Primary Care Management of Depression in Adults

Mental health issues are common
Depression: 20% incidence, up to 40% or higher in those with chronic medical conditions such as diabetes, CHF.

Screening Tools
PHQ 2: initial screening, two questions about depressed mood/irritability and anhedonia in the preceding 2 weeks
PHQ 9: addresses the following issues in more detail: depressed mood/irritability, anhedonia, sleep issues, appetite or wt change, tired, feeling bad about self, trouble concentrating, slowed down or agitated, thoughts of being dead or hurting self, and functional impairment

Diagnose Major Depressive Disorder (MDD)
Symptoms: 5 of 9 symptoms for > 2 weeks, must include mood issue and functional impairment:
- Mood: irritable or depressed plus:
- Sleep: increased or insomnia
- Interest: markedly decreased in activities
- Guilt: feeling worthless, inappropriate guilt
- Energy: fatigue or loss of energy
- Concentration: hard to think/concentrate
- Appetite: significant wt loss / gain (~ 5% change)
- Activity: physically slowed or agitated
- Suicide: thoughts, attempts, death thoughts

Domains of Function to assess: family, school/work, peer, stress/anxiety, self harm/risk taking

Rate severity of MDD based on PHQ 9 or symptoms and functional impairment

<table>
<thead>
<tr>
<th>Severity</th>
<th>PHQ 9 Score</th>
<th>Symptoms and Functional Impairment</th>
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</thead>
<tbody>
<tr>
<td>Mild</td>
<td>5 – 9</td>
<td>5-6 sx of mild severity (including mood) and function mildly impaired or nl but w/ substantial and unusual effort</td>
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<tr>
<td>Moderate</td>
<td>10 – 14</td>
<td></td>
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<tr>
<td>Moderately severe</td>
<td>15 – 19</td>
<td></td>
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<tr>
<td>Severe</td>
<td>20 – 27</td>
<td>most sx present &amp; severe, and function disabled or psychotic features</td>
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Screen for co morbidities
- Physical illness
- Substance / alcohol use
- Psychiatric disorders (anxiety, ADD, bipolar, eating disorders, PDD, learning disability)
- Psychotic sx: hallucinations, paranoia
- Abuse: physical / emotional / sexual

Assess safety: access to means of harm, suicide risks (stress, hopelessness, impulsiveness), protective factors (religious belief, wish not to harm family & friends).

Refer to psychiatrist: anyone who requests this; or depression along w/ substance abuse, eating disorder, or other complications such as severe depression, suicidality.

Assess and manage suicide risk
Assessment: inquire about suicide plans, thoughts, access to means of harm
Management: Seek immediate consultation; don’t leave pt alone.

- If pt is not of imminent danger to self or others but needs psych hospitalization and does not need emergency medical attention, call pt’s behavioral health insurance to confirm the closest in network psychiatric facility. If Stanford (SUH) is in network, call 650-725-9848 intake coordinator (or after hours, operator 650-723-4000)
- If pt needs restraint or emergency medical care, call 911
**Initial management of depression in primary care**

**General Principles**
- Form an alliance w/ the pt and affirm hope
- Educate, counsel pt about depression, tx options, limits of confidentiality
- Establish a safety plan: restrict access to lethal means, engage 3rd party to monitor, develop emergency communication plan to use if needed
- Develop a specific tx plan and goals re function in home, work/school and peer relationships
- Encourage adequate exercise and sleep
- Share resources: phone numbers, websites, handouts
- Refer pt to mental health providers
- Make it easy for pt to contact provider
- Arrange follow up visit within one week
- Have pt sign Release of Information form to allow communication w/ mental health care providers
- Obtain information from and communicate w/ mental health care providers

**Initial Treatment of MILD, Uncomplicated Depression:**
- "Active support" in primary care: this is as effective as formal psychotherapy for mild depression
- Monitor depressive symptoms and function (work/school, home, peer, extracurricular activities)
- If sx persist longer than 4 – 8 wks, offer psychotherapy and / or antidepressants

**Initial Treatment of MODERATE, Uncomplicated Depression**
- Recommend psychotherapy and consider antidepressant or refer to psychiatrist
- If pt declines psychotherapy or psychiatry and if pt not on antidepressant: provide active support, seeing pt weekly initially.

**Follow up interval**
- Moderate depression initially weekly, by phone or in person. Extend intervals to monthly if responding.
- Moderately severe depression initially weekly, by phone or in person. Extend intervals to q 2 – 4 wks if responding.
- Severe depression initially weekly, by phone or in person, continuing this until significant response.

**Medication management**

**Before starting antidepressant:**
- Rule out bipolar disorder: severe mood changes, unrealistically high self – esteem, great in energy/little sleep, increased talking, distractible, repeated high risk behavior
- Establish safety plan, close f/u
- Review medication side effects, warning signs requiring immediate attention (suicidality, sx suggesting mania).
- If dose is changed, see pt within 1 week
- If any concerns, see pt sooner and/or consult with or refer to psychiatrist.

**Continued management of depression in primary care**

**If stable and on medication:**
- 1st Episode of MDD: continue medication for 6 – 12 months. Withdraw gradually.
- 2nd episodes of MDD, uncomplicated: continue medication for 3 years. Withdraw gradually.
- 3rd or more episode or 2 episodes of MDD with complications such as rapid recurrence, > 60 yrs old, severe depression, family history of depression, or MDD w/ dysthymia: continue medication indefinitely.

**If only partially improved:**
- Confirm adherence to treatment and address barriers, including side effects to medications
- If not on antidepressant consider adding one
- If on antidepressant consider increasing dose
- If not getting psychotherapy, recommend this
- Consult with or refer to psychiatrist
- Review safety plan
- Provide further pt/family education

**If not improved:** reassess dx and if depression confirmed, do all the above and consider psychiatry consultation.