

MOH CLINICAL PRACTICE GUIDELINES 6/2011

DEPRESSION



College of Family
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Singapore Medical
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MINISTRY OF HEALTH
SINGAPORE

Executive summary of recommendations

Details of recommendations can be found in the main text at the pages indicated.

Clinical evaluation

D The basic assessment of depression includes the history, the mental state examination and physical examination.

- Take a detailed history of the presenting symptoms and determine the severity and duration of the depressive episode. Establish history of prior episodes, prior manic or hypomanic episodes, substance abuse and other psychiatric illnesses. Look out for co-existing medical conditions. Check for family history of mental illness, depression and suicide. Establish the personal history and the available supports and resources. Evaluate functional impairment and determine life events and stressors.
- Do a mental state examination. This includes an evaluation of the severity of symptoms and assessment for psychotic symptoms. All assessments of depression will include an assessment of the risk of suicide, self-harm and risk of harm to others (See Annex II on pg 58).
- Do a physical examination to exclude a medical or surgical condition.
- Laboratory testing may be indicated if there is a need to rule out medical conditions that may cause similar symptoms.
(pg 20)

Grade D, Level 4

D Screening for depression may be beneficial when it is done in high-risk populations (such as individuals with significant physical illnesses causing disability) where the benefits outweigh the risks (pg 21).

Grade D, Level 4

C The PHQ-9 (patient health questionnaire 9) may be used to screen for depression in primary care (pg 21).

Grade C, Level 2+

D Referrals to a specialist are warranted when:

- there are co-morbid medical conditions for which expertise is required regarding drug-drug interactions,
 - there is diagnostic difficulty,
 - one or two trials of medication have failed,
 - augmentation or combination therapy is needed,
 - there are co-morbid substance abuse or severe psychosocial problems,
 - psychotic symptoms are present, or
 - specialised treatment like electroconvulsive therapy is indicated.
- (pg 22)

Grade D, Level 4

Principles of treatment

GPP Consider using the Clinical Global Impression scales (both severity and improvement component scales) to measure illness severity and treatment progress during consultations (pg 25).

GPP

Pharmacotherapy

A Antidepressants should be recommended as a first-line treatment in patients with moderate to severe depression, or sub-threshold depression that has persisted for 2 years or more (pg 26).

Grade A, Level 1+

D Antidepressants are a treatment option in short duration mild depression in adults and should be considered if there is a history of moderate to severe recurrent depression or if the depression persists for more than 2–3 months (pg 26).

Grade D, Level 4

D If the patient has previously responded well to and has had minimal side-effects with a drug, that drug is preferred. Alternatively, if the patient has previously failed to respond to an adequate trial of one antidepressant or found the side-effects of an antidepressant intolerable, that medication should generally be avoided (pg 27).

Grade D, Level 4

A Once an antidepressant has been selected, start with a low dose and titrate gradually to the full therapeutic dose, while assessing patients' mental state and watching for side-effects. The frequency of monitoring depends on the severity of the depression, suicide risk, the patient's cooperation and the availability of social support (pg 27).

Grade A, Level 1+

A A selective serotonin reuptake inhibitor (SSRI) antidepressant should be used as a first-line medication for treating depression, due to its favourable risk-benefit ratio, greater tolerability and safety in overdose (pg 28).

Grade A, Level 1++

A Selective serotonin reuptake inhibitor (SSRI) antidepressants should be prescribed as a first line medication for depression in patients with concomitant cardiovascular diseases due to their favourable risk-benefit ratio (pg 28).

Grade A, Level 1++

A The “newer” antidepressants can also be considered as other first-line options for treating depression. They include:

- Serotonin and Norepinephrine Reuptake Inhibitors (SNRI) (e.g. venlafaxine)
 - Noradrenergic and Specific Serotonergic Antidepressants (NaSSA) (e.g. mirtazapine)
 - Norepinephrine and Dopamine Reuptake Inhibitors (NDRI) (e.g. bupropion).
- (pg 28)

Grade A, Level 1+

D Where there are interactions with other drugs, use of escitalopram or sertraline should be considered as they have fewer propensities for interactions, appear to be safe and possibly protective of further cardiac events (pg 28).

Grade D, Level 4

A Due to their cardiotoxic adverse effect risks, tricyclic antidepressants (TCA) should be avoided in patients at high risk of cardiovascular disease, arrhythmias and cardiac failure (pg 29).

Grade A, Level 1++

A Older tricyclic antidepressants and monoamine oxidase inhibitors (MAOIs) should be reserved for situations when first-line medication treatment has failed (pg 29).

Grade A, Level 1+

B A new class of antidepressants, known as melatonin agonists, e.g. agomelatine, may also be considered as an alternative treatment option for depression, if first-line medication is unsuitable or has failed (pg 29).

Grade B, Level 1+

D When an antidepressant is to be prescribed, tailor it to the patient with depression and a chronic physical health problem, and take into account the following:

- the presence of additional physical health disorders.
 - the side effects of antidepressants, which may impact on the underlying physical disease (in particular, selective serotonin reuptake inhibitors may result in or exacerbate hyponatraemia, especially in older people.
 - interactions with other medications.
- (pg 29)

Grade D, Level 3

C The emergence of suicidal thinking and behaviour, or unusual changes in behaviour should be monitored during the early phases (generally the first 1-2 months) of antidepressant treatment, especially in children, adolescents and young adults between 18 to 24 years old (pg 29).

Grade C, Level 2+

A Initial and short-term (2-4 week) usage of a benzodiazepine together with an antidepressant may be considered where anxiety, agitation and/or insomnia becomes problematic to patients with depression (pg 30).

Grade A, Level 1++

C All antidepressants, once started, should be continued for at least 4 to 6 weeks (pg 30).

Grade C, Level 2+

A Patients with first episode of depression without psychotic symptoms should be treated with antidepressants at full treatment dose for 6-9 months after remission of symptoms (pg 30).

Grade A, Level 1++

B Patients who have a second episode of depression should be maintained on treatment for 1-2 years - the duration may depend on the risk factors for recurrence and the patient preference (pg 31).

Grade B, Level 1+

C Patients with more than two episodes of depression should be maintained on treatment for 2 years or longer, or even lifelong - the duration may depend on the risk factors for recurrence and the patient preference (pg 31).

Grade C, Level 2+

GPP Maintenance antidepressant treatment should be carried on for as long as necessary (pg 31).

GPP

B Using higher antidepressant doses may be helpful for patients who have shown a partial response and when only low or modest doses have been tried. The patient should be closely monitored for side-effects with the increase in dose (pg 32).

Grade B, Level 2++

B Switching is preferred to augmentation as an initial strategy in accordance with general principles that combinations should preferably not be used when monotherapy will suffice (pg 32).

Grade B, Level 2++

A Both switching within the class (i.e. from a selective serotonin reuptake inhibitor to another), as well as switching from a selective serotonin reuptake inhibitor to a different class of antidepressants, may be done as both have been found beneficial (pg 32).

Grade A, Level 1++

GPP When switching medications, clinicians should be vigilant for the onset of drug-drug interactions (e.g. Serotonin syndrome) and drug discontinuation reaction (pg 32).

GPP

A Lithium augmentation and thyroid hormone augmentation (using levothyroxine or triiodothyromine) are two traditional augmentation strategies that may be used for patients who have had previous antidepressant trials and have not responded to adequate trials of other individually prescribed antidepressants (pg 33).

Grade A, Level 1++

A When discontinuing antidepressants, antidepressants should be gradually tapered off instead of suddenly stopped, to reduce side effects of discontinuation (pg 33).

Grade A, Level 1++

Psychotherapy

A Psychotherapy alone is as efficacious as antidepressant medication in patients with mild to moderate major depression and may be used as first-line treatment (pg 34).

Grade A, Level 1++

A Cognitive-behavioural therapy is recommended when the depressed patient has distorted negative thoughts (pg 35).

Grade A, Level 1++

B Cognitive-behavioural therapy is also an effective maintenance treatment and is recommended for patients with recurrent depression who are no longer on medication (pg 35).

Grade B, Level 1+

Interpersonal therapy

B Interpersonal therapy is recommended for depressed patients with interpersonal difficulties (pg 35).

Grade B, Level 1+

A Psychodynamic-interpersonal therapy is a viable alternative treatment for depressed patients with interpersonal difficulties (pg 36).

Grade A, Level 1+

A Long-term psychodynamic psychotherapy is recommended for depressed patients with co-morbid personality disorder (pg 36).

Grade A, Level 1++

A Problem-solving therapy is recommended for primary care patients with mild depression (pg 36).

Grade A, Level 1++

A Cognitive-behavioural therapy or psychodynamic interpersonal therapy should be delivered for a longer period (i.e. 16 weeks or longer) when the depression is severe (pg 37).

Grade A, Level 1+

D If a moderate improvement, at least, is not observed after 4-8 weeks of psychotherapy, a thorough review of the diagnosis, complicating conditions and issues, and treatment plan should be conducted. If there is no response, consider adding or changing to medication. If there is partial response, consider changing the intensity of psychotherapy, changing the type of psychotherapy, or adding or changing to medication (pg 37).

Grade D, Level 4

Psychoeducation and family intervention

A The following should be done:

- a. Educating the patient about the illness helps clarify uncertainty and misconceptions. Depression should be explained as a medical illness that is associated with changes in neurochemicals and brain functioning.

- b. Adequate follow-up improves treatment adherence, allows closer monitoring and earlier detection of changes in condition.
- c. Discuss the type and duration of treatment. If antidepressants are used it is advisable to explain that they are not addictive. Provide information on the different types of antidepressants available and about the possible side-effects.
- d. Advise on lifestyle changes such as exercise and reducing stress.
(pg 38)

Grade A, Level 1++

GPP Where indicated and with patients' agreement, involve family members or friends in the care of people with depression so that there is adequate support (pg 38).

GPP

A Marital or couple therapy is effective and should be considered for patients with significant marital distress (pg 38).

Grade A, Level 1+

Electroconvulsive therapy

A Electroconvulsive therapy is an effective **short-term treatment** for major depressive disorder and should be considered in patients who have not responded to antidepressant therapy (pg 41).

Grade A, Level 1++

A Patients should be maintained on antidepressants following a successful response to electroconvulsive therapy (pg 41).

Grade A, Level 1+

D Electroconvulsive therapy may be considered as a **first-line treatment** for severely depressed patients with severe psychomotor retardation (associated with food refusal leading to nutritional compromise and dehydration), active suicidality and psychotic features (pg 41).

Grade D, Level 3

D Electroconvulsive therapy may also be considered in situations when a particularly rapid antidepressant response is required, such as in pregnancy and in those with comorbid medical conditions that preclude the use of antidepressant medications (pg 42).

Grade D, Level 3

Depression in children and adolescents

D Self-administered rating scales (or questionnaires) should not be used for diagnosis, but may be used for screening of symptoms, assessing severity and monitoring improvement in older children and adolescents (pg 43).

Grade D, Level 4

D When faced with a suicidal adolescent, doctors should maintain contact, ensure close supervision and engage support systems such as family and school, and consider a “no harm” contract if the adolescent is willing (pg 44).

Grade D, Level 4

D Hospitalization is indicated if suicide risk is high, support is unavailable and there are severe symptoms of depression (pg 44).

Grade D, Level 4

A Psychosocial interventions are recommended in initial treatment of depression in children and adolescents based on the literature and local clinical experience (pg 44).

Grade A, Level 1++

D Medication should not be the only treatment given to children and adolescents with depression but care should be given to increasing self esteem, coping skills to handle stress, adapting to the changes in life and improving relationships between family members and peers. Use of medications should be cautious and not necessarily first-line treatment for major depressive disorder (pg 45).

Grade D, Level 3

D Medications are usually indicated for children and adolescents with severe depression, who have psychotic symptoms or who have failed psychotherapy (pg 45).

Grade D, Level 4

C Selective Serotonin Reuptake Inhibitors (SSRIs) should be used with caution in children and adolescents (pg 45).

Grade C, Level 2+

A Combination of psychosocial interventions and SSRIs may be considered for moderate to severe depression in children and adolescents (pg 45).

Grade A, Level 1++

A Other antidepressants such as venlafaxine may be considered as second line treatment of depression in children and adolescents (pg 46).

Grade A, Level 1++

GPP Referral of a child or adolescent with depression to a psychiatrist could be considered in any of the following situations:

- failure to improve with psychosocial interventions or requiring specialised psychological interventions
- failure to improve after at least 4 weeks of medication treatment at maximum tolerated dose
- severe symptoms such as clear suicidal intention, disruptive psychotic symptoms.

(pg 46)

GPP

Depression in pregnancy

C Consider using these two questions to effectively identify possible depression in pregnant and postpartum women:

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 having little interest or pleasure in doing things?”

If the woman answers “yes” to either question, consider asking this: “Is this something you feel you need or want help with?” (pg 47, 48)

Grade C, Level 2+

D It is strongly recommended that specialist psychiatric care be arranged for pregnant or postpartum women with:

- past or present severe mental illness including schizophrenia, bipolar disorder, psychosis in the postnatal period and severe depression
 - previous treatment by a psychiatrist/specialist mental health team including inpatient care
 - a family history of maternal perinatal mental illness.
- (pg 48)

Grade D, Level 4

D Psychological therapies (including non-directive counselling and support) should be maximised as the first-line treatment strategy for peripartum depression and medication should be considered only in severe depression (pg 48).

Grade D, Level 4

D Early referral to a specialist with expertise in perinatal mental health is recommended for women with new-onset peripartum depression, unless it is mild (pg 49).

Grade D, Level 4

D Abrupt cessation of antidepressant medication for women with pre-existing depression can precipitate withdrawal symptoms that can be distressing. It is preferable to advise patients to reduce antidepressant dose to half first whilst arranging for referral (pg 49).

Grade D, Level 4

D Early referral to a psychiatrist with expertise in perinatal mental health is recommended for women with peripartum depression and pre-existing depressive illness (pg 49).

Grade D, Level 4

Depression in the elderly

D Referrals of elderly patients to specialists should be considered:

- when the diagnosis is in doubt,
- when the depression is severe (as evidenced by psychotic depression, severe risk to health because of failure to eat or drink and suicidal risk),
- when complex therapy is indicated as in cases with medical co-morbidity, and
- when the patient does not respond to an adequate antidepressant trial.
(pg 50)

Grade D, Level 4

A Antidepressants are recommended in dysthymia as well as for mild to severe depression in the elderly. There is no difference in efficacy between the classes of antidepressants in the treatment of the elderly (pg 50).

Grade A, Level 1++

A Selective serotonin reuptake inhibitors (SSRIs) are recommended over tricyclic antidepressants (TCAs) as the first-line treatment choice for late-life depression (pg 51).

Grade A, Level 1++

B In frail elderly patients it is advisable to “start low, go slow”. In the acute phase at least six weeks of treatment may be needed to achieve optimal therapeutic effect (pg 51).

Grade B, Level 1+

B For frail elderly patients, a continuation period on the same dosage that improved them for 12 months is recommended for a first onset of major depression, longer for a recurrent episode. The duration of treatment is similar to the adult age group in the continuation and maintenance phases (pg 51).

Grade B, Level 1+

B Psychological interventions should be provided for the elderly with mild to moderate major depression (pg 51).

Grade B, Level 1+

B In severe major depression in the elderly, combination antidepressant and psychotherapy treatment is recommended (pg 51).

Grade B, Level 1+

B Supportive care should be offered to elderly patients and where relevant, their caregivers (pg 52).

Grade B, Level 1+

B Electroconvulsive therapy is indicated in the elderly:

- when the patient is actively suicidal,
 - when there is an urgent need to prevent deterioration in health (including food/fluid refusal),
 - in psychotic depression,
 - when there is inadequate response to two trials of medication,
 - when there is intolerance to medication, or
 - when there is good prior response.
- (pg 52)

Grade B, Level 1+

Levels of evidence and grades of recommendation

Levels of evidence

Level	Type of Evidence
1⁺⁺	High quality meta-analyses, systematic reviews of randomised controlled trials (RCTs), or RCTs with a very low risk of bias
1⁺	Well conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias
1⁻	Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias
2⁺⁺	High quality systematic reviews of case control or cohort studies. High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal
2⁺	Well conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal
2⁻	Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal
3	Non-analytic studies, e.g. case reports, case series
4	Expert opinion

Grades of recommendation

Grade	Recommendation
A	At least one meta-analysis, systematic review of RCTs, or RCT rated as 1 ⁺⁺ and directly applicable to the target population; or A body of evidence consisting principally of studies rated as 1 ⁺ , directly applicable to the target population, and demonstrating overall consistency of results
B	A body of evidence including studies rated as 2 ⁺⁺ , directly applicable to the target population, and demonstrating overall consistency of results; or Extrapolated evidence from studies rated as 1 ⁺⁺ or 1 ⁺
C	A body of evidence including studies rated as 2 ⁺ , directly applicable to the target population and demonstrating overall consistency of results; or Extrapolated evidence from studies rated as 2 ⁺⁺
D	Evidence level 3 or 4; or Extrapolated evidence from studies rated as 2 ⁺
GPP (good practice points)	Recommended best practice based on the clinical experience of the guideline development group.

