

Managing Depression in Adults

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KEY MESSAGE

- The majority of patients with depression are managed in primary care.
- Management of depression should actively involve patients, their families and lay carers, subject to patients' consent.
- Effective interventions that enable optimal outcomes include psychological therapies, antidepressants and evidence-based psychosocial interventions like bibliotherapy and physical activity.
- Assessment and management of risk is an integral part of treating depression.
- Voluntary sector organisations and peer support groups and activities can be very beneficial to recovery.

ABSTRACT

Depression is one of the leading causes of disability worldwide. The majority of patients suffering from depressive disorder are diagnosed and managed in the primary care. Optimal management reduces the risk of relapse and improves the quality of life. The main treatment modalities are antidepressants and psychological therapies. Lifestyle changes, exercise and psychoeducation also play an important role in management.

Depression is a syndrome with central features of low mood, lack of enjoyment, reduced energy, negative thinking, poor sleep and appetite, lack of concentration and suicidal ideation. It is classified under the category of mood disorders in ICD-10¹. It has a lifetime prevalence of 10-20%². According to the World Health Organization, depression is a leading cause of disability worldwide³. There is also an increased mortality, mainly due to suicide in patients with depression (standardized mortality ratio: 20.35)². Identification, diagnosis and treatment of depression is therefore of the utmost importance.

A majority (almost 80%) of patients suffering from depressive disorders are managed in primary care⁴. So it is very important for general practitioners and other primary care professionals and staff to be familiar with assessing and managing it.

MANAGEMENT OF DEPRESSION

Depression can co-exist with many illnesses, including diabetes, CHD, chronic pulmonary disease, cancer and long-term medical conditions. It can also be the manifestation of other medical illness, like hypothyroidism, and side effect of medications, such as antihypertensives.

In England & Wales, the National Institute of Health and Clinical Excellence (NICE) guidelines should be followed by practitioners. Practitioners are advised to follow these guidelines. The following instructions are based on the guidelines provided by NICE⁴.

Depression is a chronic illness. Up to 80% of patients suffering from a depressive episode experience a further episode². Management should involve patients, family, friends and lay carers, subject to patient's informed consent. Providing useful information and psychoeducation on the nature of the illness and available treatments, including their adverse reactions, is an essential part of management⁴. Care should be given to ensure all treatment is done with the patient's informed consent. A holistic approach should be adopted integrating biological, psychological, social and cultural factors in the management plan.

The management of depression is incomplete without an assessment and management of risk. Patients should be asked about suicidal ideation and plans especially if suffering from moderate or severe depression. If the professional detects risk of self harm, appropriate steps should be taken in managing that risk. Referral to secondary mental health services is warranted in these circumstances. Other members of staff in the practice should be aware to inform the patient's general practitioner in case of disclosure of suicidal ideation.

MILD DEPRESSION

For mild depression a two week period of watchful waiting is recommended in patients when either the patient is not willing to have an intervention or when the practitioner concludes the patient may recover without intervention. In these cases the patient is assessed further within 2 weeks⁴. It is recommended that patients be given advice on sleep hygiene. Exercise has also been shown to have beneficial effect on low mood. NICE recommends "structured and supervised" exercise up to 3 times a week for 45 minutes to 1 hour⁴.

Antidepressants are not warranted for initial management of mild depression as the evidence is not in favour of their effectiveness in this patient

group⁴. NICE also recommends guided self-help programmes based on cognitive behavioural therapy (CBT) models. Patients can also receive CBT treatment in the primary care setting. In patients who do not respond to life style and psychological interventions, NICE recommends the use of antidepressants. NICE also recommends antidepressants in patients who have a history of moderate to severe depression currently presenting with mild depression. Antidepressants should be continued for 6 months after achieving remission to minimise the risk of future episodes. Discontinuation of antidepressants should be carried out gradually to avoid discontinuation symptoms. Medications with shorter half lives, like paroxetine and venlafaxine, are more likely to cause these symptoms⁵. The duration recommended by NICE is 4 weeks. Patients should be followed up closely during this sensitive period to ensure they receive appropriate care. Secondary care mental health services consultation is the next step in case of failure of the interventions.

Note: NICE discourages healthcare professionals from prescribing St John's Wort or advising on its use. St John's Wort is not a licensed preparation in the UK. It induces hepatic enzymes and has interactions with several medications e.g. digoxin, warfarin and oral contraceptives⁵. Concomitant use with SSRIs can result in Serotonin Syndrome, a potentially fatal condition⁵. Patients should be informed of the side effects and potential interactions of St John's Wort.

MODERATE TO SEVERE DEPRESSION

Antidepressants are the recommended treatment for this group of patients. Selective serotonin reuptake inhibitors (SSRIs) should be used as the first line of treatment. This group of antidepressants have fewer side effects than the tricyclics (TCAs) and are safer in overdose. The potential side effects, withdrawal symptoms and the delayed onset of action should be discussed with the patients and their lay carers as necessary. Practitioners should be aware of the increased risk of suicide during the initial phases of antidepressant treatment. In patients receiving other medications possible drug interactions should be taken into account. If risk of harm to self or others is identified then the patient should be referred to secondary care mental health services. Antidepressants should continue for 6 months after remission.

For psychological therapies NICE recommends CBT as the treatment of choice. There are psychotherapy interventions such as interpersonal

therapy, psychodynamic psychotherapy and couple therapy which could be employed in patients with depression. For these modalities consultation with secondary care mental health services is advisable. CBT can be used when the patient chooses not to take antidepressants, is unable to take them because of side effects, or does not respond well to pharmacotherapy. In recent years the Improving Access to Psychological Therapies has been launched to support Primary Care Trusts implementing NICE guidelines in management of anxiety and depression. In London they support services in 5 different sites: Camden PCT, City and Hackney PCT, Ealing PCT, Southwark and Haringey. Detailed information can be obtained via their website: www.iapt.nhs.uk.

Finally, it is important to know that in the event of lack of response to initial treatment, patients can always be referred to a psychiatrist for further treatment including augmentation of medications. Therefore good communication between the psychiatrist and GP is an essential part of effective intervention. Written correspondence, phone conversation, joint reviews and involving GPs in Care Programme Approach (CPA) meetings are different options available. The Department of Health has provided an excellent summary of the New CPA available online. If the psychiatrist starts the patient on medication and asks the GP to continue prescribing, regular follow up must be arranged for medication review and monitoring the patient response. GP and psychiatrist should jointly decide who will take the lead in management of the patient.

APPENDIX

A list of resources which general practitioner's can use for psychosocial intervention/support.

Depression Alliance: <http://www.depressionalliance.org/>

Books on Prescription: <http://www.overcoming.co.uk/single.htm?ipg=6242>

Walking, Cycling, Other Activities: Forestry Commission
<http://www.forestry.gov.uk/website/ourwoods.nsf/mapform?OpenForm®ion=ESE>

<http://www.forestry.gov.uk/website/ourwoods.nsf/mapform?OpenForm®ion=EEE>

Mood Gym: <http://moodgym.anu.edu.au>

Information, quizzes, games and skills training to help prevent depression

Living Life to the Full
Free online life skills course for people feeling distressed and their carers
www.livinglifetothefull.com

PSYCHLOPS - a short one-page outcome measure designed to be a sensitive indicator of change, after therapy. It should be used as a before-and-after measure.
<http://www.psychlops.org.uk/>

UPstream Healthcare Ltd
MIQUEST-based software and support for optimising depression care in general practice
www.upstreamhealthcare.org

REFERENCES

1. World Health Organisation. ICD-10 Classification of Mental and Behavioural Disorders. World Health Organisation, Geneva. 1992
2. Gelder, A; Harrison, P; Cowen, P. Shorter Oxford Textbook of Psychiatry. Oxford University Press. 2006
3. World Health Organisation. The World Health Report, Chapter 2: Burden of Mental & Behavioural disorders. World Health Organisation. 2001 (available online).
4. National Institute of Health & Clinical Excellence. Management of Depression in Primary & Secondary care (amended). 2007 (available online)
5. Taylor D; Paton C; Kerwin R. The Maudsley prescribing Guidelines. 9th edition. 2007.

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