I. PURPOSE: To define recommended patterns of care for treatment of adult depression. Depression is a medical condition impacting patients, families, employers, and health care systems. Depression can worsen the prognosis for other medical conditions.

II. POPULATION: Adults 18 years of age and older.

III. GUIDELINE:
   A. Consider the diagnosis of major depression based on chronic conditions and common presentations, even if the member does not initially complain of a depressed mood.
      Conditions and symptoms considered high risk for depression include:
      1. Chronic conditions (CVD, Diabetes, cognitive impairment), chronic pain, geriatrics, tobacco use, alcohol/substance misuse/abuse, chronic anxiety, history of abuse/trauma/PTSD, combat veteran, persistent anger/irritability, recent loss.
      2. Presentations: multiple (more than five per year) medical visits, multiple somatic complaints, work or relationship dysfunction, dampened affect, changes in interpersonal relationships, poor behavioral follow-through with activities of daily living or prior treatment recommendations, weight gain or loss, sleep disturbance, chronic fatigue, memory/other cognitive complaints such as difficulty concentrating or making decisions, irritable bowel syndrome, volunteered complaints of stress or mood disturbance.
   B. Screening/diagnosing depression:
      Consider the use of universal screening for all patients, screening is required in cases of clinical suspicion for depression.

Screening:
- Use Patient Health Questionnaire (PHQ)-2 or PHQ-9. PHQ-9 has been shown to be more effective in those with chronic disease.
- "In the past 2 weeks: Have you had little interest or pleasure in doing things? Have you felt down, depressed or hopeless?"
- If "yes" on either question, complete full PHQ-9. (The PHQ-9 is a validated tool for both detecting and monitoring depression in primary care settings. The tool is available in other languages at http://www.phqscreeners.com.)

Further Assessment:
- Have you ever had a period of time when you were feeling 'up' or 'high' or 'hyper' and so full of energy that you got into trouble or that other people thought you were not your usual self? (excluding alcohol or drug intoxication)
- Have you ever had periods of time where for several days you have had increased energy and have been persistently irritable so that you had arguments or verbal or physical fights, or shouted at people outside your family? (excluding alcohol or drug intoxication)

Other considerations:
- Recent life events (Why now?)
- History of depression/bipolar disorder or alcohol/substance misuse
- Patient’s perception of problem: beliefs and knowledge about depression; cultural considerations
- Consider medical and medication causes
- Family history of depression, bipolar disorder
- Suicide risk
- Assess risk of harming others
- Screen for co-morbid psychiatric disorders

NOTE: This guideline is designed to assist providers by providing an analytical framework for the evaluation and treatment of patients, and is not intended either to replace a clinicians judgment or to establish a protocol for all patients with a particular condition.
C. Clinicians should use the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-5) criteria to determine diagnosis of major depression, persistent depressive disorder, other specified depressive disorder, and unspecified depressive disorder.

D. Treatment and management:

<table>
<thead>
<tr>
<th>Shared Decision Making</th>
<th>Promote Health Behaviors</th>
<th>Additional Considerations</th>
<th>Consider Referral or Consult</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Tailor treatment to individual patient</td>
<td>• Exercise</td>
<td>• Current or planned pregnancy; psychotherapy preferred if symptoms tolerable</td>
<td>• Educate patients under age 25 about the risk of suicidal ideation with initiation of SSRIs.</td>
</tr>
<tr>
<td>• Guides patients, families, and physicians through a reliable process that incorporates patient values, priorities, and goals in discussions of risks and benefits of treatment options</td>
<td>• Social Support</td>
<td>• Start with lower dose for anxiety or elderly</td>
<td>• Consider psychiatry consult/referral for the following:</td>
</tr>
<tr>
<td>• Provide education on diagnosis</td>
<td>• Faith/spiritual support</td>
<td>• Cultural factors that influence treatment choice</td>
<td>• Suicidal/Homicidal Patient</td>
</tr>
<tr>
<td>• Review treatment options (based on PHQ-9 score)</td>
<td>• Healthy sleep pattern</td>
<td>• SNRI or tricyclic for chronic pain</td>
<td>• Bipolar Disorder</td>
</tr>
<tr>
<td>• Discuss treatment barriers: family/work responsibilities, insurance, transportation</td>
<td>• Healthy diet</td>
<td>• Level of functioning/activities of daily living</td>
<td>• Co-occurring substance abuse</td>
</tr>
<tr>
<td>• Negotiate Treatment Plan</td>
<td>• Alcohol only in moderation</td>
<td>• Discuss safety with the patient</td>
<td>• Psychotic features</td>
</tr>
<tr>
<td>• Set Timeline: response, side effects and treatment duration</td>
<td>• Cessation of tobacco and illicit drug use</td>
<td>• Need for emergency services</td>
<td>• Multiple medications</td>
</tr>
<tr>
<td>• Educate on importance of adherence</td>
<td>• Engagement in positive activities</td>
<td>• Psychiatry referral, including ECT evaluation</td>
<td>• Consider referral to telephonic counseling for depression and anxiety as appropriate</td>
</tr>
<tr>
<td>• Develop safety plan for suicidal ideation</td>
<td>• Stress management</td>
<td>• Complementary/Alternative Medicine</td>
<td>• Referral to appropriate disease management program as indicated (DHMP Members can access Take Control Of Your Depression program)</td>
</tr>
</tbody>
</table>

Initial recommendations based on PHQ-9 are listed in the following table.

<table>
<thead>
<tr>
<th>PHQ-9 Score</th>
<th>Provisional Diagnosis</th>
<th>Treatment Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-9</td>
<td>Minimal Symptoms</td>
<td>Support, educate to call if worse; return in 1 month</td>
</tr>
<tr>
<td>10-14</td>
<td>Major Depression (mild)</td>
<td>Evidence-based psychotherapy equally effective as anti-depressant</td>
</tr>
<tr>
<td>15-19</td>
<td>Major Depression moderately severe</td>
<td>Evidence-based psychotherapy and/or anti-depressant</td>
</tr>
<tr>
<td>≥ 20</td>
<td>Major Depression, severe</td>
<td>Anti-depressant and psychotherapy (esp. if not improved on monotherapy)</td>
</tr>
</tbody>
</table>

*See Attachment A for list of common antidepressant medications used at Denver Health.*

E. Follow-up, Management, and Treatment Phases: Monitor and adjust treatment, monitor side effects:

**NOTE:**
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1. Initial follow up should occur at 2-4 weeks. The goal is to complete a medication evaluation (addressing the following issues) and provide an opportunity for the member to discuss any other concerns relating to treatment:
   • Adherence to medication
   • Monitoring of adverse effects and adjustment of medications as necessary
   • Assessment of mood/vegetative symptoms
   • Assessment of suicidality or other at risk behavior (risk may increase during early treatment phase)
2. Subsequent follow up will occur every 4-8 weeks until remission or minimal symptoms.
3. Acute Phase (Months 1-4):
   a. Treatment in the acute phase is aimed at inducing remission and achieving a full return to baseline level of functioning. Selection of initial treatment should be influenced by clinical features:
      o Severity of symptoms and presence of co-occurring disorders
      o Patient preference
      o Prior treatment experiences
   b. Medication: Selection of medication is based largely on anticipated adverse effects, safety and tolerability, pharmacologic properties, etc. Once an antidepressant has been selected, it should be titrated based on age, treatment setting, and presence of co-occurring disorders, concomitant pharmacotherapy, or adverse effects. Incomplete response to treatment is associated with poor functional outcomes. The acute phase should not be concluded prematurely for those who do not fully respond.

<table>
<thead>
<tr>
<th>Response</th>
<th>PHQ-9 score after 4-6 weeks</th>
<th>Treatment Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsive</td>
<td>Drop ≥ 5 points from baseline</td>
<td>No treatment change needed. Follow-up again after 4 weeks.</td>
</tr>
<tr>
<td>Partially Responsive</td>
<td>Drop 2-4 points from baseline</td>
<td>Often warrants increase in dose, possibly no-change needed</td>
</tr>
<tr>
<td>Non-Responsive</td>
<td>Drop 1 point or no change or increase</td>
<td>• Consider starting anti-depressant if receiving therapy alone</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Review Psychological counseling options and preferences</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Informal or formal psychiatric consultation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medications:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Increase dose, Switch medication, or Augmentation (lithium,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>thyroid, stimulant, 2nd generation antipsychotic, 2nd anti-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>depressant</td>
</tr>
</tbody>
</table>

c. Medication response should be assessed at 4 weeks
d. If response to antidepressant treatment is adequate consider the following:
   o Review evidence to ensure the diagnosis is correct
   o Evaluate compliance with medications and determine need for increased dosing or change in medications
   o If the member had 2 adequate medication trials without good response, consider referral to psychiatry for further psychopharmacological management

3. Continuation Phase (Months 4-9):

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Goal: preventing relapse by maintaining antidepressant at acute phase doses, monitoring for adherence and continued efficacy. This phase begins after symptom resolution or with significant symptom reduction toward baseline.

a. Treatment that was successful in the acute phase is continued, with less frequent monitoring (every 2-3 months)
b. Continue medications at full strength and generally with the same anti-depressant as in acute phase, monitor for signs of relapse
c. Depression-focused cognitive behavioral therapy is also recommended as applicable

4. Maintenance Phase for Recurrent Depression (after 6 months of symptom resolution)
   a. Recurrence rates for major depressive episodes are 50% after one episode, 70% after two episodes, and 90% after 3 episodes
   b. Those with 3 or more episodes should be considered a candidate for lifetime antidepressant prophylaxis against recurrent episodes of depression
   c. Consider maintenance phase for those with additional risk factors for recurrence (family history, early age onset, ongoing psychological stressors, co-occurring disorders)
   d. Use PHQ-9 for ongoing monitoring

5. Tapering Anti-Depressant Medications:
   a. Consider tapering for those with 6 months of symptom resolution and a history of 2 or fewer major depressive episodes.
   b. Taper over 1-2 months with education about side-effects and relapse
   c. Monitor closely for symptoms of severe withdrawal (SSRIs and SNRIs may experience anxiety/agitation, sweats, paresthesia’s, in addition to flu-like symptoms) if this occurs, increase back to last tolerable dose and taper more slowly
   d. Diphenhydramine may help with anticholinergic withdrawal symptoms

6. Depression in pregnancy.
   a. In addition to the PHQ-9, the 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for “perinatal” depression. Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity but should not override clinical judgment. The scale indicates how the mother has felt during the previous week. In doubtful cases, repeat the tool after 2 weeks
   b. Consider appropriateness of starting/continuing an antidepressant in a pregnant woman
      o Utilize Micromedex to access updated medication information about data/safety concerns for pregnancy and breast feeding.
      o Do not use Paxil with pregnant woman, as this medication is now Category D. Paxil is recommended to be used with caution in women of child bearing age who are not on birth control.
   c. Consider consultation with a psychiatrist for more complex presentations

IV. ATTACHMENTS:
   Attachment A – List of common antidepressant medications for Denver Health as available on Policy Stat “Ambulatory Care Services Primary Care Adult Depression Guideline” ID #1784162
   Attachment B – Edinburgh Postnatal Depression Scale (EPDS)
   Attachment C – Patient Health Questionnaire 9 (PHQ-9)

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V. REFERENCES:


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