Screening and treatment of depression – recommendations for Polish health professionals

Monika Dominiak¹, Anna Zofia Antosik-Woźnińska², Marta Baron³, Paweł Mierzejewski⁴

¹Department of Pharmacology, Institute of Psychiatry and Neurology, Warsaw, Poland
²Department of Psychiatry, Medical University of Warsaw, Warsaw, Poland
³Institute of Psychiatry and Neurology, Warsaw, Poland

Abstract

Introduction: Epidemiological data clearly indicate that depression is becoming an increasingly important health and social problem today. Depressive disorders occur at all ages, in men and women, in different cultures, affecting individuals, their families, and, more broadly, the social and economic system of the country. The gap between the recorded number of treated patients and the prevalence of depression highlights the scale of unmet needs. With limited availability of specialists in psychiatric care, the most appropriate measures seem to be those aimed at increasing the competence of other health professionals in the diagnosis and treatment of depression.

Material and methods: An overview of the literature and available recommendations for the prevention, screening, and treatment of depression was performed. This work was commissioned by the Polish Ministry of Health under the Depression Prevention Program 2016–2020.

Results: Based on the literature review, we compiled the recommendations for Polish health professionals. These recommendations focus on the management of depression in the primary care setting and provide guidelines for health professionals other than psychiatrists concerning the prevention, screening, and treatment of depression.

Conclusions: We developed a clear recommendation for non-psychiatrists concerning the screening, treatment, and further management of patients with depression. Early detection of depression and implementation of treatment improves the outcomes and prognosis and reduces the mortality rate.

Key words: depression, recommendations, screening, depression treatment, physicians, health professionals.
Meanwhile, available studies confirm the importance of early diagnosis of depression and quick implementation of appropriate therapy. A shorter period of untreated depression translates directly into higher response rates, remissions, and lower disability rates, and reduces the risk of mortality and health complications [11, 12].

Depression, especially when untreated, increases the risk of somatic diseases, and vice versa – somatic diseases, especially chronic ones, increase the risk of depression [13, 14]. According to the World Health Organization Mental Health Action Plan 2013–2020 [2], people with mental disorders experience a disproportionately greater number of disabilities and illnesses in their lives. About 31% of adults with diabetes have clinically significant symptoms of depression [15]. The relationship between depression and hypertension is also bilateral – higher rates of hypertension in people with depression were observed in the study of Wang et al. [16]. Moreover, effective antidepressant treatment led to blood pressure normalization [17]. Similarly, the relationship between depression and ischemic heart disease and the risk of sudden cardiac death has been undisputedly confirmed in many studies [18–22]. Depression is also very often associated with cancer [23], reducing the patient’s willingness to be treated, affecting the immune system, and worsening the prognosis in cancer. As many as 20 years after a cancer diagnosis, the risk of depression decreases to a comparable level as in the general population [23].

A particular problem is the occurrence of depressive episodes in the postnatal period. The prevalence of depressive disorders in women in the postnatal period is estimated to be around 15–20% [24, 25], which makes it the most common postnatal complication [26].

Patients with depression often, due to different reasons (for example fear of stigmatization, lack of knowledge about the condition, lack of insight, difficulties in access to a specialist doctor), do not go to a psychiatrist at all. With limited availability of specialist psychiatric care, the most appropriate measures seem to be those aimed at increasing the competence of doctors of other specialties, especially GPs and internists (appropriate screening tool, specific guidelines for diagnosing and treating depression) in the diagnosis and treatment of depression.

Material and methods

An overview of the worldwide literature, as well as available recommendations for prevention, screening, and treatment of patients with depression was performed. The search was conducted from inception of the database to November 2020 using the keywords “depression” OR “depressive disorder” OR “major depression” AND “guideline” OR “recommendation”. The following electronic bibliographic databases were searched: MEDLINE/PubMed, EmBASE, PsycINFO, and Cochrane library. Forward and backward citation searches of included articles was also performed to further locate papers that were not identified in the database search. Additionally, we searched the following websites of agencies and scientific associations related to mental health or preventive medicine: U.S. Preventive Services Task Force (https://www.uspreventiveservicestaskforce.org), World Federation of Societies of Biological Psychiatry (http://www.wfsbp.org), Canadian Agency for Drugs and Technology in Health (https://comp-opcm.ca/english/community-partnerships/canadian-agency-for-drugs-technologies-in-health-cadth.html), European Psychiatrist Association (http://www.europys.net/publications/guidance-papers), American Psychiatric Association (https://www.psychiatry.org), Royal College of Psychiatrists (https://www.rcgp.org.uk), National Institute of Mental Health (https://www.nimh.nih.gov), American College of Preventive Medicine (https://www.acpm.org), Michigan Quality Improvement Consortium (http://www.mqic.org), Institute of Clinical Systems Improvement (https://www.icsi.org), American Family Physician (https://www.ama-assn.org), Royal Australian College of General Practitioners (https://www.racgp.org.au), Beyondblue (https://beyondblue.org.au), Canadian Task Force on Preventive Health Care (https://canadian-taskforce.ca), Canadian Network for Mood and Anxiety Treatments (https://www.canmat.org), Department of Veterans Affairs, Department of Defense (https://www.va.gov/vadodhealth), National Institute for Health and Clinical Excellence (https://www.nice.org.uk), American Geriatrics Society (https://www.americangeriatrics.org), Scottish Intercollegiate Guidelines Network (https://www.sign.ac.uk), and New Zealand Guidelines Group (https://www.guidelinecentral.comsummaries/publications/new-zealand-guidelines-group). Guidelines that concern screening, diagnosis, and management of depression in settings other than mental health services, in English language, regularly updated, most recently over the last 5 years were considered. Further evaluation was performed in accordance with the Appraisal of Guidelines for Research and Evaluations (AGREE II instrument) [27]. The final recommendations for Polish physicians were compiled based on the selected guidelines (Table 1).

Results

The results of the literature and recommendations review in terms of the prevention of and screening for depression

According to the available data, recommendations for the prevention, screening, and treatment of depression have been developed in many countries around the world. The recent review of guidelines for the management of depression identified all national (n = 82) and international (n = 13) clinical practice guidelines from
Table 1. Guidelines for screening and treatment of depression

| Organization                                                                 | Recommendations                                                                 |
|------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| US Preventive Services Task Force [27]                                       | Recommends a routine screening of the adult population. At the same time, it indicates the need to provide coordinated treatment. |
| American College of Preventive Medicine [28]                                | It recommends routine screening for depression in the adult population. Stresses the need for coordinated patient care.               |
| Michigan Quality Improvement Consortium Guideline [29]                       | Recommends a routine screening for depression in the adult population using PHQ-2 and/or PHQ-9. In people with risk factors, the screening should be performed at each visit. |
| Institute of Clinical Systems Improvement [31]                              | Recommends routine screening for depression in the adult population using PHQ-2 and/or PHQ-9.                                      |
| American Family Physician [30]                                               | Recommends routine screening of the adult population and children and adolescents (12–18 years old) using the PHQ-2 or PHQ-9 or Geriatric Depression Scale-15 questionnaires in the elderly population. |
| Royal Australian College of General Practitioners [41]                      | It recommends routine screening of the adult population and children and adolescents (12–18 years old) using PHQ-2 and/or PHQ-9. In people with risk factors the screening should be performed at each visit. |
| Canadian Task Force on Preventive Health Care [50]                          | It does not recommend routine screening for depression in the general population or in patients at risk.                           |
| National Institute for Health and Clinical Excellence [25, 26]              | It recommends that patients in the high-risk group, especially patients with chronic somatic disease, be carefully monitored and screened using a set of 2 questions. Furthermore, it recommends a graded approach to treatment. |
| Department of Veterans Affairs, Department of Defense [61]                  | It recommends routine screening for depression using PHQ-2 in patients that are not currently treated for depression, and PHQ-9 in patients with diagnosed depression to monitor the treatment. Stresses the need for coordinated patient care. The first-choice treatment for an uncomplicated episode of mild to moderate depression should be pharmacotherapy and/or psychotherapy. Patients who have not responded to treatment with antidepressants used in the therapeutic dose after 4–6 weeks should be referred to a psychiatrist for further treatment. The treatment should be continued for at least 6 months. |
| Canadian Network for Mood and Anxiety Treatments [60]                       | Stresses the need for coordinated patient care. It specifies in detail the drugs used as first- and second-line treatment for depression. |

around the world [28]. All these recommendations were developed in the 21st century and are updated periodically. In this study we have focused on the most comprehensive guidelines targeting depression in adults in settings other than mental health services.

The most comprehensive recommendations, covering many issues related to depression, are depicted in the guidelines of the National Institute for Health and Care Excellence (NICE) [29, 30] and in documents developed by American organizations and associations (US Preventive Services Task Force – USPSTF, American College of Preventive Medicine – ACPM, Michigan Quality Improvement Consortium Guideline – MQICG, American Family Physician – AFP, Institute of Clinical Systems Improvement – ICSI) [31, 35].

Many experiences in the prevention of depression also come from Australia. One of the best-known programmes is the Australian-led Beyondblue programme [36] (www.beyondblue.org.au), which was established in 2000 as a 5-year national initiative to raise public awareness of early responses to depressive behaviour. Retrospective research conducted in subsequent years confirmed the effectiveness of this program in terms of increased public awareness and improved treatment of depression in Australia [37, 38].

Interesting experiences in this matter also come from European countries. A 2-year program to combat depression conducted in Nuremberg [39] allowed for a significant reduction in the number of suicides (by about 20%) and improved early detection and care for patients with depression. The concept of this program is based on different levels of impact: cooperation and training for GPs, social campaigns to raise awareness and basic knowledge about depression, training for key professions (i.e. teachers, priests, police, carers of elderly people), and the creation of support groups and specific facilities for access to professional care for patients with a higher risk of suicide. This program, with various modifications, has been implemented in many other countries. Evaluation of its effectiveness in subsequent years confirmed a significant decrease in the number of suicides and improved early detection of depression.

Country-specific recommendations for depression screening either in routine screening in the general population, which is widely recommended by American organizations [31, 35], or screening in selected risk groups, as applied in the UK (NICE, 2009, 2018) [29, 30]. The USPSTF recommends routine screening of adult populations [31]. The ACPM [32] supports this guideline, recommending its implementation in primary care.
settings and the development of patient care models based on collaboration with psychiatrist consultants [40]. O’Connor et al. [41] and Pignone et al. [42] also point out that screening is more effective if a system of follow-up care is properly organized. Beinap et al. [43] and Gilbody et al. [44] note that comprehensive care for depressed patients based on cooperation between different professionals is more effective than the traditional approach. The MQICG (2016) [33] also recommends routine screening of the adult population but does not specify how often such screening should take place. However, patients at higher risk of depression, as well as patients who are suspected of depressive symptoms, should be screened at every opportunity. The above guidelines recommend the use of the Patient Health Questionnaire version 2 (PHQ-2) and/or the Patient Health Questionnaire version 9 (PHQ-9) for screening. Similarly, the ICSI [35] recommending routine screening of the general population with PHQ-2 and/or PHQ-9. In the case of positive screening, further testing is recommended. The ICSI recommends referral to psychiatric care in the following situations: if the patient declares suicidal thoughts, has no response to the treatment, or has other psychiatric conditions. The doctor should also educate each patient about depression and assess the level of support in their immediate sur-

tor should also educate each patient about depression and assess the level of support in their immediate surroundings. Also, the AFP [34] (www.aafp.org), like other American organizations, recommends a routine survey of the adult and youth population (12–18 years old). It recommends the use of the most practical screening tool for a given doctor. Most often it is a PHQ-2. If the patient answers positively to any of the 2 questions, further testing with PHQ-9 is recommended.

In Australia, the Royal Australian College of General Practitioners (RACGP) [45] also recommends screening for depression in the adult population if there is a suitable structure for further treatment and coordinated patient care. In the case of a patient with risk factors, it recommends always considering the possibility of depression and performing screening in this population.

Some studies indicate the need for additional laboratory tests, e.g. assessment of TSH levels in blood in patients with symptoms of hypothyroidism [46]. The American Geriatrics Society [47] has also issued recommendations for additional tests, recommending the following tests in people with suspected depression: TSH, vitamin B12, calcium, electrolytes, parameters for kidney and liver function, morphology, and urine testing.

Concerning screening in risk groups, such an approach is recommended in the UK. Comprehensive recommendations for the detection and treatment of depression in adults and in people with chronic somatic diseases were published in 2 NICE documents (“The treatment and management of depression in adults” and “Depression in adults with a chronic physical health problem: recognition and management”).

According to the NICE document (Depression with a chronic physical health problem; NICE Clinical Guideline, 2009) [30] depression is 2–3 times more common in patients with chronic somatic diseases. Therefore, NICE and the vast majority of other guidelines recommend routine screening in the population of people with chronic somatic disease. Depression in this group of patients is often more difficult to diagnose because the symptoms of the disorders can be very similar. According to the American Psychiatric Association (APA) [48], many depressed patients do not complain at all about decreased mood or anhedonia, but instead complain about a variety of non-specific somatic problems or fatigue and are more likely to visit internists or GPs [49]. At the same time, depression worsens the prognosis in some chronic diseases, such as cardiovascular diseases or diabetes [50, 51]. Therefore, early identification of depression through screening is particularly advisable.

Depression risk factors include the following [29, 30, 52, 55]:
- past episodes of depression,
- family history of depression,
- other mental illness, addictions,
- cancers,
- Parkinson’s disease,
- cardiovascular diseases,
- diabetes mellitus,
- neck pain, chronic pain,
- other chronic somatic diseases,
- unemployment, difficult life situation,
- older people experiencing various life difficulties (chronic illness, mourning, institutional care).

NICE [29, 30] recommends that patients in the high-risk group are closely monitored and screened using a set of 2 questions:

1. Have you had feelings of sadness, depression, or hopelessness in the last month?
2. In the last month, did you experience reduced interest or reduced pleasure?

In the case of obtaining a positive answer to any of the questions, it is advisable to make a further assessment of the patient’s mental condition or refer them to a psychiatrist. For patients with chronic somatic illness, NICE recommends asking further questions:

1. Have you felt worthless during the last month?
2. Have you had problems with concentrating?
3. Have you had suicidal thoughts?

If the patient answers positively to any question, it is advisable to carry out further evaluation of the mental state or refer them to a specialist psychiatrist. It should also be considered whether the depression is not caused by drugs used in a somatic illness or otherwise related to the patient’s somatic condition.

Two questionnaires are most often mentioned in all of the above recommendations: PHQ-2 and PHQ-9.
PHQ-2 is recommended for screening the population of all people over 12 years old. It consists of 2 questions. A result of 3 or more (out of 6 possible) means an indication for further evaluation, usually using PHQ-9. PHQ-9 consists of 9 questions that help to diagnose depression and assess its severity. It takes about 3 minutes to complete the questionnaire. PHQ-9 is recommended both as an initial assessment tool and as another supplementary questionnaire after PHQ-2, and it is particularly useful in monitoring symptoms when treating depression [56, 57]. A score of 6 or above for PHQ-9 requires further examination for depression [58]. Detailed guidelines of how to use PHQ-9 can be found at http://www.phq9screeners.com/Instruc.Skala. The sensitivity of this questionnaire was assessed at 61% and its specificity at 94% [56]. A recent systematic review revealed that a 2-stage screening, in which a clinical interview confirmed or refused the preliminary PHQ-9 assessment, is the most recommended system [59].

**Suicide risk assessment**

The majority of recommendations refer to the potentially most serious depression-related situation – to an assessment of the risk of suicide, recommending an evaluation of the severity of such thoughts and an assessment of the patient’s ability to implement them. It is also stressed that the patient should be asked about their immediate environment and the support they can get there. For example, MQICG [33] recommends asking patients directly about their suicidal thoughts and plans, as well as about their family history of suicide. If such thoughts are declared, the risk of their implementation should be assessed and the patient should be referred for further psychiatric treatment (outpatient or inpatient treatment) as appropriate.

NICE [29, 30] recommends that patients with chronic somatic disease and depression are routinely asked about suicidal thoughts. If there is a positive history, it is recommended that the level of support in patient’s environment is assessed, all the medication that are taken are considered and the amount of these medications reduced if possible, intensifying contact with the patient is considered, including by telephone, and further assistance to apply to the threat is provided. However, the recommendations do not recommend routine population screening for suicide risk. The USPSTF states that there is insufficient evidence for screening the general population (U.S. Preventive Services Task Force. Screening for suicide risk. May 2004) [60].

**The results of the literature and recommendations review in terms of the treatment of depression**

In patients with dysthymia and mild depression who do not require any formal intervention, an education, a visit plan (next visit in 2 weeks), and psychosocial interventions are recommended.

The first-choice treatment for an uncomplicated episode of mild to moderate depression is pharmacotherapy and/or psychotherapy [29, 61, 62]. The choice of treatment (pharmacotherapy or psychotherapy) is often dictated by the patient’s preferences and access to a psychotherapist [63]. Among the available psychotherapeutic methods for treating depression, cognitive-behavioural psychotherapy is preferred. However, it should be taken into account when choosing the treatment method that access to psychotherapy under public health care conditions is still limited in Poland, especially outside large urban areas [64].

In moderate to severe depression, the treatment of choice is pharmacotherapy with antidepressants [29, 64, 65]. Patients who have not responded to treatment with antidepressants used in a therapeutic dose after 4–6 weeks should be referred to a psychiatrist for further treatment [29, 64, 67].

Patients with severe depression, moderate depression, and other coexisting health problems that impact normal daily functioning should receive comprehensive, coordinated care [30]. The NICE guidelines recommend a graded approach to treatment:

- **Step 1** – suspicion of depression: examination and assessment of symptoms, support, psycho-education, intensive monitoring, possibly referral to further specialist care
- **Step 2** – confirmed mild/moderate depression: psychosocial interventions, psychotherapy, pharmacotherapy, possibly referral to further specialist care
- **Step 3** – severe depression or lack of response to treatment in previous steps: pharmacotherapy, intensive psychotherapeutic interventions, combined treatment, referral to further specialist care
- **Step 4** – severe depression or other concomitant disorders, life threatening: pharmacotherapy, intensive psychotherapeutic interventions, combined treatment, referral to further specialist care, electroconvulsive therapy, hospital treatment

**Basic principles of pharmacological treatment of depression**

Basic knowledge of the diagnostics and treatment of depression by non-psychiatrists seems indispensable. It allows for the implementation of therapy in patients who would probably never go to a psychiatrist, as well as for a prompt referral to a psychiatric emergency unit (i.e. psychotic depression, auto-aggressive and aggressive behaviour, restriction of meals and liquids, presence of suicidal thoughts) [67–69]. With mild or moderate intensity of symptoms, prompt implementation of treatment by internists or GPs saves time,
Choosing an antidepressant

A meta-analysis indicates that antidepressants, regardless of their mechanism of action, generate comparable percentages of treatment responses, ranging from 50% to 75%, significantly higher than placebo [63]. It is not only the efficacy that determines the choice of drug, but also the safety and tolerability. The choice of medication should also take into account the clinical features of depression in a given patient, coexisting diseases, and consequently other drugs taken by the patient, providing him/her with information about the diagnosis, course of the disease, methods of treatment, legitimacy of taking medicines, and ways of preventing and recognizing early symptoms of relapse [65]. The effect of the drug is usually visible after 2–4 weeks.

The main aim of depression treatment is to achieve the fastest and fullest therapeutic response as well as symptomatic remission and return to pre-disease functioning. The basic principle of the treatment is to select drugs that act comprehensively, on the whole set of symptoms, and not only on its individual components (such as anxiety or sleep disorders) [65, 67, 68]. In the therapeutic process, cooperation with the patient, providing him/her with information about the diagnosis, course of the disease, methods of treatment, legitimacy of taking medicines, and ways of preventing and recognizing early symptoms of relapse is crucial [65]. The effect of the drug is usually visible after 2–4 weeks.

### Choosing an antidepressant

A meta-analysis indicates that antidepressants, regardless of their mechanism of action, generate comparable percentages of treatment responses, ranging from 50% to 75%, significantly higher than placebo [63]. It is not only the efficacy that determines the choice of drug, but also the safety and tolerability. The choice of medication should also take into account the clinical features of depression in a given patient, coexisting diseases, and consequently other drugs taken by the patient and the risk of potential interactions.

The following should be taken into account in the selection of antidepressant for a given patient [65, 67, 68]:

- Clinical features of depression,
- Side effects profile,
- Coexisting somatic diseases and all drugs taken,
- Age of the patient and body weight (e.g., features of malnutrition, cachexia),
- Treatment used in previous depressive episodes (its effectiveness and tolerance),
- Co-morbidity with other mental disorders,
- Intensity of depressive symptoms (severe depression with psychotic symptoms, severe depression without psychotic symptoms, moderate depression, mild depression),
- The patient’s compliance with the recommendations (e.g., in case of difficult cooperation with the patient, choosing a drug with the simplest possible dosing regimen, involvement in the treatment of the patient’s relatives, psychoeducation of the family),
- Doctor’s experience with the use of the medicine and the availability and price of the medicine.

Pharmacological treatment of episodes of postpartum depression in a woman who is not breastfeeding does not deviate from the recommendations for the treatment of depression not related to pregnancy and the postpartum period. The benefits of treatment for the mother should be considered when deciding on the inclusion of pharmacological treatment during breastfeeding, and the risks arising from the child’s potential exposure to the drug should be taken into account. The specificity of depression treatment during pregnancy and after childbirth in most cases requires treatment by a specialist psychiatrist (Table 2).

An important factor in the selection of antidepressant treatment is also the patient’s somatic load. When choosing a drug, it is necessary to take into account possible side effects that may occur during the therapy. The following is a simplified proposal for the treatment of depression in selected somatic diseases (Table 3, Fig. 1).

### Treatment steps

**Acute phase – active treatment** (usually takes 6–8 weeks). This is the time from the beginning of the treatment to the remission of the symptoms. During this period, it is crucial not only to choose an antidepressant, but also to establish an adequate therapeutic dose (well tolerated by the patient and at the same time falling within the range of therapeutic doses). During this period, visits should be quite frequent to monitor...
the drug tolerance, occurrence of adverse reactions, and the occurrence of therapeutic response. It should be remembered that although signs of improvement may appear at the beginning of therapy, the reaction to treatment can only be assessed by using the drug in a therapeutic dose for at least 4–6 weeks.

**Continuation of treatment with maintenance treatment** – after obtaining symptomatic remission, treatment should be continued for at least half a year (according to some authors even 9–12 months) [66]. Doses of drugs during this time should be maintained or reduced to the minimum therapeutic dose. The length of treatment depends on the intensity of symptoms at the beginning of the therapy, the time of untreated depression, the time to therapeutic response, and any coexisting adverse environmental factors (personal/family/occupational/economic difficulties). If, during maintenance treatment, the patient experiences an increase in depressive symptoms, the dose of the drug should be increased or, if this treatment proves ineffective, the drug should be changed to another one with a different mechanism of action or the combined treatment should be started.

**Preventing recurrence** – the aim is to prevent relapse in the case of recurrent depressive disorders or bipolar affective disorder.

**Withdrawal of drugs** – when deciding to discontinue antidepressant treatment, it should be remembered that doses should be reduced slowly because of the risk of withdrawal symptoms. In the case of short-term antidepressant treatment the medication should be discontinued over a period of 1–2 weeks, in the case of treatment lasting 6–8 months the doses should be reduced over a period of 6–8 weeks, and in the case of long-term treatment the dose should be reduced by 25% every 4–6 weeks until complete discontinuation.

**The most common mistakes concerning pharmacotherapy**

The most common mistakes made by doctors [67, 68] are as follows:

– underestimating suicide risk,
– insufficient dose of antidepressants,
– insufficient treatment time, rapid change from one antidepressant to another,
– polytherapy,
– underestimating adverse effects, treating somatic complaints as a sign of hypochondria, underestimating the role of drug interactions,
– underestimating the role of therapeutic contact and proper doctor-patient cooperation,
– overuse of benzodiazepines, use of benzodiazepines for too long (risk of addiction), or replacement of antidepressants with benzodiazepines,
– insufficient education of the patient and his/her relatives about the disease and the rules of its treatment.
Common reasons for treatment ineffectiveness

The aim of antidepressant treatment is to relieve symptoms and restore functioning at pre-disease levels, and to prevent relapse. In some patients, however, despite repeated modifications of the pharmacological treatment, remission and sometimes even stable improvement is still not achieved. Sometimes the treatment causes side effects that are not accepted by the patient and are the reason for early discontinuation of treatment. Studies have shown that about 20–30% of properly treated patients do not respond to treatment. In some cases, this can be so-called “pseudo-resistance”. The lack of therapeutic effect is then a result of misdiagnosis, inadequate pharmacotherapy (inappropriate drug, inadequate dose, inadequate treatment time, failure to follow the recommendations), or interaction with other drugs.

Potential causes of treatment ineffectiveness [67, 68] are as follows:
- inadequate duration of treatment,
- misdiagnosis,
- inadequate dosage,
- inappropriate choice of medication,
- non-compliance with doctor’s recommendations, lack of doctor-patient cooperation,
- coexistence of other mental or somatic disorders,
- individual characteristics of the patient’s metabolism (slow metaboliser/fast metaboliser),
- coexistence of somatic disorders,
- interactions with other drugs taken by the patient,
- presence of organic changes in the central nervous system,
- old age,
- factors supporting symptoms of disease,
- omitting psychotherapeutic assistance,
- withdrawal from treatment too early,
- associated addiction to psychoactive substances/ alcohol.

Discussion

Diagnosis of the situation in Poland – barriers and possible solutions

As already mentioned, registered reporting to psychiatric health care facilities is very low and does not reflect the prevalence of depression. This marked discrepancy highlights the scale of the problem and the extent of unmet needs. This naturally raises the question concerning the reasons. It seems that the problem is complex and requires careful consideration on several levels. Some patients do not realize the problem at all and do not seek medical help, some go to a doctor or other specialist, some to a psychologist, and only a small part to a specialist psychiatrist. The availability of public psychiatric care is a problem faced by patients throughout the country. It goes without saying that for a depressed patient, waiting several months for help and treatment is a very long and suffering-filled time, during which his/her chances of full recovery are diminishing. Studies confirm that early diagnosis and treatment of depression translates directly into a higher rate of remission, and reduces the risk of relapse and mortality [11, 12]. Various actions are possible to improve this situation. These include, in particular, increasing the knowledge and competence of doctors – the medical personnel who most often come into contact with people with depression. Many studies emphasize the need to develop recommendations in individual countries, taking into account various cultural factors as well as the specificity of the healthcare system in a given country [70]. A recent review of guidelines for the management of depression summarized all worldwide clinical practice guidelines [28]. The authors of this review also stressed the importance of considering the strategies to implement recommendations in given countries. Obviously, in various settings health-care personnel might be constrained in their ability to provide timely and appropriate mental health interventions [71]. The conclusion that could be drawn from above review is the importance of the practical aspects of application of guidelines in given countries. In particular, the government policies that require adherence to recommendations could facilitate their implementation. A clear indication on screening tools and algorithms for the treatment and management of depression could also be helpful. This could make it easier for physicians to do the work that they are already doing.

The problem of availability of specialist psychiatric care and the organization of an effective system in this field is faced by many countries, including Poland. The solutions applied in other countries vary widely. However, the common denominator seems to be the shift of part of the burden of care to primary settings, internists, or neurologists. This applies in particular to the diagnosis of depression and the first-line treatment of typical, uncomplicated cases. So, it would make sense if the doctor the patient sees first were able to establish the proper diagnosis. These patients often complain about a variety of somatic problems, and the main source of these complaints is unrecognized depression. A study conducted in Poland indicated the prevalence of depression in the population of primary care patients reaching 23% [9].

Another important issue is the organization of the overall system to provide comprehensive, coordinated care for patients with depression. Such teams include internists, family doctors, psychiatric specialists, psychologists, therapists, and members of community care teams.

Leading organizations worldwide, such as the ACPM, recommend the implementation of collaborative care
models with psychiatrist consultants [32]. In Poland, however, the separation of primary care from specialist psychiatric care is strongly expressed.

As well as system-organizational barriers, equally important and strongly rooted awareness barriers remain. The main problems seem to be lack of knowledge about depression in society and stigmatization. This has been confirmed by the results of the EZOP survey [3], which revealed very limited knowledge and experience with people with mental illness in Polish society. These views seem to be very deeply rooted and largely culturally independent, and many societies in the world are trying to rectify this problem.

**Recommendations for prevention, screening, treatment, and management of depressed patients for physicians**

The purpose of these guidelines is to define, for the use by physicians, the procedure of screening for depression in adults, as well as treatment and further management of patients with recognized depression.

**Recommendations for the prevention and screening for depression in adults**

1. It is recommended that patients and their families are educated about possible early symptoms of depression and risk factors.
2. The presence of depressive symptoms should be routinely assessed during the first visit using the PHQ-9.
3. The presence of depressive symptoms should be routinely assessed at least once a year and in any situation indicating possible mental deterioration, as well as in patients with risk factors (in particular, patients with chronic somatic disease, chronic pain, and history of depression) at every possible opportunity using the PHQ-9.
4. It is recommended that the purpose of the screening be explained to the patient and their informed consent obtained to complete the questionnaire.
5. If the patient refuses to complete the PHQ-9, the screening should be offered again at the next visit.
6. It is advisable to perform an interview regarding depression risk factors. It is recommended that the following risk factors are asked about:
   - depressive episodes in the past and mood swings,
   - mental health problems in the family,
   - somatic diseases, chronic pain,
   - living situation, support in the immediate surroundings,
   - stressful life events in recent times.
7. It is also advisable to ask about alcohol and drug addiction. In case of a positive history, it is recommend-
ed that referring the patient to psychiatric care be considered.
8. In the case of a score of more than 6 points in the PHQ-9, it is recommended that a further interview be conducted to confirm the diagnosis of depression or to refer to a psychiatrist. The interview should include questions about the occurrence of particular depressive symptoms according to ICD-10 criteria:

| Basic symptoms                          |
|-----------------------------------------|
| 1. Reduced mood                         |
| 2. Loss of interest and ability to enjoy |
| 3. Reduction of energy level, leading to increased fatigue and reduced activity |

| Additional symptoms                      |
|-----------------------------------------|
| 1. Problems with concentration or attention |
| 2. Low self-esteem and low self-confidence |
| 3. Feelings of guilt and low self-worth (even in mild episodes) |
| 4. Pessimistic, black vision of the future |
| 5. Suicidal thoughts and actions         |
| 6. Sleep disorders                       |
| 7. Reduced appetite                      |

Note: In order to establish the diagnosis, it is necessary to determine the persistence of the symptoms for a period of at least 2 weeks, although this period may be shorter if the symptoms reach very high intensity and grow rapidly. At least 2 basic symptoms (depressed mood does not have to be one of them) and 2 additional symptoms must be found. In the case of depressive disorders that do not meet the recognition criteria for a depressive episode, e.g. when there is only one symptom from the list of basic symptoms, other depressive disorders should be considered (e.g. depressive reaction or mixed depressive-anxiety disorders).

9. A positive result (6 points or more) of a screening test must be noted in the medical records. The following actions are then recommended:
   - discuss the result of the screening test with the patient,
   - if the patient agrees, inform relatives about the diagnosis and treatment plan,
   - assess the level of support in the patient’s immediate environment,
   - inform the patient about possible options for further treatment (psychotherapy, pharmacotherapy),
   - suggest a plan of further proceedings – implementation of pharmacotherapy/referral to a psychiatrist/ psychologist.

10. Coordinated care of a patient with diagnosed depression is recommended in cooperation with specialist psychiatrists and psychologists.

11. In the following cases, the patient should be referred urgently to a psychiatric consultation:
   - declaring suicidal thoughts and tendencies (or a score > 0 in point 9 on the PHQ-9 scale),
   - the severity of depressive symptoms, clearly impairing their daily functioning,
   - suspected psychotic depression,
   - suspected bipolar affective disorder,
   - when a patient refuses or significantly reduces meal or fluid intake (Figs. 2, 3).
**Fig. 2. Depression in non-psychiatrist**

- **Interview on depression and addiction risk factors**
  - Presence of addictions
  - Consideration of referral to a psychiatrist

- **Patient education (pro-healthy lifestyle, symptoms of depression)**
  - Presence of factors risks
  - Consider screening with PHQ-9 on each visit

- **Screening proposal**
  - Lack of consent
  - PHQ-9 = 0–5 points
    - Education: A proposal to repeat the test when something changes
    - Cooperation: with a psychiatrist and a psychologist

- **PHQ-9 = 6 points or above**
  - Consent
  - Screening using the PHQ-9 questionnaire
  - Perform the interview for depressive symptoms
    - note in the medical records
    - discuss the outcome with the patient
    - inform the family (if the patient agrees)
    - inform about possible treatment options
    - consider referral to a psychologist
    - first-line treatment implementation or referral to a psychiatrist

**Fig. 3. Situations requiring urgent psychiatric consultation**

- Declaring suicidal thoughts about self-harm or score > 0 in point 9 on the PHQ-9 scale
- Refusal or significant reduction of food or liquid intake
- The severity of depressive symptoms impairing daily functioning
- Suspected psychotic depression
- Suspected bipolar affective disorder

---

**Recommendations for the treatment of depression and further management of an adult patient with diagnosed depression**

1. The choice of an antidepressant should take into account the following: clinical features of depression, adverse reaction profile, coexisting somatic diseases, and all drugs taken.
2. In mild to moderate severity of symptoms, physicians may start the antidepressant treatment.
3. The patient should be referred directly to a psychiatrist in the case of doubts concerning the diagnosis, difficulties in establishing pharmacological treatment, when there is significant aggravation of symptoms, when it is a subsequent episode of depression, in the case of coexistence of other mental disorders (including alcohol dependence and sedative, sleeping pill, or other psychoactive substance abuse) or with coexistence of many somatic diseases.
4. In the situations listed above that require urgent specialist consultation, it is advisable to refer to a specialist psychiatrist without delay.
5. Antidepressants from the SSRI group are recommended as first-line drugs.
6. In the case of depression with sleep disorders and decreased appetite, treatment with mianserin or mirtazapine may be considered. In cases with sleep disorders, depression with anxiety, or anxiety disorders, trazodone or agomelatine may also be considered.
7. The drug should be administered in therapeutic doses.
8. It is recommended that the patient be informed about possible mild and transient side effects, which may occur during the first week of pharmacotherapy treatment, as well about the expected time of treatment, after which improvement may be expected (3–6 weeks).
9. If there are severe side effects, it is recommended that changing the medicine or referring patient to a psychiatrist be considered.

10. The aim of treatment is to achieve functional improvement, i.e. to return to pre-disease function.

11. The efficacy of antidepressant treatment should be assessed after 4–6 weeks.

12. If the mental state improves, antidepressant treatment should be continued for 6–9 months.

13. In the case of lack of response to treatment, it is advisable to verify the diagnosis and the patient’s compliance.

14. In the case of lack of effectiveness of treatment after 4–6 weeks, it is advisable to optimize the treatment (increase the dose) or refer to a psychiatrist.

15. Discontinuation of antidepressant treatment should be preceded by a reassessment of the patient’s mental state and an interview about the patient’s current life situation (withdrawal should be carefully considered if there are environmental risk factors for relapsing depression, such as difficult life circumstances).

16. The drug should not be discontinued suddenly; a slow dose reduction is recommended.

17. At each stage of treatment, it is advisable to consider the recommendation of psychotherapeutic interventions (in mild depression, – as the sole form of treatment, in more severe depressive symptoms – as additional treatment alongside pharmacotherapy) (Fig. 4).

**Acknowledgements**

The development of the recommendation was financed from funds at the disposal of the Polish Ministry of Health as part of the health policy program entitled “Depression Prevention Program in Poland for 2016–2020”.

**Disclosure**

The authors report no conflict of interest.

**References**

1. Andrade L, Caraveo-Anduaga JJ, Berglund P, et al. The epidemiology of major depressive episodes: results from the International Consortium of Psychiatric Epidemiology (ICPE) Surveys. Int J Methods Psychiatr Res 2003; 12: 3-21.

2. WHQ, Mental Health Action Plan, 2013. Available at: https://www.who.int/publications/i/item/9789241506021 [access: January 5, 2021].

3. Moksalewicz J, Kiejna A, Wołyniak W. Epidemiologia zaburzeń psychiatrycznych i dostęp do psychiatrycznej opieki zdrowotnej – EZOP Polska [Epidemiology of psychiatric disorders and access to psychiatric health care – EZOP Poland]. Instytut Psychiatrii i Neurologii, Warszawa 2012.

4. Sheehan DV, Nakagome K, Asami Y, et al. Restoring function in major depressive disorder: a systematic review. J Affect Disord 2017; 215: 299-313.

5. Bartelink VH, Zay-Ya K, Gulbrandsson K, et al. Unemployment among young people and mental health: a systematic review. Scand J Public Health 2020; 48: 544-558.

6. Alonso J, Angermeyer MC, Bernert S, et al. Disability and quality of life impact of mental disorders in Europe: results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project. Acta Psychiatr Scand 2004; (Suppl.420): 38-46.

7. WHO, Suicide rates Data by country, 2018. Available at: https://apps.who.int/gho/data/node.sdg.3-4-data?lang=en [access: January 5, 2021].

8. Craven MA, Bland R. Depression in primary care: current and future challenges. Can J Psychiatry 2013; 58: 442-448.

9. Drózdź W, Wojnar M, Araszkiewicz A, et al. The study of the prevalence of depressive disorders in primary care patients in Poland. Wiad Lek 2007; 60: 109-113.

10. Hirschfeld RM, Keller MB, Panico S, et al. The National Depressive and Manic-Depressive Association consensus statement on the undertreatment of depression. JAMA 1997; 277: 333-340.
11. Bukh JD, Bock C, Vinberg M, et al. The effect of prolonged duration of untreated depression on antidepressant treatment outcome. J Affect Disord 2013; 15: 42-48.

12. Ghio L, Gotelli S, Marcenaro M, et al. Duration of untreated illness and outcomes in unipolar depression: a systematic review and meta-analysis. J Affect Disord 2014; 152-154: 45-51.

13. van Eck van der Sluijs JF, Casteljns H, Eijsbroek V, et al. Illness burden and physical outcomes associated with collaborative care in patients with comorbid depressive disorder in chronic medical conditions: a systematic review and meta-analysis. Gen Hosp Psychiatry 2018; 50:1-14.

14. Thase ME. Recommendations for screening for depression in adults. JAMA 2016; 315: 349-350.

15. Ali S, Stone MA, Peters JL, et al. The prevalence of co-morbid depression in adults with type 2 diabetes: a systematic review and meta-analysis. Diabetic Med 2016; 23: 1165-1173.

16. Wang Y, Lopez JMS, Bologne SC, et al. Depression among people with type 2 diabetes mellitus, US National Health and Nutrition Examination Survey (NHANES), 2005–2012. BMC Psychiatry 2016; 16: 88.

17. Rymaszewska J, Dudek D. Zaburzenia psychiczne w chorobach somatycznych [Mental disorders in somatic diseases]. Via Medica, Gdańsk 2009.

18. Wu Q, Kling JM. Depression and the risk of myocardial infarction and coronary death: a meta-analysis of prospective cohort studies. Medicine (Baltimore) 2016; 95: e2815.

19. Lin S, Zhang H, Ma A. The association between depression and coronary artery calcification: a meta-analysis of observational studies. J Affect Disord 2018; 232: 276-282.

20. Wu Q, Kling JM. Depression and the risk of myocardial infarction and coronary death: a meta-analysis of prospective cohort studies. Medicine (Baltimore) 2016; 95: e2815.

21. Khan SA, Shahzad U, Zarak MS, et al. Association of Depression with Subclinical Coronary Atherosclerosis: a systematic review. J Cardiovasc Transl Res. 2020. doi: 10.1007/s12265-020-09985-4.

22. Gan Y, Gong Y, Tong X, et al. Depression and the risk of coronary heart disease: a meta-analysis of prospective cohort studies. BMC Psychiatry 2014; 14: 371-23.

23. Zhao Q, Okozo CA, Li J, et al. Current depression among adult cancer survivors: findings from the 2010 behavioral risk factor surveillance system. Cancer Epidemiol 2014; 38: 757-764.

24. Shorey S, Chee CVI, Ng EP, et al. Prevalence and incidence of postpartum depression among healthy mothers: a systematic review and meta-analysis. J Psychiatr Res 2018; 104: 235-248.

25. Hahn-Holbrook J, Cornell-Hinrichs T, Araya I. Economic and health predictors of national postpartum depression prevalence: a systematic review, meta-analysis, and meta-regression of 291 studies from 56 countries. Front Psychiatry 2018; 1: 248.

26. Slomian J, Honvo G, Emonts P, et al. Consequences of maternal postpartum depression: a systematic review of maternal and infant outcomes. Women's Health (Lond) 2019; 15. 174506519844044.

27. Broderick PC, Khosravi ME, Bowman GP, et al. For AGREE Next Steps Consor-tium, AGREE II: Advancing guideline development, reporting and evaluation in healthcare. CMAJ 2010; 182: E839-842.44.

28. Lee Y, Brietzke E, Cao B, et al. Global Alliance for Chronic Diseases (GACD) Mental Health Guidelines Working Group. Development and implementation of guidelines for the management of depression: a systematic review. Bull World Health Organ 2020; 98: 683-697.

29. National Institute for Health and Clinical Excellence (NICE). Clinical guideline. Depression in adults: recognition and management, 2009 [updated: September 2020]. Available at: https://www.nice.org.uk/guidance/cg90 [access: January 5, 2021].

30. National Institute for Health and Clinical Excellence (NICE). Depression in adults: a chronic physical health problem: treatment and management, 2009 [updated: September 2020]. Available at: https://www.nice.org.uk/guidance/cg91 [access: January 5, 2021].

31. Siu AL, U.S. Preventive Services Task Force (USPSTF), Bibbins-Domingo K, et al. Screening for depression in adults: U.S. preventive services task force recommendation statement. JAMA 2016; 315: 380-387.

32. Maksymyk K, Wilkerson MT, Guilloy V. Screening adults for depression in primary care: a position statement of the American College of Preventive Medicine. J Fam Pract 2009; 58: S35-S38.

33. Michigan Quality Improvement Consortium Guideline Primary Care Diagnosis and Management of Adults with Depression, 2018. Available at: https://pdf4pro.com/amp/view/michigan-quality-improvement-consortium-guideline-primary-4a789e.html [access: January 5, 2021].

34. American Family Physicians. 2016. Screening for depression in adults. Available at: https://www.aafp.org/afp/2016/0815/p305s.html [access: January 5, 2021].

35. Trange M, Cusnys K, Haight R, et al. Depression in primary care: health care guidelines, 17th ed. Bloomingon, MN: Institute of Clinical Systems Improvement, 2016.

36. Beyondblue. Clinical Practice Guidelines. Available at: https://www. beyondblue.org.au/health-professionals/practice-guidelines [access: January 5, 2021].

37. Jorm AF, Christensen H, Griffiths KM. The impact of Beyondblue: the national depression initiative on the Australian public’s recognition of depression and beliefs about treatments. Aust N Z J Psychiatry 2005; 39: 248-254.

38. Morgan A, Jorm A. Awareness of Beyondblue: the national depression initiative in Australian young people. Austrasias Psychiatry 2007; 15: 329-333.

39. Hegel U, Wittman M, Arensman E, et al. The European Alliance Against Depression (EAAAD): a multifaceted, community-based action programme against depression and suicidality. World J Biol Psychiatry 2008; 9: 51-58.

40. New Zealand Guidelines Group, 2008. Available at: https://www.health.govt.nz/publication/identification-common-mental-disorders-and-management-depression-primary-care [access: January 5, 2021].

41. O’Connor EA, Rossom RC, Henninger M, et al. Screening for depression in adults: an updated systematic evidence review for the U.S. preventive services task force. AHRQ Publication No.14-05208-ef-1. 2016.

42. Pignone MP, Gaynes BN, Rustison JL, et al. Screening for depression in adults: a summary of the evidence for the USPSTF. Ann Intern Med 2002; 136: 767-776.

43. Driort D, Bismuth M, Maurer A, et al. Management of first depression or generalized anxiety disorder episode in adults in primary care: a systematic meta-review. Presse Med 2017; 46: 1124-1138.

44. Petrosoyan Y, Sahakyan Y, Barnsley JM, et al. Quality indicators for care of depression in primary care settings: a systematic review. Syst Rev 2017; 6: 126.

45. Royal Australian College of General Practitioners (RACGP). Guidelines for preventive activities in general practice. 9th edition, East Melbourne, Vic: RACGP. 2018. Available at: https://www.racgp.org.au/running-a-practice/practice-resources/ordering-publications/guidelines-for-general-practice [access: January 5, 2021].

46. World Health Organization. Management in medical outpatients. N Engl J Med 2000; 343: 1942-1950.

47. American Geriatrics Society. Geriatrics at your finger tips. Available at: https://geriatricscareonline.org/ProductAbstract/geriatrics-at-your-fingertips-2020/B052 [access: January 5, 2021].

48. American Psychiatric Association, DSM-5 Task Force. Diagnostic and statistical manual of mental disorders: DSM-5™, 5th ed. American Psychiatric Publishing, Inc. 2013. Available at: https://doi.org/10.1176/appi.books.9780890425596 [access: January 5, 2021].

49. Simon GE, VonKorff M, Piccinelli M, et al. An international study of the relation between somatic symptoms and depression. N Engl J Med 1999; 341: 1329-1335.

50. Tolentino JC, Schmidt SL. Association between depression and cardiovascular disease: a review based on QT dispersion. Eur J Prev Cardiol 2019; 26: 1568-1570.

51. Nouwen A, Adriaanse MC, van Dam K, et al. European Depression in Diabetes (EDID) Research Consortium. Longitudinal associations between depression and diabetes complications: a systematic review and meta-analysis. Diabet Med 2019; 36: 1562-1572.

52. Köhler CA, Evangelou E, Stubbs B, et al. Mapping risk factors for depression: an updated systematic metareview. Presse Med 2017; 46: 1124-1138.

53. Hall WI. Psychosocial risk and protective factors for depression among lesbian, gay, bisexual, and queer youth: a systematic review. J Homosex 2018; 65: 263-316.

54. Canadian Task Force on Preventive Health Care, Joffres M, Jaramillo A, et al. Recommendations on screening for depression in adults. CMAJ 2018; 65: 263-316.
55. Health Quality Ontario. Screening and management of depression for adults with chronic disease. An evidence-based analysis. Ont Health Technol Assess Ser 2013; 13: 1-45.

56. Nease DE Jr, Maloin JM. Depression screening: a practical strategy. J Fam Pract 2003; 52: 118-124.

57. Paprocka-Borowicz M, Trafalska A, Borowicz W. Wpływ fototerapii na organizowanie objawów depresji u pacjentów rehabilitowanych z powodu zaburzeń narządu ruchu [The influence of phototherapy on the reduction of depressive symptoms in patients rehabilitated due to motor disorders]. Piel Zdr Publ 2015; 5: 121-130.

58. Tomaszewski K, Zarychta M, Bierkowska A, et al. Wpływ fototerapii na organizowanie objawów depresji u pacjentów rehabilitowanych z powodu zaburzeń narządu ruchu [The influence of phototherapy on the reduction of depressive symptoms in patients rehabilitated due to motor disorders]. Piel Zdr Publ 2015; 5: 121-130.

59. Constantini L, Pasquarella C, Odone A, et al. Screening for depression in primary care with Patient Health Questionnaire-9 (PHQ-9): a systematic review. J Affect Disord 2021; 279: 473-483.

60. U.S. Preventive Services Task Force. Screening for suicide risk, 2013. Available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/suicide-risk-in-adolescents-adults-and-older-adults-screening [access: January 5, 2021].

61. Santoff E, Axelsson E, Öst LG, et al. Cognitive behaviour therapy for depression in primary care: systematic review and meta-analysis. Psychol Med 2019; 49: 1266-1274.

62. Ost LG. The efficacy of Acceptance and Commitment Therapy: an updated systematic review and meta-analysis. Behav Res Ther 2014; 61: 105-121.

63. Bauer M, Severus E, Möller HJ, et al. WFSBP Task Force on Unipolar Depressive Disorders. Pharmacological treatment of unipolar depressive disorders: summary of WFSBP guidelines. Int J Psychiatry Clin Pract 2017; 21: 166-176.

64. Samochowiec J, Dudek D, Kucharska-Mazur J, et al. Diagnostyka i leczenie depresji u dorosłych – wytyczne dla lekarzy rodzinnich [Diagnosis and treatment of depression in adults – guidelines for general practitioners]. Available at: https://www.who.int/bazawiedzy/wytyczne-postepowania-w-depresji-u-doroslych-dla-lekarzy-rodzinnych/dostep [access: January 5, 2021].

65. Lam RW, Kennedy SH, Parikh SV, et al. CANMAT Depression Work Group: Canadian Network for Mood and Anxiety Treatments (CANMAT) 2016 Clinical Guidelines for the Management of Adults with Major Depressive Disorder: Introduction and Methods. Can J Psychiatry 2016; 61: 506-509.

66. The Management of Major Depressive Disorder Working Group. Clinical Practice Guideline for the management of major depressive disorder, Department of Veterans Affairs, Department of Defense, 2016. Available at: https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDCPFGFINAL82916.pdf [access: January 5, 2021].

67. Rybakowski J, Dudek D, Jaracz J. Choroby afektywne. In: Jarema M. (ed.). Standardy leczenia farmakologicznego niektórych zaburzeń psychicznych [Pharmacological treatment standards for chosen mental disorders], 2nd ed. ViaMedica, Warszawa 2015.

68. Antosik-Wójcińska A. Farmakoterapia depresji. In: Święcicki Ł. (ed.). Rozpoznawanie i leczenie depresji [Recognition and treatment of depression]. Bonnier Business Polska, cop. 2016: 57-70.

69. Arroll B, Chin WY, Martis W, et al. Antidepressants for treatment of depression in primary care: a systematic review and meta-analysis. J Prim Health Care 2016; 8: 325-334.

70. Harrison MB, Légaré F, Graham ID, et al. Adapting clinical practice guidelines to local context and assessing barriers to their use. Can Med Assoc J 2009;182: e78-e84.

71. World Health Organization assessment instrument for mental health systems (WHO-AIMS) country reports. Geneva: World Health Organization, 2017. Available at: https://www.who.int/mental_health/who_aims_country_reports/en/ [access: January 5, 2021].