



The Michigan InterPlan Behavioral Health Work Group Guideline
For Specialists
For Depressive Disorders
March 2009

The following guidelines apply to the Diagnosis and Management of Depression by the Behavioral Medicine Specialist. (Psychiatrists, Nurse Clinicians, Social Workers, Psychologists, and Counselors.)

Eligible Population	Key Components	Recommendation and Level of Evidence	Frequency
Adults 18 years or older who have been diagnosed or are at risk for major depressive disorder	Rationale	Major depression is a common and costly medical condition seen frequently in general medicine and behavioral health settings. Individuals with undiagnosed depression generally see their PCP more frequently for comorbid medical conditions and/ or vague symptomatology. Individuals with depression and several serious health conditions, including heart disease, diabetes, stroke, COPD, etc., are at much higher risk for medical complications, disability and condition related fatality. Improved screening, diagnosis and co management with the PCP can lead to an improved quality of life for the person with depression.	<ul style="list-style-type: none"> At each evaluation where the patient's high-risk status, symptoms or signs raise suspicion of current or uncontrolled depression
	Detection	Maintain high index of suspicion for depressive symptoms in persons with a family or personal history of: <ul style="list-style-type: none"> Depression or suicide attempts (A) Chronic pain Irritability or sadness Recent stressful life events and lack of social supports Chronic illnesses (i.e. diabetes, Post MI, or stroke) Malaise/symptoms of fatigue Current or past alcohol or substance abuse Screen high-risk persons through clinical interview, psychosocial history, validated screening tool ♦, and drug screen, if clinically indicated.	
	Diagnosis	Five or more of the following symptoms have been present during the same 2-week period and represent a change from previous functioning: at least one of the following symptoms is either (1) depressed mood or (2) loss of interest or pleasure. Do not include symptoms that are clearly due to general medical condition or secondary to the effects of medication or substance abuse/ dependence. <ul style="list-style-type: none"> Significant weight loss/gain Insomnia/hypersomnia Feelings of worthlessness Fatigue/loss of energy Psychomotor slowing/agitation Thoughts of suicide/death Impaired concentration/ Indecisiveness 	

♦ Examples of recommended validated screening tools include but are not limited to: PhQ-9, Beck Depression Inventory, HANDS, Zung, HAM-D, CESD, Whooley.

This guideline represents core management steps. Individual patient considerations and advances in medical science may supercede or modify these recommendations.

Individuals diagnosed with major depression	Screening for Suicide Risk	All persons with depression should be assessed for the risk of suicide by direct questioning about suicidal thinking, impulses, and personal/ family history of suicide attempts. Individuals who have been evaluated and identified as being at risk for suicide should be immediately directed to the appropriate level of care.	<ul style="list-style-type: none"> At each encounter addressing depression
	Non Pharmacological Treatment	<p>Treatment plans should be developed in conjunction with the patient. They should be individualized based on the patients' severity of signs and symptoms. The goals should be measurable and attainable. Support groups and other community resources should be utilized. Interpersonal, cognitive, and behavioral therapies have been shown to provide the most consistent benefits both acutely and in relapse prevention. It is strongly recommended that patients who have not responded to a trial of 6 sessions of psychotherapy should be evaluated for medication treatment.</p> <p>Discharge Planning: When the patient is stable provide education regarding symptom recurrence and create a relapse action plan.</p>	<ul style="list-style-type: none"> Weekly to bi-weekly and less frequently as symptoms improve Six to eighteen weeks
Individuals prescribed antidepressant medication for major depression	Pharmacological Treatment	<p>Acute Phase Initiate Antidepressant medication following manufacturer's recommended doses. (A) Use formulary antidepressant with which you are familiar. Monitor medication closely and adjust until a therapeutic dosage is attained. Medication should not be abruptly discontinued. (D) These visits are necessary to assess symptoms, effectiveness of treatment, and potential side effects.</p> <p>Continuation Phase to prevent symptom relapse Continue antidepressant medication to prevent relapse for a minimum of six months at effective dosage. (B)</p> <p>Maintenance Phase to prevent recurrence of depression Ongoing medication management for one year or longer at effective dosage. (B)</p>	<ul style="list-style-type: none"> Three office visits within the first 12 weeks following initiation of antidepressant medication, of which one visit must be with a prescribing physician (D)
Individuals diagnosed with major depression	Continuity and Coordination of Care	<p>With the member's consent, written communication with the PCP should occur throughout the course of treatment. This communication may include, but is not limited to:</p> <ul style="list-style-type: none"> Relevant information in the medical record Diagnosis and medications being prescribed Treatment plan and progress Discharge and relapse action plan Follow-up visit within 7 days post discharge after hospitalization 	<ul style="list-style-type: none"> Ongoing

Health Plans currently monitor compliance to these components through HEDIS and other review method.

Levels of Evidence for the most significant recommendations: A= randomized controlled trails; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

References: (1) Agency for Health Care Policy and Research (AHCPR) Clinical Practice Guideline: Depression in Primary Care
(2) "Diagnostic and Statistical Manual for Mental Disorders – IV-TR "Publication of the American Psychiatric Association for Mental Disorders"

This guideline represents core management steps. Individual patient considerations and advances in medical science may supercede or modify these recommendations.