

Depression

Session outline

- **Introduction to depression**
- **Assessment of depression**
- **Management of depression**
- **Follow-up**
- **Review**

Activity 1: Person's story followed by group discussion

- Present the first person account of a person living with depression.
- First thoughts.

Local descriptions of depression

- What are the local terms/names for depression?
- How are people with depression treated and perceived by the local community?

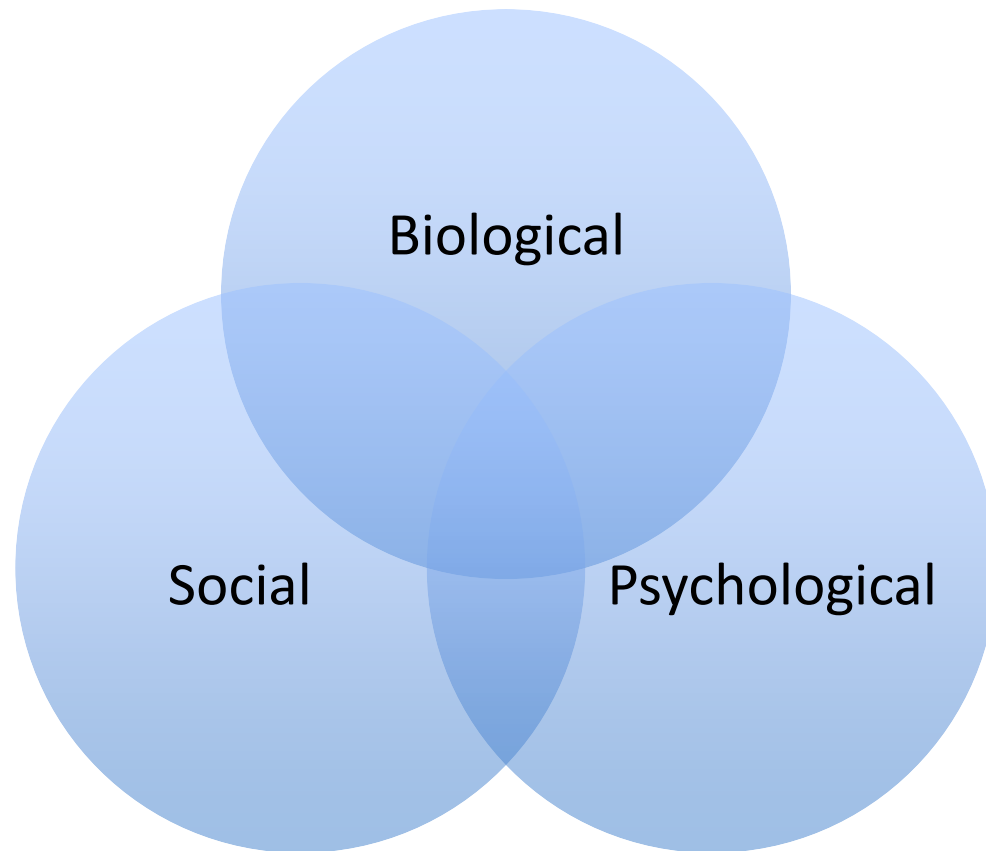
Core symptoms of depression

- Persistent depressed mood.
- Markedly diminished interest in or pleasure from activities.

Common presentations of depression

- Multiple persistent physical symptoms with no clear cause
- Low energy
- Fatigue
- Sleep problems (sleeping too much or too little)
- Anxiety
- Significant change in appetite or weight (weight gain or loss)
- Beliefs of worthlessness
- Excessive guilt
- Indecisiveness
- Restlessness/agitation
- Hopelessness
- Suicidal thoughts and acts

Contributing factors



Identifying depression

The length of time that a person experiences the symptoms is one of the distinctions between depression and general low mood.

How long do you think symptoms should be present?

Identifying depression

- Depression means that there is a considerable impairment in a person's ability to function in daily life.
- Some people may experience a persistent depressed mood but they are able to continue functioning in daily life. Therefore, their symptoms do not amount to depression and can be managed via the Module: Other significant mental health complaints in mhGAP-IG Version 2.0.

**Depression:
A public health
priority**

High prevalence rates

- 322 million people worldwide
- 4.4% in the community
- 10–20% in primary care attenders
- 10% women who have given birth

Socioeconomic impact

- High unemployment
- Worsening living conditions

Disability and mortality

- Major cause of disability
- High suicide rates

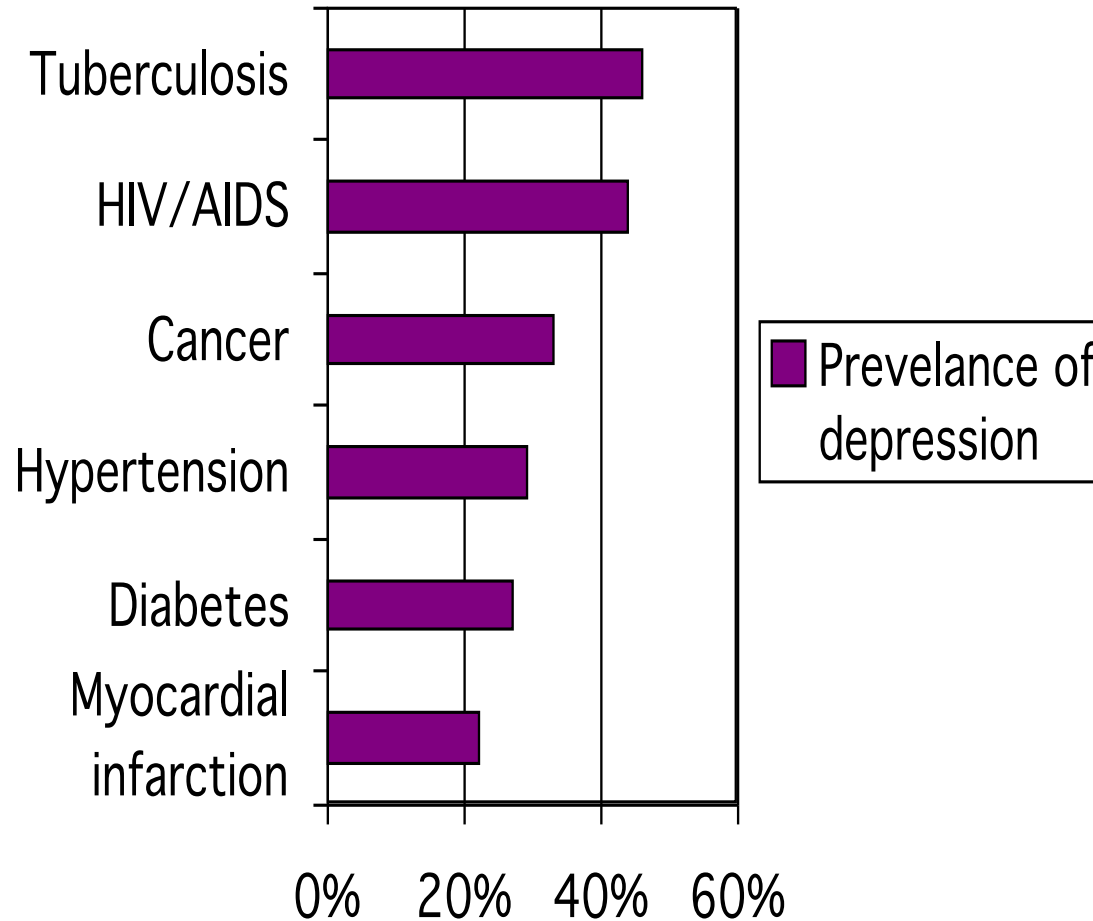
Impact on families

- Infant growth
- Family relationships
- Child rearing

**Correlations with other
physical health
conditions**


- Noncommunicable diseases
- Communicable diseases

Average prevalence of depression in people with physical diseases (70 countries)





Overview of Priority MNS Conditions

1. These common presentations indicate the need for assessment.
2. If people present with features of more than one condition, then all relevant conditions need to be assessed.
3. All conditions apply to all ages, unless otherwise specified.
4.  For emergency presentations, please see the table on page 18.

COMMON PRESENTATION

PRIORITY CONDITION

- » Low energy, fatigue, sleep problems
- » Persistent sadness or depressed mood, anxiety
- » Loss of interest or pleasure in activities that are normally pleasurable

DEPRESSION (DEP)

- » Marked behavioural changes; neglecting usual responsibilities related to work, school, domestic or social activities
- » Agitated, aggressive behavior, decreased or increased activity
- » Fixed false beliefs not shared by others in the person's culture
- » Hearing voices or seeing things that are not there
- » Lack of realization that one is having mental health problems

PSYCHOSES (PSY)

- » Convulsive movement or fits/seizures
- » During the convulsion: loss of consciousness or impaired consciousness, stiffness, rigidity, tongue bite, injury, incontinence of urine or faeces
- » After the convulsion: fatigue, drowsiness, sleepiness, confusion, abnormal behaviour, headache, muscle aches, or weakness on one side of the body

EPILEPSY (EPI)

DEP » Quick Overview



ASSESSMENT

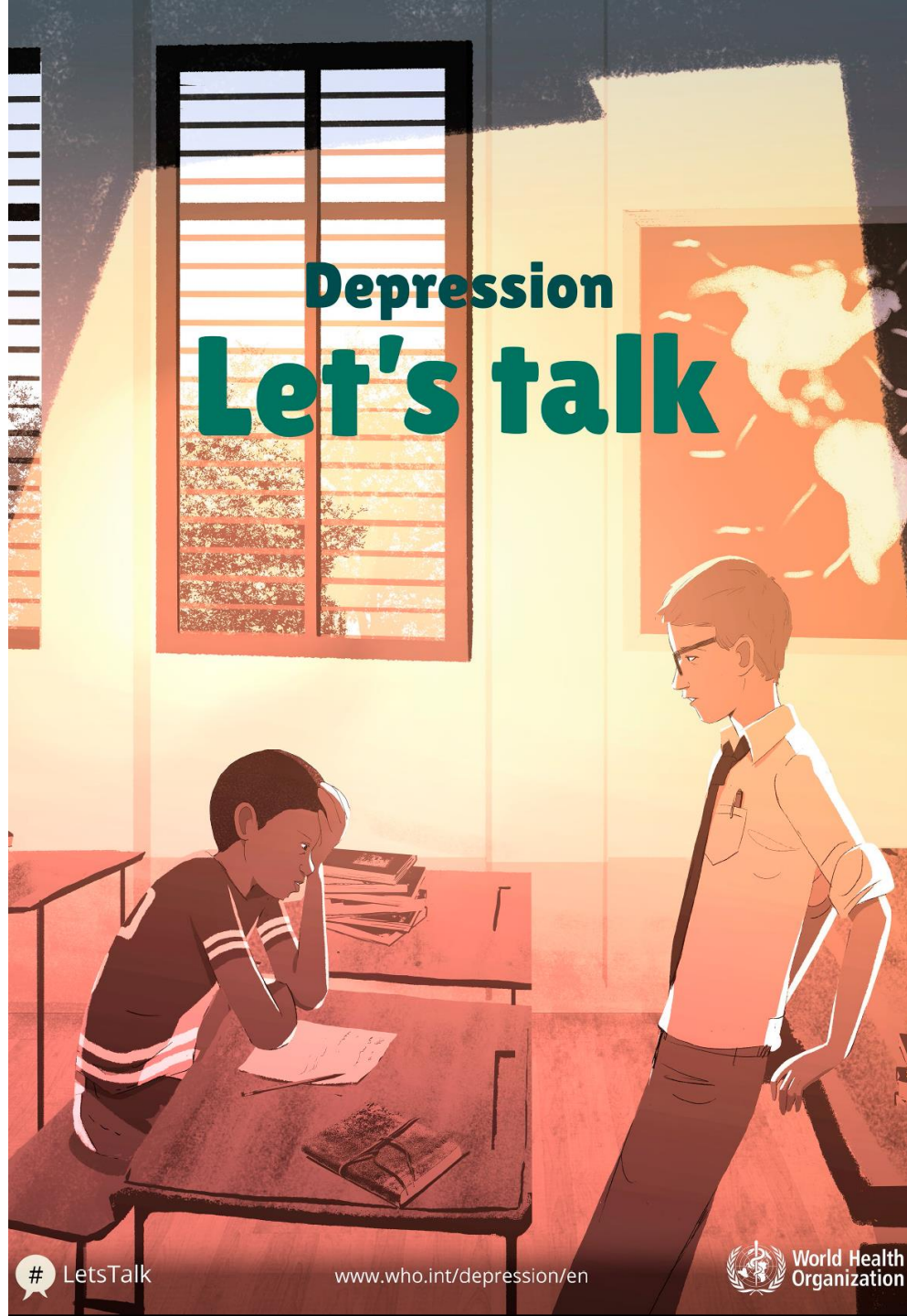
- » Does the person have depression?
- » Are there other explanations for the symptoms?
 - Rule out physical conditions
 - Rule out a history of mania
 - Rule out normal reactions to recent major loss
- » Assess for other priority MNS conditions

Activity 2: Video demonstration: Assessment

- Show the mhGAP-IG depression assessment video.

<https://www.youtube.com/watch?v=hgNAySulsjY&index=1&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>

Depression Let's talk



Process of assessment in the video

1

Does the person have depression?

Has the person had at least one of the following core symptoms of depression for at least 2 weeks?

- Persistent depressed mood
- Markedly diminished interest in or pleasure from activities

Has the person had several of the following additional symptoms for at least 2 weeks:

- Disturbed sleep or sleeping too much
- Significant change in appetite or weight (decrease or increase)
- Beliefs of worthlessness or excessive guilt
- Fatigue or loss of energy
- Reduced concentration
- Indecisiveness
- Observable agitation or physical restlessness
- Talking or moving more slowly than usual
- Hopelessness
- Suicidal thoughts or acts

Does the person have considerable difficulty with daily functioning in personal, family, social, educational, occupational or other areas?

Sarah's case

- Sarah is 23 years old and has a baby at home.
- What else do we want to know:
 - Is she breastfeeding?
 - Is she pregnant?
 - Is the baby developing well?

Consider physical conditions

2

Are there other possible explanations
for the symptoms?

IS THIS A PHYSICAL CONDITION THAT CAN RESEMBLE OR EXACERBATE DEPRESSION?

Are there signs and symptoms suggesting anaemia, malnutrition,
hypothyroidism, mood changes from substance use and medication side-effects
(e.g. mood changes from steroids)?

Physical conditions that resemble depression

Condition

- Anaemia
- Malnutrition
- Hypothyroidism

Symptoms

- Tiredness, loss of energy, problems sleeping, physical aches and pains, problems concentrating.
- Tiredness, loss of energy, loss of appetite, lack of interest in food and drinks, poor concentration, low mood, feeling weak.
- Tiredness, muscle aches and feeling weak, changes in appetite (weight gain), low mood, problems with memory and concentration (slowed thinking), loss of libido, loss of energy.

IS THERE A HISTORY OF MANIA?

Have several of the following symptoms occurred simultaneously, lasting for at least 1 week, and severely enough to interfere significantly with work and social activities or requiring hospitalization or confinement?

- Elevation of mood and/or irritability
- Decreased need for sleep
- Increased activity, feeling of increased energy, increased talkativeness or rapid speech
- Impulsive or reckless behaviours such as excessive spending, making important decisions without planning and sexual indiscretion
- Loss of normal social inhibitions resulting in inappropriate behaviours
- Being easily distracted
- Unrealistically inflated self-esteem



CLINICAL TIP:
 People with depressive episode in bipolar disorder are at risk for mania. Treatment is different from depression. **Protocol 2 must be applied.**

DEPRESSIVE EPISODE IN BIPOLAR DISORDER is likely

» Go to STEP 3 then to PROTOCOL 2

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NO

YES

DEPRESSIVE EPISODE IN BIPOLAR DISORDER is likely



CLINICAL TIP:
People with depressive episode in bipolar disorder are at risk for mania. Treatment is different from depression. **Protocol 2 must be applied.**

» Go to **STEP 3** then to **PROTOCOL 2**

HAS THERE BEEN A MAJOR LOSS (E.G. BEREAVEMENT) WITHIN THE LAST 6 MONTHS?

YES

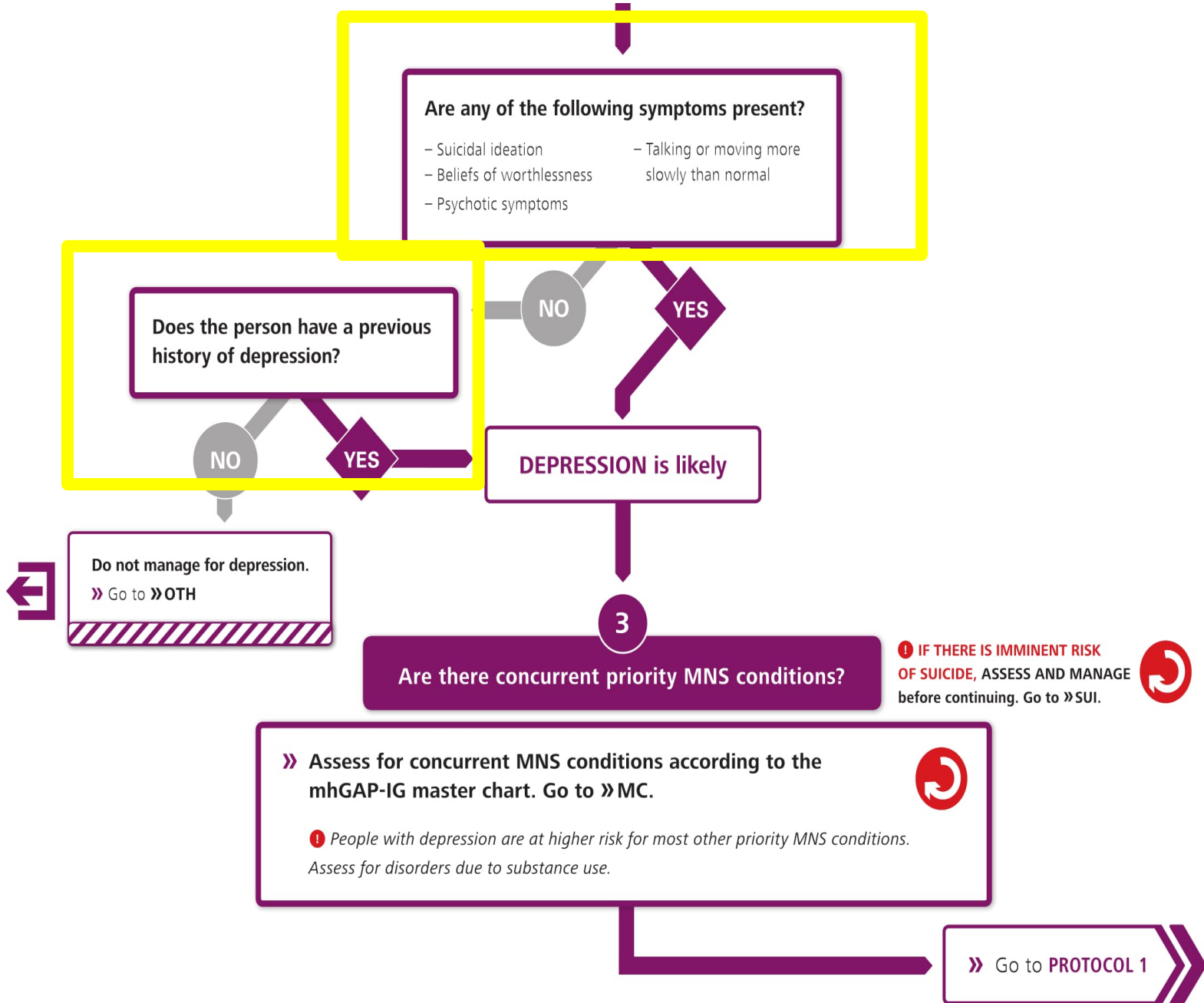
NO

DEPRESSION is likely

» Go to **STEP 3** then to **PROTOCOL 1**

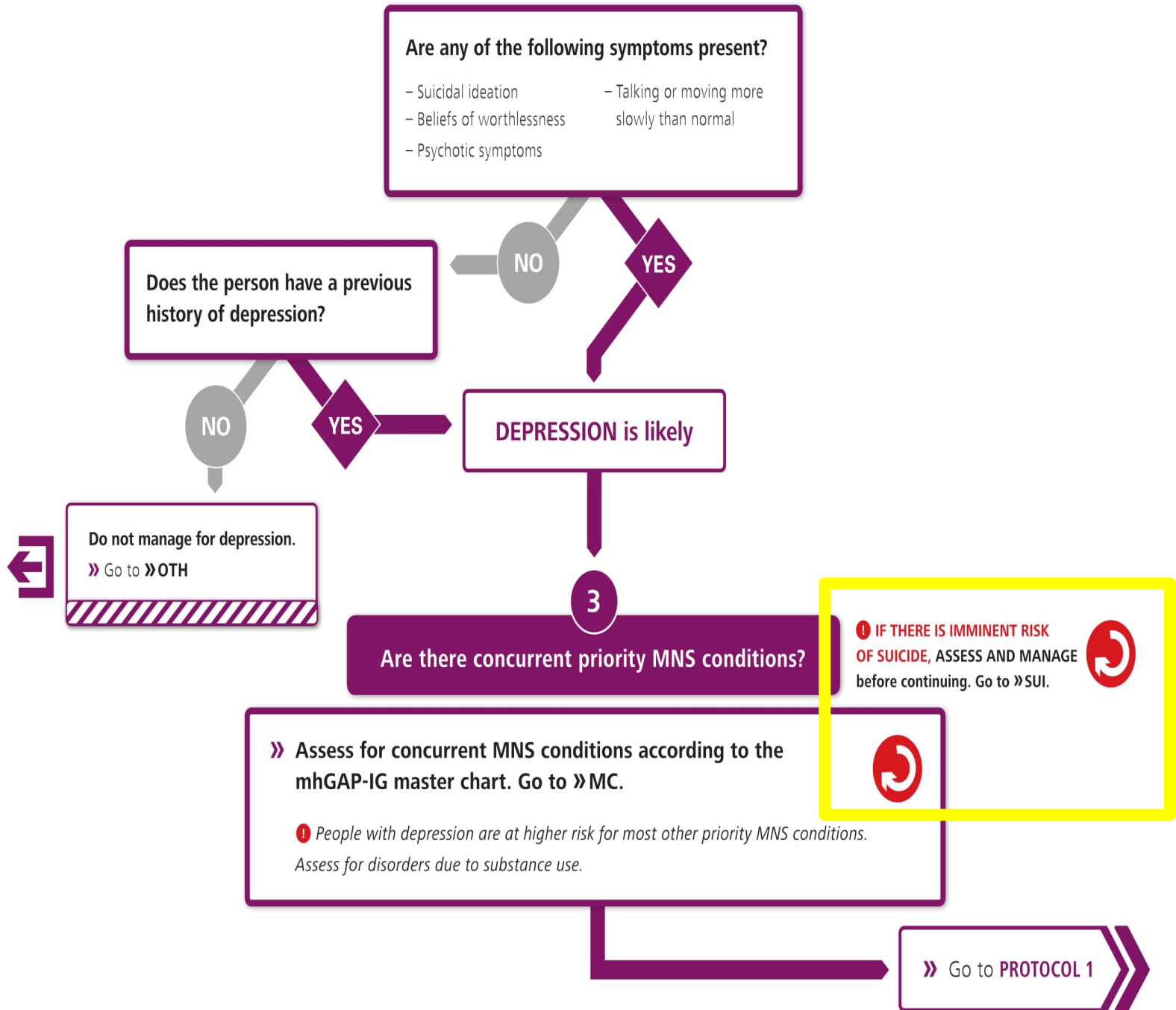
Grief

- Low mood, anxiety, fear, guilt, self-blame, irritability, loneliness, crying.
- Negative thinking, rumination, low self-esteem, hopelessness, pessimism about the future.
- Social withdrawal, loss of interest, restlessness, agitation.
- Loss of appetite, problems sleeping, loss of appetite/appetite gain, physical aches and pains, tiredness, loss of energy.



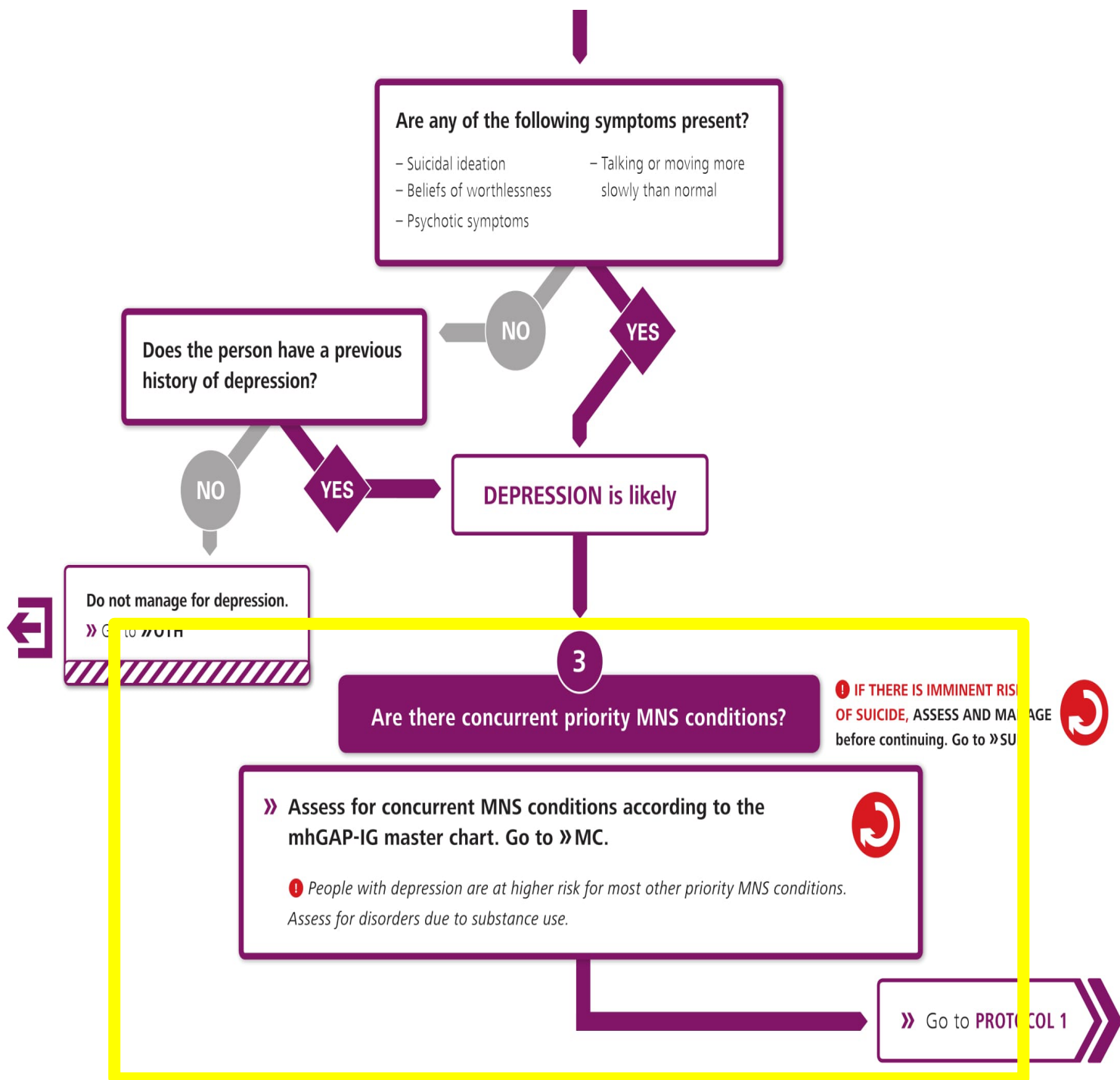
Sarah's case

- Did the health-care provider assess if Sarah had a history of mania?
- What questions could they have used to explore whether she had experienced any of these symptoms?
- Did the health-care provider assess if Sarah had experienced a major loss in the past six months? If so what questions could have been asked?



Assess for imminent risk of suicide

- Talking about self-harm/suicide is **ESSENTIAL**.
- Talking about self-harm/suicide **DOES NOT** increase the risk that the person will commit self-harm/suicide.
- If there is a risk of self-harm/suicide then **GO IMMEDIATELY TO MODULE: SELF-HARM/SUCIDE IN THE mhGAP-IG AND FOLLOW THE STEPS TO MANAGE SELF-HARM/SUICIDE**.



Special populations

Note that interventions may differ for these populations




CHILD / ADOLESCENT

- » For management of depression in children/adolescents, go to » **CMH**.



WOMEN WHO ARE PREGNANT OR BREASTFEEDING

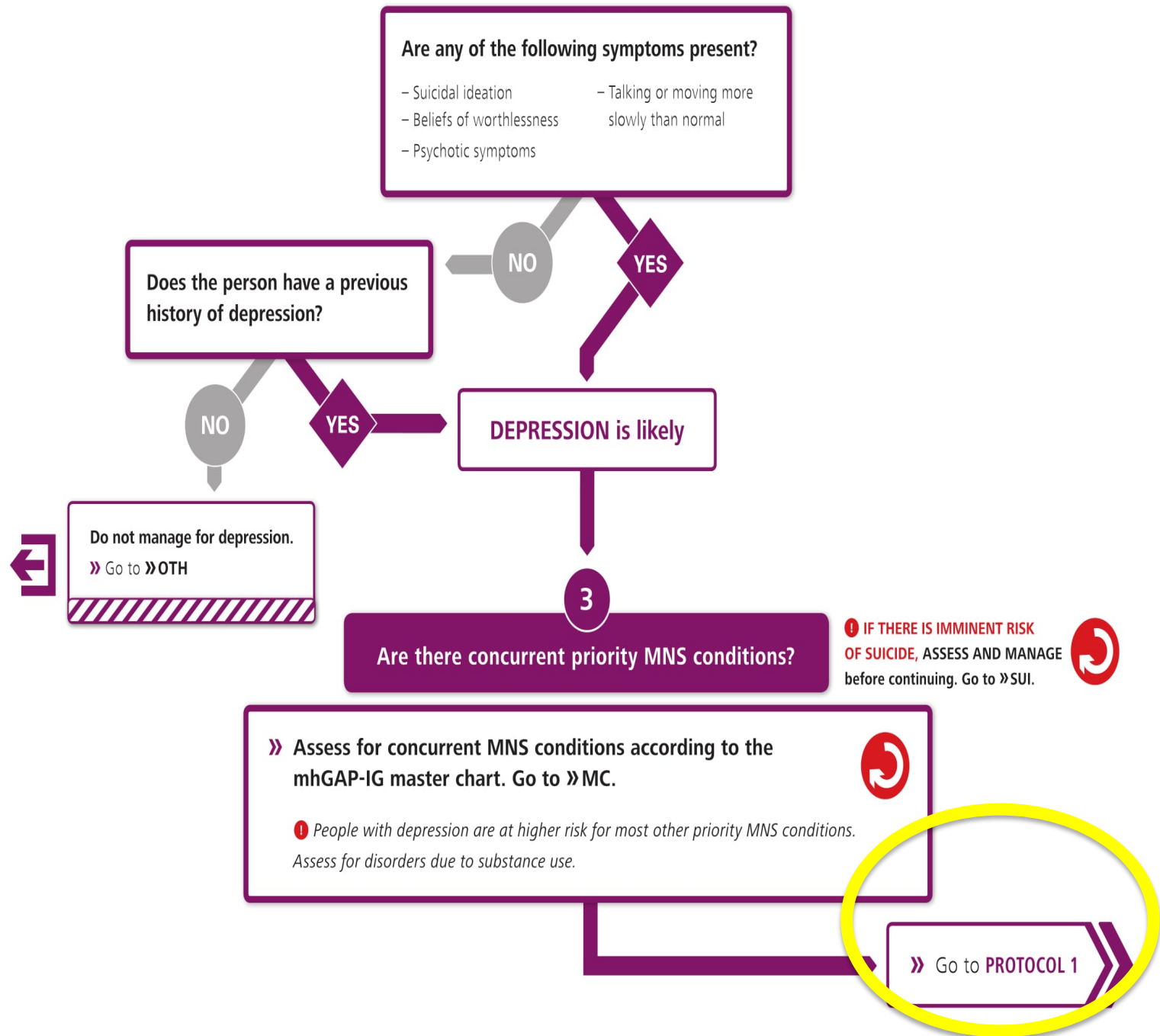
- » Follow treatment for depression (**PROTOCOL 1**) but **AVOID** antidepressants if possible, especially during the first trimester.
- » If no response to psychological treatment, consider using with caution the lowest effective dose of antidepressants.
- » If breastfeeding, avoid long acting medication such as fluoxetine.
- » **CONSULT A SPECIALIST**, if available. 

Activity 3: Depression role play 1

Assessment

A person with fatigue, poor sleep and weight loss comes to see a health-care provider.

Practise using the mhGAP-IG to assess a person for possible depression.



Are any of the following symptoms present?

- Suicidal ideation
- Beliefs of worthlessness
- Psychotic symptoms
- Talking or moving more slowly than normal

NO

YES

Does the person have a previous history of depression?

NO

YES

DEPRESSION is likely

3

Are there concurrent priority MNS conditions?

ⓘ IF THERE IS IMMINENT RISK OF SUICIDE, ASSESS AND MANAGE before continuing. Go to »SUI.

» Assess for concurrent MNS conditions according to the mhGAP-IG master chart. Go to »MC.

ⓘ People with depression are at higher risk for most other priority MNS conditions. Assess for disorders due to substance use.

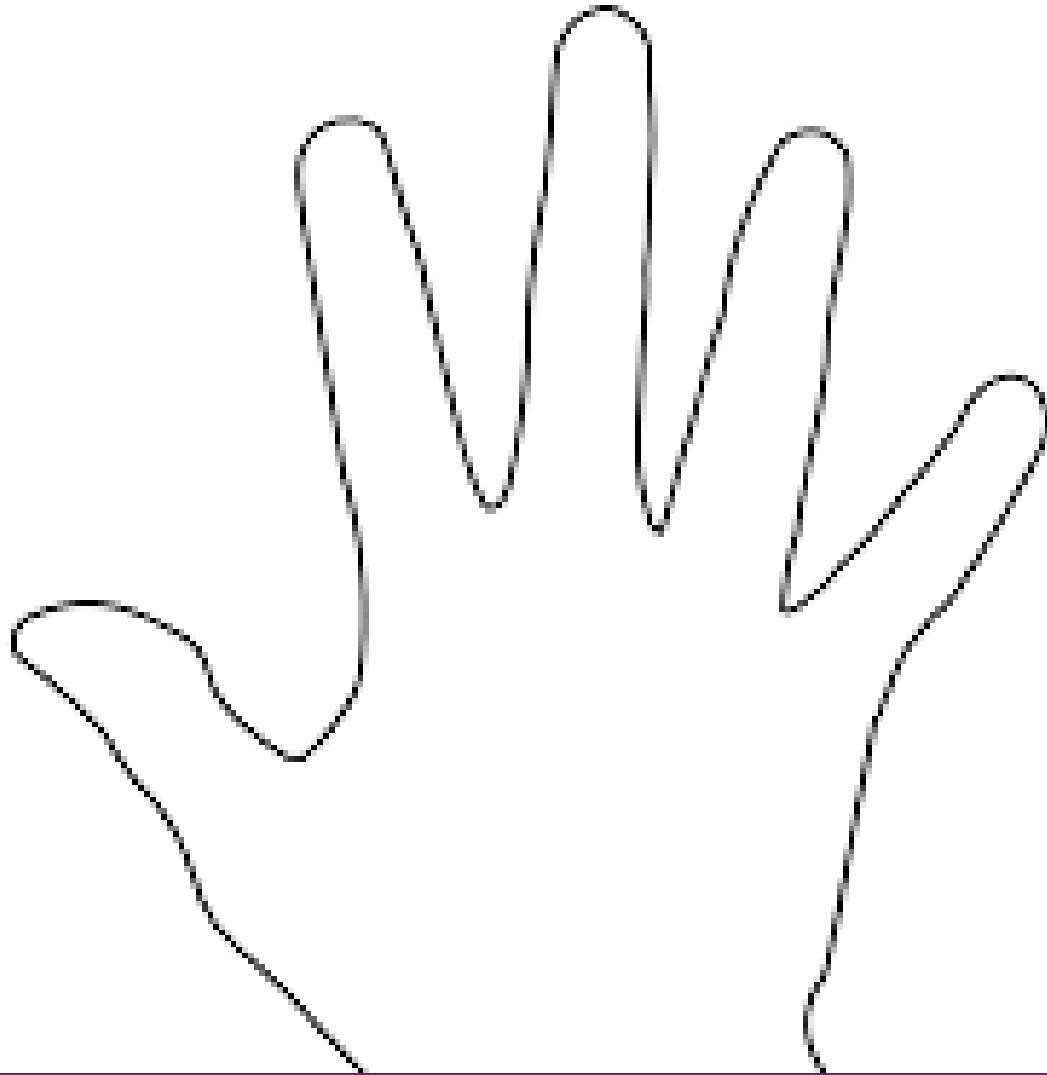
» Go to PROTOCOL 1

PROTOCOL

1

Depression

- » Provide psychoeducation to the person and their carers. (2.1) 
- » Reduce stress and strengthen social supports. (2.2)
- » Promote functioning in daily activities and community life. (2.3)
- » Consider antidepressants. (2.5) 
- » If available, consider referral for one of the following brief psychological treatments: interpersonal therapy (IPT), cognitive behavioural therapy (CBT), behaviour activation and problem-solving counselling. (2.4)
- »  **DO NOT** manage the symptoms with ineffective treatments, e.g. vitamin injections.
- » Offer regular follow-up. 



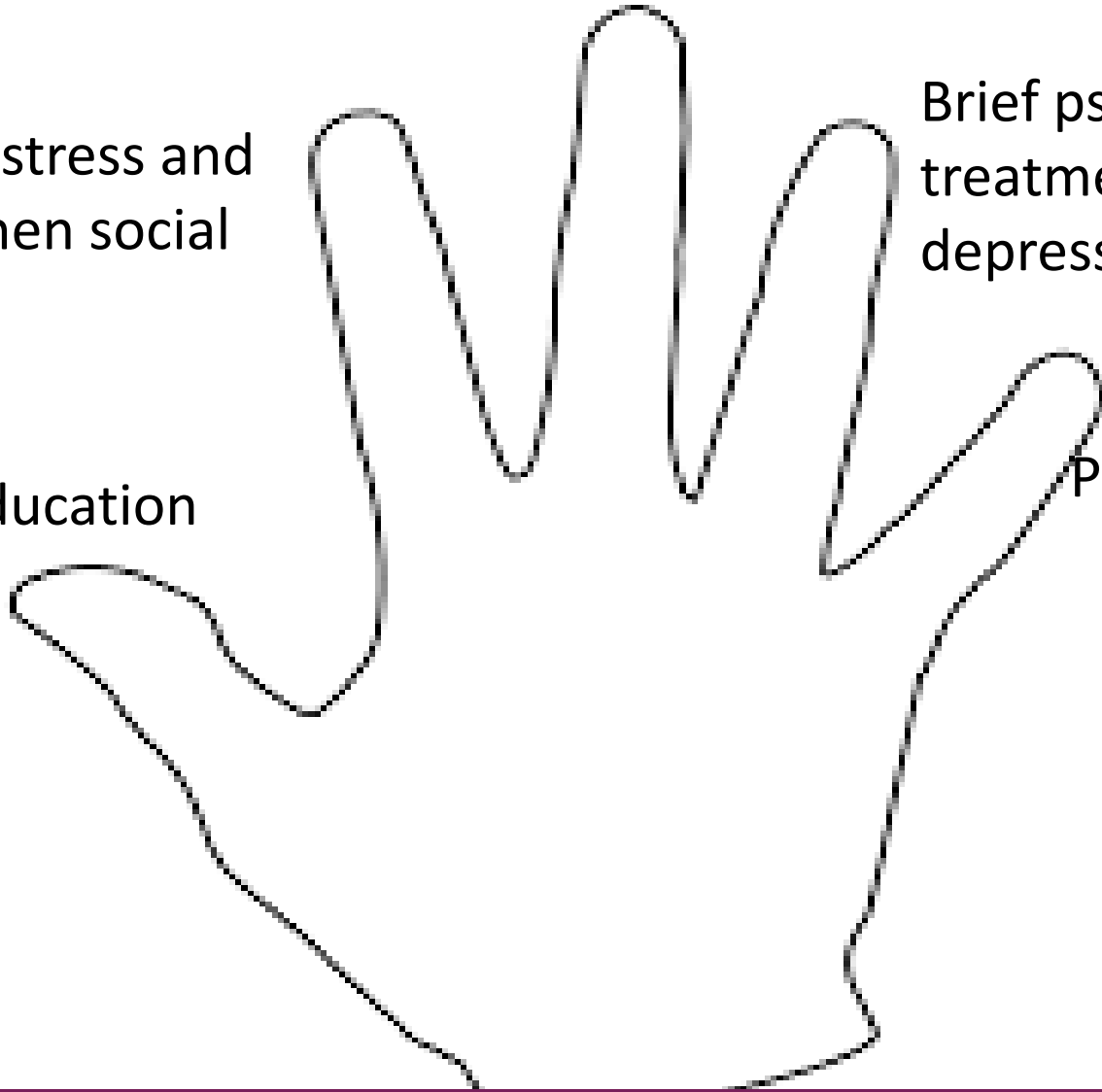
Promote functioning in daily activities

Reduce stress and
strengthen social
support

Brief psychological
treatment for
depression

Psychoeducation

Pharmacology



Treatment plans should include:

- **Presenting problem:** **What** are the person's health and social needs?
- **Which** interventions best meet the person's health and social needs?
- **Action plan:** Record the steps, goals and behaviours that need to happen, who will do them and when?
- **Manage** risks (plans for what people can do in a crisis).
- **Involve** the person and the carers to ensure ownership of the treatment plan.

Activity 4: Management of depression – which interventions?

- This is an opportunity to familiarize yourself with the psychosocial interventions for depression.
- In your groups identify the:
 - Key elements of a particular psychosocial intervention.
 - Barriers and risks of using that interventions.
 - Identify solutions to those barriers and risks.

Present the information in the form of a poster. Be as creative as you wish.

When to refer

Consider a referral to a mental health specialist (where available):

- If a person with depression shows any signs of psychotic symptoms (e.g. hallucinations and delusions).
- If the person presents with bipolar disorder.
- If the person is pregnant or a breastfeeding woman.
- In the cases of people with self-harm/suicide.

Consider a referral to a hospital:

- If a person is non-responsive to treatment.
- If a person shows serious side-effects of any pharmacological interventions.
- If a person needs further treatment for any comorbid physical condition.
- There is a risk of self-harm/suicide.

Link with other sectors

- Linking people with other sectors ensures:
 - That the person receives a comprehensive package of care.
 - It fulfils parts of the psychosocial interventions, e.g. in order to *promote functioning in daily activities and community life*. If the person has identified that they would like to return to their studies and/or start a livelihood activity, it is important to link them to livelihood organizations.

Brief psychological treatments

- As first-line therapy, health-care providers may select psychological treatments and/or antidepressant medication.
- When deciding, they should keep in mind the:
 - Possible adverse effects of antidepressant medication.
 - The ability to deliver either intervention (in terms of expertise, and/or treatment availability).
 - Individual preferences of the person.

Group interpersonal therapy (IPT)

- Assumes that depression is triggered by interpersonal difficulties in one or more problem area:
 - grief
 - interpersonal disputes
 - role transitions
 - Interpersonal deficits.
- By understanding the relationship between interpersonal events and stress, and by helping the person improve their skills to handle these events, we can help the person recover.



GROUP INTERPERSONAL THERAPY (IPT) FOR DEPRESSION

1989 Geneva Declaration on the WHO
International Guidelines for Psychiatric Rehabilitation - 1

Multi-component behavioural treatment (PM+)

- Problem-solving counselling
- Managing stress (slow breathing)
- Behavioural activation
- Strengthening social supports

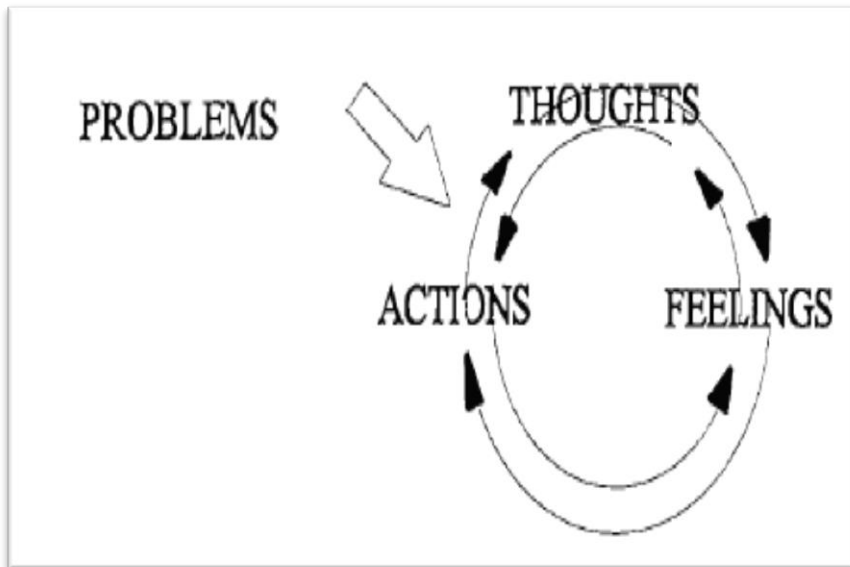


PROBLEM MANAGEMENT PLUS (PM+)
Individual psychological help for adults impaired by distress in communities exposed to adversity

WHO generic field-trial version 1.0, 2016
Series on Low-Intensity Psychological Interventions - 2



Thinking healthy – cognitive behavioural therapy for perinatal depression



Activity 5: Video demonstration: Managing depression

You will now see a video which shows the health-care provider managing Sarah's depression. Whilst watching the video think about:

1. How did the health-care provider explain the treatment options available?
2. Did the health-care provider explain the risks and benefits of different treatment interventions?

<https://www.youtube.com/watch?v=hdR8cyx2iYU&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=2>

PHARMACOLOGICAL INTERVENTIONS

2.5 Consider antidepressants


- » Discuss with the person and decide together whether to prescribe antidepressants. Explain that:
 - Antidepressants are not addictive.
 - It is very important to take the medication every day as prescribed.
 - Some side effects may be experienced within the first few days but they usually resolve.
 - It usually takes several weeks before improvements in mood, interest or energy is noticed.
- » Consider the person's age, concurrent medical conditions, and drug side-effect profile.
- » Start with only one medication at the lowest starting dose.
- » Antidepressant medications usually need to be continued for at least 9-12 months after the resolution of symptoms..
- » Medications should never be stopped just because the person experiences some improvement. Educate the person on the recommended timeframe to take medications.

CAUTION


- » If the person develops a manic episode, stop the antidepressant immediately; it may trigger a manic episode in untreated bipolar disorder.
- » Do not combine with other antidepressants, as this may cause serotonin syndrome.
- » Antidepressants may increase suicidal ideation, especially in adolescents and young adults.

Antidepressants in special populations

ADOLESCENTS 12 YEARS OF AGE OR OLDER

- » If symptoms persist or worsen despite psychosocial interventions, consider fluoxetine (but no other selective serotonin reuptake inhibitor (SSRI) or tricyclic antidepressant (TCA)).
- » If fluoxetine is prescribed, ask the adolescent to return weekly, for the first 4 weeks, to monitor thoughts or plans of suicide. 

WOMEN WHO ARE PREGNANT OR BREASTFEEDING

- » Avoid antidepressants, if possible.
- » Consider antidepressants at the lowest effective dose if there is no response to psychosocial interventions.
- » If the woman is breastfeeding, avoid long acting antidepressant medication such as fluoxetine.
- » Consult a specialist if available. 

OLDER ADULTS

- » Avoid amitriptyline if possible.

PEOPLE WITH CARDIOVASCULAR DISEASE

- »  Do NOT prescribe amitriptyline.



ADULTS WITH THOUGHTS OR PLANS OF SUICIDE

- » SSRIs are the first choice. Overdose of TCAs such as amitriptyline may be fatal and therefore should be avoided in this group.
- » If there is an imminent risk of self-harm or suicide (Go to » **SUI**), give a limited supply of antidepressants (e.g. one week supply at a time).
- » Ask the person's carers to keep and monitor medications and to follow-up frequently to prevent medication overdose.

Pharmacological interventions: When NOT to prescribe

- **Do not** prescribe an antidepressant if there is no depression. For example:
 - When the symptoms do not last two weeks and/or do not involve impaired functioning).
 - If the symptoms are part of a normal grief reaction.
 - If the symptoms are due to a physical cause.
- **Do not** prescribe an antidepressant if the person is pregnant/breastfeeding. As first-line treatment, offer psychosocial intervention first.
- **Do not** prescribe if the child is younger than 12.
- **Do not** prescribe to adolescents aged 12–18 as first-line treatment. Offer psychosocial interventions first.

TABLE 1: Antidepressants

MEDICATION	DOSING	SIDE EFFECTS	CONTRAINDICATIONS / CAUTIONS
<p>AMITRIPTYLINE (a tricyclic antidepressant (TCA))</p>	<p>Start 25 mg at bedtime. Increase by 25-50 mg per week to 100-150 mg daily (maximum 300 mg). Note: Minimum effective dose in adults is 75 mg. Sedation may be seen at lower doses.</p> <p>Elderly/Medically Ill: Start 25 mg at bedtime to 50-75 mg daily (maximum 100 mg).</p> <p> Children/Adolescents: Do not use.</p>	<p>Common: Sedation, orthostatic hypotension (risk of fall), blurred vision, difficulty urinating, nausea, weight gain, sexual dysfunction.</p> <p>Serious: ECG changes (e.g. QTc prolongation), cardiac arrhythmia, increased risk of seizure.</p>	<p>Avoid in persons with cardiac disease, history of seizure, hyperthyroidism, urinary retention, or narrow angle-closure glaucoma, and bipolar disorder (can trigger mania in people with untreated bipolar disorder).</p> <p>Overdose can lead to seizures, cardiac arrhythmias, hypotension, coma, or death.</p> <p>Levels of amitriptyline may be increased by anti-malarials including quinine.</p>
<p>FLUOXETINE (a selective serotonin reuptake inhibitor (SSRI))</p>	<p>Start 10 mg daily for one week then 20 mg daily. If no response in 6 weeks, increase to 40 mg (maximum 80 mg).</p> <p>Elderly/medically ill: preferred choice. Start 10 mg daily, then increase to 20 mg (maximum 40 mg).</p> <p> Adolescents Start 10 mg daily. Increase to 20 mg daily if no response in 6 weeks (maximum 40 mg).</p>	<p>Common: Sedation, insomnia, headache, dizziness, gastrointestinal disturbances, changes in appetite, and sexual dysfunction.</p> <p>Serious: bleeding abnormalities in those who use aspirin or other non-steroidal anti-inflammatory drugs, low sodium levels.</p>	<p>Caution in persons with history of seizure.</p> <p>Drug-Drug interactions: Avoid combination with warfarin (may increase bleeding risk). May increase levels of TCAs, antipsychotics, and beta-blockers.</p> <p>Caution in combination with tamoxifen, codeine, and tramadol (reduces the effect of these drugs).</p>

Precautions for tricyclic antidepressants (TCAs)

Avoid use in:

- The elderly, people with cardiovascular disease and people with dementia.
- People with ideas, plans or previous acts of self-harm or suicide – to minimize the risk of overdosing.

Choosing an appropriate antidepressant

Quiz time

Q&A

Which antidepressant would you recommend for adolescents 12 years and older?

Consider **fluoxetine** (but no other selective serotonin reuptake inhibitors [SSRIs] or TCAs) only when symptoms persist or worsen despite psychosocial interventions.

Q&A

Which antidepressant would you recommend for children under the age of 12?

NO antidepressants. Use only psychosocial techniques.

Q&A

Which antidepressant would you recommend for pregnant or breastfeeding women?

Avoid antidepressants if possible. Consider antidepressants at the lowest effective dose if there is no response to the psychosocial interventions. If the woman is breastfeeding, avoid fluoxetine. Consult a specialist, if available.

Q&A

In what groups should you avoid and/or not prescribe amitriptyline?

Avoid in elderly people.

Do not prescribe it to people with cardiovascular disease.

Like all antidepressants, it should not be prescribed to children, and be avoided in pregnant women.

Avoid in people with thoughts or plans of suicide (SSRIs are the first choice).

Q&A

How should you prescribe fluoxetine to someone who has an imminent risk of suicide?

If there is an imminent risk of self-harm or suicide, give only a limited supply of antidepressants (e.g. one week's supply at a time).

Ask carers to monitor medicines and to follow-up frequently to prevent medication overdose.

Activity 6: Depression role play 2: Psychosocial interventions

A 27-year-old was identified as having depression one week ago. One year ago he was employed in a busy bank in line for a promotion and engaged to be married.

Then his fiancée left him, unexpectedly, for another person. He felt that the stress of work and started to feel very anxious and worried all the time. He stopped being able to sleep or eat well. He felt more and more sad and depressed. His personality started to change; he was irritable, forgetful, socially isolated and unable to spend time with family and friends as he felt ashamed and guilty. He had no work and no income and blamed himself for everything that had happened in his life.

- Use the mhGAP-IG to develop a treatment plan using psychosocial interventions.

DEP 3 » Follow-up

1

ASSESS FOR IMPROVEMENT

Is the person improving?

NO

YES

- » If not yet receiving psychological treatment, consider psychological treatment.
- » If receiving a psychological treatment, evaluate engagement in and experience of current psychological treatment.
- » If not yet on antidepressants, consider antidepressants.
- » If on antidepressants, assess:
 - Does the person take the medication as prescribed? If not, explore reasons why and encourage adherence.
 - Are there side effects?
 - If yes, evaluate and weigh benefits of treatment.
 - If no to side effects to antidepressants, increase dose (TABLE 1). Follow-up in 1-2 weeks. ↻
 - ⚠ CAUTION WITH DOSE INCREASE. CLOSE FOLLOW-UP NEEDED DUE TO POSSIBLE INCREASE IN SIDE EFFECTS.

- » Encourage the person to continue with their current management plan until they are *symptom free for 9-12 months*.
 - » Arrange a further follow up appointment in 1-2 weeks. ↻
 - » Decrease contact as the person's symptoms improve, e.g. once every 3 months after the initial 3 months.
- Note: follow up should continue until the person no longer has any symptoms of depression.*

RECOMMENDATIONS ON FREQUENCY OF CONTACT

- » Schedule the second appointment within 1 week.
- » Initially maintain regular contact via telephone, home visits, letters, or contact cards more frequently, e.g. monthly, for the first 3 months.

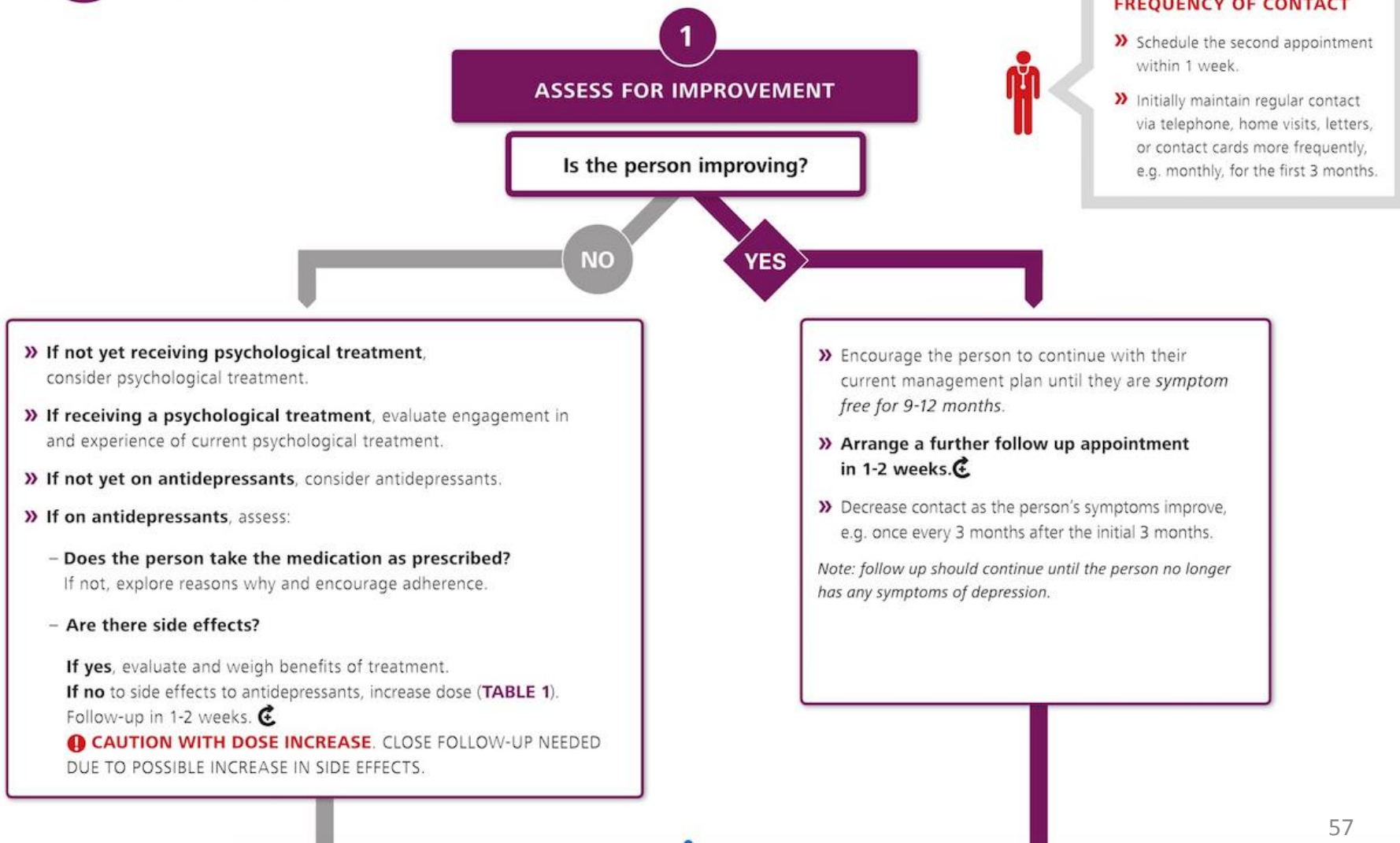


Possible presentations at follow-up

At follow up you may see people:

1. Improving (actively engaging with management interventions and their symptoms are improving).
2. Remaining the same (actively engaged in management interventions but their symptoms are remaining the same) or deteriorating (the symptoms are deteriorating and the person is feeling worse).

DEP 3 » Follow-up



Activity 7: Video demonstration: Follow-up

Show the final video of Sarah returning for a follow-up appointment with the health-care provider.

1. Which of Sarah's symptoms had improved at follow-up?
2. What new information did the health-care provider learn?
3. Why was that information important?

<https://www.youtube.com/watch?v=F3MKvTxQvF4&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=3>

Monitoring people on antidepressants

It is expected that people will have a positive response, but there are some results that will require action – if the person shows:

- symptoms of mania
- inadequate response
- no response.

What do you do when symptoms worsen or do not improve after four to six weeks (inadequate response)?

Take three important steps before increasing the dose:

1. Ensure that the assessment is correct.
2. Ensure that the person is taking the medication as prescribed.
3. Ensure that the dose is adequate.

If there is no improvement after four to six weeks at maximum dose, consult a specialist.

When and how to stop an antidepressant

If after 9–12 months of therapy the person reports no or minimal symptoms:

- Discuss the plan with the person before reducing the dose.
- Describe early symptoms of relapse.
- Plan routine and emergency follow-up.
- Reduce dose gradually over at least four weeks.


Antidepressants: Summary

- Time for response to antidepressants four to six weeks.
- Treatment should continue for 9–12 months.
- Taper slowly if ceasing medication.
- Do not prescribe antidepressants to:
 - A functioning person.
 - Someone recently bereaved.
 - Children (under 12) and pregnant/breastfeeding women.
- Avoid TCAs if:
 - The person is elderly, has dementia or has cardiovascular disease.

Are there symptoms of mania?

YES


NO

- » Discontinue antidepressant medication.
- » Treat mania and consult a specialist.  Go to » PSY.

2

MONITOR TREATMENT

At every contact:

- » Provide psychoeducation, reduce stress and strengthen social supports, promote functioning in daily activities and community life, and review, if applicable, antidepressant medication use and psychological treatment.
- » Does the person have any new symptoms of concern? Review for MNS and concurrent physical conditions.
- » Is the person a woman of childbearing age and considering pregnancy? If so, CONSULT A SPECIALIST. 
- ❗ Assess for any IMMEDIATE RISK OF SUICIDE (Go to » SUI).

3

REVISE TREATMENT AS APPROPRIATE

Has the person been symptom free for 9-12 months?

NO

YES

- » Continue medication until person is symptom free for 9-12 months.

- » Discuss with the person the risks and benefits of stopping the medication.
- » Taper the dose of medication gradually, over a minimum of 4 weeks. Monitor the person for symptom recurrence.

Review