Michigan Quality Improvement Consortium

January 2016

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.

Eligible Population	Recommendation and Level of Evidence	Frequency
Adults 18 years or older, including pregnant and postpartum women	Detection and Diagnosis: Screen for depression with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up **[A]**. Use a validated screening tool (e.g. PHQ-2, PHQ-9) **[A]**. Assess if criteria are met using DSM-5 criteria **[A].** Criteria A, B, C and D must be met.	Annually At each evaluation where the patient's high-risk status, symptoms or signs raise suspicion of current or uncontrolled depression. 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].
Individuals diagnosed with a depressive disorder	Assessment of suicide risk: 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.**	At each encounter addressing depression until patient is treated to remission and has not expressed suicidal thinking in previous visits.
	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). 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, 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. If no response after 2-4 weeks, increase dosage as tolerated not to exceed the highest recommended dose. If discontinuing antidepressant, taper dose over several weeks. 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. Patients with recurrent major depression usually require lifelong treatment. Continue medication for at least 9 - 12 months after acute symptoms resolve. **[A]**	Schedule sufficient follow-up visits to assess response to treatment and titrate dose (typically every two weeks, monthly at a minimum). **[D]**

DSM-5 criteria

DSM-5 criteria	Major Depression	Persistent Depressive Disorder
A. Symptoms	5 total for ≥ 2 weeks and must include symptom #1 or #2	3 total for ≥ 2 years. Must include symptom #1. Never > 2 months symptom-free
1. Depressed mood	x	x
2. Marked diminished interest/pleasure	x	
3. Significant weight gain/loss, appetite decrease/increase	x	x
4. Insomnia/hypersomnia	x	x
5. Psychomotor agitation/retardation noticeable by others	x	
6. Fatigue/loss of energy	x	x
7. Feelings of worthlessness or inappropriate guilt	x	x
8. Diminished concentration or indecisiveness	x	x
9. Recurrent thoughts of death or suicidal ideation	x	
10. Hopelessness		x
B. Symptoms cause clinically significant distress or impairment in functioning		
C. Symptoms not attributed to a substance or other medical condition		
D. Lack of psychotic disorder or history of manic or hypomanic symptoms		

Assess for comorbid conditions that might impact treatment (e.g., medical and medication-induced conditions, drug or alcohol abuse, bipolar disorder, anxiety disorders, psychosis).

[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; Adult Depression in Primary Care health care guideline. Institute for Clinical Systems Improvement, updated September 2013; 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.

Approved by MQIC Medical Directors January 2002, 2004, 2006, 2008, 2010, 2012, 2014, 2016

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