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

- Chronic conditions (CVD, Diabetes, cognitive impairment)
- Chronic pain
- Geriatric patient

**Screening:**

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

“In the past 2 weeks…

1. Have you had little interest or pleasure in doing things?
2. Have you felt down, depressed or hopeless?”

If “yes” on either question, complete full PHQ-9*.

**Further Assessment:**

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

**DSM IV Criteria**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Major Depression</th>
<th>Dysthymia</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 total for 2 wks duration: must include symptom #1 or 2</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>3 total for ≥2 yrs.: must include symptom #1</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Symptom</th>
<th>PHQ-9 Score</th>
<th>Provisional Diagnosis</th>
<th>Treatment Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Depressed mood</td>
<td>5-9</td>
<td>Minimal Symptoms</td>
<td>Support, educate to call if worse; return in 1 month</td>
</tr>
<tr>
<td>2. Marked Diminished Interest/ Pleasure</td>
<td>10-14</td>
<td>Minor Depression</td>
<td>Evidence-based psychotherapy equally effective as anti-depressant</td>
</tr>
<tr>
<td>3. Significant wt. loss/gain, appetite decrease/increase</td>
<td>15-19</td>
<td>Major Depression, mild</td>
<td>Evidence-based psychotherapy and/or anti-depressant</td>
</tr>
<tr>
<td>4. Insomnia/hypersomnia</td>
<td>≥20</td>
<td>Major Depression, severe</td>
<td>Anti-depressant and psychotherapy (esp. if not improved on monotherapy)</td>
</tr>
</tbody>
</table>

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

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<th>Treatment Recommendations</th>
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<tr>
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<td>Major Depression, severe</td>
<td>Anti-depressant and psychotherapy (esp. if not improved on monotherapy)</td>
</tr>
</tbody>
</table>

**Promote Health Behaviors:**

- Exercise
- Social support
- Faith/spiritual support
- Healthy sleep pattern
- Healthy diet
- Alcohol only in moderation†
- Cessation of tobacco and illicit drug use†
- 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*

**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

**Consider Referral or Consult:**

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

*See supplement for additional information.

†Go to 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*

FDA Black Box Warning: In short-term placebo controlled studies antidepressants increased the risk compared to placebo of suicidal thinking and suicide in children, adolescents, and young adults, but not in adults beyond age 24, and there was a reduction in risk in adults age >65. Monitor all patients closely for clinical worsening, suicidality, or unusual changes in behavior.

Pregnancy: Requires individualized risk/benefit discussion.*

### Medication Chart

<table>
<thead>
<tr>
<th>Category</th>
<th>Drug</th>
<th>Daily Starting Dosage</th>
<th>Usual Daily Adult Dosage</th>
<th>Pregnancy</th>
<th>Relative Cost</th>
<th>Side Effects</th>
<th>Precautions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SSRIs</strong></td>
<td>Imipramine (Tofranil)</td>
<td>10-20 mg QAM</td>
<td>20-40 mg</td>
<td>++</td>
<td>0</td>
<td>0</td>
<td>+++</td>
</tr>
<tr>
<td></td>
<td>Doxepin (Adapin, Sinequan)</td>
<td>10 mg QAM</td>
<td>10-20 mg</td>
<td>++</td>
<td>0</td>
<td>0</td>
<td>+++</td>
</tr>
<tr>
<td></td>
<td>Desipramine (Norpramin)</td>
<td>10-20 mg QAM</td>
<td>20-80 mg</td>
<td>++</td>
<td>0</td>
<td>+</td>
<td>+++</td>
</tr>
<tr>
<td></td>
<td>Clomipramine (Anafranil)</td>
<td>90 mg QAM</td>
<td>90 mg</td>
<td>++</td>
<td>0</td>
<td>+++</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>Paroxetine (Paxil)</td>
<td>10-20 mg QAM</td>
<td>20-50 mg</td>
<td>++</td>
<td>0</td>
<td>0</td>
<td>+++</td>
</tr>
<tr>
<td></td>
<td>Paroxetine (Paxil CR)</td>
<td>12.5-25 mg QAM</td>
<td>25-62.5 mg</td>
<td>++</td>
<td>0</td>
<td>0</td>
<td>+++</td>
</tr>
<tr>
<td></td>
<td>Venlafaxine (Effexor)</td>
<td>25 mg BID-TID</td>
<td>50-200 mg</td>
<td>++</td>
<td>0</td>
<td>0</td>
<td>+++</td>
</tr>
<tr>
<td></td>
<td>Venlafaxine XR (Effexor-XR)</td>
<td>37.5 mg QD</td>
<td>150-225 mg</td>
<td>++</td>
<td>0</td>
<td>0</td>
<td>+++</td>
</tr>
<tr>
<td></td>
<td>Duloxetine (Cymbalta)</td>
<td>20 mg BID or 30 mg QD</td>
<td>60 mg</td>
<td>++</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Anticholinergic</td>
<td>Desvenlafaxine (Prisit)</td>
<td>50 mg QD</td>
<td>50 mg</td>
<td>++</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Agents</td>
<td>Buproprion (Wellbutrin)</td>
<td>100 mg BID-TID</td>
<td>300-450 mg</td>
<td>++</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Buproprion (Wellbutrin SR)</td>
<td>100 mg QAM to 100 mg BID</td>
<td>150-200 mg BID</td>
<td>++</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Bupropion (Wellbutrin XL)</td>
<td>150 mg</td>
<td>400-450 mg</td>
<td>++</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Mirtazapine (Remeron or Remeron Sol-Tab)</td>
<td>15 mg QHS</td>
<td>15-35 mg</td>
<td>++</td>
<td>0</td>
<td>0</td>
<td>+++</td>
</tr>
<tr>
<td></td>
<td>Trazodone Long-Acting (Oleptro)</td>
<td>150 mg QHS</td>
<td>150-375 mg</td>
<td>++</td>
<td>0</td>
<td>0</td>
<td>+++</td>
</tr>
<tr>
<td></td>
<td>Amitriptyline (Elavil)</td>
<td>25-75 mg QHS</td>
<td>100-300 mg</td>
<td>++</td>
<td>0</td>
<td>0</td>
<td>+++</td>
</tr>
<tr>
<td></td>
<td>Clomipramine (Anafranil)</td>
<td>25-75 mg QHS</td>
<td>100-250 mg</td>
<td>++</td>
<td>0</td>
<td>0</td>
<td>+++</td>
</tr>
<tr>
<td></td>
<td>Desipramine (Norpramin)</td>
<td>25-75 mg QHS</td>
<td>100-300 mg</td>
<td>++</td>
<td>0</td>
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<td>++</td>
<td>0</td>
<td>0</td>
<td>+++</td>
</tr>
<tr>
<td></td>
<td>Nortriptyline (Aventyl, Pamelor)</td>
<td>25-50 mg QHS</td>
<td>100-300 mg</td>
<td>++</td>
<td>0</td>
<td>0</td>
<td>+++</td>
</tr>
</tbody>
</table>

*See supplement for additional information


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**

- **Responsive**
  - PHQ-9* Score after 4-6 weeks
  - Treatment Plan: No treatment change needed. Follow-up again after an additional 4 weeks.

- **Partially responsive**
  - Treatment Plan: Often warrants increase in dose. Possibly no change needed.

- **Non-responsive**
  - Treatment Plan: Consider starting anti-depressant if receiving therapy alone. Increase dose. Switch meds. Augmentation (Lithium, thyroid, stimulant, 2nd gen anti-psychotic, 2nd anti-depressant).

### Continuation Phase (months 4-9)

**Maintenance Phase for Recurrent Depression (month 9 and on)**

- Begins after symptom resolution
- Continue medications full strength
- Contact every 2-3 months (telephone appropriate in some cases)
- Monitor for signs of relapse
- Generally, use same anti-depressant dose as in Acute Phase

**Tapering Anti-Depressant Medication**

- Taper over several weeks
- Educate about side effects and relapse
- Flu-like symptoms common
- With SSRI and SNRI may also experience anxiety/agitation, sweats, paresthesias
- Diphenhydramine may help with anticholinergic withdrawal symptoms

**Goal: Prevent Relapse**