Depression Management Algorithm

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Click here to proceed

Department of Psychiatry,
University of Ottawa
Yes

No

Assess for Major Depressive Disorder

Complex presentation?

Yes

Consider Psychiatry referral or eConsult †

No

Stepped care level 1

Assess severity + Provide handouts

Mild

PHQ-9 5 to 9

(with dysfunction)

Moderate

PHQ-9 10 to 14

Moderately severe

PHQ-9 15 to 19

Severe

PHQ-9 ≥20

Choose one or more of the following options ± SSM *

SSM*  
Patient  Doctor

Medications  Patient

Psychotherapy  Patient

Consider both

Psychotherapy  Meds

Follow up

Refractory to treatment?

Suicidal Risk?

Can be used alone, with medications or while patient awaiting psychotherapy

ǂ Consider starting treatment while awaiting Psychiatry input

SSM * =Supported Self Management
Assess for Major Depressive Disorder:

- Are all criteria met?
- R/O General medical conditions
- R/O Substance abuse
- R/O Possible bipolar disorder
<table>
<thead>
<tr>
<th>Age</th>
<th>Physical exam</th>
<th>CBC</th>
<th>Lytes, BUN, Creatinine Glucose</th>
<th>B12, Folate TSH</th>
<th>Sleep study</th>
<th>Others as appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age &lt;50, healthy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age &lt;50, significant fatigue</td>
<td>✓</td>
<td>✓</td>
<td>?</td>
<td>✓</td>
<td>?</td>
<td>✓</td>
</tr>
<tr>
<td>Age &gt;50</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>?</td>
</tr>
<tr>
<td>Any age, suspected medical illness</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>?</td>
<td>✓</td>
</tr>
</tbody>
</table>
Depression Management Algorithm-Stepped Care Model (Psychotherapy)

(Please click on the blue boxes to obtain the related documents)

Psychotherapy

Does the patient have access to extended benefits/EAP/or resources to access services in community?

- Yes
  - Ottawa Academy of Psychologists

- No
  - Counselling and therapy
  - Other community counselling options
Complex Presentation

If one or more of the following are present, consider the patient’s condition to be complex (Please click on each of the following for more information):

- Suicidal/homicidal risk
- Significant dysfunction (e.g. WSAS >20)
- Possible bipolar disorder
- Substance abuse
- Co-morbid anxiety disorder
- Psychosis
- Personality disorder
- Diagnostic uncertainty
- Refractory to treatment
Assess Severity and Provide Handouts:
(Please click on any of the following to get the relevant handout)

• What is Depression?

• Behavioural Activation

• Assertiveness and communication

• Regular exercise

• Sleep hygiene

• Other Resources
Refractory depression:

Defined as <50% drop in PHQ-9 score after 3 months of antidepressant treatment and/or psychotherapy.

Consider/assess if:

- the diagnosis of depression is appropriate
- there is an undiagnosed medical condition
- there is an undiagnosed substance use
- the patient is adherent to medications
# PHQ-9 based Follow-up of Psychotherapy

## Initial Response to Psychotherapy after Three Sessions over Four - Six weeks

<table>
<thead>
<tr>
<th>PHQ-9 Score</th>
<th>Treatment Response</th>
<th>Treatment Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drop of ≥ 5 points from baseline</td>
<td>Adequate</td>
<td>No treatment change needed. Follow-up in four weeks.</td>
</tr>
<tr>
<td>Drop of 2-4 points from baseline</td>
<td>Probably Inadequate</td>
<td>Possibly no treatment change needed. Share PHQ-9 with psychotherapist.</td>
</tr>
</tbody>
</table>
| Drop of 1-point or no change or increase.        | Inadequate         | • If depression-specific psychological counseling (CBT, PST, IPT*) discuss with therapist, consider adding antidepressant.  
|                                                  |                    | • For patients satisfied in other type of psychological counseling, consider starting antidepressant.  
|                                                  |                    | • For patients dissatisfied in other psychological counseling, review treatment options and preferences |
(Please click on the blue boxes to obtain the related documents)

Follow-up*

- Suicide risk
- Reducing the risk of relapse
- Medications
- Managing S/E of antidepressant
- Disability Assessment
- Psychotherapy

* Guidelines for follow-up
- Recommend follow-up by phone or in person in one week depending upon the severity of the condition and every two weeks thereafter until remission.
- Suicidal patients will need closer follow-up.
- Once remission is achieved, gradually decrease the frequency of follow-ups.
- Consider annual follow-up once stable.
(Please click on the blue boxes to obtain the related documents)

Suicide Risk

C-SSRS-Risk Assessment-Adult

C-SSRS screener*

Triaging Suicide Risk

*If the patient answered “yes” to items # 4, 5, 6 (within the last 3 months) then consider the suicide risk to be high.
# Managing antidepressants side effects

<table>
<thead>
<tr>
<th>Side effects</th>
<th>Treatment Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gastrointestinal symptoms</strong> like nausea &amp; diarrhea</td>
<td>- Wait...&lt;br&gt;- Suggest general measures to manage minor illness, in more severe or prolone cases switching to another antidepressant might be necessary.</td>
</tr>
<tr>
<td><strong>Activating symptoms</strong> like agitation, insomnia and headaches.</td>
<td>- Wait... ...often get better with time.&lt;br&gt;- Try giving in the morning. In severe/more prolong symptoms, use less activating antidepressant.&lt;br&gt;- If very agitated or tremor present consider reducing or stopping the medication.</td>
</tr>
<tr>
<td><strong>Suicidal ideation</strong>&lt;br&gt;(Mostly in ages&lt;25)</td>
<td>Please refer to “Triaging suicidal risk” page</td>
</tr>
<tr>
<td><strong>Sexual side effects</strong>&lt;br&gt;(Reduced libido, anorgasmia, delayed ejaculation, reduced erection quality)</td>
<td>1.-Reducing the dose of antidepressant.&lt;br&gt;2.-Try a different antidepressant from the table like Wellbutrin or Mirtazapine&lt;br&gt;3.- Might consider Sildenafil, Tadalafil if not medically contraindicated&lt;br&gt;4.-Consider adding Wellbutrin for reduced libido</td>
</tr>
<tr>
<td><strong>Activation of mania/hypomania</strong>&lt;br&gt;(~0.1%)</td>
<td>1.-Stop the antidepressant&lt;br&gt;2.-Assess for safety&lt;br&gt;3.-Consult Shared care or refer the pt. to Psychiatry emergency services(PES)</td>
</tr>
</tbody>
</table>
Medication(s) follow-up

Comparison of Common Antidepressants Table which contains links to follow-up of individual antidepressants

For tapering and stopping Antidepressants click here

(Please click on the blue boxes for getting the related document)
Medications

Approach to choosing antidepressants

Comparison of common antidepressants

(Please click on the blue boxes for getting the related document)
Approach to Choosing Antidepressant

(Please click on the blue boxes or underlined words to obtain further information)

Previous response to a particular antidepressant

No

Family history of response to a particular antidepressant

Yes

Consider choosing that antidepressant

No

Choose any SSRI or SNRI unless one of the following conditions apply

- Medical co-morbidity
  - Chronic pain
  - CVS illness
  - Sertraline
    - Duloxetine
    - Venlafaxine
- On multiple Medications
  - Citalopram***
  - Escitalopram***
  - Venlafaxine
  - Desvenlafaxine
  - Vortioxetine
- Age <18
  - Fluoxetine
- Perinatal period
  - Poor sleep/appetite/weight loss
  - Smokers who wish to stop
- - No sexual s/e
- - On multiple Medications
- - CVS illness
- - Sertraline
  - Duloxetine
  - Venlafaxine

Yes

Consider choosing that antidepressant*

* Unless one of the conditions listed at the bottom of this algorithm is considered to be pertinent.

** Please click here to see Comparison of Common Antidepressant Table.

***Avoid combining it with Tamoxifen

Consider choosing Sertraline first; Visit Motherisk.org or call 1-877-439-2744

Mirtazapine

Wellbutrin (unless risk of seizures)
Most guidelines recommend switching to an antidepressant from another class although evidence for this strategy is limited.

To assist with switching consider using the following resources:
- Website: [http://wiki.psychiatrienet.nl/index.php/SwitchAntidepressants](http://wiki.psychiatrienet.nl/index.php/SwitchAntidepressants)
- UpToDate: “Antidepressant medications in adults-switching and discontinuing medication”
Continuation Phase Treatment

- Patient who receive pharmacotherapy during acute phase treatment should continue their treatment for AT LEAST 6 to 9 months after symptom remission, at the same dose that led to a therapeutic response.

- Patients with a first episode of MDD who enter remission should be followed every 3 months for the first year and at the end of 6-9 months should be evaluated for slow tapering and discontinuation of antidepressant medication.

- For those patients with two episodes of major depression consider maintaining antidepressant medication for two years. May also consider indefinite treatment depending upon the clinical situation.

- For those patients who have had 3 or more major depressive episodes consider maintaining antidepressant medication indefinitely.

- Other groups considered at high risk for depression should also be considered for maintenance treatment including those whose depression was:
  - Prolonged
  - Associated with significant functional impairment
  - Associated with significant suicidal ideation
  - Associated with psychotic symptoms

- For patients who were augmented with antipsychotics, consider gradually tapering and discontinuing the antipsychotics after 6-9 months.
Augmentation

Level 1*

Choose either:

- Mirtazapine 30 mg po qhs X 2 weeks. If less than 20% response increase to 45 mg po qhs.
- Or
- Bupropion XL 150 mg po daily X 2 weeks. If less than 20% response increase to 300 mg po daily

- If on either Bupropion or Mirtazapine as an initial agent, consider augmenting with an SSRI or SNRI

Level 2**

Choose either:

- Aripiprazole 2.0 mg po daily X 2 weeks. If less than 20% response increase to 5.0 mg po daily. or
- Quetiapine XR 50 mg po at supper X 1 week, then increase to 100 mg X 1 week and if tolerated then increase it to 150 mg po q supper. If less than 20% response after 2 weeks then increase to 300 mg po q supper

*Evidence – based psychotherapy (CBT or IPT or PST) can also be used as an augmentation strategy instead of medication

** to be used if Level 1 interventions not effective or not tolerated
Critical decision points (CDP) and PHQ-9 based care (for ages 18-65 years)

**CITALOPRAM**

- **Week 1 CDP #1**
  - 10 mg p.o. q.a.m.
  - Increase to 20 mg

- **Week 2 CDP #2**

  - **Remission**
    - If tolerating continue dose from 2 weeks prior
  - **Some improvement**
    - If tolerating continue 20 mg
  - **No improvement**
    - If tolerating consider increase to 30 mg

- **Week 4 CDP #3**

  - **Remission**
    - If tolerating continue dose from 2 weeks prior
  - **Partial response**
    - If tolerating continue same dose or consider increase by 10 mg
  - **Non-response**
    - If tolerating consider increase by 10 mg

- **Week 6 CDP #4**

  - **Remission**
    - If tolerating continue dose from 2 weeks prior
  - **Some improvement**
    - If tolerating consider increase by 10 mg (max. dose 40 mg) or augment
  - **No improvement**
    - If tolerating consider increase by 10 mg (max. dose 40 mg) or augment or switch

- **Week 8 CDP #5**

  - **Remission**
  - **Some improvement**
    - If tolerating consider increase by 10 mg (max. dose 40 mg) or augment
  - **No improvement**

- **Week 10-12 CDP #6-7**

  - **Remission**
  - **Some improvement**
    - If tolerating consider increase by 10 mg (max. dose 40 mg) or augment
  - **No improvement**

**Definitions and notes**

- **Remission**: PHQ-9 <5
- **No Improvement**: No drop in the PHQ-9 score.
- **Some Improvement**: Any drop in the PHQ-9 score.
- **Partial Response**: A drop of 5 points in PHQ-9 score at week 6 compared to score at week 1.
- **Non-response**: A drop of <5 points in PHQ-9 score at week 6 compared to score at week 1.

At CDPs 2, 3, 4, 5, 6 consider switching antidepressants if side effects are intolerable.

Lower doses or less frequent dosage increase may be better for anxious, medically compromised, geriatric patients or for those experiencing tolerable SE.

In cases of non-response reassess diagnosis, check for non-adherence and assess for impact of psychosocial factors.
Critical decision points (CDP) and PHQ-9 based care (for ages 18-65 years)

**DESVENLAFAXINE**

Week 1
- CDP #1
  - 50 mg p.o q a.m.
  - If tolerating continue 50 mg

Week 2
- CDP #2
  - Remission
    - If tolerating continue dose from 2 weeks prior
  - Some improvement
    - If tolerating continue 50 mg
  - No improvement
    - If tolerating consider increase to 100 mg

Week 4
- CDP #3
  - Remission
    - If tolerating continue dose from 2 weeks prior
  - Partial response
    - If tolerating continue same dose or consider increase by 50 mg (max. dose 100 mg) or augment
  - Non-response
    - If tolerating increase by 50 mg (max. dose 100 mg) or augment or switch

Week 6
- CDP #4
  - Remission
    - If tolerating continue dose from 2 weeks prior
  - Some improvement
    - If tolerating increase by 50 mg (max. dose 100 mg) or augment
  - No improvement
    - Augment or switch

Week 8
- CDP #5
  - Remission
    - If tolerating continue dose from 2 weeks prior
  - Some improvement
    - If tolerating increase by 50 mg (max. dose 100 mg) or augment
  - No improvement
    - Augment or switch

Week 10-12
- CDP #6-7
  - Remission
    - If tolerating continue dose from 2 weeks prior
  - Some improvement
    - If tolerating increase by 50 mg (max. dose 100 mg) or augment
  - No improvement
    - Augment or switch

**Definitions and notes**

- Remission: PHQ-9 <5
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- Lower doses or less frequent dosage increase may be better for anxious, medically compromised, geriatric patients or for those experiencing tolerable SE.

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**Critical decision points (CDP) and PHQ-9 based care (for ages 18-65 years)**

**DULOXETINE**

- **Week 1** CDP #1
  - 30 mg p.o. q a.m.
  - Increase to 60 mg

- **Week 2** CDP #2

- **Week 4** CDP #3
  - Remission: If tolerating continue dose from 2 weeks prior
  - Some improvement: If tolerating continue 60 mg
  - No improvement: If tolerating consider increase to 80 mg

- **Week 6** CDP #4
  - Remission: If tolerating continue dose from 2 weeks prior
  - Partial response: If tolerating continue same dose or consider increase by 30 mg
  - Non-response: If tolerating consider increase by 30 mg

- **Week 8** CDP #5
  - Remission: If tolerating continue dose from 2 weeks prior
  - Some improvement: If tolerating consider increase by 30 mg (max. dose 120 mg) or augment
  - No improvement: If tolerating increase by 30 mg (max. dose 120 mg) or augment or switch

- **Week 10-12** CDP #6-7
  - Remission: If tolerating continue dose from 2 weeks prior
  - Some improvement: If tolerating increase by 30 mg (max. dose of 120 mg) or Augment
  - No improvement: If tolerating increase by 30 mg (max. dose of 120 mg) or Augment or switch

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**Definitions and notes**

- **Remission**: PHQ-9 < 5
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- **Non-response**: A drop of <5 points in PHQ-9 score at week 6 compared to score at week 1

At CDPs 2, 3, 4, 5, 6 consider switching antidepressants if side effects are intolerable.

Lower doses or less frequent dosage increase may be better for anxious, medically compromised, geriatric patients or for those experiencing tolerable SE.

In cases of non-response reassess diagnosis, check for non-adherence and assess for impact of psychosocial factors.
Critical decision points (CDP) and PHQ-9 based care (for ages 18-65 years)

**Definitions and notes**

**Remission:** PHQ-9 < 5

**No Improvement:** No drop in the PHQ-9 score.

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**Non-response:** A drop of <5 points in PHQ-9 score at week 6 compared to score at week 1

At CDPs 2, 3, 4, 5, 6 consider switching antidepressants if side effects are intolerable.

Lower doses or less frequent dosage increase may be better for anxious, medically compromised, geriatric patients or for those experiencing tolerable SE.

In cases of non-response reassess diagnosis, check for non-adherence and assess for impact of psychosocial factors.

**Escitalopram**

5 mg p.o. q a.m.

Increase to 10 mg

**Week 1 CDP #1**

**Week 2 CDP #2**

**Week 4 CDP #3**

**Remission:** If tolerating continue dose from 2 weeks prior

**Some Improvement:** If tolerating continue 10 mg

**No Improvement:** If tolerating consider increase to 15 mg

**Week 6 CDP #4**

**Remission:** If tolerating continue dose from 2 weeks prior

**Partial response:** If tolerating continue same dose or consider increase by 5 mg

**Non-response:** If tolerating consider increase by 5 mg

**Week 8 CDP #5**

**Remission:** If tolerating continue dose from 2 weeks prior

**Some improvement:** If tolerating consider increase by 5 mg (max. dose 20 mg) or augment

**No improvement:** If tolerating increase by 10 mg (max. dose of 20 mg) or augment or switch

**Week 10-12 CDP #6-7**

**Remission:** If tolerating continue dose from 2 weeks prior

**Some improvement:** If tolerating consider increase by 5 mg (max. dose of 20 mg) or augment

**No improvement:** If tolerating increase by 5 mg (max. dose of 20 mg) or augment or switch
Critical decision points (CDP) and PHQ-9 based care (for ages 18-65 years)

**FLUOXETINE**

- Week 1 CDP #1
  - 10 mg p.o. q.a.m.
- Week 2 CDP #2
  - Increase to 20 mg
- Week 4 CDP #3
  - Remission: If tolerating, continue dose from 2 weeks prior
  - Some improvement: If tolerating, continue 20 mg
  - No improvement: If tolerating, consider increasing to 30 mg
- Week 6 CDP #4
  - Remission: If tolerating, continue dose from 2 weeks prior
  - Partial response: If tolerating, continue same dose or consider increasing by 10 mg
  - Non-response: If tolerating, consider increasing by 10 mg
- Week 8 CDP #5
  - Remission: If tolerating, continue dose from 2 weeks prior
  - Some improvement: If tolerating, consider increasing by 10 mg (max. dose 40 mg) or augment
  - No improvement: If tolerating, consider increasing by 10 mg (max. dose 40 mg) or augment or switch
- Week 10-12 CDP #6-7
  - Remission: If tolerating, continue dose from 2 weeks prior
  - Some improvement: If tolerating, consider increasing by 10 mg (max. dose 40 mg) or augment
  - No improvement: If tolerating, consider increasing by 10 mg (max. dose 40 mg) or augment or switch

Remission: PHQ-9 < 5
No Improvement: No drop in the PHQ-9 score.
Partial Response: A drop of 5 points in PHQ-9 score at week 6 compared to score at week 1
Non-response: A drop of < 5 points in PHQ-9 score at week 6 compared to score at week 1

At CDPs 2, 3, 4, 5, 6 consider switching antidepressants if side effects are intolerable.
Lower doses or less frequent dosage increase may be better for anxious, medically compromised, geriatric patients or for those experiencing tolerable SE.

In cases of non-response reassess diagnosis, check for non-adherence and assess for impact of psychosocial factors.
Critical decision points (CDP) and PHQ-9 based care (for ages 18-65 years)

**FLUVOXAMINE**

50 mg p.o. q hs.

Increase to 100 mg

**Remission**
If tolerating continue dose from 2 weeks prior

**Some improvement**
If tolerating continue 100 mg

**No improvement**
If tolerating consider increase to 150 mg

**Remission**
If tolerating continue dose from 2 weeks prior

**Partial response**
If tolerating continue same dose or consider increase by 50 mg

**Non-response**
If tolerating consider increase by 50 mg
(max. dose of 200 mg) or augment

**Remission**
If tolerating continue dose from 2 weeks prior

**Some improvement**
If tolerating consider increase by 50 mg
(max. dose of 200 mg) or augment or switch

**No improvement**
If tolerating consider increase by 50 mg
(max. dose of 200 mg) or augment or switch

**Remission**
If tolerating continue dose from 2 weeks prior

**Some improvement**
If tolerating consider increase by 50 mg
(max. dose of 200 mg) or augment

**No improvement**
If tolerating consider increase by 50 mg
(max. dose of 200 mg) or augment or switch

**Remission**
If tolerating continue dose from 2 weeks prior

**Some improvement**
If tolerating consider increase by 50 mg
(max. dose of 200 mg) or augment

**No improvement**
If tolerating consider increase by 50 mg
(max. dose of 200 mg) or augment or switch

**Remission**
If tolerating continue dose from 2 weeks prior

**Some improvement**
If tolerating consider increase by 50 mg
(max. dose of 200 mg) or augment

**No improvement**
If tolerating consider increase by 50 mg
(max. dose of 200 mg) or augment or switch

**Remission**
PHQ-9 <5

**No Improvement**: No drop in the PHQ-9 score.

**Partial Response**: A drop of 5 points in PHQ-9 score at week 6 compared to score at week 1

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At CDPs 2, 3, 4, 5, 6 consider switching antidepressants if side effects are intolerable.

Lower doses or less frequent dosage increase may be better for anxious, medically compromised, geriatric patients or for those experiencing tolerable SE.

In cases of non-response reassess diagnosis, check for non-adherence and assess for impact of psychosocial factors.
**Critical decision points (CDP) and PHQ-9 based care (for ages 18-65 years)**

**Mirtazapine**

- Week 1 CDP #1
  - 30 mg p.o qhs
  - Continue 30 mg

- Week 2 CDP #2
  - Remission
    - If tolerating continue dose from 2 weeks prior
  - Some improvement
    - Continue 30 mg
  - No improvement
    - If tolerating consider increase to 45 mg

- Week 4 CDP #3
  - Remission
    - If tolerating continue dose from 2 weeks prior
  - Partial response
    - If tolerating continue same dose or increase by 15 mg (max. dose 45 mg) or augment
  - Non-response
    - If tolerating consider increase by 15 mg (max. dose of 45 mg) or augment or switch

- Week 6 CDP #4
  - Remission
    - If tolerating continue dose from 2 weeks prior
  - Partial response
    - If tolerating continue same dose or increase by 15 mg (max. dose of 45 mg) or augment
  - Non-response
    - If tolerating consider increase by 15 mg (max. dose of 45 mg) or augment or switch

- Week 8 CDP #5
  - Remission
    - If tolerating continue dose from 2 weeks prior
  - Some improvement
    - If tolerating consider increase by 15 mg (max. dose of 45 mg) or augment
  - No improvement
    - If tolerating consider increase by 15 mg (max. dose of 45 mg) or augment or switch

- Week 10-12 CDP #6-7
  - Remission
    - If tolerating continue dose from 2 weeks prior
  - Some improvement
    - Augment
  - No improvement
    - Augment or switch

**Definitions and notes**

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- **Non-response**: A drop of <5 points in PHQ-9 score at week 6 compared to score at week 1

At CDPs 2, 3, 4, 5, 6 consider switching antidepressants if side effects are intolerable.

Lower doses or less frequent dosage increase may be better for anxious, medically compromised, geriatric patients or for those experiencing tolerable SE.

In cases of non-response reassess diagnosis, check for non-adherence and assess for impact of psychosocial factors.
**Critical decision points (CDP) and PHQ-9 based care (for ages 18-65 years)**

**Paroxetine**

- **Week 1 CDP #1**
  - 10 mg p.o. q.a.m.
  - Increase to 20 mg

- **Week 2 CDP #2**

- **Week 4 CDP #3**
  - Remission: If tolerating continue dose from 2 weeks prior
  - Some improvement: If tolerating continue 20 mg
  - No improvement: If tolerating consider increase to 30 mg

- **Week 6 CDP #4**
  - Remission: If tolerating continue dose from 2 weeks prior
  - Partial response: If tolerating continue same dose or consider increase by 10 mg
  - Non-response: If tolerating consider increase by 10 mg

- **Week 8 CDP #5**
  - Remission: If tolerating continue dose from 2 weeks prior
  - Some improvement: If tolerating increase by 10 mg (max. dose 40 mg) or augment
  - No improvement: Consider increase by 10 mg (max. dose 40 mg) or augment or switch

- **Week 10-12 CDP #6-7**
  - Remission: If tolerating continue dose from 2 weeks prior
  - Some improvement: If tolerating increase by 10 mg (max. dose 40 mg) or augment
  - No improvement: If tolerating consider increase by 10 mg or augment

**Definitions and notes**

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At CDPs 2, 3, 4, 5, 6 consider switching antidepressants if side effects are intolerable.

Lower doses or less frequent dosage increase may be better for anxious, medically compromised, geriatric patients or for those experiencing tolerable SE.

In cases of non-response reassess diagnosis, check for non-adherence and assess for impact of psychosocial factors.
Critical decision points (CDP) and PHQ-9 based care (for ages 18-65 years)

Sertraline

25 mg p.o. q a.m.

Increase to 50 mg

Week 1
CDP #1

Week 2
CDP #2

Week 4
CDP #3

Week 6
CDP #4

Remission

If tolerating continue dose from 2 weeks prior

Remission

If tolerating continue the same dose or consider increase by 50 mg

Remission

If tolerating continue dose from 2 weeks prior

Remission

If tolerating consider increase by 50 mg (max. dose 200 mg)

Remission

If tolerating consider increase by 50 mg or augment or switch

Some Improvement

If tolerating continue 50 mg p.o. q a.m.

Partial response

If tolerating consider increase by 50 mg

Remission

Some Improvement

If tolerating consider increase by 50 mg (max. dose 200 mg) or augment

Remission

Some Improvement

If tolerating, consider increase by 50 mg or augment or switch (max. dose 200 mg) or augment

No Improvement

If tolerating consider increase to 100 mg

Non-response

If tolerating consider increase by 50 mg

No improvement

If tolerating consider increase by 50 mg or augment or switch

Definitions and notes

Remission: PHQ-9 <5

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Non-response: A drop of <5 points in PHQ-9 score at week 6 compared to score at week 1

At CDPs 2, 3, 4, 5, 6 consider switching antidepressants if side effects are intolerable.

Lower doses or less frequent dosage increase may be better for anxious, medically compromised, geriatric patients or for those experiencing tolerable SE.

In cases of non-response reassess diagnosis, check for non-adherence and assess for impact of psychosocial factors.
### Critical decision points (CDP) and PHQ-9 based care (for ages 18-65 years)

**VENLAFAXINE**

- **Week 1 CDP #1**
  - 37.5 mg p.o. q.a.m.
  - Increase to 75 mg

- **Week 2 CDP #2**
- **Week 4 CDP #3**
  - Remission: If tolerating continue dose from 2 weeks prior
  - Some improvement: If tolerating continue 75 mg
  - No improvement: If tolerating consider increase to 150 mg

- **Week 6 CDP #4**
  - Remission: If tolerating continue dose from 2 weeks prior
  - Partial response: If tolerating same dose or consider increase by 75 mg
  - Non-response: If tolerating consider increase by 75 mg

- **Week 8 CDP #5**
  - Remission: If tolerating continue dose from 2 weeks prior
  - Some improvement: If tolerating consider increase by 75 mg (max. dose is 225 mg) or augment****
  - No improvement: If tolerating consider increase by 75 mg (max. dose is 225 mg) or augment or switch

- **Week 10-12 CDP #6-7**
  - Remission: If tolerating continue dose from 2 weeks prior
  - Some improvement: If tolerating consider increase by 75 mg (max. dose is 225 mg) or augment****
  - No improvement: If tolerating increase by 75 mg (max. dose is 225 mg) or augment or switch

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**Definitions and notes**

- **Remission**: PHQ-9 <5
- **No Improvement**: No drop in the PHQ-9 score.
- **Partial Response**: A drop of 5 points in PHQ-9 score at week 6 compared to score at week 1
- **Non-response**: A drop of <5 points in PHQ-9 score at week 6 compared to score at week 1

At CDPs 2, 3, 4, 5, 6 consider switching antidepressants if side effects are intolerable.

Lower doses or less frequent dosage increase may be better for anxious, medically compromised, geriatric patients or for those experiencing tolerable SE.

In cases of non-response reassess diagnosis, check for non-adherence and assess for impact of psychosocial factors.

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**Some Improvement**: Any drop in the PHQ-9 score.
Critical decision points (CDP) and PHQ-9 based care (for ages 18-65 years)

VORLIXETINE

10 mg p.o. q a.m.

If tolerating continue 10 mg

Remission

If tolerating continue dose from 2 weeks prior

Remission

If tolerating continue dose from 2 weeks prior

Remission

If tolerating continue 10 mg (max. dose 20 mg) or augment

Remission

If tolerating continue dose from 2 weeks prior

Some improvement

If tolerating continue 10 mg

Some improvement

If tolerating consider increase by 10 mg (max. dose 20 mg) or augment or switch

Some improvement

Augment

Non-improvement

If tolerating consider increase to 20 mg

Non-response

If tolerating increase by 10 mg (max. dose 20 mg) or augment or switch

Non-response

Augment or switch

Remission: PHQ-9 <5

No Improvement: No drop in the PHQ-9 score.

Partial Response: A drop of 5 points in PHQ-9 score at week 6 compared to score at week 1

Non-response: A drop of <5 points in PHQ-9 score at week 6 compared to score at week 1

Definitions and notes

Some Improvement: Any drop in the PHQ-9 score.

At CDPs 2, 3, 4, 5, 6 consider switching antidepressants if side effects are intolerable.

Lower doses or less frequent dosage increase may be better for anxious, medically compromised, geriatric patients or for those experiencing tolerable SE.

In cases of non-response reassess diagnosis, check for non-adherence and assess for impact of psychosocial factors.
Critical decision points (CDP) and PHQ-9 based care (for ages 18-65 years)

### BUPROPION

**Week 1**
- CDP #1
  - Bupropion XL 150 p.o. q a.m.
  - If tolerating continue 150 mg

**Week 2**
- CDP #2
  - Remission: If tolerating continue dose from 2 weeks prior
  - Some improvement: If tolerating continue 150 mg
  - No improvement: If tolerating consider increase to 300 mg

**Week 4**
- CDP #3
  - Remission: If tolerating continue dose from 2 weeks prior
  - Some improvement: If tolerating continue same dose or consider increase by 150 mg (max. dose of 300 mg)
  - No improvement: If tolerating consider increase by 150 mg (max. dose 300 mg) or augment or switch

**Week 6**
- CDP #4
  - Remission: If tolerating continue dose from 2 weeks prior
  - Partial response: If tolerating consider increase by 150 mg (max. dose 300 mg) or augment
  - Non-response: If tolerating increase by 150 mg (max. dose 300 mg) or augment or switch

**Week 8**
- CDP #5
  - Remission: If tolerating continue dose from 2 weeks prior
  - Some improvement: If tolerating consider increase by 150 mg (max. dose 300 mg) or augment
  - No improvement: If tolerating increase by 150 mg (max. dose 300 mg) or augment or switch

**Week 10-12**
- CDP #6-7
  - Remission: If tolerating continue dose from 2 weeks prior
  - Some improvement: Augment
  - No improvement: Augment or switch

---

**Definitions and notes**

**Remission**: PHQ-9 < 5

**No Improvement**: No drop in the PHQ-9 score.

**Partial Response**: A drop of 5 points in PHQ-9 score at week 6 compared to score at week 1

**Non-response**: A drop of <5 points in PHQ-9 score at week 6 compared to score at week 1

At CDPs 2, 3, 4, 5, 6 consider switching antidepressants if side effects are intolerable.

Lower doses or less frequent dosage increase may be better for anxious, medically compromised, geriatric patients or for those experiencing tolerable SE.

In cases of non-response reassess diagnosis, check for non-adherence and assess for impact of psychosocial factors.
Increasing/Maximizing antidepressant dose:

Do not increase/maximize the antidepressant dose if:

- There are significant side effects
- Significant risk of drug interactions
- Lower doses or less frequent dosage increase may be better for anxious or medically compromised patients
### COMPARISON OF COMMON ANTIDEPRESSANTS WITH S/E (for ages 18-65 years)

(Check on the name of the Antidepressant to see its follow-up and dose increase algorithm)

<table>
<thead>
<tr>
<th>NAME OF ANTIDEPRESSANT</th>
<th>STARTING DOSE</th>
<th>INITIAL TARGET DOSE</th>
<th>MAX DOSE</th>
<th>ANTICHOLINERGIC</th>
<th>SEDATION</th>
<th>INSOMNIA/AGITATION</th>
<th>ORTHOSTATIC HYPOTENSION</th>
<th>QT</th>
<th>GI</th>
<th>WEIGHT GAIN</th>
<th>SEXUAL</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SSRI'S</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Citalopram</td>
<td>10</td>
<td>20</td>
<td>40</td>
<td>0</td>
<td>0</td>
<td>1+</td>
<td>1+</td>
<td>1+</td>
<td>1+</td>
<td>1+</td>
<td>3+</td>
<td>Watch for QTc prolongation at doses &gt;40 mg/day</td>
</tr>
<tr>
<td>Escitalopram</td>
<td>5</td>
<td>10</td>
<td>20 (30*)</td>
<td>0</td>
<td>0</td>
<td>1+</td>
<td>1+</td>
<td>1+</td>
<td>1+</td>
<td>1+</td>
<td>3+</td>
<td>Escitalopram(Cipralex) is the S-isomer of Citalopram.</td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>10</td>
<td>20</td>
<td>80</td>
<td>0</td>
<td>0</td>
<td>2+</td>
<td>1+</td>
<td>1+</td>
<td>1+</td>
<td>1+</td>
<td>3+</td>
<td>Longer half life so preferable in teenagers but for the same reason caution in the elderly. Also watch for drug-drug interactions.</td>
</tr>
<tr>
<td>Sertraline</td>
<td>25</td>
<td>50</td>
<td>200</td>
<td>0</td>
<td>1+</td>
<td>2+</td>
<td>1+</td>
<td>0  to 1+</td>
<td>2+</td>
<td>1+</td>
<td>3+</td>
<td>May be used in panic d/o, consider in peripatum period.</td>
</tr>
<tr>
<td>Paroxetine</td>
<td>10</td>
<td>20</td>
<td>50</td>
<td>1+</td>
<td>1+</td>
<td>1+</td>
<td>2+</td>
<td>0  to 1+</td>
<td>1+</td>
<td>2+</td>
<td>4+</td>
<td>Watch for significant discontinuation syndrome and drug-drug interactions. Avoid in elderly and pregnancy.</td>
</tr>
<tr>
<td>Vortioxetine</td>
<td>5</td>
<td>10</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0  to 1+</td>
<td>2+</td>
<td>2+</td>
<td>0</td>
<td>Sexual S/E are dose dependent. Cross over when switching.</td>
</tr>
<tr>
<td>Fluvoxamine</td>
<td>50</td>
<td>100</td>
<td>300</td>
<td>0</td>
<td>1+</td>
<td>1+</td>
<td>1+</td>
<td>0  to 1+</td>
<td>1+</td>
<td>1+</td>
<td>3+</td>
<td>Significant GI side effects.</td>
</tr>
<tr>
<td><strong>SNRI'S</strong></td>
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</tr>
<tr>
<td>Venlafaxine XR</td>
<td>37.5</td>
<td>75</td>
<td>225</td>
<td>0</td>
<td>1+</td>
<td>2+</td>
<td>0</td>
<td>1+</td>
<td>1+</td>
<td>0</td>
<td>3+</td>
<td>May increase blood pressure! Watch for significant discontinuation syndrome.</td>
</tr>
<tr>
<td>Desvenlafaxine</td>
<td>50</td>
<td>50</td>
<td>100</td>
<td>0</td>
<td>1+</td>
<td>2+</td>
<td>0</td>
<td>0  to 1+</td>
<td>1+</td>
<td>0</td>
<td>3+</td>
<td>May increase blood pressure! Watch for significant discontinuation syndrome.</td>
</tr>
<tr>
<td>Duloxetine</td>
<td>30</td>
<td>60</td>
<td>120</td>
<td>0</td>
<td>0</td>
<td>2+</td>
<td>0</td>
<td>0  to 2+</td>
<td>0</td>
<td>0</td>
<td>3+</td>
<td>Also approved for several pain conditions.</td>
</tr>
<tr>
<td><strong>NDRI</strong></td>
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<td></td>
</tr>
<tr>
<td>Bupropion XL</td>
<td>150</td>
<td>300</td>
<td>300</td>
<td>0</td>
<td>0</td>
<td>2+</td>
<td>0</td>
<td>1+</td>
<td>1+</td>
<td>0</td>
<td>0</td>
<td>Avoid in those prone to seizures and in Eating d/o.</td>
</tr>
<tr>
<td><strong>NaSSA</strong></td>
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<td></td>
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</tr>
<tr>
<td>Mirtazapine</td>
<td>30</td>
<td>30</td>
<td>45</td>
<td>1+</td>
<td>4+</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1+</td>
<td>0</td>
<td>4+</td>
<td>Significant sedation and weight gain.</td>
</tr>
</tbody>
</table>

*Above the Health Canada maximum dose. Consider in selected cases with input from Psychiatry when possible.
Increasing/Maximizing antidepressant dose:

Do not increase/maximize the antidepressant dose if:

- There are significant side effects or drug allergies
- Significant risk of drug interactions
- Lower doses or less frequent dosage increase may be better for anxious or medically compromised patients
Tapering and stopping

• For assistance with tapering and stopping an antidepressant, go to:
  http://wiki.psychiatrienet.nl/index.php/SwitchAntidepressants
  and locate the ‘Stop’ column for respective medication.

  ➢ Withdrawal from Paroxetine, Venlafaxine and Desvenlafaxine can be more difficult. Once at lowest dose, consider substituting Fluoxetine 10-20 mg. Once the withdrawal symptoms have abated, continue Fluoxetine 10 mg for 1-2 weeks and then discontinue.
Computer Requirements

- Microsoft Windows
- 128MB of RAM (256MB recommended for complex forms or large documents)
- 110MB of available hard-disk space
- Minimum of Microsoft Internet Explorer 6.0 or 7.0, Firefox 1.5 or 2.0, Mozilla 1.7, AOL 9
- Broadband Internet connection
- Currently this Algorithm does not support IMac, Ios(Apple) or Android devices