MQIC

Michigan Quality Improvement Consortium Guideline

Primary Care Diagnosis and Management of Adults with Depression

The following guideline recommends screening for depression, assessing suicide risk, following diagnostic criteria, shared decision-making and treatment planning, monitoring and adjusting treatment.

<table>
<tr><th>Eligible Population</th><th>Recommendation and Level of Evidence</th><th>Frequency</th></tr>
<tr><td>Adults 18 years or older, including pregnant and postpartum women</td><td>Detection and Diagnosis:
Screen for depression, using a validated screening tool (e.g. PHQ-2 or 9, Edinburgh Scale) with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. [B]
Assess for other causes of symptoms, and comorbid conditions that might impact treatment (e.g., medical and medication-induced conditions, drug or alcohol abuse, bipolar disorder, anxiety disorders, psychosis).
Assess if criteria are met using DSM-5 criteria. [A] Criteria A, B, C and D must be met.
<table>
<tr><th>DSM-5 criteria</th><th>Major Depression</th><th>Persistent Depressive Disorder</th></tr>
<tr><td>A. Symptoms</td><td>5 total for ≥ 2 weeks and must include symptom #1 or #2</td><td>3 total for ≥ 2 years. Must include symptom #1. Never > 2 months symptom-free</td></tr>
<tr><td>1. Depressed mood</td><td>x</td><td>x</td></tr>
<tr><td>2. Marked diminished interest/pleasure</td><td>x</td><td></td></tr>
<tr><td>3. Significant weight gain/loss, appetite decrease/increase</td><td>x</td><td>x</td></tr>
<tr><td>4. Insomnia/hypersomnia</td><td>x</td><td>x</td></tr>
<tr><td>5. Psychomotor agitation/retardation noticeable by others</td><td>x</td><td></td></tr>
<tr><td>6. Fatigue/loss of energy</td><td>x</td><td>x</td></tr>
<tr><td>7. Feelings of worthlessness or inappropriate guilt</td><td>x</td><td>x</td></tr>
<tr><td>8. Diminished concentration or indecisiveness</td><td>x</td><td>x</td></tr>
<tr><td>9. Recurrent thoughts of death or suicidal ideation</td><td>x</td><td></td></tr>
<tr><td>10. Hopelessness</td><td></td><td>x</td></tr>
<tr><td colspan="3">B. Symptoms cause clinically significant distress or impairment in functioning</td></tr>
<tr><td colspan="3">C. Symptoms not attributed to a substance or other medical condition</td></tr>
<tr><td colspan="3">D. Lack of psychotic disorder or history of manic or hypomanic symptoms</td></tr>
</table></td><td><u>Pregnant and postpartum women</u>
At the first prenatal care visit; on post-partum visits (within 3-8 weeks of discharge) and if symptoms or signs raise suspicion using the Edinburgh Postnatal Depression Scale[1].

Annually. More often if high risk.</td></tr>
<tr><td>Individuals diagnosed with a depressive disorder</td><td>Assess risk of suicide by direct questioning about suicidal ideation, and if present, suicidal planning, potential means, and personal/family history of suicidal attempts. [D] See established clinical tools for risk assessment and suicide prevention[2,3].
■ If patient at moderate to severe risk for suicide, refer to emergency department or crisis intervention center. Develop safety plan.</td><td>At each encounter addressing depression until patient is treated to remission.</td></tr>
<tr><td></td><td>Treatment and follow-up:
Educate and engage patient. Include self-management support and life-style modifications (e.g., behavioral activation, healthy sleep and diet, exercise, stress-management, social support, spiritual support, online resources). [C]
Utilize shared decision-making in treatment planning. [A] Consider onset and severity of symptoms, impairment, past episodes, psychosocial stressors, medical and psychiatric comorbidities, patient preference, resource accessibility. For mild to moderate symptoms consider pharmacotherapy and/or evidence-based psychotherapy. [A] For severe symptoms consider both pharmacotherapy and evidence-based psychotherapy. [A]
Monitor response to treatment using standardized scale (e.g., PHQ-9) at least every 4 months until remission is obtained. On PHQ-9, adequate response is 50% reduction in score, remission=total score <5.
Consider referral to behavioral health specialist when additional counseling is desired, primary physician is not comfortable managing patient's depression, diagnostic uncertainty, complex symptoms or social situation, pregnancy, response to medication at therapeutic dose is not optimal, considering prescribing multiple agents, or more extensive interventions are warranted. [D]
If initiating antidepressant medication, follow manufacturer's recommended doses. Avoid underdosing. If inadequate response after 2-4 weeks, increase dosage as tolerated not to exceed the highest recommended dose unless directed by a psychiatrist. If discontinuing antidepressant, be aware of need to taper some medications.
If limited or no response to treatment, assess for non-adherence, inadequate dosing, diagnostic inaccuracy or comorbid conditions exacerbating symptoms. Consider: increased doses of medication or frequency of psychotherapy, switching treatments or augment treatment with other medications or psychotherapeutic interventions, consultation.
Monitoring: If medication prescribed, continue treatment and monitoring for at least 9-12 months after acute symptoms resolve. [A] Patients with recurrent major depression and/or persistent depressive disorder (≥ 2 years) usually require lifelong treatment.</td><td>Schedule sufficient follow-up visits to assess response to treatment and titrate dose (typically every two weeks, monthly at a minimum). [D]</td></tr>
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[1] Edinburgh Postnatal Depression Scale
[2] Suicide Prevention for Primary Care Toolkit
[3] Suicide Assessment Five-step Evaluation and Triage

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline is based on several sources, including: Final Update Summary: Depression in Adults: Screening. U.S. Preventive Services Task Force, January 2016; American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders Fifth Edition - DSM-5; Nonpharmacological Versus Pharmacological Treatments for Adult Patients with Major Depressive Disorder, AHRQ Publication No. 15(16)-EHC031-EF, AHRQ, December 2015; Trangle, M, et. al. Institute for Clinical Systems Improvement. Adult Depression in Primary Care. Updated March 2016; and Suicide Prevention Toolkit for Primary Care; Suicide Assessment Five-Step Evaluation and Triage - SAFE-T. Individual patient considerations and advances in medical science may supersede or modify these recommendations.