General

Guideline Title

Diagnosis and treatment of depression in adults: 2012 clinical practice guideline.

Bibliographic Source(s)

Kaiser Permanente Care Management Institute. Diagnosis and treatment of depression in adults: 2012 clinical practice guideline. Oakland (CA): Kaiser Permanente Care Management Institute; 2012 Jun. 73 p. [32 references]

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Kaiser Permanente Care Management Institute. Depression clinical practice guidelines. Oakland (CA): Kaiser Permanente Care Management Institute; 2006 Mar. 196 p. [157 references]

To keep current with changing medical practices, all guidelines are reviewed and, if appropriate, revised at least every two years.

Recommendations

Major Recommendations

Recommendations are identified as either "strong" or "weak." For definitions of the recommendation strength, see the end of the "Major Recommendations" field.

Depression Screening

1. The Patient Health Questionnaire 9 (PHQ9) or PHQ2 is recommended for depression screening. (Strong recommendation)
    a. The Geriatric Depression Scale (GDS or GDS15) is an option as a screening instrument for older patients who have difficulty completing the PHQ9. (Weak recommendation)
    b. The Edinburgh Postpartum depression scale is an option as a screening tool for pregnant or postpartum women. (Weak recommendation)

Note: The PHQ9 is recommended as the preferred diagnosis and tracking instrument.

First-Line Treatment

2. Antidepressant medication or referral to behavioral health clinicians for evidence-based psychotherapy are recommended as first-line treatment in patients with mild to moderate major depressive disorder (MDD). (Weak recommendation)
    a. Given the lack of evidence on a clearly superior approach for mild to moderate MDD, clinicians may base treatment decisions on patient and clinician preference, potential side effects, and cost. (Weak recommendation)

Note: Evidence-based psychotherapy can include Interpersonal Therapy, Cognitive Behavioral Therapy (CBT), or Problem-Solving Therapy

3. The combination of antidepressants and referral to behavioral health for evidence-based psychotherapy is recommended as first-line treatment for patients with severe or chronic MDD. (Strong recommendation)
4. First-line antidepressant use
    a. Any class of antidepressant (selective serotonin reuptake inhibitor [SSRI], tricyclic antidepressant [TCA], serotonin–norepinephrine reuptake inhibitor [SNRI], norepinephrine reuptake inhibitor [NRI], or dopamine agonist [DA]) is recommended for first-line treatment of MDD. (Strong recommendation)
    b. Given the equivalence of therapeutic effect, clinicians may base the choice of antidepressant on patients' prior response, patient and clinician preference, potential side effects, and cost. (Weak recommendation)
5. Behavioral activation in the primary care setting is an option for patients with mild to moderate depression. (Weak recommendation)

Note: Behavioral activation is a discrete, time-limited, structured psychological intervention, derived from the behavioral model of affective disorders.

6. Monitoring patients who are prescribed antidepressants for signs of new or worsening suicidal ideation is recommended. (Strong recommendation)
    a. Consultation or collaboration with a psychiatrist before prescribing TCAs or venlafaxine for patients with suicidal ideation or who have made previous suicide attempts is an option. (Weak recommendation)
    b. Consultation with specialty behavioral health for patients with MDD who are expressing suicidal intent or plan is an option. (Strong recommendation)
7. Atypical antipsychotics are not recommended as first-line treatment for (non-psychotic) MDD. (Strong recommendation)
8. Use of *Hypericum* (St. John's wort)

    a. *Hypericum* (St. John's wort) is not generally recommended for patients with severe MDD. (Weak recommendation)
    b. The Guideline Development Team (GDT) makes no recommendation for or against providing *Hypericum* (St. John's wort) to patients with mild to moderate MDD.

Second-Line Treatment

12. Assessing adherence to the initial treatment regimen for patients with MDD whose symptoms fail to remit after first-line treatment is recommended. (Strong recommendation)
13. For patients with MDD whose symptoms fail to remit after adherence to first-line treatment, recommended alternatives include:
    a. Combine antidepressant and psychotherapy. (Strong recommendation)
    b. Increase the dose of the initial antidepressant. (Strong recommendation)
    c. Switch to a different antidepressant of the same or different class. (Strong recommendation)
    d. Switch from psychotherapy to antidepressants or antidepressants to psychotherapy. (Strong recommendation)
    e. Combine pharmacologic treatment (monitoring for toxicity, side effects and drug interactions) with selective serotonin reuptake inhibitors and:
        I. Low-dose TCAs
        II. Bupropion
        III. Mirtazepine
        IV. Lithium

        (Strong recommendation)
14. Consulting psychiatry before prescribing atypical antipsychotics for MDD is recommended. (Strong recommendation)
15. Augmentation with pindolol for patients with MDD whose symptoms fail to remit after adherence to first-line treatment is not recommended. (Strong recommendation)
16. Benzodiazepines for depression treatment augmentation or antidepressant side-effect management are not generally recommended. (Weak recommendation)

Adjunctive Treatment Strategies

17. Exercise as an adjunctive strategy (in addition to antidepressants or psychotherapy) for treating MDD is recommended. (Strong recommendation)
18. Internet patient cognitive-behavioral therapy self-help programs as an adjunct strategy (in addition to antidepressants or psychotherapy) for treating MDD is an option. (Weak recommendation)

19. Selected bibliotherapy as an adjunct strategy (in addition to antidepressants or psychotherapy) for treating MDD is an option. (Weak recommendation)

Note: Bibliotherapy (e.g., reading therapy, self-help books therapy) is the use of books to help people understand mental health conditions.

20. Behavioral health education classes as an adjunctive treatment option for patients with mild to moderate MDD is recommended. However, these classes should not be used in lieu of either antidepressant medication or psychotherapy. (Strong recommendation)
21. Light therapy as a primary or adjunctive treatment for non-seasonal forms of MDD is not generally recommended. (Weak recommendation)

Long-Term Treatment, Monitoring, and Follow-up

22. The PHQ9 is recommended to monitor outcomes of care over time. (Strong recommendation)
23. For patients who are starting treatment with antidepressants for MDD, a minimum follow-up of one patient contact within the first month, and at least one additional patient contact four to eight weeks after the first contact is recommended. Assessing for adherence, side effects, suicidal ideation, and patient response during both these visits is recommended. (Strong recommendation)
24. After achieving symptom remission, at least one follow-up contact during the fifth or sixth month of treatment in patients with MDD is recommended. Assessing for continuing symptom remission and dosage/treatment adjustment during this contact is recommended. (Strong recommendation)
25. For asymptomatic patients with MDD who are continuing on antidepressants beyond 12 months:
    a. At least one annual follow-up contact to assess for continuing symptom remission, the need for ongoing treatment, and dosage/treatment adjustment is an option. (Weak recommendation)
    b. Additional follow-up should be based on patient preference and response. (Weak recommendation)
26. Continuing antidepressants at the same dose for at least an additional six to 12 months for patients with MDD who achieve symptom remission with antidepressants is recommended. (Strong recommendation)

27. Based on patient and provider preference, a trial of antidepressant discontinuation is an option for patients in their first lifetime episode of MDD, who are being treated with antidepressants, achieve remission, and remain asymptomatic for six to 12 months after acute phase treatment. (Weak recommendation)
28. For patients with two or more lifetime episodes of MDD, who are being treated with antidepressants and remain asymptomatic after acute phase treatment, maintenance on the medication and dose with which they achieved remission for at least an additional 15 months to five years after acute phase treatment is recommended. (Strong recommendation)
29. For patients with chronic MDD (e.g., continual symptoms for more than two years) or double depression (MDD and dysthymia) who improve with antidepressants during acute phase treatment, continuing antidepressants for at least an additional 15 to 28 months after acute phase treatment is recommended. (Strong recommendation)
30. Cognitive behavioral therapy is recommended to decrease the risk of relapse in patients with depression who achieve symptom remission and are considered to be at increased risk of relapse who are unable or choose not to take or continue antidepressants. (Strong recommendation)