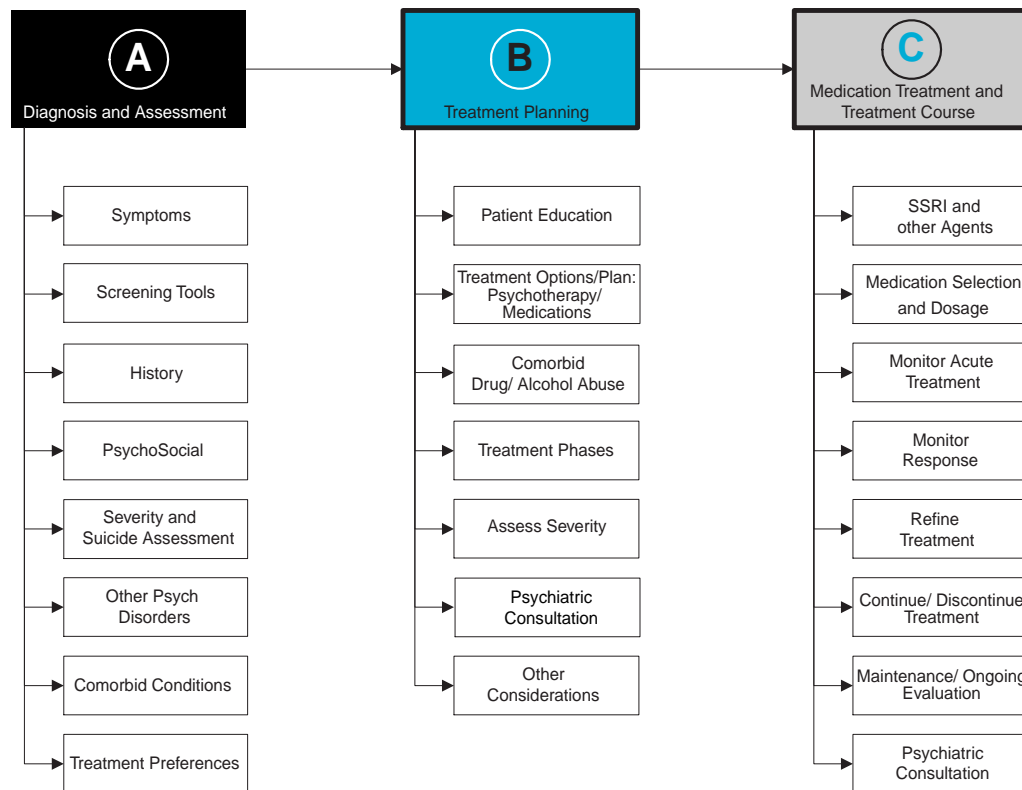


# Major Depression Disorder in Adults

## Diagnosis & Treatment Guidelines

### Overview

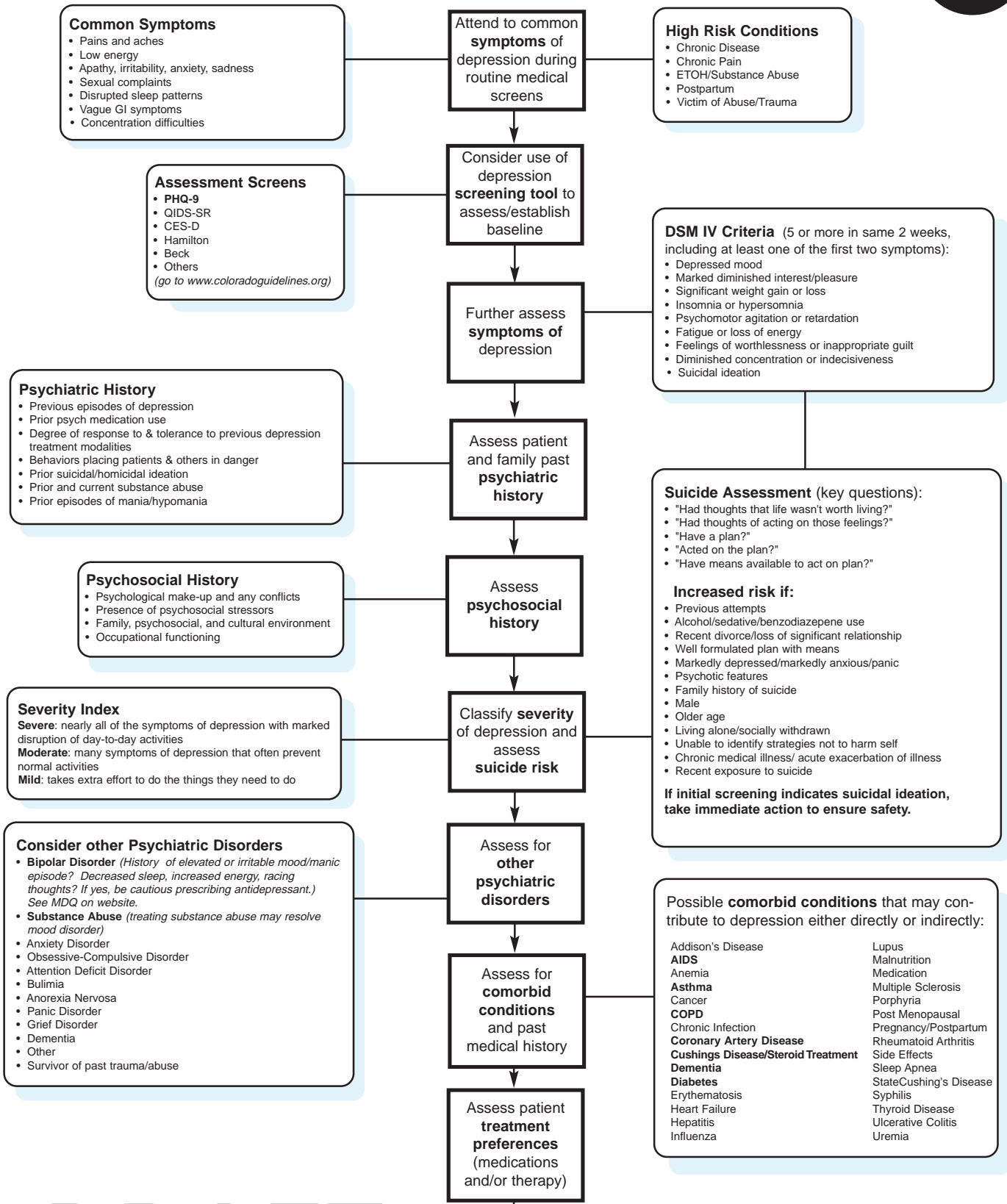
Overview .....1  
A. Diagnosis and Assessment .....2  
B. Treatment Planning .....3  
C. Medication Treatment and Treatment Course .....4  
Appendix 1. Antidepressant Classification and Dosages for Adults .....5  
Appendix 2. Adult Depression Screening Tools Comparison .....6  
Treatment Tracking Log for Patient Chart .....7  
Appendix 3. Treatment of special populations: Seniors, Adolescents/Children,  
and Pregnant Women: .....Go to www.coloradoguidelines.org for web links  
Appendix 4. Patient Self-care materials: .....Go to www.coloradoguidelines.org for web links  
Appendix 5. Screening tools (PHQ-9, QIDS-SR, MDQ): .....Go to www.coloradoguidelines.org



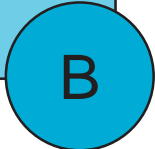
This guideline is designed to assist the clinician in the management of major depression. This guideline is not intended to replace a clinician's judgement or establish a protocol for all patients with a particular condition.

For references, medical record tracking forms and additional color copies of the guideline, go to [www.coloradoguidelines.org](http://www.coloradoguidelines.org) or call 720-297-1681 or 866-401-2092 (toll free).

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# Major Depression Disorder in Adults TREATMENT PLANNING



**Key Patient Education Tips:**

**General tips**

- Depression is a medical illness not a character defect or personal weakness.
- Treatments are effective and recovery is the rule, not the exception.
- Life stressors may trigger depression. The stressors may be resolved but the depression may continue without treatment.

**Medication tips**

- Antidepressants should be taken as prescribed, allowing 2 to 4 weeks before an effect is first noticed. Contact within one week may be useful to assess side effects or compliance.
- For best results, antidepressants should be continued even when starting to feel better. You should notify your doctor's office before discontinuing medications.
- Antidepressants are not addictive.

**Self care tips**

- Personal support and community resources may be useful in the treatment and recovery process.
- When remission has occurred, it is helpful to learn the early warning signs to prevent recurrence.
- Healthy lifestyle strategies may be useful in the recovery process, including exercise, hobbies, limiting alcohol intake, sleep hygiene, and good nutrition.

**Treatment and/or Referral Options:**

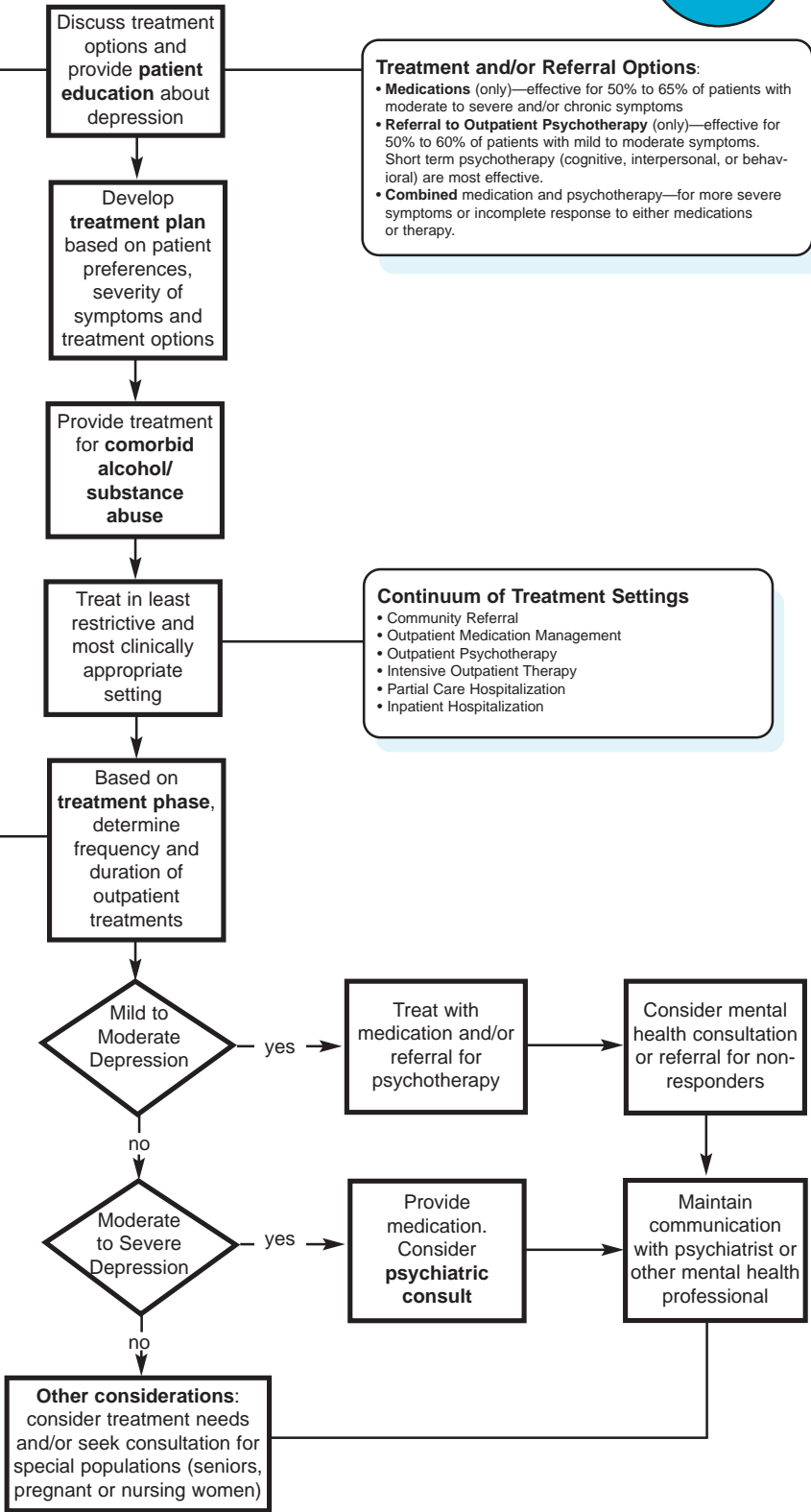
- **Medications (only)**—effective for 50% to 65% of patients with moderate to severe and/or chronic symptoms
- **Referral to Outpatient Psychotherapy (only)**—effective for 50% to 60% of patients with mild to moderate symptoms. Short term psychotherapy (cognitive, interpersonal, or behavioral) are most effective.
- **Combined medication and psychotherapy**—for more severe symptoms or incomplete response to either medications or therapy.

**Treatment phases**

- **Acute Phase**—aimed at symptom reduction in first 6 to 12 weeks. Initial follow-up appointment within 1 to 3 weeks, with additional follow-up appointment/ contact every 2 to 4 weeks as needed based on initial response.
- **Continuation Phase**—aimed at prevention of relapse for 4 to 9 months after initial symptom resolution. Medications continued at full dosage. Appointments every 2 to 3 months after remission of symptoms.
- **Maintenance Phase**—continued medication aimed at preventing recurrence past one year of onset for patients with prior episodes.
- Treat in least restrictive and most clinically appropriate setting.

**Continuum of Treatment Settings**

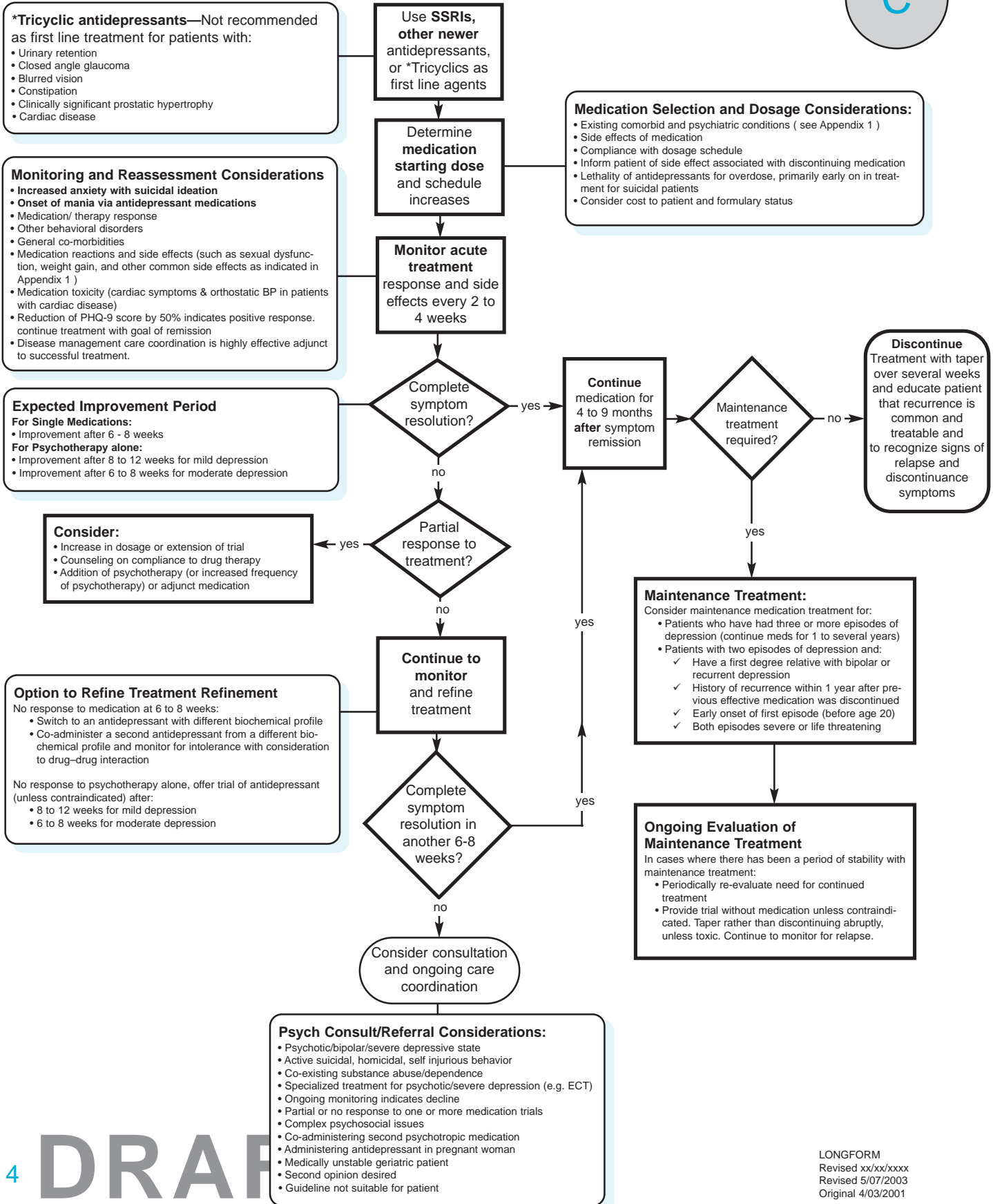
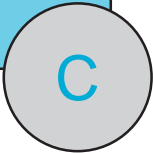
- Community Referral
- Outpatient Medication Management
- Outpatient Psychotherapy
- Intensive Outpatient Therapy
- Partial Care Hospitalization
- Inpatient Hospitalization



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# Major Depression Disorder in Adults **MEDICATION MANAGEMENT and TREATMENT COURSE**



# CCGC APPENDIX 1: Antidepressant Classification and Dosages for Adults

Category	FDA Black Box Warning Anti-depressants may increase the risk of suicidal thinking and behavior in adults and pediatric patients with major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of antidepressants must balance this risk with the clinical need. <b>Carefully monitor patients receiving anti-depressants for possible worsening of depression or suicidality, especially at the beginning of therapy or when the dose either increases or decreases.</b>	Remember to titrate up from <b>STARTING DOSE</b> after first 4-7 DAYS of treatment (except for Fluoxetine which may need to wait 3-4 weeks.)  See patient within 2-3 weeks for 1st follow-up visit. Contact within one week may be useful to assess side effects or adherence.	Relative Cost If one \$ present, generic is available	Adverse Side Effects ● 0 = absent or rare 4 = relatively common						Contra-indications (X = not recommended)							
				CNS		Cardiovascular		Other		Benign Prostatic Hypertrophy	Coronary Artery Disease	Glaucoma	Orthostatic Hypotension	Seizures	Eating Disorders	Suicidal Risk (overdose lethal)	
	Drug	Daily Starting Dosage ■	Usual Adult Dosage	ACh (Anticholinergic)	Sedation	Insomnia/Excitation	Orthostatic Hypotension	Cardiac Arrhythmia	Gastrointestinal Distress	Sexual Dysfunction	Weight Gain (>6kg)						
SSRIs	Citalopram (Celexa)	10-20 mg QAM	20-60 mg	0	2	2	0	0	3	1	*						
	Escitalopram (Lexapro)	10 mg QAM	10-20 mg	0	2	1	0	0	3	1	*						
	Fluoxetine (Prozac)	10-20 mg QAM	20-80 mg	0	1	3	0	0	3	2	*						
	Fluoxetine (Prozac weekly)	90 Qwk	90 mg	0	1	2	0	0	3	2	*						
	Fluvoxamine (Luvox) >	50 mg QHS	100-300 mg	0	2	2	0	0	3	1	*						
	Paroxetine (Paxil)	10-20 mg QAM	20-50 mg	0	2	2	0	0	3	3	*						
	Paroxetine (Paxil CR)	12.5-25 mg QAM	25-62.5 mg	0	1	2	0	0	2	3	*						
	Sertraline (Zoloft)	25-50 mg QAM	50-200 mg	0	2	2	0	0	3	2	*						
	Venlafaxine (Effexor)	25 mg BID-TID	150-375 mg	\$\$\$	1	1	2	0	1	3	2	0					X
	Venlafaxine (Effexor-XR)	37.5 mg QD	150-225 mg	\$\$\$	1	1	2	0	1	3	2	0					X
SNRIs	Duloxetine (Cymbalta)	20 mg BID	60 mg	\$\$\$	1	1	0	0	3	2	0					X	X
	Bupropion (Wellbutrin)	100 mg BID-TID	300-450 mg	\$ - \$\$\$	0	0	2	0	1	1	*					X	X
	Bupropion (Wellbutrin SR)	100 mg QD to 100 mg BID	150-200 mg BID	\$ - \$\$\$	0	0	2	0	1	0	*					X	X
	Bupropion (Wellbutrin XL)	150 mg	300-450 mg	\$\$\$	0	0	2	1	1	1	*					X	X
	Mirtazapine (Remeron or Remeron Sol-Tab)	15 mg QHS	15-45 mg	\$\$\$ - \$\$\$	1	4	~	0	0	0	1	3					
	Nefazodone (Serzone) ▲	100 mg QHS	300-600 mg	\$\$\$	1	2	~	0	0	1	1	*					
	Amitriptyline (Elavil)	25-75 mg QHS	100-300 mg	\$	4	4	0	4	3	1	~	4	X	X	X	X	X
	Amoxapine (Asendin) X	50 mg BID	100-400 mg	\$\$\$	2	2	2	2	2	0	~	2	X	X	X	X	X
	Clomipramine (Anafranil)	25-75 mg QHS	100-250 mg	\$\$\$	4	~	~	~	~	~	~	~	X	X	X	X	X
	Tricyclics and older agents	Desipramine (Norpramin)	25-75 mg QHS	100-300 mg	\$	1	1	1	2	2	0	~	1	X	X	X	X
Doxepin (Adapin, Sinequan)		25-75 mg QHS	100-300 mg	\$	3	4	0	2	2	0	~	4	X	X	X	X	X
Imipramine (Tofranil)		25-75 mg QHS	100-300 mg	\$	3	3	1	4	3	1	~	4	X	X	X	X	X
Maprotiline (Ludiomil)		25-75 mg QHS	100-225 mg	\$	2	3	0	2	2	0	~	2	X	X	X	X	X
Nortriptyline (Aventyl, Pamelor)		25-50 mg QHS	50-150 mg	\$	2	2	0	1	2	0	~	1	X	X	X	X	X
Protriptyline (Vivactil)		15 mg QAM	20-60 mg	\$	2	1	1	2	3	0	~	0	X	X	X	X	X
Trazodone (Desyrel)		50 mg QHS	150-600 mg	\$\$\$	1	4	0	3	1	1	~	2				X	X
Trimipramine (Surmontil)		25-75 mg QHS	100-300 mg	\$\$\$	4	4	0	3	3	0	~	4	X	X	X	X	X

■ Not intended for Seniors, Adolescents, and Children, Pregnant Women (go to [www.coloradoguidelines.com](http://www.coloradoguidelines.com) for web links addressing these populations).  
 > Luvox indicated for obsessive-compulsive disorder primarily and for depression secondarily only when other first line anti-depressant agents have failed.  
 \* Emerging (not yet conclusive) evidence suggests weight gain may be associated with these medications.  
 ● Since this list is NOT exhaustive, please refer to other references for additional side effects and drug interactions.  
 ▲ Black box warning of hepatic failure.  
 X Extra pyramidal side effects (EPS) including tardive dyskinesia (TD) possible.  
 ~ Insufficient data.

The sources used to compile these recommendations include: *Drug Facts and Comparisons (2006)*, *AHFS Drug Information (2006)*, *AHRQ Comparative Effectiveness of Pharmacologic Treatment of Depression, FDA package inserts, peer reviewed evidence and expert clinical opinion. Comparative relative incidence rates of adverse side effects were reviewed when available.*

## CCGC APPENDIX 2: Adult Depression Screening Tools Comparison

Screening Tool	Number of Items	Ease of Scoring	Administration considerations Can be administered by:			Clinical Considerations	
			Clinician	Office Staff	Can be Self-administered	Includes DSM-IV diagnostic criteria	Sensitive to change in severity
<b>PHQ-9*</b> Most highly recommended by CCGC committee	9	Easy	Yes	Yes	Yes	Yes	Yes
<b>Other Tools**</b>							
<b>QIDS – SR</b>	16	Moderate	Yes	Yes	Yes	No	Yes
<b>CES-D</b>	20	Easy	Yes	Yes	Yes	No	No
<b>Hamilton</b>	17	More difficult	Yes	Yes (in development)	No	No	Yes
<b>Beck Depression Inventory</b>	21	Easy	Yes	Untested	Yes	No	Yes

\* PHQ-9 has advantage of two pre-screening questions which, if negative, eliminate need to continue. It is also the only tool which can be used as a screening and diagnostic tool. (PHQ-9 is an outgrowth of Prime-MD). Go to [www.coloradoguidelines.org](http://www.coloradoguidelines.org) to download PHQ-9.

\*\* Other instruments in common use include the Zung, Mini Patient Health Survey, HANDS, Prime-MD, and others. These instruments may work well in the hands of health professionals with experience in their use, but are not recommended for those seeking a new instrument.

**Reminder:** These tools should be used in conjunction with a clinician's judgement before determining a diagnosis.

**For further information on how to access some of these tools, please visit the CCGC Website at: [www.coloradoguidelines.org](http://www.coloradoguidelines.org)**

# Treatment Tracking Log for Depression for Patient Chart

PATIENT NAME: \_\_\_\_\_

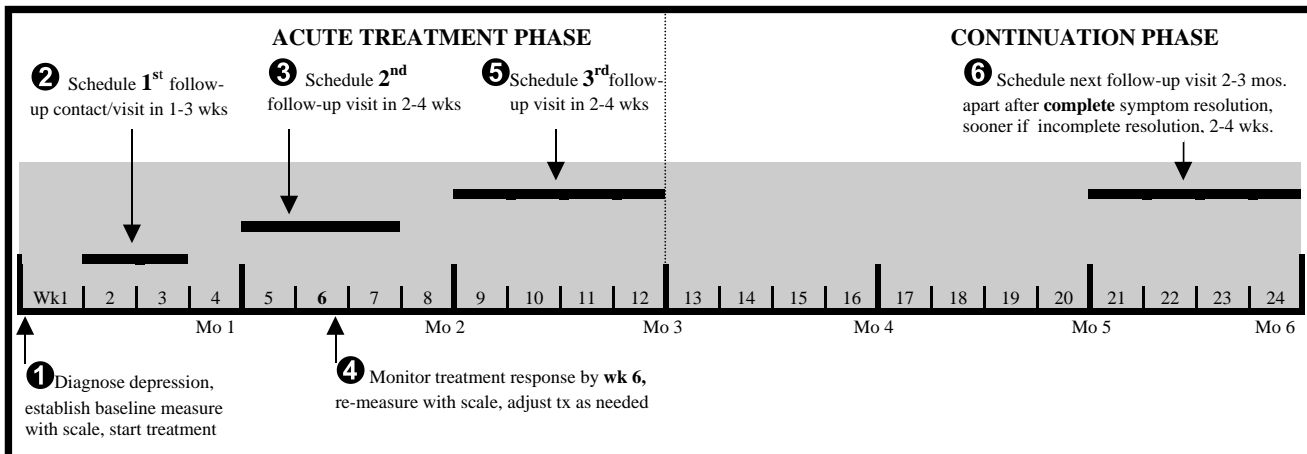
➤ **Outpatient Psychotherapist:** \_\_\_\_\_ Phone: \_\_\_\_\_  Release signed? /date \_\_\_\_\_  
 (if applicable)

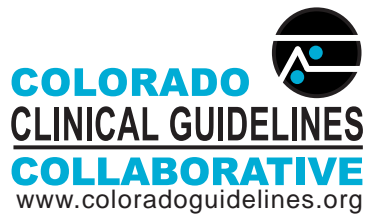
➤ **Outpatient Psychiatrist:** \_\_\_\_\_ Phone: \_\_\_\_\_  Release signed? /date \_\_\_\_\_  
 (if applicable)

<b>Date of Visit/ Contact/ (MD Initials)</b>						
<b>Assessment Type</b> V = Office Visit P = Phone						
<b>Treatment Stage</b> A = Acute (marked symptoms) C = Continuation (no symptoms) M = Maintenance (> 9 months) T = Medication taper						
<b>Depression Screen Score</b> (Instrument used: _____) and/or <b>PHQ – 9</b> two questions:						
“In the past two weeks, have you had...” ___ little interest or pleasure doing things (Y/N)	Y N	Y N	Y N	Y N	Y N	Y N
___ feeling down, depressed, hopeless, (Y/N)	Y N	Y N	Y N	Y N	Y N	Y N
<b>Follow-up Reminder Call (Y/N)</b>	Y N	Y N	Y N	Y N	Y N	Y N
<b>Mental Health Referral? (Y/N)</b>	Y N	Y N	Y N	Y N	Y N	Y N
<b>Medication (Y/N) / Medication start date</b>	Y N	Y N	Y N	Y N	Y N	Y N
<b>Medication / Dosage</b>						
<b>Medication Side Effects</b>						

**Patient Goals/Notes:**

- Notes:  Other Psychiatric Diagnosis  Tobacco Use  ETOH Abuse  Substance Abuse  
 Other Chronic Conditions  Pregnancy  Violence  \_\_\_\_\_





### **Mission Statement**

The Colorado Clinical Guidelines Collaborative is a coalition of health plans, physicians, hospitals, employers, government agencies, quality improvement organizations, and other entities working together to implement systems and processes, using evidence-based clinical guidelines, to improve healthcare in Colorado.

This guideline is designed to assist the clinician in the management of major depression. This guideline is not intended to replace a clinician's judgement or establish a protocol for all patients with a particular condition.

### **For questions or to order additional guidelines or tracking forms:**

Website: [www.coloradoguidelines.org](http://www.coloradoguidelines.org)

Email: [info@coloradoguidelines.org](mailto:info@coloradoguidelines.org)

Phone: 720-297-1681

866-401-2092 (toll free)

**274 Union Boulevard**

**Suite 310**

**Lakewood, CO 80228**

# Major Depression Disorder in Adults DIAGNOSIS & TREATMENT GUIDELINES

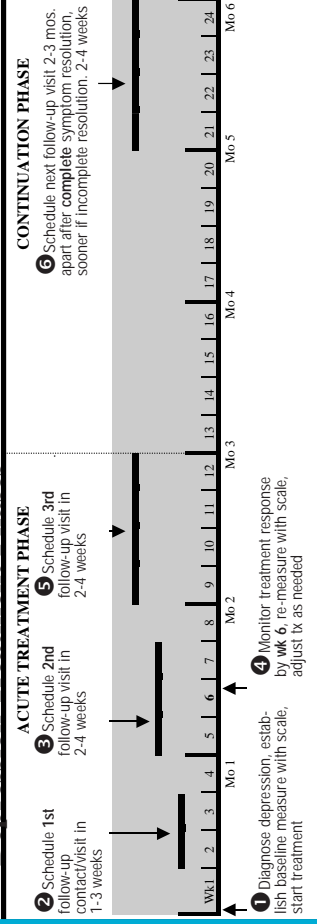


It is estimated that 10% of Americans (~26 million people) suffer from major depression and related mood disorders. Only one third to one-half of these patients are correctly diagnosed and treated initially, and up to 60% discontinue therapy before completing the recommended 6-month course. Inadequately treated depression creates a substantial social and emotional burden on both the patient and society, and costs billions of dollars per year in absenteeism and lost work productivity.

## 5 A's of Depression

- ASK all patients:**
  - In the past month, have you had little interest or pleasure in doing things?
  - In the past month, have you felt down, depressed, or hopeless?
- ASSESS severity of the depression using DSM-IV criteria (PHQ-9, QIDS and other tools may be helpful for this). Assess:**
  - Recent life events (Why is this an issue now?)
  - Personal history of depression or bipolar disorder
  - Family history of depression or bipolar disorder
  - Substance abuse
  - Risk of suicide (plans, attempts, recent exposure to suicide)
- ADVISE patient about:**
  - Treatment options
  - Possible side effects
  - Importance of compliance
- ASSIST patient by providing (as indicated):**
  - Patient education about depression and treatment
  - Counseling or referral to a practitioner at the appropriate level of care
  - A prescription for antidepressant medication
  - Crisis intervention
- ARRANGE follow-up care:**
  - Initially, within 1-3 weeks. Contact within one week may be helpful to assess side effects or compliance.
  - Then ongoing, to monitor success, failure or partial response

## Depression Treatment Phases



For references, medical record tracking forms and additional color copies of the guideline, go to [www.coloradoguidelines.org](http://www.coloradoguidelines.org) or call 720-297-1681 or 866-401-2092 (toll free).

SHORTFORM  
Revised 5/07/2003  
Original 4/03/2001

The sources used to compile these recommendations include: Drug Facts and Comparisons (2006), AHFS Drug Information (2006), AHRC Comparative Effectiveness of Pharmacologic Treatment of Depression, FDA package inserts, peer reviewed evidence and expert clinical opinion. Comparative relative incidence rates of adverse side effects were reviewed when available.

Not included for Seniors, Adolescents, and Children, Pregnant Women (go to [www.coloradoguidelines.com](http://www.coloradoguidelines.com) for web links addressing these populations). Luvox indicated for obsessive-compulsive disorder primarily and for depression secondarily only when other first line anti-depressant agents has failed. Since this list is NOT exhaustive, phase refer to other references for additional side effects and drug interactions. Extra pyramidal side effects (EPS) including tardive dyskinesia (TD) possible.

Antidepressants may increase the risk of suicidal thinking and behavior in adults and pediatric patients with major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of antidepressants must balance this risk with the clinical need. Carefully monitor patients receiving anti-depressants for possible worsening of depression or suicidality, especially at the beginning of therapy or when the dose either increases or decreases.

Category	Drug	Daily Starting Dosage	Usual Adult Dosage	Relative Cost	Adverse Side Effects		Contra-Indications
					CNS	Other	
SSRIs	Citalopram (Celexa)	10-20 mg QAM	20-60 mg	\$ - \$\$	0 2 2	0 3 1	
	Escitalopram (Lexapro)	10 mg QAM	10-20 mg	\$ - \$\$\$	0 1 3	0 0 3 1	
SNRIs	Fluoxetine (Prozac)	10-20 mg QAM	20-80 mg	\$ - \$\$\$	0 1 2	0 0 3 2	
	Fluvoxamine (Luvox)	90 Qwk	90 mg	\$ - \$\$\$	0 1 2	0 0 3 2	
Other agents	Paroxetine (Paxil CR)	10-20 mg QAM	20-50 mg	\$ - \$\$\$	0 2 2	0 0 3 3	
	Paroxetine (Paxil CR)	12.5-25 mg QAM	25-62.5 mg	\$ - \$\$\$	0 1 2	0 0 2 3	
Tricyclics and older agents	Sertraline (Zoloft)	25-50 mg QAM	50-200 mg	\$	0 2 2	0 0 3 2	
	Venlafaxine (Effexor)	25 mg BID-TID	150-375 mg	\$\$\$	1 1 2	0 1 3 2 0	
Other agents	Duloxetine (Cymbalta)	20 mg BID	60 mg	\$\$\$	1 1 2	0 0 3 2 0	
	Bupropion (Wellbutrin)	100 mg QD to 100 mg BID	150-200 mg BID	\$ - \$\$\$	0 0 2	0 1 1	
Tricyclics and older agents	Bupropion (Wellbutrin XL)	150 mg	300-450 mg	\$\$\$	0 0 2	1 1 1	
	Mirtazapine (Remeron or Remeron Sol-Tab)	15 mg QHS	15-45 mg	\$ - \$\$\$	1 4	0 0 1 3	
Tricyclics and older agents	Amitriptyline (Elavil)	25-75 mg QHS	100-300 mg	\$\$\$	4 4 0	4 3 1	
	Nortriptyline (Aventyl, Famelor)	25-50 mg QHS	50-150 mg	\$	2 2 0	1 2 0	
Tricyclics and older agents	Imipramine (Tofranil)	25-75 mg QHS	100-300 mg	\$	3 3 1	4 3 1	
	Maprotiline (Ludomil)	25-75 mg QHS	100-225 mg	\$	2 3 0	2 2 0	
Tricyclics and older agents	Desipramine (Norpramin)	25-75 mg QHS	100-300 mg	\$\$\$	4 1 1	2 2 0	
	Clomipramine (Anafranil)	25-75 mg QHS	100-250 mg	\$\$\$	4 1 1	- - -	
Tricyclics and older agents	Doxepin (Adapin, Sinequan)	25-75 mg QHS	100-300 mg	\$	3 4 0	2 2 0	
	Trimipramine (Surmontil)	25-75 mg QHS	100-300 mg	\$\$\$	4 4 0	4 3 1	
Tricyclics and older agents	Trazodone (Desyrel)	50 mg QHS	150-600 mg	\$\$\$	1 4 0	3 1 1	
	Protriptyline (Vivactil)	15 mg QAM	20-60 mg	\$	2 1 1	2 3 0	

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