

Collaborative Care for Treating Depression

Primary Care Providers

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Objective

- Discuss the origin of Collaborative Care models to treat depression in the primary care setting
- Describe a collaborative care model for treating depression in the primary care setting

Impact of Depression

- 5-6% one year prevalence
- 20% women, 10% Men will have a major depressive episode
- Impaired social functioning more than any other chronic disease
- Impaired physical functioning more than any other chronic condition except cardiac illness
 - (diabetes, asthma, arthritis, angina)

The De Facto Mental Health Care System

- General medical setting
 - Treats 50% of people with common mental health disorders
 - More for ethnic minorities, elderly, uninsured
 - Depressed patients visit PCPs 3x more often than non-depressed patients
- Many go unrecognized and untreated
 - 75% depressed primary care patients present with somatic complaints
- Screening alone has not shown better outcomes

Usual Care for Depression

- 1/3 internal medicine residents felt “very prepared” to treat Depression in primary care
- Financial disincentives for primary care providers
- Stigma
- Fragmented Health Care System
- 1/3 to 1/2 referrals to MHC do not follow through

Collaborative Care

Providers from different disciplines working together to offer complimentary services and mutual support, to ensure individuals receive the most appropriate services from the most appropriate provider in the most suitable location, as quickly as necessary, and with minimum obstacles.

(Craven and Bland)

Collaborative Care

- Collaboration most developed when co-located
- Most effective when the location is familiar and non-stigmatizing for patients
- Requires preparation and supportive structures
- System-level collaboration requires service reorganization and time to develop

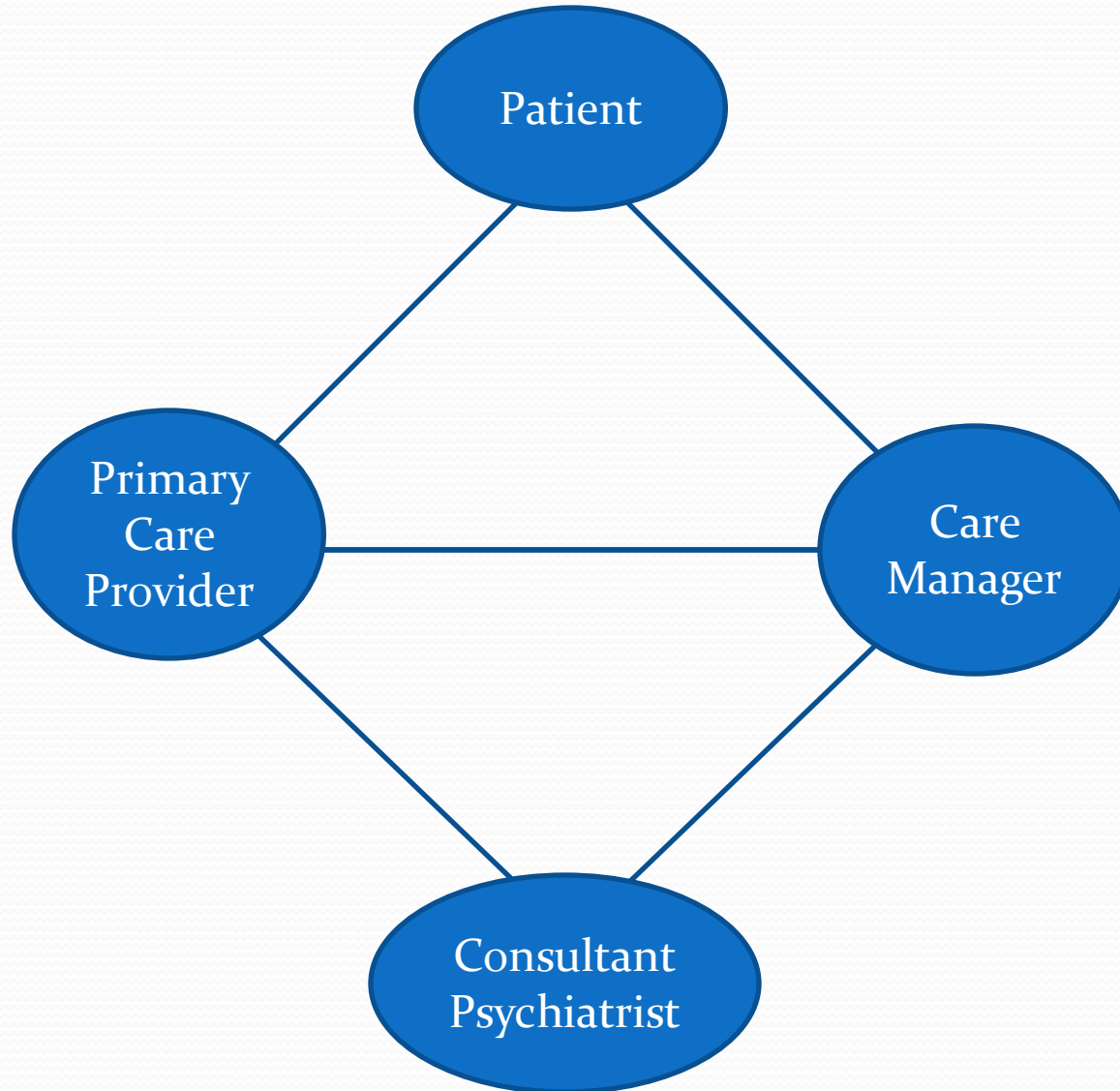
Collaborative Care

- The pairing of *collaboration with treatment guidelines* appears to offer important benefits over either treatment alone:
 - Treatment content
 - (medication management, psychotherapy)
 - Process issues
 - (roles, frequency of monitoring, referral criteria)
 - Trials with specified protocols without collaborative interventions have not shown improvements in patient-level outcomes

Stepped Care

- Systematic outcomes tracking
 - e.g., Patient Health Questionnaire (PHQ-9)
- Treatment adjustment as needed
 - - based on clinical outcomes
 - - according to evidence-based algorithm
 - - in consultation with team psychiatrist
- Relapse prevention planning

The Collaborative Care Team



Patient

- Collaborate with providers to form treatment plan
- Adhere to self management plan
- Provide feedback to providers

Care Management

- Patient assessment
- Self management support
- Acts as liaison to facilitate changes when necessary
- May provide psychotherapy
- Case management
- Use registry to manage case loads and track outcomes
- Consults weekly with team psychiatrist

Care Management Self Management Support

- Educate patient
- Develop and maintain rapport
- Encourage exercise and pleasant activities
- Encourage adherence
- Monitor progress with serial PHQ9s
- Help resolve problems that emerge during treatment
- Help develop relapse prevention plan

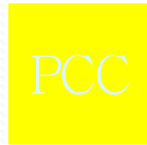
Psychiatrist

- Meet weekly with Depression Care Manager to review case load
 - New patients and their treatment plans
 - Ongoing patients who are having difficulty or are not responding
- *May* provide direct patient consultation for treatment resistant or complicated patients
- Be readily available to care managers for questions or emergencies

Primary Care Provider

- Assessment and Diagnosis
- Patient Education
- Collaborate with patient on treatment plan
- Connect patient with Care manager
- Coordinate ongoing care with Care manager
- Manage antidepressant therapy
- Consult psychiatrist if patient not improving on optimal treatment

Typical Frequency of Patient Contacts



Primary Care
Clinician Visit



Care Manager
phone or visit

Acute Phase

Continuation Phase



Using the Patient Health Questionnaire (PHQ9)

Primary Care Providers

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Objective

- Discuss how the Patient Health Questionnaire (PHQ9) can be used as a tool to aid diagnosis and monitoring of patients with depression

Patient Health Questionnaire (PHQ-9)

- 9- item, self administered questionnaire
- Validated for diagnostic purposes
 - 88% sensitivity and specificity for MDD
 - For score of 10-14
 - 68% sensitivity, 95% specificity
 - For Score ≥ 15
- Validated for follow up outcomes

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____

DATE: _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

add columns: + +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.)

TOTAL:

10. 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 _____

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at ris@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at <http://www.pfizer.com>. Copyright ©1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
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3. Trouble falling or staying asleep, or sleeping too much	0	1	✓ 2	3
4. Feeling tired or having little energy	0	1	2	✓ 3
5. Poor appetite or overeating	0	✓ 1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	✓ 2	3
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9. Thoughts that you would be better off dead, or of hurting yourself in some way	✓ 0	1	2	3

add columns:

2 + 10 + 3

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL:

15

Diagnosing Major Depression

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use “✓” to indicate your answer)

Need one or both questions endorsed “More than half” or “Nearly every day”

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	✓ 2	3
2. Feeling down, depressed, or hopeless	0	✓ 1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	✓ 2	3
4. Feeling tired or having little energy	0	1	2	✓ 3
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Diagnosing Major Depression

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(use “✓” to indicate your answer)

Need one or both questions endorsed “More than half” or “Nearly every day”

Need total of 5 or more boxes endorsed in shaded area

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	✓ 2	3
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Diagnosing Major Depression

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use “✓” to indicate your answer)

Need one or both questions endorsed “More than half” or “Nearly every day”

Need total of 5 or more boxes endorsed in shaded area

Functional impairment endorsed as somewhat difficult or greater

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	✓ 2	3
2. Feeling down, depressed, or hopeless	0	✓ 1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	✓ 2	3
4. Feeling tired or having little energy	0	1	2	✓ 3
5. Poor appetite or overeating	0	✓ 1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	✓ 2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	✓ 2	3
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9. Thoughts that you would be better off dead, or of hurting yourself in some way	✓ 0	1	2	3

add columns:

2 + 10 + 3

TOTAL:

15

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Types of Depression

- Major Depression
 - Depressed mood OR anhedonia most of the day, nearly every day
 - ≥ 2 weeks
 - AND 5 of 9 total depressive symptoms
- Dysthymia (Chronic Depression)
 - Depressed mood more days than not
 - Plus 2 more depressive symptoms
 - ≥ 2 years
- Minor Depression
 - Same symptom criteria as dysthymia
 - < 2 years

Using PHQ-9 for Diagnosis and Initial Treatment plan

PHQ-9 Score	Provisional Diagnosis	Treatment Recommendation
5-9	Minimal symptoms	Support, educate to call if worse, Return in 1 month
10-14	Minor Depression*	Support, Watchful Waiting
	Dysthymia Major Depression, mild	Antidepressant or psychotherapy
15-19	Major Depression, <i>moderate</i>	Antidepressant or Psychotherapy
≥20	Major Depression, <i>severe</i>	Antidepressant <u>and</u> Psychotherapy

*If symptoms present for ≥ one month or significant functional impairment, consider active treatment

Outcome Targets

PHQ9

- Clinically Significant Improvement (CSI)
 - 5 point decrease in PHQ9 score
- Response
 - 50% decrease in PHQ9 score
- Remission
 - PHQ9 score < 5 for 2 months

- REMISSION IS THE GOAL!

Depression Care Treatment Approaches

Primary Care Providers

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Objectives

- Discuss ways to engage patients and develop rapport
- Discuss options to consider in developing a treatment plan

Engagement

- Consider Stigma
 - “Only weak people get depressed”
 - “I should be able to get myself out of this”
 - “Having Depression means you’re crazy”
 - “Medication will change my personality”
 - “I don’t want to get addicted”
 - “Depression is against God”
 - “If I had stronger faith, I wouldn’t be depressed”

Use TACCT for Engagement

- **T**ell about the illness “You have clinical depression”
- **A**sk about reactions and concerns
- **C**are to respond to their emotions/concerns; develop rapport
- **C**ounsel in response to these concerns and explanatory model
- **T**ailor plan to patient concerns and priorities

Choosing a treatment strategy

- Behavioral Activation/pleasant events scheduling
- Watchful Waiting
- Psychotherapy
- Antidepressant medication
- Combination therapies

Many patients will need treatment adjustments

- Follow up assessment is critical!
- **30 – 50%** of patients will have a **complete response to initial treatment**
- **Remaining 50 – 70%** will require at least one change in treatment to get better

Pleasant Events Scheduling (Behavioral Activation)

- Pleasant, social, physical
- Patient creates goals
- Specific
- Attainable

Watchful Waiting

- Depression can remit spontaneously
- Consider for minor depression
- Encourage Behavioral Activation
- Consider referral to care manager for support
- Re-asses in \leq one month (ie. repeat PHQ9)
- Revisit treatment plan if no improvement

Psychotherapy

- There are several types
- Some Collaborative Care models have incorporated
 - Cognitive Behavioral Therapy (CBT)
 - Problem Solving therapy (PST)
- Effective for
 - Mild to moderate depression
 - Adjunct to Antidepressants

Pharmacotherapy

- Effective
 - Major Depression
 - Dysthymia
- Equivocal
 - Minor depression

When to Consider Mental Health Consultation

- Has complicating mental health diagnosis, such as personality disorder
- Bipolar disorder suspected
- Psychosis suspected
- Current substance dependence
- Severe anxiety
- No response after 8-10 weeks on optimal treatment

Depression Care Medication Management

Primary Care Providers

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Objectives

- Describe principles of antidepressant medication management
- Discuss ways to manage side effects
- Know when to consult a mental health specialist

Pharmacology

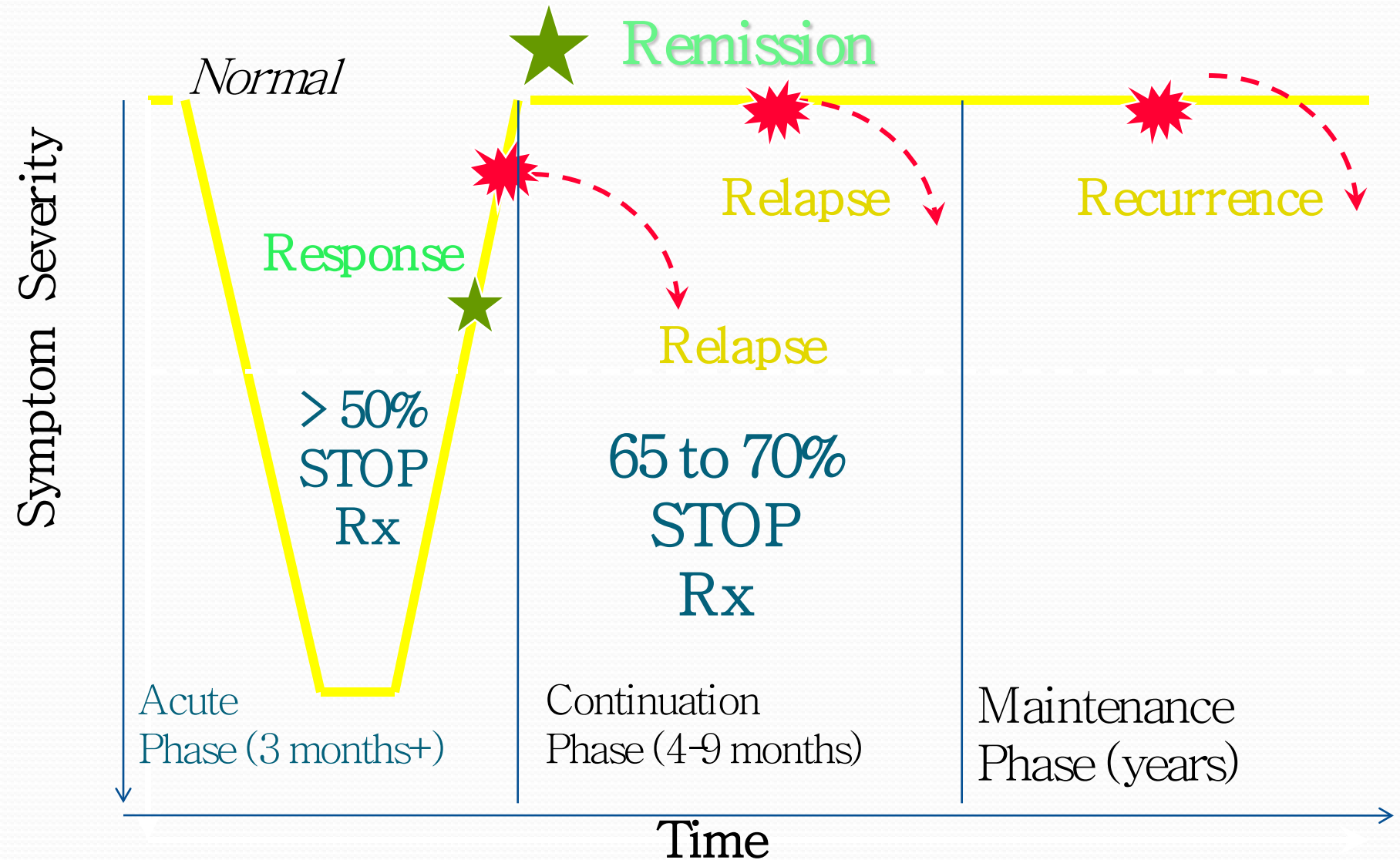
Acute Phase Treatment

- Generally start with SSRI or SNRI
- Educate
- Elicit commitment
- Early follow up (1-3 weeks)
- Titrate to adequate dose as needed
- Re-evaluate, repeat PHQ9 every month until remission

Key Educational Messages

- Antidepressant medication is not addictive
- Must be taken everyday
- Mild side effects may occur, and usually improve over 1-2 weeks
- Usually takes 2-4 weeks to notice effects
- People around you may notice a change before you do
- People respond differently. We may have to adjust the medication until we find the right dose for you
- There are many options of antidepressant medication. You may respond differently to different choices.
- If you have any problems with the medication, call me before you stop it.
- Keep taking the medication even when you feel better

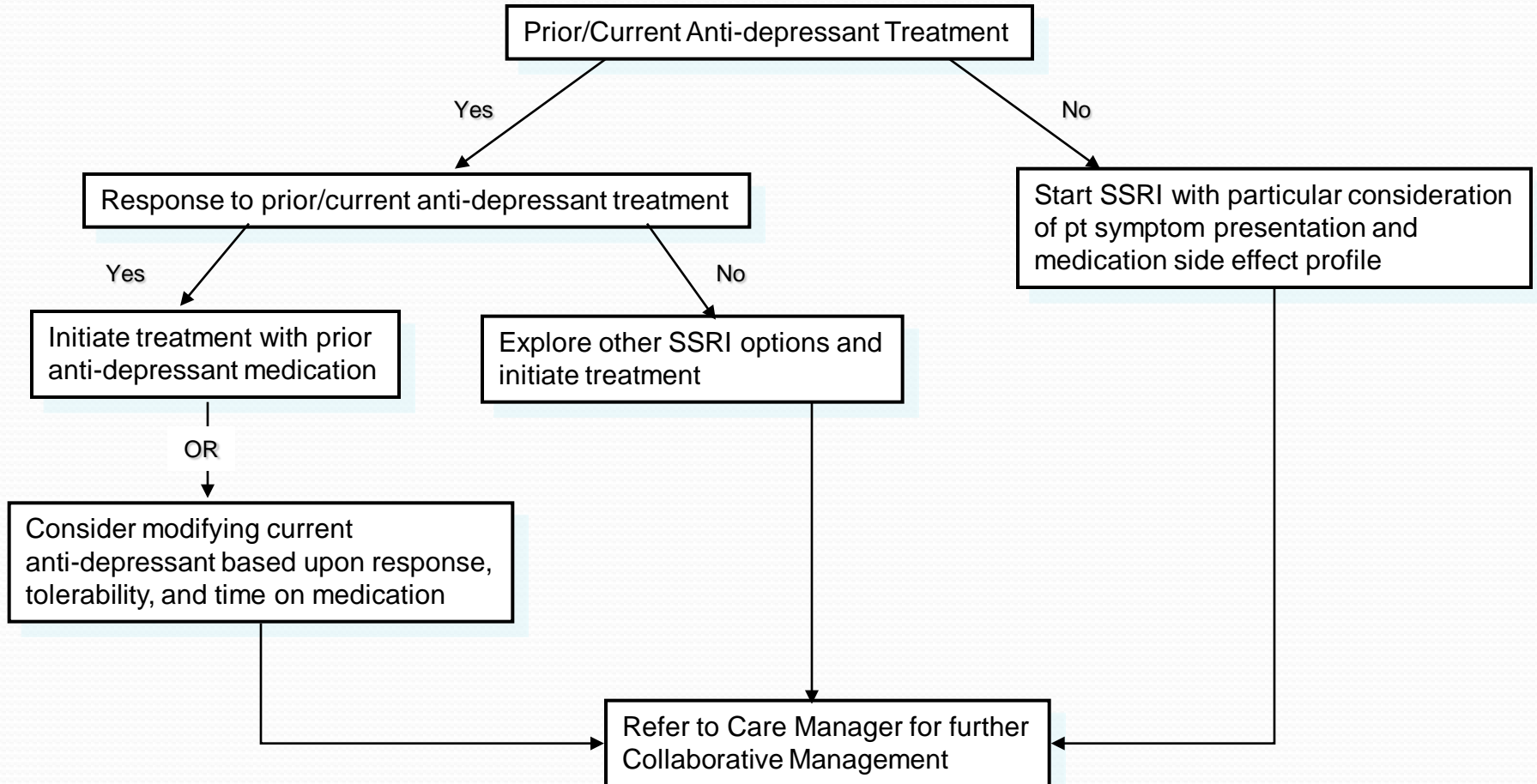
Three Phases of Treatment



Antidepressant Effectiveness

- All antidepressants have similar
 - effectiveness (30 – 50% response)
 - time to response (6 - 8 weeks)
 - discontinuation rates

The Basic Prescription Map



Choosing the agent

- Cost
 - Sertraline, fluoxetine, citalopram, paroxetine, bupropriion SR, mirtazapine are generic
- Drug interactions (CYP₄₅₀)
 - Citalopram, escitalopram, sertraline low to moderate drug interactions
 - Paroxetine, prozac inhibit P₄₅₀ at low doses
 - Check serum levels for drugs with narrow therapeutic windows: ie. TCA, digoxin, warfarin, anticonvulsants
- Side effect profile

COMMONLY PRESCRIBED PSYCHOTROPIC MEDICATIONS

po = by mouth; pm = as needed; qd = 1x/day; bid = 2x/day; tid = 3x/day; qid = 4x/day; qod = every other day; qhs = at bedtime; qac = before meals; SSRI = Selective Serotonin Reuptake Inhibitor; SNRI = Serotonin/Norepinephrine Reuptake Inhibitor; * on Wal-Mart's \$4 Rx plan, however not all dosages may be covered; † = generic available. \$ = Not available as generic or expensive.

NAME: Generic (Trade)	Dosage	KEY CLINICAL INFORMATION
Antidepressant Medications		
Bupropion (Wellbutrin)	Start: IR-100 mg bid X 3d then ↑ to 100 mg tid; SR-150 mg qam X 3d then ↑ to 150 mg bid; XL-150 mg qam X 3d, then ↑ to 300 mg qam. Range: 300-450 mg/d.	Contraindicated in seizure disorder because it decreases seizure threshold; stimulating; not good for treating anxiety disorders; second line TX for ADHD; abuse potential. † (IR/SR), § (XL)
* Citalopram (Celexa)	Start: 10-20 mg qday. Range: 20-60 mg/d.	Best tolerated of SSRIs; very few and limited CYP 450 interactions; good choice for anxious pt. †
Duloxetine (Cymbalta)	Start: 20 mg bid up to 60 mg (qday or 30 mg bid). Range: 60-120 mg/d.	More GI side effects than SSRIs; tx neuropathic pain; need to monitor BP; 2 nd line tx for ADHD. §
Escitalopram (Lexapro)	Start: 5-10 mg qday. Range: 10-30 mg/d (3X more potent than Celexa).	Best tolerated of SSRIs; very few and limited CYP 450 interactions. Good choice for anxious pt. †
* Fluoxetine (Prozac)	Start: 10-20 mg qam. Range: 20-60 mg/d.	More activating than other SSRIs; long half-life reduces withdrawal (t _{1/2} = 4-6 d). †
Mirtazapine (Remeron)	Start: 15 mg qhs X 3d then ↑ to 30 mg qhs. Range: 30-60 mg/d.	Sedating and appetite promoting; Neutropenia risk (1 in 1000) so avoid in immunosuppressed patients. †
* Paroxetine (Paxil)	Start: 10-20 mg qhs. Range: 20-60 mg/d.	Anticholinergic; sedating; very significant withdrawal syndrome. †
Sertraline (Zoloft)	Start: 25-50 qam. Range: 50-200 mg/d.	Few and limited CYP 450 interactions; mildly activating. †
Venlafaxine (Effexor)	Start: IR-37.5 mg bid X 4d then ↑ to 75 mg bid; XR-75 mg qam X 4d then ↑ to 150 qAM. Range: 150-375 mg/d.	More agitation & GI side effects than SSRIs; tx neuropathic pain above 150 mg qday; need to monitor BP; 2 nd line tx for ADHD. Very significant withdrawal syndrome. † (IR), § (XR)

*Antidepressant warnings/precautions: 1) Potential increased suicidality in first few months, 2) Long term weight gain likely (except Wellbutrin), 3) Sexual side effects common (except Wellbutrin), 4) Withdrawal syndrome frequently occurs with abrupt cessation (especially with SSRIs and SNRIs), increased risk of bleeding with SSRIs and SNRIs (especially in combo with NSAIDs), 5) Increased risk for Serotonin Syndrome (except Wellbutrin), especially with combination of drugs affecting serotonin metabolism, 6) Hyponatremia sometimes seen with SSRIs and SNRIs.

Titrating Commonly Used Antidepressants

TCAs and SSRIs

<i>Name</i>	<i>Starting dose in mg</i>	<i>Increase as needed and as tolerated (doses in mg / day)</i>	<i>Target/ high doses^c</i>
Nortriptyline	10 qhs	Increase by 10-20 mg / week	50-150 (a)
Desipramine	25 qam	Increase by 25-50 mg / week	150-300 (b)
Amitriptyline	25 qhs	Increase by 25-50/week	50-300 (c)
Fluoxetine	10 qam	Increase to 20mg after 1 wk, To 30 mg after 4 wks To 40 mg after 8 wks	40-80
Citalopram	10 qam	Increase to 20 mg after 1 wk To 30 mg after 3 weeks To 40 mg after 6 weeks	20-60
Escitalopram	10 qam	Increase to 20 mg after 1 wk	10-20
Paroxetine	10 qam	Increase to 20 mg after 1 wk To 30 mg after 4 wks To 40 mg after 6 wks	20-50
Sertraline	25 qam	Increase to 50 mg after 1wk To 100 mg after 3 wks To 150 mg after 6 wks	50-200

a. Check blood levels, especially if not effective at 75 mg – aim for level of 50-150 ng/ml.

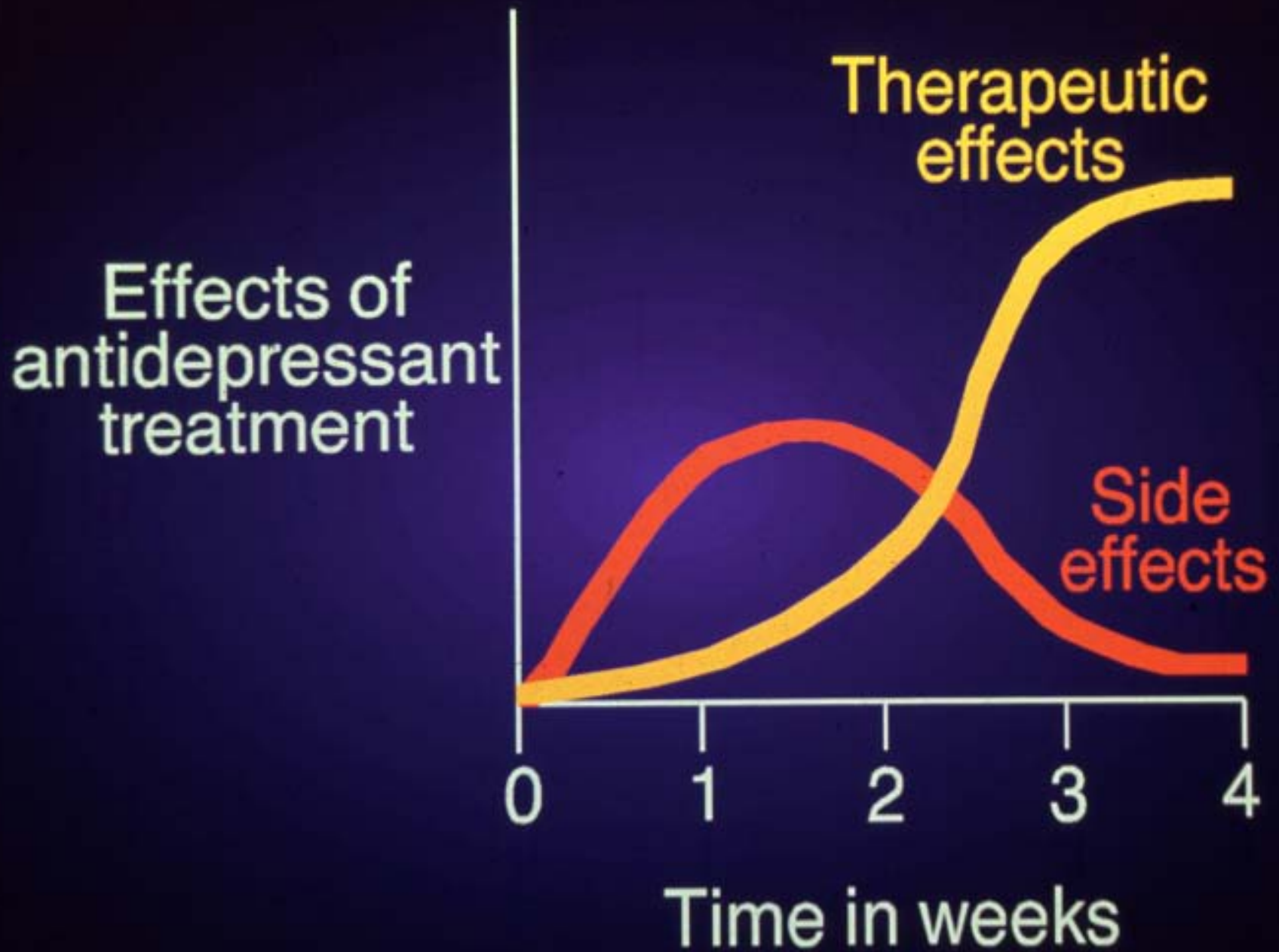
b. Check blood level if not effective at 150 mg – aim for a level of 115-180 ng / ml.

c. Check level if not effective at 100mg-aim for **Nortriptyline 50-150 ng/ml**,

http://impact-uw.org/tools/impact_manual.html

Titrating Commonly Used Antidepressants

Name	Starting dose in mg	Increase as needed and as tolerated (doses in mg / day)	Target/ high doses^c
Bupropion ^d	75 qam	Increase to 75 bid after 4 days to 100 bid after 2 wks to 150 bid after 4 wks to 150 tid after 6 wks	450
Bupropion SR	100 qam	Increase to 100 bid after 1 wk To 150 bid after 3 wks to 150 tid after 6 wks	450
Venlafaxine ^d	25 qam	Increase to 25 bid after 4 days To 50 bid after 2 wks To 75 bid after 3 wks To 100 bid after 5 wks To 150 qam/100 qhs after 6wks	250
Venlafaxine XR	37.5 qam	Increase to 75 after 1 wk to 150 mg after 3 wks to 225 mg after 6 wks	225
Mirtazapine	15 qhs	Increase to 30 qhs after 3 wks To 45 qhs after 6 wks	45



Strategies for Managing Antidepressant Side Effects

- Explore whether the side effects are ‘physical’ or ‘psychological’?
- Wait and support.
 - Many side effects will subside over 1-2 weeks of treatment (i.e., GI distress with SSRIs)
- Lower the dose (temporarily).
- ‘Treat’ the side effects
- Change to a different antidepressant.
- Change to or add PST.

Strategies for Managing Antidepressant Side Effects

Side effect	Treatment Strategies
Sedation	<ol style="list-style-type: none"> 1. Give medication at bedtime
Orthostatic hypotension /dizziness	<ol style="list-style-type: none"> 1. Consider switching to a different antidepressant 2. Adequate hydration 3. Sit-stand-get up slowly 4. Support hose
Anticholinergic (dry mouth/eyes, constipation, urinary retention, tachycardia)	<ol style="list-style-type: none"> 1. Consider switching to a different antidepressant 2. Hydration 3. Sugarless gum/candy 4. Dietary fiber 5. Artificial tears 6. For confusion – stop medication and rule out other causes
GI distress / nausea (SSRI, SNRIs)	<ol style="list-style-type: none"> 1. This often improves or resolves over 1-2 weeks 2. Take with meals 3. Consider antacids or H2 blockers
Activation / jitters / tremors	<ol style="list-style-type: none"> 1. Start with small doses (especially with underlying anxiety disorder) 2. Reduce dose 3. Try beta blocker (propranolol 10 – 20 mg bid / tid) 4. Consider short term trial of benzodiazepine

Strategies for Managing Antidepressant Side Effects

Side Effect	Treatment Strategies
Headache	<ol style="list-style-type: none">1. Lower dose2. Try acetaminophen
Insomnia	<ol style="list-style-type: none">1. Trazodone 25 – 100 mg po qhs (can cause orthostatic hypotension and priapism)2. Make sure activating antidepressants are taken in a.m.
Sexual dysfunction (SSRI, SNRIs)	<ol style="list-style-type: none">1. May be part of depression or medical disorders2. Consider switch to bupropion or mirtazapine3. Decrease dose4. Try adding bupropion 75 mg qhs or bid
Discontinuation Syndrome (especially paroxetine, venlafaxine)	<ol style="list-style-type: none">1. Taper slowly2. Consider fluoxetine as an alternative

If Patient does NOT improve consider

- Problems with treatment adherence?
- Insufficient dose/duration of treatment?
- Side Effects?
- Wrong Diagnosis?
- Comorbid psychiatric illness?
- Other factors?
 - -psychosocial stressors/barriers
 - -medical problems
 - -psychological barriers
- Initial treatment not effective (eg. Wrong drug)?
- Psychiatric Consultation

Remember

- There are over 20 FDA approved antidepressants
 - All are effective in ~ 50 % of patients
 - it may take several trials until an effective medication is identified for a particular patient
 - Patients need support during this time
- If medications are not effective after 8-10 weeks at a therapeutic dose
 - make sure patient is taking medication as prescribed
 - consult with team psychiatrist
 - a change in treatment plan is likely indicated
 - (e.g., change in medication, augmentation of medication, switch to PST-PC or other depression treatment)

'Plan B'

- Treatment recommendations for partial or non-responses
 - **Augment** initial treatment choice with psychotherapy (e.g., PST-PC) or medication
 - **Switch** to psychotherapy or another antidepressant (especially if NO response in step one)

Guidelines for Switching Antidepressants

- **Switching from SSRI to SSRI:**
 - One can usually switch from one SSRI to another without much difficulty.
- **Switching from SSRI or SNRI to TCA:**
 - Fluoxetine may be abruptly discontinued. TCAs should be increased slowly as the remaining fluoxetine may increase TCA levels.
 - Other SSRIs or SNRIs should be tapered over 1-2 weeks in small increments. A TCA may be started and increased slowly as the SSRI or SNRI is discontinued.
- **Switching from TCA to SSRI:**
 - SSRIs can significantly increase the blood levels of TCAs. Therefore, one should taper a TCA over 1-2 weeks by increments of 25-50 mg q 2-3 days. An SSRI can be started when the dose of a TCA has been significantly reduced or after the TCA is tapered off completely.

When and How to Stop Antidepressants

- Risk of relapse
 - 50% if 1 prior episode
 - 75% if 2 prior episodes
 - 90% if 3 prior episodes
 - Also increased with dysthymia and residual depressive symptoms
- Treat all adults for 4-9 months after initial response
- Treat those at high risk for relapse for 2 years or longer. Some may need lifetime treatment
- Maintenance treatment should be at full dose
- Make a relapse prevention plan
- Taper slowly to avoid discontinuation syndrome

When to Consult Psychiatry

- No response after 8-10 weeks on optimal dose
- Has complicating mental health diagnosis, such as personality disorder
- Bipolar disorder suspected
- Psychosis suspected
- Current substance dependence
- Severe anxiety