Screening for Depression

- An individual and family mental health history (including any past and current medications) should be included in the intake history
- All women should be screened at least once during pregnancy or postpartum. APEC recommends screening 3 times using the **Edinburgh Postnatal Depression Scale (EDPS) (Appendix 1 full text) at:**
  - The first prenatal visit
  - 24-28 weeks (with the BSST)
  - Postpartum [high-risk at 2 & 6 weeks; average risk at 6 weeks]
- Patients at high-risk for PP depression include those with any prior history of depression or other mental health disorder.

Assessment of EPDS

EPDS score	EPDS 0-9	EPDS 10-13	EPDS 14-18	EPDS ≥ 19
	Limited/no symptoms	*Mild symptoms*	*Moderate symptoms*	*Severe symptoms*
Treatment options			Consider inpatient hospitalization when safety or ability to care for self is a concern	Consider inpatient hospitalization when safety or ability to care for self is a concern
Medication		Consider medication	Recommend medication	Initiate medication
Additional	Counseling therapy Community/social support Physical activity Self-care	Counseling therapy Community/social support Physical activity Self-care	Counseling therapy Community/social support Physical activity Self-care	Refer for psychiatry consult in addition to counseling Community/social support Physical activity Self-care

General Management of Depression

A score of ≥ 10 on the EPDS suggests a patient is depressed.

- Always consider comorbid psychiatric conditions (e.g. psychosis & substance use) and medical causes of depression (e.g. thyroid dysfunction)
- Assess best treatment options for individual patient using table above
- If antidepressant is indicated, screen for bipolar disorder prior to prescribing monotherapy SSRI
- Always refer for psychotherapy (resources below) in addition to medication

Questions to Screen for Bipolar Disorder

Verbally ask these questions prior to starting SSRI monotherapy

Initial screen:

1. Some people have periods lasting several days or longer when they feel much more excited and full of energy than usual. Their minds go too fast. They talk a lot. They are very restless or unable to sit still and they sometimes do things that are unusual for them, such as driving too fast or spending too much money. Have you ever had a period liked this lasting several days or longer?
2. Have you ever had a period lasting several days or longer when most of the time you were so irritable or grouchy that you started arguments, shouted at people, or hit people?

If yes to questions 1 and/or 2, then continue to screen:

3. People who have episodes like this often have changes in their thinking and behavior at the same time, like being more talkative, needing very little sleep, being very restless, going on buying sprees, and behaving in ways they would normally think are inappropriate. Did you ever have any of these changes during your episodes of being excited and full of energy/very irritable or grouchy?

If yes to question 3, the patient may have bipolar disorder; refer to psychiatry

If no to question 3, OK to proceed with SSRI monotherapy

Management of Suicidal Ideation

A positive answer on **question #10** of the EPDS suggests the patient is at risk for self-harm or suicide

- Immediately assess further a positive EPDS #10 or *any* disclosure of suicidal ideation with the Columbia-Suicide Severity Rating Scale (See full text Appendix 2)
- Patients needing additional psychiatric consultation should be immediately evaluated in the Emergency Department or other clinical arena where access to Psychiatric Services are available.

Antidepressant Medical Therapy

Attempt to schedule patient with mental health provider. (Appendix 3 full text) Use these guidelines if you do not have a mental health provider available or while you are attempting to schedule appointment.

- If patient has a history of taking an antidepressant that helped, prescribe that antidepressant
- If no history of taking an antidepressant, use Zoloft (sertraline) as to date there is the most literature and clinical experience with this SSRI. Alternatives are Prozac (fluoxetine) or Celexa (citalopram).
- Start with half the recommended dose for 2 weeks, then increase to recommended dose as tolerated to minimize side effects (e.g. GI disturbance, dizziness, drowsiness)
- A single medication at a higher dose is favored over multiple medications
- Once treatment is initiated, reevaluate using the EPDS and clinical assessment
    - If no/minimal clinical improvement after 4-8 weeks:
        - If patient has no or minimal side effects, increase the dose
        - If has been on therapeutic dose for ≥ 8 weeks without response, consider switching medication versus increasing dose
        - If patient has side effects, switch medication
    - If clinical improvement and no/minimal side effects:
        - Reevaluate every month and at PP visit
        - Refer to PCP or community psych provider for ongoing care at PP visit
- If an antidepressant has helped during pregnancy, continue it during breastfeeding. Sertraline (Zoloft), paroxetine (Paxil), and fluvoxamine (Luvox) are considered the safest during lactation as they have the lowest degree of translactal passage and fewest reported adverse effects compared to other anti-depressants. If starting an SSRI postpartum, choose one of these.

Pharmacologic Agents

First line treatment (SSRIs)			
sertraline (Zoloft) 50-200 mg Increase in 50 mg increments	fluoxetine (Prozac) 20-60 mg Increase in 10 mg increments	citalopram (Celexa) 20-40 mg Increase in 10 mg increments	escitalopram (Lexapro) 10-20 mg Increase in 10 mg increments
Second line treatment			
SSRIS	SNRIs	Other	
paroxetine (Paxil) 20-60 mg Increase in 10 mg increments	venlafaxine (Effexor) 75-300 mg Increase in 75 mg increments	bupropion (Wellbutrin) 300-450 mg Increase in 75 mg increments	Consider using a second line medicine if it has worked in the past
fluvoxamine (Luvox) 50-200 mg Increase in 50 mg increments	duloxetine (Cymbalta) 30-60 mg Increase in 20 mg increments	mirtazapine (Remeron) 15-45 mg Increase in 15 mg increments	

*adapted from MCPAP For Moms

Doses are listed as **starting** dose – **max** dose