptake inhibitors (SSRIs) (the most widely prescribed)
- Serotonin-norepinephrine reuptake inhibitors (SNRIs)
- Atypical antidepressants
- Serotonin modulators
- Tricyclic antidepressants
- Monoamine oxidase inhibitors (MAOIs)

Selecting a medication should be based on multiple factors including:

- Patient response to antidepressants during prior depressive episodes
- Safety
- Side effect profile
- Specific depressive symptoms
- Comorbid illnesses
• Concurrent medications and potential drug-drug interactions
• Family (e.g., first-degree relative) history of response to antidepressants
• Ease of use (e.g., frequency of administration)
• Patient preference
• Cost

Medications should be prescribed by someone who is trained and familiar in prescribing and treating depression.

Psychotherapy
• Cognitivebehavioral therapy (CBT)\textsuperscript{27}
• Psychodynamic psychotherapy
• Interpersonal psychotherapy
• Motivational interviewing

CAM Therapies:\textsuperscript{28,29,30}
• Regular exercise\textsuperscript{31,32}
• Light Therapy\textsuperscript{33}
• Nutraceuticals – St. John’s Wort (Hypericum), Omega-3 fatty acids, \textit{Rhodiola rosea} (roseroot), \textit{Crocus sativus} (saffron), folate, S-adenosyl-L-methionine (SAMe)\textsuperscript{34}
• Acupuncture
• Mindfulness based psychotherapies

Referrals
Collaborative consultation should occur before considerations of any changes or additions to an existing treatment plan. Providing resources and referrals are crucial to good medical care, so a team can be formed and an interdisciplinary approach can be utilized.

If a patient exhibits any of the following clinical features, an immediate referral is warranted:
• Suicidal or homicidal behavior or ideation (with a specific plan and intent)
• Psychotic features (e.g. delusions or hallucinations)
• Catatonia
• Poor judgment that places the patient or others at imminent risk of being harmed
• Grossly impaired functioning (e.g. food or fluid refusal leading to malnutrition and dehydration)

A referral should be made to professionals specializing in treating behavioral/mental health/substance abuse conditions, especially in recalcitrant or severe cases, acute states, in cases where there is a current or past history of suicidal or homicidal ideation, or if the patient presents with a dual diagnosis. This might include an emergency department, psychologist, behavioral health consultants, psychiatrist, case manager, licensed social worker (LSW), or other counselor who may have experience in treating or finding appropriate resources for the patient. The National Alliance for Mental Illness (NAMI) provides extensive resources and has local emergency and suicide helplines listed for all areas of the United States (U.S.) at
www.NAMI.org. In addition, all states have differing laws in regards to reporting suicidal or homicidal ideation to local authorities.

**Resources for Clinicians**
National Association for Mental Illness (NAMI) – resources for primary care providers
http://www.nami.org/Template.cfm?Section=child_and_teen_support&Template=/ContentManagement/ContentDisplay.cfm&ContentID=120673


The Integrative Behavioral Health Project provides is a virtual toolkit for primary care providers to “to provide hotlinks to screening tools and resources recommended for use in primary care”. Their complete electronic resource guide, "Integrative Behavioral Health Screening Tools for Primary Care" is available at: http://www.ibhp.org/

SAMHSA-HRSA Center for Integrated Health Solutions. Integrating Behavioral Health into Primary Care

**Resources for Patients**

**Clinical Pathway Feedback**
CHP desires to keep our clinical pathways customarily updated. If you wish to provide additional input, please use the e-mail address listed below and identify which clinical pathway you are referencing. Thank you for taking the time to give us your comments.

Clinical Services Department: providers@chpgroup.com


