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Depression Pathway – 2016

Four tips for excellent depression care

TIP #1: Screen for depression. Every adult. Every year.

PHQ-2
Administer to all patients 12+ annually. A positive PHQ-2 screen is a score of 3 or higher. Administer the PHQ-9 to patients who screen positive on the PHQ-2.

PHQ-9
If question 9 (suicide risk) has a score of 1, 2 or 3, review and implement the SMG Suicide Assessment and Management policy.

TIP #2: Stage depression severity with the PHQ-9

A major depressive episode is defined as having five or more of the following symptoms lasting more than two weeks and must include the first **or** second symptom.

- **Depressed mood**
- **Loss of interest/pleasure**
- Insomnia/hypersomnia
- Lack of concentration
- Weight gain/loss
- Feelings of guilt/worthlessness
- Psychomotor agitation/retardation
- Fatigue/lack of energy
- Thoughts of death/suicide

Not due to medical or other psychiatric condition

Code depression based on the PHQ-9

	PHQ-9 score	ICD-10 codes
Mild	10-14	F33.0 and F32.0
Moderate	14-19	F33.1 and F32.1
Severe	20-27	F33.2 and F32.2

TIP #3: Treat to target (remission)!

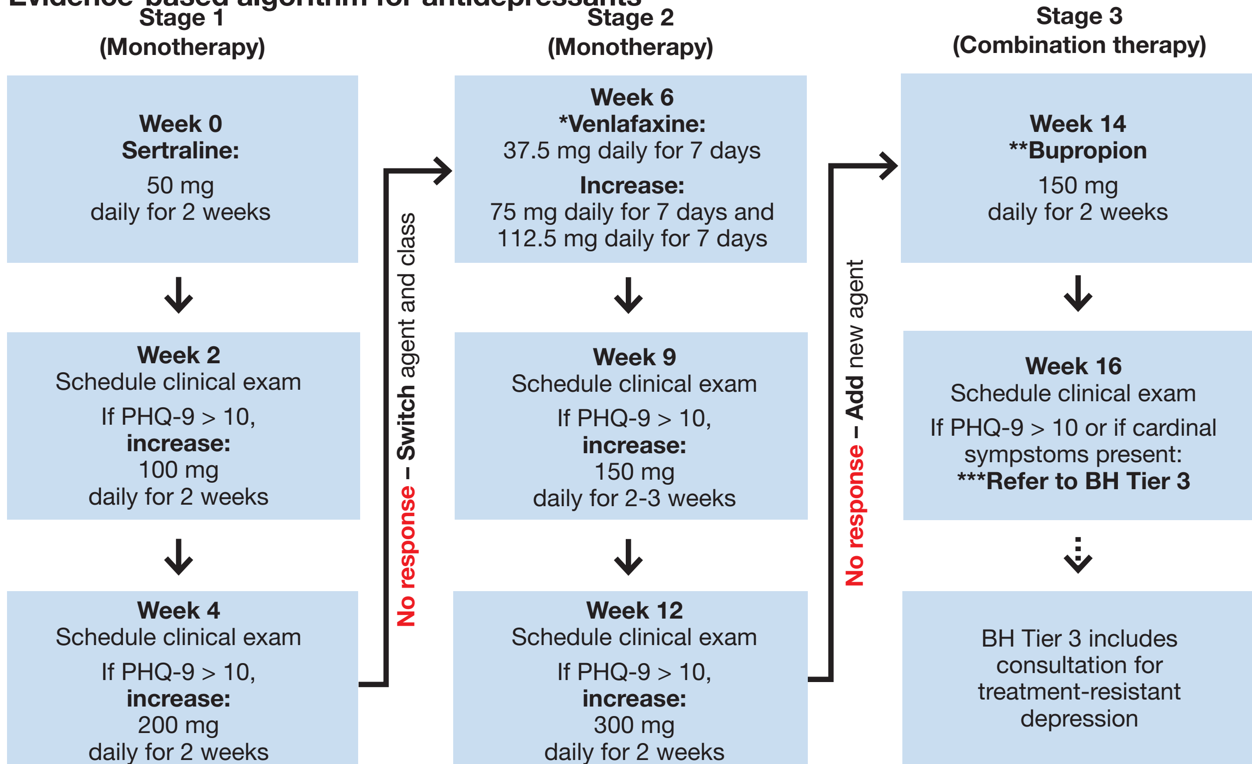
Severity	Mild	Moderate and moderate-severe	Severe
Treatment	Psycho-therapy	Pharmacotherapy with/without psychotherapy	• Pharmacotherapy necessary • Psychotherapy if patient able to participate

Evidence-based antidepressant prescribing tips:

1. Aim to achieve the maximum (target) dose of antidepressant in four to six weeks. Dose adjustments can be made as soon as two weeks based on symptoms, medication adherence and side effects.
2. Recommend follow-up in two to four weeks to re-assess PHQ-9 (target less than 10 or a 50 percent decrease in score).
3. If the symptoms do not respond to anti-depressant treatment at a maximum dose for four to six weeks, consider augmenting or changing treatment.
4. Ensure an adequate trial of antidepressants at the maximum (tolerated) dose before switching agents or augmenting treatment.

Drug class	Generic (trade)	Usual starting dose (mg/day)	Dose range (mg/day)	Max dose (mg/day)	Frequency	Common side effects	CYP P450 inhibition	Cash price
SSRI	Sertraline (Zoloft)	50	50-200	200	Qday	• May be midly activating • Some GI upset in older patients; jitteriness; possibly mild headache	Dose-dependent 2D6 inhibitor; weak 3A4 inhibitor	$
SSRI	Escitalopram (Lexapro)	10	10-20	20	Qday	• Tends to have less side effects and is generally well tolerated	Modest 2D6 inhibitor with 20mg dose	$-$$
SNRI	Venlafazine (Effexor)	75	75-375	375	IR:BID; ER: Qday	• Monitor BP in uncontrolled HTN • Warn patients of abrupt withdrawal symptoms • May have more GI upset than other SSRIs; can increase agitation; jitteriness; possibly mild headache	Weak 2D6 inhibitor	$-IR $$-ER
DNRI	Bupropion (Wellbutrin)	150	300-450	450	IR: BID-TID; SR: BID; XL: Qday	• More stimulating; less sexual side effects; may worsen anxiety and jitteriness • When using the IR formulation, second dose should be taken no later than 2 p.m. Taking it late in the day interferes with sleep. XL formulation is taken all in the morning. • Contraindication: history of seizures or TBI • At higher doses, monitor BP in uncontrolled HTN	2D6 inhibitor	$-IR $$-SR, XL

Evidence-based algorithm for antidepressants



In general, the most common side effects for antidepressants are gastrointestinal upset (nausea) and headaches which tend to resolve over time. Bupropion tends to be more stimulating and have less sexual side effects than SSRIs or SNRIs. See the Mayo Clinic Visual Aid and the AHRQ Clinician Research Summary for a comparison of side effects.

Tapering is not needed when switching from one class to another.

* IR, ER available for Venlafaxine.

** IR, SR and XL available for Bupropion – May cause anxiety in some patients due to its activating properties.

*** Red flags to trigger early referral: psychosis, mixed symptoms and suicidal ideation.

TIP #4: Refer to Behavioral Health

Embedded Behavioral Health (Tier 1) – Some clinics have an embedded behavioral health service, which consists of a combination of behavioral health consultants (BHCs) embedded in primary care clinics, delivering brief, on-demand, behavioral help to patients. Any patient with a problem that has a behavioral component can benefit. When a BHC is on staff, a warm handoff should be made, especially for patients being started on an antidepressant. Referrals are placed in EPIC using **SMG Behavioral Health Counseling* [clinic name].

Consultative Psychiatry (Tier 3) – Offers brief psychiatric consultation for patients. Tier 3 aims to stabilize patients and to return them to primary care for ongoing management. **Patients who are acutely suicidal or homicidal should be evaluated in the ED.** Please refer to the SMG Suicide Assessment and Management Policy. Referrals are placed in EPIC using **SMG Behavioral Health Psychiatry*.

Additional resources

- **Postpartum:** Visit The Lytle Center for Pregnancy and Newborns for more information: http://www.swedish.org/services/pregnancy-and-childbirth/resource-center/lytle-center-resources
- **Geriatric Depression Scale** (short form): https://www.healthcare.uiowa.edu/igec/tools/depression/GDS.pdf

References to evidence-based algorithm for antidepressants:

- 2009 Lancet Depression SSRI Meta Analysis
- 2011 Annals of Internal Medicine – Comparative benefits and harms of second generation antidepressants for treating MDD

Although there is no significant difference in efficacy between second generation antidepressants, the agents cannot be considered identical, especially with regard to side-effect profile and potential drug-interactions. The pathway team selected sertraline and escitalopram based on least potential for side effects, drug interactions and cost.

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