# CLINICAL PRACTICE GUIDELINE:
## Managing Adults with Depression in the Primary Care Setting

### Relevance to Population:
Major depression is a serious medical illness affecting 15 million American adults or approximately 5%-8% of the adult population in a given year. Among all medical illnesses, major depression is the leading cause of disability in the United States and many other developed countries (NAMI, September 2009). This disorder often disrupts an individual’s work, family, and personal life. Its impact is often severe, and can be fatal. This disease can strike alone or in combination with other diseases. Depression is often found in patients with illnesses such as diabetes, cancer, and cardiac disease. If left untreated, depression can increase both morbidity and mortality rates. Research demonstrates that depression is highly treatable. The vast majority of people seeking treatment for depression significantly improve.

At UPMC Health Plan, depression is the most common mental health disorder. In calendar year 2009, depression ranked third for the top ten inpatient behavioral health diagnoses (across all lines of business). One of our top pharmacy costs is for antidepressant medications.

### Population Covered by Guideline:
All members aged 18 and older who are diagnosed with or who are at risk for developing a major depressive disorder.

### UPMC Health Plan Goals for the Treatment of Depression:
- To ensure members suffering from depression are adequately diagnosed and treated. UPMC Health Plan aims to increase screening efforts and to promote appropriate follow-up care for those identified with depression.
- To reduce inappropriate use of antidepressant medications in the treatment of depression. Antidepressant medications are to be prescribed within recommended therapeutic ranges and for adequate lengths of time.
- To encourage appropriate referrals to behavioral health practitioners, when indicated.

### Importance of Screening for Depression in the Primary Care Setting:
Depression often is not recognized or treated, and the cost is staggering. To avoid such consequences, depression screening tools can be used to identify members suffering from depression. Screening can easily be incorporated into preventive health care visits for all adults. It is suggested that physicians or other qualified health care professionals routinely ask the following two questions (PHQ-2):
- Over the last two weeks how often have you been bothered by feeling down, depressed, or hopeless?
- Over the last two weeks how often have you been bothered by little interest or pleasure in doing things?
Importance of Screening for Depression in the Primary Care Setting (Continued):
In the event that the patient responds affirmatively to either or both questions, a more thorough evaluation should be completed. Use of a validated screening tool, such as the Patient Health Questionnaire (PHQ-9), can further aid in recognition. This tool can be found in the MacArthur Depression Toolkit at [http://www.depression-primarycare.org/](http://www.depression-primarycare.org/). The PHQ-9 is especially useful as it takes only a few minutes to complete, can be self-administered, is easily repeatable to track progress, and incorporates the 9 criteria listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders, which are to be considered in making a diagnosis of major depression.

Also assess whether the patient has symptoms of bipolar disorder.

Suicidal risk should also be assessed anytime an individual is diagnosed with depression. Directly inquire about suicidal thought, any specific suicide planning, potential means, and any history of the individual’s suicide attempts. Also, check for a family history of suicide attempts.

Suspect depressive symptoms in patients with:
- Family or personal history of depression or suicide attempts
- Recent stressful life events (including post-partum patients) and lack of social supports
- Chronic illnesses, including chronic pain
- Unexplained somatic complaints
- Symptoms of chronic fatigue, malaise, irritability, or sadness
- Current alcohol or substance abuse

Available Treatment Options for Depression in the Primary Care Setting:
- Watchful waiting with supportive guidance (mild depression only)
- Active listening, problem identification, advice about simple self-management strategies, and systematic follow-up (mild and moderate depression only)
- Psychopharmacology
- Psychotherapy (Use an evidenced-based model.)
- Referral for a psychiatric evaluation

The clinician selects the treatment modality based upon the diagnosis, severity of illness, patient preference, and monitoring of treatment response.
**EFFECTIVE MANAGEMENT OF ANTIDEPRESSANT MEDICATIONS**

**ACUTE PHASE TREATMENT — AIM TO REDUCE AND ELIMINATE DEPRESSIVE SYMPTOMS**

<table>
<thead>
<tr>
<th>Acute Phase</th>
<th>Treatment Strategy</th>
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<tbody>
<tr>
<td>Expected Response</td>
<td>*The initial goal should be to achieve a targeted dose (in the upper range of FDA recommendations for antidepressant medications) by week 6 and monitor progress for another 6 weeks. Thus a trial should be 12 weeks in duration.</td>
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<td>4 - 6 week trial — 50% reduction in symptoms. Recommend the use of standardized self-reports of symptom severity and adverse effects to be given to patient at every visit to help the clinician quantify the benefit of the antidepressant medication. Physicians can find such self-report tools as the Measurement Based Care Model of STAR*D at <a href="http://www.edc.gsp.pitt.edu/stard/public/assessment_forms.html">http://www.edc.gsp.pitt.edu/stard/public/assessment_forms.html</a></td>
<td>*Every 1 - 2 weeks, monitor patient compliance and symptoms.</td>
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<td>10 - 12 week trial — nearly 100% reduction in symptoms.</td>
<td>*If partial response/remission — the antidepressant medication trial should be continued for another 6 weeks.</td>
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**CONTINUATION/MAINTENANCE PHASE OF TREATMENT — AIM TO PREVENT RELAPSE/RECURRENCE**

<table>
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<th>Type of Patient</th>
<th>Treatment Strategy</th>
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<tr>
<td>Patient Having an Initial Episode of Depression</td>
<td>Continue antidepressant medication for at least 6 months to prevent relapse. Discuss with patient the pros/cons of continuing antidepressant therapy based on severity of episode.</td>
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<tr>
<td>Patient Having Recurrent Episodes of Depression (two or more episodes of depression in a 5-year period)</td>
<td>Continue antidepressant medication for at least 12 months using similar dosage as prescribed in acute phase.</td>
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1. Initially, the patient should be evaluated every one to two weeks to monitor patient compliance, symptom improvement, and medication side effects.
2. The patient should have at least a partial response (50% reduction in symptoms) by 6 weeks and remission by 10-12 weeks.
3. The medication dose should be increased (or, if this is ineffective, the antidepressant should be changed) if there is not a partial response by 6 weeks or remission by 10-12 weeks.
4. The antidepressant should be continued at least six months after depressive symptoms have remitted.
5. Patients who have two or more episodes of major depression in a five-year period may be considered for maintenance antidepressant therapy.
6. Psychological counseling may be used alone (if the patient prefers this to medications) in cases of mild to moderate depression. As with antidepressants, the
7. In more severe depression, psychological counseling should only be used in conjunction with antidepressants. In some patients such adjunctive psychological counseling may prevent subsequent relapses and recurrences once treatment with antidepressant ends.

**Treating Depression in the Primary Care Setting:**
Approximately one out of every two members newly diagnosed with depression is in the sole care of his/her PCP. If you elect to provide pharmacotherapy for members with depressive symptoms, please arrange for at least 3 follow-up visits in the first 12 weeks of treatment. One of these visits should be with the prescribing practitioner to adequately evaluate clinical response, side effect profile, and compliance. Behavioral health practitioners can share valuable observations for the other visits if you deem this appropriate. Coordination of care is critical to treatment success. Two-way communication among clinicians treating the same patient is essential to quality care. In managing patients who are prescribed antidepressant medications, clinical guidelines suggest to:

- Begin the medication trial following the manufacturer’s recommended doses. Selective serotonin reuptake inhibitors (SSRIs) are typically first choice.
- Use a single agent unless patients fail several trials of individual agents (i.e., three trials at full dosage for adequate length of time).
- Assess the effects of the medications frequently and adjust to a therapeutic level not to exceed the highest recommended dose.
- Switch to another antidepressant medication if the response is not satisfactory in six weeks at maximum recommended dosages. Avoid polypharmacy.
- Ensure length of medication trial is adequate. For patients suffering from a single depressive episode, continue the antidepressant for at least six months after depressive symptoms have remitted. This strategy diminishes the risk of relapse. For patients with two or more episodes of depression, continue antidepressant medication for at least one year or consider ongoing treatment indefinitely at an effective dose — typically at the same dosage used in the acute phase of the illness. Maintaining patients with a history of depression on an antidepressant medication over the long term has been found to not only reduce the likelihood of recurrence but also to reduce the severity of symptoms that are suffered if a relapse should occur.
- Medication should not be abruptly discontinued. Taper after providing education about relapse prevention.

For patients with mild depression, watchful waiting is often a highly effective strategy. Patients often can benefit from this approach provided the clinician offers support, encourages positive coping skills, and prompts behavioral changes such as increasing pleasurable activities and exercise.
Who needs behavioral health specialty care?

Physicians are encouraged to refer patients to a behavioral health practitioner if the patients have:

- Severe psychiatric disorders, for example, depression with psychotic features or mania
- History of mania
- Treatment-resistant disorders, i.e., depression not responsive to one or two adequate psychotropic medication trials
- Risk of lethality
- Severe impairment in daily functioning
- A need for a combination of psychotropic medications
- Alcohol or substance abuse
- A complicated or uncertain diagnosis
- Complex social situation
- A need for psychiatric inpatient admission
- A need for psychotherapy; this service can be utilized in combination with the PCP following a patient on an antidepressant.

Referrals should also be made if the primary physician is not comfortable managing the patient’s depression. Finally, patients hospitalized for major depression should be seen by a behavioral health specialist within seven days of discharge.

Specialty Referral Resources Available:

Please call 1-888-251-2224 for assistance in making behavioral health referrals for members covered through UPMC Commercial and UPMC for Life members. UPMC for You (Medicaid) members should be directed to refer to their UPMC for You Member Handbook for the respective toll-free number to call for behavioral health referral assistance in their particular county of residence. For Depression Case Management Services, please call 1-888-777-8754.
Member Educational Materials:
Recovery is often more successful when patients are active participants in treatment efforts. Educating patients about depression, its treatment, and especially steps they can take to get well can greatly aid in the recovery process. Excellent patient educational materials can be found at:

**Adults**

http://www.nami.org/

http://www.DBSAlliance.org

**Elderly**

www.latelifedepression.org

http://nihseniorhealth.gov/depression/toc.html

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<th>Clinical Indicator</th>
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<td>Effective antidepressant medication management of the acute phase of treatment</td>
<td>Members newly prescribed antidepressant medications will continue antidepressant medication throughout the first 12 weeks of treatment.</td>
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<td>Effective management of antidepressant medications through the continuation phase of treatment</td>
<td>UPMC Health Plan members 18 years old or older diagnosed with a new episode of depression will remain on an antidepressant medication for at least 180 days.</td>
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Selected Bibliography