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Welsh Medicines Resource Centre
Canolfan Adnoddau Moddion Cymru

Bulletin
"Independent prescribing information for NHS Wales"

Management of depression in primary care

The term 'depression' refers to a broad group of mental health problems central to which is low mood and a loss of interest and enjoyment in ordinary things. It is the most common mental disorder in the community, affecting an estimated five per cent of the UK population at any one time.[1] However, many cases are unrecognised and untreated.[2] Depressive illness can cause a greater decline in health state than chronic illnesses such as angina, arthritis, asthma, and diabetes.[3] The impact of the disorder may also be experienced by friends, family, and colleagues. It is essential that practitioners in primary care, where 95% of cases are managed, have the required skills to assess patients with depression.

This bulletin discusses the management of depression in adults, in primary care, including the appropriate use of psychological and antidepressant treatment. Another bulletin that discusses antidepressants in more depth will follow.

Recognising depression

There is now more emphasis on depression existing along a continuum of severity between normal sadness and severe illness. Defining a threshold where mood changes become clinically significant is problematic.[4] The updated NICE guideline on the treatment of depression in adults advocates the use of the *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM) IV criteria. Its definition of severity makes it less likely that a diagnosis will be based on symptom counting alone.[5]

Box 1. Symptoms of depression[5]

Key symptoms:

- Persistent sadness or low mood
- Marked loss of interest or pleasure

Associated symptoms:

- Disturbed sleep (increased or decreased)
- Decreased or increased appetite and/or weight changes
- Fatigue or loss of energy
- Agitation or slowing of movements
- Poor concentration or indecisiveness
- Feelings of worthlessness, or excessive/ inappropriate guilt
- Suicidal thoughts or acts

Summary

- Clinicians should be alert to possible depression, particularly in people with a history of the disorder or a chronic physical health problem.
- Assessment of suspected depression should take into account the degree of social and functional impairment, as well as the number, type, and duration of symptoms.
- Some cases of mild depression may improve without formal intervention; 'active monitoring' may be appropriate.
- Work can help to promote recovery and rehabilitation; individuals should be supported to remain in, or return to work where possible.
- Antidepressants should not be prescribed routinely for mild depression or subthreshold depressive symptoms.
- If an antidepressant is indicated, an SSRI should be prescribed first-line and patients should be monitored closely in the early stages of treatment.
- Appropriate antidepressant therapy should be continued for at least 6 months after remission of symptoms to reduce the risk of relapse.

To make a formal diagnosis of major depression, at least five symptoms of depression (including at least one key symptom) should be present on most days, most of the time, for at least two weeks (Box 1).

Additionally, severity should be assessed (Box 2) following diagnosis and again five to 12 weeks later, as is required by the 2009/10 Quality and Outcomes Framework (QOF).[6] This assessment should be carried out using a tool validated for use in primary care, e.g. *Patient Health Questionnaire* (PHQ-9), *Hospital Anxiety and Depression Scale* (HADS), or *Beck Depression Inventory Second Edition* (BDI-II). The scores from these questionnaires are useful to inform discussions with patients about relevant treatment options. However, such symptom scores should not be used alone to decide whether or not treatment is needed. Clinicians should also consider a patient's family and personal history, the degree of

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any social and functional disability, the duration of symptoms, and the patient's preferences when assessing the need for an intervention.[6]

Box 2. Definitions of depression severity[5]

Severe depression: Most symptoms present, and these symptoms markedly interfere with functioning. Can occur with or without psychotic symptoms.

Moderate depression: Symptoms or functional impairment are between 'mild' and 'severe'.

Mild depression: Few, if any, symptoms in excess of the five required to make the diagnosis, and only minor functional impairment.

Subthreshold depressive symptoms: Fewer than five symptoms of depression. Termed 'persistent' if symptoms have been present for a considerable time (typically several months), or persist despite low-intensity interventions.

Clinicians should be alert to possible depression, especially in people who are particularly vulnerable such as those with a past history of depression or a chronic physical health problem. The QOF includes routine assessment of patients with diabetes or coronary heart disease for the presence of depression, using two standard screening questions (Box 3).[6]

Box 3. Depression screening questions[6]

During the last month, have you often been bothered by feeling down, depressed, or hopeless?

During the last month, have you often been bothered by having little interest or pleasure in doing things?

If the person answers 'yes' to either question, a professional who is competent to perform a mental health assessment should review the person's mental state and associated functional, interpersonal and social difficulties.[5,7] Patients with an alcohol problem should have this treated first as there is good evidence that depressive symptoms frequently resolve after standard treatment for alcohol dependence.[8] People diagnosed with depression should be asked about suicidal ideation and intent. The risk of suicide should be regularly reassessed, particularly after initiating or changing treatment. If a person with depression presents an immediate risk to themselves or others, they should be urgently referred to specialist mental health services.[5]

Treatment of depression

The goal of treatment should be complete relief of symptoms (remission) where possible.[2] Treatment may be psychological (e.g. active monitoring or cognitive behavioural therapy [CBT]) or pharmacological (e.g. antidepressants). Given the continuum of depression it can be difficult to distinguish between depressive states that are relatively transient and those that are precursors of more severe, recurrent, or chronic conditions where antidepressants are likely to help.[4]

The NICE guideline recommends a 'stepped care' approach (Table 1). If a person does not benefit from, or declines an intervention, they should be offered an appropriate intervention from the next step. Before initiating treatment, the clinician should consider the patient's preferences and previous treatment experiences.

Should an antidepressant be prescribed?

Evidence suggests that the identification and subsequent treatment of cases of depression, particularly milder illness, could be improved.[2] However, once depression has been diagnosed, treatment does not necessarily need to include antidepressant therapy. Whilst it is important to identify and manage 'mild' cases to try to prevent progression to more serious depression, it is possible that overzealous clinical intervention may cause unnecessary medicalisation of some patients. Prescribing decisions are complex and not necessarily purely driven by evidence-based thinking. Decisions to prescribe medication may be influenced by several factors such as cognitive biases and patients' expectations.[9,10,11] It has been suggested that sometimes antidepressants are given 'palliatively' in an attempt to relieve troubling symptoms rather than to induce remission of an illness.[12]

> *'We don't want people who are facing social and economic problems to be put on antidepressants and psychotropic medications when their mental health problems are understandable in the context of the social and economic situation they're in.'*
>
> Ingrid Torjesen (BMJ 2010; 340:c3114)

Some people may not want an intervention and many cases of mild depression improve without one. In such cases, a period of active monitoring should be considered. Active monitoring involves a discussion on the nature and course of depression and a follow-up, normally within two weeks. The person should be contacted if they fail to attend follow-up appointments.[5] Patients currently in work should be encouraged to remain so; unemployment is associated with worsening mental health conditions.[13] Work itself can be therapeutic, can help promote recovery and rehabilitation, improve quality of life and wellbeing, and can be central to an individual's identity and social status.[13]

Table 1. Stepped care treatment of depression

Step/focus of care		Responsible for care	Interventions considered
1.	All known and suspected presentations of depression	GP, practice nurse	Assessment, support, psycho-education, active monitoring, and referral for further assessment and interventions.
2.	Mild to moderate depression; persistent subthreshold depressive symptoms	Primary care team, primary care mental health worker	Low-intensity psychosocial interventions, psychological interventions, medication, and referral for further assessment and interventions.
3.	Moderate and severe depression; mild to moderate depression with inadequate response to initial interventions; persistent subthreshold depressive symptoms	Primary care team, primary care mental health worker	Medication, high-intensity psychological interventions, combined treatments, and referral for further assessment and interventions.
4.	Severe and complex depression	Mental health specialists including crisis teams	Medication, high-intensity psychological interventions, electroconvulsive therapy, crisis service, combined treatments, multiprofessional, and inpatient care.
	Risk to life; severe self-neglect	Inpatient care, crisis teams	

Adapted from NICE[5] and WFSBP[16] guidelines

The Statement of Fitness for Work or 'fit note' can be used to facilitate discussions with employers in relation to supportive strategies, e.g. altered hours or a phased return to work after a period of sick leave. Support for job retention is available from Healthy Working Wales (www.healthyworkingwales.com), the Health at Work Advice Line (0800 1070900), and Jobcentre Plus. In some cases, resolution of work issues may be necessary before a return to work is appropriate. Where it seems that work may be a contributor to the person's condition an occupational health assessment may be beneficial. This can be suggested using the fit note. [13]

The size of benefit of antidepressant treatment, compared with placebo, appears to increase with severity of symptoms.[4,14,15] Antidepressants should not routinely be prescribed for persistent subthreshold depressive symptoms or mild depression because the risk-benefit ratio is considered poor. However, antidepressants may be considered for people with a history of moderate or severe depression, subthreshold depressive symptoms that have been present for at least two years, mild depression that persists after other interventions, or mild depression that is complicating the care of a chronic physical health problem.[5,7]

People suffering depression typically prefer psychological and psychosocial treatments to medication.[2] Certain psychological therapies, namely CBT, behavioural activation, and interpersonal therapy (IPT), have been shown to be effective in adults with mild to moderate depression.[4]

People with mild to moderate depression or persistent subthreshold depressive symptoms requiring an intervention should initially be offered one or more **low-intensity** psychosocial interventions such as individual guided self-help based on the principles of CBT, computerised CBT, or a structured group physical activity programme. Programmes typically take place over nine to 12 weeks and are supported by a trained practitioner.[5] Group CBT might be considered for those people who decline the interventions mentioned above.

In the case of moderate to severe depression, NICE recommends that an antidepressant should be offered in combination with a **high-intensity** psychosocial intervention (such as individual CBT). If the person has a chronic physical health problem and moderate depression, a high-intensity psychosocial intervention should be offered without antidepressant treatment.[5,7] The availability of different psychological and psychosocial interventions may vary according to locality.

Choice of antidepressant

Evidence suggests that, for most patients, there are no clinically important differences in efficacy between the different antidepressants (including the newer agents such as duloxetine, mirtazapine, reboxetine, and venlafaxine), although there may be differences in adverse effect profiles and tolerability.[2,4,16] Factors to consider when choosing an antidepressant include the person's preference, potential adverse effects, toxicity in overdose (if prescribing for a person considered at risk of suicide), and other drug treatments that may interact with the antidepressant.

NICE recommends that a generic selective serotonin reuptake inhibitor (SSRI) should normally be used first-line. SSRIs have a more acceptable adverse effect profile and are less toxic in overdose.

Starting treatment

When starting an antidepressant, the reasons for prescribing should be explained. The person should be informed of the importance of taking the medicine as prescribed (addiction does not occur with antidepressants) and of the possibility of adverse effects, particularly sedative effects if the person drives or has a safety-critical job that requires good concentration. The sedative effect of antidepressants is likely to be greatest in the first month after either starting therapy or increasing the dose. Patients should also be warned about the possibility of discontinuation effects should they stop taking the medicine or miss doses. The gradual onset of effect of the antidepressant should be explained.[5] It can take two to four weeks for symptoms to improve noticeably although some people may experience an improvement after a few days of treatment. A starting dose should be prescribed and titrated, where necessary, to the minimum effective dose.[17]

Assessing response to treatment

The person should normally be seen two weeks after starting treatment and regularly thereafter, typically at two to four week intervals. A person who is younger than 30 or who is considered to be at increased risk of suicide should be seen more frequently.[5] Treatment should be continued for at least four weeks at a therapeutic dose (six weeks in elderly patients) before considering any increase in the dose in line with the Summary of Product Characteristics (SPC)[5,17] For the majority of SSRIs in the treatment of depressive illness, clinical trial data do not show any additional benefit from increasing the dose above the recommended daily dose.[18] Another option is to consider switching to another antidepressant, particularly if there are adverse effects or if the person would prefer to change treatment. In cases of partial response, the antidepressant may need to be continued for a further two to four weeks, to allow the development of maximum effect, before considering whether to change treatment.[5] It should also be borne in mind that failure to respond to antidepressant treatment could be due to non-adherence to the prescribed treatment.

Switching antidepressants

If a person has not responded adequately to a prescribed therapy and adherence and adverse effects have been discussed, a change in treatment can be considered. A previous therapy that has not been adequately delivered or adhered to could be tried again (possibly with a dose increase).[5] Alternatively, a different antidepressant could be tried. NICE recommends switching to a different SSRI or a newer-generation antidepressant initially. Subsequently an antidepressant from another class could be tried. Switching antidepressants will be discussed in more detail in the next bulletin.

Maintenance and cessation of therapy

A person who has benefited from taking an antidepressant should be encouraged to continue treatment for at least six months after remission of symptoms to greatly reduce the risk of relapse.[5] If the risk of relapse is significant or if the consequences of relapse are likely to be severe, e.g. job loss, treatment should be continued for at least two years, at an effective maintenance dose. Psychological interventions, such as individual CBT or mindfulness-based cognitive therapy, can also be beneficial in some people to prevent relapse.[5]

Discontinuation symptoms are usually mild and self-limiting, but can be severe, particularly if the antidepressant is stopped abruptly. The dose of antidepressant should be reduced gradually, usually over a period of at least four weeks. For further guidance on the cessation of antidepressant treatment see the WeMeReC e-notes on stopping antidepressants (www.wemerec.org).

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The Summaries of Product Characteristics should be consulted for full prescribing information