Blue Cross Blue Shield of Rhode Island

2015 PRACTICE GUIDELINES
DEPRESSION IN PRIMARY CARE

PURPOSE:

Depression is the most common psychiatric syndrome encountered in primary care. Up to one in eight individuals may require treatment for depression during their lifetimes, yet practitioners properly recognize only one-third to one-half of those with major depressive disorder. Most studies indicate that in 40% to 60% of patients, a major life event precedes the first episode of major depression.

Depression may occur concurrently with other non-psychiatric general medical disorders or with other psychiatric disorders; it may also be brought on by the use of certain medications. Major risk factors or factors to alert one to a possible diagnosis of depression include a personal or family history of depressive disorder and/ or substance abuse, prior suicide attempts, recent loss, chronic medical illness, stressful life events that include loss (death of a loved one, divorce), traumatic events (car accident), major life changes (financial difficulty, job loss or change), domestic abuse, or violence. Patients with chronic illnesses such as diabetes, cardiovascular disease, cancer, dementia and chronic pain are at a higher risk for depression. For women severe obesity (BMI greater than 40) has been strongly associated with depression. Non- mood presentations of major depression include fatigue, pain, or other somatic complaints, (sleep disturbances, low energy, sexual dysfunction), multiple medical visits, postpartum period, infertility issues, work and relationship dysfunction.

Once identified, depression can commonly be treated successfully, either with medication, psychotherapy, or a combination of both. Not all patients respond to the same therapy, but a patient who fails to respond to the first treatment attempted is likely to respond to a different treatment, contingent upon the patient remaining engaged in any treatment protocol.

OVERVIEW:

This clinical practice guideline is based on the Clinical Practice Guideline on Depression in Primary Care published by the Agency for Healthcare Research and Quality, (AHRQ) originally published in April, 1993, revised September 2013 and the Diagnostic and Statistical Manual, 4th Edition, Primary Care Version (DSM-IV-PC), published in 1995.

This guideline will use the DSM-IV-PC criteria for Major Depressive Episode, which can be found in Table 1. While written for primary care, most aspects of this guideline are applicable to the mental health professional.

Highlights:
1. **Maintain a high index of suspicion for depression.** 2. **Assess suicidality, psychosis, and severity.** 3. **Consider potential causes such as substance abuse or an underlying medical issue.** 4. **Assess treatment efficacy at 6 weeks. Monitor acute phase treatment every 1-2 months.**

Reviewed & Approved: 3/20/13 MPRC

5. **If not improving, reconsider diagnosis and/or therapy/ies. Also consider mental health specialist referral.**
6. **Continue medication for adequate duration and consider the necessity of maintenance therapy.**

GUIDELINES:

I. Diagnosis and Screening for Depression (Major Depressive Episode)

A. If depression is suspected, screen for it:
   1. Validated and reliable tools can help clinicians identify and systematically monitor patients with major depression. Use screening and tracking tools to enhance but not replace the clinical interview.
      a. Either the Patient Health Questionnaire (PHQ)-2 or the PHQ-9 can be used to screen for depression. There is stronger evidence supporting the use of the PHQ-9 in patients with chronic disease.
      b. Use the **PHQ two-question tool** in routine screening settings.

B. PHQ two- question tool:

   Over the past two weeks, have you been bothered by:
   1. Little interest or pleasure in doing things?
   2. Feeling down, depressed or hopeless?

   If the patient answers "yes" to either of the above questions, administer the full PHQ-9 depression instrument.
   The PHQ-9 has been validated for measuring depression severity and is validated as a tool for both detecting and monitoring depression in primary care settings.

C. Steps in detecting and treating depressive conditions include:
   1. Maintain high index of suspicion and evaluate risk factors.
   2. Detect depressive symptoms with clinical interview and/or self-report questionnaire.
   3. Define mood syndrome including assessment for bipolar disorder (clinical history, interview, and report by spouse or significant other).
   4. Define potential known causes of mood syndrome (medical, medications, substance abuse, and other causal non-mood psychiatric disorders).
   5. Assess for suicide risk, evaluate for signs and symptoms of psychosis, and severe functional difficulty.
   6. Treat potential causes.
   7. Reevaluate for mood syndromes.
   8. If mood syndrome is still present, treat as primary mood disorder.

* In some cases, the mood syndrome itself and the underlying cause must each be specifically treated.

Depressed patients with concurrent substance abuse should discontinue the abused substance (and undergo detoxification treatment if needed) and their condition should be reevaluated 4

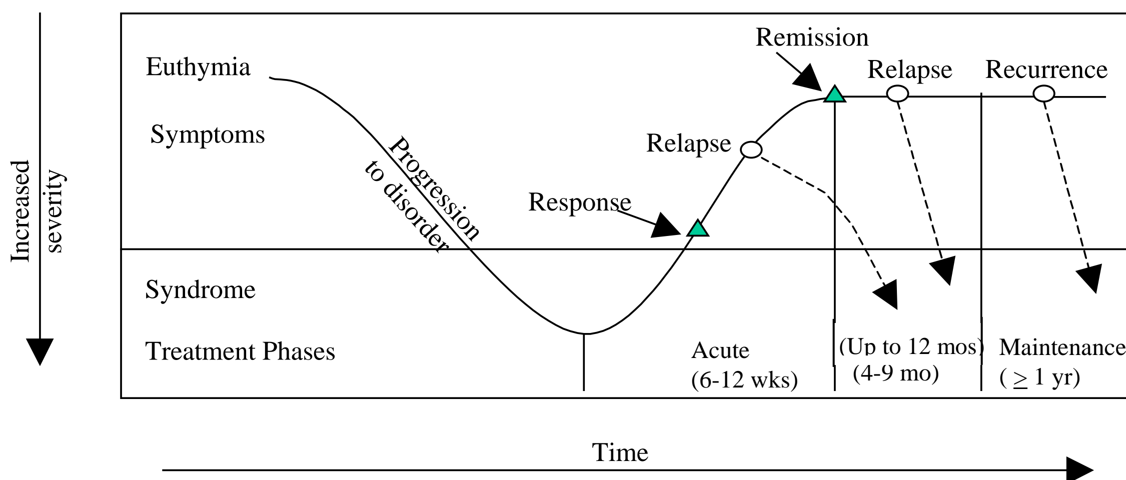
to 8 weeks after achieving a drug-free state. However, earlier treatment intervention may be warranted. If major depressive disorder is still present, it is treated as a primary mood disorder.

If depressive symptoms begin within 2 to 3 weeks of a loved one's death, the diagnosis is uncomplicated bereavement, which is not viewed as a disorder but as a normal, relatively benign state that resolves spontaneously without treatment. If symptoms of a major depressive episode are still present 2 months following the loss, the diagnosis of major depressive disorder may be made because the episode is likely to be prolonged and associated with substantial morbidity.

One should maintain a high index of suspicion for postpartum depression when seeing any woman in the post-partum period.
Routine laboratory testing to identify medical causes of depressive symptoms or to confirm a diagnosis of depression are not recommended.

II. Treatment of Major Depressive Episodes

Remission is the goal of treatment in major depression



Outcomes of Treatment

Outcome	Commonly Accepted Definition
Response	Clinically significant reduction in baseline symptom severity
Remission	Virtual absence of symptoms
Recovery	Sustained period of remission following an episode of major depression
Relapse	Return of a major depressive episode during continuation treatment (ie, before recovery)
Recurrence	New episode of depression following recovery of previous episode

A. General Considerations:
   1. Treatment proceeds in three phases: acute treatment, continuation treatment, and maintenance treatment.
      a. Acute treatment aims to remove all signs and symptoms of the current episode of depression and to restore psychosocial and occupational functioning (a remission).
      b. Continuation treatment is intended to prevent relapse. Once the patient has been asymptomatic for at least 4 months following an episode, recovery from the episode is declared however many suggest that up to 12 months may be needed to avoid risk of recurrence.
      c. Maintenance treatment is aimed at preventing a new episode of depression and may be prescribed for 1 year to a lifetime, depending on the likelihood of recurrences. The likelihood of recurrences increases when there are more episodes.
   2. Formal treatments for major depressive disorder fall into four broad domains: medication, psychotherapy, the combination of medication and psychotherapy, and neuromodulation strategies, such as electroconvulsive therapy (ECT) or transcranial magnetic stimulation (TMS). Each domain has benefits and risks, which must be weighed carefully in selecting a treatment option for a given patient (see selection of treatment options below).
   3. Consider the need for consultation with/treatment by a mental health specialist. Consultation is warranted in the presence of significant suicidal risk, severe functional impairment, psychosis, question of a bipolar syndrome, or failure to respond adequately to treatment.

B. Selection of Treatment during the Acute Phase *(See Table 2)*:
   1. Several general principles guide the selection of the first acute treatment:
      a. The selection of the first and subsequent treatments should, whenever possible, be a collaborative decision between practitioner and patient. Such shared decision making is likely to increase patient adherence and, therefore, treatment effectiveness.
      b. The initial treatment must be used in optimal fashion for a sufficient length of time to determine whether it is effective for the specific patient.
      c. Visits should be sufficiently frequent to optimize adherence. Roughly half of all patients treated for depression stop taking their medication within the first month. It is estimated that seventy percent (70%) of patients treated for depression by their Primary Care Physician do not complete six months of anti-depressant therapy.
      d. Outcome should be carefully assessed at a maximum of 6 weeks by interview for criterion signs and symptoms of depression.
      e. If the patient has been given an adequate dose of medication and does not respond within that time, it is then logical to switch to a second treatment.
      f. If the initial one or two treatments fail, a consultation with or referral to a psychiatrist or other mental health care professional trained in the diagnosis and treatment of depression is indicated.

2. Medications have been shown to be effective in all forms of major depressive disorder.
   a. Patients with moderate to severe major depressive disorder may be treated with medication whether or not formal psychotherapy is also used, although psychotherapy is typically recommended in addition to pharmacotherapy.
   b. No one antidepressant medication is clearly more effective than another and no single medication results in remission for all patients.
   c. The specific medication choice is based on side-effect profiles, patient's history of prior response, family history of response, and type of depression. If the patient has previously responded well to and has had minimal side effects with a particular drug, that agent is preferred. Similarly, if the patient has previously failed to respond to an adequate trial of or could not tolerate the side effects of a particular compound, that agent should generally be avoided. Dosing schedule and cost of therapy may also be factors that affect compliance. Generic agents are available in most classes.
   d. At present, tricyclic antidepressants are rarely used as a primary or initial treatment of depression due to their more severe side effect profile. The newer antidepressants are associated with fewer long-term side effects, such as weight gain, dry mouth, constipation, and cardiac irregularities than are the older tricyclic medications.
   e. The presence of certain non-psychiatric medical conditions may favor some agents over others because of their side-effect profiles. For example, for patients with coronary artery disease, drugs that do not lower blood pressure or are associated with no cardiac conduction changes (e.g., the newer antidepressants) may be preferable.
   f. The newer antidepressants are also safer in cases of potential overdose.
   g. If the patient has not responded at all nor has only a modest symptomatic response to medication by 6 weeks, the practitioner is advised to reevaluate the accuracy of diagnosis and the adequacy of treatment.
   h. Options for treatment of non- or partial responders include continuing the current medication at a different dosage, discontinuing the first medication and beginning a second, augmenting the first medication with a second, adding psychotherapy to the initial medication, or obtaining a consultation/referral.

3. Psychotherapy alone to reduce the symptoms of major depressive disorder may be considered a first-line treatment if (1) the depression is mild to moderate, nonpsychotic, not chronic, and not highly recurrent and (2) the patient desires psychotherapy as the first-line therapy. It should also be noted that while treatment may be appropriate in certain circumstances, improvement is initially slower than with antidepressant medication.
   a. The psychotherapy should generally be time-limited, focused on current problems, and aimed at symptom resolution rather than personality change.
   b. The therapist should be experienced and trained in the use of the therapy with patients who have major depressive disorder.
   c. Regular visits once or twice a week are typical.
   d. If the patient being treated with psychotherapy fails to show any improvement in depressive symptoms by 6 weeks or only partial response by 12 weeks, a reevaluation

and potential switch to, or addition of, medication are indicated. Given the evidence for the efficacy of medication and the lack of information regarding the efficacy of formal psychotherapy alone, we advise practitioners not to treat severe and/or psychotic major depressive disorders with psychotherapy alone.

4. Combined treatment with both medication and psychotherapy may have an advantage for patients who have responded partially to either treatment alone or who have a history of chronic episodes or poor recovery between episodes, a history of chronic psychosocial problems (both in and out of episodes of major depression), and/or a history of treatment adherence difficulties.

5. Electroconvulsive therapy is not recommended as first-line therapy for uncomplicated, nonpsychotic cases of major depressive disorder in primary care, as effective treatments that are less invasive and less expensive are available.

C. The Continuation Phase of Treatment:

1. The objective of continuation treatment is to decrease the likelihood of relapse (a return of the current episode of depression). If patients respond to acute phase medication, it is generally continued at the same dosage for up to 12 months after return to the clinically well state.

2. At continuation visits, evaluate symptoms, efficacy and side effects, and provide education to promote adherence.

3. For those with a full symptomatic response, psychosocial function may either have returned to normal or still be impaired.
    a. For full responders, continuation phase treatment should include visits every 1 to 3 months.
    b. For those who had an acute phase improvement but still have impaired psychosocial function, many are likely to improve over the next 6 weeks. Therefore, neither the dosage nor the medication type need be changed, but the patient's condition should be reevaluated in 6 weeks to determine whether normal function has returned. If so, treatment is continued.
    c. For patients who improved with pharmacotherapy in the acute phase, but persist with continued psychosocial impairment, psychotherapy focused on the residual psychosocial difficulties may be beneficial.

D. The Maintenance Phase of Treatment:

1. Maintenance treatment is aimed at preventing a new episode of depression. Patients who have had three or more episodes of major depression are potential candidates for long-term maintenance antidepressant medication. Selected other patients may warrant maintenance therapy.

2. Maintenance medications are generally of the same type and dosage found effective in acute phase treatment.

3. Maintenance psychotherapy does not appear to be effective in preventing a recurrence, although it may delay the onset of the next episode.

4. Patients who have responded fully in the acute phase of treatment need to be seen once every 1 to 3 months during the continuation and maintenance phases to evaluate symptoms, efficacy, and side effects and to promote adherence.

5. If there is significant symptom breakthrough, the patient should be seen more quickly and monitored more frequently so that timely action can be taken.
   a. Ten to twenty percent of patients report that some depressive symptoms return during continuation or maintenance treatment. This symptom breakthrough is often brief, mild, and self-limited. Support and observation are indicated.
   b. If the breakthrough is severe or prolonged, action is indicated. In some cases, symptoms may result from a change in antidepressant blood level due to induction of metabolic enzymes. If this cause is suspected, a blood level determination may be informative for medications whose lower therapeutic and toxic levels are known.
   c. Alternatively, daily doses can be increased empirically until symptom remission is again achieved. The adjusted dosage is then continued until drug treatment is discontinued. Increased side effects during symptom breakthrough may be a clinical clue to an excessive drug level.
   d. In some patients, symptom breakthrough is the result of the inability of the current medication to suppress symptoms. If dosage adjustment fails, consultation, augmentation, or alternative medications should be considered.

6. Medication Dosage Adjustments and Antidepressant Blood Levels
   a. There is no need to check blood levels routinely during continuation or maintenance treatment.
   b. However, blood level determinations for those antidepressants whose minimal and/or maximum therapeutic levels are known may be needed if patients develop a toxic reaction or if the depressive episode recurs. For patients who develop another non-psychiatric medical disorder requiring medication(s) that modify antidepressant levels, blood level determinations may also be helpful.

7. Discontinuation of Medication
   a. Antidepressant medications are generally safe, even with long-term use.
   b. However, medications should be discontinued if they are not required. Patients who take antidepressants should be advised to gradually taper the drug to avoid antidepressant discontinuation syndrome. Antidepressant discontinuation syndrome is a flu-like syndrome which appears in a significant percentage of patients when medications are abruptly stopped. Most patients with a single episode of major depressive disorder are advised to discontinue medication after 12 months of continuation treatment. Patients who have recurrent depressive episodes may need to

continue medication for an indefinite period as the likelihood of further depressive episodes increases with each recurrence.

c. Patients with recurrent major depressive episodes may be candidates for long-term treatment.

IMPLEMENTATION CONSIDERATIONS:

Primary care physicians should use evaluation and management service codes and correct ICD-9 diagnosis codes when performing services for mental health problems. Primary care physicians are allowed to be participating providers for these services. Primary care physicians are not participating mental health clinicians in the performance of psychotherapy unless they are also an approved mental health provider in the network.

MONITORING

Two HEDIS measures monitor compliance with these guidelines:

- Antidepressant Medication Management (AMM)
- Follow-up After Hospitalization for Mental Illness (FUH)

RESOURCES:

1. The Macarthur family foundation in conjunction with Dartmouth and Duke has a useful toolkit for clinicians available at www.depression-primarycare.org. The kit contains depression recognition tools, PHQ-9 questionnaire and scoring sheet and assessment fact sheets as well as patient education materials. This toolkit (rev. 2009) was used as a resource in the most recent review of this guideline.
2. Case management services including coordination of care and access to community resources are available to providers and their patients through the Case management Triage Line 401-459-2273 or 888-727-2300 x 2273.

REFERENCES:

1. Adult Depression in Primary Care, AHRQ; National Clearing House Guidelines, Sept.2013

2. Diagnostic and Statistical Manual, 4th Edition, Primary Care Version, DSM-IV-PC, 1995.

3. American Psychiatric Association practice guideline for the treatment of patients with major depressive disorder. Am J Psychiatry 2000 Apr; 157(4 Suppl):1-45.

Medical Peer Review Committee

Date: 2/05/97; 10/06/99; 07/11/01; 07/09/03; 4/6/05; 4/04/07; 4/1/09; 4/20/11; 3/20/2013

Professional Advisory Committee (PAC)

Date: 3/18/15

Table 1

DSM-IV-PC Diagnostic Criteria for Major Depressive Episode
A. At least five of the following symptoms are present during the same 2-week period, nearly every day, and represent a change from previous functioning. At least one of the symptoms must be either (1) depressed mood or (2) loss of interest or pleasure: (1) Depressed mood (or alternatively can be irritable mood in children and adolescents) (2) Markedly diminished interest or pleasure in all, or almost all activities (3) Significant weight loss or weight gain when not dieting (4) Insomnia or hypersomnia (5) Psychomotor agitation or retardation (6) Fatigue or loss of energy (7) Feelings of worthlessness or excessive or inappropriate guilt (8) Diminished ability to think or concentrate (9) Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
B. Symptoms are not better accounted for by a Mood Disorder due to a General Medical Condition, a Substance-Induced Mood Disorder, or Bereavement (normal reaction to the death of a loved one).
C. Symptoms are not better accounted for by a Psychotic Disorder (e.g., Schizoaffective Disorder).

Source: American Psychiatric Association, 1995.

Table 2

Strategic Choices in the Acute Treatment of Major Depressive Disorder			
Define Treatment Phases, Objectives, and Options with Patient (and Family, where Appropriate)			
Medication[1]	**Formal Psychotherapy**	**Combined Treatment**	**ECT[4]**
More severe	Less severe	More severe	Psychotic
Chronic	Less chronic	Chronic	Severe or extremely severe
Recurrent	Nonpsychotic	Partial response to either alone	Prior positive response
Psychotic	Prior positive response	Availability	Failure on several medications or combined treatment trials
Melancholic	Availability	Personality disorder[3]	Need for rapid response
Prior positive response	Medical contraindication to medications	Patient preference	Medical contraindication to medications
Family history	Patient preference[2]		
Patient preference			
Failure to respond to psychotherapy			

[1] Medication is always combined with clinical management.
[2] Patient preference applies more if depression is milder, nonpsychotic.
[3] This recommendation has not been empirically tested. It rests solely on clinical experience.
[4] Electroconvulsive therapy (ECT) is very rarely required for patients seen in primary care settings. It is reserved nearly always for those who have severe, often chronic, often psychotic depressions that have not responded to several trials of different standard medications

Source: Clinical Practice Guideline on Depression in Primary Care published by the AHCPR in April, 1993