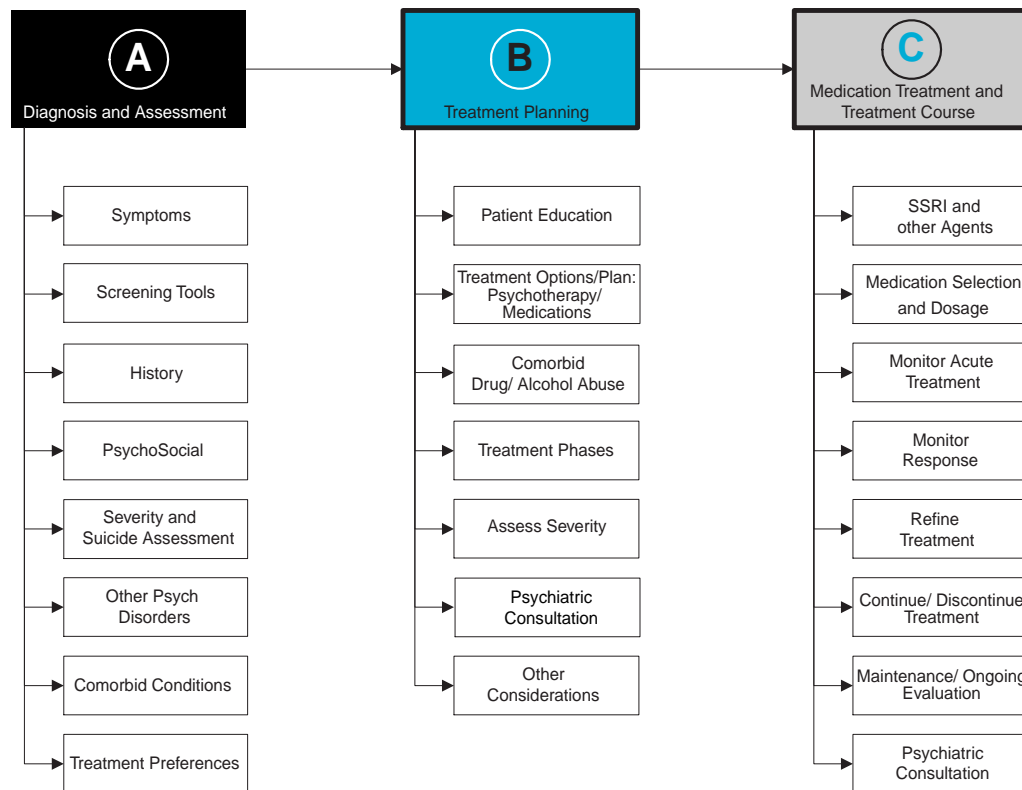


# Major Depression Disorder in Adults

## Diagnosis & Treatment Guidelines

### Overview

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Appendix 3. Treatment of special populations: Seniors, Adolescents/Children, and Pregnant Women  
Appendix 4. Patient Self-care materials  
Appendix 5. Screening tools (PHQ-9, QIDS-SR, MDQ)



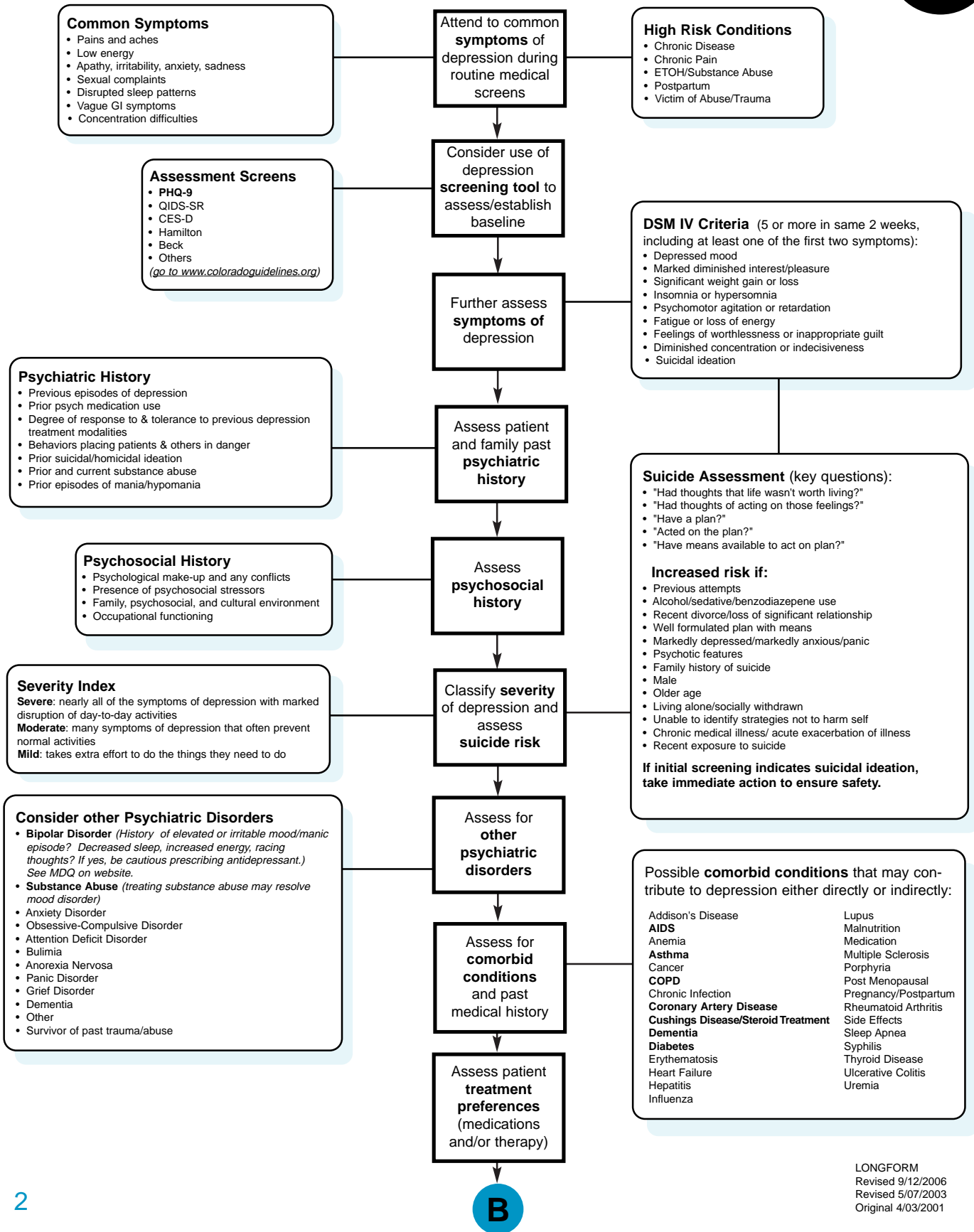
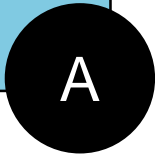
This guideline is designed to assist the clinician in the management of major depression. This guideline is not intended to replace a clinician's judgement or establish a protocol for all patients with a particular condition.

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).

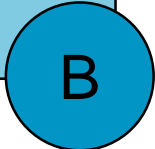
LONGFORM  
Revised 9/12/2006  
Revised 5/07/2003  
Original 4/03/2001

# Major Depression Disorder in Adults

## DIAGNOSIS AND ASSESSMENT



# 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:**

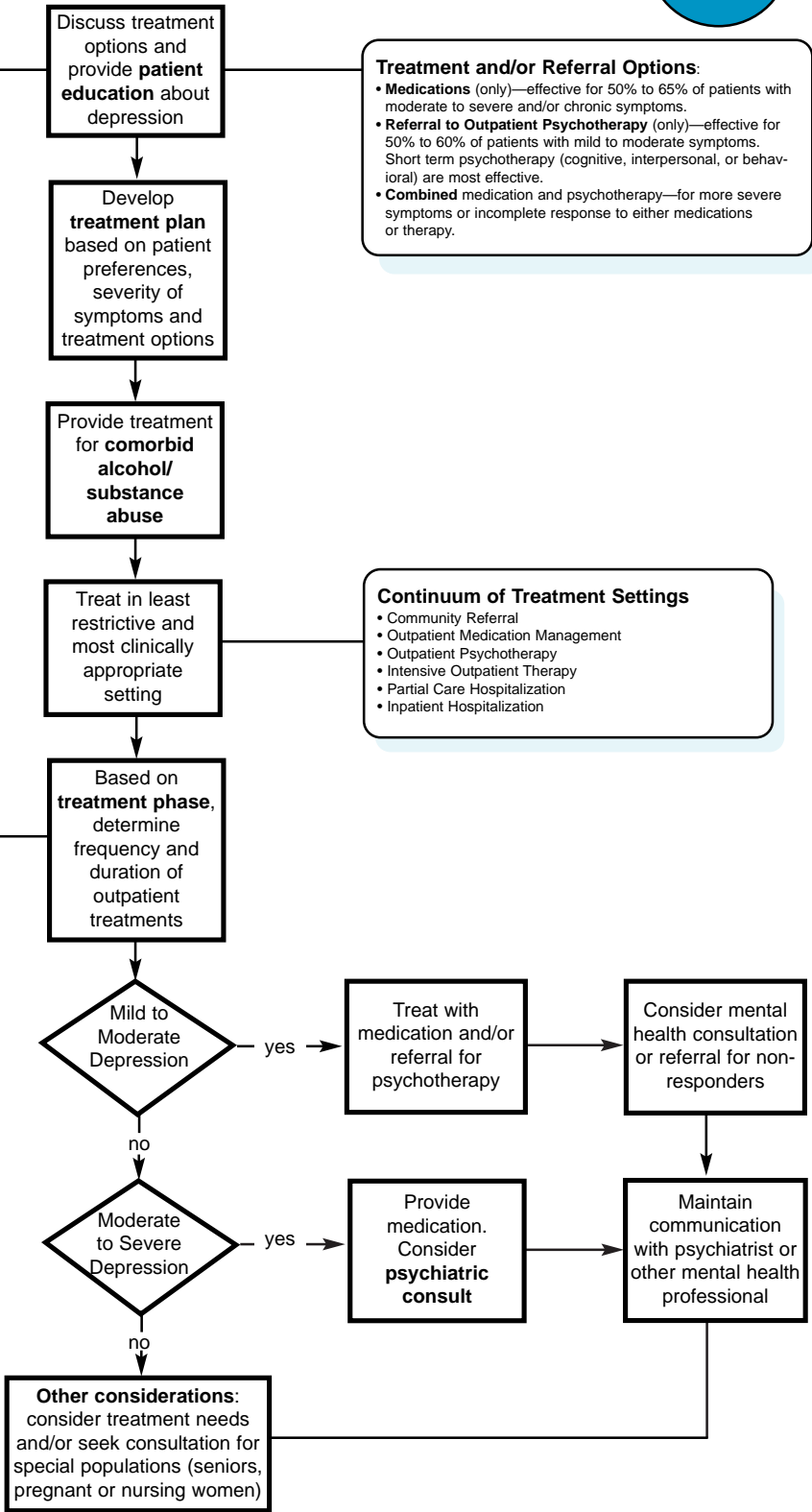
- **Medications (only)**—effective for 50% to 65% of patients with moderate to severe and/or chronic symptoms.
- **Referral to Outpatient Psychotherapy (only)**—effective for 50% to 60% of patients with mild to moderate symptoms. Short term psychotherapy (cognitive, interpersonal, or behavioral) are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

**Treatment phases**

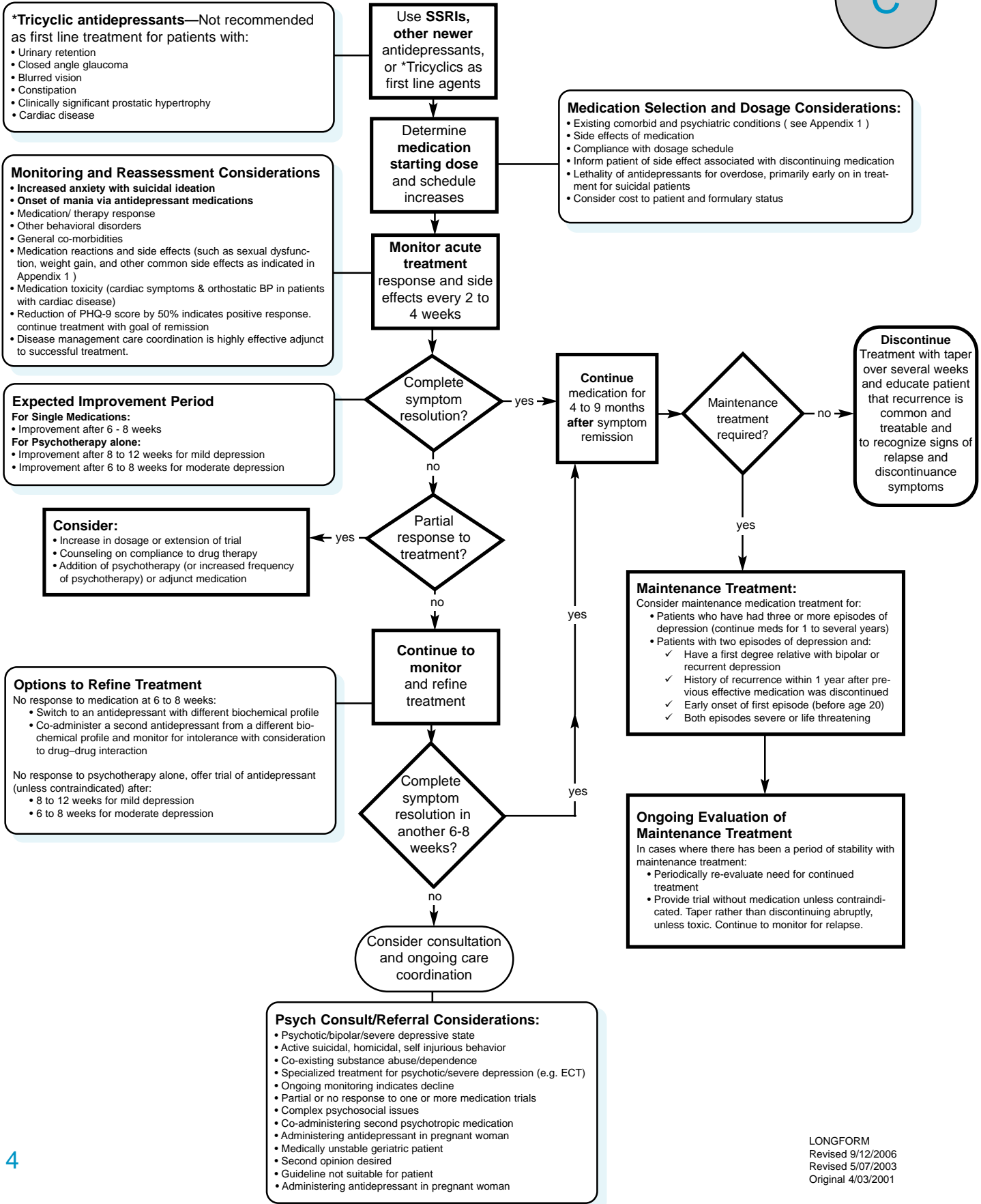
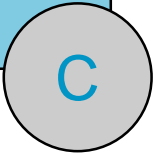
- **Acute Phase**—aimed at symptom reduction in first 6 to 12 weeks. Initial follow-up appointment within 1 to 3 weeks, with additional follow-up appointment/ contact every 2 to 4 weeks as needed based on initial response.
- **Continuation Phase**—aimed at prevention of relapse for 4 to 9 months after 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



# Major Depression Disorder in Adults MEDICATION MANAGEMENT and TREATMENT COURSE



**\*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**

- **Increased anxiety with suicidal 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 of PHQ-9 score by 50% indicates positive response. continue treatment with goal of remission
- 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

**Options to Refine Treatment**

No response to medication at 6 to 8 weeks:

- Switch to an antidepressant with different biochemical profile
- Co-administer a second antidepressant 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

**Medication Selection and Dosage Considerations:**

- Existing comorbid 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 discontinuance symptoms

**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.

**Psych Consult/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 psychosocial issues
- Co-administering second psychotropic medication
- Administering antidepressant in pregnant woman
- Medically unstable geriatric patient
- Second opinion desired
- Guideline not suitable for patient
- Administering antidepressant in pregnant woman

# CCGC APPENDIX 1: Antidepressant Classification and Dosages for Adults

Category	Drug	Remember to titrate up from STARTING DOSE after first 4-7 DAYS of treatment (except for Fluoxetine which may need to wait 3-4 weeks.)	Relative Cost If one \$ present, generic is available	Adverse Side Effects ● 0 = absent or rare 4 = relatively common										Contraindications (X = not recommended)				
				CNS		Cardiovascular		Other		Benign Prostatic Hypertrophy	Coronary Artery Disease	Glaucoma	Orthostatic Hypotension	Seizures	Eating Disorders	Suicidal Risk (overdose lethal)		
		Daily Starting Dosage ■	Usual Adult Dosage	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	0	0	3	1	*								
	Escitalopram (Lexapro)	10 mg QAM	10-20 mg	0	2	1	0	3	1	*								
	Fluoxetine (Prozac)	10-20 mg QAM	20-80 mg	0	1	3	0	3	2	*								
	Fluoxetine (Prozac weekly)	90 Qwk	90 mg	0	1	2	0	3	2	*								
	Fluvoxamine (Luvox) >	50 mg QHS	100-300 mg	0	2	2	0	3	1	*								
	Paroxetine (Paxil)	10-20 mg QAM	20-50 mg	0	2	2	0	3	3	*								
	Paroxetine (Paxil CR)	12.5-25 mg QAM	25-62.5 mg	0	1	2	0	2	3	*								
	Sertraline (Zoloft)	25-50 mg QAM	50-200 mg	\$	0	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	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	1	3								
	Nefazodone (Serzone) ▲	100 mg QHS	300-600 mg	\$	1	2	~	0	1	1	*							
	Amitriptyline (Elavil)	25-75 mg QHS	100-300 mg	\$	4	4	0	4	3	1	~	4			X	X	X	
	Amoxapine (Asendin) X	50 mg BID	100-400 mg	\$\$\$	2	2	2	2	2	0	~	2			X	X	X	
	Clomipramine (Anafranil)	25-75 mg QHS	100-250 mg	\$\$\$	4	~	~	~	~	~	~	~			X	X	X	
	Tricyclics and other agents	Desipramine (Norpramin)	25-75 mg QHS	100-300 mg	\$	1	1	1	2	2	0	~	1			X	X	X
Doxepin (Adapin, Sinequan)		25-75 mg QHS	100-300 mg	\$	3	4	0	2	2	0	~	4			X	X	X	
Imipramine (Tofranil)		25-75 mg QHS	100-300 mg	\$	3	3	1	4	3	1	~	4			X	X	X	
Maprotiline (Ludiomil)		25-75 mg QHS	100-225 mg	\$	2	3	0	2	2	0	~	2			X	X	X	
Nortriptyline (Aventyl, Pamelor)		25-50 mg QHS	50-150 mg	\$	2	2	0	1	2	0	~	1			X	X	X	
Protriptyline (Vivactil)		15 mg QAM	20-60 mg	\$	2	1	1	2	3	0	~	0			X	X	X	
Trazodone (Desyrel)		50 mg QHS	150-600 mg	\$\$\$	1	4	0	3	1	1	~	2			X	X	X	
Trimipramine (Surmontil)		25-75 mg QHS	100-300 mg	\$\$\$	4	4	0	3	3	0	~	4			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. Brand name, Serzone, withdrawn from market. Generic still available.  
 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: \_\_\_\_\_

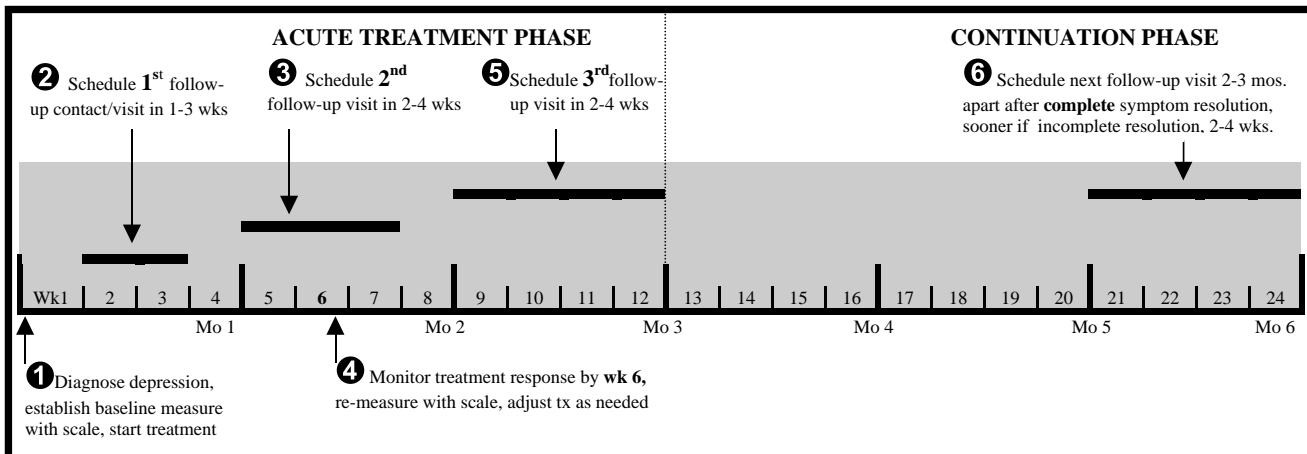
➤ **Outpatient Psychotherapist:** \_\_\_\_\_ Phone: \_\_\_\_\_  Release signed? /date \_\_\_\_\_  
(if applicable)

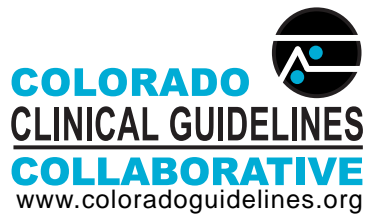
➤ **Outpatient Psychiatrist:** \_\_\_\_\_ Phone: \_\_\_\_\_  Release signed? /date \_\_\_\_\_  
(if applicable)

<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:						
<b>“In the past two weeks, have you had...”</b> ___ 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)

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