Workers’ Compensation Board’s New York Depressive Disorders Medical Treatment Guidelines

A Training Module Developed by the Medical Director’s Office
Depressive Disorders Training Module

Medical Care

- Medical care and treatment required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work, while striving to restore the patient’s health to its pre-injury status in so far as is feasible.

- Any medical provider rendering services to a workers’ compensation patient must utilize the Workers’ Compensation Board’s Medical Treatment Guidelines (MTGs) for all work-related injuries and/or illnesses.
Positive results are defined primarily as functional gains that can be objectively measured. Objective functional gains include, but are not limited to, positional tolerances, range of motion, strength, endurance, activities of daily living (ADL), cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation.
If a given treatment or modality is not producing positive results, the provider should either modify or discontinue the treatment regime. The provider should evaluate the efficacy of the treatment or modality two to three weeks after the initial visit and three to four weeks thereafter. Recognizing that treatment failure is at times attributable to an incorrect diagnosis should prompt the clinician to reconsider the diagnosis in the event of an unexpected poor response to an otherwise rational intervention.
Education of the patient should be a primary emphasis in the treatment of work-related injury or illness. An education-based paradigm should always start with communicating reassuring information to the patient. No treatment plan is complete without addressing issues of patient education as a means of facilitating self-management of symptoms and prevention of future injury.
Acuity

- Acute, Subacute and Chronic are generally defined as time frames for disease stages:
  - Acute – Less than one month
  - Subacute – One to three months, and
  - Chronic – Longer than three months
Time Frames

- Diagnostic time frames for conducting diagnostic testing commence on the date of injury.
- Treatment time frames for specific interventions commence once treatments have been initiated, not on the date of injury.
- Clinical judgment may substantiate the need to accelerate or decelerate the time frames discussed in this document.
- Specific durations of treatments and number of treatment visits are beyond the scope of this training module and the provider should refer to the recommendations in the MTGs.
### Delayed Recovery

- For those patients who fail to make expected progress 6-12 weeks after an injury, reexamination in order to confirm the accuracy of the diagnosis and reevaluation of the treatment program should be performed. Assessment for potential barriers to recovery (yellow flags/psychological issues) should be ongoing throughout the care of the patient. However, at 6-12 weeks, alternate treatment programs, including formal psychological or psychosocial evaluation, should be considered. The evaluation and management of delayed recovery does not require the establishment of a psychiatric or psychological claim.
Active Interventions

- Active interventions emphasizing patient responsibility, such as therapeutic exercise and/or functional treatment, are generally emphasized over passive modalities, especially as treatment progresses. Generally, passive and palliative interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.
Personality/Psychological/Psychosocial Evaluations

- In select patients, diagnostic testing procedures may be useful when there is a discrepancy between diagnosis, signs, symptoms, clinical concerns or functional recovery. Psychological testing should provide differentiation between preexisting depression versus injury-caused depression, as well as post-traumatic stress disorder (PTSD), and other psychosocial issues that may include work or non-work-related issues when such conditions are identified in the patient.
Personality/Psychological/Psychosocial Evaluations

- For those patients who fail to make expected progress 6-12 weeks after an injury and whose subjective symptoms do not correlate with objective signs and tests, reexamination in order to confirm the accuracy of the diagnosis should be made. Formal psychological or psychosocial evaluation may be considered.
  - This evaluation includes a one-time initial evaluation with up to two hours of additional psychometric testing.
Functional Capacity Evaluation (FCE)

- Functional capacity evaluation (FCE) is a comprehensive or more restricted evaluation of the various aspects of function as they relate to the patient’s ability to return to work.
  - In most cases, the question of whether a patient can return to work can be answered without an FCE.
Functional Capacity Evaluation (FCE)

- When an FCE is being used to determine return to a specific job site, the treating physician is responsible for understanding and considering the job duties. FCEs cannot be used in isolation to determine work restrictions. The authorized treating physician must interpret the FCE in light of the individual patient's presentation and medical and personal perceptions. FCEs should not be used as the sole criteria to diagnose malingering.
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- **Functional Capacity Evaluation (FCE)**
  - An FCE may be considered at time of maximum medical improvement, following reasonable prior attempts to return to full duty throughout the course of treatment, when the treating physician is unable to make a clear determination on work status or case closure.
Return To Work

For purposes of these guidelines, return to work is defined as any work or duty that the patient is able to perform safely. It may not be the patient’s regular work. Ascertain a return-to-work status is part of medical care, and should be included in the treatment and rehabilitation plan. It is normally addressed at every outpatient visit.
Return To Work

- A description of the patient’s status and task limitations is part of any treatment plan and should provide the basis for restriction of work activities when warranted. Early return to work should be a prime goal in treating occupational injuries. The emphasis within these guidelines is to move patients along a continuum of care and return to work, since the prognosis of an injured worker returning to work drops progressively the longer the worker has been out of work.
Return To Work

- When returning to work at the patient’s previous job task/setting is not feasible, given the clinically determined restrictions on the patient’s activities, inquiry should be made about modified duty work settings.
The Depressive Disorder MTGs address common and potentially work-related injuries. It encompasses assessment (including identification of “red flags” or indicators of potentially-serious injury or disease); diagnosis; diagnostic studies for identification of clinical pathology; work-relatedness; and management, including modified duty and activity, return to work, and an approach to delayed recovery.

- Red flags include depressed mood, reduced interest or pleasure in activities, weight changes, sleep disruption, fatigue, and reduced ability to think. Suicidal thoughts or suicide attempts may occur.
History Taking and Physical Examination

- History taking and physical examination establish the foundation/basis for and dictate subsequent stages of diagnostic and therapeutic procedures. When findings of clinical evaluations and those of other diagnostic procedures are not consistent with each other, the objective clinical findings should have preference.
History of Present Injury

- **Mechanism of injury**: Major depressive disorder (MDD) is a common form of mental illness in developed countries.

- **Relationship to work**: This includes a statement of the probability that the illness or injury is work-related;

- **Prior occupational and non-occupational injuries**

- **Ability to perform job duties** and activities of daily living; and
Past History

- Past medical history includes, but is not limited to, neoplasm, gout, arthritis, and diabetes;
- Review of systems includes, but is not limited to, symptoms of rheumatologic, neurologic, endocrine, neoplastic, and other systemic diseases;
- Smoking history;
- Vocational and recreational pursuits;
- Prior imaging studies; and
- Past surgical history.
Physical Examination/Clinical Features

- No physical findings are specific to major depressive disorder (MDD); instead, the diagnosis is based on the history and mental status examination. However, a complete mental health evaluation should always include a medical evaluation to rule out organic conditions that might imitate depressive disorders.

- The essential feature of a major depressive episode is a period of at least two weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities. A diagnosis based on a single episode is possible, although the disorder is generally recurrent.

- Associated symptoms: depressed mood, reduced interest or pleasure in activities, weight changes, sleep disruption, fatigue, and reduced ability to think. Suicidal thoughts or suicide attempts may occur.
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Assessing Red Flags

- Certain findings, or red flags, raise suspicion of potentially serious medical conditions. In the depressive disorders, these findings include depressed mood, reduced interest or pleasure in activities, weight changes, sleep disruption, fatigue, and reduced ability to think. Suicidal thoughts or suicide attempts may occur. Further evaluation/consultation or urgent/emergency intervention may be indicated, and the Depressive Disorders MTGs incorporate changes in clinical management triggered by the presence of red flags.
Diagnostic Criteria and Differential Diagnosis

- For cases presenting with Acute Stress Disorder (ASD) and PTSD, each has unique diagnostic criteria. Diagnostic and Statistical Manual of Mental Health Disorders IV (DSM-5) defines an ASD diagnosis if symptoms persist for 3 to 30 days after a traumatic event. DSM-5 defines a PTSD diagnosis if symptoms persist or occur more than 30 days after a traumatic event. Furthermore, the symptoms must significantly affect important areas of life, such as family and work. Differential diagnosis may include: head injury during the trauma, epilepsy, alcohol-use disorders, substance-related disorders, acute intoxication or withdrawal from some substances, panic disorders and generalized anxiety disorder.
Diagnostic Testing and Procedures

- One diagnostic procedure may provide the same or distinctive information as obtained by other procedures. Therefore, prudent choice of procedure(s) for a single diagnostic procedure, a complementary procedure in combination with other procedures(s), or a proper sequential order in multiple procedures will ensure maximum diagnostic accuracy, minimize adverse effect to patients and promote cost effectiveness by avoiding duplication or redundancy.
Diagnostic Testing and Procedures

- When a diagnostic procedure, in conjunction with clinical information, provides sufficient information to establish an accurate diagnosis, a second diagnostic procedure will be redundant if it is performed only for diagnostic purposes. At the same time, a subsequent diagnostic procedure can be a complementary diagnostic procedure if the first or preceding procedures, in conjunction with clinical information, cannot provide an accurate diagnosis.
Diagnostic Testing and Procedures

- It is recognized that repeat testing may be warranted by the clinical course and to follow the progress of treatment in some cases. It may be of value to repeat testing during the course of care to reassess or stage the pathology when there is progression of symptoms or findings.
Major Depressive Disorder

- Cognitive theory holds that emotional and behavioral problems are due to incorrect or maladaptive ways of thinking and distorted perceptions of oneself, others, and environmental circumstances.

- **Major depressive disorder (MDD)** is a psychiatric condition classified as a depressive disorder in the DSM-5: “The essential feature of a major depressive episode is a period of at least 2 weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities…”. A diagnosis based on a single episode is possible, although the disorder is generally recurrent.
Major Depressive Disorder

- MDD involves multiple symptoms of depression that persist and significantly interfere with normal social and/or occupational functioning. Examples of symptoms include depressed mood, reduced interest or pleasure in activities, weight changes, sleep disruption, fatigue, and reduced ability to think. Suicidal thoughts or suicide attempts may occur.
Major Depressive Disorder Diagnostic Criteria

**DSM-5 Criteria**

A. Five (or more) of the following 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 attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)
2. 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).
Major Depressive Disorder Diagnostic Criteria

DMS-5 Criteria

3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month) or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)

4. Insomnia or hypersomnia nearly every day.

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

6. Fatigue or loss of energy nearly every day.

7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

9. 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.
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Major Depressive Disorder Diagnostic Criteria

DSM-5 Criteria

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

Note: Criteria A-C represent a major depressive episode.
Major Depressive Disorder Diagnostic Criteria

DSM-5 Criteria

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode.
Medication General Guidelines

DSM-5 Criteria

- Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

- **Major Depressive Disorder** may have the further additional specifications with: anxious distress, mixed features, melancholic features, atypical features, mood-congruent psychotic features, mood-incongruent psychotic features, catatonia, peripartum onset and seasonal pattern.
Approach to Evaluation and Management

Screening and Monitoring with the Patient Health Questionnaire (PHQ)

- The PHQ-9 can be utilized as a screening and monitoring tool. While there are other tools this is an accepted and validated tool, easy to use, short, etc. This tool allows for the evaluation of severity.

Monitoring

- Monitoring of treatment progress is a critical component to the delivery of care. Monitoring should include assessment of symptomatology using the PHQ-9 (see Recommendation 4 and Appendix B for further discussion of the PHQ-9), adherence to medication and psychotherapy, emergence of adverse effects, symptom breakthrough, suicidality, and psychosocial stress. Monitoring is the responsibility of all providers involved in the patient’s care and the results of monitoring should be shared with the patient and other providers. Ideally, the PHQ-9 score will be graphed over time and provided to the patient as an educational tool.
Monitoring

- Continuation of antidepressant treatment is recommended for at least six months after a first episode of MDD.

- Discontinuation of antidepressant therapy should be done with a slow taper since withdrawal done too rapidly may result in adverse withdrawal symptoms or return of the original depressive symptoms. *Tapering should be guided by the elimination half-life of the medication and by close monitoring of the depressive symptoms.*

- Screening of patients with MDD and safety risks (suicidal ideation, risk to self or harm to others or psychotic features) require referral for urgent/emergent mental health intervention. *When screening or monitoring with the PHQ-9, attention should be paid to the last item (“Thoughts that you would be better off dead or of hurting yourself in some way?”), as it has been associated with increased risk for a suicide attempt.*
Measuring Depression Over Time: PHQ-9

- PHQ-9 is a standardized measurement tool in depression
  - Used for screening, diagnostic, measuring, and monitoring depression severity
  - In-office use: completed by patient and scored by clinician
  - Scored 5, 10, 15, 20: mild, moderate, moderately severe, or severe depression (range, 0 to 27)
  - Administered at each office visit to reflect improvement or worsening of symptoms in response to treatment
  - PHQ-9 score ≥ 10: 88% sensitivity and 88% specificity for major depression

- No improvement: treatment plan may need to be changed
- Tangible item to show patients improvement in their symptoms
  - Patients often do not recognize feelings of “better” because it is so new
  - Can offer hope to patients

Treatment Overview

- In general first-line treatment for acute uncomplicated MDD is either cognitive behavioral therapy or pharmacotherapy with anti-depressants.
- Cognitive Behavioral Therapy
- Cognitive-behavioral therapy (CBT) is one of the established nonpharmacological treatments for MDD. It has been demonstrated that a 12-16 week course of individual CBT has efficacy comparable to antidepressant pharmacotherapy, with fewer relapses after treatment is stopped. CBT also may significantly improve treatment outcomes when used in combination with pharmacotherapy, especially for patients with more severe or treatment-resistant depressive disorders.
Treatment Overview

Cognitive Behavioral Therapy

- The person learns how to distinguish between types of unproductive thinking (e.g., catastrophizing, all-or-none thinking, over-generalization) and recognize when ruminative thinking is counterproductive.
- CBT teaches how to break the ruminative thought cycle and to devise more effective ways to respond to ruminative thoughts and problematic situations.
- Cognitive restructuring involves keeping a thought record to track ruminative automatic thoughts, and to identify more adaptive alternative responses. As a result, the individual’s mood becomes more positive. CBT must address workplace issues/barriers and set return-to-work goals as part of the treatment plan. It includes a variety of component therapies such as acceptance and commitment therapy (ACT), mindfulness, computer-assisted cognitive therapy (bibliotherapy). Computer-assisted CBT (CCBT) is a strategy that could make therapy more widely available.
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Treatment Overview

- Pharmacotherapy-depression is a disease state that is theorized to be caused by a deficiency of monoamine neurotransmitters (i.e., serotonin, norepinephrine and dopamine) in the synaptic clefts. The major classes of antidepressants include:
  - Selective serotonin reuptake inhibitor (except fluvoxamine) (SSRIs)
  - Serotonin–norepinephrine reuptake inhibitor (SNRIs)
  - Mirtazapine
  - Bupropion

- SSRIs and SNRIs block the synaptic reuptake of serotonin, norepinephrine, and other neurotransmitters. TCAs and MAOIs are older antidepressants. They are effective; however, their tolerability, adverse effects, and safety profiles make them less acceptable than first-line antidepressants, such as the SSRIs or SNRIs.

- The evidence does not support recommending a specific evidence-based psychotherapy or pharmacotherapy over another.
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Treatment Overview

- Treatment for Severe, Chronic, or Recurrent MDD (Complex)
- A combination of pharmacotherapy and evidence-based psychotherapy is recommended for patients with MDD during a new episode of care when MDD is characterized as:
  - Severe (i.e., PHQ-9 >20)
  - Chronic (duration greater than two years) or
  - Recurrent (with three or more episodes)

Additional approaches to complicated chronic MDD may include psychotherapy, electroconvulsive therapy (ECT) and other adjunctive treatments.

- ECT may be indicated in patients with severe MDD and any of the following: Catatonia, Psychotic depression, severe suicidality, history of good response to ECT, need for rapid, definitive treatment response on medical or psychiatric grounds, risk of other treatments outweighs risks of ECT, history of poor response to multiple antidepressants, intolerable side effects to all classes of antidepressant medications.
Establishing a working diagnosis in a patient with depressive symptoms entails a focused clinical interview, physical examination, and pertinent laboratory and other testing with an eye toward identifying remediable co-occurring conditions or alternative diagnoses. DSM-5 criteria should be used to diagnose MDD. Alternative diagnoses may be suggested by a history of substance use disorder (SUD); decrease in cognitive function; symptoms of a neurologic disorder or history of closed head injury; symptoms or signs of PTSD; history of mania or hypomania; or use of prescription, over-the-counter or other psychoactive substances (including caffeine and nicotine) that may exacerbate or alter depressive symptoms.

Co-occurring conditions or experiences do not preclude a diagnosis of MDD yet are important in treatment planning or may require attention in their own right, such as current or past physical or sexual abuse or emotional neglect, chronic pain syndromes, sleep disorders, extreme weight loss or gain or other gastrointestinal symptoms suggestive of an eating disorder, spousal bereavement or loss of significant relationships or economic status, or a protracted caregiving role. Other important considerations may include the patient’s medical, psychiatric, marital, family, occupational and military service history.
History and Psychological/Psychiatric Examination

- Physical examination supports the clinical interview and mental status exam with attention to any neurologic deficits, evidence of endocrine or other metabolic disease or systemic illness.
History and Psychological/Psychiatric Examination

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

- Use of a structured instrument such as the PHQ-9 facilitates collection of the information required to diagnosis MDD based on DSM criteria, ascertains the baseline severity of symptoms, and helps to determine their impact on daily functioning.
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- Screening and Testing
  - There are numerous screening and psychometric tests. Screening tests generally emphasize high-sensitivity psychometric tests and require professionally trained mental health professionals to administer.
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Screening and Testing

- While these instruments (PHQ-9) may suggest a diagnosis, neither screening nor psychometric tests are capable of making a diagnosis. The diagnosis should only be concluded after careful analysis of all available data, including a thorough history and/or clinical interview.
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Screening and Testing

- Depressive Disorders
  - Recommended – Screening and testing
  - Indications – Patients at risk of depressive disorders. Evaluation should include focus on depressive disorders, anxiety disorder(s), bipolar, substance use disorder(s) and risk of suicide.
  - Benefits – Earlier identification of potential depressive disorders, assists with directing the patient to appropriate mental health services that include diagnostic confirmation, and suicide prevention.
  - Frequency/Dose/Duration – Generally only one administration for some occupational purposes.
  - Indications for Discontinuation: N/A
  - Rationale – Clinical correlation is required While these instruments may suggest a diagnosis, neither screening nor psychometric tests are capable of making a diagnosis. The diagnosis should only be concluded after careful analysis of all available data, including from a thorough history and/or clinical interview.
Screening and Testing

Psychometric Testing

- Indications – For individuals presenting with signs and symptoms consistent with a depressive disorder.
- Benefits – Provide psychometric evidence as a component of an evaluation regarding potential for depressive disorders and especially for other mental health disorder(s).
- Frequency/Dose/Duration – One-time testing unless otherwise indicated (e.g., by subsequent recurrence of or significant changes in symptoms). Requires administration by a professionally trained mental health professional.

Rationale: Clinical correlation is required. While these instruments may suggest a diagnosis, neither screening nor psychometric tests are capable of making a diagnosis. The diagnosis should only be concluded after careful analysis of all available data, including from a thorough history and/or clinical interview.
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Treatment Recommendation

- Recommended – Education

- **Frequency/Dose/Duration:** In conjunction with the initiation of treatment, with subsequent education based on response to treatment, severity, patient’s knowledge, and retention.

- **Indication:** Education teaches people about their illness and how they’ll receive treatment. Psychoeducation also includes education for family and friends where they learn things like coping strategies, problem-solving skills and how to recognize the signs of relapse. Family psychoeducation can often help ease tensions at home, which can help the person experiencing the mental illness to recover. It can be used in conjunction with treatments, such as CBT, antidepressants.
Treatment Recommendations

**Adjunctive Therapies**

- Recommended – Exercise is recommended for the treatment of patients with depressive disorders.
- Indications: Exercise may be used as adjunctive treatment to first-line therapies such as CBT and/or medication.
- Frequency/Dose/Duration: Supervised sessions of aerobic exercise based upon clinical assessment. Improvement in depressive symptoms, increased physical function and overall well-being.
Adjunctive Therapies

- **Recommended** – Yoga is recommended for select patients with depressive symptoms.
- **Indications**: Yoga may be used as adjunctive treatment to first-line therapies such as CBT and/or medication.
Appendix B: Quick Guide to the Patient Health Questionnaire (PHQ) (pgs 90-92)

Purpose: The Patient Health Questionnaire (PHQ) is designed to facilitate the recognition and diagnosis of depressive disorders in primary care patients. The PHQ-2 is used as a screening tool for depression whereas the PHQ-9 serves as an indicator of depression severity or response to treatment for patients with a depressive disorder. The instrument can be used both as a continuous measure of severity but also to align with diagnostic criteria. The instrument should not be used in isolation to make a diagnosis without considering other aspects of the assessment, including whether the symptoms are better accounted for by another disorder (e.g., PTSD, hypothyroidism).
Psychological Interventions/CBT

- **Cognitive Behavioral Therapy**
  The use of cognitive behavioral therapy is recommended for the treatment of patients with depressive disorders.

- **CBT: Acceptance and Commitment Therapy**
  Acceptance and Commitment Therapy (ACT) is a manualized psychotherapy intervention derived from relational frame theory that emphasizes acceptance of emotional distress and engagement in goal directed behaviors. A key feature of these interventions is acceptance rather than avoidance of emotional pain. This acceptance is thought to reduce affective symptom severity. To facilitate effective behavior change, ACT emphasizes identification of personal values and learning to act based on those values in spite of inevitable distress as opposed to having behaviors be focused on avoiding pain and adversity.
Psychological Interventions/CBT

- Cognitive Behavioral Therapy
  Interpersonal Psychotherapy (IPT) is derived from attachment theory and treats MDD by focusing on improving interpersonal functioning and exploring relationship-based difficulties. IPT addresses the connection between patients’ feelings and current difficulties in their relationships with people in their life by targeting four primary areas: (1) interpersonal loss, (2) role conflict, (3) role change, and (4) interpersonal skills. However, psychotherapy research is not clear on the classification of interpersonal therapy. In some systematic reviews, it is classified as a psychodynamic intervention and in others as a cognitive behavioral intervention.
Psychological Interventions/CBT

- Mindfulness-Based Cognitive Therapy (MBCT)

  - **Recommended** – MBCT integrates traditional CBT interventions with mindfulness-based skills, including mindfulness meditation, imagery, experiential exercises, and other techniques that aid patients in experiencing affect without necessarily attempting to change it. With regard to cognitions, unlike cognitive therapy, MBCT does not so much seek to modify or eliminate dysfunctional thoughts as to become more detached and able to observe thoughts as objects.

- Indications – Individuals with depressive symptoms

- Frequency/Dose/Duration – Weekly 2.5-hour sessions of mindfulness therapy

- Indications for Discontinuation – Symptom resolution or lack of efficacy
Psychological Interventions/CBT

- **Combining CBT with an Antidepressant**
  - The combined use of CBT and anti-depressant is recommended for the treatment of patient’s with severe or complicated depressive disorders.

- **Recommended** – When therapy with either CBT or an antidepressant does not result in improvement or resolution/partial resolution of symptoms in acute, mild/moderate uncomplicated MDD.
## Combining CBT with an Antidepressant

### d. Continuation and Maintenance Treatments (All Severities and Complexities of MDD)

<table>
<thead>
<tr>
<th>#</th>
<th>Recommendation</th>
<th>Strength*</th>
<th>Category†</th>
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<tbody>
<tr>
<td>15</td>
<td>In patients with MDD who achieve remission with antidepressant medication, we recommend continuation of antidepressants at the therapeutic dose for at least six months to decrease the risk of relapse.</td>
<td>Strong For</td>
<td>Reviewed, New-replaced</td>
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<tr>
<td>16</td>
<td>In patients at high risk for recurrent depressive episodes and who are treated with pharmacotherapy, we recommend offering maintenance pharmacotherapy for at least 12 months and possibly indefinitely.</td>
<td>Strong For</td>
<td>Reviewed, New-replaced</td>
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<tr>
<td>17</td>
<td>For patients at high risk for relapse (e.g., two or more prior episodes, unstable remission status), we recommend offering a course of cognitive behavioral therapy (CBT), interpersonal therapy (IPT) or mindfulness-based cognitive therapy (MBCT) during the continuation phase of treatment (after remission is achieved) to reduce the risk of subsequent relapse/recurrence. ▪ The evidence does not support recommending a specific evidence-based psychotherapy over another.</td>
<td>Strong For</td>
<td>Reviewed, Amended</td>
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Bibliotherapy/Cognitive Bibliotherapy

- **Recommended** – The use of bibliotherapy/cognitive bibliotherapy is recommended for the treatment of patients with depressive disorders.
- For patients with mild MDD, patient education about the benefits of bibliotherapy based on cognitive-behavioral principles as adjunctive treatment or an alternative to pharmacotherapy or psychotherapy.
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Bibliotherapy/Cognitive Bibliotherapy

Discussion – There is mixed evidence regarding the use of guided self-help (GSH) interventions, including bibliotherapy.

- Major Depressive Disorder
- Adjustment Disorder with Depressed Mood
- Persistent Depressive Disorder
- Acute
- Subacute
- Chronic
- Mild
- Moderate
- Severe

Indications – Depressive disorder sufficient to require treatment. CBT may be first line treatment and is often used in addition to antidepressants. For severe depressive disorders, is generally used as adjunctive, rather than as a stand-alone treatment. There is moderate quality evidence supporting the efficacy of a combination of CBT and an anti-depressant.

Frequency/Dose/Duration – Variable regimens have been used. One 45-50 min psychotherapy session and one 1.5-hour mindfulness-skills training group every week for 16-18 weeks, but studies show continuation with CBT yields best results suggesting ongoing intervention is required to maintain gains.
Short-term Psychodynamic Psychotherapy

- Short-term Psychodynamic Psychotherapy (STPP) is derived from psychoanalysis and longer-term psychodynamic psychotherapy. STPP is defined as psychodynamic psychotherapy of approximately 10 to 20 weeks duration. It focuses on the patient gaining insight into unconscious conflicts as they are manifested in the patient’s life and relationships, including his/her relationship with his/her therapist (i.e., transference). It is thought that these conflicts have their origin in the past, usually childhood relationships to parental figures. Patients gain insight into and work through such conflicts through exploration of their feelings along with interpretations offered by his/her therapist. Of note, while some label IPT as an STPP, others argue that it is a distinct model and is described in a separate annotation because it has a distinct body of literature (see IPT above).
Short-term Psychodynamic Psychotherapy

- **Recommended** – For treatment of patients with depressive disorders.
- **Indications** – Depressive disorder sufficient to require treatment. Short-term psychodynamic psychotherapy may be first-line treatment and is often used in addition to antidepressants. For severe depressive disorders, it is generally used as adjunctive to medications rather than as a stand-alone treatment.
  - Frequency/Dose/Duration – May be in-person sessions or internet based. Begin at eight sessions. May need additional prescriptions of additional blocks of eight sessions based on incremental functional gain. Among the quality trials, there are highly variable numbers of sessions used, e.g., the highest quality trial used 20 sessions, once per week over 5-6 months (confrontation, clarification, and interpretation) as did a few other trials. Other quality studies also used eight sessions. Yet others used 15-30, 16, 40, and the highest being 2-3/week for up to three years. Evidence of increase efficacy with increased numbers of appointments is poor with some evidence suggesting better efficacy with eight appointments, suggesting a need to treat for the short term and determine whether additional treatments is warranted.
  - Indications for Discontinuation – Symptom resolution, non-compliance, lack of efficacy or adverse effects.
Suicide Prevention

- **Recommended** – For the treatment of patients with depressive disorders.
- **Indications** – MDD, particularly if there has been suicidal ideation, suicide attempt(s) and/or past suicidality. Threshold for implementation among those with mild depressive symptoms should be low, particularly if suicidal ideation discovered.
- **Benefits** – Reduction in suicidality, suicide attempts and potentially suicides.
- **Frequency/Dose/Duration** – Three x 60-90-min sessions on a weekly basis and a fourth session if necessary of Attempted Suicide Short Intervention Program (ASSIP).
- **Indications for Discontinuation** – Sufficient resolution of depressive symptoms and/or suicide risk, completion of course, non-compliance.
- **Rationale** – Most quality trials have multiple co-interventions, precluding assessment of what is effective for suicide prevention. However, some evidence suggests the ability to prevent suicide attempts. The cognitive therapy employed by Brown et al reduced suicide attempts 42%. Suicide prevention is an important public health goal. It has negligible cost, some evidence of efficacy and is thus recommended.
Medications

There are many classes of anti-depressant medications used to treat depressive disorders. These include atypical anti-depressants, monoamine oxidase inhibitors, selective serotonin reuptake inhibitors (SSRIs), selective serotonin and norepinephrine reuptake inhibitors (SNRIs), and tricyclic antidepressants (TCAs).

Antidepressants

- **Recommended** – Moderately recommended for the treatment of patients with depressive disorders.
- **Indications** – Depressive disorder where medication is clinically indicated. May be prescribed as monotherapy or in conjunction with other treatments including CBT and psychotherapy.
- There is no evidence to suggest that one antidepressant drug class is superior to another for the treatment of MDD in terms of response and remission rates. Initial monotherapy with bupropion, mirtazapine, an SNRI, or an SSRI provide the best options for patients who do not have absolute contraindications to these medications (e.g., drug-drug interactions, allergies, co-occurring medical conditions).
Medications/SSRIs

- All of the SSRIs, except fluvoxamine, may be used as first-line agents in the treatment of adults with MDD. Fluvoxamine is not a Food and Drug Administration (FDA) approved drug for the treatment of MDD. Bupropion and mirtazapine are also first-line treatment options for patients with MDD.

- Selection of an anti-depressant is typically dependent on several factors, including concomitant symptoms to potentially address simultaneously (e.g., sleep disturbance), anticipated potential for adverse effects, prior adverse effects, co-morbid psychiatric morbidity (e.g., anxiety) and other medical disorders. Another option is to query the family history and information regarding what medication relatives have found most useful in the treatment of depression.

- Providers should ensure that an appropriate dose titration and target dose range has been achieved and an adequate trial period allowed (a minimum of four to six weeks) prior to considering discontinuing an antidepressant as a treatment failure.
Medications/SSRIs

- The return of symptoms of depression after a remission has been reached is common. Therefore, we recommend that continuation of antidepressant treatments be continued for at least six months after remission of MDD symptoms.

- Discontinuation of antidepressant therapy should be done with a slow taper since withdrawal done too rapidly may result in adverse withdrawal symptoms or return of the original depressive symptoms. Tapering should be guided by the elimination half-life of the medication and by close monitoring of the depressive symptoms.
Medications/Antipsychotics

- **Recommended** – For the treatment of patients with MDD and psychotic features.

- Treatment of depressive disorders with psychotic characteristics including:
  1. Serious delusions (e.g., fixed false beliefs)
  2. Visual or (typically) auditory hallucinations
  3. Confusion (incoherence)
  4. Catatonic behavior (e.g., motoric immobility or excessive agitation)
  5. Extreme negativism or mutism
  6. Peculiar movements
  7. Inappropriate affect of a bizarre or odd quality
  8. Severe symptoms
Depressive Disorders Training Module

Medications/Antipsychotics

- Recommended – ECT with or without psychotherapy in patients with severe MDD and any of the following conditions:
  - Catatonia
  - Psychotic depression
  - Severe suicidality
  - A history of a good response to ECT
  - Need for rapid, definitive treatment response on either medical or psychiatric grounds
  - Risks of other treatments outweigh the risks of ECT (i.e., co-occurring medical conditions make ECT the safest treatment alternative)
  - A history of a poor response to multiple antidepressants
  - Intolerable side effects to all classes of antidepressant medications (e.g., seizures, hyponatremia, severe anxiety)
Electroconvulsive Therapy

- **Recommended** – For patients with treatment-resistant major depressive disorder.

- **Indications** – Treatment-resistant depression, generally having failed at least three medications, CBT, and psychotherapy.

- **Benefits** – Prompt improvement in depressive symptoms and/or psychosis.

- **Frequency/Dose/Duration** – One administration. Generally not repeated unless severe MDD recurs and is again treatment resistant.
Depressive Disorders Training Module

Medications

Nitrous Oxide
- **Not Recommended** – For the treatment of patients with depressive disorders.

Ketamine
- **Not Recommended** – For the treatment of patients with depressive disorders.

Esketamine
- **Not Recommended** – For the treatment of patients with depressive disorders.
Depressive Disorders Training Module

- Tumor Necrosis Factor Inhibitors
  - Not Recommended – For treatment of patients with depressive disorders.
Depressive Disorders Training Module

- **Alternative Therapy**
  - **Not Recommended** – St. John’s Wort (Hypericum Perforatum)
  - **Not Recommended** – Omega-3 Fatty Acids
  - **Not Recommended** – Vitamin D; vitamin D medications (including topical creams)
  - **Not Recommended** – B vitamins (folate, thiamine, riboflavin) for use with antidepressants; vitamin B medications (including topical creams)
Neuromodulation Therapies

- **Recommended** – Repetitive transcranial magnetic stimulation (rTMS) may be used during a major depressive episode in patients with treatment-resistant MDD.

- **Not Recommended** – Vagal nerve stimulation (VNS) for patients with MDD, including patients with severe treatment-resistant depression outside of a research setting.

- **Not Recommended** – Deep brain stimulation (DBS) for patients with MDD outside of a research setting.
Neuromodulation Therapies

- **Transcranial magnetic stimulation**, a non-invasive brain stimulation treatment, has been suggested for treatment of numerous neuropsychiatric conditions such as anxiety, suicidal ideation and used extensively for depression.

- **Recommended** – Transcranial magnetic stimulation and repetitive transcranial magnetic stimulation (rTMS) for patients with treatment-resistant major depressive disorder.

- **Indications** – Major depressive disorder resistant to treatment with at least three antidepressant medications, CBT and psychotherapy; generally should include patient declining ECT; or MDD with suicidal ideation.
Depressive Disorders Training Module

- Neuromodulation Therapies
  - Deep Brain Stimulation
  - **Not Recommended** – For treatment of patients with depressive disorders.
Depressive Disorders Training Module

Vagal Nerve Stimulation

- **Not Recommended** – For the treatment of depressive disorders.
- **Evidence for the Use of Vagal Nerve Stimulation**
- **Recommended** – ECT with or without psychotherapy in patients with severe MDD and any of the following conditions:
  - Catatonia
  - Psychotic depression
  - Severe suicidality
  - A history of a good response to ECT
  - Need for rapid, definitive treatment response on either medical or psychiatric grounds
  - Risks of other treatments outweigh the risks of ECT (i.e., co-occurring medical conditions make ECT the safest treatment alternative)
  - A history of a poor response to multiple antidepressants
  - Intolerable side effects to all classes of antidepressant medications (e.g., seizures, hyponatremia, severe anxiety)
Low-Field Magnetic Stimulation

- **Recommended** – For patients with treatment-resistant major depressive disorder.
- **Indications** – Treatment-resistant depression, generally having failed at least three medications, CBT, and psychotherapy.
- **Benefits** – Relatively rapid improvement
Depressive Disorders Training Module

- Injection Therapies
  - Botulinum Toxin Injections
    - Not Recommended – For the treatment of patients with depressive disorders.
  - Cyanocobalamin (vB12) Injections
    - Not recommended – For the treatment of patients with depressive disorders.
Depressive Disorders Training Module

- Allied Health Interventions
  - Acupuncture
    - Not Recommended – For the treatment of depressive disorders.
  - Massage
    - Not Recommended – For the treatment of depressive disorders.
Depressive Disorders Training Module

For additional questions, please email MTGTrainings@wcb.ny.gov.
Thank You