Managing Depressive Disorders in Homebound Patients

**Q: Best adjunct therapy after first line SSRIs?**

A: There is an ongoing controversy about whether to switch vs augment. Switching provides a less complicated solution, sometimes less expensive, and less risk of drug/drug interactions. Augmenting can be quicker and preserves a partial response to the initial drug. No study proves one approach is universally better, and it turns out surprisingly that switching to a drug with a different mechanism of action is not necessarily more effective than switching to another drug of the same class.

If an adjunct is chosen, based on partial response to the initial drug (let’s say an SSRI), think about the patient’s symptoms. If fatigued and apathetic with limited anxiety, a low dose of bupropion might be best. If anxious and insomniac or with low appetite, mirtazapine might be good. If delusional (or severely depressed even without delusions) and especially if not also demented (otherwise boxed warning is applicable) a low dose of aripiprazole or brexpiprazole may be best. Other strategies include T3, testosterone, or lithium—but these are more fraught with complications. Don’t use bupropion in the presence of psychosis, moderate anxiety, eating disorder history, or seizure history. There may be additional medical considerations on an individualized basis.

**Q: What are the quality measures related to depression? What are some national benchmarks we should be aware of?**

A: Following response with the GDS or PHQ is an outcome measure approach. Measuring the number of people screened, the number detected, or the number started on medication is a process approach.

**Q: Interested in innovative strategies to help homebound patients access therapies such as PST, BA, CBT given workforce shortage of mental health providers who do house calls, also strategies to address loneliness in re: geriatric depression in homebound.**

A: For insomnia, I often recommend the app called CBT-I, and there are forms of CBT available online both as apps or through telecounseling services. It’s important for Practices to research their local area and collect a list of mental health providers and resources. Certain counties may be lucky enough to have in-home counseling resources; others may rely on virtual specialist support or social workers. Zencare is one resource of an online database of mental health providers. Right now, only NYC and Boston have in-home therapists listed; however, the following states do have therapists listed who offer remote video counseling sessions. (Chicago, NYC, Boston, CT, Rhode Island, Seattle, New Jersey, Washington DC, and Westchester.)

**Q: Please address depressions with delusional features in older adults.**

A: Start by assessing risk for violence to self or others, ability to care for basic self needs—because this is a dangerous and debilitating condition that can lead to murder or suicide (or both) and it may justify hospitalization. Somatic treatment begins with an antidepressant (usually
SRI, avoid bupropion which may fail to help psychosis or severe anxiety) and shortly thereafter add an antipsychotic – both are needed. Significant response should not take longer than 2-3 weeks so be ready to refer for ECT evaluation.

**Q: Is it more effective to combine two low dose or medium dose antidepressants rather than increase the dose of one?**

A: Generally, to avoid adverse pharmacokinetic or pharmacodynamic interactions, it’s best to optimize one antidepressant, then either switch or augment rather than combine 2 low or medium dose drugs – also, don’t augment one serotonergic drug with another serotonergic drug.

**Q: Medication choices for elderly, in home talk therapy options.**

A: First line antidepressant for MOST depressed elderly patients is SRI, usually sertraline or escitalopram. For very apathetic, may want to consider bupropion. For very anxious or not eating/sleeping, may want to consider mirtazapine. Home talk therapy options require either digital connection with therapist at a distance or visit from available therapist.

**Q: When you change from one SSRI to another, do you wean down one and slowly go up on the other? Or, do you just switch?**

A: If drug being discontinued has long elimination half-life, it can be stopped quicker. If the drug being discontinued has a very short half-life, discontinuation symptoms can be diminished by cross-tapering, starting new drug earlier in the tapering process. Keep in mind that depression/anxiety symptoms after tapering first drug may represent EITHER discontinuation symptoms (i.e. withdrawal) or re-emergence of the depression that was being treated.

**Q: What are your thoughts about cannabis?**

A: Not enough evidence to recommend for depression treatment.