Depression Practice Guidelines

Sources:


Diagnosis

- Complete history and physical, including:
  - History of the present illness and current symptoms
  - Psychiatric history, including symptoms of mania, current and past treatments (including duration and dosages), and responses to treatment
  - General medical history
  - Medications, including prescribed and over-the-counter agents and supplements
  - History of substance use and treatment for substance use disorders
  - Personal history (e.g., psychological development, response to life transitions, major life events)
  - Social, occupational, and family histories
  - Review of the patient's prescribed and over-the-counter medications
  - Review of systems
  - Mental status examination
  - Perform diagnostic tests as indicated to rule out general medical causes of depressive symptoms

- Screen for depression using a validated screening tool (such as the Patient Health Questionnaire PHQ-2 or PHQ-9). PHQ-9 has evidence that it can help predict suicide attempts.
  - A validated tool for assessing postpartum depression is the Edinburgh Postnatal Depression Scale.

- For positive Depression screens proceed to a formal evaluation

- Formal Evaluation - Assess if criteria for major depression are met using Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-5):
  - At least five 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 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 mood-congruent delusions or hallucinations)
  - Depressed mood most of the day, nearly every day as indicated either by subjective report (e.g. feels sad or empty) or observation made by others (e.g. appears tearful) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
  - Significant weight loss when not dieting or weight gain (e.g. a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day
  - Insomnia or hypersomnia nearly every day
  - Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
  - Fatigue or loss of energy nearly every day
  - Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
  - Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide

- Regarding bereavement, sadness with some mild depressive symptoms in the face of loss should not necessarily be viewed as major depression.
  - In grief, painful feelings come in waves, often intermixed with positive memories of the deceased; in depression, mood and ideation are almost constantly negative.
  - In grief, self-esteem is usually preserved; in MDD, corrosive feelings of worthlessness and self-loathing are common.
  - However, evidence does not support the separation of loss of a loved one from other stressors in terms of its likelihood of precipitating a major depressive episode or the relative likelihood that the symptoms will remit spontaneously.

- Evaluate the safety of patient and others

  NOTE: Patients with major depressive disorder are at greater risk for suicide. Suicide risk should be assessed initially and over the course of treatment. If the patient has suicide ideation, intention or a plan, close surveillance is necessary. Referral to Emergency services or hospitalization may be indicated.

- Components of an Evaluation for Suicide Risk:
  - Presence of suicidal or homicidal ideation, intent or plans
  - Access to means for suicide and the lethality of those means
  - Presence of psychotic symptoms, command hallucinations, or poor reality testing
  - Presence of severe anxiety, panic attacks, agitation, and/or impulsivity
  - Presence of alcohol or substance abuse
  - History and seriousness of previous attempts
  - Family history of or recent exposure to suicide
  - History of and risk for violence to others
  - History of or recent exposure to suicide.
  - Presence of chronic or debilitating medical co-morbidities
  - Influence of gender
  - Influence of age
  - Uncontrolled panic attacks and/or insomnia

- Evaluate functional impairments, including:
  - Patient’s ability to care for dependents
  - Impairments in domains such as work, school, family, social relationships, leisure activities, and maintenance of health and hygiene.

- Primary care healthcare providers should screen for depression in adults and adolescents
Treatment

- Determine a treatment setting
- Determine the least restrictive setting that will be most likely to address safety and promote improvement in the patient's condition.
- Consider the patient's clinical condition, including symptom severity, co-occurring psychiatric or general medical conditions, and level of functioning, available support systems; and ability to adequately care for self, provide reliable feedback to the psychiatrist, and cooperate with treatment.
- Reevaluate optimal setting on an ongoing basis.
- Consider hospitalization if the patient:
  - poses serious threat of harm to self or others (involuntary hospitalization may be necessary if patient refuses);
  - is severely ill and lacks adequate social supports (alternatively, intensive day treatment may be appropriate);
  - has certain co-occurring psychiatric or general medical conditions; or
  - has not responded adequately to outpatient treatment.
- Establish and maintain a therapeutic alliance
- Monitor the patient’s psychiatric status and safety
- Assess for psychosocial stressors
- Provide education to the patient and, when appropriate, to the family
- Enhance treatment adherence
- Work with the patient to address early signs of relapse

Medication

- Tricyclics and tetracyclics
  - Tertiary amine tricyclics
    - Amitriptyline
    - Clomipramine
    - Doxepin
    - Imipramine
    - Trimipramine
  - Secondary amine tricyclics
    - Desipramine
    - Nortriptyline
    - Protriptyline
  - Tetracyclics
    - Amoxapine
    - Maprotiline
- SSRIs
  - Citalopram
  - Fluoxetine
  - Fluvoxamine
- Paroxetine
- Serataline
- Escitalopram

- **Dopamine-norepinephrine reuptake inhibitors**
  - Bupropion
  - Bupropion, sustained release

- **Serotonin-norepinephrine reuptake inhibitors**
  - Venlafaxine
  - Venlafaxine, extended release
  - Duloxetine
  - Desvenlafaxine (noted to be safe for patients with Liver impairment)
  - Viibryd (Vilazodone)

- **Serotonin modulators**
  - Trazodone
  - Oleptro

- **Norepinephrine-serotonin modulator**
  - Mirtazapine

- **MAOIs**
  - Selegiline
  - Phenelzine
  - Tranycypromine
  - Moclobemide

- **Selective noradrenaline reuptake inhibitor**

**Augmentation** - The use of Augmentation medications is supported in clinical research. For example: FDA has approved Abilify and Seroquel in the treatment of depression. Lithium has been an effective augmentation treatment for Unipolar Depression.

Monitor medication frequently and adjust to a therapeutic level as assessed by clinical data. If no response after 2-3 weeks on therapeutic dosage, increase dosage as tolerated, and begin new observation period. If no response after 2-3 weeks on maximal dosage, then antidepressant should be switched. If partial response after 2-3 weeks on maximal dosage, antidepressant should be changed or augmented with an additional agent.

**Factors to Consider in Choosing a First-Line Anti-Depressant Medication**

1. Anticipated side effects and their safety or tolerability
2. History of prior response in patient or family member
3. Patient preference
4. Cost
5. Pregnancy and breast-feeding status
6. Quantity and quality of clinical trial data

7. MAOIs: generally reserve for patients who do not respond to other treatments – dietary restrictions are a consideration

8. SSRIs or MAOIs: consider for patients with atypical symptoms

- Carefully monitor the patient's response to treatment, including
  - symptomatic status, including functional status and quality of life;
  - degree of danger to self and others;
  - signs of "switch" to mania;
  - other mental disorders, including alcohol and other substance use disorders;
  - general medical conditions;
  - side effects of treatment; and
  - adherence to treatment plan.

Often family members or caregivers notice changes in the status of the patient first and are therefore able to provide valuable input.

- Physical activity is also useful in easing symptoms of Major Depression.
  - Anticipate barriers – hopelessness and fatigue make physical exertion difficult
  - Keep expectations realistic (to reduce guilt and self-blame if they fail to carry out the regimen)
  - Introduce a feasible plan such as walking, alone or in a group
  - Choice of exercise should be guided by the patient's preferences
  - A goal of 30 minutes of moderate to intense aerobic activity, three to five days a week, is recommended for most otherwise healthy adults

- For psychotherapy treatment, 8-10 weeks of regular therapy may be required to show improvement
  - Cognitive behavioral therapy can reduce risk of relapse by helping patients with depression-related beliefs
  - Focused psychotherapy can significantly reduce patient symptoms and help to restore psychosocial and occupational functioning

- Acute Phase
  - Choice of an initial treatment modality
    1. Antidepressant medications
    2. Psychotherapy
    3. Psychotherapy plus antidepressant medications
    4. Electroconvulsive therapy
      - Factors that may suggest that a given patient is a candidate for ECT:
        - May be treatment of choice for depression with psychosis in pregnant patients
        - Geriatric depression especially with cachexia
        - Antidepressants have not been tolerated or pose a significant medical risk
        - Antidepressant medication trials have not been successful
        - ECT has been successful in previous episodes
- Catatonia is present
- When a rapid response is needed due to severe suicide risk or because the patient’s health has been significantly compromised by the depression (ie/severe cachexia)
  - Choice of specific pharmacologic treatment

- **Enhance treatment adherence.**
  - Assess potential barriers to treatment adherence—for example, lack of motivation or excessive pessimism due to depression; side effects of treatment; problems in the therapeutic relationship; and logistical, economic, or cultural barriers to treatment.
  - Collaborate with the patient (and, if possible, the family) to minimize barriers.
  - Encourage the patient to articulate concerns about treatment or its side effects, and consider the patient's preferences when developing or modifying the treatment plan.
  - Recognize that during the acute phase, depressed patients may be poorly motivated and unduly pessimistic and may suffer deficits of memory. During the maintenance phase, euthymic patients may undervalue the benefits and focus on the burdens of treatment.

- **Continuation Phase**
  - During the 16-36 weeks following remission, patients who have been treated with antidepressant medication in the acute phase should be maintained with these agents to prevent relapse.
  - Frequency of visits must be determined by the patient’s clinical condition as well as the specific treatments being provided.
  - If treatment is discontinued, patients should be monitored for relapse, and treatment should be promptly reinstated if relapse occurs.

- **Maintenance Phase**
  - Maintenance phase should be considered for patients to prevent recurrences of major depressive episodes.
  - In general, treatment that was effective in the acute and continuation phases should be used in the maintenance phase.
  - Frequency of visits may vary.
  - Optimal length of maintenance therapy varies depending on frequency and severity of recurrences, tolerability of treatments, and patient preferences.
  - Patients with recurrent Major Depression usually require lifelong treatment. Medications should be continued for 9-12 months after acute symptoms resolve.

- **Discontinuation of Active Treatment**
  - Decision to discontinue maintenance treatment should be based on the same factors considered in the decision to initiate maintenance treatment including the:
    - probability of recurrence
    - frequency and severity of past episodes
    - persistence of depressive/dysthymic symptoms after recovery
    - presence of co-morbid disorders
    - patient preferences
  - When the decision is made to discontinue maintenance pharmacotherapy, it is best to taper the medication over the course of at least several weeks.
  - After the discontinuation of active treatment, patients should be reminded of the potential for a depressive relapse. Early signs should be reviewed, and a plan for seeking treatment in the event of a recurrence of symptoms should be established.

Women who are thinking about becoming pregnant should discuss with their doctors the risks and benefits of continuing with antidepressant medication and whether any changes should be made to their drug regimens.

Use of Light Therapy is recommended for the treatment of Major Depression when a seasonal specifier is well established.
### Risk Factors for Recurrence of Major Depressive Disorder

- Prior history of multiple episodes of major depressive disorder
- Persistence of dysthymic symptoms after recovery from an episode of major depressive disorder
- Presence of an additional non-affective psychiatric diagnosis
- Presence of a chronic general medical disorder

### Specific Clinical Features Influencing the Treatment Plan

#### Psychiatric Features
- Suicide Risk
- Psychotic Features
- Catatonic Features
- Atypical Features
- Alcohol or substance abuse or dependence
- Comorbid panic or other anxiety disorder
- Major depressive disorder-related cognitive dysfunction (pseudodementia)
- Dysthymia
- Comorbid personality disorders
- Seasonal major depressive disorder

#### Demographic and Psychosocial Variables
- Major psychosocial stressors
- Bereavement
- Family distress
- Cultural factors
- Children and adolescents
- Older age
- Gender and pregnancy
- Family history

#### Treatment Implications of Concurrent General Medical Disorders
- Asthma
- Cardiac Disease
- Dementia
- Epilepsy
- Glaucoma
- Hypertension
- Obstructive Uropathy
- Parkinson’s disease
### Education

- Actively engage the patient and, where possible, his/her family participation in self-management.
- Use language that is easily understood by the patient.
  - Provide education regarding:
    - Nature of the disease with emphasis on the point that depression is a medical illness, not a character defect.
    - Clarify common misperceptions about the illness (e.g., depression is not a real illness) and about treatment (e.g., antidepressants are addictive).
    - Educate about the need for a full course of treatment, the risk of relapse, early recognition of recurrent symptoms, and the importance of obtaining treatment early.
    - Patient education should also include general promotion of healthy behaviors such as exercise, good sleep hygiene, good nutrition, and decreased use of tobacco, alcohol, and other potentially deleterious substances
    - Risks/benefits of treatment options
    - Medication dose, duration, type, and side effects.
      - Emphasize when and how to take medications
      - The typical 2-4 week lag before beneficial effects are noticed
      - The need to continue medication even after feeling better
      - Potential side effects and potential treatments for side effects
      - The need to consult with the prescribing physician before discontinuing medications.
      - The need to taper antidepressants when they are being discontinued.
    - Importance of adherence to medications and psychotherapy appointments.
    - Prognosis
      - Treatment is effective for most people.
    - Relapse prevention.

### Treatment Goals/Objectives

- Achieve remission of symptoms.
- Reduce relapse.
- Decrease risk of suicide.
- Reduce need for hospitalization.
- Reduce side effects of treatment.
- Return patient to their previous levels of occupational and psychosocial functioning.
  - It is not uncommon for patients to have a substantial but incomplete response in terms of symptom reduction or improvement in functioning during acute phase treatment.
  - It is important not to conclude the acute phase of treatment for such patients, as partial response is often associated with poor functional outcomes.
  - Identifying patients who have not had a complete response to treatment and formally assessing the extent to which patients have returned to their baseline may be aided by the use of structured measures of depression symptom severity and functional status.
  - When patients are found to have not fully responded to an acute phase treatment, a change in treatment should be considered.
Performance Measurement

Health Integrated utilizes population-based and/or outcomes performance measurements to evaluate practitioner adherence or performance against the depression guideline at least annually through use of the following HEDIS® measures:

- Anti-depressant medication management (AMM) - acute and continuation phase

Health Integrated collaborates with health plan clients, as applicable, on the collection and reporting of HEDIS measures.

This guideline summary is not intended to replace a clinician’s judgment or to establish a protocol for all patients with a particular condition. Some patients will not fit the conditions contemplated by a guideline; moreover, a guideline will rarely establish the only appropriate approach to a problem. The guideline is intended to assist clinicians by providing a framework, based on evidence-based research, for evaluation and treatment of certain behavioral health and medical conditions.