FEDERAL BUREAU OF PRISONS
CLINICAL PRACTICE GUIDELINES
MANAGEMENT OF MAJOR DEPRESSIVE DISORDER
MAY, 2001

PURPOSE

The Federal Bureau of Prisons Clinical Practice Guidelines for the Management of Major Depressive Disorder provide recommendations for the management of depression in federal inmates. These practice guidelines do not include recommendations for the medical management of bipolar disorders that require other special treatment considerations.

REFERENCES

American Psychiatric Association: Practice Guideline for Major Depressive Disorder in Adults (Revision), *Am J Psychiatry* 2000; 157 (April supplement).

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition (DSM-IV), Washington, DC, APA, 1994.

Surgeon General's Report on Mental Health, US Department of Health and Human Services, August 1999.

Agency for Health Care Policy and Research: Depression in Primary Care: Volume 1, Detection and Diagnosis; and Volume 2, Treatment of Major Depression, Clinical Practice Guideline, Number 5, Rockville, MD, AHCPR Publication Nos. 93-0550 and 93-0551, 1993.

Whooley, MA and Simon, GE, Managing depression in medical outpatients, *N Engl J Med,* 2000;343:1942-50.

Glick I, et al., Psychopharmacologic treatment strategies for depression, bipolar disorder, and schizophrenia, *Ann Intern Med,* 2001;134:47-60.

Rush AJ, et al: Consensus guidelines in the treatment of major depressive disorder, *J Clin Psych* 1998;59(S20):73-84.

Comprehensive Textbook of Psychiatry, Seventh Edition, Kaplan and Kaplan, ed., Chapter 14, "Mood Disorders," pp:1284-1440, Lippincott Williams & Wilkins, 2000.

Spitzer, RL, et al., Validation and utility of a self-report version of PRIME-MD, *JAMA*, 1999;282:1737-1744.

American Medical Directors Association: Pharmacotherapy companion to the depression clinical practice guideline, Columbia, MD, American Medical Directors Association, 1998.

Clinical Handbook of Psychotropic Drugs, eighth revised edition, Bezchlibnyk-Butler, KZ and Jeffries, JJ, ed., Hogrefe & Huber Publishers, 1998.

Physician Desk Reference 2000, third edition: Psychotropic Prescribing Guide.

Texas Medication Algorithm Project (TMAP): Major Depression Module and Bipolar Depression Module, www.mhmr.state.tx.us/centraloffice/medicaldirector/Disclaimer.html

"APA Depression Guideline Revision Reflects Latest Research Findings," Psychiatric News, March 17, 2000, page 33.

Brody DS, et al., Identifying patients with depression in the primary care setting, *Arch Intern Med*, 1998;158:2469-2475.

DEFINITIONS

Adjustment disorder with depressed mood is a disorder in which there is a significant disturbance in mood in response to identifiable stressors. The mood disturbance causes significant distress or impairment in functioning in excess of what one would expect from the severity of the stressor. Evident signs and symptoms do not meet the criteria of another mood disorder or bereavement.

Anhedonia is a loss of interest or pleasure in all regular activities.

Bereavement is a normal reaction to a significant loss and may resemble a depressive disorder in its symptomatology. A major depressive disorder is not diagnosed unless the symptoms persist for longer than two months or are characterized by marked functional impairment, the presence of morbid preoccupation, suicidal ideation, psychotic symptoms or marked psychomotor retardation.

Catatonic features can be present in severe mood disorders or psychotic disorders and consist of a marked disturbance of

psychomotor activity, immobility, or agitation. Features include: extreme negativism, mutism, peculiarities of voluntary movement such as posturing or stereotypical movements, echolalia (senseless repetition of a word or phrase used by another person), echopraxia (repetitive imitation of movements of another person), catalepsy (waxy flexibility) or stupor, and purposeless excessive motor activity not influenced by external stimuli. Severe catatonic stupor or excitement can be associated with significant morbidity and mortality, including: dehydration, malnutrition, exhaustion, hyperpyrexia, self-inflicted injury, deep venous thrombosis, pulmonary emboli, autonomic instability, and decubiti.

Clinician is a physician or midlevel provider.

Delusions are disturbances of thought processes and are fixed, false beliefs that are very strongly held and immutable even in the face of evidence to the contrary. Delusions can be simple, that is contain few elements, or complex, encompassing virtually all of a person's reality. Delusions vary in type and include: delusions of persecution, delusions of grandeur, delusions of influence, delusions of having sinned, delusions of replacement of significant others, delusions with nihilistic, somatic, erotomanic or jealous characteristics, and delusions about mood, perception or memory. Delusions can be shared with significant others.

Depressive disorders are a group of conditions delineated and defined in the *Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition* (DSM-IV) which have as their major feature a disturbance of mood that causes significant clinical distress or impairment in functioning. The mood disturbance may include any or all of the following: depression, sadness, irritability, hopelessness.

Depressive disorder not otherwise specified is a mood disorder in which the criteria for more specific depressive disorders are not met (or there is inadequate information present), however there is significant functional impairment or distress present.

Dysthymic disorder is a condition in which a depressed mood has been present more days than not and lasted for at least two years and has not been of a severity to meet the criteria for major depressive disorder.

Hallucinations are a disturbance of perception and occur in the absence of corresponding sensory stimuli. They can include any of the sensory experiences, alone or in combination, i.e.,

auditory, visual, gustatory, olfactory or tactile. Hallucinations can occur in a number of mental disorders, but they can also occur as a symptom of many medical/neurological conditions, such as drug withdrawal, tumor, toxic disturbances, inflammatory or infectious processes.

Major depressive disorder is characterized by one or more **major depressive episodes**, a specific mood disturbance in which there is the persistent presence of a pervasive, depressed, anhedonic or apathetic mood for at least two weeks and is accompanied by significant distress or impairment in functioning. Additionally four other symptoms as outlined in DSM-IV criteria must be present. These could include: change in appetite or weight, disturbance or change in sleep pattern, increased or decreased psychomotor activity, decreased energy, decreased concentration, indecisiveness, feelings of worthlessness or excessive guilt, morbid preoccupation or suicidal thinking. The symptoms are not due to the direct effects of substances (alcohol or illicit drugs) or medications, or a general medical condition. The symptoms are not better accounted for by bereavement.

Melancholic features are symptoms of a major depressive episode in which there is a loss of pleasure or interest in all, or almost all activities, as well as the presence of at least three of the following: a depressed mood that shows diurnal variation (worse in the morning), early morning awakening, psychomotor retardation or agitation, anorexia (loss of appetite) or weight loss, or excessive or inappropriate guilt.

MAOIs are monoamine oxidase inhibitors, a category of antidepressant medications.

Psychotic features are symptoms of hallucinations or delusions that can be congruent or incongruent with the depressed mood. Psychotic features **always** indicate the presence of a severe mood disorder or episode.

SSRIs are selective serotonin reuptake inhibitors, a category of antidepressant medications.

Serotonin syndrome is a rare, but potentially fatal, syndrome due to excessive serotonergic activity that is usually associated with the use of multiple serotonergic agents, such as selective serotonin reuptake inhibitors (SSRIs) together with MAOIs, but can occur with SSRIs alone. The syndrome can include abdominal pain, diarrhea, flushing, sweating, hyperthermia, lethargy, mental status changes, tremor, myoclonus, rhabdomyolysis, renal failure, cardiovascular shock, and possible death.

Serotonin withdrawal syndrome is a phenomenon that has been observed to sometimes occur with the abrupt discontinuation of certain SSRIs, particularly those with short half-lives. Symptoms can include: agitation, anxiety, panic attacks, depression, nausea, sweating, lethargy, sensory disturbances, sleep disturbance and dizziness. Symptoms vary from mild to severe and may require reinstitution of the medication followed by a gradual taper over several weeks.

Somatic treatments refer to the use of medications or electroconvulsive therapy (ECT) in the treatment of depressive disorders.

Specifiers are terms used to better define the nature of the current or most recent mood disorder and includes descriptors of onset, severity, additional features or symptoms, level of recovery, or the presence of a seasonal component. For example all of the following can be used for specifying the nature of the current major depressive episode: mild, moderate, severe without psychotic features, severe with psychotic features (mood-congruent or mood-incongruent), in partial remission, in full remission, chronic, with catatonic features, with melancholic features, with atypical features, with postpartum onset, with seasonal pattern.

TCAs are tricyclic antidepressants, a category of antidepressant medication.

INTRODUCTION

Depressive disorders are one of the most common medical conditions seen in the primary care setting. Major depression affects between 5% and 10% of all patients and disproportionately affects women and the elderly. The causes of depressive disorders are unknown, but risk factors include: genetic factors, stress, bereavement, comorbid medical and psychiatric illnesses, certain medications, substance abuse, intoxication or withdrawal, cognitive impairment or brain injury, and a history of childhood trauma. Despite the availability of highly effective treatments, depressive disorders are frequently underdiagnosed and undertreated resulting in unnecessary patient suffering, lost productivity and a marked increase in the cost of medical care. The direct and indirect health care costs associated with the management of depression are greater than all other medical conditions except ischemic heart disease.

The diagnosis of depression should be considered for patients who repeatedly present with unexplained somatic symptoms, since as

many as half of all primary care visits are for psychiatric conditions that present with medical complaints such as pain without significant organic cause, fatigue, dizziness and sleep problems. Depression should also be considered for inmates who present with certain psychiatric and medical conditions that are frequently associated with depression. Up to 62% of depressed patients suffer from another mental disorder, most often some type of anxiety disorder, conversely, up to 70% of patients with anxiety disorders suffer from a depressive disorder. Comorbid conditions associated with depression also include substance use disorders, somatoform disorders, personality disorders, schizophrenia, dementia, and medical conditions, such as thyroid disease, cardiac disease (particularly after bypass surgery), nutritional disorders, cancer with and without paraneoplastic syndromes, HIV infection, connective tissue diseases, diseases of the hypothalamic-pituitary-adrenal axis and neurologic diseases. Depression can also be precipitated or exacerbated by certain medications, including but not limited to steroids, narcotics, benzodiazepines, interferon, and reserpine.

Natural History

Depressive disorders can develop at any age beginning in childhood through late adulthood. A fully developed major depressive disorder can evolve subacutely over days to weeks or more slowly after a prodromal period of anxiety and mild depression that lasts for weeks to months. Between 50 and 85% of persons with a single episode of major depressive disorder will suffer another episode during their lifetime. Individuals who have suffered three or more episodes of major depressive disorder within a five year period have a greater than 90% chance of recurrence. For the majority of patients, depressive disorders should be thought of as chronic illnesses requiring regular reassessment for signs and symptoms of a recurrence, long term follow-up, and in many cases, lifetime treatment.

Only 20% of all primary care patients diagnosed with a depressive disorder receive adequate treatment, even though treatment for depressive disorder is remarkably effective. At least 80-90% of patients with major depressive disorder can be brought into a full remission with appropriate medication or electroconvulsive treatment. An untreated episode of depression frequently lasts six months or longer. Spontaneous remissions may be full or partial, but many untreated depressed persons remain intermittently symptomatic for several years and a small subset of patients remain chronically ill. Patients with untreated depression are more likely to commit suicide and are more likely to suffer complications of comorbid medical conditions since they

are less likely to be compliant with recommended treatments or engage in appropriate self-care activities.

SPECIAL CONSIDERATIONS

Stigma can be a major barrier to the expedient diagnosis and treatment of mental disorders and may be particularly important within the institutional environment. Inmates on psychiatric medications must attend pill line and consequently may be observed by other inmates and labeled as "crazy" or viewed in a derogatory manner.

Cultural factors can have a significant influence on access to adequate treatment for mental disorders. Ethnicity and cultural norms can affect the expression of psychiatric symptoms and the patient's acceptance of his or her illness. Health care providers may also suffer from the misconception that inmates of certain ethnicities are less likely to have certain mental health conditions. Language barriers can increase these misunderstandings and further complicate diagnosis and treatment.

Elderly patients have a higher rate of depression than do younger patients and while less likely to complain of depressive symptoms, the elderly are much more likely to suffer significant morbidity and mortality. Providers are more likely to ascribe depressive symptoms to the consequences of aging rather than a mental health condition. Elderly patients have a higher rate of successful suicides than do younger adults; yet many providers believe suicidal thinking and morbid preoccupation is normal in this age group. Depressive symptoms in the elderly may herald the onset of dementia.

Women are up to twice as likely to suffer from depressive disorders than are men, however, men are more likely to successfully complete suicide. Women are more likely to suffer comorbid anxiety disorders, while men are more likely to suffer comorbid substance use disorders.

Postpartum depression: The postpartum period is a high risk period for the development of depression, especially in women with a history of a mood disorder. Women suffering from postpartum depression may experience profound guilt and shame and be reluctant to report symptoms of depression to their health care provider. Postpartum depression is especially severe when associated with psychotic symptoms that may include delusions about the infant as well as homicidal hallucinations or impulses. The presence of any depression in the postpartum period can

profoundly affect the mother-infant bond and other parenting tasks.

Personality disorders: Persons with personality disorders are more likely to develop a depressive disorder and have greater problems with impulse control with an increased risk of committing acts of self harm or harm towards others.

Substance use disorders can cause symptoms consistent with any of the depressive disorders. In the great majority of cases, such symptoms resolve with abstinence, however, a significant minority of inmates will require treatment for their mood disorder in conjunction with substance abuse treatment. Some inmates with chronic addiction suffer from low grade symptoms of withdrawal that may be difficult to distinguish from a primary depressive disorder. The efficacy of antidepressant treatment in these individuals is uncertain, therefore the best approach is careful assessment followed by treatment when symptoms meet the criteria of a diagnosable depressive disorder.

Brain injury, dementia, or other cognitive impairment: Cognitively impaired inmates are at increased risk for a number of psychiatric conditions with atypical presentations that are frequently associated with behavioral disturbances. A careful evaluation, including attention to possible organic factors, is necessary in these inmates, since they are unlikely to provide an accurate history.

PROCEDURES

1. SCREENING

All inmates entering Bureau of Prisons facilities are screened for mental health problems in accordance with Bureau policy. **Additionally, nursing staff and clinicians should consider screening inmates for depression during subsequent health encounters, including sick call, chronic care clinics, and inmate interviews in segregated housing units when evaluating the following inmates:**

- Inmates with unexplained medical conditions or complaints

- Inmates with chronic pain

- Inmates with a personal history of depression and suicide attempts or family history of depression or suicide

- Inmates who display or verbalize any of the diagnostic criteria for major depressive disorder

Simple screening methods have proven highly sensitive for detecting depression in the primary health care setting, however, a negative screening interview does not necessarily rule out the presence of a depressive disorder. **Positive findings for two or more core diagnostic symptoms (low self esteem, sleep disturbance, anhedonia, and decreased appetite) are particularly sensitive for screening for depression.** Screening can be effectively accomplished by asking the following questions:

- Do you have trouble falling asleep, sleeping too much or awakening too early?

- Do you feel that you are a bad person, have failed or have let people down?

- Have you lost your appetite or find that you are not interested in eating?

- Have you lost interest in most things or no longer take pleasure in activities that you normally found pleasurable?

Inmates with positive responses to two of the four screening questions or who otherwise confirm other significant diagnostic criteria for depression during the screening process should be further evaluated.

More comprehensive screening methods, based on DSM-IV criteria for major depression, are indicated on a case by case basis for inmates with multiple comorbid medical conditions, for inmates with histories of drug seeking behaviors, for inmates who are poor historians or present with significant cultural or language barriers, and when otherwise clinically indicated.

2. DIAGNOSIS

The diagnosis of major depressive disorder is based on DSM-IV criteria as enumerated in **Appendix 1, DSM-IV Criteria for Major Depressive Episode,** and **Appendix 2, DSM-IV Criteria for Major Depressive Disorder, Single Episode and Recurrent Episode.** The diagnosis of depression is made through a clinical interview in conjunction with a physical examination and laboratory assessment to screen for comorbid conditions. In some cases, the evaluation process may also include radiologic studies, such as MRI of the brain and psychological testing. Major depressive disorder can be further characterized into the following three levels of severity:

- **Mild depression:** Patient has few symptoms in excess of those required for the diagnosis of major depressive disorder and has minimal impairment in functioning.

- **Moderate depression:** Patient has greater number and intensity of depressive symptoms with moderate impairment in functioning.

- **Severe depression:** Patient has marked intensity of depressive symptoms with substantial impairment in functioning.

Clinical interview: The patient interview may be structured or unstructured, but should address the presence or absence of symptoms of a major depressive episode or disorder as well as address risk factors for suicide and homicide as enumerated in **Appendix 3, Risk Assessment for Patients with Depression.**
The assessment of suicide risk and risk of harm towards others is a crucial part of the clinical interview for inmates with suspected or known depression. The clinician should not worry that such questioning will produce or provoke suicidal or violent behavior. The evaluating clinician should specifically ask the inmate the following questions:

- "Do you ever feel so bad that you wish you were dead?" regardless of the answer, ask the next follow-up question:

- "Do you ever think of hurting yourself or taking your own life?"

- If the answer is yes, the clinician should follow-up by asking, "Do you currently have a plan?"

- And, if the answer is yes, "What is your plan?"

Documentation of the risk assessment is essential whenever evaluating inmates with suspected or known depression.
A complete risk assessment includes the following factors which should be reviewed and documented for all inmates with depression until symptoms have completely abated. The presence of these factors may indicate an increased risk of suicide or violence towards others. Some patients are more likely to act on suicidal thoughts during the early phase of recovery than during the acute phase of the disease:

- Past history of acts of harm towards self or others
- Presence of thoughts of harm towards self or others
- Presence of plan to harm self or others, including:
    - -Lethality of plan
    - -Presence of means to carry out plan

-Presence of intent to carry out plan

- Family history of suicide or violence
- Presence of psychotic symptoms
- History of substance abuse
- Lack of support systems
- Recent severe stressor or loss
- Presence of comorbid personality disorder or anxiety disorder

The clinical interview should also include a past psychiatric history, past medical history, review of symptoms, and family history in accordance with the following:

- **Past psychiatric history** should be assessed and include past symptoms, any suicidal or violent behaviors, hospitalizations, diagnoses and treatment interventions. A past history of manic episodes signals the presence of a bipolar disorder requiring specific treatment considerations.

- **Medical history and review of systems** should include screening for comorbid medical conditions as well as medications that may be the cause of the depressive symptoms as listed in **Appendix 4, Pharmacologic/Toxic Agents Which Can Cause or Exacerbate Depressive Symptoms.** Adherence to prescribed treatments for medical conditions should also be assessed, since depressed inmates are more likely to be noncompliant and suffer related complications.

- **Family history:** Clinicians should inquire about any diagnosable mental conditions and related treatments that family members have received, since this information is helpful for diagnostic and treatment decisions for the inmate. Inmates with a family history of suicide, violence and homicide are at higher risk of similar behaviors.

- **Physical examination** should include a screening neurologic examination and also be directed by the results of the clinical interview and by the need to rule out specific medical and neurological conditions that may be complicating or causing the depressive symptoms as outlined in **Appendix 5, Medical Conditions Associated with Depression.**

Laboratory evaluation should be patient-specific based on potential comorbid medical conditions and diagnostic concerns. Unless obtained during the past year the following baseline studies should be obtained:

Baseline studies:
-Complete blood count and differential

-Comprehensive chemistry panel

-TSH

Additional studies should be obtained as medically indicated:

Additional studies
-Drug levels of medications such as digoxin, theophylline, and anti-seizure medications

-B-12 and folate for inmates with risk factors for deficiencies such as the elderly, HIV seropositive inmates, inmates with a history of gastrointestinal disorders or surgery, vegetarians, alcoholics, inmates with a history of malnutrition or homelessness, autoimmune disorders or on medications known to cause deficiencies such as methotrexate and 5-FU.

- Electrocardiogram in individuals with cardiac risk factors or if over 50 years of age and receiving tricyclic antidepressants or lithium

- MRI of the brain when a neurologic disorder is suspected; or in inmates refractory to treatment

- EEG in inmates with a history of seizures

- Evaluations for autoimmune or connective tissue diseases, infection or malignancy when clinically indicated

3. TREATMENT: OVERVIEW

The goal of treating depression is to achieve and maintain a complete clinical remission. As a multimodal process, the successful treatment of depression requires a correct diagnosis, a patient-clinician therapeutic rapport, education of the inmate regarding the disease and recovery process, the proper use of medications and understanding of potential side effects, a regular assessment of self-harm and harm towards others (with appropriate interventions), and treatment compliance.

- Medications (along with ECT, when specifically indicated) are the mainstays of treatment for severe or recurrent major depressive disorder. **All current medication treatments for depressive disorders require weeks of therapy before a significant clinical response is achieved.** Therefore, not only

must the inmate tolerate painful symptomatology while awaiting a clinical response to therapy, but he or she must also adhere to a medication regimen that is inconvenient (pill line) and may include uncomfortable side effects. Clinicians should simplify medication regimens, whenever feasible, through strategies such as avoiding multiple daily dosaging in order to maximize patient compliance.

- **Psychotherapy** is usually reserved as an adjunctive therapy for the treatment of major depressive disorder rather than as the sole therapeutic intervention, unless the depression is mild.

- **Informed consent** must be obtained for all medical treatments for psychiatric conditions, including depression, prior to prescribing therapy. Informed consent requires at a minimum: a review of the diagnosis and recommended treatments, potential risks and benefits of recommended treatments, alternatives to the recommended treatments (including the alternative of no treatment), a review of the inmate's understanding of the information given and a review of the inmate's competence to give informed consent. Applicable BOP forms should be used in accordance with BOP policy to document informed consent. If informed consent cannot be obtained because of inmate refusal or lack of competence, court proceedings for involuntary hospitalization and treatment in accordance with BOP policy should be considered for those inmates suffering from a severe major depressive disorder or who are at risk of harm to self or others.

- **Psychiatric referral**: The treatment of major depressive disorder should be initiated by a physician with experience managing depression. Psychiatric expertise is not always required for managing inmates with major depressive disorder. Consultation with a psychiatrist should be considered on a case by case basis, but particularly for the following clinical conditions:

- Inmates with suicidal ideation, psychotic symptoms, catatonia, mania, severe functional decompensation or other signs of severe depression

- Inmates with refractory depression after completing an adequate trial of medications

- Inmates already receiving psychotropic medications for another mental health condition

4. TREATMENT: STAGES OF THERAPY

The treatment of major depressive disorder is divided into three distinctive therapeutic phases: the acute phase, the continuation phase and the maintenance phase.

Acute phase treatment: The treatment goal for managing depression is to sustain a full remission. For inmates with moderate to severe depressive symptomatology this usually means designing and implementing a treatment plan which includes prescribed medications, adjunctive psychological interventions, close monitoring of safety issues, inmate education, establishment of a patient-clinician therapeutic rapport, monitoring compliance and regular clinic follow-up appointments. **Hospitalization** (or inpatient medical referral center care) may be necessary if the inmate appears to be at risk of harm to self or others, or if his or her physical or medical condition warrants acute intervention.

Regular clinic appointments of sufficient frequency to address and monitor safety concerns, compliance issues and drug side effects are necessary during the acute phase of treatment of major depressive disorder. The frequency and duration of evaluations should be determined on a case by case basis (as often as daily to every 2 weeks) depending on the severity of symptoms and comorbid medical conditions. The acute phase generally lasts 8-12 weeks, but may be longer depending on the time necessary to achieve a full remission.

- **Medications:** Medications are the primary treatment for patients with moderate to severe depression. Selective serotonin reuptake inhibitors (SSRIs) are commonly the drugs of choice for the treatment of moderate to severe depression without psychosis, since these medications have a low side effect profile, are relatively safe in overdose, are easily administered, have little potential for abuse and have proven efficacy. Clinical indications for antidepressant medications and dosaging are enumerated in **Appendix 6, Antidepressant Medications: Indications and Dosaging.** Side effects of antidepressant medications are described in **Appendix 7, Side Effects of Antidepressant Medications.** If a medication is chosen that requires titration of the dosage, drugs should be slowly titrated over one to two weeks or as the inmate's condition and tolerance of side effects allows. Once a therapeutic dose is achieved, clinical improvement can be expected over the next four to six weeks, and continued improvement anticipated over the next six or more weeks.

Inmates with depression complicated by psychotic symptoms may require combination drug therapy. An antipsychotic medication along with an SSRI is effective in 60-70% of patients, which is

two to three times as effective as either type of medication alone. Psychotic patients with depression are at increased risk for acts of harm towards self or others and may require hospitalization or medical referral center admission in the early phase of treatment.

- ECT: ECT, administered in accordance with Bureau policy, should be considered on a case by case basis for inmates suffering from a severe major depressive episode in which their health is being compromised with severe functional impairment, or when psychotic symptoms or catatonic symptoms are present. ECT has a more rapid response rate than antidepressant medications and can be lifesaving for patients refusing food and/or fluids.

- Psychotherapy: Inmates acutely suffering from major depressive disorder should be referred to a mental health provider for psychotherapy if any of the following patient-related factors are present: recent significant psychosocial stressors, interpersonal problems, comorbid psychiatric illnesses, poor compliance or suicidal or homicidal ideation, plan or intent. The type, intensity and duration of psychotherapy provided will vary depending on the skills of the provider and on the inmate's mental condition and personal preference. Interpersonal or cognitive-based psychotherapy are both effective interventions for treating mild depression, however, for acutely ill patients with moderate to severe depression, psychotherapeutic interventions are ordinarily limited to supportive and educational efforts.

- Augmentation: If the inmate does not show significant response to treatment after six to eight weeks of initial therapeutic interventions, a thorough review of relevant clinical concerns should be undertaken prior to adjusting the treatment regimen as described in **Appendix 8, Augmentation Strategies.** Whenever a change in the treatment regimen is undertaken, close monitoring of the inmate is indicated and consultation with a psychiatrist should be considered, if not done previously. If no further improvement is evident after an additional six to eight weeks of therapy, a thorough re-evaluation by a psychiatrist is indicated to determine appropriate changes in the treatment regimen.

Continuation phase treatment: The continuation phase of treatment begins **only** after the patient has achieved a **full remission** from depression and usually lasts 16-20 weeks beyond the acute phase, but may need to be extended depending on the patient's symptomatology and risk factors for relapse. Ongoing treatment and monitoring of depression during the continuation phase are essential to prevent relapse. Because of the high risk of

relapse of depression in the first two years following an episode of major depression, strong consideration should be giving to moving the patient into the maintenance phase of treatment (see below) after completion of the continuation phase.

Antidepressant medications should be continued at the same dose used in the acute phase. The indications for maintaining ECT during the continuation phase are poorly defined, but ECT is generally continued at a less frequent rate for patients who respond to ECT during the acute phase. Psychotherapy can also be an effective treatment modality during the continuation phase, however, the optimal frequency and length of treatment necessary to maintain clinical improvement is uncertain.

Clinician evaluations every two to three months are usually sufficient for monitoring stable inmates during the continuation phase of treatment. Clinicians should assess inmates for the recurrence of depressive symptoms, adherence to recommended treatments, drug side effects, and treatment efficacy. Counseling efforts should focus on education of the inmate on the signs and symptoms associated with relapse, importance of early intervention if symptoms do recur and the appropriate use of medication or other treatments.

Maintenance phase treatment: Long term chronic care management of patients with major depression depends on the specific needs of the patient. The goal of maintenance therapy is to prevent recurrent major depressive episodes, primarily through the continuation of somatic treatments. Many inmates in full remission following their first episode of a moderate major depressive illness will not require ongoing treatment beyond the continuation phase, however, between 50% and 85% of patients with a single episode of major depressive disorder will have further episodes. Therefore, maintenance treatment should be given strong consideration for high risk inmates with the following:

- History of severe symptoms or severe functional impairment
- History of suicidal or homicidal ideation, plan, intent or behavior
- History of psychotic or catatonic symptoms
- Presence of residual symptoms or functional limitations
- Presence of significant psychosocial stressors
- Comorbid psychiatric disorders, such as dysthymia, substance use disorder, anxiety disorder, personality disorder

Other factors to consider in placing an inmate in the maintenance phase include:

- Occurrence of drug side effects during continuation phase
- Inmate preference

If a decision is made to continue medication during the maintenance phase, the same dosage is recommended that was prescribed for the acute and continuation phases. The duration of maintenance therapy should be individualized for stable patients treated for a single episode of major depressive disorder. Inmates with recurrent episodes of major depressive disorders will ordinarily require long term maintenance therapy. Patients with a history of three or more episodes in a five year period have a greater than 90% chance of recurrence and probably require life-long treatment.

If the inmate has responded to ECT, this treatment can be continued in the maintenance phase, usually on a monthly basis, however the frequency and duration of treatment necessary to maintain remission should be individualized.

No evidence supports the efficacy of continued psychotherapy in the maintenance phase; however, on a case by case basis, psychotherapy may be appropriate and may be chronically necessary for inmates with a history of recurrent major depressive episodes.

Discontinuation and relapse: The decision to discontinue medications and psychotherapeutic interventions should be individualized. When the decision is made to discontinue treatment the inmate should have a clear understanding of the signs and symptoms of early relapse and be instructed to seek help as soon as possible. Early treatment while the inmate is still in partial remission may prevent unnecessary morbidity or suicide.

Discontinuation of medication should occur slowly over several weeks or even months. Stopping medications abruptly, especially short-acting antidepressants, can provoke a discontinuation withdrawal syndrome that is extremely uncomfortable and mimics the depressive episode. Medications should be tapered slowly. Once the medication has been completely discontinued patient follow-up every two to three months for the next six to twelve months is warranted for assessment and review.

During the discontinuation process, the inmate should be monitored regularly for signs and symptoms of relapse. Should a relapse occur, the medication should be increased back to the dose that brought the inmate into remission, and the inmate should be placed back in the acute phase of treatment, followed

by the continuation phase and then managed with maintenance therapy. ECT and psychotherapeutic interventions should be reinstituted selectively on a case by case basis when managing inmates who have relapsed with recurrent depression.

5. TREATMENT: MEDICATIONS

The following factors should be considered when selecting antidepressant medications:

- Previous response to medication by inmate or blood relative
- Side effect profile
- Potential drug-drug interactions
- Comorbid medical conditions
- Inmate preference
- Frequency of administration
- Formulary status

Drug classes, indications, and dosaging: Major categories of antidepressant medications include SSRIs, TCAs and MAOIs, along with other classes of medications. Drug treatment options for depression, including clinical indications and dosaging are listed in **Appendix 6.**

Selective Serotonin Reuptake Inhibitors (SSRIs) are commonly the first line drugs for the treatment of depression, since these medications are as effective as other antidepressants and have a side effect profile that is generally more favorable than that of the tricyclics or monoamine oxidase inhibitors. Differences in efficacy between the different SSRIs have not been demonstrated, therefore the choice of medication should be based on other relevant clinical and practical factors. Shorter acting SSRIs can cause a syndrome of tinnitus, vertigo ,anxiety and paresthesias when abruptly discontinued; therefore, this potential complication should be considered in medication selection. SSRIs are much less toxic than tricyclic antidepressants when taken in greater than recommended therapeutic dosages and are rarely fatal in overdose. The measurement of drug levels is not generally useful for SSRIs.

Tricyclic Antidepressants (TCAs) can be abused for their anticholinergic and antihistaminic side effects and are far more toxic than SSRIs in higher than therapeutic doses and can be fatal in overdose. Tricyclic antidepressants should ordinarily be reserved for those inmates who have a documented non-response to an adequate trial of another class of medication known to be efficacious in depression. Tricyclic medications should be crushed or dispensed in liquid form whenever possible and

administered with careful observation of ingestion. Blood levels should be monitored whenever the dose is changed or medications with potential drug interactions are added, discontinued or their dosage is changed. EKG monitoring should be obtained for inmates over 50 years of age or who are at risk for cardiac complications.

The side effect profile of tricyclics make them a poorer choice for patients with any number of medical problems including diabetes, heart disease, obesity, hypertension, prostatic enlargement, cognitive problems and glaucoma. The elderly are especially susceptible to anticholinergic and antihistaminic side effects even without underlying medical conditions and should ordinarily not be treated with tricyclic antidepressants.

Monoamine Oxidase Inhibitors (MAOIs) present unique clinical challenges and therefore should not be prescribed without knowledge of the complications associated with this class of antidepressants. MAOIs are reserved for those patients who have been refractory to multiple adequate trials of other classes of medications; however, MAOIs are not inherently superior to other strategies for treatment-refractory patients. Potential side effects of MAOIs are significant and include orthostatic hypotension, edema, weight gain, sexual dysfunction, headaches, insomnia, sedation, myoclonic jerks, paresthesias and peripheral neuropathy. Drug interactions are a concern due to the potential for hypertensive crises and serotonin syndrome, both potentially fatal conditions as outlined in **Appendix 9, Severe Drug-Drug Interactions with MAOIs.** Food-drug interactions can also cause a hypertensive crisis when the patient ingests foods containing large amounts of tyramine or other pressor amines, as listed in **Appendix 10, Foods to Avoid During Treatment with MAOIs.**

Drug washout times (changing antidepressant treatment regimens): Switching drug treatment regimens requires the appropriate tapering of medications and the timely initiation of an alternative drug regimen as described in **Appendix 11, Drug Washout Times Between Antidepressant Trials.**

Drug side effects: Major side effect profiles of the various classes of antidepressants are enumerated in **Appendix 7.**

Drug-drug interactions are an important complicating factor in the treatment of depression. Some of these interactions are of minor significance and consist primarily of an increase in uncomfortable side effects. However, many drug-drug interactions can cause significant morbidity and may be life threatening. Prescribers should be particularly aware of the potential for

antidepressants to induce liver enzymes and directly affect the blood levels of concurrently prescribed medications. SSRIs can alter the level of warfarin and increase the prothrombin time, which should be monitored at least weekly until stable. Carbamazepine decreases the plasma level of SSRIs. SSRIs increase the plasma level of carbamazepine, valproate, phenytoin, and tricyclic medications. Blood levels of tryicyclics should be monitored regularly until stable when used with SSRIs. Because of the many potential serious drug interactions with antidepressant medications, providers should consult with their pharmacist and other current resource materials when prescribing antidepressants to inmates taking other medications.

6. TREATMENT: PREGNANCY

Pregnancy does not in and of itself preclude somatic treatment for depression. The decision to institute or continue medication or ECT in a pregnant inmate is based on potential risks of the treatment to the fetus and mother and potential risks of untreated depression which can include significant impairment in ability to parent, interference in other significant relationships, suicide, acts of harm towards others, inadequate weight gain and low birth weight of the baby, and poor self-care. Treatment decisions should be made in conjunction with the inmate and spouse, if possible, following a frank discussion of the risks and benefits of treatment. The inmate's primary physician and obstetrician should also be part of the decision process.

Tricyclics and SSRIs have not been shown to increase the risk of intrauterine death or major birth defects, however, one study has shown an increase in the occurrence of three or more minor physical anomalies in infants exposed to fluoxetine versus the comparison group as well as an association with lower maternal weight gain and lower birth weight. A limited number of behavioral studies of children exposed to tricyclics or fluoxetine have not revealed any long term effects on cognition, temperament or behavior.

Antidepressant medications prescribed during pregnancy should be limited to those SSRIs that have been studied (fluoxetine and sertraline). Blood levels in the mother should be monitored whenever tricyclics are prescribed (nortriptyline is the recommended tricyclic antidepressant, having the best known relationship between plasma levels and therapeutic effect). Tapering antidepressants over the last few weeks of pregnancy should be considered, since mild neonatal withdrawal syndromes have been seen in infants exposed to fluoxetine, sertraline and

tricyclics.

ECT can be an alternative safe and effective treatment for pregnant women and in select cases is the treatment of choice for pregnant women, particularly those suffering from a major depressive episode with psychotic features.

Antidepressant medications should be reinstituted after delivery whenever feasible. If the mother is breastfeeding, the risk of untreated depression should be weighed against the risk of side effects for the infant if the medication is excreted in breast milk.

7. INMATE EDUCATION

Patients often view depression as a personal weakness and are reluctant to discuss their feelings because of the stigma associated with a mental health problem. Clinicians, nursing, and social work staff can help alleviate patient stress associated with the diagnosis of depression by emphasizing that depression is a common and highly treatable medical condition. Key concepts for group or individual educational efforts as well as resources on depression are enumerated in **Appendix 12, Inmate Education Program - Depression (Outline and Resources), and Appendix 13, Inmate Education Program - Depression, (Fact Sheet and Patient Assessment).**

8. CLINICIAN SELF-ASSESSMENT

A clinician self-assessment tool is attached in **Appendix 14, Clinician Self-Assessment: Management of Major Depressive Disorder.**

ATTACHMENTS

Appendix 1: DSM IV Criteria for Major Depressive Episode

Appendix 2: DSM-IV Criteria for Major Depressive Disorder, Single Episode; DSM-IV Criteria for Major Depressive Disorder, Recurrent

Appendix 3: Risk Assessment for Patients with Depression

Appendix 4: Pharmacologic/Toxic Agents Which Can Cause or Exacerbate Depressive Symptoms

Appendix 5: Medical Conditions Associated with Depression

Appendix 6: Antidepressant Medications: Indications and Dosaging

Appendix 7: Side Effects of Antidepressant Medications

Appendix 8: Augmentation Strategies

Appendix 9: Severe Drug-Drug Interactions with MAOIs

Appendix 10: Foods to Avoid During Treatment with MAOIs

Appendix 11: Drug Washout Times Between Antidepressant Trials

Appendix 12: Inmate Education Program - Depression (Outline and Resources)

Appendix 13: Inmate Education Program - Depression (Fact Sheet and Patient Assessment)

Appendix 14: Clinician Self-Assessment: Management of Major Depressive Disorder

DSM-IV Criteria for Major Depressive Episode

Five (or more) of the following nine symptoms have been present during the same 2-week period and represent a change from previous functioning; **at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure** (Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations).

- **Depressed mood** most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad or empty) or observation made by others (e.g. appears tearful)
- **Anhedonia:** Markedly diminished interest or pleasure in all, or almost all, activities most of the day nearly every day (as indicated by either subjective account or observation made my others)
- **Weight change:** weight loss or gain when not dieting or attempting to gain weight (e.g., a change of more than 5% body weight in a month), or decrease or increase in appetite nearly every day
- **Insomnia** or hypersomnia nearly every day
- **Psychomotor changes:** agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
- **Fatigue or loss of energy** nearly every day
- **Feelings of worthlessness or excessive or inappropriate guilt** (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
- **Poor concentration:** Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
- **Suicidal thoughts:** Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

Also:
- The symptoms do not meet criteria for a mixed episode.
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
- The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one; the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

DSM-IV Criteria for Major Depressive Disorder, Single Episode

A. Presence of a single major depressive episode.

B. The major depressive episode is not better accounted for by schizoaffective disorder and is not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified.

C. There has never been a manic episode, a mixed episode, or a hypomanic episode. Note: This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment-induced or are due to the direct physiological effects of a general medical condition.

DSM-IV Criteria for Major Depressive Disorder, Recurrent

A. Presence of two or more major depressive episodes.

B. The major depressive episode is not better accounted for by schizoaffective disorder and is not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified.

C. There has never been a manic episode, a mixed episode, or a hypomanic episode. Note: This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment-induced or are due to the direct physiological effects of a general medical condition.

Risk Assessment for Patients with Depression

The risk assessment should be documented at each inmate visit for inmates diagnosed with major depressive disorder. Note: some patients are more likely to act on suicidal thoughts during the early phase of recovery than during the acute phase of the disease.

The following factors should be considered and/or reviewed in all inmates with depression until symptoms are in full remission, (The presence of these factors may indicate an increased risk of suicide or violence towards others).

- Past history of acts of harm towards self or others

- Presence of thoughts of harm towards self or others

- Presence of plan to harm self or others
  - -Lethality of plan
  - -Presence of means to carry out plan
  - -Presence of intent to carry out plan

- Family history of suicide or violence

- Presence of psychotic symptoms

- History of substance abuse

- Lack of support systems

- Recent severe stressor or loss

- Presence of comorbid personality disorder or anxiety disorder

Pharmacologic/Toxic Agents Which Can Cause or Exacerbate Depressive Symptoms

Cardiovascular	alpha-methyldopa, reserpine, propranolol, clonidine, guanethidine, thiazide diuretics, digoxin/digitoxin
Hormones	oral contraceptives, ACTH, glucocortocoids, anabolic steroids
Anti-Inflammatories and Anti-Infectives	NSAIDs, sulfonamides
Anti-Cancer Agents	cycloserine, vincristine, vinblastine, others
Anti-Emetics	droperidol, metoclopramide, prochlorperazine, perphenazine
Psychiatric medications	benzodiazepines, sedatives/hypnotics, antipsychotics, anticholinergics
Others	narcotics, cimetidine, ranitidine, baclofen, other muscle relaxants, ethambutol, disulfiram
Illicit substances	all can cause or exacerbate depression during any phase of use, i.e. intoxication, chronic use, withdrawal
Toxins	heavy metals, alcohol, thallium, anticholinesterase insecticides

Medical Conditions Associated with Depression

(May cause or can present as depression)

Endocrine	Hypo- or Hyperthyroidism Hyperparathyroidism Hypopituitarism Adrenal disease: Cushing's or Addison's disease Diabetes
Infectious Diseases	Pneumonia Hepatitis Infectious mononucleosis HIV infection Toxoplasmosis Tertiary syphilis
Connective Tissue Disorders	Lupus Rheumatoid arthritis Mixed connective tissue disease
Nutritional disorders	Excessive intake of B-6 B-12 or folate deficiency Thiamine deficiency Pellagra (niacin deficiency)
Neurologic disorders	Stroke Multiple sclerosis Parkinson's disease Dementia Head injury Subdural hematoma (chronic) Seizure disorder CNS tumors Sleep disorders
Malignancies	Any, but especially abdominal or gastrointestinal Paraneoplastic syndrome Carcinomatosis Hematologic
Cardiac disease	Ischemic heart disease Congestive heart failure
Miscellaneous	Anemia Asthma/COPD/emphysema Chronic pain syndromes Smoking cessation Any chronic illness

Antidepressant Medications: Indications and Dosaging

Class	Name	Indications*	Start Dose (mg) daily unless noted otherwise	Usual Dose** (mg) daily, unless noted otherwise
TCA	Amitriptyline Doxepin Imipramine Desipramine	D, A	25-50	100-300***
TCA	Nortriptyline	D, A	10-25	50-200***
SSRI	Citalopram	D, A	20	20-60
SSRI	Fluoxetine	D, d, A, OCD, E	10-20	20-60
SSRI	Sertraline	D, d, A, OCD	25-50	75-200
SSRI	Paroxetine	D, d, A, OCD	20	20-60
SDRI	Buproprion	D, D in Bipolar pts, ADD, ADHD, Sm	75 BID, or 150 daily in time release	100 TID, or 150 BID in time release
NaSSA	Mirtazapine	D, S, A	7.5-15	7.5-45
SSNI	Venlafaxine	D, d, A, OCD	37.5-75 per day (BID dosing in non time release)	75-225 total daily dose (BID dosing in non time release)
Triazolopyridine	Trazodone	S(D? efficacy)	25-50	50-150 for S 150-300 for D
Phenylpiperazine	Nefazodone	D, A(?)	50-100 BID	200 BID

*D=Depressive Disorders; d=Dysthymia; A=Anxiety disorders other than OCD; OCD=Obsessive Compulsive Disorder; S=Sleep Disturbance-insomnia; ADD=Attention Deficit Disorder; ADHD=Attention Deficit Hyperactivity Disorder; Sm=Smoking Cessation; E=Eating Disorder

**Severely depressed inmates may need higher doses. See PDR for indications. Elderly inmates may need lower doses, both as starting dose and as therapeutic dose.

***Blood levels vary as much as factor of 10 between individuals. Blood levels should be checked during titration and once steady state is reached. Nortriptyline has definitive therapeutic window, above or below which it has decreased effectiveness.

Side Effects of Antidepressant Medications

(For complete list of side effects consult the PDR)

Class of Drug	Examples	Side Effects
Selective Serotonin Reuptake Inhibitors (SSRIs)	fluoxetine fluvoxamine paroxetine sertraline citalopram	headache, nausea, flatulence, somnolence, insomnia, agitation, anxiety, weight loss or anorexia, weight gain, tremor, sexual dysfunction, myoclonus, restless legs, bruxism, akathisia, increased dreaming/nightmares, bradycardia, galactorrhea, paresthesias, mania
Selective Dopamine-Reuptake Inhibitor (SDRI)	buproprion	**increased risk of seizures:** do not use in inmates with eating disorders or with seizure disorders; insomnia, anxiety, agitation, headache, tremor, myoclonus, tinnitus, palpitations
Selective Serotonin Norepinephrine Reuptake Inhibitor (SNRI)	venlafaxine	headache, agitation, anxiety, insomnia, somnolence, dry mouth, sweating, urinary retention, constipation, increased blood pressure-dose related; nausea, dizziness, tachycardia, orthostatic hypotension, sexual dysfunction, mania
Noradrenergic/ Specific Serotonergic Antidepressant (NaSSA)	mirtazapine	**weight gain**, sedation, dry mouth, constipation, increased sweating, blurred vision, urinary retention, dizziness, orthostatic hypotension, tachycardia, decreased WBC, increased LFT's, mania
Tricyclic Antidepressants (TCAs)	amitriptyline clomipramine doxepin imipramine trimipramine desipramine nortriptyline protriptyline	**anticholinergic–**dry mouth, constipation, urinary retention, blurred vision, dry eyes, sweating, confusion; **antihistaminic–**weight gain, somnolence, nightmares, confusion; **other–**cardiac arrhythmia, prolonged conduction time, orthostatic hypotension, seizures, tachycardia, tremor, sexual dysfunction, mania

Antidepressant Side Effects (Appendix 7, p. 2)		
Class of Drug	**Examples**	**Side Effects**
Tetracyclic Antidepressant	maprotiline	same as Tricyclics, and maprotiline has increased risk of **seizures**
MAOIs	phenelzine tranylcypromine	constipation, anorexia, weight gain, headache, anxiety, insomnia, somnolence, nausea, vomiting, dry mouth, urinary retention, sexual dysfunction, paresthesias, orthostatic hypotension, increased blood pressure, myoclonus, edema, electrolyte imbalance, mania
Triazolopyridine	trazodone	somnolence, dizziness, tachycardia, orthostatic hypotension, priapism, nausea, dry mouth, mania
Phenylpiperazine	nefazodone	dry mouth, nausea, constipation, somnolence, orthostatic hypotension, mania
Dibenzoxazepine	amoxapine	amoxapine can cause **tardive dyskinesia**, extrapyramidal side effects and all the same side effects as other typical antipsychotics as well as TCAs

Augmentation Strategies

A thorough treatment reassessment should occur if the inmate does not show a significant response to treatment for depression after 6-8 weeks of acute phase therapy.

RE-ASSESSMENT: Review steps 1 through 9, prior to altering therapy

1. Thorough review of presentation, symptoms, and diagnosis: Consider another cause for depressive symptoms.
2. Evaluate for complicating medical condition or illness not yet diagnosed, e.g. an autoimmune disorder, infectious process, B-12 deficiency, etc.
3. Review compliance with inmate and pharmacy (pill line attendance via MAR forms.) Nonadherence is the most likely cause of poor response to treatment.
4. Ensure adequate dose and trial period of medication.
5. Check blood levels in medications with known therapeutic levels or when compliance is in doubt.
6. Consider drug-drug interactions that may be lowering plasma level of antidepressant.
7. Consider active substance abuse.
8. Review with inmate possible presence of ongoing or new significant stressors that may be impacting the inmate's functioning.
9. Consider consultation for second opinion.

TREATMENT: If the above steps yield no specific answer, adjustment of the treatment regimen is reasonable; Consider the following options:

1. Increase dose of current medication.
2. Switch to another medication (different SSRIs have different efficacy in individual inmates).
3. Add another antidepressant to medication, e.g. add low dose TCA to SSRI, but monitor blood level of TCA.
4. Add triiodothyronine, 25-50 micrograms per day. If no improvement after 3 weeks, discontinue.
5. Add lithium. Blood levels of 0.5-0.8 mEq/L of lithium are usually sufficient for treating depression not complicated by a bipolar disorder. If no response is evident by 6 weeks, discontinue.
6. Add, change type, or increase frequency or intensity of psychotherapy.
7. ECT

Wait 6-8 weeks (unless otherwise indicated) after treatment augmentation, while monitoring the inmate closely. If incomplete or no response: repeat assessment steps 1-9 and then reconsider treatment options 1-7.

Severe Drug-Drug Interactions With MAOIs*

Absolutely Contraindicated

Class of Drug	Example	Effect/Interaction
Anorexiants	fenfluramine defenfluramine	serotonin syndrome
Antidepressants (See Appendix 11 for Washout Periods)	clomipramine trazodone nefazodone venlafaxine fluoxetine paroxetine sertraline buproprion mirtazapine	serotonin syndrome
Herbs, supplements	L-tryptophan St. John's Wort	serotonin syndrome
Antimigraine	sumatriptan zolmatriptan	serotonin syndrome
Sympathomimetics	cocaine amphetamines ephedrine pseudoephedrine dopamine tyramine phenylpropanolamine methylphenidate	hypertensive crisis
Narcotics	meperidine dextromethorphan diphenoxylate tramadol	encephalopathy, death serotonin syndrome

***Many other potential drug-drug interactions exist and have been reported with MAOIs. Check with your pharmacist prior to adding MAOIs to any medications or any medications to MAOIs. Over-the-counter medications, especially cold, hay fever and sinus medications can be dangerous and potentially life threatening. Caution inmates on these issues.**

Foods to Avoid During Treatment with MAOIs*

Very High Tyramine Content

- All matured or aged cheeses (e.g. cheddar, brick, blue, Gruyere, Stilton, brie, Swiss, Camembert, Parmesan, mozzarella)
- Broad beans (fava)
- Orange pulp
- Meat extract, e.g. Marmite, Bovril
- Concentrated yeast extracts or yeast vitamin supplements
- Dried, salted, pickled or smoked fish
- Sauerkraut
- Aged sausage (e.g., salami, pepperoni)
- Tap beer, Chianti, other beer and wine
- Chicken or beef liver
- Packaged soup
- Summer sausage

Moderately High Tyramine Content or reactions have been reported with these foods (no more than 1-2 servings per day)

- Soy sauce
- Sour cream, yogurt
- Meat tenderizers
- Caviar, snails
- Ripe bananas
- Caffeine
- Avocados
- Plums, raisins
- Chocolate
- Overripe fruit
- Chinese food
- Spinach
- Tomatoes

*Adapted from Clinical Handbook of Psychotropic Drugs , See References

Drug Washout Times Between Antidepressant Trials

Antidepressant Change	**Minimum Washout Period**
From SSRI to SSDI, SNRI, NaSSA	2-5 days (Recommended)*
From SSRI, SSDI, SNRI, NaSSA to SSRI	2-5 days (Recommended)*
From TCA to TCA	None
From SSRI, SSDI, SNRI, NaSSA to TCA	1-2 weeks depending on half-life of SSRI and its active metabolites (Recommended)*
From TCA to SSRI, SNDI, SNRI, NaSSA	5-7 days (Recommended)*
From drug with short half-life metabolites, e.g., paroxetine, fluvoxamine, venlafaxine, TCA to MAOI	2 weeks (Required)
From drug with long half-life metabolites, e.g., fluoxetine, to MAOI	5 weeks (Required)
From MAOI to non-MAOI	2 weeks (Required)
From MAOI to MAOI	2 weeks (Required)

*****An absolute washout of the previous medication is not necessary prior to instituting the new medication. The first medication may be tapered down as the new medication is gradually tapered upwards, while remaining cognizant of potential drug-drug interactions and half-lives of the medication and its active metabolites.

Inmate Education Program - Depression (Outline and Resources)

Objectives

1. Define depression
2. List 3 symptoms of depression
3. Describe the treatment for depression

What is depression?

Depression is a very common medical condition affecting nearly 10% of Americans. A depressive disorder is not the same as a passing blue mood and is not a sign of personal weakness or a condition that can be willed or wished away. People with a depressive illness cannot merely "pull themselves together" and get better. Depression is a medical disorder with a biological basis that affects a person's thoughts, moods, feelings, behavior and physical health.

Depressive illnesses often interfere with a person's normal activities such as eating and sleeping, and cause pain and suffering, not only to those who have the disorder, but also to those who care about them. Up to 70% of people who commit suicide may have some form of depression.

Depressive disorders come in different forms as in the case with other illnesses such as heart disease. Depression may occur as a one time episode, as repeated episodes with periods free of depression, or as a chronic condition, requiring lifetime care.

What causes depression?

There is no single cause for depression. Experts believe depression may be caused by imbalances in brain chemicals called neurotransmitters. Sometimes a stressful life event triggers depression. Other times, depression seems to occur spontaneously, with no identifiable specific cause. The following factors are viewed as causes of depression:

- **Heredity**: Depression often "runs" in families.
- **Stress**: Stressful life events, particularly a loss or threatened loss of a loved one or a job can trigger depression.
- **Medications**: Long-term use of certain medications, such as some drugs that control high blood pressure, sleeping pills, or occasionally, birth control pills, may cause depression.

- **Illnesses:** Having a chronic illness, such as heart disease, stroke, diabetes, or cancer puts a person at a higher risk for developing depression.
- **Personality:** Certain personality traits, such a having low self-esteem and being overly dependent, self-critical, pessimistic and easily overwhelmed by stress, can make a person more vulnerable to depression.
- **Alcohol, nicotine, and drug abuse:** Studies show that using these substances can cause or worsen depression and anxiety disorders.

What are the symptoms of depression?

Two hallmark symptoms of depression are:

- Loss of interest in normal daily activities
- Depressed mood with feelings of sadness, helplessness, hopelessness, often with periods of crying spells

Other symptoms may include:

- Sleep disturbances
- Significant weight loss or gain
- Decreased interest in sex
- Agitation or slowing of body movements
- Irritability and feeling easily annoyed
- Fatigue
- Low self-esteem
- Thoughts of death
- Impaired thinking or concentration - difficulty making decisions, unable to concentrate or problems with memory, feeling that life is in slow motion

Many people with depression have symptoms of anxiety as well. Anxiety that develops after age 40 is often related to depression rather than being an independent problem.

Depression can also contribute to a wide variety of other health problems, such as generalized itching, blurred vision, excessive sweating, dry mouth, gastrointestinal problems (indigestion, constipation, and diarrhea), headaches, and backaches.

How is depression diagnosed?

A physician determines a person has depression by asking the patient health-related questions, performing a physical examination, and conducting certain tests to exclude other conditions that can cause symptoms of depression. A good diagnostic evaluation will include a complete history of symptoms, i.e., when they started, how long they have lasted, how severe they are, whether the person has had them before and, if so, whether the symptoms were treated and what treatment was given. Patients should be asked about personal alcohol and drug use, about the presence of thoughts of death and suicide, and whether other family members have had a depressive illness.

How is depression treated?

Treatment choices will depend upon the outcome of the evaluation. If the doctor sees signs of severe depression or suspects the possibility of suicide, he or she may refer the person to a psychiatrist (a medical doctor who specializes in mental illness) or even recommend immediate hospitalization.

Some people with milder forms of depression may do well with counseling alone. People with moderate to severe depression most often benefit from medications called antidepressants that provide symptom relief along with counseling that helps people learn more effective ways to deal with life's problems and depression itself.

Once treatment for depression begins, it is managed on a daily basis:

- See your health care provider regularly to monitor your progress, provide support and encouragement and adjust medications if necessary
- Take your medications as ordered by your doctor
- **Note: Many patients do not feel better until 4 to 8 weeks after beginning their medications**
- Don't become isolated
- Participate in normal activities.
- Join a depression support group if available
- Take care of yourself; eat a healthy diet and get the right amount of sleep and exercise
- Don't abuse alcohol or illegal drugs; they will slow recovery
- Accept support from your family and friends

Resources

National Institute of Mental Health
Information Resources and Inquiries Branch
6001 Executive Boulevard
Room 8184, MSC 9663
Bethesda, MD 20892-9663
Depression brochures: 1-800-421-4211
http://www.nimh.nih.gov

National Alliance for the Mentally Ill
2107 Wilson Boulevard, Suite 300
Arlington, VA 22201-3042
1-800-950-NAMI
http://www.nami.org

National Depressive and Manic Depressive Association
730 N. Franklin, Suite 501
Chicago, IL 60601
1-800-826-3632
http://www.ndmda.org

National Foundation for Depressive Illness, Inc.
PO Box 2257
New York, NY 10016
1-800-239-1265
http://www.depression.org

National Mental Health Association
1021 Prince Street
Alexandria, VA 22314-2971
1-800-969-6642
http://www.nmha.org

Inmate Education Program - Depression (Fact Sheet)

What is depression?

Depression is a brain disorder that affects thoughts, moods, feelings, behavior, and physical health.

Causes

Depression has been linked to:

- heredity
- stress
- medications
- illnesses
- personality
- alcohol and nicotine abuse
- illicit drug abuse

Symptoms

Hallmark symptoms include:

- loss of interest in daily activities
- depressed mood

Other symptoms may include:

- sleep disturbances
- weight loss or gain
- agitation
- slowing of body movements
- irritability
- fatigue
- low self-esteem
- thoughts of death
- impaired thinking
- difficulty concentrating
- less interest in sex

Diagnosis

Medical and psychological evaluation

Treatment

Hospitalization, if severe
Antidepressants
Counseling (psychotherapy)
Day-to-day management

Inmate Education Program - Depression (Patient Assessment)

True or False

1. Depression is a brain disorder that affects thoughts, moods, feelings, behavior and physical health.

2. A depressive disorder is the same as a passing blue mood.

3. Depression has a biological or medical basis.

4. There is no single cause for depression.

5. Stressful events rarely trigger depression.

6. Alcohol does not contribute to depression.

7. Loss of interest in normal daily activities is a hallmark symptom of depression.

8. Many people with depression have symptoms of anxiety.

9. Some people with severe forms of depression do well with psychotherapy or counseling alone.

10. It is not necessary to manage depression on a day-to-day basis.

Inmate Education Program - Depression
(Answers to Patient Assessment)

1. **True**. Depression is a brain disorder that affects thoughts, moods, feelings, behavior and physical health.

2. **False**. A depressive disorder is not the same as a passing blue mood. People with a depressive illness cannot merely "pull themselves together" and get better.

3. **True**. Depression is a medical disorder that has a biological basis.

4. **True**. There is no single cause for depression. Experts believe depression may be caused by imbalances in brain chemicals called neurotransmitters. There are many other factors that contribute to depression.

5. **False**. Stressful life events, particularly a loss or threatened loss of a loved one or job can trigger depression.

6. **False**. Studies show that using alcohol, nicotine, and drug abuse may actually contribute to depression and anxiety disorders.

7. **True**. Loss of interest in normal daily activities and a depressed mood are two hallmark symptoms of depression.

8. **True**. Many people with depression have symptoms of anxiety as well. Anxiety that develops after age 40 is often related to depression rather than being an independent problem.

9. **False**. Some people with milder forms of depression may do well with psychotherapy or counseling alone. People with moderate to severe depression most often benefit from antidepressant medications.

10. **False**. Once treatment for depression begins, it still has to be managed on a day-to-day basis.

Clinician Self-Assessment
Management of Major Depressive Disorder

1. DSM-IV criteria for a major depressive episode require that one of two criteria must be present. These two criteria are:

A. Insomnia or anorexia
B. Fatigue or depressed mood
C. Depressed mood or loss of interest or pleasure
D. Anhedonia or suicidal thoughts

2. The drug(s) of choice for treating depression based on efficacy and lack of major toxicities are which of the following?

A. Tricyclic antidepressants (e.g. Elavil, Doxepin)
B. SSRIs (e.g. Prozac, Zoloft)
C. Lithium
D. Bupropion (Wellbutrin)
E. Diazepam (Valium)

3. True or False: ECT may be the treatment of choice in a pregnant woman with a major depressive episode associated with psychotic features.

4. Which of the following statements is false?

A. Depression can mimic dementia in the elderly.
B. Repeatedly asking an inmate about suicidal thoughts may worsen their depression and cause them to attempt suicide.
C. Frequent (weekly) health care provider monitoring is desirable during the acute phase of treatment.
D. Life long maintenance treatment is usually necessary for inmates with a history of three or more depressive episodes.

5. True or False: Psychotherapy should be tried for 6 to 8 weeks prior to starting medication in an inmate with severe depression and a history of substance abuse.

6. True or False: The elderly are less likely to develop depression than are younger adults.

7. Which of the following statements is false?

A. Inmates who repeatedly present to sick call with vague somatic complaints may have depression.
B. Inmates are most likely to commit suicide just before treatment is initiated.
C. Inmates who come into your institution on MAO inhibitor antidepressants may be immediately switched to a formulary SSRI.
D. The treatment of depression in bipolar disorder is ordinarily very different from the treatment of major depressive disorder.
E. Drug levels are ordinarily monitored when prescribing tricyclics, but are not indicated when prescribing SSRIs.

8. All of the following are risk factors for suicide except:

A. Past history of suicidal behavior or “gestures”
B. Presence of psychotic symptoms
C. Family history of suicide
D. Female gender more than male gender

9. True or False: Noncompliance is the most likely cause of poor response to treatment.

10. True or False: Treatment for a single episode of major depression is continued two weeks after a full remission and can then be stopped.

11. True or False: During the maintenance phase of treatment, the effective dose of medication is lower than that used in the acute phase or continuation phase of treatment.

12. Match the potential drug side effect with one of the following antidepressant medications: mirtazapine, buproprion, amitriptyline, tranylcypromine, or paroxetine.

A. Hypertensive crisis if taking ephedrine or eating avocados
B. Weight gain/increased appetite/agranulocytosis
C. Cardiac arrhythmia/dry mouth/urinary retention
D. Paresthesias and tinnitus after abrupt discontinuation
E. May precipitate seizures/insomnia

13. Which of the following transitions from one antidepressant medication to another requires a 5 week washout period?

A. Amitriptyline to nortriptyline
B. Paroxetine to imipramine
C. Paroxetine to tranylcypromine
D. Tranylcypromine to phenelzine
E. Fluoxetine to tranylcypromine

Answers to Clinician Self-Assessment (Management of Major Depressive Disorder)

1. Answer is C. Five of nine symptoms are required to diagnose major depressive disorder; one of the symptoms must be either (1) depressed mood or (2) loss of interest or pleasure (anhedonia), (See Appendix 1).

2. Answer is B. SSRIs are commonly the drugs of choice for treating depressive disorders due to their efficacy, low side effect profile, and relative safety in overdose.

3. Answer is True.

4. Answer is B. Health care providers often shy away from asking patients about suicidal ideation for fear of precipitating suicidal gestures. Inquiring about suicidal intent, however, does not worsen a patient's depression or encourage suicidal behaviors. On the contrary, an open discussion of suicidal feelings helps alleviate patient stress and provides an opportunity for suicide prevention measures when indicated.

5. Answer is False. Medications(and ECT, when specifically indicated) are the mainstays of treatment for severe or recurrent major depressive disorder. Psychotherapy should rarely be the sole treatment modality for inmates with severe major depressive disorders. Combination treatment (medication and psychotherapy) has been shown to be more efficacious than medication alone in the treatment of severe depression.

6. Answer is False. The elderly have a higher rate of depression than younger adults (though it can occur at any age) and are more likely to commit suicide than their younger counterparts.

7. Answer is C. Inmates seen frequently at sick call for vague somatic complaints are frequently depressed, and should be assessed for depressive symptoms. Depressed individuals are at highest risk for suicide during the early acute phase of treatment. Inmates who arrive on MAOI medication should be thoroughly evaluated prior to making any decisions about changing to a different class of antidepressant, (See Appendix 8 and 9 regarding drug-drug and food-drug interactions with these medications). If a decision is made to change the inmate from an MAOI to another type of antidepressant, the MAOI must be discontinued for at least two weeks prior to initiation of another drug, (See Appendix 11, regarding washout times when switching antidepressant medications). The treatment of depression in an inmate with a

diagnosis of bipolar disorder requires different treatment considerations than treatment of major depressive disorder and should be done in consultation with a psychiatrist. Drug levels are often monitored when treating depression with tricyclics, but are not indicated when prescribing SSRIs.

8. Answer is D. While women are more likely to make attempts to harm themselves, men are more likely to use a lethal means and succeed in their efforts. Other risk factors for suicide include: active or past substance abuse; thoughts, plans, means and intent to harm self; recent severe stress or loss; lack of support systems; presence of comorbid personality disorder or anxiety disorder.

9. Answer is True. Noncompliance is a common problem in the treatment of all chronic illnesses, including psychiatric conditions. Treatment compliance can be monitored through direct observation at pill line, review of medication administration records (MAR forms), discussion with the patient and pharmacist, and when appropriate the testing of medication blood levels.

10. Answer is False. Major depressive disorder rapidly recurs when treatment is stopped during the first six months, even if a full remission has been achieved. Major depression carries with it a significant risk for morbidity and mortality and treatment should be continued for at least 4-5 months after a **full** remission if this is the first episode. If the individual has had multiple episodes of depression or suffered severe symptoms, strong consideration should be given to long-term, even lifetime treatment.

11. Answer is False. The effective dose of medication remains the same throughout all phases of treatment.

12. Answers are the following:

A. tranylcypromine
B. mirtazapine
C. amitriptyline
D. paroxetine
E. buproprion

13. Answer is E: long acting SSRI (fluoxetine) to MAOI (tranylcypromine)