



Clinical Practice Guidelines for Depression in Adults in the Primary Care Setting

Disease criteria

Major depression

The essential feature of a major depressive episode is a period of at least two weeks during which there is depressed mood or the loss of interest or pleasure in nearly all activities.

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 depressed mood or loss of interest or pleasure.

- depressed mood
- loss of interest or pleasure in nearly all activities
- thoughts of death/suicidal
- weight loss/gain
- fatigue/loss of energy
- insomnia/hypersomnia
- psychomotor retardation/agitation
- worthlessness/guilt
- impaired concentration

Dysthymia

This is a depression of less severity than major depression that usually begins in childhood and adolescence, and must be present for at least two consecutive years without a period of greater than two months of absence of symptoms.

Depressive disorder not otherwise specified (NOS)

This is a depression that does not strictly meet the severity or duration criteria of the other diagnoses.

Screening

A patient self-reported questionnaire is recommended (refer to Appendices 1 and 2 for examples of patient screening tools and Appendix 3 for patient questionnaire scoring guidelines). Screening may be completed by the patient during the office visit.

Screening is recommended for:

- all new patients
- existing patients (at least annually)
- high-risk patients (e.g., stroke, dementia, diabetes, coronary artery disease, chronic pain)

Suicidality assessment

An essential part of the initial evaluation of clinical depression is assessing suicide potential. The evaluation should include:

- assessment of suicide risk factors: hopelessness, general medical illnesses, family history of substance use and/or suicide, psychotic symptoms, living alone with little social support, prior suicide attempts
- direct inquiry about the content and frequency of suicidal ideation, intent, and plans
- factors that argue against the patient making an attempt
- patient's access to means of suicide and lethality of those means

If the evaluation reveals any significant degree of suicidal risk, then an immediate call should be made to the mental health provider for psychiatric assessment at the appropriate level of care.

Goals of treatment

- Reduce if not remove all symptoms of the disease.
- Restore occupational and psychosocial functioning.
- Reduce the likelihood of relapse and recurrence.

Types and evaluation of treatment

- **Psychotherapy**—Patients with mild to moderate clinical depression (usually dysthymia or depressive disorder NOS) may be selected for psychotherapy alone, if the patient prefers. If symptoms do not significantly improve within two to three months, then medication should be strongly considered.
- **Medication**—Patients with moderate to severe clinical depression (usually major depression) are appropriately selected for medication, whether or not formal psychotherapy is also used.

- **Medication and psychotherapy**—This combination may hold a particular advantage for complicated, chronic depressions. It may also be advantageous for patients with only a partial response to either treatment alone.
- **ECT**—This is a first-line treatment option for only certain patients. It is recommended that this option be selected only after psychiatric consultation.

Initial medication selection and management

- An antidepressant medication is recommended as an initial treatment in individuals with mild-moderate major depressive disorder.
- Since the effectiveness of different antidepressants are comparable in nature, initial selection of a specific agent should be based on anticipated side effects and safety or tolerability. Generally, a selective serotonin reuptake inhibitor (SSRI) would usually be the first choice unless the patient has a history or risk of intolerable side effects, is taking other essential medications that put the patient at risk for significant drug interactions, or has a personal or family history of a positive response to another class of antidepressants. Some authorities recommend lower starting doses for women.
- Starting dosages may have to be reduced to lessen side effects and improve compliance. It is highly recommended in the elderly to reduce these starting dosages by half.

Note: Specific Member benefit coverage formulary can be found at [carefirst.com/rx](https://www.carefirst.com/rx).

Office visit frequency

- Frequent office visits with the prescribing physician during the first 4–12 weeks of treatment are usually necessary to assess efficacy and side effects, as well as make any medication adjustments to optimize response.
- **A first follow-up visit is recommended within one to four weeks after the initial prescription.** At follow-up visits re-assess the diagnosis of depression and measure changes in symptom severity (depression scores) and patient function. (Refer to Appendix 6 for an example of a depression monitoring tool).
- **The patient should be seen at least three times in the critical 12 weeks acute treatment phase.**
- If treating a patient in concert with a behavioral health therapist conducting psychotherapy, then only one of these three follow-up visits need to be with the PCP.
- It is recommended to advise the patient to call the PCP between visits for any side effect problems.
- Continue to monitor for safety.

Secondary adjustment strategies

- Early signs of positive response can occasionally be seen after one week, but usually four to six weeks is required for a full response.
- Adequate treatment for six to eight weeks is necessary before concluding that a patient is not responsive to a particular medication.
- If side effects are tolerable, then titration of the dosage upward is a first adjustment strategy to consider.
- Occasionally, titration of the dosage downward is a first adjustment strategy if it is concluded that the depressive symptoms are responding but side effects are interfering.
- Either of these strategies can certainly be followed during the first six to eight weeks if judged as useful to increase response.

- If a patient is deemed unresponsive to a particular SSRI or has intolerable side effects, then a trial of a different SSRI often yields positive results.
- Other medication alternatives include selecting an antidepressant from a different class, combining antidepressants, or adding augmentation medications such as stimulants, lithium, or thyroid hormone.
- Combining antidepressants and adding augmentation medications are best managed by a psychiatrist.

Antidepressant side effects

Side effects account for as many as two-thirds of all premature discontinuations of antidepressants. Most side effects are early onset and time limited and includes decreased appetite, nausea, diarrhea, agitation, anxiety, and headache. These side effects can be managed by temporary aids to tolerance. Persistent or late onset side effects, which may include apathy, fatigue, weight gain, and sexual dysfunction, may require additional medications or a switch in antidepressants.

Strategies for managing antidepressant side effects include:

- Allow the patient to verbalize his/her complaint about side effects.
- Wait and provide support. Some side effects will subside over one to two weeks.
- Lower the dose temporarily.
- Treat the side effects. (Refer to Appendix 5)
- Change to a different antidepressant.
- Discontinue medications and start psychological counseling.

Continuation of treatment

- If this is an episode of clinical depression in a patient with a good premorbid mood history and without significant family history of depression, then **effective medication should be continued for at least 12 months** before considering discontinuation.
- Generally, medications should be discontinued through a gradual taper to avoid any uncomfortable physical withdrawal.
- If this is a chronic or recurrent clinical depression, “double depression” (major depressive episode in a patient with dysthymia), or depression in a patient with a positive family history, then indefinite maintenance on effective antidepressant medication should be considered.
- Risk factors for recurrence of major depressive disorder (MDD) include a prior episode of MDD, dysthymia, additional psychiatric diagnosis, the presence of a comorbid medical disorder, or a comorbid substance abuse disorder.

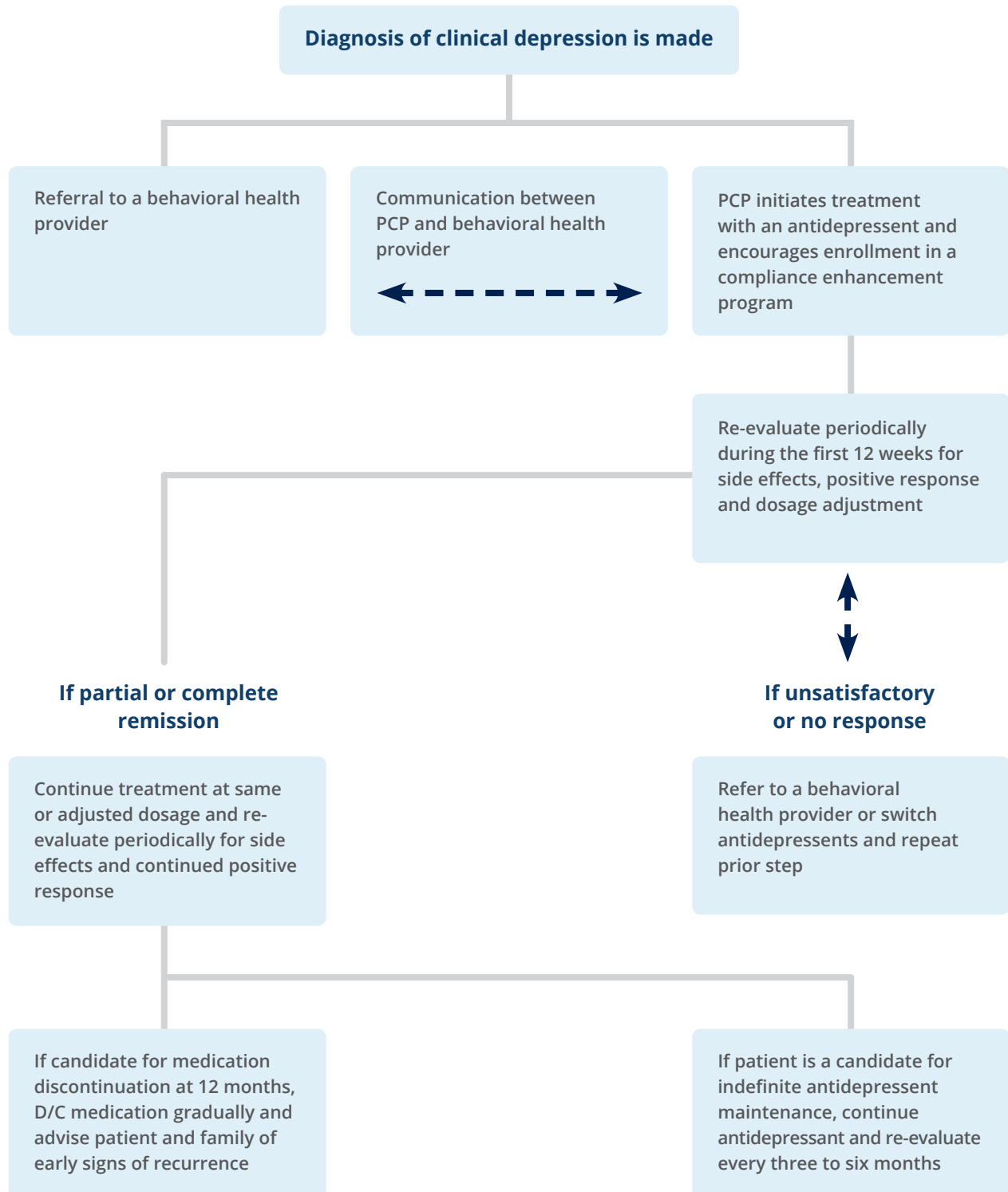
Psychiatric referral

Referral for psychiatric consultation, treatment, and/or psychotherapy can occur at any time at the PCP's discretion and/or the patient's choice. In all cases, the mental health provider should communicate and coordinate with the PCP, after obtaining the patient's permission.

It is strongly recommended that referral to the mental health provider be considered in any of the following circumstances:

- significant evidence of danger to self or others
- suspicion of bipolar disorder (**Note:** strongly consider psychiatric referral to any member who describes periods of (1) too much energy, and (2) lack of need for sleep. Use of antidepressant medications with bipolar members may further destabilize the clinical picture.)
- presence of psychotic symptoms
- treatment-resistant depression
- depression during pregnancy and postpartum
- childhood depression
- depression with comorbid psychiatric/ substance use disorders
- depression with eating disorders
- depression with dementia
- depression with severe/chronic medical disorder

Algorithm for clinical practice guidelines for depression in adults in the primary care setting



References

- Agency for Health Care Policy and Research: Depression in Primary Care, Vol 1–11, April 1993.
- Agency for Health Care Policy and Research: Treatment of Depression-Newer Psychopharmacotherapies. Evidence Report Technology Assessment # 7. Publication # 99-E014.
- American Medical Association Report 4 of the Council of Scientific Affairs, Approved by the AMA House of Delegates, December 2000. Women's Health: Sex and Gender Based Differences in Health and Disease, page 2, lines 25–29.
- American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, fourth edition: Primary Care Version, 1995.
- American Psychiatric Association: Practice Guideline for Major Depressive Disorder in Adults, 1993.
- American Psychiatric Association: Practice Guideline for the Treatment of Patients with Major Depressive Disorder, Second Edition, April 2000.
- Apler, JT: Fluoxetine treatment in depressed patients who failed treatment with sertraline. Presented at the 34th Annual Meeting of the American College of Neuropsychopharmacology, December 11–15, 1995, San Juan, Puerto Rico.
- Blehar MC, Oren DA. Women's Increased Vulnerability to Mood Disorders: Integrating Psychobiology and Epidemiology. *Depression* 1995;3:3–12.
- Brown, WA: Are patients who are intolerant to one serotonin selective reuptake inhibitor intolerant to another? *J. Clin Psychiatry* 1995; 56:30–34.
- Harris RZ, Benet LZ, Schwartz JB, Gender Effects in Pharmacokinetics and Pharmacodynamics, *Drugs* 1995;50 (2): 222–39.
- Hoffman E, Women's Health and Complexity Science, *Academic Medicine*, 75,11, 1102–1106, November 2000.
- Klasco RK (Ed): DRUGDEX® System. Thomson Reuters, Greenwood Village, Colorado (Edition expires 03/2011), Retrieved in February 15, 2011.
- Lexi-Comp Online™, Lexi-Drugs Online™, Hudson, Ohio: Lexi-Comp, Inc. (2011), Retrieved on March 8th, 2013.
- MacArthur Foundation's Initiative on Depression and Primary Care. Depression Management Tool Kit. 2004 Trustees of Dartmouth College, V 1.3, June 2004.
- Montano, CB: Recognition and Treatment of Depression in a Primary Care Setting. *J Clin Psychiatry* December 1994; 55[12,suppl]: 18–34.
- Murray CJL, Lopez AD eds, The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries, and Risk Factors in 1990 and projected to 2020. Cambridge MA: Harvard University Press, 1996.
- National Institutes of Health, Office of Director, Agenda for Research on Women's Health for the 21st Century, NIH Publication 99–4386, 1999.
- Pollock BG II, The Endocrine-Treatment Interface: Gender Differences in Psychotropic Metabolism. *Psychopharmacol Bull* 1997; 33:235–41.
- Sternbach HS. The serotonin syndrome. *Atn J Psychiatry* 1991; 148; 705–713.
- Thase, ME: Treatment-resistant depression, In Blom. FE: *Psychopharmacology: The Forth Generation*. New York, Raven Press, 1995.
- Weissman MM, Olfson M, Depression in Women: Implications for Health Care Research. *Science* 1995; 269; 799–801.
- Whooley MA, Avins AL, Miranda J, Browner WS: Case-finding instruments for depression, two questions are as good as many. *J Gen Intern Med* 1997;12:439–445.
- Zarate, Ca: Does intolerance and lack of response with fluoxetine predict the same will happen with sertraline? *J Clin Psychiatry*, in press.
- Zung, WWK. The role of rotating scales in the identification and management of the depressed patient in the primary care setting. *J Clin Psychiatry* 1990; [6,suppl]:72–76.

Appendix 1 (adapted from Whooley Depression Screen)

Patient Screening Tool

Patient Name	Date
--------------	------

Depression screen

Please answer each question by circling Yes or No.

During the past month, have you often been bothered by feeling down, sad, and hopeless?	<input type="radio"/> Yes	<input type="radio"/> No
During the past month, have you noticed a decrease in your interest or pleasure in doing things?	<input type="radio"/> Yes	<input type="radio"/> No

Bipolar screen

Has there ever been a 4 day or longer period when you had racing thoughts, talked faster than usual, felt unusually good, and didn't need your usual amount of sleep?	<input type="radio"/> Yes	<input type="radio"/> No
---	---------------------------	--------------------------

Appendix 2 (adapted from PHQ-9 Nine Symptom Depression Checklist)

Patient Questionnaire

Patient Name	Date
--------------	------

Symptom checklist

1. Over the last 2 weeks, how often have you experienced any of the following problems? (Place a ✓ in the response box)	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
A. Little interest or pleasure in doing things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Feeling down, sad, or hopeless.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Trouble falling asleep/staying asleep, sleeping too much.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Feeling tired or having little energy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Poor appetite or overeating.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F. Feeling bad about yourself or that you are a failure or have let yourself or your family down.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
G. Trouble concentrating on things, such as reading the newspaper or watching television.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
H. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you are moving around more than usual.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I. Thoughts that you would be better off dead or of hurting yourself in some way.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. How difficult have these problems made it to do your work, take care of things at home, or get along with other people? (Check response.)

- Not difficult at all
 Somewhat difficult
 Very difficult
 Extremely difficult

Appendix 3

Patient Questionnaire scoring guideline

Appendix 1: Patient Screening Tool

How to score Patient Screening Tool

This is a screening tool for both major depression and bipolar disorder. The first 2 screening questions relate to major depression and the 3rd question relates to bipolar disorder. A positive response to either screen does not confirm a diagnosis, rather a trigger for further evaluation. Strongly consider a psychiatric referral if the patient screens positive for bipolar disorder, since the diagnosis and treatment usually requires specialty oversight including the use of mood stabilizing agents and NOT antidepressants.

Appendix 2: Patient Questionnaire

How to score Patient Questionnaire

Major depressive syndrome is suggested if:

- of the nine items (A-I), five or more are checked as at least “more than half the days” and
- either item A or B is positive, that is, at least “more than half the days”

Other depressive syndrome is suggested if:

- of the nine items (A-I), if B, C, or D are checked as at least “more than half the days” and
- either item A or B is positive, that is, at least “more than half the days”

If depression is suspected, the score can be used to plan and monitor treatment. To score the questionnaire, tally each response by the number value under the answer headings:

- not at all = 0
- several days = 1
- more than half the days = 2
- nearly every day = 3

Add the numbers together to total the score. Interpret the score by using the following guide.

Guide for interpreting Patient Questionnaire score

Score	Action
≤ 4	The score suggests the patient may not need depression treatment.
5–14	Physician uses clinical judgment about treatment, based on patient’s duration of symptoms and functional impairment.
≥ 15	Warrants treatment for depression, use antidepressant, psychotherapy and/or a combination of treatment.

A functional health assessment is reflected in Question 2, which asks the patient how emotional difficulties or problems impact work, things at home, or relationships with other people. Patient responses can be one of four: not difficult at all, somewhat difficult, very difficult, or extremely difficult. A response of very difficult or extremely difficult suggests that the patient’s functionality is impaired. After treatment begins, functional status is again measured to see if the patient is improving.

Appendix 4

Side effects management chart

Side effect	Selective Serotonin Reuptake Inhibitors (SSRIs) & Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)	Tricyclic antidepressants (nortriptyline, amitriptyline, imipramine)	bupropion (Wellbutrin, Wellbutrin SR)	mirtazapine (Remeron)	Symptom Management Strategy
Sedation	+/-	++	-	+	<ul style="list-style-type: none"> ■ Give medication at bedtime ■ Try caffeine ■ Add modafinil or methylphenidate
Anticholinergic-like symptoms, dry mouth/eyes, constipation, urinary retention, tachycardia	+/-	++	-	+/-	<ul style="list-style-type: none"> ■ Increase hydration ■ Sugarless gum/candy ■ Dietary fiber ■ Artificial tears ■ Consider switching medication
GI distress, nausea, vomiting	++	-	+	+/-	<ul style="list-style-type: none"> ■ Often improves in one to two weeks ■ Take with meals ■ Consider antacids or H2 blockers
Restlessness, jitters/tremors	+	+/-	++	-	<ul style="list-style-type: none"> ■ Start with small doses, especially with anxiety disorder ■ Reduce dose temporarily ■ May go away within one to two weeks
Headache	+	-	+	-	<ul style="list-style-type: none"> ■ Lower dose ■ Analgesics
Insomnia	+	-	+	-	<ul style="list-style-type: none"> ■ Take medication in morning ■ Try adding a sedative-hypnotic at bedtime or melatonin
Sexual dysfunction	++	-	-	-	<ul style="list-style-type: none"> ■ May be part of depression or medical disorders ■ Decrease dose ■ Try switching to an NDRI ■ Try adding sildenafil or tadalafil

Key: (-) Very unlikely (+/-) Uncommon (+) Mild (++) Moderate

Side effect	Selective Serotonin Reuptake Inhibitors (SSRIs) & Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)	Tricyclic antidepressants (nortriptyline, amitriptyline, imipramine)	bupropion (Wellbutrin, Wellbutrin SR)	mirtazapine (Remeron)	Symptom Management Strategy
Seizures	-	-	+	+/-	<ul style="list-style-type: none"> ■ Discontinue antidepressant
Weight gain	+/-	+	+/-	++	<ul style="list-style-type: none"> ■ Exercise ■ Diet ■ Consider changing medications
Agranulocytosis	-	-	-	+/-	<ul style="list-style-type: none"> ■ Monitor for signs of infection, flu-like symptoms ■ Stop drug, check WBC

Key: (-) Very unlikely (+/-) Uncommon (+) Mild (++) Moderate

Appendix 5

Depression Monitoring Tool (physician tool for re-assessment)

Patient Name	Date of birth
--------------	---------------

Depression monitoring					
Symptoms	Date	Date	Date	Date	Date
	Week	Week	Week	Week	Week
Interest					
Mood					
Sleep					
Fatigue					
Appetite/weight					
Self-esteem					
Concentration					
Psychomotor					
Death/suicide					
Patient questionnaire (PQ) score					
Suicidality (PQ question 1 score)					
Functioning (PQ question 2)					
Patient impression					
Behavioral health referral					
Medications/ dosage					
Compliance with recommendations					

Approved by CareFirst's Quality Improvement Council, April 2018.

These guidelines are general recommendations for members with no special risk factors. Variations are appropriate based on individual clinical circumstances.

