ASPIRUS™ NETWORK
Passion for excellence. Compassion for people.

Primary Care Diagnosis and Management of Adults with Depression Guideline

May 2013

The following guideline recommends being alert to depressive symptoms and risk for suicide, following diagnostic criteria, when indicated using pharmacologic treatment in adequate dose and for appropriate duration, and when to refer to Behavioral Health Specialists.

Eligible Population	Key Components	Recommendation and Level of Evidence	Frequency
Adults 18 years or older with high risk for major depressive disorder including prenatal and postpartum populations	Detection and Diagnosis	■ Assess for major depression using a validated screening tool (e.g. PHQ-2) and diagnostic tool (e.g. PHQ-9), **or,** ■ Assess if criteria for major depression are met using DSM-IV. **[A]** Must have a total of five symptoms for at least two weeks. One of the symptoms must be depressed mood or loss of interest. Relevant symptoms include: ♦ Little interest or pleasure in doing things ♦ Feeling down, depressed, or hopeless ♦ Insomnia/hypersomnia ♦ Feeling tired or having little energy ♦ Poor appetite or overeating ♦ Feeling bad about one's self (failure, let yourself or family down) ♦ Trouble concentrating ♦ Moving/speaking so slowly that others could have noticed, or fidgety/restless ♦ Thoughts of being better off dead, or of hurting one's self ■ Assess for drug and alcohol use. ■ **Assess by six weeks post-partum using the Edinburgh Postnatal Depression Scale.** ■ Assess whether patients have symptoms suggesting bipolar disorder **[C],** or psychosis.	♦ 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 six weeks of discharge) and if symptoms or signs raise suspicion.
Individuals diagnosed with significant mood symptoms, particularly those meeting criteria for major depression	Screening for 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]** ■ **If screening suggests current risk for suicide, refer patient for crisis evaluation.**	At each encounter addressing depression until patient is treated to remission and has not expressed suicidal thinking in previous visits.
	Management of patients who are prescribed antidepressant medication	■ Initiate antidepressant medication following manufacturers recommended doses. **[A]** ■ Consider referral to Behavioral Health Specialist when **[D]**: ♦ Additional counseling as desired. ♦ Primary physician not comfortable managing patient's depression. ♦ Diagnosis is uncertain or complicated by other psychiatric factors (e.g. bipolar disorder, psychosis). ♦ Complex social situation. ♦ Management is complex, response to medication at therapeutic dosage is not optimal, or considering prescribing multiple agents. ♦ Psychotherapy and/or hospitalization required. ■ Monitor medication frequently (e.g. every two weeks) and adjust to a therapeutic level as assessed by clinical data not to exceed the highest recommended dose. **[D]** Medication should not be abruptly discontinued. ■ If no response after 2 - 3 weeks on therapeutic dosage, increase dosage as tolerated and begin new observation period. If no response after 2 - 3 weeks on maximal dosage, then switch antidepressant. If partial response after 2 - 3 weeks on maximal dosage, then switch antidepressant or augment with additional agent. ■ 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]**

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

Used with permission of Michigan Quality Improvement Consortium. This guideline is based on several sources, including: Major Depression in Adults in Primary Care guideline. Institute for Clinical Systems Improvement, 2011 (*www.icsi.org*). Individual patient considerations and advances in medical science may supersede or modify these recommendations.