



Clinical Practice Guideline 2008 Key Points

Adult Depression

Highmark Behavioral Health Clinical Quality Improvement Committee

Reviewed by the Mountain State Blue Cross Blue Shield Medical Advisory Committees

Mountain State Blue Cross Blue Shield (MSBCBS), in accordance with its commitment to quality care and in conjunction with the Highmark Blue Cross Blue Shield (HBCBS), the Highmark Behavioral Health Quality Improvement Committee,, consisting of network Primary Care Physicians and Specialists, has adopted the **MacArthur Tools for Managing Depression** as an aid to primary care physicians in caring for patients who suffer from depression. The care management process set forth in the MacArthur Tools builds on the Agency for Healthcare Research and Quality (formerly Agency for Health Care Policy and Research) guidelines^{1,2} and other evidence-based sources. The committee also adopted the **American Psychiatric Association (APA) Clinical Practice Guideline for the Treatment of Patients with Major Depression**. This practice guideline is a more extensive guide intended to assist Psychiatrists in the management of adult patients suffering from major depressive disorder.

Selected Clinical Resources and Guidelines

These resources are available on the following World Wide Web sites:

- <http://www.depression-primarycare.org/clinicians/toolkits/full/>
- http://www.psych.org/psych_pract/treatg/pg/MDD2e_05-15-06.pdf

Additional Practitioner and Member References and Resources

- To access the **Behavioral Health Unit** for information regarding behavioral health benefits, levels of care available to members, or care and case management services, call 1-800-344-5245.

¹ AHCPR Depression Guideline Panel. Depression in Primary Care: Volume 1. Detection and Diagnosis of Dpression Clinical Practice Guideline, Number 5. Rockville, MD. US Department of Health and Human Services, Public Health Service, Agency for Healthcare Policy and Research. 1993.

² AHCPR Depression Guideline Panel. Depression in Primary Care: Volume 2. Detection and Diagnosis of Dpression Clinical Practice Guideline, Number 5. Rockville, MD. US Department of Health and Human Services, Public Health Service, Agency for Healthcare Policy and Research. 1993.

KEY POINTS		PCP Consider Psychiatric or Behavioral Health Consult
<ul style="list-style-type: none"> ▪ Some flexibility in specific cases will require deviations from guideline recommendations ▪ All providers are responsible for individualizing recommendations to the specific clinical characteristics of each patient 		
Evaluation	<p>Screen all patients with two-question depression screen (U.S. Preventive Services Task Force): "Over the past two weeks,</p> <ul style="list-style-type: none"> • Have you felt down, depressed, irritable, or hopeless? • Have you felt little interest or pleasure in doing things?" <p>Perform mental health evaluation if patient answers "yes" to either question. Use a standard evaluation tool such as the Patient Health Questionnaire (PHQ)-9 for adults under age 65 or the Geriatric Depression Scale (GDS) for those ages 65 or older.</p>	
Diagnosis	<ol style="list-style-type: none"> 1. Accurately establish a diagnosis (please refer to DSM-IV-TR) <ol style="list-style-type: none"> a. Major Depressive Disorder b. Bipolar Disorder----- c. Dysthymia d. Adjustment Disorder with Depressed Mood 2. Determine the severity of symptoms 3. Evaluate the risk of suicide or harm³----- 4. Determine family history of psychiatric illness⁴----- 5. Determine past history of illness and response to treatment 6. Determine presence of co-morbid physical or mental illnesses⁵----- <ul style="list-style-type: none"> • Prior to initiating an antidepressant medication, review patients symptoms and family history for Bipolar Disorder 7. Determine functional impairment 	<p>X</p> <p>X</p> <p>X</p> <p>X</p>
Treatment	<ol style="list-style-type: none"> 1. Discuss treatment alternatives, benefits and risks, with the patient and family (Please note FDA Antidepressant Medication Warning) 2. Determine and implement a treatment plan <ol style="list-style-type: none"> a. Medication with Patient Management----- <ul style="list-style-type: none"> • If positive for Bipolar Disorder, establish a mood stabilizer first • If medication is prescribed, monitor closely, and be alerted to the FDA warning regarding antidepressants and suicide b. Psychotherapy can be considered at all phases c. Integrated Psychotherapy/Medication Management⁶----- d. Split Psychotherapy/Medication e. Consultation (psychiatrist or mental health professional) f. Secure support services g. Referral for inpatient or intermediate care (partial hospitalization or IOP) 	<p>X</p> <p>X</p>
Follow-Up and Re-Evaluation	<ol style="list-style-type: none"> 1. Communicate treatment plan to PCP/psychotherapist/psychiatrist 2. See the patient at least three times during the 12- week acute treatment phase to assess progress, reevaluate the risk of harm and the presence of co-morbid conditions. 3. Communicate treatment status to PCP/psychotherapist/psychiatrist 4. If not substantially recovered at 12 weeks and not on medication managed by a psychiatrist, consider a psychiatric referral.⁷----- 5. Monitor patient for relapse for an additional twelve weeks, continuing antidepressant medication. 6. Educate the patient and family on the risk recurrence and establish a recurrence prevention plan. 7. Document all evaluation and treatment visits with the patient and family in the medical record. 	<p>X</p>

As with any insurance, members are eligible for services only as long as they are active members of the plan and the services are covered benefits of their group or direct pay contract.

³ Consider a consult with a psychiatrist or mental health practitioner with the presence of any suicidal ideation or behaviors. The danger of suicidal signs can be difficult to assess.

⁴ Consider a psychiatric consult first if patient/family members have ever suffered an attack of mania (fast, pressured speech; euphoria; grandiose feelings, impulsivity, hyperactivity, staying up and active much of the night; excessive sexual behavior). Placing patient on an anti-depressant alone could risk mania.

⁵ Depression may be a precursor to, comorbid with, or the result of a medical condition. Behavioral Health practitioners will help patients adapt to catastrophic illness, chronic disorders such as diabetes, pain, Alzheimer's etc., assess suicidal risks and aid in compliance and decision making.

⁶ A Mental Health practitioner can address psychosocial stressors through psychotherapy which will help monitor a potentially unstable emotional state, help patient learn how thinking styles can sustain or improve depression, learn how to cope better with the difficult stressors, and involves the family and social network in the patient's care.

⁷ Psychiatric consultation may be indicated based on the patient's level/type of response under the following circumstances; the patient has not responded to adequate trials of two antidepressants taken 6 to 8 weeks each, a partial response to one medication at a maximal dose or there is a good response to the antidepressant but side effects are excessive.