WELCOME to the

Mental Health and Substance Use Part 1
ECHO Session 3

Session will start in less than 15 minutes

Project ECHO®

Dartmouth-Hitchcock

For educational and quality improvement purposes, we will be recording this video-session

By participating in this clinic you are consenting to be recorded –
we appreciate and value your participation

If you have questions or concerns, please email

ECHO@hitchcock.org

Attendance

- Please type your name, organization, and email into chat
- If you joined as a group, please include all the names of those in your group
- Introductions of HUB team

Respect Private Health Information

To protect patient privacy, please only display or say information that doesn't identify a patient or that cannot be linked to a patient.

- **Names:** Please do not refer to a patient's first/middle/last name or use any initials, etc.
- **Locations**: Please do not identify a patient's county, city or town. Instead please use only the patient's state if you must.
- **Dates:** Please do not use any dates (like birthdates, etc) that are linked to a patient. Instead please use only the patient's age(unless > 89)
- **Employment:** Please do not identify a patient's employer, work location or occupation.
- **Other Common Identifiers:** Patient's family members, friends, co-workers, phone numbers, e-mails, etc.

Treating depression

Jules Knight, MD, PhD

Director, Mood Disorders Clinic

Conflict of Interest Disclosure Statement

No Conflicts of Interest

Learning Objectives

- List major categories of treatment options available for depression
- Understand basic principles of antidepressant management
- Describe first steps for managing “treatment resistant” depression
- Name two common neuromodulation treatments

Common treatment options for depression

- Psychotherapy
- Psychotropic medications
- Neuromodulation/Brain Stimulation
- Exercise

Psychotherapy for Depression

- Considered first line management for mild-to-moderate depression

- Types of evidence-based psychotherapies for depression:
  - **Cognitive Behavioral Therapy (CBT)**
  - **Interpersonal Therapy**
  - Cognitive behavioral-analysis system of psychotherapy (CBASP)
  - Dialectical Behavior Therapy

Psychopharmacology:
Basic Principles of Prescribing Antidepressants

- Discuss utility of non-pharmacologic strategies
- Discuss likely outcomes, sx improvement over 3-6 weeks
- For a single episode, Continue treatment for at least 6-9 months after resolution of symptoms
- Withdrawal tx gradually, inform pt of risk and nature of discontinuation symptoms
- Patients with 2 prior episodes and functional impairment should be treated for at least 2 years

Basic Principles of Prescribing Antidepressants

- 20% recover; 30% respond to placebo, and 50 % respond to antidepressants[1]
- NNT for SSRI is 3 over no-treatment control
- Metanalysis has shown robust response of antidepressants over placebo[2]

[1]Anderson et al, J Psychopharmacol, 2008
[2] Cipriani et al. Lancet, 2018; Cipriani et al. Lancet, 2009

Basic Principles of Prescribing Antidepressants

- takes 4-6 weeks for mood to improve after starting an antidepressant (or increasing dose)
- If tolerating starting dose, increase after one week
- Continue dose escalations until minimum effective dose is reached
- May continue escalating dose if partial response & tolerating
- If no response after 1-2 months, *switch* to alternative antidepressant
- If partial response, *add* adjunctive medication

Dosing range for common antidepressants

SSRI	Minimum effective dose	MAX dose
Fluoxetine (Prozac)	20-40 mg	80 mg
Sertraline (Zoloft)	100-150 mg	250 mg
Citalopram (Celexa)	20 mg	40 mg
Escitalopram (Lexapro)	10 mg	20 mg
Fluvoxamine (Luvox)	150 mg	300 mg

SNRI	Minimum effective dose	MAX dose
Duloxetine (Cymbalta)	40 mg	120 mg
Venlafaxine (Effexor)	150-225 mg	375 mg

Other	Minimum effective dose	MAX dose
Buproprion (Wellbutrin)	150-300 mg	450 mg (for XL formulation)
Mirtazapine (Remeron)	30 mg	45 mg
Vilazodone (Viibryd)	40 mg	80 mg
Vortioxetine (Trintellix)	10 mg	20 mg

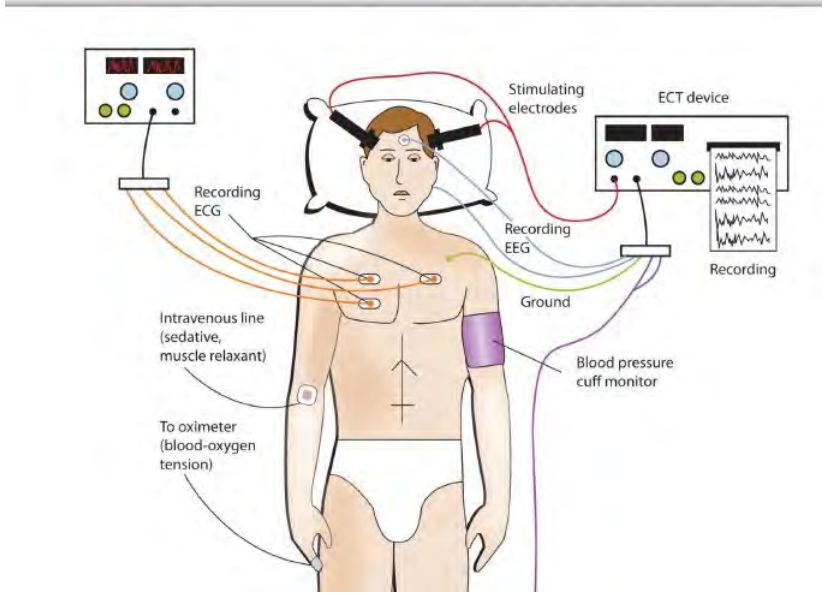
Treatment-Resistant Depression: Approach

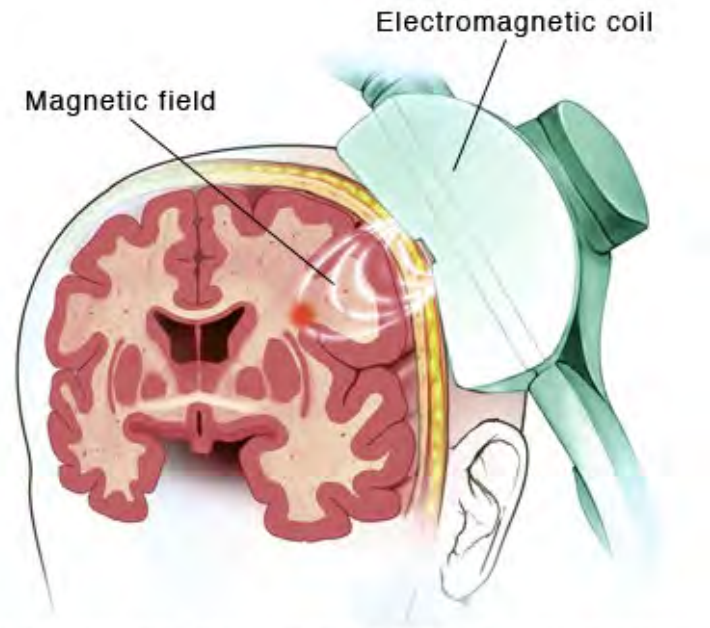
- Re-evaluation diagnosis
- Screen for: SUD, vitamin D deficiency, OSA, personality disorders, bipolar, and PTSD
- Was patient compliant with medications?
- Were past trials “truly” therapeutic trials? (with respect to BOTH time and dose)
- If ‘partial’ responder, best to add adjunctive medication

Adjunctive options for Treatment-resistant depression	Advantages	Disadvantages
Add Lithium	• Well established • Well supported by the literature • Recommended by NICE	• Side effects • Narrow therapeutic window • need for blood level monitoring
Add buspirone	• Well tolerated • Supported by STAR-D • Anxiolytic effects	• Delayed onset of action and long up-titration period
Add T3	• Usually well tolerated • Good literature support	• TFT monitoring
Olanzapine + Fluoxetine combo	• High level of evidence	• Weight gain • Most data relate to bipolar depression
Add quetiapine	• Good evidence base • Usually well tolerated	• Dry mouth, sedation, constipation • Weight gain
Add mirtazapine	• Recommended by NICE • Usually well tolerated • Excellent evidence base	• Theoretical risk of serotonin syndrome • Weight gain
Add aripiprazole	• Good evidence base • Low doses (2-10 mg) may be effective	• Akathisia, restlessness • Weight gain
Add bupropion	• Good evidence base • Generally well tolerated	• Increased anxiety, restlessness/agitation

Neuromodulation

- **Electroconvulsive Therapy (ECT)**
  - Safe & effective
  - appropriate for: treatment resistant, severely ill, acutely suicidal
  - Memory problems occur, but resolve shortly after stopping treatment
- **Transcranial Magnetic Stimulation (TMS)**
  - Non-invasive, well tolerated
  - Better side-effect profile than medications
  - Need to prove ‘treatment resistance’ in order for insurance to cover





Summary: Depression Treatment

- Many different treatment options available
- Treatments help for the majority of patients
- Partial responders and non-responders are managed differently
- Neuromodulation is a good option when medications and psychotherapy have failed
- Depression Management Clinical Treatment Guideline Resource:
  - SUMHI DH: https://med.dartmouth-hitchcock.org/documents/depression-clinical-practice-guideline-brief.pdf

Reminders:

- Next session Sept. 24th – Anxiety (Nisha Baliga, MD)

- Please type your name, organization, and email into chat
- Slides will be posted to the D-H ECHO Connect site
- Please complete post-session survey (link will be emailed)
- Please submit cases