Stepped Treatment of Depression 2019

1. Start with your favorite SSRI

Push dose at 1 month if no better

	Initial	Next Step	Max
Fluoxetine (Prozac)	20 mg/d	40 mg/d	80 mg/d
Escitalopram (Lexapro)	10 mg/d	15 mg/d	20 mg/d
Sertraline§ (Zoloft)	50 mg/d	100 mg/d	200 mg/d

§Preferred in pregnancy and lactation

2. If PHQ9 > 5 at 2 months on max dosage of initial SSRI then either Augment or Switch

Augment: Cognitive therapy, IPT, or ACT Therapy

or

Bupropion XL (Wellbutrin XL)

Add 150 mg qd for 3 days
Increase to 300 mg bid
Increase to 450 mg bid starting week 8 if PHQ9 > 5

or

T3 (Cytomel)

Start 25 µg/d for weeks 1, 2, 3, 4
Increase to 50 µg/d

Switch: Taper previous SSRI over 2 weeks and concurrently start new medication

Different SSRI

or

Venlafaxine XR (Effexor XR)

37.5 mg/d for week 1
75 mg/d for week 2
150 mg for week 3, 4, 5
Increase to 225 mg starting week 6 if PHQ9 > 5

or

Bupropion XL (Wellbutrin XL)

Add 150 mg qd for 3 days
Increase to 300 mg bid
Increase to 450 mg bid starting week 8 if PHQ9 > 5

or

Cognitive therapy, IPT, or ACT Therapy

3. If PHQ9 >5 at 4 months consider consultation

Questions to help understand why the patient's depression did not respond to treatment

1. Is the person taking the medication as prescribed? *Not taking antidepressant medication as prescribed is thought to be the most common reason for antidepressant treatment failure.*
2. Have I waited long enough? *Half of the patients who ultimately are in remission by Week 12 will report only limited response by Week 6.*
3. Did I get the diagnosis right? *Antidepressants treat depression. Unfortunately we can confuse substance use, personality disorders, medical disorders, bipolar disorder, psychosocial distress, adjustment reaction, grief, and burn out for depression.*
4. Do I have the right dose of medication? *There is some evidence, and wider acceptance, that higher doses of SSRIs are associated with a higher response rate.*
5. Am I using the right medication? *While all SSRIs seem to have the same response rates, About half of the people who don't respond to the first SSRI they try will respond to a different one.*

Adjuncts to depression therapy

1. Regular exercise helps many people with management of mood and anxiety symptoms (plus it has many other health benefits).
2. Regular sleep can help improve mood, energy, and concentration. For people experiencing insomnia with depression, consider CBT-I, sleep hygiene strategies, or trazodone 50mg qhs prn. Avoid prescribing sedative/hypnotics (benzodiazepines) for insomnia.
3. Developing a plan to enhance social connectedness can reduce isolation and improve mood. Social isolation contributes to and worsens depression.
4. Consider whether substance use is contributing to depression. Alcohol is a common contributor to depression, and mood may improve simply with abstinence from alcohol.
5. There are many smartphone apps that can be used to monitor and treat depression. Some apps target patients, others target clinicians. Examples include My Coping Plan (includes mood monitoring and safety plan development) and Suicide Safe by SAMHSA (provides guidance for suicide risk reduction), but new apps are developed often.

Suicide Concerns

1. Most antidepressants have a black box warning about suicidal ideation. It is important to tell a patient starting an antidepressant that *"Suicidal thinking is a rare but serious potential effect from antidepressant medications. If this happens to you, stop taking the medication and call the clinic to let us know about it. If you feel unsafe, go to the nearest emergency room."*
2. Include a statement about screening for suicide risk in the medical record. Ask about thoughts of suicide or self-harm. If positive, ask about a plan. What would they do and how would they do it? Assess access to means (e.g. pills, firearm) and develop a safety plan for reducing access to means and seeking help if suicidal thoughts occur/persist/worsen.