

## Prescribing Guidelines for Antidepressants<sup>1-5</sup>

- Use of depression-focused psychotherapy is recommended as an initial treatment option for patients with mild to moderate major depressive disorder, or for women who are pregnant or breastfeeding.<sup>3</sup>
- Psychotherapy always should be strongly considered in combination with pharmacotherapy for patients with moderate to severe major depressive disorder.<sup>3</sup>
- ECT (electroconvulsive therapy) is recommended as a treatment of choice for patients with severe major depressive disorder who are not responsive to psychotherapy and/or pharmacological intervention.<sup>3</sup>
- The patient and caregiver should be informed about the medication therapy, including information on the delay in onset of therapeutic effect, potential side effects, dosing regimen, danger of overdose, any possible drug-drug or drug-food interactions, and early signs of relapse. The patient and caregiver also should understand the importance of taking the medication daily as prescribed and to continue taking it, regardless of symptomatic improvement.
- Effectiveness between and within classes of antidepressants is generally comparable.
- When choosing a first-line antidepressant, some of the factors that should be considered are:
  - Side effects
  - Safety and tolerability
  - Previous response in patient or family member
  - Patient co-morbid conditions, other medications, clinical features and preference
  - Cost.
- Providers should disclose the potential for the emergence and/or worsening of suicidal ideation during antidepressant therapy, particularly for patients below 25 years of age.<sup>4</sup>
- If at least a moderate response has not been seen after two to four weeks of therapy with a therapeutic dose, the treatment plan should be re-evaluated. Medication adherence also should be assessed. Options for non-responders include changing medications, adding psychotherapy, ECT and augmentation.<sup>4,6</sup>
- If a patient is showing a partial response, extend the medication trial to four to six weeks. For patients on modest dosages or who have low serum drug levels despite usual doses, use of higher doses may be helpful. Augmentation per practice guidelines is acceptable. Patients should be treated to remission.
- Side effects should be monitored closely, especially for patients who have had their dose increased. If side effects are intolerable, a period of sub-therapeutic treatment is acceptable. However the goal is to reach therapeutic target levels observed in evidence-based studies. If the intolerable side effects persist, consider a change of medication.
- Patients should continue therapy at the same dosage that produced the therapeutic response for an additional four to nine months after remission (this is known as the “continuation phase treatment”). Schedule regular patient visits and monitor adherence and signs of relapse.
- Maintenance phase treatment should be considered for patients with multiple or severe episodes of depression, residual symptoms between episodes, and/or other co-morbid psychiatric disorders. Side effects and patient preference also should be taken into account.

- Patients who do not require maintenance phase treatment should be slowly tapered off their medication over several weeks.
- **Monitor for suicide:**<sup>1</sup>
  - Educate patients and families on the warning signs of suicide, as well as general suicide prevention strategies (e.g., removal of weapons).
  - Closely monitor patients via weekly office visits in the first few months (supplemented by phone calls between visits for the first two weeks) of medication therapy and after any dosage changes.
  - Monitor for new or more frequent thoughts of suicide, increased anxiety, agitation, aggressiveness or impulsivity, and involuntary restlessness or hypomania.
  - Contact all patients who miss appointments.

*These guidelines are not intended to replace a practitioner's clinical judgment. They are designed to provide information and to assist practitioners with decisions regarding care. The guidelines are not intended to define a standard of care or exclusive course of treatment. Health care practitioners using these guidelines are responsible for considering their patient's particular situation in evaluating the appropriateness of these guidelines.*

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4. Nutt D, et al. International consensus statement on major depressive disorder. *J Clin Psychiatry*. 2010;71 Suppl E1:e08.
5. Suehs B, et al. Texas Medication Algorithm Project Procedural Manual: Major Depressive Disorder Algorithms 2008. Available at [http://www.dshs.state.tx.us/mhprograms/pdf/TIMA\\_MDD\\_Manual\\_080608.pdf](http://www.dshs.state.tx.us/mhprograms/pdf/TIMA_MDD_Manual_080608.pdf) Accessed November 29, 2010.
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