

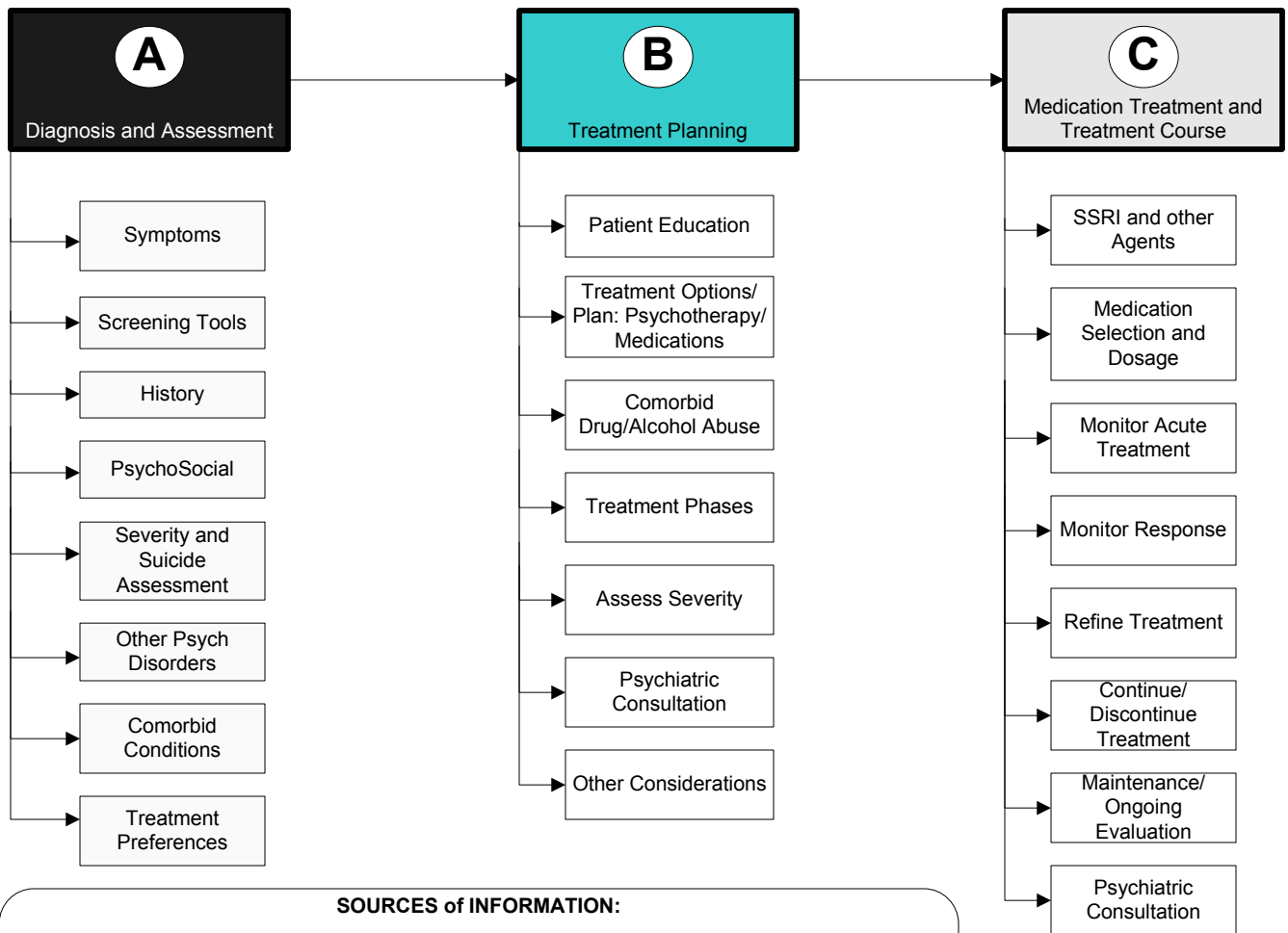


Major Depression Disorder in Adults

Diagnosis & Treatment Guidelines

Overview

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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



SOURCES of INFORMATION:

Depression in Primary Care, Clinical Practice Guideline, AHCPR, Agency for Health Care Policy and Research, U.S. Department of Health and Human Services, April 1993

Practice Guideline for Major Depressive Disorders in Adults, American Psychiatric Association, April 1993

Diagnosis and Treatment of Major Depressive Disorders in Adults, Rocky Mountain HMO Clinical Practice Guideline, 1998

Adoption and Approval

Adapted from the **Colorado Clinical Guideline Collaborative: Major Depression Disorder in Adults,** February 2001, with Organizational Contributors:

Colorado Access (Medicaid HMO), Mental Health Association of Colorado, Colorado Business Group on Health, Colorado Chapter NASW, Coors Brewing Company (Employer Group), Pacificare Behavioral Health, Denver Health Medical Plan, PRO Behavioral Health, CIGNA Behavioral Health, Rocky Mountain HMO, Anthem Blue Cross/Blue Shield HMO Colorado, Social Work PRN, Kaiser Permanente, United Behavioral Health, Magellan Behavioral Health

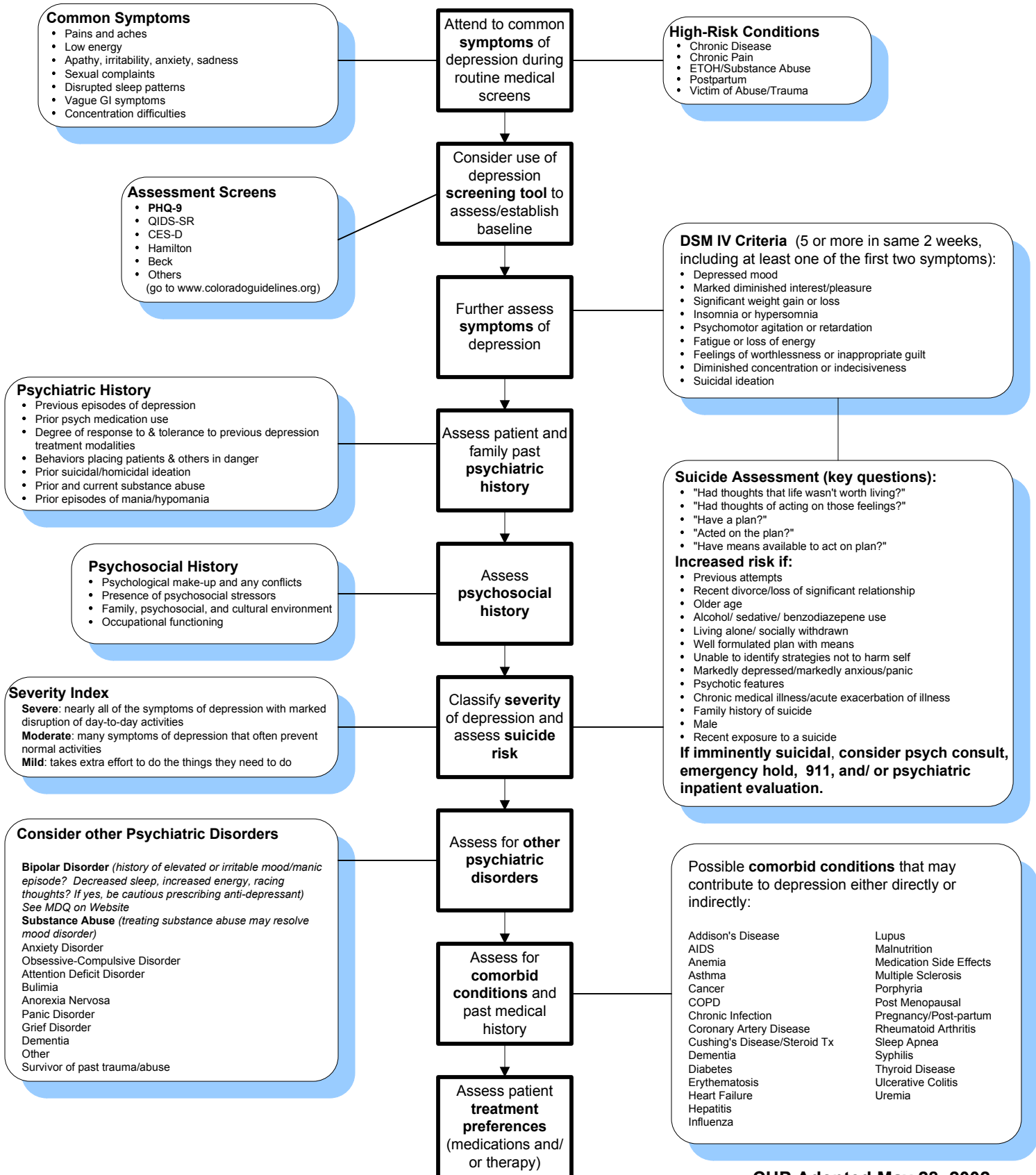
Approved by **Columbia United Providers** Practitioner Guideline Advisory Panel, May 28, 2002

CUP Adopted May 28, 2002
(Adapted from the Colorado Clinical Guideline Collaborative)
Revised May 2007



Major Depression Disorder in Adults DIAGNOSIS AND ASSESSMENT

A



B

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Major Depression Disorder in Adults TREATMENT PLANNING

B

Key Patient Education Tips:

- Refer patient to CUP's *Living Well with Chronic Conditions* workshop. This free six-week evidence-based workshop is appropriate for anyone with a chronic condition, including depression. Call CUP at 449-8925 for more information or to order referral prescription pads for your practice.

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

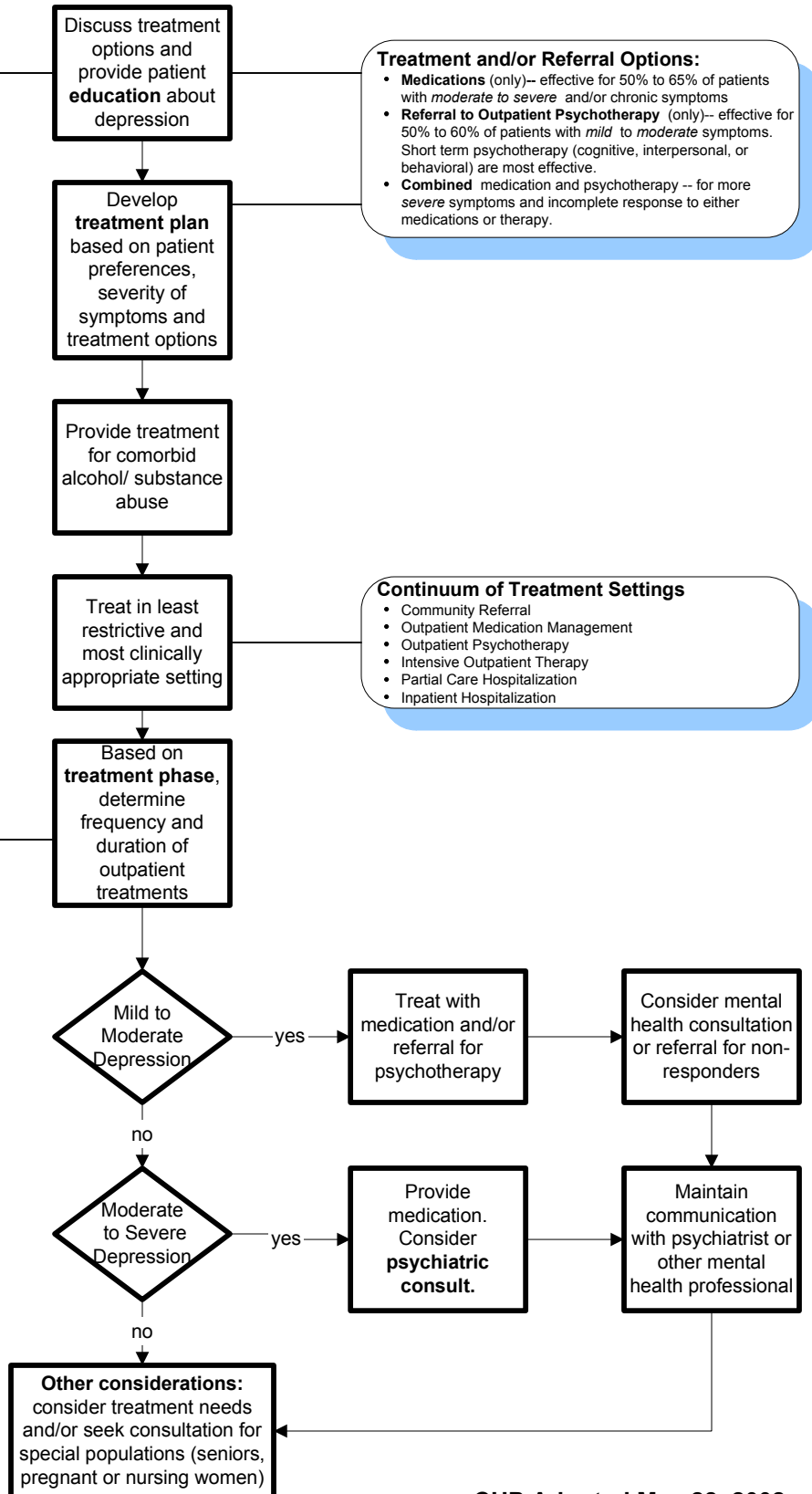
- Antidepressants should be taken as prescribed, allowing 2 to 4 weeks before an effect is first noticed. Contact within one week may be useful to assess side effects or adherence.
- For best results, antidepressants should be continued even when starting to feel better. You should notify your doctor's office before discontinuing medications.

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 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.



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 and incomplete response to either medications or therapy.

Continuum of Treatment Settings

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

CUP Adopted May 28, 2002

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Revised May 2007

C



Major Depression Disorder in Adults

MEDICATION MANAGEMENT and TREATMENT COURSE

C

Tricyclic antidepressants--Not recommended as first line treatment for patients with:

- Urinary retention
- Closed angle glaucoma
- Blurred vision
- Constipation
- Clinically significant prostatic hypertrophy
- Cardiac disease

Monitoring and Reassessment Considerations

- **Increase anxiety with suicide ideation**
- **Onset of mania via antidepressant medications**
- Medication/ therapy response
- Other behavioral disorders
- General co-morbidities
- Medication reactions and side effects (such as sexual dysfunction, weight gain, and other common side effects as indicated in Appendix 1)
- Medication toxicity (cardiac symptoms & orthostatic BP in patients with cardiac disease)
- Reduction in PHQ-9 score by 50% indicates positive response.
- Disease management care coordination is highly effective adjunct to successful treatment.

Expected Improvement Period

- For Single Medications**
- Improvement after 6 - 8 weeks
- For Psychotherapy alone:**
- Improvement after 8 to 12 weeks for mild depression
 - Improvement after 6 to 8 weeks for moderate depression

Consider:

- Increase in dosage or extension of trial
- Counseling on compliance to drug therapy
- Addition of psychotherapy (or increased frequency of psychotherapy) or adjunct medication

Option to Refine Treatment Refinement

- No response to medication at 6 to 8 weeks:
- Switch to an antidepressant with different biochemical profile
 - Co-administer a second anti-depressant from a different biochemical profile and monitor for intolerance with consideration to drug--drug interaction.
- No response to psychotherapy alone, offer trial of antidepressant (unless contraindicated) after:
- 8 to 12 weeks for mild depression
 - 6 to 8 weeks for moderate depression

Use **SSRIs, other newer antidepressants, or Tricyclics** as first line agents

Determine **medication starting dose and schedule increases**

Monitor acute treatment response and side effects every 2 to 4 weeks

Complete symptom resolution?

Partial response to treatment?

Continue to monitor and refine treatment

Complete symptom resolution in another 6-8 weeks?

Consider consultation and ongoing care coordination

- Psych Consultation/Referral Considerations**
- Psychotic/bipolar/severe depressive state
 - Active suicidal, homicidal, self injurious behavior
 - Co-existing substance abuse/dependence
 - Specialized treatment for psychotic/severe depression (e.g. ECT)
 - Ongoing monitoring indicates decline
 - Partial or no response to one or more medication trials
 - Complex psychological issues
 - Co-administering second psychotropic medication
 - Administering antidepressant in pregnant women
 - Medically unstable geriatric patient
 - Second opinion desired
 - Guideline not suitable for patient

Medication Selection and Dosage Considerations:

- Existing co-morbid and psychiatric conditions (see Appendix 1)
- Side effects of medication
- Compliance with dosage schedule
- Inform patient of side effect associated with discontinuing medication
- Lethality of antidepressants for overdose, primarily early on in treatment for suicidal patients
- Consider cost to patient and formulary status

Discontinue Treatment with taper over several weeks and educate patient that recurrence is common and treatable and to recognize signs of relapse and discontinuation symptoms

Continue medication for 4 to 9 months after symptom remission

Maintenance treatment required?

- Maintenance Treatment:**
- Consider maintenance medication treatment for:
- Patients who have had three or more episodes of depression (continue meds for 1 to several years)
 - Patients with two episodes of depression and:
 - ✓ Have a first degree relative with bipolar or recurrent depression
 - ✓ History of recurrence within 1 year after previous effective medication was discontinued
 - ✓ Early onset of first episode (before age 20)
 - ✓ Both episodes severe or life threatening

- Ongoing Evaluation of Maintenance Treatment**
- In cases where there has been a period of stability with maintenance treatment:
- Periodically re-evaluate need for continued treatment
 - Provide trial without medication unless contraindicated. Taper rather than discontinuing abruptly, unless toxic. Continue to monitor for relapse.

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