Enhancing Provider Competency in the Treatment of Depression in Primary Care

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The members of the committee appointed to examine the clinical project of CHRISTOPHER AICHELE find it satisfactory and recommend that it be accepted.

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Abstract

Depression is the number one mental health disorder treated in primary care. As nurse practitioners nationwide increase their role in primary care, they are treating more mental health disorders, especially depression. There are many treatment options available; however prescribing antidepressants is the most common treatment in primary care. This article provides an overview of depression and a guide to assist primary care nurse practitioners in their care for patients with depression with increased efficacy, safety and comfort.

Key words: depression, primary care, antidepressants, nurse practitioners
Enhancing Provider Competency in the Treatment of Depression in Primary Care

Major depressive disorder, the disease typically associated with the term depression, has received significant attention recently in the media, in healthcare circles, in religious arenas, and in popular culture in turn has led more patients to seek care for depression than ever. Depression can be a diagnosis unto itself or a comorbid diagnosis and a barrier to the healing of any medical diagnosis, disease, and chronic or acute illness. It can affect physical and mental health, as well as influence family dynamics, social interactions, and all aspects of everyday life.

Depression is the most common mental illness encountered by primary care providers. This may be related to a generalized lack of access to mental health services or a lack of access to qualified psychiatric providers. As the role of primary care nurse practitioners continues to increase related to treatment of mental disorders such as depression, providers need to be equipped with the knowledge and tools necessary to effectively diagnose and treat it. Patricia Benner developed a conceptual framework which placed professional development along a continuum from novice to expert. This paper was written to assist nurse practitioners at any stage of professional development treat patients with depression. The prescribing information and knowledge in this paper is provided to primary care providers with the hope that its integration will increase provider competency, promote greater patient safety, and enhance treatment efficacy in the area of prescribing antidepressants.

The Problem of Depression

Depression affects people across the spectrum and the population being seen in primary care may be equally varied. Depression commonly affects people between the ages of 20 and 40. In a study of young adults aged 17 to 39 years old, 4.1% met diagnostic criteria for major depression yet only 7.4% of those who met diagnostic criteria were being treated for depression.
Low-income urban women have a rate of depressive symptoms in excess of 40-50%. Depression in adults over age 65 can be a recurrent or chronic problem in a staggering 50% of the population causing functional impairment, decreased quality of life and often times leading to suicide. Depression is often overlooked in older adults as being a normal variant of aging instead of being recognized as a disease state amenable to treatment. Depression leads to increased health care costs, increased use of primary care visits, consultations, and laboratory studies as well as longer hospital stays in this population.

Prior to initiating therapy for depression, it is essential to ascertain that the correct diagnosis has been made and that substance abuse and other diagnoses such as bipolar disorder are not present. A detailed review of screening tools for depression is not within the scope of this paper. Some of these tools are completed by the patient and others by the provider. This paper includes a brief overview of the diagnosis of depression and primary care treatment of depression once an accurate diagnosis of depression has been made.

Diagnosing Depression

The World Health Organization defines depression as a common mental disorder presenting as depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration. These problems can be chronic or recurrent and lead to substantial impairments in an individual's ability to take care of his or her everyday responsibilities.

In order to be diagnosed with major depressive disorder, the following criteria, found in the Diagnostic and Statistical Manual of Mental Disorders text revised edition number four, must be met:
An individual must have five or more of the following symptoms present in the same two week period and symptoms must represent a change from baseline functionality. The diagnostic criteria may be observed or recorded by a subjective report from the patient or by direct observations of people close to the individual. At least one of the five must include a depressed mood or a loss of interest in pleasure.

- A depressed mood for most of the day, more days than not. In adolescents or children, this can be expressed as an irritable mood.
- Decreased pleasure or interest in most activities.
- A significant weight loss or gain without trying to lose or gain weight. This may be objectively measured as a change of more than 5% from baseline body weight in a month. The patient may report any decreases or increases in appetite on a daily basis. In children, a failure to make expected gains according to their previously established height and weight graphs may be an indication.
- Insomnia or hypersomnia.
- Observable psychomotor agitation or retardation, not just a report of restlessness or low energy.
- Fatigue or overall energy loss.
- Feelings of worthlessness or guilt.
- Unable to concentrate or think, indecisive behaviors.
- Suicidal ideation or thoughts of death.

The nurse practitioner must also rule out other psychiatric disorders such as bipolar I or II, mixed episodes, dysthymia, as well as alcohol or drug abuse and should consider underlying health considerations such as hypothyroidism, diabetes, vitamin B12 deficiency since many of these
disease processes have features that may mimic or present as depression. The symptoms must cause impairment in social, occupational or some other area of functionality. Situational depression, such as the loss of a loved one or major change in life circumstances, is different from major depressive disorder. In order to meet criteria for depression, the symptoms must occur for greater than two months after the episode occurred.

Treatment of Major Depressive Disorder in Primary Care

Once a diagnosis of major depressive disorder, commonly known as depression, is made, there are three main treatment options available in primary care. Difficult cases or ones that require advanced diagnostics or treatment options should be referred to a psychiatric nurse practitioner or psychiatrist. A referral to counseling services may also be used as a primary treatment option. With the development of the SSRIs, medication usage as treatment for depression increased from 37.3% in 1987 to 74.5% in 1997 with treatment primarily initiated by PCPs, an increase from 68.9% to 87.3%.¹

A literature review revealed no clear or easily accessible guidelines or models regarding the selection of a medication to those in primary care practice and much of the literature that is present in this area is greater than five years old. The American Psychiatric Association published guidelines in 2000.¹² However, since then, medications have been added or changed to generic versions, and some have new usage warnings that would likely affect the order of recommendations. In 2006 Kaiser Permanente published some guidelines for the treatment of depression¹³ within their system. These guidelines are very basic and do not address practical treatment, specifically with regard to medication management. According to these guidelines, selecting an antidepressant is first line therapy. If this is ineffective, psychotherapy or psychiatric consultation is next line treatment. Increasing the dosage of the medication, selecting
another medication, and taking into account an appropriate length of time of treatment with antidepressants are at the lower end of the recommendations list. Traditional practice in primary care outside of the Kaiser system without such ready access to psychiatric care providers may lean towards moving these interventions up as opposed to jumping right to psychotherapy or consultation, though either of these options may be appropriate depending on the patient situation.¹⁹,²⁰

Successful treatment of depression entails reevaluation of the diagnosis, evaluation of the progression of signs and symptoms associated with the diagnosis, adjusting medication doses as needed or selecting a new medication for trial. One study revealed internists reported being “very comfortable” prescribing antidepressants and benzodiazepines; however, the same study revealed that less than half the internists who prescribed selective serotonin reuptake inhibitors, or SSRIs, for a diagnosis of depression had scheduled follow-up visits, a common practice in the management of patients on antidepressant therapy.¹⁴ A retrospective study regarding antidepressant treatment for depression¹⁵ revealed adequate antidepressant therapy was present in only 46% of the patients reviewed. Adequate antidepressant therapy is defined as being on the minimum effective dose of a medication for 90 days while acknowledging that 6 months is the standard benchmark for assessing adequate length of therapy. Early discontinuation (treatment lasting less than 8 weeks at therapeutic levels) rates in a 2004 retrospective study were as high as 41.4%.¹⁶

Prescribing Competencies

Basic Considerations

Several factors go into the decision making process of selecting a medication. These factors include side effect profile, overdose and lethality potential, provider educational
preparation, and influence from practice style and personal experience. An important key to note when prescribing antidepressants is that it can take between two and four weeks for the effects of these medications to begin. Teaching patients what to expect when initiating antidepressant therapy is a major component in increasing adherence to medication therapy. It is important to consider that the initial dose of a medication is not always the therapeutic dose. Before labeling a medication as ineffective, the practitioner should attempt to increase the dose to its maximum therapeutic dose or the point where its side effects are no longer tolerable to the patient. This will ensure an adequate trial of the medication. Augmentation of an antidepressant at a therapeutic level with another antidepressant from another class may also be considered to maximize the effects of pharmacologic treatment. Treatment for depression with antidepressants should continue for six months to one year after the initial episode of depression and after the minimum therapeutic dosage has been achieved. For subsequent episodes of depression, medication therapy may need to be considered on an indefinite basis.

There are many precautions to observe when initiating antidepressant therapy. Monitoring for suicidal ideation should occur during the first few weeks of therapy and when changes in the dosage of these medications are made as there is a clearly greater risk of suicide within the first three to four weeks of therapy and with dose changes. Likewise, consideration should be paid to hepatic and renal impairment, pregnancy and breastfeeding status, general health, and the body’s ability to tolerate the medications. There is the chance of uncovering undiagnosed bipolar disorder as antidepressant medication monotherapy may induce mood lability and a hypomanic or manic state. However, since antidepressants are among the most commonly prescribed drugs in the world, being familiar with the different types of medications
and some of the nuances involved in prescribing them, increasing the dosage, and switching between medications is an important tool at the disposal of the nurse practitioner.

Once a medication is prescribed, there can be many reasons that it may be discontinued and another medication selected. The medication may not produce the desired results in a timeframe deemed acceptable by a patient or provider. The medication may also cause intolerable side effects. In the case of switching from one medication to another, easily accessible guidelines must be provided for titrating off one medication and onto another.

Considerations for Specific Drug Selection

Selective serotonin reuptake inhibitors (SSRIs)

There are many classes of drugs that a provider may choose from when treating depression. The most popular class of medications used to treat depression is that of selective serotonin reuptake inhibitors (SSRIs). The SSRIs primarily work at the synaptic cleft to increase the amount of serotonin available through different mechanisms of action depending on the drug. Studies have shown that compliance with SSRI therapy is much higher than therapy with older classes of medications including tricyclic antidepressants and monoamine oxidase inhibitors. There are several side effects commonly associated with SSRIs. These include sexual dysfunction (decreased desire, libido and delayed ejaculation), insomnia, weight gain, agitation, drowsiness, fatigue, dry mouth, constipation or diarrhea, and headache.

One commonly used medication in this class that requires added caution is fluoxetine. This medication has a long half life so caution needs to be exercised when discontinuing it. A careful taper off the medication and the initiation of a new antidepressant should be done to avoid serotonin syndrome, a medically serious and potentially fatal condition. Fluoxetine is also the only medication FDA approved antidepressant for the treatment of depression in
children and adolescents. There is limited evidence for the use of citalopram and paroxetine in treating children as well but they are not FDA approved.

*Serotonin norepinephrine reuptake inhibitors (SNRIs)*

Another popular class of medications are the serotonin norepinephrine reuptake inhibitors (SNRIs). This class includes medications such as venlafaxine and duloxetine. These work by inhibiting the reuptake of serotonin and norepinephrine at the synaptic cleft thus increasing the amount of neurotransmitter available to bind with postsynaptic receptors. Considerations with these medications include frequent monitoring of blood pressure as the additional norepinephrine can cause hypertension and anticholinergic effects, as well as teaching that flu-like side effects can occur with one or two missed doses. Caution should be used with venlafaxine at high doses as it is contraindicated in patients with high risk for ventricular arrhythmias or difficult to control hypertension.

*Infrequently Used Medications:*

*Tricyclic antidepressants (TCAs) and Monoamine Oxidase Inhibitors (MAOIs)*

Tricyclic antidepressants (TCAs) were once the medication of choice for treatment of depression. The advent of newer classes of medications has made monotherapy with TCAs rare. The unfavorable side effects of TCAs include orthostatic hypotension, sedation, anticholinergic activity, overdose lethality, and cardiac considerations make them an unpopular choice for medication monotherapy. Some of these medications, however, are used to augment other therapies such as chronic pain control, insomnia, or incomplete resolution of depression from other classes of medications. Nurse practitioners should consider referral to trained psychiatric practitioners if monotherapy with TCAs is being considered.
Another medication class is the MAOIs which have steadily declined in popularity since the advent of the SSRIs due to the severe dietary restrictions (tyramine restricted) that accompany their use. New medications within this class, such as seligiline transdermal patches, are demonstrating high effectiveness without a need for strict dietary control indicating this class is not obsolete. While this class is not a first line intervention, primary care providers are likely to see it used as a transdermal patch in treatment refractory geriatric patients who have been treated by a specialist. Since they are rarely used at primary care treatment options, detailed discussion and usage guidelines should be done in consultation with a psychiatric provider.

Other Medications

Other medications are used in the treatment of depression but do not fit into a particular class. The first drug to be discussed is bupropion which is a norepinephrine and dopamine reuptake inhibitor. Bupropion is used for a number of purposes. In one study of psychiatrists, 43% of respondents prescribed bupropion to counter some of the sexual side effects of SSRIs. It also carries an FDA approval as a smoking cessation aid. For a patient with depression who also wishes to quit smoking, this agent may be a good one to select. It is an activating drug and has been used as an adjuvant to other medications to reverse daytime fatigue and apathy so it should not be taken close to bedtime. There are sustained release and long acting versions which may help to decrease side effects thus increase use. It may also be used to treat children and adolescents who wish to quit smoking or who are diagnosed with attention deficit hyperactivity disorder.

Mirtazapine is not typically selected by primary care providers as a first line agent for the treatment of depression but more often as an adjuvant. Mirtazapine has a complex and multivariated mechanism of action working as a reuptake inhibitor, a histamine receptor blocker,
and a presynaptic agent. This results in an increase in the amount of serotonin, norepinephrine and histamine available for neurotransmission. Its major side effects are weight gain and sedation. Sedation may occur almost immediately after initiation of the medication facilitating its use in treating refractory insomnia, anxiety, or insomnia induced by other medication treatment. With weight gain as a side effect, it should be used with caution in patients with a body mass index greater than 25. Aggressive exercise and dietary counseling and modifications can be initiated to prevent weight gain should a trial of mirtazapine be desired. Monitoring should also include lab tests to assess liver functions, white blood cell counts which may be lowered, fasting lipid panels as cholesterol may increase, and fasting blood glucose levels.

Trazodone was once used as a primary treatment option for depression but has declined dramatically over time. In one survey however, 78% of responding psychiatrists added trazodone for SSRI-induced insomnia. Unlike other forms of sleep aids, trazodone is not habit forming when used for the treatment of primary or secondary insomnia and has been shown to be effective as an adjuvant to primary depression or anxiety treatment with other medications.

Reference Guide for Primary Care

As mentioned before, there are no concise, well documented recommendations for how to initiate and tailor antidepressant medication therapy. Psychotropic medications require finesse in prescribing as side effects and treatment results can vary widely from person to person. The following two tables were compiled to aid in tailoring an antidepressant treatment profile to individual patients. Tables 1 and 2 can be used to determine a rational approach to the antidepressant medication selection based for individual patients. Table 1 primarily summarizes what the medication was FDA approved to treat along with practice tips from experts in the field. Table 2 addresses starting doses, dosage ranges, half life, titration amounts up or down, and how
to discontinue a medication. Should a medication not be effective for a patient, this table helps provide some easy to follow guidelines regarding how quickly and safely a medication can be discontinued and how soon another medication can be initiated.

Recommendations and Conclusions

Consultation with mental health providers when available may need to be considered for patients who are refractory to treatment, sensitive to medications or simply when expert consultation is desired by either the patient or the provider to ensure safe and efficacious treatment. This article is one step in providing an overview of some of the many resources available to primary care providers which hopefully will enhance the efficacy and safety of current practice.


<table>
<thead>
<tr>
<th>Category of Drug</th>
<th>Drug Name (generic)</th>
<th>Drug Name (trade)</th>
<th>Uses (FDA approval)</th>
<th>Practice Pearls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citalopram</td>
<td>Celexa</td>
<td>MDD</td>
<td></td>
<td>Has some antihistamine properties so may cause sedation. Especially well tolerated in the elderly.</td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>Prozac</td>
<td>MDD, OCD, PMDD, bulimia, panic</td>
<td>May also increase norepinephrine and dopamine transmission. Activating (AM dosing better tolerated). When used with olanzapine can treat bipolar depression effectively. Titration off rarely needed since it tapers itself after immediate discontinuation due to long half life of parent drug and its metabolites. Adding or initiating antidepressants should be with extreme caution for up to 5 weeks after discontinuation due to long half life. Approved for use in children and adolescents. Long half life effective for people who may not take medication regularly. Long half life complicated by renal or hepatic impairment or in the elderly.</td>
<td></td>
</tr>
<tr>
<td>Sertaline</td>
<td>Zoloft</td>
<td>MDD, OCD, PMDD, PTSD, social phobia</td>
<td>Activating, (AM dosing better tolerated). Most side effects are immediate but often go away with time. Withdrawal effects may include dizziness, nausea, cramps, sweating and fatigue. Approved for use in children and adolescents for OCD treatment.</td>
<td></td>
</tr>
<tr>
<td>Escitalopram</td>
<td>Lexapro</td>
<td>MDD and GAD</td>
<td>Unlike Citalopram, this isomer doesn't have antihistamine properties so there is no sedation side effect. May be among the best-tolerated antidepressants, minimal side effects, no sedation, minimal weight gain, easy to reach therapeutic dosage, and fewer drug interactions that any other SSRI. 10 mg of escitalopram is equal to 40 mg of citalopram.</td>
<td></td>
</tr>
<tr>
<td>Paroxetine</td>
<td>Paxil</td>
<td>MDD, OCD, PMDD, PTSD, GAD, panic, social phobia</td>
<td>Mildly anticholinergic, caution with patients prone to this effect. Sedation is a common side effect, dose should be taken at bedtime. May have difficulty with discontinuation requiring the taper to be done over months.</td>
<td></td>
</tr>
<tr>
<td>Fluvoxamine</td>
<td>Luvox</td>
<td>OCD</td>
<td>Sedating-insomnia and anxiety may be decreased shortly after drug initiation. May be a preferred treatment with anxious depression or MDD with a comorbid anxiety disorder.</td>
<td></td>
</tr>
<tr>
<td>Category of Drug</td>
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<td>Uses (FDA approval)</td>
<td>Practice Pearls</td>
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</tr>
<tr>
<td>SNRI-serotonin and norepinephrine reuptake inhibitor</td>
<td>Duloxetine</td>
<td>Cymbalta</td>
<td>MDD, GAD, diabetic peripheral neuropathic pain, neuroleptic or chronic pain</td>
<td>Can reduce neuropathic pain within a week but onset may take longer. Need to monitor blood pressure before initiating treatment and regularly during treatment. May have agitation, sedation or anticholinergic side effects. Approved in many countries for treatment of stress incontinence. Caution when using in men with prostate disorders. Cannot crush or chew as it is enteric coated. Not recommended for use in severe renal impairment or dialysis dependence.</td>
</tr>
<tr>
<td></td>
<td>Venlafaxine</td>
<td>Effexor</td>
<td>MDD, GAD, social phobia, panic disorder</td>
<td>Need to monitor blood pressure before initiating treatment and regularly during treatment. Missing one or two doses may lead to flu-like symptoms including headache, nausea, fatigue, and dizziness. Caution with hepatic or renal impairment. May use extended release version, especially with nausea as a side effect. May be helpful with hot flashes in post-menopausal women, neuropathic pain, and fibromyalgia. Caution should be used in patients with heart disease.</td>
</tr>
<tr>
<td>Others</td>
<td>Bupropion</td>
<td>Wellbutrin</td>
<td>MDD and nicotine addiction</td>
<td>Activating, may reverse sexual side effects and apathy associated with SSRI treatment. Side effects due to additional norepinephrine and dopamine levels may include tremor, agitation, insomnia (take dose in AM to reduce effects), headache or dizziness. There is also a sustained release (SR) and an extra long (XL) version which may help with dosing compliance and side effects. Nicotine addiction may require treatment for up to 6 months. May be used for treatment of ADHD or nicotine cessation in adolescents. Caution in patients with seizure disorders or anorexia.</td>
</tr>
<tr>
<td>Category of Drug</td>
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</tr>
<tr>
<td>Others</td>
<td>Mirtazapine</td>
<td>Remeron</td>
<td>MDD</td>
<td>Sedating-insomnia and anxiety may be decreased shortly after drug initiation. Monitor liver functions, blood counts (may lower white blood cell counts), fasting blood glucose levels, and fasting lipid panels (drug may increase cholesterol) while using medication. Associated with significant weight gain, use with caution in patients with BMI greater than 25. May have anticholinergic side effects. Not usually considered to be a first line treatment option for depression. Caution in patients with renal, hepatic, and cardiac impairment as well as with seizure disorders. Limited interactions with other medications.</td>
</tr>
<tr>
<td></td>
<td>Trazodone</td>
<td>Desyrel</td>
<td>MDD</td>
<td>Rarely used as a monotherapy for the treatment of depression. It is used primarily to augment other therapies and treat insomnia. Has some anticholinergic side effects.</td>
</tr>
</tbody>
</table>

MDD-major depressive disorder
OCD-obsessive compulsive disorder
PMDD-premenstrual dysphoric disorder
PTSD-post traumatic stress disorder
GAD-generalized anxiety disorder
ADHD-attention deficit hyperactivity disorder
<table>
<thead>
<tr>
<th>Category of Drug</th>
<th>Drug Name (generic)</th>
<th>Drug Name (trade)</th>
<th>Dosing Recommendations #</th>
<th>Initial dose</th>
<th>Titration up *</th>
<th>Titration down or off</th>
<th>Half-Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSRI-selective serotonin reuptake inhibitors</td>
<td>Citalopram</td>
<td>Celexa</td>
<td>20-60 mg per day</td>
<td>10-20 mg</td>
<td>20 mg weekly</td>
<td>50% every 3 days</td>
<td>23-45 hours</td>
</tr>
<tr>
<td></td>
<td>Fluoxetine</td>
<td>Prozac</td>
<td>20-80 mg per day</td>
<td>10-20 mg</td>
<td>20 mg weekly</td>
<td>Immediate cessation okay</td>
<td>2 weeks for parent drug and metabolites</td>
</tr>
<tr>
<td></td>
<td>Sertaline</td>
<td>Zoloft</td>
<td>50-200 mg per day</td>
<td>25-50 mg</td>
<td>25-50 mg weekly</td>
<td>50% every 3 days</td>
<td>22-36 hours</td>
</tr>
<tr>
<td></td>
<td>Escitalopram</td>
<td>Lexapro</td>
<td>10-20 mg per day</td>
<td>10 mg</td>
<td>10 mg once</td>
<td>50% every 3 days</td>
<td>27-32 hours</td>
</tr>
<tr>
<td></td>
<td>Paroxetine</td>
<td>Paxil</td>
<td>20-60 mg per day</td>
<td>10-20 mg</td>
<td>10-40 mg weekly</td>
<td>50% every 3 days. May have difficulty with discontinuation requiring the taper to be done over months.</td>
<td>24 hours</td>
</tr>
<tr>
<td></td>
<td>Fluvoxamine</td>
<td>Luvox</td>
<td>100-300 mg per day</td>
<td>50 mg</td>
<td>50 mg every 3-4 days</td>
<td>50% every 3 days</td>
<td>9-28 hours</td>
</tr>
<tr>
<td>SNRI-serotonin and norepinephrine reuptake inhibitor</td>
<td>Duloxetine</td>
<td>Cymbalta</td>
<td>40-90 mg per day (may be divided if needed)</td>
<td>20-40 mg</td>
<td>20 mg weekly</td>
<td>50% every 3 days. May need to be much slower due to withdrawal effects including dizziness, nausea, vomiting, headache, paresthesias or irritability.</td>
<td>12 hours, absorption may be delayed up to 3 hours after evening dose</td>
</tr>
<tr>
<td></td>
<td>Venlafaxine</td>
<td>Effexor</td>
<td>75-225 mg per day (may be divided if needed)</td>
<td>37.5 mg</td>
<td>37.5-75 mg weekly</td>
<td>50% every 3 days. May need to be much slower due to withdrawal effects including dizziness, nausea, vomiting, headache, paresthesias or irritability.</td>
<td>3-14 hours</td>
</tr>
<tr>
<td>Others</td>
<td>Bupropion</td>
<td>Wellbutrin</td>
<td>225-450 mg in two or three doses</td>
<td>75 mg twice daily for depression, 150 mg for nicotine addiction (SR format)</td>
<td>25-50 mg weekly</td>
<td>There is no documented cessation protocol.</td>
<td>10-30 hours</td>
</tr>
<tr>
<td>Category of Drug</td>
<td>Drug Name (generic)</td>
<td>Drug Name (trade)</td>
<td>Dosing Recommendations #</td>
<td>Initial dose</td>
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<td>Titration down or off^</td>
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</tr>
<tr>
<td>Others</td>
<td>Mirtazapine</td>
<td>Remeron</td>
<td>15-45 mg at night</td>
<td>15 mg</td>
<td>15 mg every 1-2 weeks</td>
<td>There is no documented cessation protocol.</td>
<td>20-40 hours</td>
</tr>
<tr>
<td></td>
<td>Trazodone</td>
<td>Desyrel</td>
<td>150-600 mg per day</td>
<td>150 mg</td>
<td>50 mg every 3-4 days</td>
<td>There is no documented cessation protocol.</td>
<td>3-9 hours</td>
</tr>
</tbody>
</table>

* Higher ceiling doses may be available but should be done in consultation with a mental health specialist.

* When starting new antidepressants, wait a minimum of 2-4 weeks before beginning titration up.

^ If withdrawal effects occur, increase dose back to last dose before effects occurred.