

## KCQC Guidelines for Management of Depression

The following guidelines apply to adult (18+) patients who are at high risk for or have been diagnosed with major depression.

Eligible Population	Key Components	Recommendation	Frequency / Duration								
Adults at risk	Detection, Diagnosis	Explore history for: <ul style="list-style-type: none"> <li>▪ family / personal history of depression or suicide attempts;</li> <li>▪ recent stressful life events and lack of social supports;</li> <li>▪ chronic illnesses, chronic pain; symptoms of fatigue, insomnia, anorexia, malaise, irritability or sadness;</li> <li>▪ unresolved physical complaint(s), unexplained somatic complaints</li> <li>▪ current alcohol or substance abuse.</li> </ul> Determine if DSM-IV criteria for major depression are met.	At each visit where the patient's status, symptoms, or signs raise suspicion of depression								
Adults diagnosed with Depression	Screening for diagnosis / suicide risk Monitor Progress	<ul style="list-style-type: none"> <li>▪ When Dx in doubt and to assess personal / family history of suicide attempts</li> <li>▪ To assess risk of suicide and suicide thinking or planning</li> <li>▪ Consider use of validated tools to document &amp; monitor progress</li> </ul>	At initial visit and each encounter where uncontrolled depressive symptoms are present								
On antidepressant medication	Medication Management	Acute Phase: <ul style="list-style-type: none"> <li>▪ Frequent office visits (at least monthly) are needed to assess symptoms, medication compliance, effectiveness of treatment and potential side effects.</li> <li>▪ Achieve recommended doses.</li> </ul> Continuation and maintenance phases: <ul style="list-style-type: none"> <li>▪ Switch to another medication if inadequate response in 6 weeks (make sure you are at target doses, use another class if first drug fails).</li> <li>▪ After control, continue medications to prevent relapse.</li> <li>▪ Patients with recurrent depression require longer term therapy</li> </ul>	Acute phase: initial visit then 3 more office visits within 12 weeks  <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;"><u>Depression Episode</u></th> <th style="text-align: left; border-bottom: 1px solid black;"><u>Rx Duration</u></th> </tr> </thead> <tbody> <tr> <td>First</td> <td>6 - 12 months</td> </tr> <tr> <td>Second</td> <td>2 years</td> </tr> <tr> <td>Third</td> <td>Lifetime</td> </tr> </tbody> </table>	<u>Depression Episode</u>	<u>Rx Duration</u>	First	6 - 12 months	Second	2 years	Third	Lifetime
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Psychotherapy	<ul style="list-style-type: none"> <li>▪ Best response when done in conjunction with antidepressants</li> <li>▪ PCP may chose to provide brief, goal oriented, supportive or behavioral therapy</li> </ul>	Initial and along with, or in place of, drug therapy									
Referral Considerations	Referral to a specialist is recommended when: <ul style="list-style-type: none"> <li>• Identified or suspected risk of suicide</li> <li>• Alcohol or substance abuse</li> <li>• Primary physician not comfortable treating depression or antidepressant medication management</li> <li>• Diagnosis is uncertain or complicated by other psychiatric factors</li> <li>• Management is complex or response to medication is not optimal</li> <li>• Psychotherapy and/or hospitalization required</li> </ul>	Consider at each visit									

Criteria for depression: anhedonia; fatigue; psychomotor; change in: sleep habits, eating habits, concentration; low self-esteem; hopelessness; (for 2 weeks); suicide ideation

References: Landis, BJ, Bryant, SG, Mental Health Disorders. In: Younkin EQ, Sawin KJ, Kissinger JF, Isreal DS, eds. Pharmacotherapeutics: A Primary Care Clinical Guide, Stamford CN: Appleton & Lange; 1999  
 Wells BG, Mandos LA, Hayes PE, Depressive Disorders. In: Dipiro JT, Talbert RL, Hayes PE, et al, eds. Pharmacotherapy: A Pathophysiologic Approach, Stamford CN: Appleton & Lange; 1997: 1395-1418  
 Whelan AJ, Patient Care in Internal Medicine. In: Ewald GA, McKenzie CR, eds. The Washington Manual of Medical Therapeutics. Boston, MA: Little Brown and Company; 1995, 1-28.

This guideline represents core management steps. Individual patient considerations and advances in medical science may supercede or modify these recommendations. The guideline is based on the Agency for Healthcare Research and Quality (AHRQ) Clinical Practice Guideline: Depression in Primary Care and HEDIS®