

Outpatient Primary Care Screening for Depression and Suicidality

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The limited access to practicing psychiatrists elevates the importance of primary care physicians to offer both diagnostic and therapeutic services for their patients experiencing depression. This article discusses screening tools that can be utilized under the time constraints and within the skill set of the primary care provider.

Major depressive disorder (MDD) is a debilitating condition that affects approximately 10% of the primary care population, with a lifetime prevalence of 13.4%.^{1,2} There is a significant economic burden as depression is the leading cause of disability worldwide.³ Although the diagnostic criteria for major depressive disorder are well studied, including the ominous symptom of suicidality, there is a wide range in the severity of those afflicted. Oftentimes, people can be diagnosed with mild depression that may remit spontaneously, whereas severe depression is much more dependent on treatment.⁴ At present, there is a shortage of practicing psychiatrists in this nation.⁵ As a result, primary care practitioners (PCPs) have become the vanguard and gatekeepers in treating those with mental illness, managing upwards of 50% of non-elderly adults who receive treatment for MDD.² Furthermore, the depressive symptomatology and acuity of outpatients treated in primary care and psychiatric settings are equivalent, underscoring the critical nature primary care practitioners have in treating the mentally ill.^{2,6,7}

A controversial topic that has recently been garnering more attention is whether or not to screen primary care patients for symptoms of depression. Guidelines on this matter are mixed, with the 2009 U.S. Preventative Services Task Force and 2005 Canadian Task Force on Preventive Health Care recommending screening only if supports are in place to deal with positive responses, whereas in the United Kingdom, the 2010 National Collaborating Center for Mental Health guidelines recommend against screening.^{2,8,9} With three different guidelines on screening, it can conceivably be left to individual practitioners to decide what is best for their

practices as there is a preponderance of strong evidence to support whichever decision. Intuitively, the benefits of screening outweigh the risks, and not screening patients for depression with as little as two questions is impractical. This justification is strengthened by the 2013 Preventative Services Task Force failing to identify any appreciable harm in screening.¹⁰ Therefore, it would be ideal to screen patients during each visit; however, if practicality or time constraints make this challenging, screening patients during the initial assessment, annual assessment, and well-visit should be encouraged.

It has been argued that the purpose of screening patients for depression is to recognize individuals who are suffering from previously unrecognized or untreated depression; however, it should also serve to identify individuals with known depression who are still symptomatic despite current treatment.¹¹ Therefore, the goal of this screening is to identify individuals who are suffering with the symptoms of depression regardless of their diagnostic status. The two most practical screening methods include administering self-questionnaires to patients or questioning patients from a standardized questionnaire or scale. Positive screens would then require further evaluation.

In 2009, the U.S. Preventive Services Task Force, which recommends screening, found little evidence showing the superiority of one screening tool over another, giving physicians the freedom to implement whichever tool they find most practical.^{2,12} Many screening tools for depression exist, but for busy primary care practitioners an effective initial screen to use is the Patient Health Questionnaire (PHQ-2), which is adapted from the Prime-MD diagnostic instrument for common mental disorders.¹³ The PHQ-2 is free of charge and readily available in numerous languages, and at this time, an easy way to view and print the questionnaire is through the website: <http://www.phqscreeners.com>.¹⁴ The PHQ-2 consists of the first two questions from the nine-question Patient

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Health Questionnaire (PHQ-9), which in itself is relatively brief (Figure 1). Each question on the PHQ-9 is designed to detect one of the criteria needed for the DSM-V diagnosis of major depressive disorder.¹⁵ The first two questions, which make up the PHQ-2, ask about the frequency of the symptoms of depressed mood and anhedonia, scoring each as 0 (not at all) to 3 (nearly every day)^{16,17} Furthermore, scoring the PHQ-2 is straightforward, with a score of 2 or more having a sensitivity and specificity for major depressive disorder of 86% and 78% respectively; a score of 10 or more on the PHQ-9 has a sensitivity and specificity of 74% and 91% respectively.¹⁶ The American Academy of Pediatrics updated its preventive pediatric health care guidelines to include use of the PHQ-2 as well as other tools for annual depression screening beginning at age 11,¹⁸ and although other screening tools are applicable, the PHQ-2 is especially useful for PCPs due to its effectiveness and brevity.

Although the PHQ-2 is a brief and effective screening tool, a strategy suggested in a study by Arroll, while validating the PHQ-2 and PHQ-9 in primary care settings, is to administer the PHQ-9 to each patient that scores ≥ 2 on the PHQ-2.¹⁶ The rationale for this strategy is to reduce the false positives from the PHQ-2 screening, while maintaining the brevity of the PHQ-2 for patients that screen negative. If this is logistically challenging, another option would be to raise the scoring cutoff on the PHQ-2 from ≥ 2 to ≥ 3 , but this reduces the sensitivity of the test from 86% to 61%. An additional reason to administer the PHQ-9 to positive screens rather than increasing the threshold on the PHQ-2 is that it allows for categorizing the depression. On the PHQ-9, a score from 10-14 equates with mild depression, 15-19 with moderate depression, and 20 or greater with severe depression.¹⁶ Both the PHQ-2 and PHQ-9 can easily be added as internet links to an existing electronic medical record patient portal for patients to complete and bring in prior to or in follow-up with a primary care physician, saving time for results review instead of completion.

The rationale for screening a patient for depression should also be briefly addressed to clarify why screening is recommended. Ultimately, screening for depression is of critical importance because, if done effectively, it has the potential to limit suicidality. Suicide has become the 10th greatest cause of death in this country, accounting for more than 38,000 deaths a year.¹⁹ Studies have shown that between 45% and 50% of suicide victims, and 75% of geriatric victims, visit their PCPs in the month prior to their deaths compared with only 20% having seen a mental health professional during that time.^{20,5} Furthermore, a small study showed that 18% of suicide victims visited their PCPs in the week leading up to their deaths compared with only 4% in their control group.²¹

There are several possibilities that could explain the high rate of visits in the month prior to suicide. Due to the shortage of psychiatrists in many areas, many patients and primary care practitioners find it difficult to locate psychiatrists. This places the onus on the PCP by necessity, and thus, many depressed individuals do not have psychiatrists despite their need or desire. Furthermore, in areas with psychiatrists, many patients prefer to be seen by their PCPs either because of the rapport that they have established over the years or due to the stigma associated with seeing a psychiatrist.⁴

In addition to determining why suicide victims see their PCPs in the month preceding their deaths, it also needs to be examined why they see a provider at all. Several ideas can be postulated, but all underscore the critical relationship patients have with their PCPs. Many patients that have decided upon suicide merely wish to say goodbye to a cherished doctor that did right by them over the years; however, more frequently there is likely some ambivalence about suicide.²⁰ In times like this, trying to connect with a part of the patient that is still committed to living can be effective. For example: "I understand that 95% of you may be prepared to die, but I wish to speak to the 5% of you that still wants to live." This serves to deepen the discrepancy in the patient's mind, while offering empathy and supporting their wish to live. Not all patients will be forthright with their depression or suicidality, and for that reason, even if a provider has no suspicion, a special consideration is to be mindful of the doorknob statement. A doorknob statement is when a patient waits until the last possible moment, oftentimes while grasping the doorknob, to reveal a critical bit of information. A doorknob comment could be used when a patient may desperately want help, but is too afraid to ask for it directly. In a patient with even the tiniest glimmer of ambivalence, this "final goodbye" should be examined closely and never minimized. If a closing comment is the slightest bit ambiguous or causing for concern, it should be immediately addressed due to the high percentage of patients that see their PCPs prior to suicide.

Although the primary scope of this article is to discuss the merits and rationale of screening patients for depression and suicidality, there are also the practical issues of what to do with a positive result, what the financial implications of screening can be for a PCP, and to alleviate any fears that asking about suicide will in turn make someone suicidal. In fact, patients are typically relieved when a provider shows that they care and are attuned to mental illness, thus further strengthening the therapeutic alliance rather than impairing it.²⁰ However, screening for depression is not enough. Several studies have shown that for screening to be beneficial, integrated systems need to be in place to address the positive results.^{2,5,8} These systems will depend on the resources available, but could

include a timely referral to a mental health practitioner or psychiatric clinic. If no referrals are available, or the patient is reticent of the stigma associated with seeing a mental health practitioner, increased visits to the PCP should be arranged to follow the course and progression of the patient's depression.

Depression screening tools, such as the PHQ-9, can be billed either in a packaged option or by itself under Medicare Part B coverage. Screening tools for depression are packaged as one of the many required parts of either the Initial Preventive Physical Examination (IPPE) or the Initial Annual Wellness Visit (AWV). A PHQ-9 is one of the many depression screening tool options a provider can utilize to meet one of the many criteria for either of these examinations. Note that the code utilized for the IPPE is G0402 and for the AWV is G0438, and should only be submitted when all components of either examination are completed. In these cases, the PHQ-9 is billed as part of the examination and not separate to the codes for the packaged visits.

A provider may also perform an annual screening on patients for assistance with the diagnosis, treatment or follow-up for depression. The code that is used in this situation would be G0444 (Annual Depression Screening, 15 minutes). This service can be utilized if the patient comes in for complaints directly related for depression and this screening is the only service provided. Screening can be performed one time in each 12-month period, noting that if the tool was used in either the IPPE or AWV examination, additional screening would not be appropriate for billing purposes.

CONCLUSION

Screening patients for depression and suicidality gives providers a chance to recognize a patient that is preparing to take his own life, and if symptoms of depression are discovered, a chance to act. Taking the few moments to screen a primary care patient can open the dialogue for a patient minimizing their symptoms or just waiting for someone to ask them about their mood.

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Figure 1: Patient Health Questionnaire-9 (PHQ-9)

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + + +
=Total Score:

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all <input type="checkbox"/>	Somewhat difficult <input type="checkbox"/>	Very difficult <input type="checkbox"/>	Extremely difficult <input type="checkbox"/>
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