COLORADO CLINICAL GUIDELINES COLLABORATIVE

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HealthTeamWorks

Depression in Adults: Diagnosis & Treatment Guideline

~14% of adults have a major depressive episode in their lifetime
~30% of adults with major depression do not receive treatment

This guideline is intended for ages ≥18 years. For adolescents and pre-adolescents, use GLAD PC or Teen Screen Mental Health Check-ups.

Prepare your practice: put systems in place for accurate diagnosis, treatment, and follow-up.

Tip 1: Implement staff assisted patient self-management and care coordination (possible by phone).
Tip 2: Compile info on psychiatry and mental health consultation and referral options.
Tip 3: Identify resources to address treatment barriers.
Tip 4: Monitor symptoms with PHQ-9*.

1. Screening and Assessment

Consider Depression: High Risk Conditions and Cues

- Chronic conditions (CVD, Diabetes, cognitive impairment)
- Chronic pain
- Geriatric patient
- Multiple somatic complaints
- Postpartum
- Tobacco Use
- ETOH/Substance misuse/abuse
- Chronic anxiety
- History of Abuse/Trauma/PTSD
- Combat veteran
- Persistent anger/irritability
- Recent loss

Screening:

Screen if systems are in place for adequate diagnosis/ treatment/follow-up/referral. Use PHQ-2*.

"In the past 2 weeks…

1. Have you had little interest or pleasure in doing things?
2. Have you felt down, depressed or hopeless?"

If "yes" on either question, complete full PHQ-9*.

Further Assessment:

1. Recent life events (Why now?)
2. History of depression/bipolar disorder or alcohol/substance misuse
3. Patient's perception of problem:
   - » Beliefs and knowledge about depression
   - » Cultural considerations (language, stigma, influence on symptom presentation)
4. Consider medical and medication causes of depression
5. Family history: depression/bipolar disorder
6. Suicide risk (thoughts, plans, means, previous attempts, recent exposure). "Are you thinking of harming or killing yourself?"*
7. Assess risk of harming others
8. Screen for co-morbid psychiatric disorders: bipolar, anxiety, PTSD, panic disorder, tobacco†, substance misuse†
9. Complementary/Alternative Medicine or other treatments currently used*

2. Diagnosis *(first episode or recurrence?)*

DSM IV Criteria	Major Depression	Dysthymia
Symptom	**5 total for 2 wks duration: *must include symptom #1 or 2***	**3 total for ≥2 yrs.: *must include symptom #1***
1. ***Depressed mood***	✔	✔
2. ***Marked Diminished Interest/Pleasure***	✔	
3. Significant wt loss/gain, appetite decrease/increase	✔	✔
4. Insomnia/hypersomnia	✔	✔
5. Psychomotor Agitation/Retardation	✔	
6. Fatigue/loss of energy	✔	✔
7. Feelings of worthlessness or inappropriate guilt	✔	✔
8. Diminished concentration or indecisiveness	✔	✔
9. Suicidal ideation: thoughts, plans, means, intent	✔	
10. Hopelessness		✔

Severity Rating (Based on initial PHQ-9* score):

PHQ-9 Score	Provisional Diagnosis	Treatment Recommendations
5-9	Minimal Symptoms	Support, educate to call if worse; return in 1 month
10-14	Minor Depression	Evidence-based psychotherapy equally effective as anti-depressant
	Dysthymia	
	Major Depression, mild	
15-19	Major Depression, moderately severe	Evidence-based psychotherapy and/or anti-depressant
≥20	Major Depression, severe	Anti-depressant and psychotherapy (esp. if not improved on monotherapy)

3. Plan Treatment *(see page 2 for treatment chart)*

Shared Decision Making:

- Tailor treatment to individual patient
- Provide education on diagnosis
- Review treatment options (based on PHQ-9 score)
- Discuss treatment barriers: family/work responsibilities, insurance, transportation
- Negotiate treatment plan
- Set timeline: response, side effects and treatment duration
- Educate on importance of adherence
- Develop safety plan for suicidal ideation

Promote Health Behaviors:

- Exercise
- Social support
- Faith/spiritual support
- Healthy sleep pattern
- Healthy diet
- Alcohol only in moderation†
- Cessation of tobacco and illicit drug use†
- Engagement in positive activities
- Stress management
- Educational books and online resources

Additional Considerations:

- Current or planned pregnancy: psychotherapy preferred if symptoms tolerable*
- Start with lower dose for anxiety or elderly*
- Cultural factors that influence treatment choice*
- SNRI or tricyclic for chronic pain
- Level of functioning/activities of daily living
- Discuss safety with the patient*
- Need for emergency services
- Psychiatry referral, including ECT evaluation
- Complementary/Alternative Medicine*

Consider Referral or Consult:

- Suicidal patient
- Bipolar disorder
- Co-occurring substance abuse
- Psychotic features
- Multiple medications

*See supplement for additional information.

†Go to www.healthteamworks.org for guidelines on Tobacco & Alcohol/Substance Use.

This guideline is designed to assist the primary care provider in the diagnosis and treatment of depression. It is not intended to replace a clinician's judgment or establish a protocol for all patients. The Depression Guideline supplement, references, and additional copies of the guideline are available at www.healthteamworks.org or call (720) 297-1681. This guideline was supported through funds from The Colorado Health Foundation. *Approved 1/3/2011.*

3. Plan Treatment *Continued:* Treatments for Depression

Evidence-Based Psychotherapies*
- Cognitive/behavioral therapy (CBT)
- Interpersonal psychotherapy (IPT)
- Problem-solving therapy (PST)
- Psychodynamic therapy
- Couples/Family therapy

If receiving therapy alone:
- Onset of effectiveness is more gradual
- Discuss and share PHQ-9* with therapist

Considerations for Medication Selection
- Cost
- Formulary
- Responsiveness to prior treatment
- Responsiveness in a first degree relative
- Complementary/Alternative Medicine*

Medication Chart

FDA Black Box Warning: In short-term placebo controlled studies antidepressants increased the risk compared to placebo of suicidal thinking and suicidality in children, adolescents, and young adults; but not in adults beyond age 24; and there was a reduction in risk in adults age >65. ***Monitor all patients closely for clinical worsening, suicidality, or unusual changes in behavior.***

Pregnancy: Requires individualized risk/benefit discussion.*

Adverse Side Effects and Precautions‡

+++ = strong ++ = moderate + = mild 0 = very low, none X = generally contraindicated

Category	Drug	Daily Starting Dosage	Usual Adult Dosage	Relative Cost: Generic?	Relative Cost: On the $4 plan?	Side Effects: Anticholinergic	Sedation	Activation	Sexual Dysfunction	Weight Gain	Orthostatic Hypotension	Precautions: Eating Disorders	Liver Disease	Seizure Disorder	Cardiac Arrhythmia	Withdrawal Syndrome Risk	High Potential for Lethal Overdose
SSRIs	Citalopram (Celexa)	10-20 mg QAM	20-60 mg	✔	✔	0	0	++	+++	+	0					++	
	Escitalopram (Lexapro)	10 mg QAM	10-20 mg			0	0	++	+++	+	0					++	
	Fluoxetine (Prozac)	10-20 mg QAM	20-80 mg	✔	✔	0	+	+++	+++	+	0					+	
	Fluoxetime (Prozac weekly)	90 Qwk	90 mg			0	0	+++	+++	+	0					+	
	Paroxetine (Paxil)	10-20 mg QAM	20-50 mg	✔	✔	0	0	++	+++	+	0					+++	
	Paroxetine (Paxil CR)	12.5-25 mg QAM	25-62.5 mg	✔		0	0	++	+++	+	0					+++	
	Sertraline (Zoloft)	25-50 mg QAM	50-200 mg	✔		0	0	+++	+++	+	0					++	
SNRIs	Venlafaxine (Effexor)	25 mg BID-TID	150-375 mg	✔		+	0	++	++	0	0	X			X	+++	
	Venlafaxine XR (Effexor-XR)	37.5 mg QD	150-225 mg	✔		+	0	++	++	0	0	X			X	+++	
	Duloxetine (Cymbalta)	20 mg BID or 30 mg QD	60 mg			+	0	++	+	0	0		X	X	X	++	
	Desvenlafaxine (Pristiq)	50 mg QD	50 mg QD			0	0	++	+	0	0					+	
Other Agents	Bupropion (Wellbutrin)	100 mg BID-TID	300-450 mg	✔		0	0	++	0	0	0	X		X		+	
	Bupropion (Wellbrutin SR)	100 mg QD to 100 mg BID	150-200 mg BID	✔		0	0	++	0	0	0	X		X		+	
	Bupropion (Wellbrutin XL)	150 mg	300-400 mg	✔		0	0	++	0	0	0	X		X		+	
	Mirtazapine (Remeron or Remeron Sol-Tab)	15 mg QHS	15-45 mg	✔		+	++	0	0	+++	+					++	
	Trazodone Long-Acting (Oleptro)	150 HS	150-375 mg			+	+++	0	+	+	+++			X	X	+	
Tricyclics	Amitriptyline (Elavil)	25-75 mg QHS	100-300 mg	✔	✔	+++	+++	0	+	+++	+++			X	X	++	✔
	Clomipramine (Anafranil)	25-75 mg QHS	100-250 mg			+++	+	+	++	++	+++			X	X	++	✔
	Desipramine (Norpramin)	25-75 mg QHS	100-300 mg	✔		+	0	++	+	+	+++			X	X	++	✔
	Doxepin (Adapin, Sinequan)	25-75 mg QHS	100-300 mg	✔	✔	+++	+++	0	++	++	+++			X	X	++	✔
	Imipramine (Tofranil)	25-75 mg QHS	100-300 mg	✔		+++	++	+	+	++	+++			X	X	++	✔
	Nortriptyline (Aventyl, Pamelor)	25-50 mg QHS	30-150 mg QHS	✔	✔	++	++	+	+	++	++				X	++	✔

‡**References**: Applied Therapeutics: the clinical use of drugs. Edited by Mary Anne Koda-Kimble, et al. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, c2009. 9th edition. International consensus statement on major depressive disorder. Nutt DJ, et al. *J Clin Psychiatry*. 2010; 71 Suppl E1:308. Drug facts and comparisons. St. Louis: Facts and Comparisons, c1981-2010. *Circulation*. 2009 September 22; 120(12): 1123-1132. Expert opinion.

4. Monitor and Adjust Treatment. Monitor Side Effects. *Goal of treatment is complete remission.*

First follow-up contact at 1-2 weeks, then every 4-8 weeks (consider telephone contact in some cases). Perform ongoing suicide risk assessment; risk may increase during early treatment phase. If starting dose was low, consider up-titration at initial check-in.

Acute Phase (months 1-4)

Response	PHQ-9* Score after 4-6 weeks	Treatment Plan
Responsive	Drop ≥5 points from baseline	No treatment change needed. Follow-up again after an additional 4 weeks.
Partially responsive	Drop 2-4 points from baseline	Often warrants increase in dose. Possibly no change needed.
Non-responsive	Drop 1 point or no change or increase	• Consider starting anti-depressant if receiving therapy alone • Increase dose • Switch meds • Augmentation (Lithium, thyroid, stimulant, 2nd gen anti-psychotic, 2nd anti-depressant) • Review psychological counseling options and preferences • Informal or formal psychiatric consulation (ECT an option in some cases)

Continuation Phase (months 4-9)	Maintenance Phase for Recurrent Depression (month 9 and on)	Tapering Anti-Depressant Medication
• Begins after symptom resolution • Continue medications full strength • Contact every 2-3 months (telephone appropriate in some cases) • Monitor for signs of relapse • Generally, use same anti-depressant dose as in Acute Phase	• For patient with history of 3+ episodes of Major Depression or chronic Major Depression • Also consider for patient w/ additional risk factors for recurrence (family history, early age onset, ongoing psychological stressors, co-occurring disorders) • May need to maintain for one to several years • Use PHQ-9* for ongoing monitoring **Goal: Prevent Relapse**	• Taper over several weeks • Educate about side effects and relapse • Flu-like symptoms common • With SSRI and SNRI may also experience anxiety/agitation, sweats, paresthesias • Diphenhydramine may help with anticholinergic withdrawal symptoms

*See supplement for additional information