Diagnosis and Treatment of Adult Depression

Clinician Guide

August 2018

Introduction

This Clinician Guide is based on the 2018 National Depression guideline and was developed to assist primary care physicians and other clinicians in the diagnosis and treatment of depression in adults. For the 2018 update, the guideline was overhauled, and recommendations were adopted or adapted from a 2016 depression clinical practice guideline published by the Veterans Administration/Department of Defense (VA/DoD). The GDT agrees on the need for coordinated, collaborative care in the treatment of depression. This guideline is not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by practitioners.

Key Points

- For all pregnant and postpartum women, screen using the Edinburgh Postnatal Depression Scale, the Patient Health Questionnaire (PHQ)-9[1] or other validated questionnaire.
- In adults with suspected MDD, administer a diagnostic evaluation that includes a determination of functional status, medical history, past treatment history, and relevant family history. Evaluate for other contributing medical or psychiatric illnesses using appropriate history and diagnostic tools, such as screening for substance misuse and checking thyroid function tests.
- In adults with MDD, provide patient education about the condition and treatment options, including risks and benefits. Develop an individualized treatment plan using shared decision-making principles, and define the provider, patient, and support roles.
- In adults with MDD, use the PHQ-9 to monitor treatment response at 4 to 6 weeks, after each change in treatment, and until full remissions (ie, sustained PHQ-9 at 0-4 for a minimum of 2 months) is achieved. At a minimum, assessments should include a measure of symptoms, as well as adherence to treatment, emergence of adverse effects, and the therapeutic alliance.
- In pregnant or breastfeeding women with mild to moderate MDD, offer an evidence-based psychotherapy group treatment or group support for initiation of treatment.
- In adults with treatment resistant depression, refer to psychiatry for management.

Identification

- For all pregnant and postpartum women, screen using the Edinburgh Postnatal Depression Scale, the Patient Health Questionnaire (PHQ)-9[2] or other validated questionnaire.
- Screen older adults, individuals with chronic illness, or patients with a history of MDD using a validated questionnaire such as the PHQ2 or PHQ9.

[1]The PHQ-9 is often bundled into other regional assessment tools (e.g., AOQ, iCOT, TPI).
[2]The PHQ-9 is often bundled into other regional assessment tools (e.g., AOQ, iCOT, TPI).

- When screening adults for MDD, use a validated questionnaire[3] such as the PHQ-9 and ensure that adequate systems to facilitate accurate diagnosis, effective treatment, and appropriate follow-up are in place.

Assessment and Triage

- In adults with suspected MDD, assess for acute safety risks (eg, harm to self or others, psychotic features) during the initial assessment and periodically thereafter as needed.
- In adults with suspected MDD, administer a diagnostic evaluation that includes a determination of functional status, medical history, past treatment history, and relevant family history. Evaluate for other contributing medical or psychiatric illnesses using appropriate history and diagnostic tools, such as screening for substance misuse and checking thyroid function tests.
- In adults with MDD, use the PHQ-9 or other validated tool to quantitatively measure depression severity in initial treatment planning.

Treatment Setting

- In adults with complex MDD (ie severe, chronic, or recurrent), offer specialty care providers with mental health expertise to ensure better outcomes and effective delivery of evidence-based treatment strategies.

Management

Treatment for Uncomplicated Mild to Moderate MDD

- In adults with MDD, provide patient education about the condition and treatment options, including risks and benefits. Develop an individualized treatment plan using shared decision-making principles, and define the provider, patient, and support roles.
- As first-line treatment for uncomplicated mild to moderate MDD[4] in adults, choose from psychotherapy[5], pharmacotherapy, or both based on patient preference, safety/side effect profile, history of prior response to a specific medication, family history of response to a medication, concurrent medical illnesses, concurrently prescribed medications, cost of medication, and provider training.
    - For pharmacotherapy, choose from one of the following agents:
        - Selective serotonin reuptake inhibitor: fluoxetine, paroxetine, sertraline, citalopram, escitalopram
        - Serotonin norepinephrine reuptake inhibitor: venlafaxine, duloxetine
        - Mirtazapine
        - Bupropion

[3] Such as the PHQ-9 or Edinburgh scale.

[4] Moderate depression is defined as a PHQ-9 score of 10-14. Mild depression is defined as a PHQ-9 score of 5-9.

[5] Types of psychotherapy include acceptance and commitment therapy (ACT), behavioral therapy/behavioral activation (BT/BA), cognitive behavioral therapy (CBT), interpersonal therapy (IPT), mindfulness-based cognitive therapy (MBCT), problem-solving therapy (PST). The evidence does not support recommending a specific evidence-based psychotherapy or pharmacotherapy over another.

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- In adults who have demonstrated partial or no response to initial pharmacotherapy monotherapy (maximized) after a minimum of 4 to 6 weeks of treatment, switch to another monotherapy (medication or psychotherapy) or augment with a second medication or psychotherapy.
- In adults with MDD who select psychotherapy as a treatment option, consider offering individual or group format based on patient preference.

Treatment for Severe, Chronic, or Recurrent MDD (Complex)

- In adults with MDD, consider offering a combination of pharmacotherapy and evidence-based psychotherapy (eg, behavioral therapy/activation) for the treatment of patients with MDD during a new episode of care when the MDD is characterized as:
  - Severe, including significant role impairment of PHQ-9 > 20
  - Chronic (duration > 2 years)
  - Recurrent (≥3 episodes)

Monitoring (All Severities and Complexities of MDD)

- In adults with MDD, use the PHQ-9 to monitor treatment response at 4 to 6 weeks, after each change in treatment, and until full remissions (ie, sustained PHQ-9 at 0-4 for a minimum of 2 months) is achieved. At a minimum, assessments should include a measure of symptoms, as well as adherence to treatment, emergence of adverse effects, and the therapeutic alliance.

Continuation and Maintenance Treatment (All Severities and Complexities of MDD)

- In patients with MDD who achieve remission with antidepressant medication, continue antidepressants at the therapeutic dose for at least 6 months to decrease risk of relapse.
- In patients at high risk for recurrent depressive episodes (≥ 3 past depressive episodes) and who are treated with pharmacotherapy, provide maintenance pharmacotherapy for at least 12 months and possibly indefinitely.
- In patients at high risk for relapse (eg, ≥ 2 prior episodes or unstable remission status), provide psychotherapy during the continuation phase of treatment after remission is achieved to reduce the risk of subsequent relapse/recurrence[6].

Other Treatment Considerations

Recommendations for Specific Populations with Mild to Moderate MDD

- In pregnant or breastfeeding women with mild to moderate MDD, offer an evidence-based psychotherapy group treatment or group support for initiation of treatment.

[6] The evidence does not support recommending a specific evidence-based psychotherapy over another.

- In pregnant women with a history of MDD before pregnancy who responded to antidepressant medications and are currently stable on pharmacotherapy, weigh risk/benefit balance to both mother and fetus in treatment decisions.

Severe, Chronic, or Recurrent MDD (Complex)

- In adults with treatment resistant depression, refer to psychiatry for management.

Self-Help, Complementary and Alternative Treatments

- In adults with MDD, there is no recommendation for or against acupuncture as a treatment for depression
- For patients with MDD, consider discussing the benefits of exercise as an adjunct to other evidence-based treatments for depression or as monotherapy when patients are unwilling or unable to engage in first-line evidence-based psychotherapy or pharmacotherapy.
- In adults with mild MDD, consider offering patient education about the benefits of bibliotherapy based on cognitive-behavioral principles as adjunctive treatment or psychotherapy based on patient preference.

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TERMINOLOGY		
Recommendation Language	**Strength***	**Action**
Start, initiate, prescribe, treat, etc.	Strong affirmative	Provide the intervention. Most individuals should receive the intervention; only a small proportion will not want the intervention.
Consider starting, etc.	Conditional affirmative	Assist each patient in making a management decision consistent with personal values and preferences. The majority of individuals in this situation will want the intervention, but many will not. Different choices will be appropriate for different patients.
No recommendation for or against	None	Given that the balance between desirable and undesirable effects, the evidence quality, the values and preferences, and the resource allocation implications of an intervention do not drive a recommendation in one particular direction, recommendations will be made at the discretion of the individual clinician.
Consider stopping, etc.	Conditional negative	Assist each patient in making a management decision consistent with personal values and preferences. The majority of individuals in this situation will not want the intervention, but many will. Different choices will be appropriate for different patients.
Stop, do not start, etc.	Strong negative	Do not provide the intervention. Most individuals should not receive the intervention; only a small proportion will want the intervention.

*Refers to the extent to which one can be confident that the desirable effects of an intervention outweigh its undesirable effects.

DISCLAIMER

This guideline is informational only. It is not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by practitioners, considering each patient's needs on an individual basis. Guideline recommendations apply to populations of patients. Clinical judgment is necessary to design treatment plans for individual patients.