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Review article

Optimizing the management of depression: primary care experience

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ABSTRACT

This article is intended to identify some of the most important challenges faced by family physicians when treating MDD and to provide practical solutions. Key issues, reviewed from a primary care view point will include: treating to remission (and not just response), identification of high-risk groups, diagnosis, acute treatment approaches (including pharmacotherapy and the management of related side effects), the use of psychotherapy and somatic therapies, assessment of the adequacy of treatment including the assessment of remission, response measurement, optimal follow-up care throughout the phase of treatment, the key components of patient education and strategies for partial/limited response to the first-line antidepressant (switching, augmentation and combination strategies), how to provide support for improved treatment adherence, and approaches to prevent the recurrence of depressive episodes.

Contents

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1. Introduction

Worldwide, depression is a common and disabling psychiatric disorder. It is frequently under-recognized and undertreated. In many instances, despite recognition and treatment, outcome is often less than optimal. Undertreated depression has serious repercussions for the individual, the family, the workplace, and society in general. It is an important challenge to not only diagnose and initiate the treatment of depression; it is just as vital to ensure that the treatment leads to an optimal outcome, which is the complete resolution of all signs and symptoms and a return to full normal functioning. Primary care nurses, nurse practitioners and physicians are the gateway to diagnosis and treatment, and without the awareness of the diagnosis and its comorbidities, patients, their loved ones, and our economy will suffer. In this article, we will present key issues concerning the optimal treatment of depression, as well as approaches to dealing with commonly encountered challenges faced by primary care clinicians in the provision of care for all concerned.

2. Burden of illness

The prevalence of major depressive disorder (MDD) in the population can vary from a current one-month prevalence of 1.3–5.6%, to a 12-month prevalence of 3.9–10.7%, to a lifetime prevalence of 10.8–16.2% in various countries (Patten et al., 2009). In Canada the 12-month prevalence of MDD is 4.8% and 12.2% of the Canadian population has met criteria for MDD in their lifetime (Public Health Agency of Canada, 2006). According to the World Health Organization (WHO), depression is the leading cause of disability as measured by "years lived with disability" (YLDs) and the fourth leading contributor to the global burden of disease in "disability adjusted life years" (DALYs) in 2000. By the year 2020, depression is projected to reach second place in the ranking of DALYs calculated for all ages and sexes. Today, depression is the second most common cause of DALYs in the age category 15–44 years for both sexes. Despite the fact that depression can be reliably diagnosed and treated in primary care, fewer than 25% of those affected have access to effective treatments (WHO report, n.d.).

Depressive disorders have a significant impact on quality of life in several spheres of function including health, work, social, and family life. Because cognitive symptoms are prominent in MDD, the move towards a knowledge-based economy is further expected to magnify the impact of this illness on occupational functioning (The Standing Senate Committee on Social Affairs Science and Technology, 2006).

MDD affects occupational functioning in terms of both absenteeism and presenteeism (defined as a loss of productivity while at work but unwell). The effects on cognitive function can result in a reduced ability to perform mental interpersonal tasks, organize time management, perform output tasks, and perform physical tasks (Adler et al., 2006). There are associated greater rates of unemployment with depression (Lerner et al., 2004) and time off work (Hoge et al., 2002). In addition, depression can negatively affect social and family life. For example, depression in women may have a detrimental effect on the development of their children and family dynamics (Toney, 2007). Depression can reduce adherence to medical treatment, reduce participation in preventive activities, as well as alter physical health risk factors such as obesity, smoking, and sedentary lifestyle (Santaguida, 2012).

Depression is recognized as an independent risk factor for cardiovascular disease in the general population in Canada (Gilmour, 2008), and while there has been much interest in the relationship between MDD and chronic medical conditions such as heart disease and diabetes, the conditions most strongly associated with depression in the Canadian population are neurological (e.g., migraine, multiple sclerosis, epilepsy, back problems) and conditions related to pain and inflammation (e.g., emphysema/chronic obstructive pulmonary disease, cancer, asthma) (Patten et al., 2009).

Although MDD can occur at any age, peak prevalence occurs in those between the ages of 15 and 45 years (Patten et al., 2006). As a result, MDD has a disproportionately large impact on education, work productivity, relationships, and parenting. (Patten et al., 2009) The prevalence of depression in Canada is not related to level of education but is related to having a chronic medical condition, to unemployment and to (low) income (Patten et al., 2006).

Primary care physicians are well positioned to provide the essential elements for high-quality care for depressed patients – patient education, prescription of antidepressant medication, follow-up care, and appropriate use of specialists and resources (Whooley et al., 2000; Schulberg et al., 1998).

In a study by Katon et al. (1996), 153 primary care patients with major and minor depression were entered into a structured depression treatment program in the primary care setting that included both behavioral treatment to increase use of adaptive coping strategies and counseling to improve medication adherence. Control patients received "usual" care by their primary care physicians. Outcome measures included adherence to antidepressant medication, satisfaction with care of depression and with antidepressant treatment, and reduction of depressive symptoms over time. At the 4-month follow-up, significantly more intervention patients with major and minor depression than usual care patients adhered to antidepressant medication and rated the quality of care they received for depression as good to excellent. Intervention patients with major depression demonstrated a significantly greater decrease in depression severity over time compared with usual care patients on all four outcome analyses. A multifaceted primary care intervention improved adherence to antidepressant regimens and satisfaction with care in patients with major and minor depression. The intervention consistently resulted in more favorable depression outcomes among patients with major depression.

O'Connor et al. (2009) conducted a systematic review to assess the benefits of screening depression in primary care settings for adults. The review indicated that primary care screening instruments are most effective when other assessments or programs are utilized, such as initializing mental health treatment programs in coordination with primary care (O'Connor et al., 2009).

3. Diagnosis of major depressive disorder

Depression is an illness with a variety of clinical presentations. The *DSM-IV* defines depression (Table 1) as a symptom-based diagnostic entity (American Psychiatric Association, 2000). In