

Adult Depression Guideline

These clinical guidelines are designed to assist clinicians by providing an analytical framework for the evaluation and treatment of patients. They are not intended to replace a clinician's judgment or to establish a protocol for all patients with a particular condition. A guideline will rarely establish the only approach to a problem.

GUIDELINE HISTORY and APPROVAL

ACTION	SEED GUIDELINE and/or MAIN INFORMATION & GROUP SOURCE(S)	DATE	ORGANIZATION
Guideline Reviewed, Revised, and Approved	Depression Guideline Panel. Depression in Primary Care: Clinical Practice Guideline. Vol. 1. Detection and Diagnosis. Vol. 2. Treatment of Major Depression. U.S. H.H.S., P.H.S., AHCPR; 1993; Institute for Clinical Systems Improvement (ICSI) Depression in Primary Care Guideline, 1998. Original Geisinger Health System Depression Guideline, April 1998.	April 6, 2000	Geisinger Health Plan/ Guideline Committee
Guideline Reviewed and Approved	Same as above	April 26, 2000	Geisinger Health Plan/ Quality Improvement Committee
Guideline Reviewed, Revised, and Approved	Institute for Clinical Systems Improvement (ICSI) Depression in Primary Care Guideline, 1999. Geisinger Health Plan Depression Guideline, 2000.	May 23, 2001	Geisinger Health Plan Guideline Review Conference/Depression Team
Guideline Reviewed, Revised, and Approved	Same as above	July 5, 2001	Geisinger Health Plan/ Guideline Committee
Guideline Reviewed, Revised, and Approved	Same as above	July 25, 2001	Geisinger Health Plan/Quality Improvement Committee
Guideline Reviewed, Revised, and Approved	2001 HEDIS Behavioral Health Standards	October 4, 2001	Geisinger Health Plan/ Guideline Committee
Guideline Reviewed and Approved	2001 HEDIS Behavioral Health Standards	October 24, 2001	Geisinger Health Plan/Quality Improvement Committee
Guideline Reviewed, Revised, and Approved	Practice Guideline for the Treatment of Patients with Major Depression. American Psychiatric Association, Steering Committee on Practice Guidelines, Work Group on Major Depressive Disorder. April 2000. Institute for Clinical Systems Improvement (ICSI) Depression in Primary Care Guideline, 2002. <i>Continued on pg. 2</i>	December 11, 2002	Geisinger Health Plan Guideline Review Conference/Depression Team

Guideline History And Approval, Continued

ACTION	SEED GUIDELINE and/or MAIN INFORMATION SOURCE	DATE	ORGANIZATION & GROUP
Guideline Reviewed, Revised, and Approved	<p><i>Continued from pg. 1</i></p> <p>Trivedi, Madhukar H., et al; Texas Implementation of Medication Algorithms (TIMA); Guidelines for Major Depressive Disorder, TIMA Physician Procedural Manual. December 2000.</p> <p>Geisinger Health Plan Depression Guideline July 2001 version.</p>	December 11, 2002	Geisinger Health Plan Guideline Review Conference/Depression Team
Guideline Reviewed and Approved	Same as above	December 17, 2002	Geisinger Health Plan/ Guideline Committee
Guideline Reviewed and Approved	Same as above	January 22, 2003	Geisinger Health Plan/Quality Improvement Committee
Guideline Reviewed, Revised, and Approved	<p>Practice Guideline for the Treatment of Patients with Major Depression. American Psychiatric Association, Steering Committee on Practice Guidelines, Work Group on Major Depressive Disorder. April 2000.</p> <p>Trivedi, Madhukar H., et al; Texas Implementation of Medication Algorithms (TIMA); Guidelines for Major Depressive Disorder, TIMA Physician Procedural Manual. December 2000.</p> <p>Institute for Clinical Systems Improvement (ICSI) Depression in Primary Care Guidelines, 2002.</p> <p>Geisinger Health Plan Depression Guideline, 2003 version.</p> <p>2004 HEDIS Behavioral Health Standards</p> <p>US Preventive Services task Force (USPTF). Screening for Depression: recommendations and rationale. <i>Ann Intern Med</i> 2002 May 21; 136 (10): 760-4.</p>	March 11, 2004	Geisinger Health Plan Guideline Review Conference/Depression Team
Guideline Reviewed, Revised, and Approved	Same as above.	March 5, 2004 & April 28, 2004	Geisinger Health Plan Pharmacy
Guideline Reviewed, and Approved	Same as above.	July 12, 2004	Geisinger Health Plan/Guideline Committee
Guideline Reviewed and Approved	Same as above.	December 20, 2004	Geisinger Health Plan Medical Management Committee (MMC)

Depression Clinical Guideline

Guideline Reviewed and Approved	Same as above.	January 2005	Geisinger Health Plan/Quality Improvement Committee
Guideline Reviewed and Approved	<p>Practice Guideline for the Treatment of Patients with Major Depression. American Psychiatric Association, Steering Committee on Practice Guidelines, Work Group on Major Depressive Disorder. April 2000.</p> <p>Institute for Clinical Systems Improvement (ICSI) Depression in Primary Care Guidelines, 2006.</p> <p>Geisinger Health Plan Depression Guideline, 2005 version.</p> <p>US Preventive Services Task Force (USPTF). Screening for Depression: recommendations and rationale. <u>Ann Intern Med</u> 2002 May 21; 136 (10): 760-4.</p>	July 5 – Aug. 18, 2006	<p>Geisinger Health Plan/ Guideline Committee</p> <p>United Behavioral Health</p>
Guideline Reviewed and Approved	Same as above	July 5-24, 2006	Geisinger Health Plan Pharmacy
Guideline Reviewed and Approved	Same as above	Sept. 26 –Oct. 6, 2006	Geisinger Health Plan Medical Directors
Guideline Reviewed and Approved	Same as above	Nov. 6, 2006	Geisinger Health Plan Medical Management Committee (MMC)
Guideline Reviewed and Approved	Same as above	Jan. 24, 2007	Geisinger Health Plan Quality Improvement Committee
Guideline Reviewed and Revised	Institute for Clinical Systems Improvement (ICSI) Depression, Major, in Adults, in Primary Care Guidelines, 2008.	June 2008	Geisinger Health Plan/Guideline Committee
Guideline Reviewed and Approved	Same as above	July 2008	Geisinger Health Plan Pharmacy
Guideline Reviewed and Approved	Same as above	Nov 25-Dec. 1, 2008	Geisinger Health Plan Medical Directors
Guideline Reviewed and Approved	Same as above	Dec.1, 2008	Geisinger Health Plan Medical Management Committee (MMC)
Guideline Reviewed and Approved	Same as above	Jan 28,2009	Geisinger Health Plan Quality Improvement Committee

Depression Clinical Guideline

Guideline Reviewed and Approved	Same as above	Oct 1, 2010 – Jan. 26, 2011	Geisinger Health Plan/Guideline Committee
Guideline Reviewed and Approved	Same as above	Dec. 20, 2010	Geisinger Health Plan Medical Management Committee (MMC)
Guideline Reviewed and Approved	Same as above	Jan. 26, 2011	Geisinger Health Plan Quality Improvement Committee



Vice President, Chief Medical Officer
Geisinger Health Plan

OVERVIEW

Depression is a prevalent and debilitating illness. Depressed patients often present first in the primary care setting. Primary care providers provide 53% of the mental health visits in the US, and spend an average of 23% of their workweek on mental health problems. They write approximately 70% of the antidepressant prescriptions. This guideline is focused on those patients who present with depression in primary care. It covers detection, pharmacotherapy, psychotherapy, specialty referrals, and maintenance treatment. It attempts to provide answers to common questions about depression management from primary care providers.

TARGET POPULATION

Adults and late adolescents characterized by the following:

- Complaints of sadness, sleep problems, worry, headache, fatigue, or pains
- Multiple visits to a health care provider with unexplained poor treatment response
- Anxiety, social phobia, chronic irritability

SEED GUIDELINE

Major Sources, which provide summaries of research and recommendations regarding issues covered in the Guideline:

US Preventive Services Task Force (USPTF). Screening for Depression: recommendations and rationale. Ann Intern Med 2002 May 21; 136 (10) : 760-4.

Pignone M, Gaynes BN, Rushton JL, et al. Screening for Depression. Systematic Evidence Review No. 6 (Prepared by the Research Triangle Institute—University of North Carolina Evidence-based practice Center Under Contract No. 290-97-0011) AHRQ Publication. No. 02-S002. Rockville, MS: Agency for Healthcare Research and Quality, May 2002.

Geisinger Health Plan Depression Guideline (2007 version).

Institute for Clinical Systems Improvement (ICSI) Depression, Major, in Adults, in Primary Care Guidelines, 2008.

http://www.icsi.org/guidelines_and_more/gl_os_prot/behavioral_health/depression_5/depression_major_in_adults_in_primary_care_4.html

Practice Guideline for the Treatment of Patients with Major Depression. American Psychiatric Association, Steering Committee on Practice Guidelines, Work Group on Major Depressive Disorder. April 2000.

http://www.psych.org/psych_pract/treatg/pg/Depression2e.book.cfm

<http://www.mhmr.state.tx.us/centraloffice/medicaldirector/tima.html>

Guideline Watch: Practice Guideline for the Treatment of Patients With Major Depressive Disorder, 2nd Edition 2005 <http://www.psychiatryonline.com/content.aspx?aid=148217>

GOALS

Improve detection of Major Depressive Disorder, with particular attention to patients presenting with co-morbid medical disorders.

Improve physician knowledge of evidence-based medication choices, dosing, and recommendations for length of treatment.

Propose strategies for improving patient knowledge of the disease process and compliance with treatment.

Reduce unnecessary suffering and disability resulting from undiagnosed and untreated or under treated depression.

FAST FACTS

1. Depression is about as common as hypertension. Screening is warranted and can be adequately performed using two questions:
 - a. During the past month have you often been bothered by feeling down, depressed, or hopeless?
 - b. During the past month have you often been bothered by little interest or pleasure in daily things?

This should be used as a common initial screening tool to identify patients who need more attention regarding the possibility of the existence of a mood disorder.

2. Additional screening for patients who respond positively to the initial screen can be completed via a clinical interview with the PCP, a licensed counselor, or a psychiatrist. Additional screening with tools such as the Hamilton Depression Screen, the Zung Depression Scale, or the CES-D, may be useful in conjunction with the clinical assessment.
3. Yearly training for at least one employee in Depression Management will ensure the availability of an in-office resource for patients other than a physician, and should be helpful in offering education on depression to patients, as well as encouraging feedback regarding side effects and other issues that may interfere with medication adherence.
4. Use appropriate first line medications consisting of monotherapy. If there is a partial response, maximize the therapeutic dose and ensure that the patient has been medication compliant. If a particular medication fails, consider switching to another medication, either in the same or a different class. Antidepressants newer than the tricyclics are not structurally similar to one another, and patients may respond to one or more medications within a class although not to others. It can also be effective to switch to an antidepressant that targets a different neurotransmitter. Partial responses despite therapeutic doses and adequate treatment time (8 weeks) can be augmented by adding lithium or buspirone, or by switching from an antidepressant that primarily affects one neurotransmitter to one that affects two or more. If two full trials of medication fail, consider consultation with a psychiatrist.

5. Benzodiazepines are not considered appropriate treatment for depression, or depression with comorbid anxiety. Consider a different medication if use is expected to exceed two to three weeks.
6. For a GHP participating psychiatric resource Call OptumHealth Behavioral Solutions for referral or consultation at (888) 839-7972.
7. Antidepressant medication therapy consists of an 8-week trial, including upward titration.

Note: Pharmaceutical coverage is dependent upon individual pharmacy benefit design and certain drugs may require prior authorization. Providers are encouraged to review the GHP formulary at <http://www.thehealthplan.com>, or contact the GHP Pharmacy Department at 1-800-988-4861.

BIBLIOGRAPHY

US Preventive Services Task Force (USPTF). Screening for Depression: recommendations and rationale. *Ann Intern Med* 2002 May 21; 136 (10):760-4.

Pignone M, Gaynes BN, Rushton JL, et al. Screening for Depression. Systematic Evidence Review No. 6 (Prepared by the Research Triangle Institute—University of North Carolina Evidence-based practice Center Under Contract No. 290-97-0011) AHRQ Publication. No. 02-S002. Rockville, MS: Agency for Healthcare Research and Quality, May 2002.

Geisinger Health Plan Depression Guideline (2007 version).

Practice Guideline for the Treatment of Patients with Major Depression. American Psychiatric Association, Steering Committee on Practice Guidelines, Work Group on Major Depressive Disorder. April 2000.

Trivedi, Madhukar H., et al; Texas Implementation of Medication Algorithms (TIMA); Guidelines for Major Depressive Disorder, TIMA Physician Procedural Manual. December 2000.

Whooley MA, Avins AL, Miranda J, Browner WE: Case finding instrument for depression: Two questions are as good as many. *J Gen Intern Med* 1997;12:439.

Brown W, Harrison W. Are patients who are intolerant to one serotonin selective reuptake inhibitor intolerant to another? *J. Clin Psychiatry*. 1995;56:30-34.

Preskorn S, Burke M. Somatic therapy for major depressive disorder: selection of an antidepressant. *J Clin Psychiatry*. 1992;53 (Suppl. 9):5-18.

Diagnostic and Statistical Manual of mental Disorders. DSM-IV TR American Psychiatric Association, 2000.

Guideline Watch: Practice Guideline for the Treatment of Patients With Major Depressive Disorder, 2nd Edition 2005 <http://www.psychiatryonline.com/content.aspx?aid=148217>

ALGORITHM

Part 1

1

During History, Patient Manifests:

- Sadness
- Sleep
- Multiple Visits to Provider
- Chronic Anxiety or Benzodiazepine use
- Provider Suspicion of Anxiety/Depression
- Worry
- Pains
- Headache
- Fatigue

Exclusion Criteria

- Patient Currently Under Psychiatric Care
- Multiple Psychotropic Medications
- Psychiatric, bipolar, or eating disorder
- Grief

ESAD SIG: E CAPS

SAD Feel **SAD**, down, depressed, hopeless or irritable?

S Trouble with **SLEEP**: Falling or staying asleep, sleeping too much?

I Lost **INTEREST** in your job, hobbies or usual pleasures?

G Feel **GUILTY**, down on yourself or that you've let others down?

E Tired or have low **ENERGY**?

C Difficulty **CONCENTRATING**, remembering or making decisions?

A **Appetite** disorder (increased/decreased?)

P Poor **PHYSICAL** changes – fidgety, restless or more slowed down than usual?

S Ever feel that life isn't worth living, feel like hurting yourself, or **SUICIDAL**?

2

Consider Depression

Use two question Whooley Depression Screening

1. During the past month, have you often been bothered by feeling down, depressed or hopeless?
2. During the past month, have you often been bothered by little interest or pleasure in doing things?

OR

Ask SAD SIG ECAPS Questions About Depression

Negative Responses

Negative Responses

Consider Other Diagnoses

4

Perform Appropriate PE & Lab Evaluation

6

Treat Condition

5

If Cause due to:

1. Medical Condition
2. Medications
3. Drug and Alcohol use

7

Depressive Symptoms Persist or Depressive Symptoms /Conditions are Co-morbid

8

Patient Meets Criteria for Depression

Routine Follow-up

9

High Risk Situation?

Yes

10

Consult Psychiatry Same Day

11

High Complexity Patient?

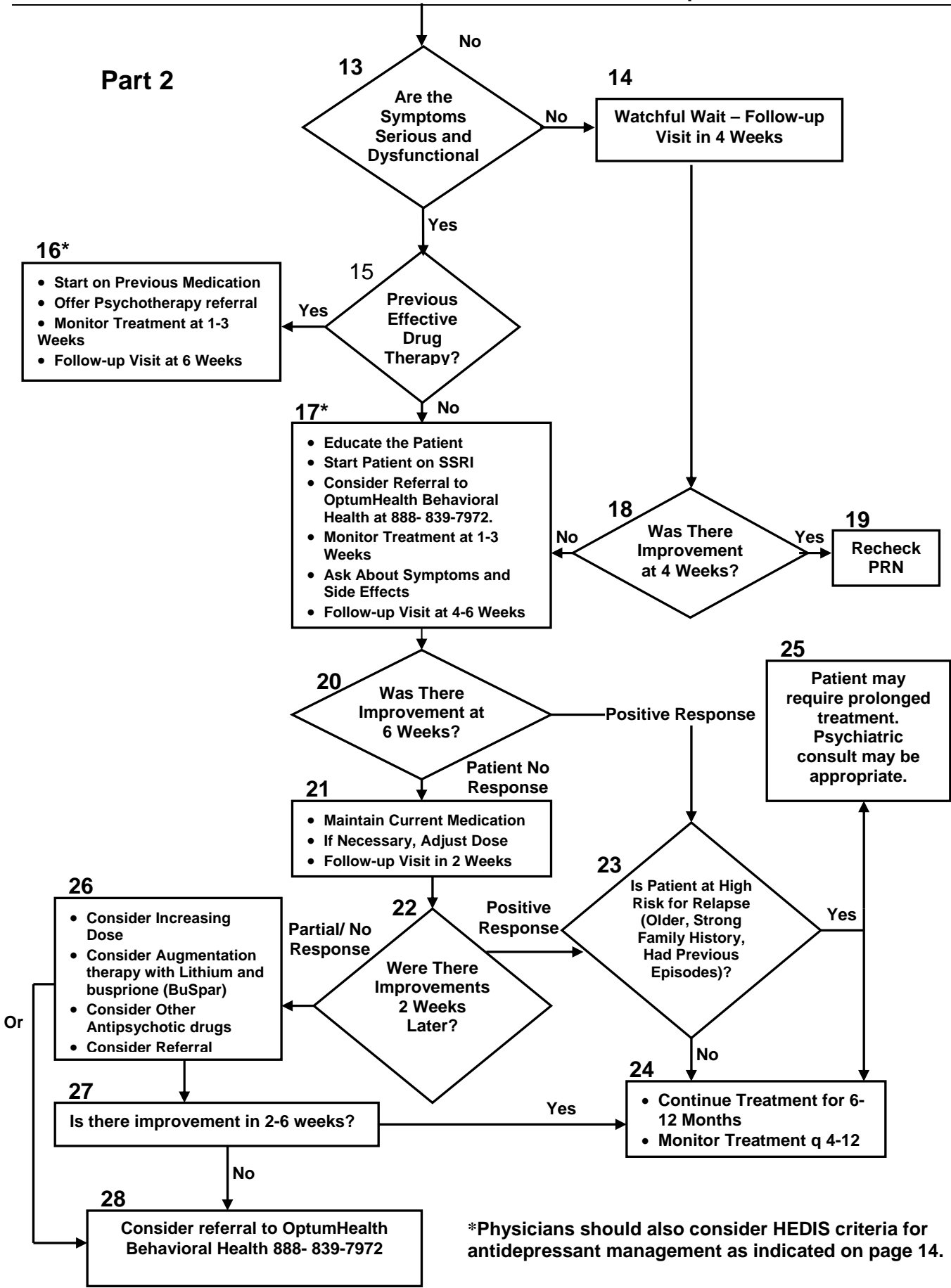
Yes

12

Encourage patient to contact OptumHealth Behavioral Health for Referral or Consultation at 888- 839-7972

No

Part 2



*Physicians should also consider HEDIS criteria for antidepressant management as indicated on page 14.

ANNOTATIONS

BOX 1 - During History:

Primary Care Providers need to maintain a high degree of suspicion for depression because many depressed patients present with physical symptoms, not mood complaints. Providers need to suspect the diagnosis and consider depression when during the history, a patient presents any of the symptoms listed in Box 1. A family history of depression and/or alcohol problems, chronic illness, recent loss, and a history of anxiety disorder are all significant depression risk factors.

The current “gold standard” in the US for depression diagnosis is the set of criteria in the Diagnostic and Statistical Manual of Mental Disorders. A summary of DSM-IV TR criteria for the diagnosis of depression is as follows:

Five or more of the following symptoms present during a 2 week period. The symptoms should be present throughout most of the day, nearly every day. These symptoms should represent a change from previous functioning and cause significant distress or impairment. The symptoms should not be specifically caused by a medical condition, drugs of abuse, or medications. Also, they should not be the result of bereavement (which lasts about 2 months after the death of a loved one). The symptoms include:

- i. Depressed mood
- ii. Diminished interest or pleasure in almost all activities
- iii. Significant weight loss (not through dieting) or gain, or significant change in appetite
- iv. Insomnia or hypersomnia
- v. Psychomotor agitation or retardation
- vi. Fatigue or loss of energy
- vii. Feelings of worthlessness or excessive, inappropriate guilt
- viii. Indecisiveness, diminished capacity to think, or to concentrate
- ix. Recurrent thoughts of death, suicidal ideation, or a suicide attempt

BOX 4 & 5 - Appropriate PE and LABS

There are many disease processes that can produce depressive symptoms. More common examples include Thyroid disease, Hyperparathyroidism, Cushing’s, and Addison’s diseases, B12 deficiency, electrolyte abnormalities, CNS vasculitis, and CNS degenerative diseases, such as Parkinson's.

Several lists of drugs, which can be associated with depression, are available from other sources. The team recommends that the medication history be carefully reviewed to determine whether the development of symptoms correlates with any medication. It is also important to remember that substance abuse or withdrawal can produce depressive symptoms.

The CAGE questions may be helpful: (C=Have you felt the need to CUT DOWN your drinking? A=Have you been ANNOYED by other's criticism of your drinking? G=Have you ever felt GUILTY about your drinking? E=Have you ever had an EYE OPENER?)

Screening laboratory tests are not necessary in all patients, but should be relied upon more if the medical review of symptoms reveals signs or symptoms that are rarely encountered in depression and/or if the patient is older.

The clinician should perform sufficient history, physical and laboratory evaluation to identify potential organic etiologies, while recognizing that the lifetime risk of primary depression is greater than any of the above conditions.

BOX 10 - High Risk Situation?

Psychiatry resources should be contacted immediately if there is any concern over suicidal or homicidal thoughts. While at times it may be difficult the clinician must ask directly about such ideation, plans, and previous acts. Patients unable to care for himself or herself, out of touch with reality, or who make the clinician concerned about a person's safety deserve emergent psychiatric support.

CONTACT A GHP participating psychiatric resource (OptumHealth Behavioral Solutions 1-888- 839-7972), or Contact County MH/MR Program or Crisis Line for emergencies.

BOX 11 - High Complexity Patient?

Certain patients presenting with depression will be too time consuming or complex to be treated adequately in the primary care setting. It is strongly suggested that high complexity patients be referred for a routine psychiatric evaluation. This includes those with: 1) Medical problems or medication regimens which confound diagnosis and/or treatment, 2) Severe mental illness--psychotic, bipolar disorder, 3) Patients with chaotic lives and "chronic sense of burden" who make differential diagnosis and treatment difficult, 4) Presentation of symptoms that make the primary care provider uncertain regarding diagnosis.

BOX 12 –OptumHealth Behavioral Solutions can be contacted at 888- 839-7972 for referral or consultation.

BOX 13 - Are The Symptoms Serious and Dysfunctional?

This decision requires clinician judgment.

ASSESS FUNCTIONING: Ask the patient how much of an impact the distress has had on their work, and interpersonal relationships during the past two weeks. If the symptoms (especially lack of sleep, poor appetite, low interest) have had a great impact on their functioning, follow the algorithm for treating serious depression. Minor depression symptoms in a patient with previous episodes of depressed mood or loss of interest are more likely to signal the beginning of another episode of major depression and should be treated aggressively.

ANXIETY AND DEPRESSION

Remember, there is significant comorbidity between anxiety and depression. Even though the presenting complaint may be anxiety, treat as depression if depressive symptoms are present.

BOX 14 - Watchful Wait

If the patient has no history of major depression and the depressive symptoms are minor (less severe, 2-4 SIGECAPS symptoms), the clinician may try "watchful waiting" and schedule a return visit in four weeks. A portion of those with Minor Depression return to baseline in 30 days. It is also possible that these patients are in the early stages of a Major Depression, so even if symptoms remit after watchful waiting, the patient should be rescheduled for follow-up over the next 6-12 months to assess for Major Depression.

BOX 15 - PREVIOUS MEDICATION EFFECTIVE?

If a patient presents in primary care with a new onset of depressive symptoms AND had a previous episode of depression for which they received effective medication treatment AND the patient is willing to start that same medication again, then prescribe it. The other elements of Box 16 are covered under Box 17.

BOX 17 – Start Treatment

EDUCATE THE PATIENT

Successful treatment requires that patients understand their illness and follow through with the treatments prescribed. The patient must walk out of the office after the first visit seeing light in the tunnel, feeling optimistic and secure that the clinician truly understands their difficulty.

Remember to educate the patient about time course – 3 to 6 weeks until medications reach full effect, patient will take maintenance dose for 6-12 months.

START PATIENT ON SSRI

Before any patient is started on an antidepressant, current symptoms of mania or a previous manic or hypomanic episode have been ruled out. A significant number of patients who present with depression may have a bipolar disorder. Starting these patients on an antidepressant without an additional mood stabilizer or antipsychotic can precipitate mania.

The treatment of choice for serious and dysfunctional depression is antidepressant pharmacotherapy.

Numerous studies have shown the SSRI's (Selective serotonin reuptake inhibitors), to be the preferred drugs for the initial treatment of depression in almost all patient populations. As a class, SSRI's are safer than TCA's (Tricyclic antidepressants) if taken as an overdose. A lower side effect profile and single daily dose administration enhance compliance.

All SSRI's are equally effective for the initial management of depression and have an equally rapid onset of clinical effectiveness. Although they differ in half-life, none reduces clinical symptoms more quickly than the others, on the average. SSRI's differ with regard to side effects and effectiveness with particular patients.

GERIATRIC PATIENTS

Start low, go slow. Start the SSRI at one half the usual dose and increase dosage more slowly, e.g. after 2 weeks.

MANAGING INSOMNIA

Insomnia troubles patients. It is a symptom of depression and most often will improve when the

depression improves, so there is no need to select a sedating antidepressant for a patient troubled with insomnia. During the first few weeks of treatment, until the antidepressant is fully effective, it may be useful to consider Trazodone (Desyrel) 50 mg qhs or Ambien 10 mg. They can be discontinued once the antidepressant is effective.

Note: Pharmaceutical coverage is dependent upon individual pharmacy benefit design and certain drugs may require prior authorization. Providers are encouraged to review the GHP formulary at <http://www.thehealthplan.com>, or contact the GHP Pharmacy Department at 1-800-988-4861.

CONSIDER OptumHealth Behavioral Solutions at 888- 839-7972

Medication is the preferred treatment for severe depression, but medications or psychotherapy are effective with mild to moderate depression. Both medications and psychotherapy are effective in treating depression and in general equal outcomes after four months of treatment. Antidepressants produce more rapid recovery. This decision requires patient collaboration; the provider should discuss therapy and may counsel patients for a period of time or refer to a trained psychotherapist.

Psychotherapy is appropriate at any stage of treatment, especially if: 1) The patient requests it, 2) Psychological (e.g. self esteem) and/or psychosocial issues (e.g. relationship loss) are prominent, 3) Adequate trials of medications now or in the past yield an incomplete response, 4) Medical conditions rule out medications.

If a patient receiving psychotherapy alone has not responded after 12 weeks, then reconsider medications.

MONITOR TREATMENT q 1-3 WEEKS

It is vital to follow-up with patients during the first three weeks of treatment because this is the interval when many patients discontinue medications and are lost to follow-up, only to return later with an untreated depression. Monitor treatment every 1-3 weeks by any of the following methods: Schedule return visits, call the patient, have a nurse call the patient, have the patient call you.

SCHEDULE A FOLLOW-UP VISIT AT SIX WEEKS

BOX 20 - Improvement at 6 Weeks?

Response should be carefully assessed at 6 weeks. A 4-6 week medication trial should usually result in at least partial improvement if the medication ultimately will be effective. Patients who are clearly worse or who have intolerable side effects are considered to have an ADVERSE response. POSITIVE or PARTIAL/NO RESPONSE will be evident to the provider. Remember to ask about side effects and functioning. Remind patients about treatment time course – at least 6-12 months after symptoms remit.

BOX 21 – Partial or No Response to The First Six Weeks of Medication

Partial or no response may be due to: 1) Noncompliance, 2) Inadequate dose, 3) Inadequate duration of therapy, 4) Occult substance abuse, 5) An ineffective drug for a particular patient. If there is no improvement or minor improvement then increase the drug to the next titration level.

BOX 23, 25 – Is Patient at High Risk for Relapse?

Depression is a recurring illness for 50% of patients who have one episode of major depression. Patients with two episodes have a 70% likelihood of recurrence, and those with three have a 90% likelihood of recurrence.

Those with severe depressive episodes, symptom onset past age 60, strong family history of depression, or patients who have had three episodes of depression, may require prolonged (lifelong) treatment. If there is a question about the length of treatment then phone psychiatrist or refer for consultation.

BOX 24 – Continuation Phase of Treatment

It is recommended that once the patient achieves a response they be continued on medications 6-12 months. See the patient to monitor symptoms and side effects every 1-3 months during that period. Expect a psychotherapist to work in a goal-focused way with patients over a 3-9 month period for a typical episode of depression. The majority of patients will be seen in less than 15 visits, with the average being 6-10. There is mild evidence that psychotherapy helps prevent relapse.

DISCONTINUING MEDICATIONS (If it is not indicated to stay on medications)

Timing – Patient has been relatively symptom-free for 6 months. Major psychosocial stressors have been resolved. If in Pennsylvania, try not to discontinue during the winter months, in case there is a seasonal affective component to the depression. When you are considering discontinuation, involve the patient in the decision.

RELAPSE PREVENTION PLAN

Because relapse is so common in depression, it is important that whenever treatment ends the patient leaves with a RELAPSE PREVENTION PLAN including which symptoms would indicate the beginning of a relapse and whom they should call should they sense symptom recurrence.

BOX 26 – Partial or No Response After 8 Week Trial of The First Medication

After a patient has been on a therapeutic dose of an antidepressant for 8 weeks (Don't count time spent titrating the medication to a therapeutic level) and they show no improvement or only minor improvement, then change the medication. It is reasonable to “cross-taper” – that is, to start a new medication at low but slowly increasing dose while tapering the old medication. Most antidepressants (with the exception of MAOIs) are compatible with each other in this manner.

CHOICE OF SECOND MEDICATION

Pick another SSRI. Research shows that response or lack of response to one SSRI does not predict the same response to another. Some research even suggests that patients who have adverse side effects on one SSRI can tolerate another, so it is reasonable to pick another SSRI and try it for 8 weeks. Effectiveness of SSRI's should be considered.

OR

Switch drug class. So far, research provides little guidance on switching drug classes. When a patient has no response or an adverse response to an adequate trial of two SSRI's, psychiatrists are likely to switch to one of the newer agents – norepinephrine reuptake inhibitors (Ludiomil), norepinephrine/dopamine enhancers (Wellbutrin, Zyban [or generic equivalents]), serotonin/norepinephrine reuptake inhibitors (Eleavil, Tofranil, Sinequan, Effexor [or generic equivalents]), 5HT₂ antagonists/serotonin reuptake inhibitors (Desyrel, Serzone [or generic

equivalents), norepinephrine / serotonin 5HT₂/5HT₃ antagonists (Remeron), or monoamine oxidase inhibitors (Nardil, Parnate).

Tricyclics are not preferred because of adverse side effects, difficulty in titration, and danger in overdose. Nonetheless, they are effective, cheap, and some practitioners are quite comfortable with their use. Secondary amines -- desipramine (Norpramin) and nortriptyline (Pamelor) -- influence norepinephrine with some effect on serotonin and have fewer side effects than other tricyclics. Pamelor is preferred over Norpramin because of availability of accurate, meaningful serum levels. Tertiary amines (imipramine/Tofranil, amitriptyline/Elavil, and doxepin/Sinequan) should probably be avoided because they have high anticholinergic side effects.

BOX 26 – If still no improvement 2 weeks later:

Consider increasing dose.

Consider augmentation therapy with agents such as Lithium or busprione (BuSpar).

BOX 27 – Is there improvement in 2-6 weeks?

If YES, go to BOX 24. Continue treatment for 6-12 months. Monitor treatment every 4-12 weeks.

If NO, go to BOX 28, Consider OptumHealth Behavioral Solutions 888-839-7972

MEASURES

2011 HEDIS Behavioral Health Measures

ANTIDEPRESSANT MANAGEMENT

The following three components of this measure assess different facets of the successful pharmacological management of depression:

EFFECTIVE ACUTE PHASE MANAGEMENT: Remain on antidepressants for first 12 weeks (84 days). The percentage of members age 18 years and older as of April 30 of the reporting year, who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant drug the entire 12-week (84 day) Acute Treatment Phase. This intermediate outcome measure assesses the percentage of adult members initiated on an antidepressant drug who received a continuous trial of medication treatment during the Acute Treatment Phase.

EFFECTIVE CONTINUATION PHASE TREATMENT: Remain on medications six months (180 days). The percentage of members age 18 years and older as of April 30 of the reporting year, who were diagnosed with a new episode of major depression, treated with antidepressant medication, who remained on an antidepressant drug for at least 180 days (6 months). The intermediate outcome measure assesses the effectiveness of clinical management in achieving medication compliance and the likely effectiveness of the established dosage regimen by determining whether adult members completed a period of Continuation Phase Treatment adequate for defining a recovery according to AHRQ Depression in Primary Care

(Source: Depression in Primary Care, Vol. 2. Treatment of Major Depression. Clinical Practice Guideline, Number 5, Rockville, MD. U.S. Dept. of Health and Human Services, Public Health Services, Agency for Health Care Research and Quality, AHRQ Publication No. 93-0551. April 1993).

