Depression in Primary Care

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Overview

- Diagnosis, DSM5 Disorders
- Differential Diagnosis
- Comorbidities
- Treatment Planning – Comprehensive
- Polypharmacy
- Behavioral Health Integration Initiatives
- Q and A (Stump the Psychiatrist?)
Diagnosis

- Disruptive Mood Dysregulation Disorder
- Major Depressive Disorder
- Persistent Depressive Disorder
- Premenstrual Dysphoric Disorder
- Substance/Medication Induced Depressive Disorder
- Depressive Disorder Due to Another Medical Condition
- Other Specified Depressive Disorder
- Unspecified Depressive Disorder
Disruptive Mood Dysregulation Disorder (DMDD)

- Rationale for adding new disorder
- **Essential feature**: Severe temper outbursts with underlying persistent, angry or irritable mood
  - **Temper outburst frequency**: Three or more times a week
  - **Duration**: Temper outbursts and the persistently irritable mood between outbursts lasts at least 12 months
  - **Severity**: Present in two settings and severe in at least one
  - **Onset**: Before age 10 but do not diagnose before age 6. Cannot diagnose for the first time after age 18.
- **Common rule-outs**:
  - Bipolar disorder, intermittent explosive disorder, depressive disorder, ADHD, autism spectrum disorder, separation anxiety disorder,
  - Substance, medication or medical condition
  - If ODD present, do not also diagnose it
Issues with DMDD

• Was it ready for prime time?

• What are the treatment implications?
  – No empirically supported treatments
  – Avoid bipolar medications
  – Consider CBT treatments used for depression in children:
    • Coping skills for thoughts, feelings and behavior
    • Parent training
    • Parent support group
Major Depressive Episode

- **Essential features**: Either depressed mood or loss of interest or pleasure plus four other depressive symptoms
- **Duration**: At least two weeks
- **Common rule outs**: Medical condition, medications, substance use, bipolar disorder, or a psychotic disorder
- **Note**: Be careful about diagnosing major depression following a significant loss because normal grief “may resemble a depressive episode.”
Grief vs. a Major Depressive Episode in DSM-5 (p. 161)

**Grief**
- Dominant affect is feelings of emptiness and loss
- Dysphoria occurs in waves, vacillates with exposure to reminders and decreases with time
- Capacity for positive emotional experiences
- Self-esteem preserved
- Fleeting thoughts of joining deceased

**Major Depression**
- Dominant affect is depressed mood
- Persistent dysphoria that is accompanied by self-critical preoccupation and negative thoughts about the future
- Limited capacity to experience happiness or pleasure
- Worthlessness clouds esteem
- Suicidal ideas about escaping life versus joining a loved one
Diagnosing Major Depressive Disorder

**Essential features:**
- Meets criteria for a Major Depressive Episode
- No history of a Manic or Hypomanic Episode

**Coding Steps:**
1. Start with noting whether it is a single episode or recurrent (see columns in table on page 162)
   - Major Depressive Disorder, single episode
   - Major Depressive Disorder, recurrent episode
2. The code number indicates the type of episode (single or recurrent) as well as the severity, presence of psychotic features and remission status (partial or full). Find the correct code number by dropping down your selected episode column to locate the applicable severity, psychosis or remission term. For a recurrent episode that is moderate severity you would put:
   - 296.32 Major Depressive Disorder, recurrent episode
3. Now state the severity, psychosis or remission status term right after single or recurrent episode:
   - 296.32 Major Depressive Disorder, recurrent episode, moderate severity
4. Finally, add any of the specifiers that apply (see next slide)
   - 296.32 Major Depressive Disorder, recurrent episode, moderate severity, with peripartum onset

**NOTE:** After October 1, 2014, you would write out the diagnosis in the exact same way but use the code numbers that are in parentheses. The diagnosis above would be:
F33.1 Major Depressive Disorder, recurrent, moderate severity, with peripartum onset
Specifiers for Major Depressive Disorder*

- With anxious distress
- With mixed features
- With melancholic features
- With atypical features
- With mood-congruent psychotic features or with mood-incongruent psychotic features
- With catatonia (code separately)
- With peripartum onset
- With seasonal pattern

*See pages 184-188 of DSM-5
Persistent Depressive Disorder (Dysthymia)

• **Essential feature**: Depressed mood plus at least two other depressive symptoms

• **Duration**: The symptoms persist for at least two years (one year for children and adolescents)

• May include periods of major depressive episodes (double depression)

• **Rule outs**: Be sure it is not due to another psychotic disorder, substance, medication or medical condition
Specifiers for Persistent Depressive Disorder

- **Severity**: Mild, moderate or severe
- **Remission status**: In partial or full remission (if applicable)
- **Onset**: Early (before 21) or late (21 or older) onset
- **Specify mood features**: With anxious distress, mixed features, melancholic features, atypical features, mood-congruent or mood-incongruent psychotic features, and peripartum onset
- **Course specifiers**:
  - With pure dysthymic syndrome
  - With persistent major depressive episode
  - With intermittent major depressive episodes, with current episode
  - With intermittent major depressive episodes, without current episode
- **Sample code**: 300.4 Persistent Depressive Disorder, mild severity, late onset, with atypical features, with pure dysthymic syndrome
Premenstrual Dysphoric Disorder (PMDD)

- **Essential feature**: Significant affective symptoms that emerge in the week prior to menses and quickly disappear with the onset of menses.

- **Symptom threshold**: At least five symptoms which include marked affective lability, depressed mood, irritability, or tension.

- **Duration**: Present in all menstrual cycles in the past year and documented prospectively for two menstrual cycles.

- **Impairment**: Clinically significant distress or impairment.

- **Rule outs**: An existing mental disorder (e.g., MDD), another medical condition (e.g., migraines that worsen during the premenstrual phase) or substance or medication use.
• **Sleep disorder** (increased or decreased)
• **Interest deficit** (anhedonia)
• **Guilt** (worthlessness, hopelessness, regret)
• **Energy deficit**
• **Concentration deficit**
• **Appetite disorder** (increased or decreased)
• **Psychomotor retardation or agitation**
• **Suicidality**
### Appendix B – Patient Health Questionnaire (PHQ-9)

#### Patient Health Questionnaire-9

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by any of the following problems?</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**For Office Coding**

\[ \_0 + _1 + _2 + _3 \]

= Total Score: __________

---

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- [ ] Not difficult at all
- [ ] Somewhat difficult
- [ ] Very difficult
- [ ] Extremely difficult

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PHQ-9 QUICK DEPRESSION ASSESSMENT

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✔️️ in the two right columns (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.
3. Consider Major Depressive Disorder
   • If there are at least 5 ✔️️ in the two right columns (one of which corresponds to Question #1 or #2).
4. Consider Other Depressive Disorder
   • If there are 2 to 4 ✔️️ in the two right columns (one of which corresponds to Question #1 or #2).

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (e.g., every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✔️️ by column. For every ✔️:
   “Several days” = 1  “More than half the days” = 2  “Nearly every day” = 3
3. Add together column scores to get a TOTAL score.
4. Refer to accompanying PHQ-9 Scoring Card to interpret the TOTAL score.
5. Results may be included in patients’ files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

**PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION**

Scoring—add up all checked boxes on PHQ-9

For every ✔️: Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3

<table>
<thead>
<tr>
<th>Interpretation of Total Score</th>
<th>Total Score</th>
<th>Depression Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>5-9</td>
<td>Mild</td>
<td></td>
</tr>
<tr>
<td>10-14</td>
<td>Moderate</td>
<td></td>
</tr>
<tr>
<td>15-19</td>
<td>Moderately severe</td>
<td></td>
</tr>
<tr>
<td>20-27</td>
<td>Severe</td>
<td></td>
</tr>
</tbody>
</table>

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Differential

- **Medical causes**
  - Autoimmune disorders
  - Bacterial-viral-parasitic infection
  - Blood disorders
  - Chronic fatigue syndrome
  - Dietary disorders
  - Endocrine system disorders
  - Adrenal gland
  - Thyroid and parathyroid glands
  - Pituitary tumors
  - Pancreas
  - Neurological
  - Neurotoxicity
  - Neuropsychiatric
  - Nutritional
  - Sleep disorders

- **Bipolar**
  - Family Hx or psychosis?

- **Substance Use Disorders**

- **Bio-Psycho-Social**
Mood Disorder Questionnaire (MDQ)

The MDQ can help your doctor determine what type of mood disorder you may be experiencing.

Your Name: __________________________ Date: __________________________

Instructions: Please check one answer for each question.

1. Has there ever been a period of time when you were not your usual self and...

   - ...you felt so good or so hyper that other people thought you were not your normal self, or you were so hyper that you got into trouble?  
     - Yes  
     - No
   - ...you were so irritable that you shouted at people or started fights or arguments?  
     - Yes  
     - No
   - ...you felt much more self-confident than usual?  
     - Yes  
     - No
   - ...you got much less sleep than usual and found you didn't really miss it?  
     - Yes  
     - No
   - ...you were much more talkative or spoke faster than usual?  
     - Yes  
     - No
   - ...thoughts raced through your head or you couldn't slow your mind down?  
     - Yes  
     - No
   - ...you were so easily distracted by things around you that you had trouble concentrating or staying on track?  
     - Yes  
     - No
   - ...you had much more energy than usual?  
     - Yes  
     - No
   - ...you were much more active or did many more things than usual?  
     - Yes  
     - No
   - ...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?  
     - Yes  
     - No
   - ...you were much more interested in sex than usual?  
     - Yes  
     - No
   - ...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?  
     - Yes  
     - No
   - ...spending money got you or your family into trouble?  
     - Yes  
     - No

2. If you checked “Yes” to more than one of the above, have several of these ever happened during the same period of time?  
   - Yes  
   - No

3. How much of a problem did any of these cause you—like being unable to work; having family, money, or legal troubles; getting into arguments or fights?  
   - No problem  
   - Minor problem  
   - Moderate problem  
   - Serious problem

--Adapted with permission from Robert M. A. Hirschfeld, MD.
Screening For Bipolar Disorder

The Mood Disorder Questionnaire (MDQ)* is a screening tool that may be used to help determine whether patients are experiencing symptoms of Bipolar Disorder.

Scoring the MDQ for Bipolar Disorder

The MDQ screens for a lifetime history of manic or hypomanic symptoms by including 13 yes/no items derived from both the DSM-IV criteria and clinical experience.

Positive screen for Bipolar Disorder requires the patient to answer:
• “Yes” to at least 7 of the 13 parts in question 1, and
• “Yes” to question 2, and
• “Moderate” to “serious” to question 3.

References:

* The MDQ, as adapted with permission from Robert M. A. Hirschfeld, is copyrighted in 2005 by the GlaxoSmithKline Group of Companies.
Comorbid Disorders

• Anxiety - MOST COMMON
• SUDs
Treatment—Comprehensive

- Exercise—mild, moderate, or any depression. Moderate exercise—walking!
- Diet—healthy brain=healthy foods
  - Nutrients—fats—Omega 3s, fish, flax
  - Folate
  - Simple sugars—fatigue and depression
  - Whole grains, healthy snacks, nuts/seeds
  - Caffeine, chocolate (!)
- Counseling/psychotherapy
Psychotherapies

- CBT
- IPT (Interpersonal Psychotherapy)
- Psychodynamic
- Problem Solving-CBT+IPT
- Marital
- Family
- Group
APA Summary Treatment Guidelines for the Diagnosis of Depression

SCREEN FOR DEPRESSION
- Assess for a history for Manic/Hypomanic episodes
- Multiple Somatic Complaints with no clear organic etiology
- 2 or more visits in a 6 month period with no organic etiology found to explain patient's complaints
- Chronic medical conditions
- Sleep disturbance
- Depressed mood; Diminished interest or pleasure in most activities; Insomnia; Hypersomnia; Appetite disturbance;
  Psychomotor agitation/slowing; Fatigue or loss of energy; Impaired concentration; Feelings of worthlessness; Thoughts of death/suicide
- 5 or more of these signs/symptoms required for DSM IV diagnosis of depression
- History of substance abuse

SELECT AND INITIATE TREATMENT
- Psychopharmacology (Mild, Moderate and Severe Depression) and/or Cognitive, Behavioral or interpersonal Psychotherapy (Mild or Moderate Depression) by a qualified clinician

MONITOR ACUTE TREATMENT
- Regular and frequent monitoring for maximum compliance and outcome.
- At a minimum, three medication management follow-up visits in the first 12 weeks of antidepressant treatment. At least one of the three follow-up contacts must be with a prescribing practitioner (HEDIS@, 2008).
- Titrate medication to full therapeutic doses generally over initial week(s) but may vary depending on development of side effects, patient's age, and presence of comorbid illnesses.
- Frequency of contact can vary from once a week to multiple times per week as a function of need to titrate medications; safety; degree of danger to self or others; response to treatment; functional and symptomatic status; comorbidities; medical, mental, substance abuse; specific clinical condition and age; availability of social support system; emergence of side effects; patient's treatment compliance; signs of switch to mania.

AT 4 to 8 WEEKS: CLEAR IMPROVEMENT
- Patient is clearly better and/or continuing to improve: Continue present treatment until complete remission.

AT 4 to 8 WEEKS: SOME IMPROVEMENT
- Adjust dosage and/or augmentation if on medication.
- If therapy alone being used, consider adding antidepressant and a psychiatric consultation.

AT 4 to 8 WEEKS: NO RESPONSE TO PRIOR ADJUSTMENTS IN MEDICATIONS OR PSYCHOTHERAPY
- Change medication usually to a different class of medication or reassess effectiveness of therapy.
- Once patient responding continue until complete remission.
- If psychotherapy alone being used, add antidepressant medication. Strongly consider a consultation with a psychiatrist or other mental health professional.

AT 8 WEEKS: POSITIVE RESPONSE
- Positive response/remission of symptoms
- Continue medication for 10-20 weeks (Continuation Phase)
- CONSIDER MAINTENANCE TREATMENT

MAINTENANCE TO AVOID RECURRENT
CONSIDERATIONS IN THE DECISION TO USE MAINTENANCE TREATMENT
- Factor
  - Risk of recurrence
  - Severity of episodes
  - Side effects experienced with continuous treatment
- Component
  - Number of other episodes; presence of comorbid conditions; residual symptoms between episodes
  - History of suicidality; psycho features; severe functional impairments
  - Patient preferences

RELAPSE
If relapse while in Continuation Phase, Adjust/change medication and/or augmentation;
Psychiatric consultation; Add cognitive-behavioral or IPT therapy if clinically indicated

RECURRENT
If recurrence of depression, restart prior treatment that was effective and continue for at least 1 or more years (Maintenance Phase). Assess for compliance with treatment.
# PeaceHealth Depression Drug Formulary

<table>
<thead>
<tr>
<th>Mechanism of Action</th>
<th>Drug</th>
<th>Dosage Ranges (mg/day)</th>
<th>Cost</th>
<th>Potential Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Start</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selective serotonin</td>
<td>Citalopram (Celexa)</td>
<td>10 mg q.d.</td>
<td></td>
<td>GI (N/V, diarrhea); Activation/Insomnia; Sexual dysfunction; Neurological (headaches,</td>
</tr>
<tr>
<td>reuptake inhibitor</td>
<td></td>
<td>20-60 mg q.d.</td>
<td>$$$</td>
<td>etc.); Weight changes; Serotonin syndrome; Drug interactions (MAOIs). Avoid fluoxetine</td>
</tr>
<tr>
<td>(SSRI)</td>
<td>Flexeran (Prozac)</td>
<td>20-75 mg q.d.</td>
<td>$$$</td>
<td>and paroxetine in pregnancy; can cause birth defects.</td>
</tr>
<tr>
<td></td>
<td>Paroxetine (Paxil)</td>
<td>25 mg q.d.</td>
<td>$$$</td>
<td>Discontinuation syndrome: flu-like symptoms, insomnia, nausea, imbalance, sensory</td>
</tr>
<tr>
<td></td>
<td></td>
<td>50-200 mg q.d.</td>
<td>$$$</td>
<td>disturbances, hyperactivity (paroxetine).</td>
</tr>
<tr>
<td></td>
<td>Sertraline (Zoloft)</td>
<td>5 mg q.d.</td>
<td>$$$</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>10-20 mg q.d.</td>
<td>$$$</td>
<td></td>
</tr>
<tr>
<td>Dopamine noradrenaline</td>
<td>Bupropion (Wellbutrin)</td>
<td>75-100 mg b.i.d.</td>
<td>$$$</td>
<td>Helpful for nicotine-dependent patients who wish to stop smoking and for patients</td>
</tr>
<tr>
<td>reuptake inhibitor</td>
<td></td>
<td>75-150 mg t.i.d.</td>
<td>$$$</td>
<td>overweight or obese. Anxiety; Neurolepticat risk of seizures; insomnia, Psychotic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>150 mg q.d.</td>
<td>$$$</td>
<td>symptoms; Dizziness.</td>
</tr>
<tr>
<td></td>
<td>Dopamine noradrenaline</td>
<td>150 mg q.d.</td>
<td>$$$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>reuptake inhibitors</td>
<td>300-450 mg q.d.</td>
<td>$$$</td>
<td></td>
</tr>
<tr>
<td>Serotonin noradrenaline</td>
<td>Vanafaxine (Effexor)</td>
<td>37.5 mg q.d.</td>
<td>$$$</td>
<td>Similar side effect profile to SSRIs, including N/V, sexual dysfunction, and</td>
</tr>
<tr>
<td>reuptake inhibitors</td>
<td></td>
<td>37.5-150 mg</td>
<td>$$$</td>
<td>activation. Possible dose-related BP increase; increased risk of liver damage for</td>
</tr>
<tr>
<td></td>
<td>Vanlafaxine (Effexor XR)</td>
<td>37.5 mg q.d.</td>
<td>$$$</td>
<td>patients with substantial alcohol use or pre-existing liver disease.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>75-375 mg q.d.</td>
<td>$$$</td>
<td>Discontinuation syndrome: flu-like symptoms, insomnia, nausea, imbalance, sensory</td>
</tr>
<tr>
<td></td>
<td>Serotonin modulators</td>
<td>50 mg q.d.</td>
<td>$$$</td>
<td>disturbances, hyperactivity (venlafaxine).</td>
</tr>
<tr>
<td></td>
<td>Duloxetine (Cymbalta)</td>
<td>60 mg q.d.</td>
<td>$$$</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>60-120 mg q.d.</td>
<td>$$$</td>
<td></td>
</tr>
<tr>
<td>Noradrenaline-sorotonin</td>
<td>Nortriptyline (Pamelor)</td>
<td>50 mg b.i.d.</td>
<td>$$$</td>
<td></td>
</tr>
<tr>
<td>reuptake inhibitors</td>
<td></td>
<td>300-480 mg b.i.d.</td>
<td>$$$</td>
<td></td>
</tr>
<tr>
<td>Noradrenaline-sorotonin</td>
<td>Mirtazapine (Remeron)</td>
<td>30 mg b.i.d.</td>
<td>$$$</td>
<td></td>
</tr>
<tr>
<td>reuptake inhibitors</td>
<td></td>
<td>15-45 mg b.i.d.</td>
<td>$$$</td>
<td></td>
</tr>
<tr>
<td>Tricyclics and</td>
<td>Amitriptyline (Elavil, Endep, Vanadryl)</td>
<td>25-50 mg q.d.</td>
<td>$$$</td>
<td>Sedation, Weight gain; Dry mouth.</td>
</tr>
<tr>
<td>tetracyclics</td>
<td></td>
<td>100-300 mg q.d.</td>
<td>$$$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Doxepin (Adapin, Sinequan)</td>
<td>25 mg q.d.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Imipramine (Tofran, Tofran PM)</td>
<td>25-50 mg q.d.</td>
<td>$$$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Desipramine (Norpramin)</td>
<td>25-50 mg q.d.</td>
<td>$$$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nortriptyline (Avanti HCL, Pamelor)</td>
<td>25 mg q.d.</td>
<td>$$$</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>50-200 mg q.d.</td>
<td>$$$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trimipramine (Surmontil)</td>
<td>25-50 mg q.d.</td>
<td>$$$</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>75-300 mg q.d.</td>
<td>$$$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mapiptyline (Vivactil)</td>
<td>10-20 mg q.d.</td>
<td>$$$</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>20-60 mg q.d.</td>
<td>$$$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maprotiline (Ludioc)</td>
<td>75 mg q.d.</td>
<td>$$$</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>100-225 mg q.d.</td>
<td>$$$</td>
<td></td>
</tr>
<tr>
<td>Monoamine oxidase</td>
<td>Selegiline transdermal (Deprenyl)</td>
<td>6 mg q.d.</td>
<td>$$$</td>
<td>Skin reaction. Caution with tyramine containing foods (meats that are</td>
</tr>
<tr>
<td>inhibitors (MAOIs)</td>
<td></td>
<td>6-12 mg q.d.</td>
<td>$$$</td>
<td>potentially spoiled or pickled, aged, smoked, fermented, or marinated; chocolate,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$$$</td>
<td>alcohol beverages; and fermented foods. Narcotics such as demerol.</td>
</tr>
<tr>
<td></td>
<td>(Irreversible,</td>
<td></td>
<td>$$$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MAO B selective inhibitor)</td>
<td></td>
<td>$$$</td>
<td></td>
</tr>
</tbody>
</table>

## Defining Depression Severity

Define severity of depression from rating scale (PHQ-9). Consider matching treatment based on depression severity from rating scale.

<table>
<thead>
<tr>
<th>Depression Severity</th>
<th>Treatment Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>MILD (5-9)</td>
<td>Psychotherapy alone</td>
</tr>
<tr>
<td>MODERATE (10-14)</td>
<td>Anti-depressants alone or Psychotherapy alone</td>
</tr>
<tr>
<td>SEVERE WITHOUT</td>
<td>Antidepressants and Psychotherapy</td>
</tr>
<tr>
<td>PSYCHOTIC FEATURES</td>
<td>Consider referral to psychiatric hospital</td>
</tr>
<tr>
<td>(15-19)</td>
<td>Antidepressants and Antipsyhtic combination</td>
</tr>
<tr>
<td>SEVERE WITH</td>
<td>Consider psychiatric referral</td>
</tr>
<tr>
<td>PSYCHOTIC FEATURES</td>
<td>Antidepressants and Antipsychotic combination</td>
</tr>
</tbody>
</table>

## Considerations

- Consider screening for Bipolar disorder with Mood Disorder Questionnaire (MDQ) before initiating antidepressants.

### FIRST LINE ANTIDEPRESSANT TREATMENT OPTIONS
- SSRIs
- SNRIs
- Mirtazapine
- Bupropion

### MEDICATIONS
- Start at half the usual dose for the first 1-2 weeks.
- If not responsive to usual dose in 4-6 weeks consider pushing to a higher therapeutic level.
- Consider adding Bupropion to a Serotonin agonist when indicated.
- Consider sleep agent as Ambien or Trazodone as needed.

### ANTIDEPRESSANT RESPONSE
- Goal is Full Remission
  - No/Marginal: <25% reduction in pre-symptom severity—consider referral
  - Partial/Marginal: 25%-75% reduction in pre-symptom severity—consider augmentation
  - Full Response/Remission: >75% reduction in pre-symptom severity—propose to maintenance phase

### AUGMENTATION STRATEGIES
- Combining antidepressants or adding augmenting agents (bupropion, lamotrigine)
- Complimentary (i.e., fish oil, S-adenosylmethionine (SAMe), L-methionol, aripiprazole (Abilify), quetiapine (Sarate), Bright light (a.m. therapy)

### PSYCHOTHERAPY
- Consider psychotherapy if there are psychosocial stressors associated with depression.
New Antidepressants
<table>
<thead>
<tr>
<th>Drug</th>
<th>FDA-Approved Indicationsa</th>
<th>Usual Adult Dose (once daily unless otherwise noted)b</th>
<th>Adverse Effectsx,1,3 --absent or rare to +++relative common</th>
<th>CYP450 Inhibitiona</th>
<th>Commentsa</th>
<th>Costc</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Selective Serotonin Reuptake Inhibitors, continued</strong></td>
<td></td>
<td></td>
<td>Anti-cholinergic</td>
<td>Arrhythmia</td>
<td>Sedation</td>
<td>Weight Gain</td>
</tr>
<tr>
<td>Sertraline (Zoloft)</td>
<td>Depression, OCD, panic disorder, PTSD, PMDD, social anxiety disorder Pediatrics: OCD</td>
<td>Initial: 50 mg (25 mg for panic, PTSD, children ages six to 12, and social anxiety) Max: 200 mg (children/adults)</td>
<td>--</td>
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<td>+</td>
<td>+</td>
</tr>
<tr>
<td><strong>Selective Serotonin Reuptake Inhibitor/Serotonin Reuptake Inhibitor (5-HT1A) Partial Agonist</strong></td>
<td></td>
<td></td>
<td>Anti-cholinergic</td>
<td>Arrhythmia</td>
<td>Sedation</td>
<td>Weight Gain</td>
</tr>
<tr>
<td>Vilazodone (Viibryd)</td>
<td>Depression</td>
<td>Initial: 10 mg Usual: 40 mg Max: 40 mg</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td><strong>Selective Serotonin Reuptake Inhibitor/Serotonin Reuptake Inhibitor Agonist (5-HT1A) Partial Agonist (5-HT1B)/Antagonist (5-HT3A, 5-HT7)</strong></td>
<td></td>
<td></td>
<td>Anti-cholinergic</td>
<td>Arrhythmia</td>
<td>Sedation</td>
<td>Weight Gain</td>
</tr>
<tr>
<td>Vortioxetine (Brintellix)</td>
<td>Depression</td>
<td>Initial: 10 mg Usual: 20 mg Consider 5 mg if poorly tolerated.</td>
<td>--</td>
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<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Drug</td>
<td>FDA-Approved Indications&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Usual Adult Dose (once daily unless otherwise noted)&lt;sup&gt;ab&lt;/sup&gt;</td>
<td>Adverse Effects&lt;sup&gt;a1-3&lt;/sup&gt;</td>
<td>CYP450 Inhibition&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Comments&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Cost&lt;sup&gt;c&lt;/sup&gt;</td>
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<td>----------------------------------------------------------------------</td>
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<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Serotonin Norepinephrine Reuptake Inhibitors</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Desvenlafaxine succinate extended-release tablet (Pristiq)</td>
<td>Depression</td>
<td>Initial: 50 mg</td>
<td>--</td>
<td>--</td>
<td>CYP2D6 inhibition not clinically significant at doses ≤100 mg.</td>
<td><strong>Pristiq</strong> 50 mg once daily $177</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Usual: 50 mg</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Max: 400 mg (no additional benefit of doses &gt;50 mg)</td>
<td></td>
<td></td>
<td>Monitor blood pressure.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Max dose 50 mg daily in moderate renal impairment, and 50 mg every other day in severe renal impairment.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Max dose 100 mg daily in moderate to severe hepatic impairment.</td>
<td></td>
</tr>
<tr>
<td>Desvenlafaxine extended-release tablet (Khedezla)</td>
<td>Depression</td>
<td>Initial: 50 mg</td>
<td>--</td>
<td>--</td>
<td>CYP2D6 inhibition not clinically significant at doses ≤100 mg.</td>
<td>As above.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Usual: 50 mg</td>
<td></td>
<td></td>
<td></td>
<td><strong>50 mg</strong> once daily $133.50</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Max: 400 mg (no additional benefit of doses &gt;50 mg)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug</td>
<td>FDA-Approved Indications&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Usual Adult Dose (once daily unless otherwise noted)&lt;sup&gt;ab&lt;/sup&gt;</td>
<td>Adverse Effects&lt;sup&gt;1,3&lt;/sup&gt;</td>
<td>CYP450 Inhibition&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Comments&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Cost&lt;sup&gt;c&lt;/sup&gt;</td>
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<td>---------------------------------------------------------------</td>
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<td>-------------------------------</td>
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<td>----------------</td>
</tr>
<tr>
<td><strong>Serotonin Norepinephrine Reuptake Inhibitors, continued</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duloxetine (Cymbalta)</td>
<td>Depression, GAD, diabetic peripheral neuropathy, fibromyalgia, chronic musculoskeletal pain</td>
<td>Initial: 30 mg for pain or fibromyalgia. May start with 60 mg for other indications. Usual: 60 mg Max: 120 mg (no evidence of benefit vs 60 mg)</td>
<td>Anti-cholinergic Arhythmia Sedation Weight Gain</td>
<td>Moderate CYP2D6 inhibitor</td>
<td>Monitor blood pressure. Avoid with potent CYP1A2 and CYP2D6 inhibitors.</td>
<td>60 mg once daily $219</td>
</tr>
<tr>
<td>Levo-milnacipran extended-release capsules (Fetzima)</td>
<td>Depression</td>
<td>Initial: 20 mg Usual: 40 mg to 120 mg Max: 120 mg Limit dose to 80 mg in patients on a strong CYP3A4 inhibitor such as ketoconazole.</td>
<td>-- -- -- --</td>
<td>None</td>
<td>Monitor blood pressure and pulse. Max dose 80 mg daily in moderate renal impairment, and 40 mg daily in severe renal impairment. Stronger inhibitor of norepinephrine reuptake than serotonin reuptake.</td>
<td>80 mg once daily $202.50</td>
</tr>
</tbody>
</table>
Antidepressant Side Effects
# TABLE 7: Potential Treatments for Side Effects of Antidepressant Medications

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Antidepressant Associated With Effect</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arrhythmias</td>
<td>TCAs</td>
<td>Avoid in patients with cardiac instability or ischemia. Attend to interactions with anti-arrhythmics.</td>
</tr>
<tr>
<td>Hypertension</td>
<td>SNRIs, bupropion</td>
<td>Monitor blood pressure. Keep dose as low as possible. Add antihypertensive.</td>
</tr>
<tr>
<td>Hypertensive crisis</td>
<td>MAOIs</td>
<td>Seek emergency treatment. If hypertension is severe, intravenous antihypertensive agents (e.g., labetalol, sodium nitroprusside) may be required.</td>
</tr>
<tr>
<td>Increase in cholesterol</td>
<td>Mirazapine</td>
<td>Add a statin.</td>
</tr>
<tr>
<td>Orthostatic hypotension</td>
<td>TCAs, trazodone, nefazodone, MAOIs</td>
<td>Add fluodrocortisone. Add salt to diet.</td>
</tr>
<tr>
<td>Anticholinergic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constipation</td>
<td>TCAs</td>
<td>Encourage adequate hydration. Add bulk laxative.</td>
</tr>
<tr>
<td>Delirium</td>
<td>TCAs</td>
<td>Evaluate for other possible contributors to delirium.</td>
</tr>
<tr>
<td>Dry mouth</td>
<td>TCAs, SNRIs, bupropion</td>
<td>Suggest use of sugarless gum or candy.</td>
</tr>
<tr>
<td>Urinary hesitancy</td>
<td>TCAs</td>
<td>Add bethanechol.</td>
</tr>
<tr>
<td>Visual changes</td>
<td>TCAs</td>
<td>Add pilocarpine eye drops.</td>
</tr>
<tr>
<td>Neurologic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td>SSRIs, SNRIs, bupropion</td>
<td>Assess for other etiologies (e.g., caffeineism, bruxism, migraine, tension headache).</td>
</tr>
<tr>
<td>Myoclonus</td>
<td>TCAs, MAOIs</td>
<td>Add clonazepam.</td>
</tr>
<tr>
<td>Seizures</td>
<td>Bupropion, TCAs, amoxapine</td>
<td>Assess for other etiologies, and add anticonvulsant medication, if clinically indicated.</td>
</tr>
<tr>
<td>Sexual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arousal, erectile dysfunction</td>
<td>TCAs, SSRIs, SNRIs</td>
<td>Add sildenafil, tadalafil, buspirone, or bupropion.</td>
</tr>
<tr>
<td>Orgasm dysfunction</td>
<td>TCAs, SSRIs, venlafaxine, desvenlafaxine, MAOIs</td>
<td>Add sildenafil, tadalafil, buspirone, or bupropion.</td>
</tr>
<tr>
<td>Priapism</td>
<td>Trazodone</td>
<td>Obtain emergency urological evaluation.</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activation</td>
<td>SSRIs, SNRIs, bupropion</td>
<td>Administer in the morning.</td>
</tr>
<tr>
<td>Akathisia</td>
<td>SSRIs, SNRIs</td>
<td>Add a beta-blocker or benzodiazepine.</td>
</tr>
<tr>
<td>Bruxism</td>
<td>SSRIs</td>
<td>Obtain dental consultation, if clinically indicated.</td>
</tr>
<tr>
<td>Diaphoresis</td>
<td>TCAs, some SSRIs, SNRIs</td>
<td>Add an α1-adrenergic antagonist (e.g., terazosin), central α2-adrenergic agonist (e.g., clonidine), or anticholinergic agent (e.g., benztrapine).</td>
</tr>
<tr>
<td>Fall risk</td>
<td>TCAs, SSRIs</td>
<td>Monitor blood pressure for evidence of hypotension or orthostasis; assess for sedation, blurred vision, or confusion; modify environment to reduce risk.</td>
</tr>
<tr>
<td>Gastrointestinal (GI) bleeding</td>
<td>SSRIs</td>
<td>Identify whether concomitant medications may affect clotting.</td>
</tr>
<tr>
<td>Side Effect</td>
<td>Antidepressant Associated With Effect</td>
<td>Treatment</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td><strong>Other (continued)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatotoxicity</td>
<td>Nefazodone</td>
<td>Provide education about and monitor for clinical evidence of hepatic dysfunction. Obtain hepatic function tests, if clinically indicated.</td>
</tr>
<tr>
<td>Insomnia</td>
<td>SSRIs, SNRIs, bupropion</td>
<td>Use morning dosing. Add a sedative-hypnotic at bedtime. Add melatonin. Provide CBT or education in sleep hygiene.</td>
</tr>
<tr>
<td>Nausea, vomiting</td>
<td>SSRIs, SNRIs, bupropion</td>
<td>Administer after food or in divided doses.</td>
</tr>
<tr>
<td>Osteopenia</td>
<td>SSRIs</td>
<td>If clinically indicated, obtain bone density monitoring and add specific treatment to reduce bone loss (e.g., calcium and vitamin D supplements, bisphosphonates, selective estrogen receptor agents).</td>
</tr>
<tr>
<td>Sedation</td>
<td>TCAs, trazodone, nefazodone, mirtazapine</td>
<td>Use bedtime dosing. Add modafinil or methylphenidate.</td>
</tr>
<tr>
<td>Severe serotonin syndrome</td>
<td>MAOIs</td>
<td>Obtain emergency evaluation. Consider admission to a critical care unit.</td>
</tr>
<tr>
<td>Weight gain</td>
<td>SSRIs, mirtazapine, TCAs, MAOIs</td>
<td>Encourage exercise. Obtain input from dietician. If changing antidepressants, consider a secondary amine (if a TCA is required) or other antidepressant with fewer weight issues (e.g., bupropion).</td>
</tr>
</tbody>
</table>
Augmentation Meds

- Benzo
- Atypical antipsychotic, low dose
- Lithium
- Thyroid
- Ritalin

- Correct Diagnosis???
Telephone Triage Protocol for Suicidal Children/Adolescents/Adults

1. **Is the child/adolescent/adult in immediate danger?**
   a. **Has taken pills, has a weapon and has used it or is threatening to use it, or is otherwise in immediate danger of bodily harm?**
   
   **If so, have parent hang up and dial 911**

2. **Is the child/adult at high risk for suicide attempt?**
   a. Does the person have a plan to hurt themselves? Ask caller, or have parent/caregiver calmly ask “have you thought about how you would do this?” Examples of a concrete plan are: “I know how to get pills” “I have pills” or “I know where to find a gun”.  
   b. Is there a psychiatric history?  
   c. Has there been a previous suicide attempt?  
   d. Are there family members or friends who have recently committed or attempted suicide?  
   
   **If so, refer to UD emergency department for crisis evaluation** Advise parent to stay calm and stay engaged with the adolescent. Advise that emotional outbursts by parents such as crying, pleading, scolding or dismissing the concerns of the adolescent are not helpful. Instruct parent to remove all weapons and medications from the home or carefully secure them.*

3. **Is the child/adult depressed, but at low risk for suicide attempt?**
   a. The patient made a brief, one time, passing comment such as "I wish I was dead" or "The world would be better off without me", with no high risk features.  
   b. Diary entries, Facebook and phone messages which are purposely dramatic. Remind parents that the writer of a diary did not intend the parent (or anyone else) to read the entry. What an adolescent writes in a diary can be quite shocking and not reality based.  
   
   **Instruct patient/parent to make appointment with PCP or counselor.** Most mental health agencies in the area (including Peace Health) have rapid access appointments available.  
   The adolescent should not be left alone.  
   Keep lines of communication open, with calm, non-judgmental conversation.  
   Instruct parent/caregiver to remove all weapons and medications from the home or carefully secure them.*

4. **Is the child/adult at intermediate risk for suicide attempt?**
   a. Less concerning than high risk, but more than low risk  
   
   **Mobile Mental Health Crisis Response Program (for Children and Adolescents): 1-888-989-9990.**  
   **White Bird Crisis Line (for any age, includes CAHOOTS): 541-687-4000 or 1-800-422-7558**  
   
   They take calls 24 hours, assess the situation including plan, intent and acuity, and create a safety plan with the family. If the crisis is current/active, the Mobile team has capacity to dispatch a 2 person team to go to the child/adolescents home to further assess or assist, and offer crisis placement if observation is indicated but there is not an emergent need to involve the ED.  

   **Default:** It is always ok to refer to ED if you are not sure how serious the situation is.

   *Note that Tylenol is very toxic when taken as an overdose. Often patients will need hospitalization for treatment to prevent liver damage. In contrast ibuprofen is relatively safe even in overdose situation.*
ECT
Polypharmacy
BH Integration Initiatives

- PeaceHealth, Family Medicine Department
  - Integration: 2 clinics, 3 “Behavioral Health Consultants” (therapists)
  - Psychiatric consultation, virtual/EMR, plus f2f
  - Reverse Integration—FNP as PCP, BH supports, and psychiatric consultation

- CCO/Trillium support

- Planned expansion, including more psych providers involved, and to Pediatrics!
Cases, Q & A