Clinical Guideline
Primary Care Physicians Managing Adults with Depression

RELEVANCE TO POPULATION:
Depression is the most common mental health disorder in the U.S., affecting more than 12 million adults. Major depression can be incapacitating and is a leading cause of disability, carrying high direct and indirect health care costs. Up to 15 % of individuals with a severe depressive disorder die from suicide. Approximately 5-10% of adults suffer from depression, making it one of the most commonly seen disorders in primary care practices. Despite the substantial effects depression has on health and functioning, the disorder is both under-diagnosed and under-treated. Studies show that early detection and adequate treatment with pharmacotherapy, psychotherapy, or a combination of both is up to 85% effective on individuals with depression. Among the Gateway Health Plan® population the prevalence of depression in members≥18 years old is 7% (6,248/84,709).

Medical conditions such as heart disease, arthritis, diabetes, cancer, chronic pain, and substance abuse are often associated with depression. Primary care practices that integrate recognition and management programs to treat depression show improved medical care outcomes, yet only one-third to one-half of depressed patients are identified for treatment. Accurate diagnosis is vital. It is important for the physician to differentiate depression from other mental health diagnoses such as bipolar disorder, dysthymia, schizoaffective disorder, or bereavement. Physiologic causes for depressive symptoms such as hypothyroidism or dementia must be ruled out by performing a thorough history and physical evaluation.

Healthy People 2010 identified mental health as a Leading Health Indicator, with an objective to: *Increase the proportion of adults with recognized depression who receive treatment.* (Healthy People 2010, U.S. Preventive Services Task Force)

POPULATION COVERED BY GUIDELINE:
All members age 18 and older who have been diagnosed or are at risk for major depressive disorder

GOALS FOR TREATING DEPRESSION IN PRIMARY CARE SETTING:
- Increase the number of patients with depression who are appropriately **identified for treatment**
- Increase the number of patients who are **appropriately referred to a mental health provider**.
- Increase the number of patients who receive **adequate dosage and duration of treatment** for depression when prescribed pharmacologic and/or psychotherapy
- Increase the number of patients **receiving timely follow-up visits** after initial diagnosis
- Reduce **mortality rates** from suicide

SCREENING FOR DIAGNOSIS OF DEPRESSION:
For new or existing patients, depression screening should be performed as a component of most preventive health care visits and whenever the individual's high-risk status, symptoms, or illness raise a question of a current, uncontrolled/undiagnosed depression. The U.S. Preventive Services Task Force recommends that PCP's screen when staff-assisted depression care supports (clinical staff that assists the PCP by providing some direct depression care and/or coordination, case management, or mental health treatment) are in place to assure accurate diagnosis, effective treatment, and follow-up.

RECOMMENDATION:

I. Be alert for symptoms in patients with:

- Family or personal history of depression or suicide attempt
- Presence of major life stressors or a recent loss
- Chronic illness or chronic pain
- Unexplained somatic complaints such as fatigue, irritability, insomnia,
- Expressed emotional symptoms of depression such as sadness or apathy
- Alcohol or Substance abuse
- Current or recent perinatal or postpartum period

II. The U.S. Preventive Services Task Force found good evidence to suggest that when physicians or other qualified health care professionals routinely ask patients about sad feelings, more adults with depression are identified. Asking the following two questions may help recognize depression as effectively as a longer set of questions.

1) Over the past 2 weeks have you ever felt down, depressed or hopeless?
2) Over the past 2 weeks have you felt little interest or pleasure in doing things?

Careful attention must be paid to accurate diagnosis and correct diagnostic coding. This is best achieved through the use of a valid, standardized depression-screening instrument, a thorough history and physical evaluation, application of the DSM-IV diagnostic criteria, and referral to a mental health professional if the mental health disorder as appropriate (remove uncertain or complex)The PHQ-9 Patient Health Questionnaire is a valid, standardized screening tool that has been attached to the guideline to assist in this process. The PHQ-9 can also be used to assess the severity of depression symptoms. Gateway Health Plan®'s network physicians may reproduce paper copies of the PHQ-9 with instructions solely for use in their clinical practice for the purpose of diagnosing patients in in-office settings. All copies must include the copyright legend as it appears on the original document.

TREATMENT OPTIONS:

Include:

- Pharmacotherapy
- Psychotherapy
- Combined Pharmacotherapy & Psychotherapy

Treatment decisions are best determined through accurate diagnosis and are dependent upon severity of the illness and patient preferences.

PHARMACOTHERAPY FOR DEPRESSION:

Always review with patient for any currently prescribed medications or self-selected herbal or alternative therapies to treat depression.

In general, first line recommended medications are:

Selective Serotonin Reuptake Inhibitors (SSRI)

- SSRIs are becoming agents of first choice due to ease of use, more tolerable side effects, superior safety profile and overall efficacy
- Consider SSRIs in patients with a history of cardiac conditions (especially conduction abnormalities)

- Consider SSRIs in patients with medical conditions that may be exacerbated by the side effects of Tricyclic Antidepressants (TCA) (e.g. orthostatic hypotension, BPH, glaucoma, seizure, and chronic constipation.)

Tricyclic Antidepressants (TCA):

- Consider TCA for medical conditions such as chronic pain syndromes, diarrhea-predominant IBS, headache
- Consider TCA when patients are intolerant of SSRI side effects (after all reasonable adjustments have been made)

Miscellaneous agents (such as NSRI): For select patients, other medications that do not fall into these categories may be appropriate in the treatment of depression.

MANAGEMENT CONSIDERATIONS:

- **Suicidal ideation should be assessed initially and at each follow-up visit until optimal response to treatment is achieved. Patients may be at increased risk for suicide as their energy level improves while feelings of hopelessness and depressed mood persist.**
- Assess for a family history of bipolar disorder or other mental health symptoms which may warrant additional mental health management.
- Failure to take initial prescription or to refill prescriptions is a leading cause of treatment failure.
- Close follow-up, within 30 days and at least monthly for 3-6 months until depression is in remission, is the best practice to improve compliance.
- Medication is taken in the acute phase for a minimum of 4-6 weeks for early benefit and at least 8-12 weeks for optimal response.
- Increased dose of antidepressant may be necessary if the patient shows no response after 2 weeks of an adequate trial of an SSRI or partial response after 4 weeks. If no response to an increased dose or to the trial of an alternative drug, consider referral to mental health provider.
- In general, patients require at least 4-9 months of medication therapy to prevent relapse.
- For an episode of depression that exceeds 2 years or for patients with recurrent episodes, long-term maintenance treatment is generally advised.
- A clinician-and/or patient administered rating scale for psychiatric symptoms with treatment statregies;
- ECT for treatment-resistant depression but also monoamine oxidase inhibitors, as other potential options.
- Aerobic exercise or resistance training to improve mood symptoms, especially in older adults with comorbidities.
- Consideration of maintenance treatment after continuation phase, especially for patients at risk for recurrence.

EDUCATION:

Improved adherence rates can be achieved when the patient is fully involved in determining the treatment plan and educated about the disorder and its treatment.

- Assess patient's comfort level with medication and/or counseling to aid in the selection of an optimal treatment plan and to increase compliance.
- Whenever possible, include the family in the education and treatment plan.
- Firearms should be removed from the home if there is any risk for a suicide attempt.
- Advise patient on the importance of medication adherence to prevent relapse.
- Advise patient that initial clinical benefits may take 2-6 weeks.
- Discuss "contract for safety"
- Advise patient that a follow-up visit within 30 days is essential to assess response to treatment. Monthly visits are necessary for at least 3 months and until therapeutic effects are achieved.

In case of active suicidal or homicidal ideation, refer for emergency psychiatric evaluation or involuntary commitment.

REFERRAL TO AND COORDINATION WITH MENTAL HEALTH PROVIDER IF:

- Co-morbid alcohol or substance abuse
- Psychotic symptoms, including hallucinations or delusional thinking
- Lifelong or recurrent depression
- PCP is not comfortable managing the patient's depression
- Social situation is complex
- Diagnosis is uncertain or complicated by other psychiatric factors
- Management is complex, or response to treatment is suboptimal, especially if 2 or more antidepressants have been tried
- Psychotherapy or hospitalization is required
- Referrals to a mental health professional should be considered when mental illness such as bipolar disorder or schizophrenia is identified or suspected

CLINICAL INDICATORS MEASURED BY GATEWAY HEALTH PLAN® **ARE:**

- Follow-up visit to PCP within 30 days of depression diagnosis
- Continuation of medication through the 6 week (42 day) acute phase of treatment

Please note: This guideline lists core management steps for non-behavioral health specialists. Individual patient considerations and advances in medical science may modify or supercede these recommendations.

DIAGNOSTIC CRITERIA FOR MAJOR DEPRESSION as defined by the American Psychiatric Association

Criteria for Major Depressive Episode:

A. Five (or more) of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents, this can be irritable mood.

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)

(3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains.

(4) insomnia or hypersomnia nearly every day

(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
(6) fatigue or loss of energy nearly every day
(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
(8) diminished ability to think or concentrate or indecisiveness, nearly every day (either by subjective account or as observed by others)
(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms do not meet criteria for a Mixed Episode (see p. 365*).
C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g. hypothyroidism).
E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

***Refer to the page noted in the DSM-IV™**

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SCIENTIFIC EVIDENCE SOURCES:

Aditi Mehta, MD; Sandeep Sheth, MD. Postpartum Depression: How to Recognize and Treat This Common Condition. Medscape. April 24, 2006.

American Psychiatric Association: Practice Guideline: Treatment of Patients with Major Depressive Disorder. Third Edition. American Psychiatric Association 2010.

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders. Fourth Edition revised. Washington DC. American Psychiatric Association, 2000.

American Psychiatric Association Practice Guidelines: The Treatment of Major Depression: Treating Depression In The Primary Care Setting. American Journal of Psychiatry, April 2000.

Brody DS. Improving the management of depression in primary care: recent accomplishments and ongoing challenges. Disease Management & Health Outcomes 2003; 11(1): 21-31

Care Management Institute: Depression Clinical Practice Guidelines, 2001.

Dobscha SK, Gerrity MS, Ward MF. Effectiveness of an intervention to improve primary care provider recognition of depression. Eff Clin Pract. 2001; 4: 163-171.

Grace Tsai, Ph.D. Depression: Discovery Health Features-Mental Health, 2001.

Healthy People 2010

Intermountain Health Care Clinical Education Services. The Primary Care Clinical Program: Management of Depression, 2000.

Jerrold F. Rosenbaum, MD. Clinical Update on the Treatment of Depression, Medscape. September 17, 2002.

Larzelere MM, Wiseman P. Anxiety, depression, Insomnia. Primary Care Clinics in Office Practice 2002; 29, 2.

Montano, C. Brendan. New Frontiers in the Treatment of Depression, Medscape. September 30, 2003

New Zealand Guideline Group. Guidelines for the Treatment and Management of Depression by Primary Healthcare Professionals, 1998-2002.

Spitzer RL, Kroenke, K, Williams JB. Validity and utility of a self-report version of PRIME-MD: The PHQ Primary Care Study. JAMA 1999; 282(18): 1737-1744.

U.S. Preventive Services Task Force. Screening for depression: recommendations and rationale. Guidelines from Guide to Clinical Preventive Services: 3rd Ed. (2000-2003).

Whooley, MA, Simon, GE. Primary care: managing depression in medical outpatients. NEJM 2000: 343: 1942-1950.

Zajecka, John M. Treating Depression to Remission J Clinical Psychiatry 2003:64

US Preventive Services Task Force: Screening for Depression in Adult Patients in Primary Care Settings. December 2009