ECHO: Treating Depression at Primary Care Settings, Part 2 Treatment

December 1, 2020

Why Treat Adults with Depression in a Primary Care Setting?

- **Depression is one of the leading causes of disability and impaired quality of life.**
- **Depression is an independent risk factor for the development of multiple major medical disorders.**
- **Coexisting depression is associated with treatment resistance and failure with multiple medical disorders.**
- Longer duration of untreated depression is associated with:
  - More severe symptoms,
  - More problematic behaviors,
  - Resistance to mental health treatments.
- **Depression comorbid with common medical disorders escalates treatment costs.**

Primary Care Treatment of Depression: Most Recent Guideline

- Alongside or before prescribing any form of treatment, consideration should be given to the implementation of **strategies to manage stress, ensure appropriate sleep hygiene and enable uptake of healthy lifestyle changes.** See Appendix for sleep hygiene handouts.
- **For mild to moderate depression, psychological management alone is an appropriate first line treatment, especially early in the course of illness.**
- **For moderate to severe depression, pharmacological management is usually necessary and is recommended first line, ideally in conjunction with psychosocial interventions.**

Malhi, Outhred, Hamilton et al., 2018

Involve Your Patient in the Treatment of Depression

- **Exercise:** (Josefsson, Lindwall, Archer, 2014)
- **Socialize**: Visit friends and or family, call friends or family or use mental health care coordinator, or find a helpful group.
- **Reduce stress:**
  - Learn relaxation methods and stress reduction techniques.
  - Simplify your life
  - Write in a journal
  - Structure your time.
- If not in therapy or using a mental health app, read reputable self help books (See Appendix for my suggestions).
- Don't make important decisions, especially about your medication or treatment when you are down.

https://www.mayoclinic.org/diseases-conditions/depression/symptoms-causes/syc-20356007

Aerobic Exercise Alleviates Depressive Symptoms Among Patients with Chronic Illness

- Objective: To assess whether aerobic exercise was superior to usual care in alleviating depressive symptoms in patients living with a major non-communicable disease.
- Results: Twenty-four studies were included (4111 patients).
- Aerobic exercise (short sessions 2-3 times per week) alleviated depressive symptoms better than did usual care.
- Conclusion: **Aerobic exercise alleviated depressive symptoms in patients living with a major non-communicable disease**, particularly in cardiac populations.

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Béland, Lavoie, Briand, et al., 2019

If Patients are Willing, Refer to Mental Health Clinicians

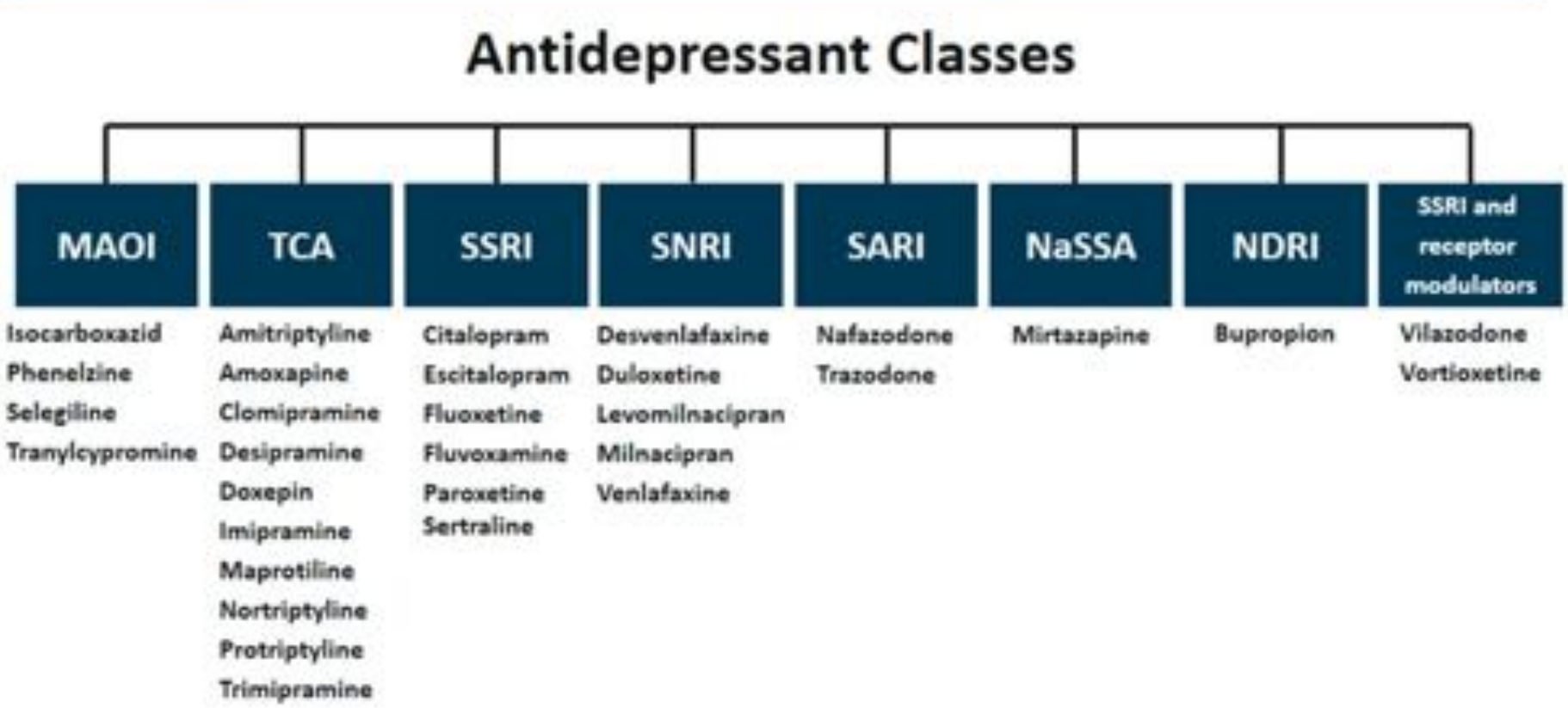
- **Meta-analysis on the effects of treatment with antidepressant medication were compared to the effects of combined pharmacotherapy and psychotherapy in adults with MDD** or anxiety disorder.
- A total of 52 studies (with 3,623 patients), 32 on depressive disorders and 21 on anxiety disorders.
- The overall difference between pharmacotherapy and combined treatment was Hedges' g = 0.43 (95% CI: 0.31-0.56), indicating a **moderately large effect and clinically meaningful difference in favor of combined treatment.**
- There was sufficient evidence that **combined treatment is superior for major depression**, panic disorder, and obsessive-compulsive disorder (OCD).

Cuijpers, Sijbrandij, Koole, Andersson, Beekman, Reynolds, 2014

Combining Psychotherapy with Medication is a Superior Treatment

- **The effects of combined treatment compared with placebo were about twice as large as those of pharmacotherapy compared with placebo only**, underscoring the clinical advantage of combined treatment.
- **The results also suggest that the effects of pharmacotherapy and those of psychotherapy are largely independent from each other**, with both contributing about equally to the effects of combined treatment.
- We conclude that combined treatment appears to be more effective than treatment with antidepressant medication alone in major depression, panic disorder, and OCD.
- These **effects remain strong and significant up to two years after treatment**.
- **Monotherapy with psychotropic medication may not constitute optimal care for common mental disorders** (Cuijpers, Sijbrandij, Koole, Andersson, Beekman, Reynolds, 2014)

Antidepressant Classes and Approaches



First-line treatment is usually an SSRI or an SSRI

Clinicians often try to match medications to the patients' most pressing symptoms, which in turn are presumed to reflect disturbances in dopamine, norepinephrine and serotonin pathways

Thase ME, et al. *J Clin Psychiatry.* 2015;76:720-727.

Right Drug: Shared Decision Making

- Importance: **The translation of evidence of comparative effectiveness of antidepressants into practice is suboptimal. This deficit directly affects depression treatment outcomes and quality of care.**
- To overcome this problem, we developed the Depression Medication Choice (DMC) encounter decision aid, designed to help patients and clinicians consider the available antidepressants and the extent to which they improved depression and other patient important issues.
- Design: cluster randomized trial by which primary care practices were randomly allocated to treatment of depression with or without use of the DMC decision aid.
- Intervention: DMC, a series of cards, each highlighting the effect of the available options on an issue of importance to patients for use during face-to-face consultations

LeBlanc, Herrin, Williams et al., 2015

Shared Decision Making (2)

- Results: Compared to usual care, use of DMC significantly improved patients' decisional comfort, knowledge, satisfaction, and involvement.
- DMC also improved clinicians' decisional comfort and satisfaction.
- There were no differences in encounter duration, medication adherence, or improvement of depression control between arms.
- Conclusion and Relevance: **The DMC decision aid helped primary care clinicians and patients with moderate to severe depression select antidepressants together, improving the decision-making process without extending the visit.**
- Handout of DMC included.

LeBlanc, Herrin, Williams et al., 2015

Only Two Antidepressants Marketed in US Have Evidence to Support Both Superior Efficacy and Tolerability

- **Escitalopram** (Lexapro) **is a SSRI** with FDA approval for the treatment of major depressive disorder (MDD) in adolescents and adults, and generalized anxiety disorder in adults.
- **Escitalopram is generic, 90 day cost from $7 to $43.**
- **Vortioxetine** (Trintellix) **is a novel antidepressant**, clinical action is mediated mainly by selective blockade of serotonin reuptake (by inhibiting the serotonin transporter [SERT]) and direct modulation of 5-HT receptors activity (such as 5-HT_3, 5-HT_7, 5-HT_{1D} and 5-HT_{1B}).
- Approved by the FDA for MDD with recommended dosage range of 5-20 mg/day..
- Vortioxetine is proprietary, a one month supply costs about $254.

Right Dose: SSRI Optimal Dosing

- 77 studies with 19,364 participants; mean age 42·5 years, 60·9% women.
- For SSRIs, the dose-efficacy curve showed a gradual increase up to doses between 20 mg and 40 mg fluoxetine (Prozac) equivalents, and a flat to decreasing trend through the higher licensed doses up to 80 mg fluoxetine equivalents.
- Dropouts due to adverse effects increased steeply through the examined range.
- The relationship between the dose and dropouts for any reason indicated optimal acceptability for the SSRIs in the lower licensed range between 20 mg and 40 mg fluoxetine (Prozac) equivalents (Furukawa, Cipriani, Cowen et al., 2019).
- **The optimal dose of escitalopram** (Luvox) **is 10 to 20 mg daily.**

Using a Depression Symptom Inventory Improves Care

- Outpatients with moderate to severe MDD were consecutively randomized to 24 weeks of either measurement-based care (N=61), or standard treatment (N=59).
- Time to response and remission were the primary endpoints.
- **Significantly more patients in the measurement-based care group achieved response (86.9% compared with 62.7%) and remission (73.8% compared with 28.8%).**
- **Similarly, time to response and remission were significantly shorter with measurement-based care (for response, 5.6 weeks compared with 11.6 weeks, and for remission, 10.2 weeks compared with 19.2 weeks).**
- **CONCLUSIONS: The results demonstrate the feasibility and effectiveness of measurement-based care for outpatients with moderate to severe MDD, suggesting that this approach can be incorporated in the clinical care of patients with major depression.**

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Guo, Xiang, Xiao et al., 2015

Right Duration

- **Use a depression symptom inventory to assess antidepressant treatment response** (Kennedy, Lam, McIntyre, et al., 2016; Rizvi, Grima, Tan et al., 2015).
- If you already using to PHQ-9 for screening, you can also use it to assess treatment response (Zimmerman, Walsh, Bocrescu, Attiullah, 2017).
- **The goal of treatment is remission, a PHQ-9 score of 4 or less.**
- **If the PHQ-9 score falls by 20 to 30 % in the first 2 to 4 weeks, it is likely that the patient will respond to remission within 10 to 14 weeks** (Wagner, Engel, Engelmann et al., 2017).
- A moderately severe initial score is 19, so a decrease to 13 to 15 range within the first four weeks indicates likely remission, stay the course.

Right Duration (2)

- **If the patient has not responded with a 20 to 30% reduction in PHQ-9 by week 4 and is tolerating the medication, a dose increase to the high end of the optimal range is indicated.**
- A moderately severe initial score is 19, a score of 16 to 17 at 4 weeks without complaints of side effects suggests an increase of escitalopram to 20 mg per day.
- **If the patient has not responded with a 20 to 30% reduction in PHQ-9 by week 6 to 8 with an increased dose or the patient cannot tolerate the increased dose, it is time to switch or augment** (Kennedy, Lam, McIntyre, et al., 2016).
- An initial moderately severe score is 19, if the PHQ-9 score is 16 or higher at six to eight weeks indicates time to switch or augment.

Exercise Augments Antidepressant Medication

- 14 eligible studies were retrieved, of which nine had low risk of bias.
- We found **low quality of evidence that exercise as augmentation to treatment as usual has a small effect compared to treatment as usual.**
- **CONCLUSION: In general, exercise appears to be beneficial in the treatment of depression when used in combination with medication.**

Danielsson, Noras, Waern, Carlsson, 2014

- Twenty-two full-text articles were retrieved by the search.
- Among the 13 papers that fulfilled our inclusion criteria, we found methodological weaknesses in the majority.
- However, **the included studies showed a strong effectiveness of exercise combined with antidepressants.**

Mura, Moro, Patten, Carta, 2014

If the First Antidepressant isn't Working or Not Tolerated

- **If there is some response to the first medication (but not to the 20 to 30% level) and the patient is tolerating the medication well, an augmentation is a reasonable option.**
- The best way to assess is to ask the patient: Is this antidepressant helping you enough that you are willing to tolerate the side effects?
- **If there is minimal response to the first antidepressant or if it is not tolerated, switching to a second antidepressant is the best strategy.**
- Once the decision has been made to switch antidepressants due to a lack of efficacy or tolerability problems, there is limited evidence to guide the choice of which new agent to prescribe (Gaynes et al., 2012; Santaguida et al., 2012; Tadic et al., 2016).

Switching Antidepressants

- A meta-analysis found minimal randomized controlled trials that assessed switching after nonresponse and an absence of high-quality data to support switching versus continuing on the same antidepressant (Bschor et al., 2016).
- **Based on current efficacy and tolerability data, vortioxetine** (Trintellix) **is a good option as the switch antidepressant** (Cipriani, Furukawa, Salanti et al., 2018).
- However, vortioxetine is expensive.
- **If a relatively inexpensive antidepressant is a requirement for the second trial, there is evidence for superior efficacy with generic mirtazapine** (Remeron) **($8 to $30 for month's supply) or venlafaxine** (Effexor) **($20 to $50 for a 90 day supply).**
- However, both medications are less tolerable than vortioxetine (Trintellix) or escitalopram (Luvox).

Cipriani, Furukawa, Salanti et al., 2018

Venlafaxine (Effexor) and Mirtazapine (Remeron) Dosing

- Venlafaxine (16 treatment groups) had an initially increasing dose-efficacy relationship up to around 75-150 mg, followed by a more modest increase.
- Mirtazapine (11 treatment groups) efficacy increased up to a dose of about 30 mg and then decreased.
- Both venlafaxine and mirtazapine showed optimal acceptability in the lower range of their licensed dose. These results were robust to several sensitivity analyses.
- **For the most commonly used second-generation antidepressants, the lower range of the licensed dose achieves the optimal balance between efficacy, tolerability, and acceptability in the acute treatment of major depression.**

Furukawa, Cipriani, Cowen, Leucht, Egger, Salanti, 2019

Adequately Treating Most of Your Patients Will Take Two Antidepressant Trials

- **About one-third of patients with MDD achieve remission with an adequate trial of a standard antidepressant after 10 to 14 weeks of treatment** (Trivedi, Rush, Wisniewski, et al., 2006).
- **Remission in half of the patients often required six months of treatment and two antidepressant trials** (Judd, Akiskal, Schettler et al., 2002)

Cognitive Behavioral Therapy (CBT) Works for Patients Who Do Not Respond to Antidepressants

- Pragmatic, multicenter RTC with follow-up at 3, 6, 9 and 12 months.
- A total of 469 patients were randomized (intervention: n = 234; usual care: n = 235), with 422 participants (90%) and 396 (84%) followed up at 6 and 12 months.
- Ninety-five participants (46.1%) in the intervention group met criteria for 'response' at 6 months compared with 46 (21.6%) in the usual-care group.
- Conclusions: **Among patients who have not responded to antidepressants, augmenting usual care with CBT is effective in reducing depressive symptoms.**
- The effects, including outcomes reflecting remission, are maintained over 12 months.
- The intervention was cost-effective. (Wiles, Thomas, Abel et al., 2014).

Develop a Simplified Algorithm:
Treating Depression Does Not Have To Be Complicated

- Choose an SSRI and an antidepressant with a different mechanism.
- **Escitalopram (Luvox) is one of the recommended first line antidepressants for outpatient depression** by The Psychopharmacology Algorithm Project at the Harvard South Shore Program (PAP-HSSP) (Giakoumatos & Osser, 2019).
- Choose a second medication with a different mechanism of action; vortioxetine, (Trintellix), mirtazapine (Remeron) or venlafaxine (Effexor) are my recommendations.
- **Mirtazapine and venlafaxine are two of the recommended first line antidepressants for inpatient depression** by the PAP-HSSP) (Giakoumatos & Osser, 2019).

Develop a Simplified Algorithm (2)

- Determine optimal dosing for the antidepressants.
- **Escitalopram (Luvox) optimal dosing is 10 to 20 mg.**
- **Optimal dosing of venlafaxine (Effexor) is up to 75 -150 mg,**
- **Optimal dosing of mirtazapine is up to 30 mg,**
- **Optimal dosing of vortioxetine (Trintellix), has not been established.**
- Above these limits, no further increase in efficacy for SSRIs or mirtazapine occurred, but there was a slight increase in efficacy for venlafaxine.
- **There was clear dose dependency in dropouts due to adverse effects for all drugs** (Furukawa, Cipriani, Cowen, Leucht, Egger, Salanti, 2019).

Determining the Next Step

- **Over 1/3 of patients with MDD do not have an adequate response to first-line antidepressants.**
- Next step treatment options include **switching to a different antidepressant, combining more than one antidepressant, or augmentation.**
- Which treatment approach should be applied, and in what order remains unclear.
- Only randomized controlled trials were included, resulting in 66 articles.
- This review identified several effective strategies that are currently available.
- Augmentation with certain second generation antipsychotics, such as quetiapine or aripiprazole is effective, and may be preferred over switching to antidepressant monotherapy*.
- Other effective strategies include augmentation with lithium, T3, lamotrigine, or **combination of antidepressants including bupropion**, tricyclics, or mirtazapine.

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Ruberto, Jha and Murrough, 2020

Determining the Next Step* (2)

- There is significant variation among clinical practice guidelines on the use of antipsychotic medication to augment antidepressants, **one point of view is that antipsychotic augmentation is overtreatment*** (Simons, Cosgrove, Shaughnessy, Bursztajn, 2017).
- **A recent meta analysis found an increased mortality risk with antipsychotic augmentation of antidepressants*** (Gerhard, Stroup, Correll et al., 2020).
- Combining Bupropion (Wellbutrin) and escitalopram (Luvox) is a next step approach with recent evidence support (Zuilhof, Norris, Blondeau et al., 2018).

Determining the Next Step (3)

- Department of Veterans Affairs study, a multisite, randomized, single-blind trial of 1,522 patients who did not have an adequate response to antidepressant treatment meeting minimal standards for dosage and duration.
- For 12 weeks, participants received one of three possible next-step treatments**: switch to another antidepressant-sustained-release bupropion; combination with another antidepressant-sustained-release bupropion; or augmentation with an antipsychotic-aripiprazole.**
- Conclusions: Among a predominantly male population with MDD unresponsive to antidepressant treatment, **augmentation with aripiprazole resulted in a statistically significant but only modestly increased likelihood of remission during 12 weeks of treatment.**
- **Given the small effect size and adverse effects associated with aripiprazole, further analysis including cost-effectiveness is needed to understand the net utility of this approach** (Mohamed, Johnson, Chen et al., 2017).

Determining the Next Step (4)

- Data from the U.S. Department of Veterans Affairs (VA) Augmentation and Switching Treatments for Improving Depression Outcomes (VAST-D) study, a multisite, randomized, single-blind trial of 1,522 Veterans Health Administration patients.
- Two features suggested specific next-step treatment selections: **Age ≥65 years** (augmentation with aripiprazole was more effective than switch to bupropion) and **severe mixed hypomanic symptoms** (augmentation with aripiprazole and combination with bupropion were more effective than switch to bupropion).
- **If replicated, these preliminary findings could help clinicians determine which patients with depression requiring next-step treatment will benefit most from a specific augmentation, combination, or switching strategy** (Zisook, Johnson, Tal et al., 2019).

Determining the Next Step (5)

- After 12 weeks, non-remitters on a single drug received the other one in addition.
- Escitalopram could be given up to 40 mg/day and bupropion up to 450 mg/day.
- A 6-month prolongation was then implemented in remitters, maintaining the double-blind design.
- **At week 2, combination treatment was superior in remission rate (5/28) compared with both bupropion (0/26) and escitalopram monotherapies (0/31; *P*=0.03 and *P*=0.02, respectively).**
- **The 6-week augmentation produced remission in 7/21 monotherapy non-remitters and 0/6 in the switch group (*P*=0.13).**
- **Remission was sustained in 28/31 patients enrolled in the 6-month maintenance.**
- These results suggest that combination of escitalopram and bupropion from treatment initiation is superior to either monotherapy in speed of onset.
- **The addition of a second drug in non-remitters can lead to additional remissions, as shown with other combinations of medications.**
- **Treatment prolongation using optimized regimens leads to low relapse rates.**

Zuilhof, Norris, Blondeau et al., 2018

Bipolar Disorder is Difficult to Distinguish From MDD

- **There is growing evidence that major depressive disorder (MDD) might be over diagnosed at the expense of bipolar disorder (BPD).**
- Ten-year prospective longitudinal and family study including 3 follow-up waves.
- Results: Among 488 respondents with MDD, 286 (58.6%) had pure MDD and 202 (**41.4%) had subthreshold BPD.**
- Conclusions: **Data suggest that MDD is a heterogeneous concept including a large group with subthreshold BPD, which is clinically significant and shares similarities with BPD**.
- Findings might support the need for a broader concept and a more comprehensive screening of bipolarity.

Zimmermann, Brückl, Nocon, et al., 2009

Bipolar Disorder II among Primary Care Patients with Depression

- Bipolar disorder is a common, severe mental health condition and a major financial burden for healthcare systems across the globe.
- **There is some evidence that unrecognized bipolar disorder is prevalent amongst patients with depression in primary care which can lead to non-optimal treatment.**
- Ten studies with 3803 participants with depression in primary care.
- The pooled prevalence of bipolar disorder in those with depression was 17% (95% CI = 12 to 22).
- **Over 3 in 20 patients with depression have unrecognized bipolar disorder in primary care which can lead to harmful patient outcomes.**
- **Increased awareness of unrecognition of bipolar disorder in primary care patients with depression and efficient assessment strategies in primary care are warranted.**

Daveney, Panagioti, Waheed, Esmail, 2019

Determining the Next Step (6)

- There is preliminary evidence that **adding bupropion (Wellbutrin) to escitalopram especially among patients with partial response will increase the response rate and the likelihood of remission.**
- There is also preliminary evidence that **seniors (over age 65) and patients with hypomanic symptoms or mood instability who are partially responding or unresponsive to first line antidepressant treatment may respond to second generation antipsychotic augmentation of the first line antidepressant**. However, the increased side effect burden and mortality risk needs to be considered before using this option.
- **Two trials of antidepressants of different mechanism with adequate duration and dose without adequate response (to remission) or stopped because of side effects supports a treatment resistant depression and a referral to a psychiatrist is recommended.**

Right Duration (2)

- **After the patient achieves remission the recommended duration of treatment is six to nine months.**
- Some patients will require longer treatment up to 2 years.
- Factors indicating the need for longer treatment include:
  - Frequent, recurrent episodes
  - Severe episodes (psychosis, severe impairment, suicidality)
  - Chronic episodes
  - Presence of comorbid psychiatric or other medical conditions
  - Presence of residual symptoms
  - Difficult-to-treat episodes

Kennedy, Lam, McIntyre, et al., 2016

Suicide Risk

- **About two-thirds of all patients with depression contemplate suicide and 10% to 15% will attempt suicide** (Maksimowski & Raddock, 2017).

- Even if a patient does not endorse a risk of suicide at the onset of treatment,

- Suicide risk should be assessed regularly and documented.

COVID Depression Update

- Objective: **To estimate the prevalence of depression symptoms among US adults during versus before the COVID-19 pandemic**.
- Design, setting, and participants: This nationally representative survey study used 2 population-based surveys of US adults aged 18 or older.
- During COVID-19, estimates were derived from the COVID-19 and Life Stressors Impact on Mental Health and Well-being study, conducted from March 31, 2020, to April 13, 2020.
- Before COVID-19 estimates were derived from the National Health and Nutrition Examination Survey, conducted from 2017 to 2018.
- Main outcomes: Depression symptoms, defined using the PHQ-9 cutoff of 10 or higher. Categories of depression symptoms were defined as none (score, 0-4), mild (score, 5-9), moderate (score, 10-14), moderately severe (score, 15-19), and severe (score, ≥20).
- Results: the final during-COVID-19 sample included 1441 participants, The pre-COVID-19 sample included 5065 participants (Ettman, Abdalla, Cohen et al., 2020).

COVID Depression Update (2)

- Results: **Depression symptom prevalence was higher in every category during COVID-19 compared with before COVID**.
- Higher risk of depression symptoms during COVID-19 was associated with having lower income, having less than $5000 in savings, and exposure to more stressors.
- Conclusions and relevance: **These findings suggest that prevalence of depression symptoms in the US was more than 3-fold higher during COVID-19 compared with before the COVID-19 pandemic.**
- Individuals with lower social resources, lower economic resources, and greater exposure to stressors (e.g., job loss) reported a greater burden of depression symptoms.
- Post-COVID-19 plans should account for the probable increase in mental illness to come, particularly among at-risk populations (Ettman, Abdalla, Cohen et al., 2020).

COVID Depression Update (3)

- **The increase in population depressive symptom prevalence due to COVID is unprecedented,** similar surveys performed in New York City after 9/11 and Africa during the Ebola epidemic found a doubling of the population depressive symptom prevalence at the height of these crises (Van Beusekom, 2020).
- New York City responded to the 9/11 mental health crisis by developing Project Liberty which provided crisis counseling to 1.5 million affected individuals.
- Dr. Lloyd I. Sederer, the head of NYC's 9/11 response advocates for a similar approach to COVID mental health issues instead of traditional psychotherapy (https://www.medscape.com/viewarticle/928306).

COVID Depression Update (5)

- FEMA has approved grants for 30 states for COVID related Crisis Counseling (https://www.fema.gov/news-release/20200726/fema-administrator-approves-30-states-crisis-counseling).
- COVID in Hawaii has significantly decreased the supply of new psychiatric appointments.
- The supply of new mental health appointments especially through telehealth is still robust and mostly available within 24 hours.
- **Counseling is the most appropriate referral for recent onset depressive symptoms of mild to moderate severity.**

Traumatic Life Events and Thinking Style Are the Largest Determinants of Anxiety and Depression Symptoms

- **Traumatic life events are the single biggest determinant of anxiety and depression.**
- However, **a person's thinking style was as much a factor in the level of anxiety and depression a person experienced as traumatic life events** (Kinderman, Schwannauer, Pontin, Tai, 2013; Kinderman, Tai, Pontin, Schwannauer, Jarman, Lisboa, 2015).
- Relieving trauma associated anxiety and depression can occur early in the course with crisis counseling or
- After the symptoms have become established with psychotherapy, particularly, CBT treatment.

The Evidence Base for the Use of Psychotherapy For Mild to Moderate "COVID" Depression

- **Meta analytic evidence supports that psychotherapy is equivalent to antidepressant treatment for mild to moderate depressive symptoms** (PHQ-9 scores 5 to 14) and is also effective for severe depressive symptoms (Cuijpers, Andersson, Donker, van Straten, 2011).
- Multiple more recent meta analytic studies replicated the findings of **similar effectiveness of CBT to second generation antidepressants across the range of depression severity** (Amick, Gartlehner, Gaynes et al.,2015; Furukawa, Weitz, Tanaka et al., 2017; Gartlehner, Wagner, Matyas et al., 2017).
- A meta analysis found that **antidepressants demonstrated clinical benefit over placebo only at PHQ-9 scores of 20 and above** (Fournier, DeRubeis, Hollon et al., 2010).

Mnemonic for Primary Care Treatment of Depression

- **D**iagnosis: make sure you are treating depression that is appropriate for your practice setting, screen for bipolar depression with MDQ, screen for psychotic symptoms, assess for substance use, assess for Drug Induced Depression.
- **E**xpectations: elicit and shape expectations.
- **T**eam: Use a team approach, use other resources such as care coordination, psychotherapy, and computer and mobile based mental health applications, and include the patient.
- **E**ducate: if the patient understands the why's and how's of your treatment recommendations, they are more likely to follow them.
- **R**ight Drug, **R**ight Dose, **R**ight Duration: use a shared decision model or your own algorithm.
- **S**uicide Risk: assess initially at regular intervals.

Thank You

Contact Us

808-695-7700

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Appendix
Patient Resources

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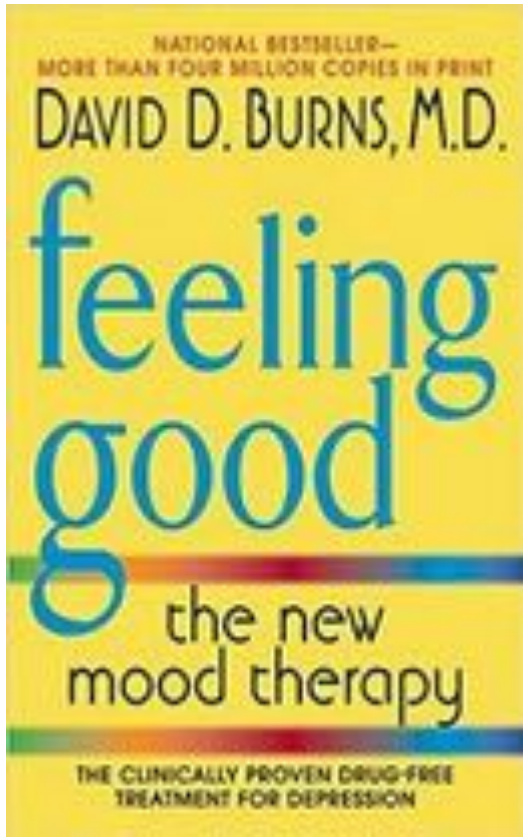
HMSA's Online Care®
call 1 (866) 939-6013 toll-free or
email HOCInfo@hmsa.com.

Self Help for Depression: Evidence Based



I recommend using the book and the workbook together. Available in print form or electronically from $7 to $30 separately depending on the type of media.

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Sleep Hygiene Handouts

https://depts.washington.edu/hcsats/PDF/TF-%20CBT/pages/4%20Emotion%20Regulation%20Skills/Client%20Handouts/Sleep%20hygiene/Sleep%20Hygiene%20Tips.pdf

https://www.cci.health.wa.gov.au/-/media/CCI/Mental-Health-Professionals/Sleep/Sleep---Information-Sheets/Sleep-Information-Sheet---04---Sleep-Hygiene.pdf