Depression Screening

Screening is recommended for adults when staff-assisted care supports are in place to assure accurate diagnosis, effective treatment, and follow-up. (USPSTF - Grade: B\(^a\))

Adults should not be screened for depression when staff-assisted care supports are not in place. There may be considerations that support screening for depression in an individual patient. (USPSTF - Grade: C\(^b\))

The PHQ9\(^c\) or PHQ2 is recommended for depression screening. (Strong recommendation)

First-Line Treatment

Antidepressant medication or referral to behavioral health clinicians for evidence-based psychotherapy\(^d\) are recommended as first-line treatment in patients with mild to moderate major depressive disorder (MDD). (Weak recommendation)

1. Given the lack of evidence on a clearly superior approach for mild to moderate MDD, clinicians may base treatment decisions on patient and clinician preference, potential side effects, and cost. (Weak recommendation)

The combination of antidepressants and referral to behavioral health for evidence-based psychotherapy is recommended as first-line treatment for patients with severe or chronic MDD. (Strong recommendation)

First-line antidepressant use

1. Any class of antidepressant (SSRI\(^e\), TCA\(^f\), SNRI\(^g\), NRI\(^h\), or DA\(^i\)) is recommended for first-line treatment of MDD. (Strong recommendation)

2. Given the equivalence of therapeutic effect, clinicians may base the choice of antidepressant on patients’ prior response, patient and clinician preference, potential side effects, and cost. (Weak recommendation)

Behavioral activation\(^j\) in the primary care setting is an option for patients with mild to moderate depression. (Weak recommendation)

Monitoring patients who are prescribed antidepressants for signs of new or worsening suicidal ideation is recommended. (Strong recommendation)

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\(^a\) Grade B definition: The USPSTF recommends that clinicians provide [the service] to eligible patients. The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.

\(^b\) Grade C definition: The USPSTF notes that clinicians may provide this service to selected patients depending on individual circumstances. However, for most individuals without signs or symptoms there is likely to be only a small benefit from this service.

\(^c\) The PHQ9 is recommended as the preferred diagnosis and tracking instrument.

\(^d\) Evidence-based psychotherapy can include Interpersonal Therapy, Cognitive Behavioral Therapy (CBT), or Problem-Solving Therapy.

\(^e\) SSRI: Selective Serotonin Reuptake Inhibitor.

\(^f\) TCA: Tricyclic Antidepressant.

\(^g\) SNRI: Serotonin–Norepinephrine Reuptake Inhibitor.

\(^h\) NRI: Norepinephrine Reuptake Inhibitor.

\(^i\) DA: Dopamine Agonist.

\(^j\) Behavioral activation is a discrete, time-limited, structured psychological intervention, derived from the behavioral model of affective disorders.
1. Consultation or collaboration with a psychiatrist before prescribing TCAs or venlafaxine for patients with suicidal ideation or who have made previous suicide attempts is an option. (Weak recommendation)

2. Consultation with specialty behavioral health for patients with MDD who are expressing suicidal intent or plan is an option. (Strong recommendation)

Atypical antipsychotics are not recommended as first-line treatment for (non-psychotic) MDD. (Strong recommendation)

**Pregnancy and Breastfeeding**

The recommendations for depression treatment in pregnancy and breastfeeding are currently under review.

**Second-Line Treatment**

Assessing adherence to the initial treatment regimen for patients with MDD whose symptoms fail to remit after first-line treatment is recommended. (Strong recommendation)

For patients with MDD whose symptoms fail to remit after adherence to first-line treatment, recommended alternatives include

1. Combine antidepressant and psychotherapy. (Strong recommendation)
2. Increase the dose of the initial antidepressant. (Strong recommendation)
3. Switch to a different antidepressant of the same or different class. (Strong recommendation)
4. Switch from psychotherapy to antidepressants or antidepressants to psychotherapy. (Strong recommendation)
5. Combine pharmacologic treatment (monitoring for toxicity, side effects and drug interactions) with SSRIs and
   1. Low-dose TCAs
   2. Bupropion
   3. Mirtazapine
   4. Lithium. (Strong recommendation)

Consulting psychiatry before prescribing atypical antipsychotics for MDD is recommended. (Strong recommendation)

Augmentation with pindolol for patients with MDD whose symptoms fail to remit after adherence to first-line treatment is not recommended. (Strong recommendation)

Benzodiazepines for depression treatment augmentation or antidepressant side-effect management are not generally recommended. (Weak recommendation)

**Adjunctive Treatment Strategies**

Exercise as an adjunctive strategy (in addition to antidepressants or psychotherapy) for treating MDD is recommended. (Strong recommendation)

Internet patient cognitive-behavioral therapy (CBT) self-help programs as an adjunct strategy (in addition to antidepressants or psychotherapy) for treating MDD is an option. (Weak recommendation)

Selected bibliotherapy as an adjunct strategy (in addition to antidepressants or psychotherapy) for treating MDD is an option. (Weak recommendation)

Behavioral health education classes as an adjunctive treatment option for patients with mild to moderate MDD is recommended. However, these classes should not be used in lieu of either antidepressant medication or psychotherapy. (Strong recommendation)

Light therapy as a primary or adjunctive treatment for non-seasonal forms of MDD is not generally recommended. (Weak recommendation)

**Long-Term Treatment, Monitoring, and Follow-up**

The PHQ9 is recommended to monitor outcomes of care over time. (Strong recommendation)

For patients who are starting treatment with antidepressants for MDD, a minimum follow-up of one patient contact within the first month, and at least one additional patient contact four to eight weeks after the first contact is recommended. Assessing for adherence, side effects, suicidal ideation, and patient response

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*Bibliotherapy (e.g., reading therapy, self-help books therapy) is the use of books to help people understand mental health conditions.*
during both these visits is recommended.  
(Strong recommendation)

After achieving symptom remission, at least one follow-up contact during the fifth or sixth month of treatment in patients with MDD is recommended. Assessing for continuing symptom remission and dosage/treatment adjustment during this contact is recommended.  
(Strong recommendation)

For asymptomatic patients with MDD who are continuing on antidepressants beyond 12 months:

1. At least one annual follow-up contact to assess for continuing symptom remission, the need for ongoing treatment, and dosage/treatment adjustment is an option.  
(Weak recommendation)

2. Additional follow-up should be based on patient preference and response.  
(Weak recommendation)

Continuing antidepressants at the same dose for at least an additional six to 12 months for patients with MDD who achieve symptom remission with antidepressants is recommended.  
(Strong recommendation)

Based on patient and provider preference, a trial of antidepressant discontinuation is an option for patients in their first lifetime episode of MDD, who are being treated with antidepressants, achieve remission, and remain asymptomatic for six to 12 months after acute phase treatment.  
(Weak recommendation)

For patients with two or more lifetime episodes of MDD, who are being treated with antidepressants and remain asymptomatic after acute phase treatment, maintenance on the medication and dose with which they achieved remission for at least an additional 15 months to five years after acute phase treatment is recommended.  
(Strong recommendation)

For patients with chronic MDD (e.g., continual symptoms for more than two years) or double depression (MDD and persistent depressive disorder) who improve with antidepressants during acute phase treatment, continuing antidepressants for at least an additional 15 to 28 months after acute phase treatment is recommended.  
(Strong recommendation)

Cognitive behavioral therapy (CBT) is recommended to decrease the risk of relapse in patients with depression who achieve symptom remission and are considered to be at increased risk of relapse who are unable or choose not to take or continue antidepressants  
(Strong recommendation)

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1 “Dysthymia” was replaced with “persistent depressive disorder” following the 2013 publication of the DSM-5.