

## Depression Clinical Practice Guidelines for Primary Care Physicians

<b>Rationale</b>	Depression is a persistent disorder of mood lasting longer than two weeks associated with vegetative symptoms. Common in the primary care populations and closely associated with a many medical conditions, depression is typically treated by the PCP. Co-morbid conditions associated with depression include chronic pain, RA, heart disease, cancer, collagen diseases and other medical conditions. Early screening, proper diagnosis, close follow up and effective dosing of medication can improve outcomes and decrease morbidity.
<b>Detection</b>	Early screening in the form of short screening scales (Zung, Prime MD, Beck) as well as personal and family history can be effective in identifying patients with depressive disorders. Psychosocial stressors, chronic illness and family conflict can increase the frequency of depression. Somatization can be an indirect expression of depression.
<b>Presentation</b>	Depression can present as sadness, “the blues,” increased irritability or somatization (physical complaints with no organic etiology). Poor performance at work or in the home can also be an early sign of depression.
<b>Diagnosis</b>	<ul style="list-style-type: none"> <li>• Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). (In children and adolescents, this may be characterized as an irritable mood.)</li> <li>• Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day</li> <li>• Significant weight loss when not dieting or weight gain (e.g., a change of more than five lbs. of body weight in a month), or decrease or increase in appetite nearly every day</li> <li>• Insomnia or hypersomnia nearly every day</li> <li>• Psychomotor agitation or retardation nearly every day</li> <li>• Fatigue or loss of energy nearly every day</li> <li>• Feelings of worthlessness or excessive or inappropriate guilt nearly every day</li> <li>• Diminished ability to think or concentrate, or indecisiveness, nearly every day</li> <li>• Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide</li> </ul>
<b>Screening for Suicide/Homicide Risk</b>	Patients identified with depression need to be carefully queried as to current suicidal thoughts, plans and actions, intentional or unintentional. A past history of suicidal thinking, acts, impulsive behavior, violent behavior and risk taking behavior should be considered and raise concerns about the safety to self and others. Individuals at risk should be referred to a local psychiatrist, a mental health specialist, or facility.
<b>Referral Considerations</b>	<p>Referral to a psychiatrist should be considered when:</p> <ul style="list-style-type: none"> <li>• There is a risk of suicide or a potential for acting out</li> <li>• When delusions and hallucinations are identified</li> <li>• Where inpatient hospitalization is a consideration</li> <li>• When the patient has not responded to therapeutic doses of medication</li> <li>• When co-morbidities exist such as alcohol or drug abuse</li> <li>• When complicated polypharmacy is evident</li> <li>• When a significant personality disorder exists and is associated with self-destructive acting out</li> <li>• When individual, marital and/or family therapy might be in order</li> </ul>
<b>Treatment Phases</b>	<p><b>Acute—Antidepressant medication for 12 weeks</b></p> <ul style="list-style-type: none"> <li>• Use WellCare formulary medications</li> <li>• Identify benefits and risks of the medication, including the potential for suicidal ideation</li> <li>• Stress the importance of frequent follow up to monitor “target symptoms”</li> <li>• Adjust or change meds if s/e 's are significant and document the drug failure</li> <li>• Increase to maximum dose with patients not responding within six weeks</li> </ul>
	<p><b>Continuation— Six months of continuous treatment with therapeutic doses of antidepressant medication.</b></p>
	<p><b>Maintenance—Continuation of medication at effective doses for at least one year for patients with a history of two or more episodes of depressive disorder.</b></p> <ul style="list-style-type: none"> <li>• Patients stable for three full months might be candidates for discontinuation.</li> <li>• When discontinuing the medication, do it slowly, watch for, and warn the patient of the potential for relapse.</li> <li>• For those with frequent relapses, elderly patients and those with a history of severe depression, lifetime medication may be in order.</li> </ul>
<b>Optimum Practitioner Contact</b>	At least three follow-up office visits with a primary care physician (PCP) or mental health provider in the three-month acute treatment phase. At least one of the three follow-up contacts must be with a prescribing



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	For post hospitalized patients: A follow-up visit within seven days but no later than 30 days post discharge.
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*This clinical guideline is designed to help and guide the clinician and patient in the diagnosis and treatment of depression. It is not designed to replace the judgment of the clinician in treating an individual patient.*