Screening and long-term follow-up of depression in my practice

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Depression is a very common problem for our patients; the prevalence of this problem in family practices is 5% to 9%.[1] Both the US Preventive Services Task Force and the Canadian Task Force on Preventive Health Care recommend that we screen our adult patients for depression, but only if they can then be diagnosed, managed, and followed up appropriately.[2,3]

In my practice, screening for depression is done as part of the organized preventive health examination (**http://drgreiver.com/tables.htm**).[4] I have to ensure, however, that screening for depression is time efficient, and that I am able to further test patients whose results are positive without backing up my office for the rest of the day.

Asking patients these 2 questions is a valid and accurate screening method[5]:

- Over the past 2 weeks, have you experienced feelings of depression or hopelessness?
- Over the past 2 weeks, have you experienced little interest or pleasure in doing things?

I have been asking these questions routinely, usually prefaced by a statement such as "Is your stress level okay?"

If a patient answers yes to either or both questions, I then give them the Patient Health Questionnaire (PHQ-9)[6]—available from **www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/questionnaire**—which they complete after I see them. The PHQ-9 contains the *Diagnostic and Statistical Manual of Mental Disorders,* 4th edition, criteria for depression, and gives me a numerical score that I can use to help me diagnose depression.[6] Some family physicians use checklists for diagnosing depression because they are time efficient.[7] I ask the patient to let me review the form before they leave. If the score indicates depression is likely, they are asked to book another, longer, appointment (unless suicidal thoughts are present, in which case they are reviewed immediately).

At the next appointment, we review the inventory results and discuss diagnosis and possible treatments. I suggest antidepressant medications or cognitive behavioural therapy, depending on what the patient prefers.[8] Periodically during treatment I will ask my patients to complete a PHQ-9 to check for remission.

The risk of recurrence of depression can be as high as 85% over 15 years,[9] especially if remission is only partial. Using cognitive behavioural therapy or long-term antidepressants reduces this risk; however, many patients object to, or might not require, lifelong medication, and many might forget or not use the cognitive behavioural therapy skills they were taught. I have started to use the PHQ-9 at preventive health examinations to detect recurrences in patients with a history of depression. I have also given some patients copies of the PHQ-9 to have at home, with instructions to return if scores are increasing, especially if above 10 (indicating moderate depression). I keep several copies of the inventory in the desk drawer of each examination room so I can access them easily.

Screening and long-term follow-up of depression can be provided in a family practice. I use 2 screening questions and a depression inventory to help me manage this common and serious problem.

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Competing interests
None declared

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