



Depressive Disorders in Children, Adolescents, and Adults

OBJECTIVE

The objective of this Clinical Practice Guideline (CPG) is to provide evidence-based practice recommendations for the treatment of depressive disorders in children, adolescents, and adults. The CPG discusses the management and treatment of depression including an outline of the organizations that WellCare aligns with regarding depression as well as relevant Measureable Health Outcomes.

OVERVIEW

Major depressive disorder has significant potential morbidity and mortality, contributing to suicide, incidence and adverse outcomes of medical illness, disruption in interpersonal relationships, substance abuse, and lost work time. With appropriate treatment, 70-80% of individuals with major depressive disorder can achieve a significant reduction in symptoms.¹ Most patients with major depressive disorder present with a normal appearance. In patients with more severe symptoms, a decline in grooming and hygiene may be observed, as well as a change in weight. Patients may also show the following:

- Psychomotor retardation
- Flattening or loss of reactivity in the patient's affect (e.g., emotional expression)
- Psychomotor agitation or restlessness

Criteria for a major depressive episode includes at least 5 of the following symptoms having been present during the same 2-week period (with at least 1 symptom being diminished interest/pleasure or depressed mood):¹

- Depressed mood: For children and adolescents, this can also be an irritable mood
- Diminished interest or loss of pleasure in almost all activities (anhedonia)
- Significant weight change or appetite disturbance; for children, this can be failure to achieve expected weight gain
- Sleep disturbance (insomnia or hypersomnia)
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness
- Diminished ability to think or concentrate; indecisiveness
- Recurrent thoughts of death, suicidal
- A pattern of long-standing interpersonal rejection ideation, suicide attempt, or specific plan for suicide

Child or adolescent patients may also show the following symptoms:²

- Withdrawal from friends and social events
- Excessive weight change
- Substance abuse
- Decline in academic performance
- Physical complaints such as stomach pain (with no medical cause)

Self-report screening instruments for depression include the following:¹

- Patient Health Questionnaire-9 (PHQ-9): A 9-item depression scale; each item is scored from 0-3, providing a 0-27 severity score
- Beck Depression Inventory (BDI): A 21-question symptom-rating scale
- BDI for primary care: A 7-question scale adapted from the BDI
- Zung Self-Rating Depression Scale: A 20-item survey
- Center for Epidemiologic Studies-Depression Scale (CES-D): A 20-item instrument that allows patients to evaluate their feelings, behavior, and outlook from the previous week

In contrast to the above self-report scales, the Hamilton Depression Rating Scale (HDRS) is performed by a trained professional, not the patient. The HDRS has 17 or 21 items, scored from 0-2 or 0-4; a total score of 0-7 is considered normal, while scores of 20 or higher indicate moderately severe depression. The Geriatric Depression Scale (GDS), although developed for older adults, has also been validated in younger adults. The GDS contains 30 items; a short-form GDS has 15 items.¹

Laboratory Studies. No diagnostic laboratory tests are available to diagnose major depressive disorder, but focused laboratory studies may be useful to exclude potential medical illnesses that may present as major depressive disorder.¹

Hierarchy of Support

GUIDELINE HIERARCHY

CPGs are updated annually or as necessary due to updates made to guidelines or recommendations by the American Academy of Child and Adolescent Psychiatry (AACAP), American Psychiatric Association (APA), and the National Institute for Health and Clinical Excellence (NICE). When there are differing opinions noted by national organizations, WellCare will default to the member's benefit structure as deemed by state contracts and Medicaid / Medicare regulations. If there is no specific language pertaining to depression, WellCare will default (in order) to the following:

- National Committee for Quality Assurance (NCQA);
- United States Preventive Services Task Force (USPSTF), National Quality Strategy (NQS), Agency for Healthcare Research and Quality (AHRQ);
- Specialty associations, colleges, societies, etc. (e.g., American Academy of Family Physicians, American Congress of Obstetricians and Gynecologists, American Cancer Society, etc.).

Links to websites within the CPGs are provided for the convenience of Providers. Listings do not imply endorsement by WellCare of the information contained on these websites. NOTE: All links are current and accessible at the time of MPC approval.

WellCare aligns with AACAP, APA, and NICE on the topic of depression. Highlights from their respective publications are noted below.

AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY (AACAP)

WellCare adheres to the American Academy of Child and Adolescent Psychiatry (AACAP) *Practice Parameter for the Assessment and Treatment of Children and Adolescents With Depressive Disorders*. The AACAP publication describes the epidemiology, clinical picture, differential diagnosis, course, risk factors, and pharmacological and psychotherapy treatments of children and adolescents with major depressive or dysthymic disorders. Side effects of the antidepressants, particularly the risk of suicidal ideation and behaviors are discussed. Recommendations regarding the assessment and the acute, continuation, and maintenance treatment of these disorders are based on the existent scientific evidence as well as the current clinical practice. To access the full practice parameter, click [here](#).³

AMERICAN PSYCHIATRIC ASSOCIATION (APA)

WellCare adheres to the 2010 practice guideline set forth by the APA. The guideline summarizes the specific approaches to treatment of individuals with major depressive disorder. It presupposes that the psychiatrist has diagnosed major depressive disorder, according to the criteria defined in DSM-IV-TR, in an adult patient and has evaluated the patient to identify general medical conditions that may contribute to the disease process (e.g., hypothyroidism, pancreatic carcinoma) or complicate its treatment (e.g., cardiac disorders). When patients experience

depressive symptoms in the context of another disorder and do not meet the diagnostic criteria for major depressive disorder, the APA practice guideline pertaining to the primary diagnosis should be consulted. To access the full guideline, click [here](#).⁴

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE (NICE)

NICE recommends the following depression screening instruments and the ability to provide detailed information regarding sensitivity, specificity, positive and negative predictive validity, receiver operator characteristic (ROC) curves, likelihood ratios and diagnostic odds ratios of screening tools:⁵

- Hamilton Depression Rating Scale (HAM-D)
- Beck Depression Inventory (BDI)
- Zung Self-Rating Depression Scale (SDS)
- Center for Epidemiological Studies Depression Scale (CES-D)
- Geriatric Depression Scale (GDS and GDS-SF)
- General Health Questionnaire (GHQ)
- Patient Health Questionnaire (PHQ-2 and PHQ-9)
- Cornell Scale for Depression in Dementia (CSDD)

To access the full guideline, click [here](#).⁵

Evidence Based Practice

MEASUREMENT OF COMPLIANCE

WellCare is committed to adhering to the measures and standards published by the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA). Please reference WellCare's Clinical Policy Guiding Document titled *Quality Improvement*.

NOTE: To access Clinical Policy Guiding Documents visit www.wellcare.com – select the Provider tab, then “Tools” and “Clinical Guidelines”.

Care Management

The goals for Care Management are to support the member's ability to self-manage their disorder, minimize risk factors and remove barriers preventing the member from achieving goals. Goals of treatment of depression should include assessment of symptoms and evaluation of symptom improvement, ensuring compliance of prescribed medications, assisting with getting members to attend timely follow up appointments with providers, communicating and collaborating with the Interdisciplinary Care Team and educating member on depression including symptoms, treatment and recognizing signs of decompensation. In all patient populations, the combination of medication and psychotherapy generally provides the quickest and most sustained response.

Pharmacotherapy. Drugs used for treatment of depression include the following:

- Selective serotonin reuptake inhibitors (SSRIs)
- Serotonin/norepinephrine reuptake inhibitors (SNRIs)
- Atypical antidepressants
- Tricyclic antidepressants (TCAs)
- Monoamine oxidase inhibitors (MAOIs)
- St. John's wort (*Hypericum perforatum*)

Psychotherapy. Types of psychotherapy that have been used for the treatment of major depressive disorder, especially in the pediatric population, include the following:

- Behavior therapy
- Cognitive-behavioral therapy
- Family therapy
- Group psychotherapy
- Interpersonal psychotherapy
- Interpersonal therapy
- Mindfulness-based cognitive therapy
- Psychodynamic psychotherapy
- Supportive psychotherapy

In mild cases, psychosocial interventions are often recommended as first-line treatments. The American Psychiatric Association (APA) guideline supports this approach but notes that combining psychotherapy with antidepressant

medication may be more appropriate for patients with moderate to severe major depressive disorder.

Electroconvulsive Therapy (ECT) is a highly effective treatment for depression. Indications include the following:

- Need for a rapid antidepressant response
- Failure of drug therapies
- History of good response to ECT
- High risk of suicide
- High risk of medical morbidity and mortality

Stimulation Techniques. Transcranial magnetic stimulation (TMS) is approved by the FDA for treatment-resistant major depression. Vagus nerve stimulation (VNS) was approved by the FDA for use in adult patients who have failed to respond to at least 4 adequate medication and/or ECT treatment regimens. The stimulation device requires surgical implantation.

MEASURABLE HEALTH OUTCOMES

Targeted Case Management outcomes (**Extended Program Goals**) result from successful self-management (see Case Management Objectives).

- **Symptoms:** Member will score <20 on the PHQ9 screening within 90 days
- **Symptoms:** Member will show an (increase or decrease) in at least 20 minutes of sleep a night >80% of the time as evidenced by member written documentation of a sleep log within 90 days
- **Symptoms:** Member will show a >5% (increase or decrease) in weight as evidenced by provider report or member written log of weight within 90 days
- **Adherence:** Member's prescription refills will show an adherence of >80% as evidenced by pharmacy claims within 90 days
- **Adherence:** Member will attend >75% of behavioral health appointments as evidenced by medical claims or provider report within 90 days
- **Engagement:** Member will increase attendance at work or at school by >10% as evidenced by member or provider report within 60 days
- **Engagement:** Member's physical activity will increase to at least 30 minutes a day >80% of the time as evidenced by member or caregiver verbal report within 60 days
- **Utilization:** Member will have > 20% reduction of depression related inpatient days as evidenced by service authorizations within 60 days

CASE MANAGEMENT GOALS

Goals should target specific care gaps and/or adherence issues, and measure the member's progress towards self-management and adherence which lead to the targeted health outcomes above.

- **Symptoms:** Member will list at least 3 sleep hygiene recommendations within 30 days
- **Symptoms:** Member will be able to list at least 3 signs and symptoms of depression and importance of treatment adherence within 30 days
- **Symptoms:** Within 60 days member will obtain a mood journal and list at least three things that will be tracked on it including general mood, sleep patterns, symptoms, side effects and/or coping skills used
- **Adherence:** Member will schedule CBT, inter-personal psychotherapy and/or family therapy (for children and adolescents) within 30 days
- **Adherence:** Member will schedule psychiatry appointments & fill prescribed medications on time within 30 days
- **Adherence:** Member will list at least 3 reasons for taking prescribed medications and log adherence and side effects to share with provider within 90 days
- **Engagement:** Member or caregiver will be connected to a peer or educational support group for managing depression within 30 days
- **Engagement:** Member will list at least 3 ways that diet and exercise help to improve mood within 30 days
- **Engagement:** Within 30 days member will write down at least one small goal that can be completed daily such as bathing, dressing or completing a chore
- **Engagement:** Member will list at least 2 social activities or peer relationships that member will pursue within 30 days

CASE MANAGEMENT OBJECTIVES

- Educate member or caregiver on the cause and treatment of depression, recognizing risks of suicide as well as coping strategies
- Refer to Cobalt for members 16 and older
- Refer member or caregiver to self-help books that can be obtained at the local library or websites educating on depression and coping strategies
- Educate on relaxation techniques to reduce anxiety
- Refer member or caregiver to psychiatrist and/or therapist that can see member in a timely fashion
- Assess for risks of suicide including thoughts, plans, intent, means and past history of attempts
- Review safety planning with member and caregiver
- Educate member or caregiver on medications including how to take, side effects and how long it will take to see therapeutic effects. For children and adolescents on SSRIs, educate parent on possible risks of increased suicidal ideation.
- Educate member or caregiver on creating a mood journal to track daily mood, sleep patterns, symptoms, side effects of medications and coping skills utilized
- Evaluate specific barriers to attending follow up appointments and taking medications and work towards removing them
- Refer member or caregiver to support groups for depression such as NAMI or DBSA
- Educate on the role good nutrition and physical activity have on improving mood
- Utilize motivational interviewing techniques to increase adherence
- Refer member to community resources such as food banks or supportive housing as needed
- For children and adolescents, initial assessment over 2-4 weeks including child and parent interviews, psychoeducation regarding depressive disorder and risk management should be done before an SSRI is prescribed (Prozac being the first line drug recommended for ages 8 and older for moderate to severe depression, many other antidepressants are not approved for use in children or adolescents)⁶

MANAGEMENT AND TREATMENT

In all patient populations, the combination of medication and psychotherapy generally provides the quickest and most sustained response. Drugs used for treatment of depression include the following:

- Selective serotonin reuptake inhibitors (SSRIs)
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- Atypical antidepressants
- Tricyclic antidepressants (TCAs)
- Monoamine oxidase inhibitors (MAOIs)
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Types of psychotherapy that have been used for the treatment of depressive disorders, especially in the pediatric population, include:

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|--------------------------------|---------------------------------------|
| • Behavior therapy | • Interpersonal therapy |
| • Cognitive-behavioral therapy | • Mindfulness-based cognitive therapy |
| • Family therapy | • Psychodynamic psychotherapy |
| • Group psychotherapy | • Supportive psychotherapy |
| • Interpersonal psychotherapy | |

In mild cases, psychosocial interventions are often recommended as first-line treatments. The American Psychiatric Association (APA) guideline supports this approach but notes that combining psychotherapy with antidepressant medication may be more appropriate for patients with moderate to severe major depressive disorder. In addition, electroconvulsive Therapy (ECT) is a highly effective treatment for depression. Indications for ECT include:

- | | |
|--|--|
| • Need for a rapid antidepressant response | • Patient preference |
| • Failure of drug therapies | • High risk of suicide |
| • History of good response to ECT | • High risk of medical morbidity and mortality |

Transcranial magnetic stimulation (TMS) is approved by the FDA for treatment-resistant major depression. Vagus nerve stimulation (VNS) has been approved by the FDA for use in adult patients who have failed to respond to at least 4 adequate medication and/or ECT treatment regimens. The stimulation device requires surgical implantation.

MEDICAL BEHAVIORAL INTEGRATION

Depression rates are higher among older adults with co-morbid medical conditions, including chronic pain. Individuals with depression are four times as likely to develop a heart attack and are at a significantly increased risk of death or a second heart attack. There are several medical conditions that may initially present as depression including; viral illness, endocrine disorders, anemias, post-CVA, Rheumatoid disorders, lupus, Parkinson's disease and sleep apnea. Certain medications for medical disorders can trigger depression such as; beta-blockers, calcium-channel blockers, Interferons, Histamine-2 blockers, clonidine and other anti-hypertensives, corticosteroids, Procainamide, Indomethacin, narcotics, Phenytoin, and anabolic steroids.⁷

PHARMACOLOGY

A database of medication guidelines has been developed by the University of South Florida (USF) and is available [here](#). Medications are searchable by childhood or adult disorders.¹⁸

MEMBER EDUCATIONAL RESOURCES

WellCare contracts with Krames/StayWell for Member educational materials utilized by Case Managers. Items are available to review with Members to address knowledge gaps. Case Managers verbally educate Members on the topics below related to asthma. (Titles may also be sent to the member).

NOTE: Links are internal for WellCare Care Management staff. Please see below for public links.

- Counseling for Depression
- Depression Affects Your Mind and Body
- Depression and the Brain's Chemical Balance
- Know the Signs and Symptoms of Depression
- Stress Relief – Changing Your Response
- Stress Relief – Relaxation
- Using Antidepressants
- Warning Signs for Suicide and What You Can Do
- What Can Cause Depression

Providers may wish to research the titles above related to asthma that Case Managers utilize with Members. The following Web sites are valuable resources for patient and family education:

- **National Institute of Mental Health: Depression** – <http://www.nimh.nih.gov/health/topics/depression/index.shtml>
- **MedlinePlus: Depression** - <http://www.nlm.nih.gov/medlineplus/depression.html>
- **FamilyDoctor.org: Depression** - <http://familydoctor.org/online/famdocen/home/common/mentalhealth/depression/046.html>
- **Depression and Bipolar Support Alliance (DBSA)** – <http://www.ndmda.org/>
- **Families for Depression Awareness** – <http://www.familyaware.org/>

Related WellCare Guidelines

In addition to the information contained in this document, please reference the following CPGs: *Behavioral Health Conditions and Substance Use in High Risk Pregnancy* (HS-1040); *Behavioral Health Screening in Primary Care Settings* (HS-1036); *Child and Adolescent Behavioral Health* (HS-1049); and *Suicidal Behavior* (HS-1027).

NOTE: Clinical Policies can be accessed by going to www.wellcare.com – select the Provider tab, then “Tools” and “Clinical Guidelines”.

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- [childhood-adult-depression/](#). Published December, 10, 2014. Accessed May 31, 2018.
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*Easy Choice Health Plan ~ Harmony Health Plan of Illinois ~ Missouri Care ~ 'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona
OneCare (Care 1st Health Plan Arizona, Inc.) ~ Staywell of Florida ~ ~ WellCare Prescription Insurance ~ WellCare Texan Plus (Medicare – Dallas and Houston markets)
WellCare (Arizona, Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)*

Medical Policy Committee Approval History

Date	History and Revisions by the Medical Policy Committee
6/7/2018	<ul style="list-style-type: none"> • Approved by MPC. No changes.
6/28/2017	<ul style="list-style-type: none"> • Approved by MPC. Merged with Major Depressive Disorder in Adults: HS-1008. Included new sections on Care Management and Health Equity, Health Literacy, and Cultural Considerations.
3/5/2015	<ul style="list-style-type: none"> • Approved by MPC. Updated HEDIS measures.
1/9/2014	<ul style="list-style-type: none"> • Approved by MPC.
12/1/2011	<ul style="list-style-type: none"> • New template design approved by MPC.
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