Guideposts for the Treatment of Major Depressive Disorder

Optum is committed to assuring our members receive the highest quality evidence based and person-centered care available. Optum recognizes the time demand on staff and providers and offers this resource to give rapid access to evidence based strategies and guidance from professional organizations. These key components from several best practice guidelines will serve as a common language among Optum, providers and members that allows us to all work together in a member-centric manner. We want to partner to provide the highest quality care to our members.

Assessment:

1. **Rule out depression secondary to other causes (e.g., hypothyroidism, vitamin B-12 deficiency, syphilis, pain, chronic disease) (VA, 2022; VA/DoD Clinical Practice Guideline. (2022). The Management of Major Depressive Disorder. Washington, DC: U.S. Government Printing Office).**
2. **A comprehensive assessment can help identify factors that might require modifications to a treatment recommended by clinical practice guidelines. These include patient factors such as race; ethnicity; socioeconomic status; culture and/or heritage; or other features of their identities, values, or preferences. In addition, the patient's comorbidities, social support, and ability to obtain childcare when needed must be considered (APA 2019; Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts, American Psychological Association, Guideline Development Panel for the Treatment of Depressive Disorders, Adopted as APA Policy Feb. 16, 2019).**

Treatment:

3. **We recommend that MDD be treated with either psychotherapy or pharmacotherapy as monotherapy, based on patient preference. Factors including treatment response, severity, and chronicity may lead to other treatment strategies such as augmentation, combination treatment, switching of treatments, or use of non-first line treatments (VA, 2022).**
4. **Ensure that an evidence-based, timely and appropriate discharge plan will be in place. This should include, but not be limited to: (NAMI, 2018; NAVIGATING A MENTAL HEALTH CRISIS | A NAMI resource guide for those experiencing a mental health emergency)**
    - **Safety plan is in place and agreed to by the member;**
    - **Member involvement in the development of the discharge plan and member agreement with the plan of care;**
    - **Assessing potential barriers to success;**
    - **Consideration of SDOH, and other special needs, including substance use and other identified comorbid issues;**

- **Identify the type(s) of practitioner the member needs to see (psychiatrist, therapist, etc.).**

Support:

5. **The collaborative care model, in which primary care, specialty care, and patients are engaged in a coordinated overall care plan, has been shown in systematic reviews and randomized controlled trials of young people and adults (including patients in older age groups) to decrease the severity of depressive symptoms (APA, 2019).**

Guideposts Details

Assessment:

1. **Rule out depression secondary to other causes (e.g., hypothyroidism, vitamin B-12 deficiency, syphilis, pain, chronic disease) (VA, 2022; VA/DoD Clinical Practice Guideline. (2022). The Management of Major Depressive Disorder. Washington, DC: U.S. Government Printing Office).**

Background Information:

Patients should receive a thorough diagnostic assessment in order to establish the diagnosis of major depressive disorder, identify other psychiatric or general medical conditions that may require attention, and develop a comprehensive plan for treatment. This evaluation generally includes:

- a history of the present illness and current symptoms;
- a psychiatric history, including identification of past symptoms of mania, hypomania, or mixed episodes and responses to previous treatments;
- substance use history and/or treatment;
- a general medical history (e.g., medical conditions, physical health);
- a personal history including information about psychological development and responses to life transitions and major life events;
- a social, occupational, and family history (including mood disorders and suicide);
- review of the patient's prescribed and over-the-counter medications;
- a review of systems;
- a mental status examination;
- a physical examination;
- and appropriate diagnostic tests as indicated to rule out possible general medical causes of depressive symptoms.

A physical examination should be conducted to support the clinical interview and mental status exam and consider a range of medical conditions that can mimic or induce depression. Attention should be given to any neurologic deficits, evidence of endocrine or other metabolic disease or systemic illness.

Laboratory testing is performed as clinically indicated. Useful tests may include thyroid studies (thyroid-stimulating hormone (TSH)), complete blood count (CBC), chemistry profile, pregnancy screen and/or toxicology panel.

Use of a structured instrument such as a PHQ-9 facilitates collection of the information required to diagnose MDD based on DSM criteria, ascertains the baseline severity of symptoms, and helps to determine their impact on daily functioning. Furthermore, a brief test for cognitive impairment is likely appropriate in the elderly and in those with a history of traumatic brain injury. (VA, 2022)

Assessment of substance use should evaluate past and current use of illicit drugs and other substances that may trigger or exacerbate depressive symptoms. This should include substance use patterns, including the type, frequency and quantity of substances used. Substance use screening tools can be helpful (e.g., AUDIT, DAST, CAGE).

2. **A comprehensive assessment can help identify factors that might require modifications to a treatment recommended by clinical practice guidelines. These include patient factors such as race; ethnicity; socioeconomic status; culture and/or heritage; or other features of their identities, values, or preferences. In addition, the patient's comorbidities, social support, and ability to obtain childcare when needed must be considered (APA 2019; Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts, American Psychological Association, Guideline Development Panel for the Treatment of Depressive Disorders, Adopted as APA Policy Feb. 16, 2019).**

Background Information:

Major depressive disorder can alter functioning in numerous spheres of life including work, school, family, social relationships, leisure activities, or maintenance of health and hygiene. The treating provider should evaluate the patient's activity in each of these domains and determine the presence, type, severity, and chronicity of any dysfunction. In developing a treatment plan, interventions should be aimed at maximizing the patient's level of functioning as well as helping the patient to set specific goals appropriate to his or her functional impairments and symptom severity (APA).

Clinicians strive to individualize treatments. So how might one follow evidence-based clinical practice guidelines, yet honor the individuality of patients? A comprehensive assessment can help identify factors that might require modifications to a treatment recommended by clinical practice guidelines. These include patient factors such as race; ethnicity; socioeconomic status; culture and/or heritage; or other features of their identities, values, or preferences. In addition, the patient's comorbidities, social support, and ability to obtain childcare when needed, as well as the clinician's accessibility, location, hours of operation, available appointments, proximity to public transportation, and other resources that can affect treatment, must be considered (American Psychological Association).

Decent, safe, affordable housing lays a foundation for recovery, yet without financial assistance, independent housing is out of reach for many people on a fixed income. A recent study of mental health caregivers found that 45% of the care recipients lived with the caregiver. Although there are advantages to living as an extended family, the situation can also be stressful. Mental

health agencies often employ housing specialists to help with subsidized housing. In some communities, the waiting lists are long, but signing up is still worthwhile (NAMI).

Treatment:

3. **We recommend that MDD be treated with either psychotherapy or pharmacotherapy as monotherapy, based on patient preference. Factors including treatment response, severity, and chronicity may lead to other treatment strategies such as augmentation, combination treatment, switching of treatments, or use of non-first line treatments (VA, 2022).**

Background Information:

For initial treatment of adult patients with depression, the following is recommended in the context of sharing decision-making with the patient when considering options (APA, 2019)

- That clinicians offer either psychotherapy or second-generation antidepressant. When selecting between treatments, the following options are recommended:
    - Second-generation antidepressants (selective serotonin reuptake inhibitors (SSRIs) or serotonin-norepinephrine reuptake inhibitors (SNRIs)).
    - Effectiveness studies demonstrated similar effects across psychotherapy. Thus, general models that appear to have comparable effects include:
        - Behavioral therapy
        - Cognitive, cognitive-behavioral (CBT), and mindfulness-based cognitive-therapy (MBCT)
        - Interpersonal psychotherapy (IPT)
        - Psychodynamic therapies
        - Supportive therapy
- If considering combined treatment, cognitive-behavioral therapy (CBT) or interpersonal psychotherapy (IPT) plus a second-generation antidepressant is recommended.

Treatment in the acute phase should be aimed at inducing remission of the major depressive episode and achieving a full return to the patient's baseline level of functioning. Acute phase treatment may include pharmacotherapy, depression-focused psychotherapy, the combination of medications and psychotherapy, or other somatic therapies such as electroconvulsive therapy (ECT), transcranial magnetic stimulation (TMS), or light therapy. Selection of an initial treatment modality should be influenced by clinical features (e.g., severity of symptoms, presence of co-occurring disorders or psychosocial stressors) as well as other factors (e.g., patient preference, prior treatment experiences). Any treatment should be integrated with psychiatric management and any other treatments being provided for other diagnoses (APA).

4. **Ensure that an evidence-based, timely and appropriate discharge plan will be in place. This should include, but not be limited to: (NAMI, 2018; NAVIGATING A MENTAL HEALTH CRISIS | A NAMI resource guide for those experiencing a mental health emergency)**

    a. **Safety plan is in place and agreed to by the member;**
    b. **Member involvement in the development of the discharge plan and member agreement with the plan of care;**

c. **Assessing potential barriers to success;**
d. **Consideration of SDOH, and other special needs, including substance use and other identified comorbid issues;**
e. **Identify the type(s) of practitioner the member needs to see (psychiatrist, therapist, etc.).**

Background Information:

- Safety plan is in place & agreed to by the member:
    - A crisis or safety plan is designed to address symptoms and behaviors and help individuals prepare for crisis in advance. The plan should be personal and individualized but should contain some common elements. A plan should:
        - identify warning signs and symptoms,
        - coping skills,
        - informal supports, formal supports/services, and
        - specifically address safety concerns.

    NAMI MN, *Mental Health Crisis Planning for Adults*. December 2018. namimn.org/wp-content/uploads/sites/188/2018/12/MHCrisisPlanningAdult_2018.12.14.pdf

    National Action Alliance for Suicide Prevention; Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient Care to Outpatient Care, 2019. report_-_best_practices_in_care_transitions_final.pdf (theactionalliance.org)

- Member involvement in the development of the discharge plan and member agreement with the plan of care:
    - When providing evidence-based treatment recommendations, take into consideration the following:
        - Culture
        - Language preference
        - Physical impairments in hearing or speech
        - Any learning disabilities
    - Selection of the specific intervention should be accompanied by appropriate patient education and patient-centered shared decision-making. The availability of appropriately trained staff and technology should also be considered.

Clinical Practice Guideline for the Management of Major Depressive Disorder; Department of Veteran Affairs, Department of Defense, 2016

- Assess for potential barriers to success. Patients often are unable to keep scheduled appointments or adhere to medication recommendations due to issues around:
    - Transportation
    - Childcare
    - Cost
    - Time off from work
    - Stigma

A full assessment of these potential barriers should be completed as part of the discharge planning process.

- Consideration of Social Determinants of Health and other special needs, including substance use and other identified comorbid issues:
    - See detailed background above in #2
- Identify the type of provider the member needs to see (therapist, psychiatrist, PCP, etc.)
    - Patients hospitalized for mental health issues are vulnerable after discharge and follow-up care by trained mental health clinicians is critical for their health and well-being.
    - An appointment should ideally be made within 7 days post discharge, and always within 30 days post discharge. The appointment should be with the member's usual mental health practitioner (if established) at a time and date that fits with the person's preferences, and transportation for the appointment should be arranged if needed.

ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/

Support:

5. **The collaborative care model, in which primary care, specialty care, and patients are engaged in a coordinated overall care plan, has been shown in systematic reviews and randomized controlled trials of young people and adults (including patients in older age groups) to decrease the severity of depressive symptoms (APA, 2019).**

Background Information:

The ultimate decision about treatment should be based on shared decision-making with the patient and /or their supports and, in the case of youth patients, the parents/guardians or family members actively involved in their care (APA Depression Guideline). Regardless of the venue and modalities for mental health treatment, care coordination around chronic medical conditions and heightened attention to unmet psychosocial needs or situational stressors are important elements of effective care.

Sources:

- **APA 2019**: Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts, American Psychological Association, Guideline Development Panel for the Treatment of Depressive Disorders, Adopted as APA Policy Feb. 16, 2019.
- **NAMI, 2018:** NAVIGATING A MENTAL HEALTH CRISIS | A NAMI resource guide for those experiencing a mental health emergency.
- **National Action Alliance for Suicide** Prevention, 2019: Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient Care to Outpatient Care, 2019. report - best practices in care transitions final.pdf (theactionalliance.org)
- **VA, 2022**: VA/DoD Clinical Practice Guideline. (2022). The Management of Major Depressive Disorder. Washington, DC: U.S. Government Printing Office.