
Many of the studies that were used in developing the AHCPR Depression Guidelines (the “Guidelines”) were conducted with patients in specialty mental health settings, using older medications. Since their publication in 1993, there is more evidence about the treatment of depression in primary care practice and the “Guidelines” themselves. Schulberg and colleagues reviewed studies published between 1992 and 1998 that gave further information on the treatment of depression. Using the Cochrane Collaboration Depression, Anxiety, and Neurosis Trials Register, they applied intent-to-treat analysis regarding the efficacy of pharmacological and psychotherapeutic treatments of major depression, first-line treatment choices, cost-effectiveness of treatments, and experiences with guideline implementation. The evidence in the newer studies supported that both antidepressant pharmacotherapy and time-limited depression-targeted psychotherapies are efficacious in primary care settings, as already demonstrated in mental health care settings. Irrespective of the treatment choice, there is a high attrition rate in the treatment of depression. Given the data supporting either or both modalities, the authors suggest using patient preference to guide treatment choice; hopefully this will decrease the high attrition. Selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants (TCAs) were both found to have similar total treatment cost per depressive episode despite higher acquisition costs for
SSRIs. This was attributed to a higher rate of switching antidepressants when using TCAs because of their worse side effect profile.

Further studies reviewed suggest that improving treatment of depression in primary care requires properly organized treatment programs, regular follow-up, actively monitoring treatment adherence, and a prominent role for the mental health specialist as educator, consultant, and clinician for the more severely depressed.