Major Depression (Age ≥ 12) Practice Guideline

EVALUATION AND TREATMENT

Suspect and Screen for Major Depression

- *Sanford One Care* clinics: Administer Behavioral Health Screening tool (BHS-6) (FLOWSHEET ID 1497, *SC T BHS-6)*
- All other clinics: Administer Patient Health Questionnaire screening tool (PHQ-9) **(APPENDIX A)** ***OR*** (FLOWSHEET ID 613, *SC T PHQ-9*) annually for universal screening. PHQ-9 should be administered any time depression is suspected.
- Presentations, in addition to obvious sadness **(TABLE A)**
- Risk factors **(TABLE B)**

Diagnose and Characterize Major Depression with Clinical Interview

- Diagnostic and Statistical Manual of Mental Disorders (DSM-V) criteria **(TABLE C)**
- History of present illness (onset and severity of symptoms, functional impairment, past episodes and psychosocial stressors)
- Rule out secondary causes of depression (e.g. thyroid dysfunction, substance abuse, medications)
- Consider special population factors (cultural considerations, adolescents, geriatrics, perinatal/postpartum) **(TABLE D)**

Assess if patient is at risk for suicide or self harm

Patient Is NOT at Risk for Suicide or Self Harm

- Assess need for additional resources: substance abuse or psychiatric comorbidity (e.g. depression/anxiety, trauma, bipolar)
- Involve behavioral health and/or chemical dependency professionals, same day if needed **(TABLE E)**

Patient IS at Risk for Suicide or Self Harm

- Use regional policy/workflow to assess and minimize suicide risk
- Refer to ED for assessment and possible hospitalization
- If hospitalization is not necessary, involve behavioral/chemical health **(TABLE E)**

Comprehensive Treatment Plan

Educate and engage patient (see *Krames* in the *Resource Tab* of *Sanford One Chart*)

- Discuss treatment recommendations **(TABLE F)**
  - **Psychotherapy**
    - Cognitive behavioral therapies
    - Interpersonal psychotherapy
    - Solution focused psychotherapy
    - Behavioral activation
    - Phototherapy (if seasonal component suspected)
  - **Pharmacotherapy**
    - Common drugs and doses of antidepressants in Ages 12-18 **(TABLE G)**
    - Selective serotonin reuptake inhibitors (SSRI) in Age ≥18 **(TABLE H)**
    - Serotonin–norepinephrine reuptake inhibitors (SNRI) in Age ≥18 (not to be used in adolescents) **(TABLE I)**
    - Other antidepressants in Age ≥18 **(TABLE J)**
- Establish follow-up plan

- Administer PHQ-9 at least every 6 months for follow-up and monitoring of treatment response **(TABLE F)**
- ***MN Community Measurement* Depression Measure:** Patients ≥ 18 years of age that score >9 on PHQ-9 must be rescreened within 6 months (+/- 30 days) of initial screen with a goal score <5. See *Depression Care Measures 2014* for complete details and exclusions.

Not Responding to Treatment: Unchanged or Increased PHQ-9 Total Score

- Clinical judgment reveals concerns about response (e.g. poor patient insight, medication side effects)
- Assess need for additional resources (substance abuse or psychiatric co-morbidity)
- Involve behavioral/chemical dependency professionals

Responsive to Treatment

- Continue to monitor and follow as indicated

Medication and/or Psychotherapy Evaluation

- Evaluate dose, duration, type and adherence with medication and/or psychotherapy
- Reconsider accuracy of diagnosis or impact of comorbidities

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REFERENCE INFORMATION

TABLE A: Presentations for Major Depression Include

- Multiple (> 5 per year) medical visits
- Multiple unexplained symptoms
- Fatigue
- Dampened affect
- Weight gain or loss
- Sleep disturbance
- Work, school or relationship dysfunction Changes in interpersonal relationships
- Volunteered complaints of stress or mood disturbance
- Irritable bowel syndrome (IBS)
- Memory/other cognitive complaints such as difficulty concentrating or making decisions
- Volunteered complaints of stress or mood disturbance
- Poor behavioral follow-through with activities of daily living or prior treatment recommendations

TABLE B: Risk Factors for Major Depression

- Bullying
- Recent loss
- Chronic medical illness
- Domestic abuse/violence
- Family or personal history of major depression and/or substance abuse
- Stressful life events (e.g. death of a loved one, divorce)
- Traumatic events (e.g. car accident)
- Major life changes (e.g. job change, financial difficulties)

TABLE C: DSM-V Criteria for Major Depressive Episode

A. Must have a total of five symptoms, nearly everyday for at least two weeks and represent a change from previous functioning. One of the symptoms must be depressed mood or loss of interest. Do not include symptoms that are clearly attributable to another medical condition.

- Depressed mood, most of the day
- Markedly diminished interest or pleasure in all or almost all activities
- Significant (>5% body weight in a month) weight loss or gain when not dieting, or increase or decrease in appetite
- Insomnia or hypersomnia nearly every day
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feeling of worthlessness or inappropriate guilt
- Diminished concentration or indecisiveness
- Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, suicide attempt, or a specific plan for committing suicide
- Irritability in children/adolescents

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of substance or to another medical condition.

Note: Criteria A-C represent a major depressive episode.

Note: Responses to a significant loss (e.g. bereavement, financial ruin, losses from a natural disaster, a serious medical illnesses or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss. The presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered.

D. The occurrence of the major depressive episode is not better explained by schizophrenia spectrum disorder or other psychotic disorders.

E. There has never been a manic episode or hypomanic episode.

Note: This exclusion does not apply if all of the manic-like or hypomanic like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

TABLE D: Considerations for Special Populations

Adolescents

- 40-90% of youths with depressive disorder also have other psychiatric disorders, with up to 50% having two or more comorbid diagnosis
- The most frequent comorbid diagnoses are anxiety disorders and attention-deficit/hyperactivity disorder (ADHD)

Cultural

- Ask questions regarding patient's cultural norms and beliefs and incorporate into treatment plan

Elderly

- Multiple medical conditions are more likely to be co-occurring with depression
- They exhibit more vegetative signs and cognitive disturbance

Perinatal and Post Partum

- Between 14-23% of pregnant woman and between 10-15% of women will have a depressive disorder
- Differential diagnosis needed to rule out bipolar disorder

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TABLE E: Involve Behavioral/Chemical Dependency Professional
Involve same-day behavioral health for: • Suicidal thoughts and/or plans that make the clinician uncertain of the patient's safety • Assaultive or homicidal thoughts and/or plans that make the clinician uncertain about the safety of the patient or others • Recent loss of touch with reality (psychosis), or inability to care for self/family **Involvement could include:** • Appointment with psychiatrist and/or psychotherapists • Phone consultation with psychiatrist and/or psychotherapists • Referral to the ED

TABLE F: Treatment Recommendations Based on PHQ9 Symptoms, Severity, and Diagnosis

PHQ-9 Score	PHQ-9 Severity	Treatment Recommendations
5-9	Mild	• Education on emergency services • Physical activity • Motivational interviewing/behavioral activation • If no improvement after one or more months, consider referral to behavioral health for evaluation
10-14	Moderate	• Pharmacotherapy or psychotherapy • Education on emergency services • Physical activity • Motivational interviewing/behavioral activation • Initially consider weekly contacts to ensure adequate engagement, then at least monthly
15-19	Moderately Severe	• Pharmacotherapy and/or psychotherapy • Education on emergency services • Physical activity • Motivational interviewing/behavioral activation • Initially consider weekly contacts to ensure adequate engagement, then minimum every 2-4 weeks
≥ 20	Severe	• Pharmacotherapy necessary and psychotherapy when patient able to participate • Education on emergency services • Physical activity • Motivational interviewing/behavioral activation • Weekly contacts until less severe

REFERENCE INFORMATION

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Warning: Suicidality and Antidepressant Drugs

Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of Major Depressive Disorders (MDD) and other psychiatric disorders. Anyone considering the use of antidepressants in child, adolescent, or young adult must balance this risk with the clinical need. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction in risk with antidepressants compared to placebo in adults aged 65 and older. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber.

OFF-LABEL USE OF MEDICATIONS

Medications discussed in this practice guideline may not have indications from the U.S. Food and Drug Administration for the disorder or condition for which they are recommended. Off-label use of medications by individual physicians is permitted and common. Decisions about off label use can be guided by the evidence provided in the APA practice guideline, other scientific literature, and clinical experience.

TABLE G: Common Drugs and Doses of Antidepressants in Ages 12-18

Drug	Brand Names	Starting Dose per APA	Usual Dose per APA
Fluoxetine	Prozac	10 mg/day	10-60 mg/day
Sertraline	Zoloft	25 mg/day	50-200 mg/day
Escitalopram	Lexapro	5 mg/day	10-20 mg/day

Abbreviation: APA, American Psychiatric Association

Reference:

1. APA, 2010 November

TABLE H: Common Doses for SSRI's for Depression in Age ≥ 18

Drug	Brand Names	Starting Dose per APA*	Usual Dose per APA
Citalopram**	Celexa	20 mg/day	20-60 mg/day
Escitalopram	Lexapro	10 mg/day	10-20 mg/day
Fluoxetine	Prozac	20 mg/day	20-60 mg/day
Paroxetine	Paxil, Pexeva	20 mg/day	20-60 mg/day
Sertraline	Zoloft	50 mg/day	50-200 mg/day

Abbreviation: APA, American Psychiatric Association

*Lower starting doses recommended for elderly, comorbid medical conditions, panic disorder, significant anxiety or hepatic disease.

**The FDA issued a Drug Safety Communication stating that citalopram should no longer be used at doses greater than 40 mg/day, because it could potentially cause dangerous abnormalities in the electrical activity of the heart. Higher doses may cause QTc prolongation.

For patients who have not responded to trials of SSRI's, a trial of an SNRI may be helpful. Augmentation of an antidepressant medication from a different pharmacological class may be helpful, or seek a psychiatric consult.

References:

1. APA, 2010 November
2. U.S. Department of Health and Human Services (AHRQ). Clinical Practice Guideline on Major Depression in Childhood and Adolescence. May 7, 2011

REFERENCE INFORMATION

TABLE I: Common Doses for SNRI's for Depression in Age ≥ 18			
Drug	**Brand Names**	**Starting Dose per APA***	**Usual Dose per APA**
Venlafaxine	Effexor, Effexor XR	37.5 mg/day	75-375 mg/day
Desvenlafaxine	Pristiq	50 mg/day	50-100 mg/day
Duloxetine	Cymbalta	60 mg/day	60-120 mg/day

Abbreviation: APA, American Psychiatric Association.

*Lower starting doses recommended for elderly, comorbid medical conditions, panic disorder, significant anxiety or hepatic disease.

Reference:

1. APA, 2010 November

TABLE J: Common Doses for Other Antidepressants for Depression in Age ≥ 18			
Drug	**Brand Names**	**Starting Dose per APA***	**Usual Dose per APA**
Bupropion	Wellbutrin, Wellbutrin XL	150 mg/day	300-450 mg/day
Bupropion sustained-release	Wellbutrin SR	150 mg/day	300-400 mg/day
Mirtazapine	Remeron	15 mg/day	15-45 mg/day
Vilazodone	Viibryd	10 mg/day	20-40 mg/day

Abbreviation: APA, American Psychiatric Association.

*Lower starting doses recommended for elderly, comorbid medical conditions, panic disorder, significant anxiety or hepatic disease.

Reference:

1. APA, 2010 November

Clinical Pearls

- Usual course of medical treatment for newly diagnosed depression in adults is individualized, but is typically 18 months, inclusive of dose tapering. Life-long treatment should be strongly considered for second episodes or beyond.
- For adolescents treatment duration is, again, individualized, but taper can begin as early as six months if symptom free.
- Keep differential of Bipolar Depression high on the list of differential diagnosis for unipolar depression.
- Consider switching to different class of antidepressant if two (2) adequate trials of antidepressant from class fail
- Patients who continue to have residual symptoms of depression have much higher rate of relapse
- If patient fails to respond to or has erratic response to antidepressant medication, consider possibility of Bipolar Disorder
- In case of partial response to an antidepressant, consider augmenting strategies
- In children – moods can vary from visit to visit
- Monitor adolescents more closely for Bipolar depression switch from depression to mania

References

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APPENDIX A: PHQ-9 Patient Health Questionnaire Screening Tool

NAME: _____ DATE: _____

DOB: _____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?		Not at All	Several Days	More Than Half the Days	Nearly Every Day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

10 If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult at All	Somewhat Difficult	Very Difficult	Extremely Difficult
1	1	2	3

SANFORD ONE CHART DOCUMENTATION FLOWSHEET ID 613, *SC T PHQ-9*