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DEPRESSION SCREENING IN THE FAMILY PRACTICE

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Abstract:

Introduction: *Depression is considered one of the major health issue worldwide. There are many categories such as depressive disorder (MDD), persistent depressive disorder, and other subsyndromal disorders, are crucial causes of morbidity and mortality and an indirect cause of mortality. It is a worldwide problem that is affecting the United States as well. The prevalence of depression is suggested to be more than ten percent. In US, the twelve month prevalence for depressive disorders is nine percent, and three percent for major depression.1 The data from the National Health and Nutrition Examination Study (NHANES) suggested that about seven percent of the US population aged 12 and older had moderate or severe depressive.2 The worldwide data show about 350 million people affected by depressive disorders, making it 1 of the top three causes of morbidity as measured by disability-adjusted life-years. 3*

*The moderate and severe depression is linked to significant consequences on quality of life, especially the social, work, and family life. People with moderate or severe depressive symptoms were seen to be more likely to report difficulties in these aspects of life, in comparison to those with symptoms.2 Depression have financial economic burden, suggested in the United States.4 Depressive disorders in adults begin to increase in prevalence in those ages twenty, and remians to increase into middle age, with females more likely to be affected than males. In the US, people living below the poverty level are more than twice as likely to have moderate or severe depressive symptoms as those with higher incomes. After taking into consideration income, depressive symptom prevalence does not vary significantly across different races or ethnic groups. Depression is common in those who are unmarried, divorced, or widowed, in comparison to those who are married; in those who have suffered traumatic life events; and in those with a family history of depression.2 But, rates of depression continue to be significant even in those without these risk factors. Depression is also associated with increased risk from other comorbid conditions, involving cardiovascular disease.5 Sadly, more than seventy percent of patients who screen positive for depression do not receive management.6****Aim of work:*** *In this review, we will discuss, depression screening in the family practice*

Methodology: *We did a systematic search for depression screening in the family practice using PubMed search engine (http://www.ncbi.nlm.nih.gov/) and Google Scholar search engine (https://scholar.google.com). We only included full articles.*

*The terms used in the search were: Depression, screening, family practice, management****Conclusions:*** *Depression is a major cause of morbidity and mortality worldwide. It usually goes without recognition or effective treatment. Screening has the ability to improve detection of depression. Coupled with a strong system for management that uses collaborative care, screening has the ability to decrease symptoms and improve quality of life and functional status. Despite evidence of efficacy, depression screening continues to be incompletely implemented. Healthcare providers who wish to improve their effectiveness in implementation should apply a standard office approach to screening and diagnostic confirmation, followed by shared decision-making about treatment options. Providers also should develop a standard approach for follow-up to ensure treatment effectiveness. The most efficient approaches involve a multidisciplinary team, and use both inpatient and outpatient care.*

Key words: *Depression, screening, family practice, management*

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INTRODUCTION:

Depression is considered one of the major health issues worldwide. There are many categories such as depressive disorder (MDD), persistent depressive disorder, and other subsyndromal disorders, are crucial causes of morbidity and mortality and an indirect cause of mortality. It is a worldwide problem that is affecting the United States as well. The prevalence of depression is suggested to be more than ten percent. In US, the twelve month prevalence for depressive disorders is nine percent, and three percent for major depression [1]. The data from the National Health and Nutrition Examination Study (NHANES) suggested that about seven percent of the US population aged 12 and older had moderate or severe depressive [2]. The worldwide data show about 350 million people affected by depressive disorders, making it 1 of the top three causes of morbidity as measured by disability-adjusted life-years [3].

The moderate and severe depression is linked to significant consequences on quality of life, especially the social, work, and family life. People with moderate or severe depressive symptoms were seen to be more likely to report difficulties in these aspects of life, in comparison to those with symptoms. Depression have financial economic burden, suggested in the United States [4]. Depressive disorders in adults begin to increase in prevalence in those ages twenty, and remians to increase into middle age, with females more likely to be affected than males. In the US, people living below the poverty level are more than twice as likely to have moderate or severe depressive symptoms as those with higher incomes. After taking into consideration income, depressive symptom prevalence does not vary significantly across different races or ethnic groups. Depression is common in those who are unmarried, divorced, or widowed, in comparison to those who are married; in those who have suffered traumatic life events; and in those with a family history of depression. But, rates of depression continue to be significant even in those without these risk factors. Depression is also associated with increased risk from other comorbid conditions, involving cardiovascular disease [5]. Sadly, more than seventy percent of patients who screen positive for depression do not receive management [5].

In this review, we will discuss the most recent evidence regarding depression screening in the family practice.

METHODOLOGY:

We did a systematic search for depression screening in the family practice using PubMed search engine (http://www.ncbi.nlm.nih.gov/) and Google Scholar search engine (https://scholar.google.com). We only included full articles.
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Who Should Be Screened?

The US Preventive Services Task Force (USPSTF) suggests screening all adults for depression [6]. The Task Force emphasizes that "screening should be applied with sufficient systems in place to ensure precise diagnosis, effective management, and proper follow-up." The American Academy of Family Physicians makes a similar recommendation [7]. Opposite to, the Canadian Task Force on Preventive Health Care (CTFPHC) does not suggest the routine screening. The CTFPHC sites a lack of evidence on benefits and harms of screening in asymptomatic individuals, complicated by a concern for potential harms through false positives and unnecessary management [8].

Special Populations

Older adults

For people older than sixty five years old, the data that recommend screening is less strong because of lacking of clinical trials in elderly. However, in 2016, the USPSTF suggested screening in elderly based on the totality of the evidence across the age spectrum and advised for more research into the best approach for screening and management in older adults. Diagnosing depression in elderly could be more

challenging than in young people, due to the fact that depression could present as somatic complaints, like weight loss, fatigue, insomnia, and poor concentration that mimic physical ailments common in older patients. Depression is also more likely to occur with other medical comorbidities, like cancers, neurologic diseases, arthritis, and cardiovascular disease [9].

Pregnant and postpartum women

Both the USPSTF and the American College of Obstetrics and Gynecology (ACOG) emphasis on the importance of screening females during pregnancy and the postpartum period, when the risk of depression is higher than the normal [10].

Screening methods

A wide range of screening tests are used for depression screening in asymptomatic patients without a history of depression. The Patient Health Questionnaire (PHQ) is validated and widely used in a variety of clinical settings. The PHQ-2, a 2-question form of the PHQ, is popular for screening because it is short and highly accurate. An expanded form [11].

Special Populations

Older adults

For elderly, a review of eighteen studies in patients older than sixty five compared nine different screening methods, such as the Geriatric Depression Scale (GDS 30-item and 15-item versions), the Center for Epidemiologic Studies Depression Scale, and the SelfCARE(D). These three commonly used screening methods are performed similarly with sensitivities of up to one hundred percent and specificities of range between fifty percent to ninety five percent for MDD [12].

Frequency of Screening

The best frequency of screening is not yet determined. Many physicians perform the screening yearly in those who have previously screened negative, but the effectiveness and efficiency of this interval has not been established yet in clinical trials.

Benefits of Screening

The recent evidence recommends the advantages of screening for depression when coupled with proper resources for the treatment of of disease. As early as 2002, the USPSTF published support for depression screening [13]. A meta-analysis of seven trials, including more than two thousands adults, showed that depression screening and feedback of the results to providers resulted in a nine percent absolute decrease in the proportion of patients with persistent depression at six months in comparison to the usual patient care.

Disadvantages of Screening and Treatment

Extensive literature reviews show less evidence on disadvantages of screening for depression, such as management avoidance, deterioration in patient-provider relationship, labeling or stigma, and unnecessary treatment as a result of screening have not been borne out in any studies to date, even though very few trials directly studied the disadvantages of depression screening [14].

IMPLEMENTATION OF THE SCREENING PROCESS

Emerging, executing, and sustaining a highly sensitive screening method is an essential first step for improving the care of patients with depression in primary care. Managing the Screening Instrument As noted earlier, literature suggests the beginning with screening with the PHQ-2, based on its well proven accuracy, short duration, and easy usage.

Following up on an Abnormal Depression Screen

The PHQ-9 has been proven to be useful in recognizing the severity of depressive symptoms (mild, moderate, or severe) [15]. But, before starting the management, it can be appropriately determined, extra assessment is warranted. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria for a major depressive episode require the presence of five or more symptoms to have occurred together over a two-week period, that these symptoms “cause clinically significant distress or impairment,” and that they are not better explained by another disorder (eg, substance misuse, a medical condition such as hyperthyroidism, schizoaffective disorder, or bipolar disorder). Suicide is the most dangerous outcome of depressive disorders.

TREATING DEPRESSION

Studied have suggested strategies for applying screening and diagnosis of depression. Studied shown to improve treatment adherence, depression outcomes, and quality of life [16], multi-displinary care models are evidence-based approaches to depression treatment and follow-up that can be possibly initiated in the primary care setting. Collaborative care is multidisciplinary, engaging both the primary care provider and another team member, usually a nurse, social worker, care manager, psychologist, or psychiatrist.

Initial treatment

Early management for depression should include psychotherapy, pharmacotherapy, or a combination of both. It is important to partner with the patient to develop an personalized treatment strategy. Higher PHQ-9 scores reflect more severe symptoms, and patients with a higher symptom burden should be offered multimodal treatment initially. Patient safety always should be the highest priority, and indications of suicidality or psychosis should be explored and triaged to acute care settings or psychiatric consultation as indicated.

Follow-up of Treatment

In the acute phase of management, follow-up can enhance depression outcomes. Many organizations have developed treatment algorithms that include follow-up contact one to two weeks. This close follow-up is typically performed by nonphysician members of the care team, such as medical assistants, care managers, nurses, or social workers. The care team should follow-up on treatment in a stepwise approach, increasing the intensity of treatment every eight to ten weeks to have ideal depression outcomes [17].

INTEGRATING BEHAVIORAL HEALTH INTO PRIMARY CARE

Mixing behavioral health into the primary care setting eliminates significant barriers to providing comprehensive care for patients with depression. Traditional practices (least integrated) offer independent primary care and behavioral health services that rarely communicate with each other.

Managing the Health of Populations

To attain the top level of efficiency in screening and treatment of depression, Physicians must create systems to address care gaps outside of established office visits. Such systems require coordination of the roles of different team members, including development of standard care processes. It is essential to recognize which care team members are responsible for non–visit-based population management and give them protected time to complete the work. Several types of tools enable population health management of depression (and other chronic conditions). Some electronic health records allow a practice to recognize patients diagnosed with depression and follow their symptom control over time.

MEASURING IMPROVEMENT

Making and maintaining a high-quality depression program needs commitment in continuous improvement, including tracking of process, outcome, and balancing measures. Specific processes will vary from practice to practice, but there are basic measures that represent the foundation of solid depression management practices and can foster support for a collaborative care model, even in a fee-for-service environment in which team members' work is not directly refunded.

Cost-Effectiveness of Screening

The cost-effectiveness of screening for depression continues to be debated. Valenstein and colleagues36 used a Markov decision analytical approach to model the cost-effectiveness of screening in primary care. They discovered one-time screening to have a cost-utility ratio of just more than $45,000 per quality-adjusted life-year gained [18].

CONCLUSIONS:

Depression is a major cause of morbidity and mortality worldwide. It usually goes without recognition or effective treatment. Screening has the ability to improve detection of depression. Coupled with a strong system for management that uses collaborative care, screening has the ability to decrease symptoms and improve quality of life and functional status. Despite evidence of efficacy, depression screening continues to be incompletely implemented. Healthcare providers who wish to improve their effectiveness in implementation should apply a standard office approach to screening and diagnostic confirmation, followed by shared decision-making about treatment options. Providers also should develop a standard approach for follow-up to ensure treatment effectiveness. The most efficient approaches involve a multidisciplinary team and use both inpatient and outpatient care.

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