RAPIDS assessment detected clinical features consistent with

Major Depressive Disorder, moderately severe
Generalized Anxiety Disorder, mild
Insomnia, mild

Screening Overview

Diagnostic screening

ADHD Self-Report - Part A (ASRS-A)
3 - Negative for ADHD

Generalized Anxiety Disorder-7 (GAD-7)
5 - Mild anxiety

Patient Health Questionnaire-9 (PHQ-9)
16 - Mod.-severe depression

Rapid Mood Screener (RMS)
2 - Negative for bipolarity

Comorbidity

Insomnia Severity Index (ISI)
12 - Mild insomnia

Functional Impairment

Work and Social Adjustment Scale (WSAS)
20 - Moderate impairment

What is a RAPIDS assessment?

A RAPIDS assessment is based on the analysis of intake information, including scores from validated clinical scales (see Medical Summary). The personalized guidance in this report is intended to facilitate the rapid implementation of optimal psychiatric care. If you agree with the RAPIDS assessment, please consider the biopsychosocial treatment guidance that follows. RAPIDS guidance is limited to specific diagnoses. If the patient has other concurrent conditions, it is important to consider the report in the context of the patient's complete clinical presentation.

Treatment Guidance

Safety

Evaluate

- Suicide risk and potential risk to others
- Insight and impulsivity
- Self-care and ability to care for dependents

Guidance Summary

Major Depressive Disorder and Generalized Anxiety Disorder

Switch antidepressant treatment (ADT)

Insomnia

Pharmacotherapy not recommended for mild insomnia

Treatment Guidance

Pharmacotherapy

Major Depressive Disorder and Generalized Anxiety Disorder

Switch antidepressant treatment (ADT)

Initial guidance

- **Switch** to a preferred ADT with a different mechanism of action and anxiolytic benefits. The presence of anxiety was considered when compiling the preferred medication options.
- **Rationale:** The current treatment is not well tolerated and is optimized without remission and with <2 previous ADT trials for the current episode.
- For practical guidance, consult the **attached medication information sheets**.
- Practical guidance on ADT switching may be accessed at: switchrx.com.

escitalopram | Cipralex
Total daily dose: 40 mg

Preferred options – sorted by efficacy and tolerability:

bupropion XL | Wellbutrin XL

vilazodone | Viibryd

desvenlafaxine | Pristiq

Additional options:

- **levomilnacipran** | Fetzima
- **duloxetine** | Cymbalta
- **vortioxetine** | Trintellix

Follow-up guidance

- **Optimize** the ADT dose if there is a partial response or no response at 2–4 weeks but the treatment is well tolerated (see attached medication information sheets).

Additional options if optimization is not successful:

- **Switch** to a preferred ADT with a different mechanism of action if the ADT dose has been optimized for ≥4 weeks without a response or remission or the ADT is not well tolerated after ≥2 weeks, and there has not been a previous ADT trial.
- **Consider adding** an adjunctive treatment if the ADT is well tolerated, the dose has been optimized for ≥4 weeks without a response or remission, and there have been ≥2 previous ADT trials.
  - Preferred adjunctive treatment options include: **cariprazine, brexpiprazole, aripiprazole**.
- Practical guidance on ADT switching and combining strategies may be accessed at: switchrx.com.

Insomnia

Pharmacotherapy not recommended for mild insomnia

Initial guidance

- For mild insomnia, non-pharmacological options are recommended.
- Pharmacotherapy is generally reserved for moderate or severe insomnia.

Considerations for insomnia

- Review the patient's sleep hygiene and provide sleep education.
- Review the patient's current pharmacotherapy and daily intake of caffeine to determine if they might be contributing to insomnia. Common medication culprits include stimulants and decongestants.
- Optimize the clinical management of the patient's comorbid psychiatric and physical conditions, especially chronic pain.
- If suspicious, consider additional screening for common disorders. These include:
  - STOP-Bang questionnaire for obstructive sleep apnea
  - International RLS Study Group rating scale (sIRLS) for restless legs syndrome

Treatment Guidance

Neurostimulation

Consider recommending neurostimulation therapy (see Appendix for more information)

- Neurostimulation can be delivered with or without medication, but current treatments for mood disorders are generally maintained if they are well tolerated.

Intervention	Major Depressive Disorder
Repetitive transcranial magnetic stimulation (rTMS)	✓

Psychological Treatments

Consider recommending one or more adjunctive psychological interventions (see Appendix for more information)

Intervention	Major Depressive Disorder	Anxiety	Insomnia
Cognitive-behavioural therapy (CBT)	✓	✓	
Behavioural activation (BA)	✓		
Interpersonal therapy (IPT)	✓		
Mindfulness-based cognitive therapy (MBCT)	✓		
Cognitive-behavioural therapy for insomnia (CBT-I)			✓
Sleep hygiene/Psychoeducation			✓

Complementary Treatments

Consider recommending one or more adjunctive complementary interventions

Natural health options

Intervention	Major Depressive Disorder	Anxiety	Insomnia
Mediterranean diet	✓		
Omega-3 fatty acids	✓		
S-adenosyl-L-methionine (SAM-e)	✓		
L-tryptophan			✓
Melatonin			✓

Treatment Guidance

Physical and meditative treatment options

Intervention	Major Depressive Disorder	Anxiety	Insomnia
Mindfulness meditation	✓	✓	✓
Physical activity	✓	✓	✓
Yoga	✓	✓	
Light therapy (10,000 lux)	✓		

Follow-up Guidance

Clinical assessments and considerations

- The goal of treatment is complete symptom remission and full functional recovery.
- To monitor treatment response, administer clinical scales within 2–4 weeks of a treatment change.
- **Note:** Recognizing that access to specialist psychiatric care is often limited, referral to a psychiatrist may be appropriate, especially for patients with a severe illness, multiple comorbidities, or a high risk for self/other harm.
    - Delaying treatment is not recommended, so please consider the guidance in this report to initiate or optimize treatment.

Treatment Impact

Scale	Baseline	No Response	Partial Response	Response	Remission
GAD-7	5	≥ 5	4 to 4	0 to 3	≤ 4
PHQ-9	16	≥ 13	9 to 12	0 to 8	≤ 4
ISI	12	N/A	N/A	0 to 7	≤ 7
WSAS	20	≥ 16	11 to 15	0 to 10	≤ 9

Medical Summary

The following Medical Summary includes the intake information (from referral notes, diagnostic screening, and clinical interviews) used to create the RAPIDS Guidance Report.

Patient Information

Date of birth:	Age:	Sex at birth:	Weight:	Height:	BMI:
1 Jan 1980	45 years	Male	160 lbs	68 in	24.3

Clinical area of concern from referral

Major Depressive Disorder

Psychiatric Scales

ADHD Self-Report - Part A (ASRS-A) | Score: **3 - Negative for ADHD** | Date performed: 28 Oct 2025
Generalized Anxiety Disorder-7 (GAD-7) | Score: **5 - Mild anxiety** | Date performed: 28 Oct 2025
Insomnia Severity Index (ISI) | Score: **12 - Mild insomnia** | Date performed: 28 Oct 2025
Patient Health Questionnaire-9 (PHQ-9) | Score: **16 - Mod.-severe depression** | Date performed: 28 Oct 2025
Rapid Mood Screener (RMS) | Score: **2 - Negative for bipolarity** | Date performed: 28 Oct 2025
Work and Social Adjustment Scale (WSAS) | Score: **20 - Moderate impairment** | Date performed: 28 Oct 2025

Current prescribed psychopharmacological treatments

escitalopram / Cipralex | 40 mg | Frequency: Once a day | Total daily dose: 40 mg | Period: Less than 2 months | Tolerated: No | Reason for use: Depression

Past prescribed psychopharmacological treatments

citalopram / Celexa | Reason for discontinuation: Side effect/intolerance/allergy

Substance use

Is the patient currently using any illicit or non-prescribed drug, alcohol, or cannabis? Not documented

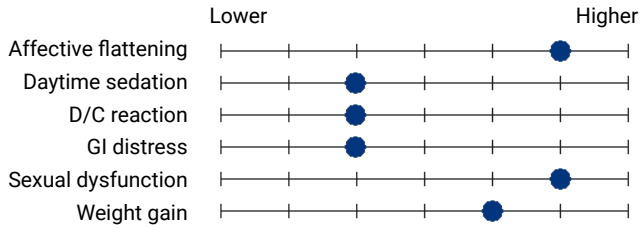
Supplementary Anxiety Questionnaire

Has your anxiety persisted for six months or more? Yes
Do you feel significant anxiety even when you are not depressed? In other words, were you anxious even prior to feeling depressed? Yes

Medication information

escitalopram | Cipralex

RAPIDS tolerability rating*: (2 / 5)



Potential additional benefits for managing: Anxious distress

**The tolerability rating reflects the risk of common side effects compared to other antidepressant treatments (ADTs).*

Neuroscience-based Nomenclature (NbN):

- Serotonin/Reuptake inhibitor

Health Canada/FDA indications:

- Major Depressive Disorder (MDD)
- Generalized Anxiety Disorder (GAD)
- Obsessive-Compulsive Disorder (OCD)

Other usage:

- Other Anxiety Disorders

MDD (monotherapy or in combination with another ADT or an adjunctive treatment)

How to start and optimize:

1. **Initiation:** Start escitalopram at 5 mg for 1 week and, if well tolerated, increase to 10 mg.
2. **Titration:** After 2 weeks, if well tolerated but the patient has not had a clinical response (<25% improvement on clinical scale), increase by 10 mg every 3–4 weeks, based on efficacy and tolerability.
3. **Potential optimization:** If, after 3–4 weeks at the product monograph maximum dose, the treatment is well tolerated but the patient is not fully remitted, consider increasing the dose by 10 mg every 3–4 weeks, based on efficacy and tolerability, to a maximum of 40 mg.

Timing: Morning or evening (initiating at suppertime meal may increase tolerability)

Frequency: Once daily

Administration: With food for tolerability

Health Canada recommended maximum dose: 20 mg

General Guidance:

- A good first-choice selective serotonin reuptake inhibitor (SSRI). Usually very effective and well tolerated.
- For anxiety disorders, especially OCD, higher doses are sometimes required and response and remission often take longer to achieve.
- Due to the inconsistency of many generic products, branded products are preferred whenever possible.

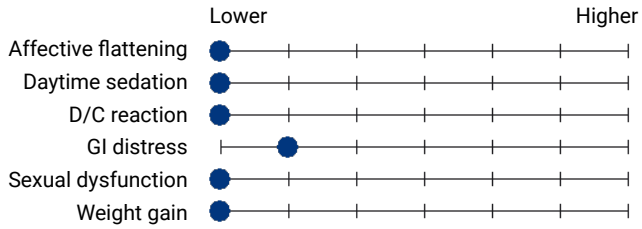
Safety Guidance:

- Potential for QT interval prolongation at higher than usual doses. Before initiating a 40 mg dose, consider performing a baseline electrocardiogram (ECG).
- Not indicated by Health Canada for patients under age 18, but that does not preclude its use in that population.
  - Only two ADTs have an FDA indication for pediatric MDD: escitalopram (age 12–17 years) and fluoxetine (age 8–17 years).
  - No ADTs have a Health Canada indication for pediatric MDD.
  - The decision to prescribe an ADT to a patient under age 18 should be made on an individual basis, following a discussion regarding the potential risks and benefits, between the patient, their supporter(s) (e.g., family, caregivers, when appropriate) and the prescriber.
- All ADTs have a Health Canada/FDA "black box" warning regarding an increased risk of suicidal ideation and behaviour in children, teenagers and young adults.
  - No studies have demonstrated an increase in completed suicides associated with treating young patients with ADTs. It is critical to diagnose and treat depression in this population.
- Clinicians should closely monitor patients of all ages for clinical worsening and development of suicidal ideation or behaviour.

Medication information

bupropion XL | Wellbutrin XL

RAPIDS tolerability rating*: (5 / 5)



Potential additional benefits for managing: Anxious distress, Cognitive functioning, Fatigue/loss of energy, Weight loss

**The tolerability rating reflects the risk of common side effects compared to other antidepressant treatments (ADTs).*

Neuroscience-based Nomenclature (NbN):

- Norepinephrine, dopamine/Reuptake inhibitor, releaser

Health Canada/FDA indications:

- Major Depressive Disorder (MDD)
- MDD (Seasonal Pattern)

Other usage:

- Attention-deficit/Hyperactivity Disorder (ADHD) (adjunctive)
- Generalized Anxiety Disorder (GAD) (mild to moderate anxiety symptoms)
- Smoking Cessation

MDD (monotherapy or in combination with another ADT or an adjunctive treatment)

How to start and optimize:

1. **Initiation:** Start bupropion XL at 150 mg for 1–2 weeks.
2. **Titration:** If well tolerated but the patient has not had a clinical response (<25% improvement on clinical scale), increase to 300 mg.
3. **Potential optimization:** If, after 3–4 weeks at 300 mg, the treatment is well tolerated but the patient is not fully remitted, consider increasing to 450 mg.

Timing: Morning

Frequency: Once daily

Administration: With or without food

Health Canada recommended maximum dose: 300 mg

General Guidance:

- Very well tolerated antidepressant treatment (ADT) for most patients.
- In general, not recommended for severe anxiety or anxiety disorders, but can be useful for managing mild or moderate anxiety.
- May support smoking cessation and weight loss, especially in combination with naltrexone.
- Data support use to treat ADHD, if first-line treatments are ineffective or intolerable.
- At usual doses (300–450 mg), is safe for a patient with a seizure disorder.
- Due to the inconsistency of many generic products, branded products are preferred whenever possible.

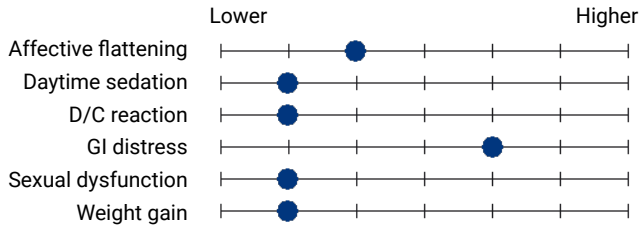
Safety Guidance:

- Avoid non-XL formulations due to increased risk of seizure at higher doses above 450 mg.
- Not indicated by regulatory bodies for patients under age 18, but that does not preclude its use in that population.
  - Only two ADTs have an FDA indication for pediatric MDD: escitalopram (age 12–17 years) and fluoxetine (age 8–17 years).
  - No ADTs have a Health Canada indication for pediatric MDD.
  - The decision to prescribe an ADT to a patient under age 18 should be made on an individual basis, following a discussion regarding the potential risks and benefits, between the patient, their supporter(s) (e.g., family, caregivers, when appropriate) and the prescriber.
- All ADTs have a Health Canada/FDA "black box" warning regarding an increased risk of suicidal ideation and behaviour in children, teenagers and young adults.
  - No studies have demonstrated an increase in completed suicides associated with treating young patients with ADTs. It is critical to diagnose and treat depression in this population.
- Clinicians should closely monitor patients of all ages for clinical worsening and development of suicidal ideation or behaviour.

Medication information

vilazodone | Viibryd

RAPIDS tolerability rating*: (4 / 5)



Potential additional benefits for managing: Anxious distress

**The tolerability rating reflects the risk of common side effects compared to other antidepressant treatments (ADTs).*

Neuroscience-based Nomenclature (NbN):

- Serotonin/Multimodal

Health Canada/FDA indications:

- Major Depressive Disorder (MDD)

Other usage:

- Generalized Anxiety Disorder (GAD)
- Other Anxiety Disorders

MDD (monotherapy or in combination with another ADT or an adjunctive treatment)

How to start and optimize:

1. **Initiation:** Start vilazodone at 10 mg for 1 week and, if well tolerated, increase to 20 mg.
2. **Titration:** If well tolerated but the patient has not had a clinical response (<25% improvement on clinical scale), increase by 10 mg every 2–4 weeks, based on efficacy and tolerability.
3. **Potential optimization:** The usual optimized dose is 40 mg.

Timing: Morning or evening (initiating at meal time may increase tolerability)

Frequency: Once daily

Administration: With food—required for adequate absorption

Health Canada recommended maximum dose: 40 mg

General Guidance:

- For anxiety disorders, higher doses are sometimes required and response and remission often take longer to achieve.
- Must be taken with food to be adequately absorbed – does not require high-fat meal or specific caloric intake, but absorption is poor when taken on an empty stomach.
- Some patients experience nausea and/or diarrhea, especially when initiating the medication. However, these side effects tend to be short-lived and usually resolve within a few weeks.
- Does not tend to negatively impact sleep architecture.
- Due to the inconsistency of many generic products, branded products are preferred whenever possible.

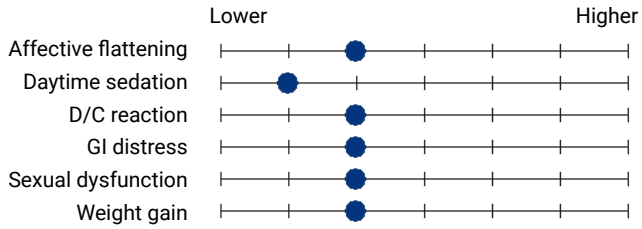
Safety Guidance:

- Not indicated by regulatory bodies for patients under age 18, but that does not preclude its use in that population.
  - Only two ADTs have an FDA indication for pediatric MDD: escitalopram (age 12–17 years) and fluoxetine (age 8–17 years).
  - No ADTs have a Health Canada indication for pediatric MDD.
  - The decision to prescribe an ADT to a patient under age 18 should be made on an individual basis, following a discussion regarding the potential risks and benefits, between the patient, their supporter(s) (e.g., family, caregivers, when appropriate) and the prescriber.
- All ADTs have a Health Canada/FDA "black box" warning regarding an increased risk of suicidal ideation and behaviour in children, teenagers and young adults.
  - No studies have demonstrated an increase in completed suicides associated with treating young patients with ADTs. It is critical to diagnose and treat depression in this population.
- Clinicians should closely monitor patients of all ages for clinical worsening and development of suicidal ideation or behaviour.

Medication information

desvenlafaxine | Pristiq

RAPIDS tolerability rating*: (4 / 5)



Potential additional benefits for managing: Anxious distress, Menopausal hot flashes

**The tolerability rating reflects the risk of common side effects compared to other antidepressant treatments (ADTs).*

Neuroscience-based Nomenclature (NbN):

- Serotonin, norepinephrine/Reuptake inhibitor

Health Canada/FDA indications:

- Major Depressive Disorder (MDD)

Other usage:

- Generalized Anxiety Disorder (GAD)
- Other Anxiety Disorders

MDD (monotherapy or in combination with another ADT or an adjunctive treatment)

How to start and optimize:

1. **Initiation:** Start desvenlafaxine at 50 mg for 2 weeks.
2. **Titration:** If well tolerated but the patient has not had a clinical response (<25% improvement on clinical scale), increase to 100 mg.
3. **Potential optimization:** If, after 3–4 weeks at 100 mg, the treatment is well tolerated but the patient is not fully remitted, consider increasing the dose by 50 mg every 3–4 weeks, based on efficacy and tolerability, to a maximum of 200 mg.

Timing: Morning or evening (initiating at suppertime meal may increase tolerability)

Frequency: Once daily

Administration: With food for tolerability

Health Canada recommended maximum dose: 100 mg

General Guidance:

- Well tolerated antidepressant treatment (ADT). A good first-choice serotonin-norepinephrine reuptake inhibitor (SNRI).
- For anxiety disorders, higher doses are sometimes required and response and remission often take longer to achieve.
- Norepinephrine benefit not apparent until 100 mg for most patients.
- May be helpful for perimenopausal sweating at low doses.
- Does not tend to negatively impact sleep architecture.
- Due to the inconsistency of many generic products, branded products are preferred whenever possible.

Safety Guidance:

- As with all agents that impact norepinephrine, use caution with unstable cardiac status, as the medication may provoke tachycardia and/or hypertension at higher doses in vulnerable individuals. This is rarely clinically relevant.
- Not indicated by regulatory bodies for patients under age 18, but that does not preclude its use in that population.
  - Only two ADTs have an FDA indication for pediatric MDD: escitalopram (age 12–17 years) and fluoxetine (age 8–17 years).
  - No ADTs have a Health Canada indication for pediatric MDD.
  - The decision to prescribe an ADT to a patient under age 18 should be made on an individual basis, following a discussion regarding the potential risks and benefits, between the patient, their supporter(s) (e.g., family, caregivers, when appropriate) and the prescriber.
- All ADTs have a Health Canada/FDA "black box" warning regarding an increased risk of suicidal ideation and behaviour in children, teenagers and young adults.
  - No studies have demonstrated an increase in completed suicides associated with treating young patients with ADTs. It is critical to diagnose and treat depression in this population.
- Clinicians should closely monitor patients of all ages for clinical worsening and development of suicidal ideation or behaviour.