

## Prepare your practice: put systems in place for accurate diagnosis, treatment, and follow-up.

**Tip 1:** Implement staff assisted patient self-management and care coordination (possible by phone).

**Tip 2:** Compile info on psychiatry and mental health consultation and referral options.

**Tip 3:** Identify resources to address treatment barriers.

**Tip 4:** Monitor symptoms with PHQ-9\*.

### 1. Screening and Assessment

#### Consider Depression: High Risk Conditions and Cues

- Chronic conditions (CVD, Diabetes, cognitive impairment)
- Chronic pain
- Geriatric patient
- Multiple somatic complaints
- Postpartum
- Tobacco Use
- ETOH/Substance misuse/abuse
- Chronic anxiety
- History of Abuse/Trauma/PTSD
- Combat veteran
- Persistent anger/irritability
- Recent loss

#### Screening:

Screen if systems are in place for adequate diagnosis/treatment/follow-up/referral. Use PHQ-2\*.

"In the past 2 weeks..."

- Have you had little interest or pleasure in doing things?
- Have you felt down, depressed or hopeless?\*

If "yes" on either question, complete full PHQ-9\*.

#### Further Assessment:

- Recent life events (Why now?)
- History of depression/bipolar disorder or alcohol/substance misuse
- Patient's perception of problem:
  - Beliefs and knowledge about depression
  - Cultural considerations (language, stigma, influence on symptom presentation)
- Consider medical and medication causes of depression
- Family history: depression/bipolar disorder
- Suicide risk (thoughts, plans, means, previous attempts, recent exposure). "Are you thinking of harming or killing yourself?""\*
- Assess risk of harming others
- Screen for co-morbid psychiatric disorders: bipolar, anxiety, PTSD, panic disorder, tobacco<sup>†</sup>, substance misuse<sup>†</sup>
- Complementary/Alternative Medicine or other treatments currently used\*

### 2. Diagnosis (first episode or recurrence?)

DSM IV Criteria	Major Depression	Dysthymia
<b>Symptom</b>	<b>5 total for 2 wks duration: must include symptom #1 or 2</b>	<b>3 total for ≥2 yrs.: must include symptom #1</b>
1. Depressed mood	✓	✓
2. Marked Diminished Interest/Pleasure	✓	
3. Significant wt loss/gain, appetite decrease/increase	✓	✓
4. Insomnia/hypersomnia	✓	✓
5. Psychomotor Agitation/Retardation	✓	
6. Fatigue/loss of energy	✓	✓
7. Feelings of worthlessness or inappropriate guilt	✓	✓
8. Diminished concentration or indecisiveness	✓	✓
9. Suicidal ideation: thoughts, plans, means, intent	✓	
10. Hopelessness		✓

#### Severity Rating (Based on initial PHQ-9\* score):

PHQ-9 Score	Provisional Diagnosis	Treatment Recommendations
5-9	Minimal Symptoms	Support, educate to call if worse; return in 1 month
10-14	Minor Depression	Evidence-based psychotherapy equally effective as anti-depressant
	Dysthymia	
	Major Depression, mild	
15-19	Major Depression, moderately severe	Evidence-based psychotherapy and/or anti-depressant
≥20	Major Depression, severe	Anti-depressant and psychotherapy (esp. if not improved on monotherapy)

### 3. Plan Treatment (see page 2 for treatment chart)

#### Shared Decision Making:

- Tailor treatment to individual patient
- Provide education on diagnosis
- Review treatment options (based on PHQ-9 score)
- Discuss treatment barriers: family/work responsibilities, insurance, transportation
- Negotiate treatment plan
- Set timeline: response, side effects and treatment duration
- Educate on importance of adherence
- Develop safety plan for suicidal ideation

#### Promote Health Behaviors:

- Exercise
- Social support
- Faith/spiritual support
- Healthy sleep pattern
- Healthy diet
- Alcohol only in moderation<sup>†</sup>
- Cessation of tobacco and illicit drug use<sup>†</sup>
- Engagement in positive activities
- Stress management
- Educational books and online resources

#### Additional Considerations:

- Current or planned pregnancy: psychotherapy preferred if symptoms tolerable\*
- Start with lower dose for anxiety or elderly\*
- Cultural factors that influence treatment choice\*
- SNRI or tricyclic for chronic pain
- Level of functioning/activities of daily living
- Discuss safety with the patient\*
- Need for emergency services
- Psychiatry referral, including ECT evaluation
- Complementary/Alternative Medicine\*

#### Consider Referral or Consult:

- Suicidal patient
- Bipolar disorder
- Co-occurring substance abuse
- Psychotic features
- Multiple medications

\*See supplement for additional information.

<sup>†</sup>Go to [www.healthteamworks.org](http://www.healthteamworks.org) for guidelines on Tobacco & Alcohol/Substance Use.

### 3. Plan Treatment *Continued*: Treatments for Depression

#### Evidence-Based Psychotherapies\*

- Cognitive/behavioral therapy (CBT)
- Interpersonal psychotherapy (IPT)
- Problem-solving therapy (PST)
- Psychodynamic therapy
- Couples/Family therapy

#### If receiving therapy alone:

- Onset of effectiveness is more gradual
- Discuss and share PHQ-9\* with therapist

#### Considerations for Medication Selection

- Cost
- Formulary
- Responsiveness to prior treatment
- Responsiveness in a first degree relative
- Complementary/Alternative Medicine\*

Medication Chart																
Category	FDA Black Box Warning: In short-term placebo controlled studies antidepressants increased the risk compared to placebo of suicidal thinking and suicidality in children, adolescents, and young adults; but not in adults beyond age 24; and there was a reduction in risk in adults age >65. <b>Monitor all patients closely for clinical worsening, suicidality, or unusual changes in behavior.</b>			Relative Cost		Adverse Side Effects and Precautions <sup>‡</sup>										
	Pregnancy: Requires individualized risk/benefit discussion.*			Generic?	On the \$4 plan?	Side Effects							Precautions			
	Drug	Daily Starting Dosage	Usual Daily Adult Dosage			Anticholinergic	Sedation	Activation	Sexual Dysfunction	Weight Gain	Orthostatic Hypotension	Eating Disorders	Liver Disease	Seizure Disorder	Cardiac Arrhythmia	Withdrawal Syndrome Risk
SSRIs	Citalopram (Celexa)	10-20 mg QAM	20-40 mg	✓	✓	0	0	++	+++	+	0					++
	Escitalopram (Lexapro)	10 mg QAM	10-20 mg			0	0	++	+++	+	0					++
	Fluoxetine (Prozac)	10-20 mg QAM	20-80 mg	✓	✓	0	+	+++	+++	+	0					+
	Fluoxetine (Prozac weekly)	90 Qwk	90 mg			0	0	+++	+++	+	0					+
	Paroxetine (Paxil)	10-20 mg QAM	20-50 mg	✓	✓	0	0	++	+++	+	0					+++
	Paroxetine (Paxil CR)	12.5-25 mg QAM	25-62.5 mg	✓		0	0	++	+++	+	0					+++
	Sertraline (Zoloft)	25-50 mg QAM	50-200 mg	✓		0	0	+++	+++	+	0					++
SNRIs	Venlafaxine (Effexor)	25 mg BID-TID	150-375 mg	✓		+	0	++	++	0	0	X			X	+++
	Venlafaxine XR (Effexor-XR)	37.5 mg QD	150-225 mg	✓		+	0	++	++	0	0	X			X	+++
	Duloxetine (Cymbalta)	20 mg BID or 30 mg QD	60 mg			+	0	++	+	0	0		X	X	X	++
	Desvenlafaxine (Pristiq)	50 mg QD	50 mg			0	0	++	+	0	0					+
Other Agents	Bupropion (Wellbutrin)	100 mg BID-TID	300-450 mg	✓		0	0	++	0	0	0	X		X		+
	Bupropion (Wellbutrin SR)	100 mg QAM to 100 mg BID	150-200 mg BID	✓		0	0	++	0	0	0	X		X		+
	Bupropion (Wellbutrin XL)	150 mg	300-450 mg	✓		0	0	++	0	0	0	X		X		+
	Mirtazapine (Remeron or Remeron Sol-Tab)	15 mg QHS	15-45 mg	✓		+	++	0	0	+++	+					++
	Trazodone Long-Acting (Oleptro)	150 mg QHS	150-375 mg			+	+++	0	+	+	+++			X	X	+
Tricyclics	Amitriptyline (Elavil)	25-75 mg QHS	100-300 mg	✓	✓	+++	+++	0	+	+++	+++			X	X	++
	Clomipramine (Anafranil)	25-75 mg QHS	100-250 mg			+++	+	+	++	++	+++			X	X	++
	Desipramine (Norpramin)	25-75 mg QHS	100-300 mg	✓		+	0	++	+	+	+++			X	X	++
	Doxepin (Adapin, Sinequan)	25-75 mg QHS	100-300 mg	✓	✓	+++	+++	0	++	++	+++			X	X	++
	Imipramine (Tofranil)	25-75 mg QHS	100-300 mg	✓		+++	++	+	+	++	+++			X	X	++
	Nortriptyline (Aventyl, Pamelor)	25-50 mg QHS	30-150 mg	✓	✓	++	++	+	+	++	++				X	++

<sup>‡</sup>References: Applied Therapeutics: the clinical use of drugs. Edited by Mary Anne Koda-Kimble, et al. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, c2009. 9th edition. International consensus statement on major depressive disorder. Nutt DJ, et al. *J Clin Psychiatry*. 2010; 71 Suppl E1:308. Drug facts and comparisons. St. Louis: Facts and Comparisons, c1981-2010. *Circulation*. 2009 September 22; 120(12): 1123-1132. Expert opinion.

### 4. Monitor and Adjust Treatment. Monitor Side Effects. Goal of treatment is complete remission.

First follow-up contact at 1-2 weeks, then every 4-8 weeks (consider telephone contact in some cases). Perform ongoing suicide risk assessment; risk may increase during early treatment phase. If starting dose was low, consider up-titration at initial check-in.

Acute Phase (months 1-4)		
Response	PHQ-9* Score after 4-6 weeks	Treatment Plan
Responsive	Drop ≥5 points from baseline	No treatment change needed. Follow-up again after an additional 4 weeks.
Partially responsive	Drop 2-4 points from baseline	Often warrants increase in dose. Possibly no change needed.
Non-responsive	Drop 1 point or no change or increase	<ul style="list-style-type: none"> <li>• Consider starting anti-depressant if receiving therapy alone</li> <li>• Increase dose</li> <li>• Switch meds</li> <li>• Augmentation (Lithium, thyroid, stimulant, 2nd gen anti-psychotic, 2nd anti-depressant)</li> <li>• Review psychological counseling options and preferences</li> <li>• Informal or formal psychiatric consultation (ECT an option in some cases)</li> </ul>
Continuation Phase (months 4-9)		Maintenance Phase for Recurrent Depression (month 9 and on)
<ul style="list-style-type: none"> <li>• Begins after symptom resolution</li> <li>• Continue medications full strength</li> <li>• Contact every 2-3 months (telephone appropriate in some cases)</li> <li>• Monitor for signs of relapse</li> <li>• Generally, use same anti-depressant dose as in Acute Phase</li> </ul>		<ul style="list-style-type: none"> <li>• For patient with history of 3+ episodes of Major Depression or chronic Major Depression</li> <li>• Also consider for patient w/ additional risk factors for recurrence (family history, early age onset, ongoing psychological stressors, co-occurring disorders)</li> <li>• May need to maintain for one to several years</li> <li>• Use PHQ-9* for ongoing monitoring</li> </ul> <p><b>Goal: Prevent Relapse</b></p>
		Tapering Anti-Depressant Medication
		<ul style="list-style-type: none"> <li>• Taper over several weeks</li> <li>• Educate about side effects and relapse</li> <li>• Flu-like symptoms common</li> <li>• With SSRI and SNRI may also experience anxiety/agitation, sweats, paresthesias</li> <li>• Diphenhydramine may help with anticholinergic withdrawal symptoms</li> </ul>

\*See supplement for additional information