Protocol for antidepressant use

Preamble clarifying basis for this protocol

I. Successful treatment for depression depends heavily on successful provider-client relationships
    1. Helpful relationships build hope and increase chance of recovery
    2. Treatment plans must account for an individual's goals and definition of recovery
    3. The preferred model is one that allows individuals to work with the same provider over time
II. Successful treatment for depression depends heavily on an appropriate assessment, which includes
    1. Current symptoms assessed in the context of a person's function, distress and life circumstances
    2. Gaining and understanding of a person's expectations and desires
    3. Screening for the presence of bipolar symptoms
    4. Screening for underlying physical causes of depression
III. Successful treatment for depression always minimizes the risk of harm.
    1. Specific treatment for depression ought to be undertaken only when confident that an untreated underlying medical condition is not responsible for the depressive symptoms
    2. Antidepressants should not be prescribed unless there is confidence the person does not have a bipolar disorder.
    3. When antidepressants are prescribed, there will be vigilance for the emergence of hypomanic or manic symptoms.
    4. Antidepressant medications must not be first line treatment for mild depressive symptoms
    5. Because we believe there exists a group of depressed people who will have better long term outcomes if they never take antidepressants, providers must embrace patients' choices to treat depression without medications.
    6. Since there is growing evidence that antipsychotic medications do long-term damage to brains (see the excellent work of Green and Gordon), providers must not only discourage the use of antipsychotics as adjuncts in the treatment of depression, providers must also embrace non-dangerous patients' choices to treat psychotic depression without the use of antipsychotic medications.
    7. Providers ought to avoid polypharmacy (does alcohol count as polypharmacy?).
IV. Successful treatment for depression embraces the context and complexity of the human condition
    1. First-line treatment for mild depressive symptoms should be addressed with effective treatments with low risk profiles must be tried first, preferably in combination. Areas addressed by these treatments include (but are not limited to):
        1. Community/Connectedness (relationship assessment, community life, pets/animals)
        2. Spirituality (dream statement, spiritual assessment/plan)
        3. Physical wellness (exercise, nutrition/neutraceuticals, massage therapy, diaphragmatic breathing, tai chi, chi gong, mindfulness, sleep assessment/hygeine, sobriety programs)
        4. Intellectual learning/creativity (creativity, music, dance, class/reading)
        5. Purpose/Productivity (meaningful work, life skills training, supported employment)
        6. Emotional/Psychological Health (psychotherapy, ECT, VNS, DBS, Neurofeedback, light therapy, Reike therapy)
        7. Empowerment/Independence (peer support, informed choice/collaboration)
    2. When antidepressant medications are selected for moderate to severe depressive symptoms, they must always be used in concert with (at least 2?) of the above-mentioned treatments

3. Such treatments are important because they help set in place the support and skills necessary for sustained recovery

V. When antidepressants are described, there must be vigilance for opportunities to begin medication tapering protocols (see the excellent work by Fisher, Falk and Hall)
   1. Antidepressants must always be used at the lowest effective dose.
   2. Antidepressants must always be used for the shortest effective course.
   3. Since there is scant evidence for continuing antidepressants beyond 12 months, and since there is accumulating evidence for long term harm associated with antidepressant use, any treatment plan that includes antidepressant use for longer than 12 months must include a provider-client conversation about tapering protocols.
   4. Since relationships are key for recovery, tapering someone off medications should not arbitrarily indicate discontinuation of care.

Where do the following fit?

Where does substance use fit in?

LMPs ought to be more than prescribers

When is it appropriate for LMPs to refuse to prescribe or refuse to continue to prescribe?

Should antidepressants be prescribed for only depression and anxiety (or FDA approved indications?)

What is the role of trauma in the expression of psychiatric symptoms

Where is the role of trauma-informed care in our protocol?

What if the two treatments in addition to medication are fish oil and tryptophan? Have we really stepped away from treating only with pills?