NEIGHBORHOOD HEALTH PLAN OF RHODE ISLAND	
Section: Clinical Practice Guideline	**Subject:** Diagnosis and Treatment of Depressive Disorders in Adult Primary Care Patients (over age 18)
Effective: February 10, 2005	**Updated: 2/07, 12/08, 12/10, 12/12; 12/14; 11/16, 1/19/18, 11/29/18**

Goals

To support Neighborhood Health Plan of Rhode Island practitioners in identifying and treating depression in adult primary care patients.

Current Guidelines adopted:

Institute for Clinical Systems Improvement (ICSI) GUIDELINE:
https://www.icsi.org/guidelines__more/catalog_guidelines_and_more/catalog_guidelines/catalog_behavioral_health_guidelines/depression/ **(March 2016)**

Limitations

This document is a guideline, and is not meant to replace any practices based on clinical judgment, experience or specific aspects of individual patient situations.

Guideline Overview

Factors to consider when treating an adult for depression in the primary care setting; please refer to guideline listed above for full details.

Major depression is a treatable cause of pain, suffering, disability and death, yet primary care clinicians detect major depression in only one-third to one-half of their patients with major depression. Additionally, more than 80% of patients with depression have a medical comorbidity. Usual care for depression in the primary care setting has resulted in only about half of depressed adults getting treated and only 20-40% showing substantial improvement over 12 months. Approximately 70-80% of antidepressants are prescribed in primary care, making it critical that clinicians know how to use them and have a system that supports best practices.

Behavioral Health Referrals: For information please contact Beacon Health Strategies, Neighborhoods behavioral health partner, at: **1-800-215-0058**.

a. **Diagnosis:** The clinic or medical group should have a reliable process for routine evaluation and documentation of DSM-5 criteria for major depression.

b. **Screening** Patients who are geriatric, pregnant, postpartum or have a high risk of common comorbid depression conditions such as substance abuse, diabetes, cardiovascular and cerebrovascular disease, dementia/cognitive impairment and chronic pain should be screened for depression.

   a. Regardless of the screening tool chosen, it is crucial to document that the patient meets the criteria of at least five symptoms for at least two weeks as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) criteria for major depression. One of the symptoms must be depressed mood or loss of interest or pleasure.

   b. Sample tools for Office Based Screening
      i. PHQ9:
         English: **https://www.icsi.org/guideline_sub-pages/depression/appendix_a__patient_health_questionnaire_phq-9/**

         Spanish:
         http://www.phqscreeners.com/select-screener

      ii. Beck Depression Inventory II:
         http://www.beckinstitute.org/beck-inventory-and-scales/

Crisis Referrals /Emergency Referrals- Patients who are actively suicidal or psychotic should be referred promptly for formal psychiatric evaluation, utilizing Crisis Assessment Teams and emergency department facilities, when necessary. The following characteristics identify patients with increased risk for fatal suicide attempts:

- Prior suicide attempts
- Family history of death by suicide
- Older males, particularly if living alone
- Substance abuse
- Psychosis
- Lack of social supports and/or isolation

The clinic or medical group should have a systematic way to provide and document:

a. **Engagement and Education:** The patient and his/her family are actively engaged and participating in self-management, based on knowledge of the nature of the disease, risk/benefits of treatment options, and consideration of patient preferences.

b. **Ongoing Contacts:** Each clinic or medical group should have a documented system to assure ongoing contacts with the patient during the first 12 months of care (scheduled follow-up appointments, phone calls and some way to react and/or reach out if the patient drops out of treatment and to track treatment response).

c. **PCP/BH Communication**: Educate members about the importance of signing release of information forms for ongoing communication to occur between the Primary Care Provider and the Behavioral Health Provider(s). Ongoing communication between providers enhances the treatment process and member outcomes.

Medication Management/Adherence: If treatment plan includes psychopharmalogical interventions; it is important for members to remain on their medication. It is recommended to combine pharmalogical and psychotherapy treatment as a best practice. If the initial medication response is incomplete after six weeks of a possibly therapeutic dose (e.g., partial positive response to medication), increase the dose, if side effects allow, and educate the patient that the effect of the medication changes may take 4-6 weeks. If medication response is still incomplete, add or substitute another medication, or add another treatment modality. When considering how long to continue medication after remission of acute symptoms, two issues need to be considered:

- Continuation and Maintenance treatment:
    1. **Acute Phase of treatment** involves remission of acute symptoms (usually 3 months.)

    2. **Continuation phase of treatment**, (usually lasting 6-12 months after the acute treatment), consists of prolonged administration of treatment after disappearance of acute depressive symptoms and aims to maintain a euthymic state.

    3. Maintenance treatment consists of long-term efforts to prevent recurrence and can extend for years. It should be strongly considered for all patients at the risk of recurrence. (Continuation treatment and Maintenance Treatment should consist of full dose antidepressant therapy)

       Risk factors for recurrence include:
       1. More than one previous major depressive episode.
       2. Two prior episodes with associated family history of bipolar disorder, psychosis or severe depression.
       3. Pre-existing dysthymia.
       4. Severe episodes.
       5. Seasonal patterns.