CEP | Providers

Treatment of Adult Major Depressive Disorder (MDD) Tool

This tool is designed to support primary care providers in the treatment of adult patients (≥ 18 years) who have major depressive disorder (MDD). MDD is the most prevalent depressive disorder, and approximately 7% of Canadians meet the diagnostic criteria every year.[1,2] The treatment of MDD involves psychotherapy and/or pharmacotherapy. Providers should work with patients to create a treatment plan together using providers' clinical expertise and keeping in mind the patient's preferences, as well as the practicality, feasibility, availability and affordability of treatment.

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SECTION A: Overview of MDD pathway

Patient has suspected depression

Consider unexpected life events (e.g. death in the family, change in family status, financial crisis). Consider special patient populations.

Screen the patient using the PHQ-9[3] for depression

PHQ-9 (a score of 0-4 does not meet criteria for MDD)

Set EMR reminders to follow-up at the patient's next appointment to see if their PHQ-9 score changes.

PHQ-9 Scores of ≥ 5

Mild (score 5-9) | Moderate (score 10-14) | Severe (score >14)

Conduct Risk Assessment

Is the patient at immediate risk of harm to self and/or others? Use the CEP's Keeping Your Patients Safe: A Guide to Primary Care Management of Mental Health and Addictions-related Risks and Functional Impairments[4] tool to assess the patient.

Yes

Advise your patient, their family, caregivers and friends to **call 911 or get them to the nearest Emergency Department**

Consult the Asessing suicdality and managing suicide-related behaviour section for more information.

No

Conduct Diagnostic Work-up

- Rule out causes of secondary MDD by considering testing for B-12 deficiency, CBC, folic acid deficiency, corticosteroid medication, hypothyroidism and syphilis
- Rule out comorbid alcohol[5] and substance use disorder[6]
- Rule out bipolar disorder[7]
- Assess if patient has a sleeping disorder[8]
- Rule out other chronic diseases

Yes → Treat the cause of secondary MDD and other disorders

No → Confirm the diagnosis of MDD using the DSM-V criteria*

Create a safety plan with lower risk patients.

Consult the Asessing suicdality and managing suicide-related behaviour section. Proceed with the following sections: Psychotherapy options, Pharmacotherapy management , Complementary and alternatives medicine.

Refer to Follow-up and Monitoring

Talking Points

It is important to provide your patient with non-judgmental care (e.g. "Being diagnosed with depression is nothing to be ashamed of, it is very common and many adults are diagnosed with it every year")

- Don't use clinical/psychiatric language (e.g. "mental health," "psychiatric," and/or "maladaptive") unless the patient uses these terms first
- Use understandable language for cognitive distortions (e.g. "assumption" which covers many cognitive distortions, "thought trap" instead of rumination)
- Use positive language, and maintain a focus on your patient's strengths
- Avoid stigmatizing labels (e.g. "abnormal", "unusual")
- Talk about symptoms instead of disorders/diagnoses

* A DSM-V score of ≥ 5 with symptoms during the same two week period that are a change from the previous functioning. Depressed Mood (Q1) and/or loss of interest/pleasure (Q2) must be present[9]

SECTION B: Assessing suicidality and managing suicide-related behaviour

Suicidal thoughts, plans, and attempts are very common among people with MDD.[10] Every clinical encounter with a patient that has MDD should include an assessment of suicide risk.[10]

Assess if a patient is at risk of suicide or developing suicidal thoughts by using the Columbia-Suicide Severity Rating Scale (C-SSRS)

In case of an emergency:

- **Advise your patient, their family, caregivers and friends to call 911 or go to the Emergency Department**
- Consult the CEP's Keeping Your Patients Safe on how to complete a Form 1, if you believe that your patient is at **immediate** risk of harming themselves or others

Talking Points

- Use active listening: involves receiving a message, processing it, and sending it back.
- Remember that your patient is the expert on their own experience.

- Schedule periodic follow-up appointments to track your patient's progress and assess their well-being
- Monitor the presence and strength of the patients' protective factors[4]
- Create a safety plan with lower-risk patients
- Help your patient identify the nearest distress centre[11]

Safety plan[12]

Having a safety plan in place is important for both patients and providers as it:

- Facilitates honest communication between patient and provider
- Establishes a collaborative relationship between patient and provider
- Facilitate the patient's active involvement
- Enhances patient's commitment to treatment

Basic components of a safety plan

Work with your patient to develop a safety plan that they can use when in crisis.

1. Recognize warning signs that are proximal to an impending suicidal crisis.
2. Identify and employ internal coping strategies without needing to contact another person.
3. Use contacts with people as a means of distraction from suicidal thoughts and urges (e.g. going to healthy social settings without discussing suicidal thoughts).
4. Contact family members or friends who may help to resolve a crisis and with whom suicidality can be discussed.
5. Contact mental health professionals or agencies.
6. Reduce the potential use of lethal means.

See Keeping Your Patients Safe and Portico for more information

Click here to access a safety plan template

SECTION C: Psychotherapy options

When selecting a specific type of psychotherapy consider the patient's treatment goals and preferences (e.g. group or individual therapy), whether the patient has had a prior positive response to psychotherapy treatment and if providers skilled in the preferred psychotherapy approach are available.

The stepped care approach: Start with the least intrusive form of care and progress to more intensive care if needed.

Talking Points

Set realistic expectations when initiating treatment

- "If you stick to your treatment, you should feel better than you do now. It's also okay if you don't feel better right away. We can help to eventually make your life feel easier."
- "Recovery will have its ups and downs."
- "People who stick to their treatment plan are the ones who see the most improvement over time. So, we are going to work together to make sure that happens."

Provide your patient with adequate support

- "Depression is a common experience, you're not alone in this. It takes a lot of strength to seek support."

First-line psychotherapy options

Mild to Moderate [13,14]

- Cognitive-behavioral therapy (CBT)
- Interpersonal psychotherapy (IPT)
- Behavioral therapy/behavioral activation (BT/BA)
- Acceptance and commitment therapy (ACT)
- Mindfulness-based cognitive therapy (MBCT)
- Problem-solving therapy (PST)

Refer to ConnexOntario for Addiction, Mental Health, and Problem Gambling Treatment Services.

Severe [13,14]

It is suggested to offer a combination of both psychotherapy (see Mild to Moderate for first-line psychotherapy options) and pharmacotherapy (see SECTION D: Pharmacotherapy management) for patients with severe forms/presentations of MDD.

For additional help, consult specialists across the province to provide the best care possible for patients with complex MDD at OTN eConsult[15] and the Collaborative Mental Health Network (CMHN).[16]

For more details on psychotherapy options and second-line treatments please see Appendix A

SECTION D: Pharmacotherapy management

The medications listed below (organized by drug class), are all equal in efficacy and in evidence.[17,18] The selection of a first-line antidepressant is dependent on the following considerations:

Patient:

- Clinical features and dimensions (refer to Appendix F)
- Comorbid conditions
- Response and side effects of previous use of antidepressants
- Patient preference

Medication:

- Comparative efficacy
- Comparative tolerability warnings, contraindications and precautions
- Potential interactions with other medications (refer to Appendix E)
- Simplicity of use
- Cost and availability

First-line antidepressants [17,19]

Drug Class	Antidepressant	Formulations	Dosage	Side Effects	Warnings, Contraindications and Precautions
DAA	**Bupropion** Product monograph for SR[51] Product monograph for XL[52]	100 mg and 150 mg tablet	**SR formulation (doses >150 mg/day PO should be given in divided doses):** Initial: 150 mg/day PO Usual: 150–300 mg/day PO High: 375–450 mg/day PO **XL formulation (given once daily):** Initial: 150 mg/day PO Usual: 150–300 mg/day PO High: 450 mg/day PO	• Agitation • Insomnia • Anorexia	• Contraindicated in seizure disorders • Contraindications for any patient undergoing abrupt discontinuation of alcohol[49] • There is an increased risk of seizure in patients with anorexia nervosa or bulimia[49] • Contraindications for any patient undergoing abrupt discontinuation of alcohol
SM	Vortioxetine Product monograph[53]	5 mg, 10 mg, 15 mg, 20 mg tablet	Initial: 5–10 mg daily PO Usual: 10–20 mg daily PO	• Nausea • Constipation • Vomiting Transient symptoms associated with abrupt discontinuation include: • Headache • Increased dreaming • Mood swings • Muscle tension • Vertigo • Rhinorrhea	
SNRI	**Desvenlafaxine** Product monograph[54]	50 and 100 mg extended-release tablet	Initial: 50 mg daily PO Usual: 50 mg daily PO High: 100 mg daily PO	• Nausea • Sleep disturbance • Drowsiness • Nervousness • Dizziness • Dry mouth	
	Duloxetine Product monograph[55]	30 mg and 60 mg delayed-release capsule	Initial: 60 mg daily PO Usual: 60 mg daily PO High: 120 mg/day PO If necessary, for tolerability, may start with 30 mg/day and increase to 60 mg in 1–2 wk	• Nausea • Drowsiness • Insomnia • Dizziness • Dry mouth	• Do not use in patients with severe renal impairment (ClCr <30 mL/min) • QT interval at doses beyond 120mg BID is prolonged
	Venlafaxine Product monograph[56]	37.5 mg, 75 mg, 150 mg capsule	Initial: 37.5–75 mg/day PO Usual: 112.5–225 mg/day PO High: 300–375 mg/day PO	• Nausea • Sleep disturbance • Drowsiness • Nervousness • Dizziness • Dry mouth • Dose-related hypertension rarely occurs, particularly at doses ≥225 mg/day	• Can prolong the QTc interval at a dose of 450 mg/day (given as 225 mg twice a day)[43]

SECTION D: Pharmacotherapy management (continued)

First-line antidepressants [17,19] (continued)

Drug Class	Antidepressant	Formulations	Dosage	Side Effects	Warnings, Contraindications and Precautions
SSRI*	**Citalopram** Product monograph[57]	10 mg, 20 mg, 40 mg tablet	Initial: 10–20 mg/day PO Usual: 20–40 mg/day PO High: 40 mg/day PO[19] Increase as needed by 20 mg daily, at intervals of ≥1 wk[39]	• Nausea • Dry mouth • Sleep disturbance • Somnolence • Sweating • Sexual dysfunction	• Increased risk of GI bleeding, SIADH • Dose-dependent QT interval prolongation that is clinically significant with the 60 mg daily dose[37]
	Escitalopram Product monograph[58]	10 mg and 20 mg tablet	Initial: 10 mg/day PO Usual: 10–20 mg/day PO High: 20 mg/day PO Increase as needed by 5–10 mg daily at intervals of ≥1 wk[39]	• Nausea • Dry mouth • Sleep disturbance • Somnolence • Sweating • Sexual dysfunction	• Increased risk of GI bleeding, SIADH • Dose-dependent QTc prolongation
	Fluoxetine Product monograph[59]	10 mg and 20 mg capsule	Initial: 10–20 mg/day PO Usual: 20–40 mg/day PO High: 60–80 mg/day PO	• Nausea • Nervousness • Anorexia • Insomnia • Sexual dysfunction	• Increased risk of GI bleeding
	Fluvoxamine Product monograph[60]	50 mg and 100 mg tablet	Initial: 50–100 mg/day PO Usual: 150–200 mg/day PO High: 300 mg/day PO Increase as needed by 50 mg daily every 3–4 days[39]	• Nausea • Drowsiness • Sweating • Anorexia • Sexual dysfunction	• Increased risk of GI bleeding
	Paroxetine, Controlled-Release Product monograph[61]	12.5 mg, 25 mg controlled-release tablet	Initial: 12.5–25 mg/day PO Usual: 25–50 mg/day PO High: 75 mg/day PO Increase as needed by 12.5 mg daily at intervals of ≥1 wk[39]	• Nausea • Drowsiness • Fatigue • Sweating • Constipation • Dry mouth • Dizziness • Sexual dysfunction	• Increased risk of GI bleeding
	Paroxetine, Immediate-Release Product monograph[62]	10 mg, 20 mg, 30 mg, 40 mg immediate-release tablet	Initial: 10–20 mg/day PO Usual: 20–40 mg/day PO High: 60 mg/day PO Increase as needed by 10 mg daily at intervals of 1–2 wk[39]	• Nausea • Drowsiness • Fatigue • Sweating • Constipation • Dry mouth • Dizziness • Sexual dysfunction	• Increased risk of GI bleeding
	Sertraline Product monograph[63]	25 mg, 50 mg, 100 mg capsule	Initial: 25–50 mg/day PO Usual: 50–100 mg/day PO High: 150–200 mg/day PO Increase as needed by 25 mg daily at intervals of ≥1 wk[39]	• Nausea • Tremors • Diarrhea • Dry mouth • Sexual dysfunction	• Increased risk of GI bleeding
Tetracyclic antidepressant	**Mirtazapine** Product monograph[64]	15 mg, 30 mg, 45 mg tablet	Initial: 15–30 mg/day PO Usual: 30–45 mg/day PO High: 60 mg/day PO	• Weight gain • Sedation	• The risk of QT prolongation and/or ventricular arrhythmias (e.g. Torsades de Pointes) may be increased with concomitant use of medicines that prolong the QTc interval[42]

Bolded = covered by Ontario Drug Benefit[18]

Legend
PO = oral administration
DAA=Dual Action Antidepressants
SSRI=Selective Serotonin Reuptake Inhibitors
SNRI=Serotonin-Norepinephrine Reuptake Inhibitors
SM = Serotonin Modulators

* Avoid combined use with drugs associated with prolonged QTc interval[19]
For details on drug interactions, please see Appendix E
For more details on second-line pharmacotherapy options please see Appendix B

SECTION E: Complementary and alternative medicine

Complementary and alternative medicine (CAM) treatments are a group of diverse medical and health care systems, practices and products that are not generally considered part of conventional medicine.[20] Patients may prefer CAM treatments due to fewer side effects, lower costs, precived efficacy and empowerment. CAM treatments may be appropriate for patients with mild MDD while pharmacological and psychological treatments remain the first-line interventions for moderate to severe MDD. **The following is presented as guidance for clinicians when considering CAM treatments in the context of individual patients and not as standards of care.**[20]

Exercise

Monotherapy

First-line for **Mild** and **Moderate** MDD

Second-line for **Severe** MDD

Administration:

30 minutes of moderate-intensity exercise at least 3 times weekly for a minimum of 9 weeks is considered effective.

St. John's wort

Monotherapy

First-line for **Mild** and **Moderate** MDD

Second-line for **Severe** MDD

Administration:

Formulations of SJW have varied widely, as has the dose range (500 to 1800 mg/day), while treatment duration has spanned 4 to 12 weeks.

Light therapy

Monotherapy or adjunctive

Second-line for **Mild**, **Moderate** and **Severe** MDD

Administration:

The standard protocol is 10,000 lux (light intensity) for 30 minutes per day during the early morning for up to 6 weeks.

Omega-3

Monotherapy or adjunctive

Second-line for **Mild**, **Moderate** and **Severe** MDD

Administration:

The typical dose range is 3 to 9 g/day of 0-3 or 1 to 2 g of EPA plus 1 to 2 g of DHA per day. Duration of treatment ranges from 4 to 16 weeks.

SAM-e

Adjunctive

Second-line for **Mild**, **Moderate** and **Severe** MDD

Administration:

Oral (over-the-counter): 800 – 1600 mg/day given in divided doses with meals over 4-12 weeks.

Intravenous and intramuscular formulations: SAM-e, at doses of 200 to 400 mg/day across 2 to 8 weeks, which may be more effective than oral supplements.

Yoga

Adjunctive

Second-line for **Mild**, **Moderate** and **Severe** MDD

Administration:

Duration varies, averaging 2-4 sessions a week over a course of 2-3 months.

Table adapted from the Canadian Network for Mood and Anxiety Treatments (CANMAT). 2016 Clinical Guidelines for the Management of Adults with Major Depressive Disorder: Section 5. Complementary and Alternative Medicine Treatments. 2016.[20]

Caution: St. John's wort can cause many side effects, including gastrointestinal issues, headaches, skin irritation, photosensitivity and dry mouth. There is a concern that higher potency extracts may interfere with the metabolism of various medications, including antidepressants.[20]

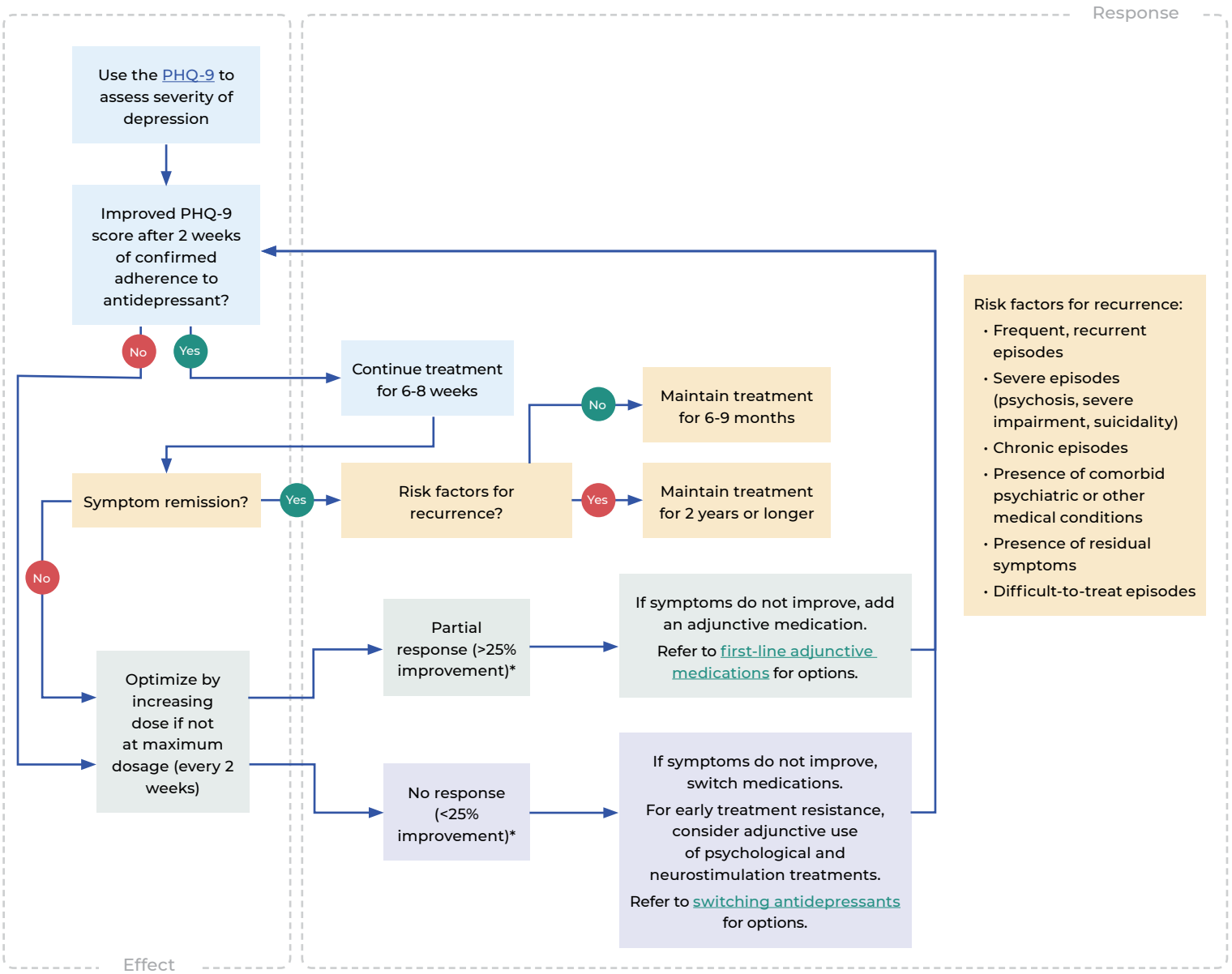
SECTION F: Follow-up and monitoring

Functional outcomes of treatment

Recovery from depression includes both symptom relief and improved functioning.[17] After achieving symptom remission, treatment is recommended to be maintained for 6-9 months. Use clinical expertise and consider patient's life events before determining tapering and/or stopping treatments. Unless there are clinical reasons otherwise, it is recommended to slowly taper patients off antidepressants over several weeks to avoid discontinuation syndrome. It is helpful to explain to patients what to watch out for once they have discontinued antidepressants (e.g. flu-like symptoms, insomnia, nausea and imbalance). If symptoms persist or are worrisome the patient should contact their providers.

Inadequate treatment response pathway

In patients who have not achieved remission on the highest tolerated dose after two weeks of confirmed adherence, it is recommended to switch to another monotherapy (medication or psychotherapy) or augment with a second medication or psychotherapy. Use the pathway below to determine next steps.



**For chronic (characterized as MDD with duration greater than two years)[13] and resistant (treated with, but failed to respond to, at least four adequate medication and/or ECT treatment regimens)[13] depressions, consider: (1) a chronic disease approach, with less emphasis on symptom remission and more emphasis on improvement in functioning and quality of life; and, (2) larger evaluation periods for improvement.*

For early treatment-resistant patients, consider switching to an antidepressant with superior efficacy or use other medications adjunctively.[17]

SECTION F: Follow-up and monitoring (continued)

Switching antidepressants

Considering switching to another antidepressants when:

- It is the first antidepressant trial (in subsequent trials lack of response may not be a factor for choosing between switching and adding adjunctive medications)
- There is failure of one or more antidepressants (in this case, consider switching to a second- or third-line antidepressant)
- There are poorly tolerated side effects to the initial antidepressant. Work with your patient to see if they can try to tolerate the side effects for one to two weeks to see if they disappear or are no longer problematic before switching
- There is more time to wait for a response (less severe, less functional impairment)
- Patient prefers to switch to another antidepressant

Options

When considering switching to another antidepressant, there is not enough of a difference in efficacy between antidepressants to make a decision on this factor alone. When initially selecting an antidepressant base it on tolerability first but if there is no improvement, consider switching to a different antidepressant. There has been some Meta-analysis on a few antidepressants that suggest there may be a very slight difference in efficacy. When switching, you may want to consider these medications with a slightly better efficacy.

Antidepressants with Superior Efficacy	Level of Evidence
Escitalopram	• • • •
Mirtazapine	• • • •
Sertraline	• • • •
Venlafaxine	• • • •
Citalopram	• • •

Recommendations for adjunctive medications[17]

Consider adding an adjunctive medication to your patient's treatment when:

- There have been two or more antidepressant trials
- The initial antidepressant is well-tolerated
- There are specific residual symptoms or side effects to the initial antidepressant that can be targeted
- There is less time to wait for a response (more severe, more functional impairment)
- Patient prefers to add on another medication

First-line adjunctive medications

Adjunctive Agent	Level of Evidence	Dosing	Adverse Effects
Aripiprazole	• • • •	2-15 mg	EPS (akathisia, parkinsonism), dizziness, orthostatic hypotension, headache, GI complaints, nasopharyngitis, tremor, sedation, insomnia[19]
Quetiapine	• • • •	150-300 mg	Sedation, dizziness, weight gain, orthostatic hypotension, hepatic transaminase elevation, headache, anticholinergic effects, increased risk of diabetes and dyslipidemia, possible increased risk of cataracts. May reduce thyroid hormone levels[19]
Risperidone	• • • •	1-3 mg	Sedation, headaches, weight gain, orthostatic hypotension, rhinitis, anxiety, dose-related hyperprolactinemia, EPS. Risk of intraoperative floppy iris syndrome in patients undergoing cataract surgery who have been exposed to risperidone[19]

Consider consulting with a pharmacist before initiating adjunctive medication.

For second-line adjunctive medications, see Appendix C

Level of evidence:
• • • • = Meta-analysis with narrow confidence intervals and/or 2 or more RCTs with adequate sample size, preferably placebo-controlled,
• • • = Meta-analysis with wide confidence intervals and/or 1 or more RCTs with adequate sample size,
• • = Small-sample RCTs or nonrandomized, controlled prospective studies or case series or high-quality retrospective studies,
• = Expert opinion/consensus

SECTION G: Special patient populations

Antenatal and postpartum MDD

For pregnant and postpartum women use the Edinburgh Postnatal Depression Scale (EPDS)[35] to screen for depression.

Although postpartum psychosis is rare, women with this disorder may have homicidal impulses toward the newborn. Careful assessment of homicidal and suicidal ideation, as well as intention and plans are important. Postpartum psychosis must always be treated as a psychiatric emergency, with hospitalization considered for the safety of the mother and baby.[14]

For women who wish to become pregnant, are pregnant, or are breastfeeding, depression-focused psychotherapy alone is recommended. Depending on the severity of symptoms, depression-focused psychotherapy should be considered as the first option.[14] Most medications can be safely used by breastfeeding mothers. Consider all risks and benefits of pharmacotherapy for both mother and baby before prescribing medication.

First-line treatment options for antenatal MDD

Mild to Moderate[21]

- CBT (individual or group)
- IPT (individual or group)

Severe*

- Pharmacotherapy is the first-line treatment, either alone or in combination with CBT or IPT[21]

Specialists are available across the province to provide the best care possible for your patients at OTN eConsult[15] and the Collaborative Mental Health Network (CMHN)[16]

First-line treatment options for postpartum MDD

Mild to Moderate[21]

- CBT (individual or group)
- IPT (individual or group)

Severe*

- Pharmacotherapy should be used first-line, with or without psychotherapy[21]
- Citalopram
- Escitalopram
- Setraline[21]

Specialists are available across the province to provide the best care possible for your patients at OTN eConsult[15] and the Collaborative Mental Health Network (CMHN).[16]

For second-line treatment options for antenatal and for postpartum MDD please see Appendix D

*Electroconvulsive therapy (ECT) can be an effective treatment for severe MDD in pregnant and postpartum patients who:

1) have psychotic features;

2) treatment-resistant patients; and,

3) who elect to use this modality as a matter of preference.[14,21]

Weigh the risks and benefits of ECT with pregnant patients before recommending treatment.

- Valproate and paroxetine must not be used in pregnant women[13,22]
- St John's Wort must not be used in pregnant or breastfeeding women[13]

Consult Resources for antenatal and postpartum MDD at the end of this tool

SECTION G: Special patient populations (continued)

Older Adults

Late-life depression (LLD) can be defined as MDD occuring in adults 60 years and older. It is important to differentiate early adult-onset (MDD) depression recurring in late life from late-onset depression[21]. For older adults use the Geriatric Depression Scale (GDS) to screen for depression.

- Check the patient's family history, consult patient's family or caregiver to provide input on their cognition and conduct assessments to rule out dementia
  - Use the Montreal Cognitive Assessment (MoCA) or Mini-Mental State Exam (MMSE) to asses the patient
  - The MoCA Clinic and Institute recommends to complete the MoCA Training & Certification Program[46] before providers administer, interpret and score test results to avoid misdiagnosis and liability.[25]
- Start at the lowest possible dose of an antidepressant and increase dose as needed (See Section D: Pharmacotherapy management for first-line antidpressants and Appendix B: Pharmacotherapy options for second-line antidepressants tables for recommended dosages)
- Monitor sodium level closely when starting or changing dosages in older adults [25]

> ! According to the 2019 American Geriatric's Society Beers Criteria: antipsychotics, mirtazapine, SNRIs, SSRIs and TCA are to be used with caution in the older adult population because it may exacerbate or cause SIADH or hyponatremia.[25]

Mild to Moderate[13,21]

- ACT
- BT/BA
- Bupropion
- Citalopram/escitalopram
- CBT
- Desvenlafaxine
- IPT
- MBCT
- Mirtazapine*
- PST
- Sertraline
- Venlafaxine
- Vortioxetine

Severe[21]

- Bupropion
- Citalopram/escitalopram
- Desvenlafaxine
- Mirtazapine*
- Sertraline
- Venlafaxine
- Vortioxetine

Specialists are available across the province to provide the best care possible for your patients at OTN eConsult[15] and the Collaborative Mental Health Network (CMHN).[16]

For second-line treatment options see Appendix D

Patients on Tamoxifen

Patients with MDD that are being treated for breast cancer with Tamoxifen should not be prescribed antidepressants that inhibit CYP2D6 (buproprion, duloxetine, fluoxetine, paroxetine) because it will decrease the efficacy of the breast cancer treatment.[26]

For women already taking tamoxifen and other medications (e.g. aromatase inhibitors)[27] with a known CYP2D6 inhibitor, any change in antidepressant treatment should be gradual to minimize the risks of SSRI withdrawal and adverse effects commonly seen on initiation of treatment.[26]

Moderate inhibitors that impart lesser degrees of inhibition and are reasonable alternatives:[26,28]

- Sertraline
- Citalopram
- Escitalopram
- Doxepin
- Venlafaxine

RESOURCES

Resources for providers

[I] Columbia-Suicide Severity Rating Scale - Provides suggested probes to understand the presence and severity of an individual's suicidal ideation. Ultimately, the determination of the presence of suicidal ideation or behavior depends on the judgment of the individual administering the scale: https://www.integration.samhsa.gov/clinical-practice/Columbia_Suicide_Severity_Rating_Scale.pdf

[II] Centre for Effective Practice - Keeping Your Patients Safe: A Guide to Primary Care Management of Mental Health and Addictions-related Risks and Functional Impairments tool https://cep.health/clinical-products/adult-mental-health/

[III] Provides mindfulness-based cognitive therapy (MBCT), mindfulness-based stress reduction (MBSR), mindful selfcompassion (MSC) and specialized mindfulness training to the general public https://www.mindfulnessstudies.com/

[IV] Medical calculators, equations, scores, and guidelines at MDCalc https://www.mdcalc.com/

[V] Ontario College of Family Physician's (OCFP) Collaborative Mental Health Network (CMHN): https://www.ontariofamilyphysicians.ca/education/collaborative-mentoring-networks/collaborative-mental-health-network

[VI] Ontario Drug Benefit formulary search: https://www.formulary.health.gov.on.ca/formulary/

[VII] OTN eConsult: https://otn.ca/providers/

[VIII] SwitchRx - aims to provide healthcare professionals with the most current and useful information to guide their clinical practice when adjusting their patient's psychotropic treatment regimens: https://switchrx.ca/

[IX] RxFiles - antidepressant comparison chart: https://www.rxfiles.ca/RxFiles/uploads/documents/members/cht-Psyc-Antidepressant.pdf

Resources for patients, their family, caregivers and friends

Information on depression

[X] Greenspace - Connects people with therapists across Ontario: https://www.greenspacehealth.ca/patients/

[XI] Canadian Mental Health Association brochure on depression: https://cmha.ca/wp-content/uploads/2015/12/Depression-and-Bipolar-NTNL-brochure-2014-web.pdf

[XII] Here - Resource on helping patients manage their depression: https://www.heretohelp.bc.ca/managing-depression

[XIII] Informed Choices About Depression: Information about depression and treatments for depression: https://depression.informedchoices.ca/fact-sheets/

[XIV] Centre for Clinical Intervention resource on helping patients understand and work through their depression: https://www.cci.health.wa.gov.au/Resources/Looking-After-Yourself/Depression

Online therapy

[XV] BounceBack Ontario - Guided self-help program grounded in cognitive behavioural therapy designed to help adults manage symptoms depression. Involves 6 telephone sessions with trained coaches who lead the patient through a series of workbooks. Cost is free. Patient is contacted within 5 business days of referral to schedule first appointment. Referral or patient self-referral is required: https://bouncebackontario.ca

[XVI] Centre for Mindfulness Studies: Provides mindfulness-based cognitive therapy (MBCT), mindfulness-based stress reduction (MBSR), mindful self-compassion (MSC) and specialized mindfulness training to the general public. Available from: https://www.mindfulnessstudies.com/

[XVII] Headspace - An online site for meditation: https://www.headspace.com/

[XVIII] Mindshift app - This app uses scientifically proven strategies based on Cognitive Behavioural Therapy (CBT) to help you learn to relax and be mindful, develop more effective ways of thinking, and use active steps to take charge of your anxiety. Available on the App Store and Google Play

[XIX] Moodgym - A 5-module online cognitive behavioural therapy program for depression. Cost is $39 AUD for 12 month access: https://moodgym.com.au/

Support groups and wellness services

[XX] Canadian Mental Health Association (CMHA) - Locate your local CMHA for mental health support services and programs: https://cmha.ca/find-your-cmha

[XXI] Mood Disorders Association of Ontario - Provides free support programs to people across Ontario, and their families, who are living with depression: https://www.mooddisorders.ca/

[XXII] Thought Spot app - Provides a live map for easily identifying and accessing health, mental health and wellness services in the Greater Toronto Area. Available on the App Store and Google Play

Suicide prevention

[XXIII] Canadian Association for Suicide Prevention - Tips on how to identify suicidal thoughts and tips for the patient's loved ones or caregivers: https://suicideprevention.ca/im-concerned-about-someone

[XXIV] Distress and Crisis Ontario (DCO) - DCO have distress centres that provide a listening ear for lonely, depressed, and/or suicidal people, usually 24 hours a day, 7 days a week. Many centres also have Suicide Survivor programs, support services for youth, telephone call out programs for seniors and vulnerable people, mental health Crisis Lines services and much more: http://www.dcontario.org/about.html

[XXV] ReMinder Suicide Safety Plan app - Helps you to create a simple suicide safety plan, that can be accessed at any time on your phone. Available on the App Store and Google Play

[XXVI] Portico Network - This toolkit includes information, resource and tools to support clinicians in providing comprehensive care to clients and patients who demonstrate suicide-related behaviour: https://www.porticonetwork.ca/web/opop/tools/suicide-risk-assessment-toolkit

Resources for antenatal and postpartum MDD

[XXVII] e-lactancia - Is a resource to check the compatibility of medications whilst breastfeeding: http://e-lactancia.org/

[XXVIII] LactMed - Is a database that contains information on drugs and other chemicals to which breastfeeding mothers may be exposed: https://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm

[XXIX] Infant Risk Centre - Is a leading resource on the safety of medications during pregnancy and lactation: https://www.infantrisk.com/

[XXX] Medications and Mother's Milk - Online reference for evaluating medication use in breastfeeding mothers. Cost is $59.99 USD for 12 month access: https://medsmilk.com/

[XXXI] SickKids - Is accepting referrals to the Motherisk Clinic from health-care providers. The Motherisk Clinic is a specialized referral-only service that assesses the safety of medications and/or substances consumed by pregnant or nursing women and the potential effects on their babies. Health-care providers can continue to send referrals through EpicCareLink: http://www.sickkids.ca/HealthcareProfessionalsandStudents/Referring-a-Patient/index.html

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NURSE PRACTITIONERS' ASSOCIATION OF ONTARIO