



Depression Clinical Guideline

Rationale	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. About 5-10% of adults suffer from depression, making it one of the most commonly seen disorders in primary care practices. Despite the substantial effects of depression on health and functioning, the disorder is 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. Medical conditions such as heart disease, arthritis, diabetes, cancer, chronic pain, and substance abuse are often associated with depression. Practitioners 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. It is important for the physician to differentiate depression from other mental health diagnoses such as bipolar disorder, dysthymia, schizoaffective disorder, or bereavement. Accurate diagnosis is vital since antidepressant medication and treatment may worsen other conditions. 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: <i>Increase the proportion of adults with recognized depression who receive treatment.</i>
Population	Members age 18 and older who have been diagnosed or are at risk for major depressive disorder
Detection and Screening	Early screening in the form of short screening scales (Beck, PHQ-2) and personal and family history can be effective in identifying patients with depressive disorders. Psychosocial stressors, chronic illness and family conflict can increase the frequency of depression. Somatization can be an indirect expression 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 depression. Because a significant percentage of depressed patients have bipolar disorder, and because treatment of these patients with antidepressants may often worsen after this disorder, we recommend formal screening for bipolar disorder when depression is first diagnosed and at regular intervals.
Diagnosis	<u>From the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR)</u> - Five or more of the following symptoms present during the same 2-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 • 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). • Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day • Significant weight loss when not dieting or weight gain (e.g., a change of more than five lbs. of body weight in a month), or decrease or increase in appetite nearly every day • Insomnia or hypersomnia nearly every day • Psychomotor agitation or retardation nearly every day (observable by others; not merely subjective feelings of restlessness or being slowed down) • Fatigue or loss of energy nearly every day • Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick) • Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others) • 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



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Suicide or Homicide Risk Screening	Patients must be assessed at every appointment for suicidal and/or homicidal thoughts, plans, and actions. History of suicidal thinking or actions as well as violent, impulsive behavior, or risk-taking behavior should raise concerns about safety to self and others. Individuals assessed to be at risk to themselves or others must be referred to a local psychiatrist, crisis team, or hospital emergency department.
Referral to Psychiatrist and/or other mental health professional	Primary care physicians (PCP) should strongly consider a referral to a psychiatrist and/or other mental health professional when any of the following apply: • Co-morbid alcohol or drug use • Psychotic symptoms, including delusions or hallucinations • Lifelong or recurrent depression • PCP is not comfortable managing the patient's depression • 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. • Mental illness such as bipolar disorder or schizophrenia is identified or suspected. • Social situation is complex and family or marital therapy may be appropriate.
Antidepressant Medication Recommendations	<i>Acute—Antidepressant medication for 12 weeks</i> • Use HNE formulary medications • Specify the risks and benefits of the medication, including potential for suicidal ideation. • Stress the importance of frequent follow up to monitor “target symptoms.” • Follow up within 2-3 weeks of starting an antidepressant to monitor side effects and usefulness of the medicine. • A second follow-up within another 2-3 weeks to determine if dose requires adjusting to obtain maximum benefit. • Adjust or change meds if side effects are significant and document the drug failure. • Increase to maximum dose with patients not responding within six weeks.
	<i>Continuation— Six months of continuous treatment with therapeutic doses of antidepressant</i>
	<i>Maintenance—Continuation of medication at effective doses for at least one year for patients with a history of two or more episodes of depressive disorder.</i> • Patients stable for three full months might be candidates for discontinuation. • When discontinuing the medication, do it slowly, watch for, and warn the patient of the potential for relapse. • For those with frequent relapses, elderly patients and those with a history of severe depression, lifetime medication may be in order.
Optimum Practitioner Contact	At least 3 follow-up office visits with PCP or mental health provider in the three month acute treatment phase. At least one of the three follow-up contacts must be with a prescribing practitioner. Post-hospitalized patients: Follow-up visit within 7 days but no later than 30 days post discharge
Clinical Indicators Measured by HNE	Percentage of members 18 years or older who were diagnosed with a new episode of major depression, treated with antidepressant medication who: • had at least 3 follow-up office visits with PCP or mental health provider in the three month acute treatment phase; • remained on the medication for at least 84 days; and, • remained on the medication for at least 180 days.

1 Guideline References

- APA: Practice Guideline for the Treatment of Patients with Major Depressive Disorder. Third Edition. American Psychiatric Association 2010, <http://www.psych.org/guidelines/mdd2010>