BEST PRACTICE

SPECIAL EDITION

Adult Depression

bpac nz
better medicine

Best Practice Journal (BPJ)
ISSN 1177-5645

BPJ, Special Edition: Adult Depression
June, 2009

BPJ is published and owned by bpac^{nz} Ltd

Level 8, 10 George Street, Dunedin, New Zealand.

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This Special Edition of Best Practice is funded through contracts with the Ministry of Health.

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This magazine is printed on an environmentally responsible paper managed under the environmental management system ISO 14001, produced using Certified ECF pulp sourced from Certified Sustainable & Legally Harvested Forests.

ABOUT THIS JOURNAL

This journal focuses on the management of depression in adults and is based on the relevant material in the Evidence Base Practice Guideline for the Identification of Common Mental Disorders and Management of depression in Primary Care, published in July 2008 by the New Zealand Guidelines Group.[1]

This journal is also a supporting information resource for the *bestpractice* Depression Decision Support Module. This module is freely available to all New Zealand General Practices. Please contact Jamie Murley, for further information (see back cover).

The advisory group recognises the importance of guidance on the diagnosis and management of depression in specific groups such as children/adolescents, the elderly and in pregnant/ breastfeeding women. These subjects will be covered in follow up journals scheduled to be published over the next 18 months. In addition, management tools for these patient groups will be added and integrated in to the *bestpractice* Decision Support Module as further resources are developed.

Future bpac[nz] publications in this series:

- Childhood and adolescent depression
- Treatment of depression during pregnancy, breastfeeding and postnatal depression
- Treatment of depression in the elderly

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Key Messages

- Depression is common in primary care and is a major cause of disability
- Routine psychosocial assessment is the key to improving the recognition of depression. The use of simple, verbal 2 – 3 question screening tools is recommended when targeting adults at high risk for depression
- Assessment should include identification of key stresses contributing to the presentation so that these can be addressed in the management plan
- A high index of suspicion is needed for substance use disorder as it is often harder to recognise than other mental disorders
- K10 and PHQ-9 are useful assessment and monitoring tools
- Most people can be managed within primary care using a stepped care approach
- Use of self-management strategies, including e-therapy, should be encouraged and supported by practitioners
- Psychological and pharmacological therapies are equally effective for treating adults with moderate depression
- Where antidepressant therapy is planned, SSRIs are first-line treatment, with few exceptions
- Planned treatment for depression should reflect the individual's values and preferences and the risks and benefits of different treatment options

Introduction

Mental disorders are extremely common with over one third of adults who attend primary care likely to have met the criteria for a DSM-IV diagnosis within the past year.[1]

It is probable that a significant number of people with mental disorders are not identified. This can be due to time and resource constraints and relatively low priority placed on patients with minimal functional impairment, especially if they have more urgent medical problems. On the other hand, many people with a diagnosis of depression will be prescribed antidepressants when psychological therapy alone would have been effective treatment. Adjunctive psychological therapy with antidepressants is often neglected due to lack of available services, cost or time constraints.

Epidemiology of Mental Disorders in New Zealand.[1]

Mental disorders are very common in the New Zealand population. A survey conducted between 2003 and 2004, in 13,000 people aged 16 years and over, identified a 40% self-reported lifetime prevalence of a mental disorder. Overall, anxiety disorders were the most frequently reported (lifetime prevalence rate of 25%), followed by depression and other mood disorders (20%) and substance use disorders -predominantly alcohol (12%).

Other New Zealand studies have shown that half or more of all people who develop a serious mental disorder had experienced the disorder by age 18 years. However, a first episode of depression can occur at any time of life with about a quarter of first episodes reported in people aged 50 years and older. Women have a higher lifetime prevalence rate of disorder than men, particularly major depressive disorder.

New Zealand research has also shown that people with mental disorders do use primary care services although they may not present with these as their main problem. Primary care is well placed to provide effective management of these treatable disorders.

Cultural Issues

There is an inextricable link between health and culture. Cultural identity is an essential component of good health and effective services must reflect all dimensions of wellness. Central to this is recognition of whānau ora, building on the strengths of whānau and encouraging their

involvement in the process of recovery. Services will improve when models of practice incorporate a better understanding of the importance of whānau, and the interface between culture and clinical practices.[7]

Traditional Māori and Pacific perspectives challenge some commonly held assumptions, such as the focus on developing individuality and self advocacy. There is speculation that therapies that focus on the individual may be less relevant and less acceptable for Māori and Pacific patients, who place more emphasis on relationships beyond the individual.[1]

Key cultural issues that need to be addressed in the care of all patients include: [1]

- acknowledgement of environmental factors such as the role of the wider whānau
- awareness of different belief systems and lifestyles
- knowledge of existing support systems such as kaiatawhai (Māori health workers), whānau, kaumatua (elders), ministers, consumer advisers and other specialist service providers

Kaupapa Māori Mental Health Services have wide networks and diverse expertise including the assessment of patients with culturally specific syndromes. Similarly for Pacific peoples input from cultural advisors, leaders, healers or ministers of religion may be needed.[1]

see BPJ 14 – "Māori Mental Health" for more information on culturally specific syndromes

The primary care sector is the logical place for the delivery of mental health care to Māori, Pacific Peoples and other ethnic groups. It offers better prospects for early intervention and the management of comorbidities.

Depression in Māori and other ethnicities

Tangata Whenua

Māori have higher prevalence rates of mental health disorders overall than the rest of the population and experience greater severity, burden and impact.[2-7] Te Rau Hinengaro, the New Zealand Mental Health Survey, reported that 3 in 5 Māori are predicted to experience a mental illness sometime in their lifetime.[6] Major depression was the most common mood disorder among Māori with almost 1 in 3 experiencing major depression at some point in their lives.[3]

Poorer access to services

There is significant unmet need among Māori with mental illness. Research has shown that less than a third of Māori with a mental health need had any contact with mental health services and most Maori with serious or moderate disorders had no contact with any services. For those Māori with mental health needs that did have contact, general practice services were the services most often used. Māori tend to access mental health services at a later stage of illness, with more severe symptoms and get less health care than others for their mental health issues relative to need (Table 1).[2]

When Māori access services they tend to use mainstream providers. Therefore, it is important to ensure mainstream services are responsive and effective in working.[5] Primary health care and early intervention can reduce the impact and severity of mental illness and addiction-related issues among Māori.[2]

Table 1: Severity of mental health disorder, ethnicity, access to services for mental health needs.[2]

Severity	Māori		Non-Māori	
	Prevalence	**Access**	**Prevalence**	**Access**
Serious	9%	48%	4%	64%
Moderate	13%	25%	9%	39%
Mild	8%	16%	6%	19%

Rangatahi

Rangatahi (youth) are likely to be experiencing higher rates of mental illness than previous generations. Alcohol and other substance-use disorders have contributed to this increase.[6] A higher proportion of Māori are in the age groups where mental disorders are likely to first occur, therefore the impact of unmet mental health need among rangatahi will have a significant impact on Māori as a population.[2]

Pasifika

Pacific peoples have a high prevalence of mental disorders and suicidal behaviour, compounded by significant underutilisation of health services. Pacific peoples frequently present late to services, and report difficulty accessing culturally appropriate care and information.[1]

Asian

Although diverse as a group, the New Zealand Asian population shares a range of risk factors for mental disorders, such as social isolation, language barriers and unemployment. There is a strong stigma associated with mental disorders which may delay presentation and treatment. Somatisation (the physical manifestation of mental distress) is more common in this population than in Western societies.[1]

The Mental Health Commission report on Asian mental health highlighted, in particular, the high mental health needs of women and refugees within smaller migrant communities (e.g. Vietnamese, Indonesian), and of older migrants and refugees suffering from pre-migration trauma, combined with the stress of adapting to a new culture. There is general recognition of the need for general practitioners to develop skills in interacting with Asian patients and to increase their awareness of how cultural factors influence the presentation and treatment of mental disorders in this population.[1]

Etiology of depression and risk factors.[1]

The cause of depression is multifactorial and complex. It involves the interaction of individual vulnerability with exposure to stressors. Genetic, developmental, nutritional, endocrine, psychosocial and life stress factors can all contribute. This complexity may explain the wide variation in clinical presentation and response to treatment.

A number of risk factors (vulnerability) and resilience factors (protective) have been described (Table 2). For example, a history of depression in one or both parents puts their children at a three-fold increased risk of depression, whereas good parenting (emotional warmth, cognitive stimulation) is viewed as protective in the presence of risk factors.

These concepts fit well in to the "stress vulnerability model" whereby stressful situations may trigger depression in susceptible (vulnerable) people, but not in others who display protective traits or resilience. The concept of resilience was once considered to be a personal trait but is now viewed as more of dynamic development process which can be used as part of intervention and prevention programs.

Although depression can present spontaneously, there is usually an underlying factor such as work stress, job loss, grief or relationship breakdown that can precipitate depression, especially if the person is vulnerable and has low resilience (see below).

Alcohol, cannabis and other recreational drug use are all associated with depression. Although low socioeconomic status alone does not appear to be predictive for development of depression, people in low socio-economic groups may be less likely to access services and receive effective treatment.

Analysis of antidepressant use in New Zealand

Antidepressants are a mainstay of the treatment of moderate to severe depression (see page 18).

In this analysis of prescribing data (Figure 1) we have looked at the SSRIs (Selective Serotonin Reuptake Inhibitors) and venlafaxine but not TCAs (Tricyclic Antidepressants) as data for the latter are confounded by their significant use for other indications such as pain.

This analysis estimates the number of patients using one of the available SSRIs or venlafaxine. Two consecutive 12 month periods have been considered (August 2006 to July 2007 and August 2007 to July 2008). The volume of venlafaxine prescribing is influenced by its special

Table 2: Risk factors and resilience factors for depression

Common risk factors (which could lead to vulnerability)	**Resilience factors** (protective in the presence of risk factors)
Parental history of depression	Good parenting
Difficult temperament as a child	Easy temperament as a child
Attachment difficulties/parental neglect	Good peer relationships
Family discord	Stability in love relationships
Previous depression/anxiety in adulthood	Has coped with past difficulties well
Ruminating over negative circumstances	

authority status and the current restrictions on its use. However, venlafaxine use has been steadily increasing over the last two years since vocationally trained general practitioners were given authority to prescribe it.

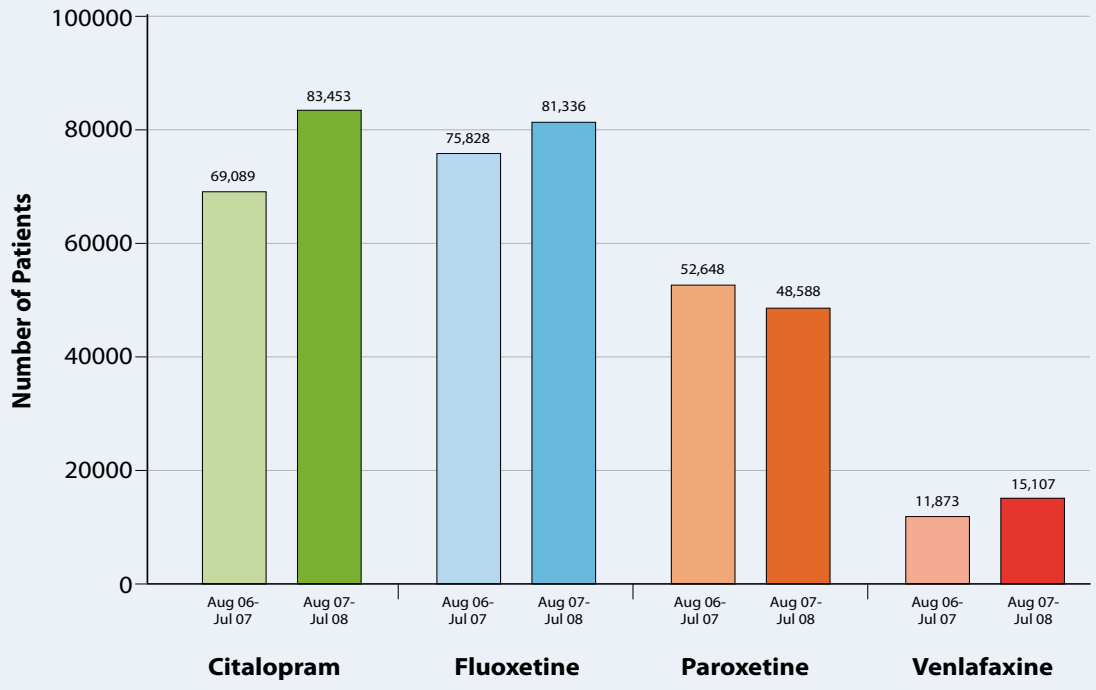
Notes:

- The data are not exclusive for the treatment of depression.
- The number of patients has been estimated over the two consecutive twelve month periods analysed.

At a national level citalopram and fluoxetine are the most commonly used SSRIs whilst paroxetine appears to be the least favoured SSRI.

Although all SSRIs are generally accepted to be similar in effectiveness, certain SSRIs may be preferred in specific patient groups. Paroxetine has not been shown to be effective in adolescents and is linked with a higher rate of suicidal ideation. Fluoxetine is the preferred SSRI for adolescents although this is not a licensed indication in New Zealand. In the elderly, citalopram may be preferred due to its lower potential for interactions. Paroxetine should be avoided in pregnancy because of reported higher rates of congenital malformations.

Fig 1: New Zealanders receiving an SSRI or an SNRI (August 06 – July 07 and August 07 – July 08)



Notes:

– The data are not exclusive for the treatment of depression.

– The number of patients has been estimated over the two consecutive twelve month periods analysed

Assessment of **depression** in **adults** in primary care

Adapted from: Identification of Common Mental Disorders and Management of Depression in Primary care. New Zealand Guidelines Group [1]

The questions and tools described here are adjuncts to screening and monitoring and none are diagnostic tools for common mental disorders or depression. In assessing a mental disorder, it is important that clinicians explore potential reasons for the disorder to get some understanding about what is going on behind the symptoms. Addressing these triggers or contributing factors is an essential part of treatment.

Short two to three question screening tools (see Verbal Screening Tools box opposite) can be viewed as initial case-finding. These can then be followed up with formal screening using the structured questions in one of the assessment tools.

This publication focuses on the assessment and management of depression in primary care, but initial screening and assessment should always consider common co-morbidities such as anxiety. For this reason a tool such as the K10 may be preferred to the PHQ-9 for initial assessment as the latter is specific for depression.

Screening for mental disorders in primary care

Every consultation in primary care provides the opportunity for screening for mental health problems. New Zealand research has shown that up to a third of people who attend a GP consultation are likely to have mental health issues.

There are several groups that are at high risk of depression and related disorders that can be targeted for simple screening:

- People with chronic illness, e.g., cardiovascular disease, diabetes, respiratory disease (especially COPD), chronic pain, dementia, Parkinson's disease, rheumatoid arthritis
- People with multiple symptoms and comorbidities
- People with a terminal illness
- People with physical and intellectual disability
- Māori, particularly Māori women
- People from ethnic minorities, especially recent immigrants
- People with a history of mental disorder or suicide attempt

- People with a history of substance misuse (including alcohol) or addiction
- People with a significant personal loss such as bereavement, relationship change or a major negative life event
- Older adults in residential care
- Women in antenatal or postnatal period

Many mental illnesses start in childhood (e.g. anxiety, disruptive behaviour) and adolescence, (depression, substance abuse) so screening should also be considered in these groups. The New Zealand Guidelines[1] has a specific section on the assessment of common mental disorders and the management of depression in young people. This will also be covered in a subsequent edition of Best Practice Journal.

Questions for targeted screening

Simple screening questions can help to identify people who would benefit from a more formal assessment for a mental disorder and are quick and easy to administer (for an example of simple screening questions, see Box: Verbal screening tools). Some practitioners may prefer a less structured approach and even a simple question such as "so how are you coping with all the changes in your life at the moment?" may provide useful insight.

Verbal screening tools

Verbal two to three question screening tools for common mental disorders (NZGG)[1]

Questions for depression

- During the past month, have you been bothered by feeling down, depressed or hopeless?
- During the past month, have you been bothered by little interest or pleasure in doing things?

If **yes** to either question, ask Help question below

Question for anxiety

- During the past month have you been worrying a lot about everyday problems?

If **yes**, ask Help question below

Questions for alcohol and drug problems*

- Have you used drugs or drunk more than you meant to in the last year?
- Have you felt that you wanted to cut down on your drinking or drug use in the past year?

* These two questions have been shown to pick up about 80% of current drug and alcohol problems

If **yes** to either question, ask Help question below

The Help question

- Is this something that you would like help with?

CHAT

The Case-finding and Help Assessment Tool (see CHAT – Appendix 9) is a case-finding questionnaire for general lifestyle assessment developed in New Zealand.[9] It has been validated in primary care to case-find for nicotine dependency, alcohol and other drug misuse, problem gambling, depression, anxiety, stress, abuse and other lifestyle issues. Patients can be asked to complete it in the waiting room, and hand it to the clinician at the beginning of the consultation. This allows the clinician to move directly to an appropriate screening and assessment tool in the consultation. The CHAT tool is in the *bestpractice* decision support module.

Accurate assessment of acuity and severity of depression and anxiety is important for its management in primary care or referral.

Assessment (Formal Screening) Tools for General Practice

Following simple screening questions, using a brief but more formal validated primary care assessment tool offers significant advantages:

- They provide structure and prompts for assessment
- They give a score or rating to guide treatment or referral
- They provide a baseline score for gauging effectiveness of interventions and treatment
- A standardised assessment means a range of health professionals can carry out repeat assessments

A wide range of tools is available. The *bestpractice* decision support module includes:

- Kessler 10 (K10) for the assessment of depression, anxiety and general mental health
- Patient Health Questionnaire (PHQ-9) for depression
- GAD-7 for anxiety
- AUDIT for assessment of problem drinking

The K10 and PHQ-9 are the most widely used and validated assessment tools in primary care. The questions in the K10 cover depression, anxiety and general mental health and this tool is usually preferred for use as an initial assessment to the PHQ-9 which is specific for depression. Factors such as individual preference, experience and local policies may also determine which tools are used.

In the *bestpractice* decision support module, the K-10, PHQ-9 and the other assessment tools can be selected from the menu. A combination of tools can be used, for example the K10 in combination with AUDIT to specifically assess problem drinking.

A brief description of these tools follows. Refer to Appendices 5 to 9 for reproductions of the assessment tools with guidance on their interpretation.

A more complete range of assessment tools for mental disorders is available from:
www.nzgg.org.nz/CMD-assessmenttools

Kessler Psychological Distress Scale 10 (K10)

The K10 (Appendix 5) measures psychological distress, particularly anxiety and depression. Used widely in population surveys and secondary care clinical settings it has been validated for use in population surveys rather than in primary care.

Patient Health Questionnaire (PHQ-9)

For depression, the PHQ-9 has been widely used in New Zealand and the scores obtained are applied in the algorithms for the treatment of depression published in the New Zealand Guidelines (also available in the Appendices 1–4 of this publication).

The PHQ-9 (Appendix 6) quantifies the severity of depression. It consists of nine key symptoms of depression, and roughly how much they have been present over the last fortnight. The score indicates the severity of depression and thus guides treatment.

PHQ-9 score	Provisional Diagnosis
10–14	Mild depression
15–19	Moderate depression
≥ 20	Severe Depression

There are two versions of the PHQ-9. This document uses the simplified 3 category version, published in the New Zealand Guidelines. Some versions of the PHQ-9, including the widely circulated A4 card, have five severity categories. We recommend using the three category version.

Alcohol and Substance Abuse (AUDIT)

The AUDIT questionnaire (Appendix 8) is an accurate tool for identifying and assessing risky, harmful and hazardous drinking. This tool contrasts with the CAGE questionnaire which is used to assess alcohol dependence.

Anxiety (GAD-7 and GAD-2)

The GAD-7 (Appendix 7) is valid for detecting anxiety disorders. The GAD-7 score is calculated by assigning scores of 0, 1, 2 and 3 to the response categories of "not at all," "several days," more than half the days," and "nearly every day" respectively. The GAD-7 total for the seven questions ranges from 0 to 21.

The severity of the anxiety disorder is represented by the following scores:

5–9	mild anxiety
10–14	moderate anxiety
15–21	severe anxiety

The shortened GAD-2 consists of the first two questions of the GAD-7 and a score of 3 or more suggests a possible anxiety disorder and should be followed by the GAD-7.

Monitoring response to treatment

Assessment tools can be used to gauge and monitor the response to treatment. A baseline score can be recorded and compared with subsequent evaluations to determine the degree of response.

Remission: only minimal signs of illness remain

Response: a significant level of improvement; or a clinically relevant reduction in symptom severity of more than 50% on a scale such as the PHQ-9

Partial response: a reduction in symptom severity of at least 25% on a scale such as the PHQ-9

For example using the PHQ-9:

- A drop of 5 points or more from baseline after 4–6 weeks of initial treatment indicates an adequate response. The same treatment should be continued and followed up after 4 weeks.
- If the drop from baseline is only 2–4 points then treatment is probably inadequate and an increase in antidepressant dose or more intensive psychological therapy may be justified.
- A drop of only one point or no change indicates that the treatment response is inadequate, there is worsening of stressors or reduced support. This indicates the need for more intensive treatment, dose increase or augmentation, specialist referral or the addition of psychological therapy.

If people do not respond to treatment it is important to consider a review of the diagnosis and other factors such as compliance, co-morbid conditions or substance abuse.

Assessment of Suicide Risk[1]

Assessment of suicide risk can be challenging as there is no evidence for absolute markers that indicate presence or intensity of suicide risk. Assessment also only provides a snapshot of risk at a given time. Therefore assessment of suicide risk should be on-going during treatment as new triggers can emerge even if a person's mental state is improving or staying the same.

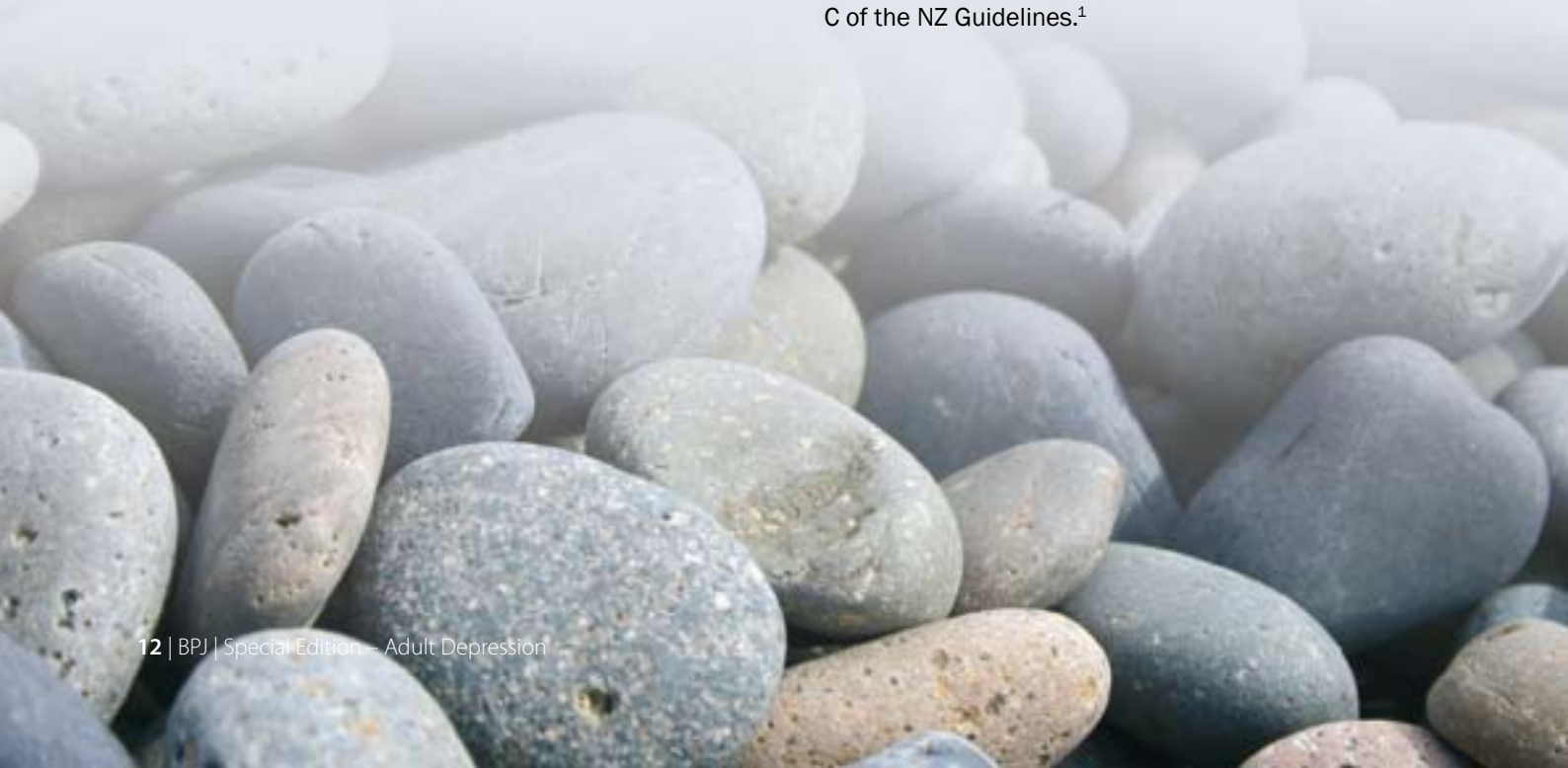
The most immediately important factors to consider are contextual triggering factors and current mental state:

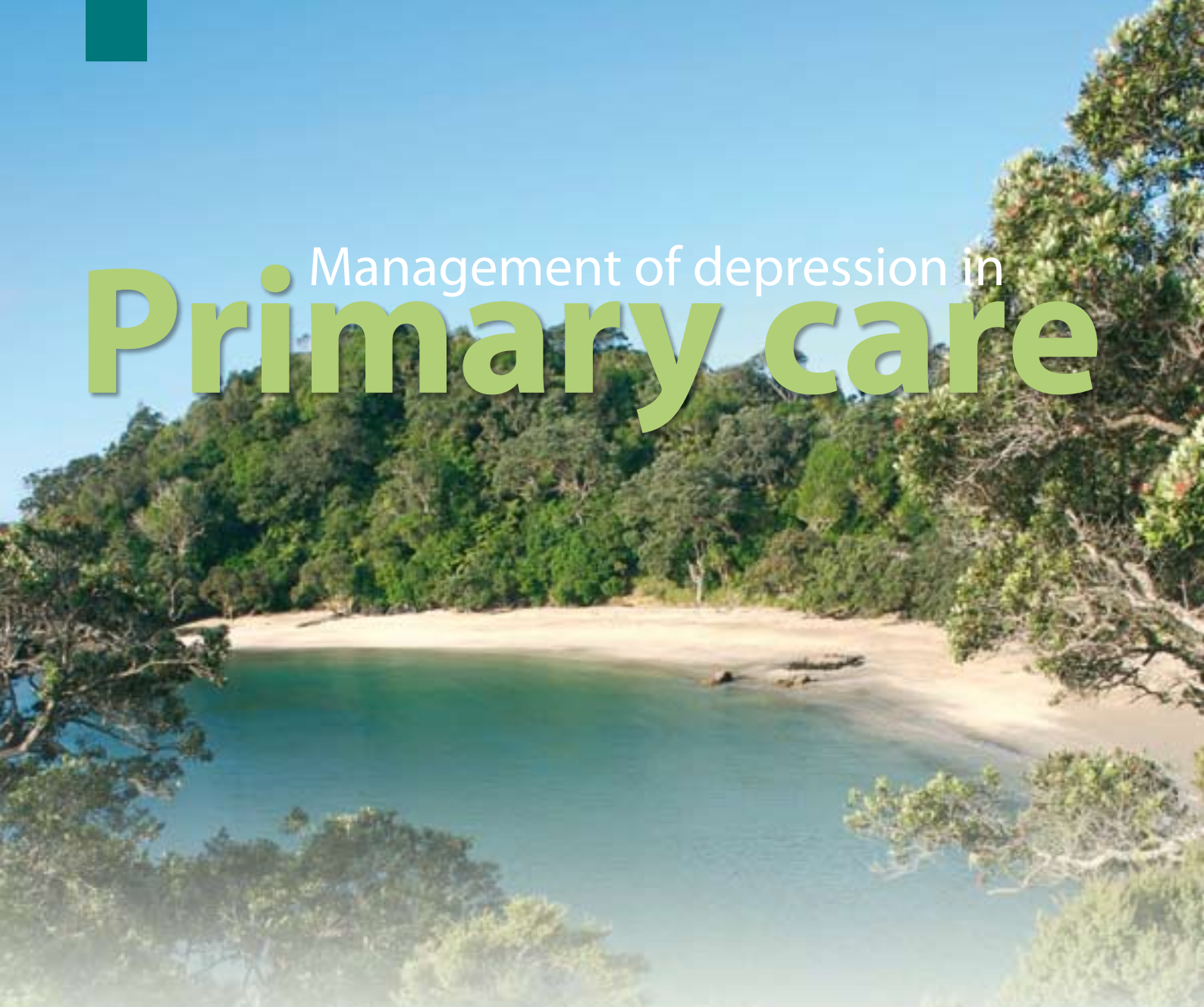
- Intent/definite plan
- Lethality of likely means
- Access to means
- Presence of risk factors (e.g. mental or physical illness, chronic pain, alcohol use)
- Hopelessness
- Psychosocial triggers
- Lack or presence of protective factors

It is important to realise that any individual's suicide risk may increase as a consequence of an acute stressor or situation. For example chronic risk factors such as male gender, childhood adversity or chronic pain remain static but an acute stressor such as a relationship breakdown or drinking binges may rapidly elevate the person's risk of suicide. Therefore recognition of potential dynamic factors is important in any management plan.

Deliberate self-harm, such as cutting, is a non-suicidal behaviour which is used as an attempt to cope and manage. It must be recognised that the emotional distress that leads to self-harm can also lead to suicidal thoughts and actions.

Questions to assist in assessing suicide risk are available in the *bestpractice* decision support module and in Appendix C of the NZ Guidelines.[1]





Management of depression in Primary care

General Principles

Most adults with depression present with mild depression and can be treated in primary care.

The goal of treatment is to achieve remission of symptoms and prevent relapse or recurrence.

The intensity of intervention should be determined by the severity of depression and with repeated assessment to evaluate the effectiveness of interventions. This is the basis of the "stepped care" approach.[1]

Interventions for depression in adults comprise a spectrum of therapies, ranging from exercise and self-management, psychological therapies (of varying length and intensity), antidepressants, to intensive interdisciplinary interventions.[1]

Clinical management should always include discussion with the patient and/or family about relevant acute or chronic stressors, the nature of the depression, its course, treatment options and likelihood of response to treatment.

Reassurance as to the probable effectiveness of treatment is important in combating the feelings of hopelessness and in maintaining treatment adherence. Some psychological techniques, such as structured problem solving or stress management, may be undertaken in the primary care setting.

Initial management of depression in adults

Summary algorithms for the general management of mild, moderate and severe depression based on the PHQ-9 score are available in Appendices 1–4.

Mild	Active management
Moderate	Active management and either an SSRI or structured psychological intervention
Severe	Active management, antidepressant plus structured psychological intervention

Everyone with depression requires active management which involves lifestyle review, identification of stressors, support strategies and how to achieve change.

Stepped Care

The stepped care model involves starting with low intensity therapy (e.g. guided self help, exercise), monitoring response and moving to more intensive treatment (e.g. structured psychological therapy, antidepressants) only if the problem persists. Support and encouragement during guided self help and repeated clinical assessment are important features of this approach.

The choice of initial therapy depends on the severity of the disorder, the person's needs and preferences, service availability and access.

Interdisciplinary Approach

The management and screening for depression ideally involves an interdisciplinary approach including input from general practitioners, nursing staff and a wide range of other health care professionals. There are numerous situations and opportunities for health care professionals to act as the first point of contact by identifying those with problems and referring on for further advice if necessary.

Shared decision making

Treatment for depression is influenced by an individual's values, preferences, lifestyle, and cultural perspectives. Successful management requires active patient choice between treatment options.

Culturally competent care – pause, ask and act

All practitioners need to be competent in dealing with patients whose cultures differ from their own. There is evidence that when the practitioner and the patient come from different cultural or racial groups, the practitioner devotes less attention to building and maintaining the relationship.[1]

No one can be expected to be an expert on every culture, the basic approach is to pause, ask and act.

For more on this approach see "Providing Palliative Care to Māori" available from: **www.bpac.org.nz?keyword=palliative**

The needs and perceptions of people of different ethnicity, race and sexual orientation should be considered. Simply recognising that people from different cultures might perceive and deal with mental health problems in different ways is an important first step. Practitioners should consider consulting appropriate persons to assist cultural understanding. Language and comprehension differences can also pose challenges.

The stigma associated with depression has been significantly reduced in recent years but this may still be a major barrier in some groups, particularly among recent immigrants from countries where mental illness may be perceived as a personal failing rather than an illness.

Active support and management

Successful management of depression depends largely on enabling the patient to be an active participant in the care process. A collaborative partnership between practitioner and patient is a consistent predictor of therapy outcomes for both pharmacological and psychological treatments.

Active support also involves identifying any problems and either taking to steps to resolve them or finding coping strategies. For example, in cases of workplace stress, support may be provided by an employee assistance program (EAP) to identify and resolve workplace issues that may be adversely affecting a person's mental health. Liaison between the general practitioner or practice nurse and an EAP might be required. Relationship counseling, moral or religious support are other avenues of support that may be considered.

Key components of active support include:

- Identifying specific problems and working to either remove them or come to accept them
- Offering practical support to problem solving, e.g. EAP
- Forming a supportive and collaborative relationship between the person with depression and their family/whānau
- Incorporating the needs and resources of the family/whānau into the care plan
- Involving the patient in treatment planning such as setting goals, exercise and healthy eating
- Providing accurate information about the importance of active family/whānau involvement, adherence to treatment and follow up
- If appropriate, referring to e-therapy (see page 17) and self support resources

Self-management includes exercise, activities (involving family/whānau and friends), advice on sleep hygiene, e-therapy (see page 17), improving lifestyle and diet and avoiding alcohol and recreational drugs. Patients can be encouraged to keep a diary to aid in self monitoring and reviewing the effects of any lifestyle changes.

Māori, Pacific people and other groups may include other approaches such as prayer and traditional healing.

Guided self-help and e-therapy

Guided self-help refers to the provision of psychological therapy in the form of written materials, booklets or electronic based resources.

IT based materials have become known as e-therapy. This refers to a range of techniques using internet communication technology to facilitate counselling, support and self motivated management of life issues that are impacting on mental health. In the past it has been referred to as on-line counselling or coaching, but these do not cover the range of techniques now being used which include: email, real time chat and video, on-line conferencing, video games and interactive tools. It can

be used in conjunction with traditional psychotherapy or a lifestyle management tool. E-therapy can also be used in combination with antidepressant treatment and to help prevent relapse of depressive symptoms once they have resolved.

There are encouraging signs that web-based self management interventions may be useful in treating depressive symptoms in primary care patients. However, there are literally hundreds of resources that can be retrieved by a search on the internet and most of these have not been validated and may be of dubious quality. It is preferable to direct patients to reputable sites (see e-therapy resources on next page).

Psychological Therapy

Brief structured psychological interventions can be effective for the common mental disorders presenting in primary care. They can be provided by primary care practitioners with appropriate training.

A structured psychological intervention is a treatment option for all patients with moderate depression and as combination therapy with antidepressants in patients with severe depression.

For moderate depression a psychological intervention could consist of 6–8 sessions of Cognitive Behaviour Therapy (CBT), Interpersonal Therapy (IPT), or structured Problem Solving Therapy (PST) over 10–12 weeks. Most primary care practitioners already draw on elements of these in much briefer interventions in their routine clinical practice. Full courses of specific treatment should be provided by suitably trained practitioners.

For a patient with more severe depression, a longer structured psychological intervention (e.g. 16–20 sessions of CBT or IPT) is an appropriate first-line treatment if this is available. In severe depression, a combination of antidepressant treatment and structured psychological intervention should be considered as the combination is more effective than either treatment used alone.

Cognitive Behavior Therapy

CBT is an active, structured intervention in which the patient and therapist work collaboratively to identify the effects of thoughts, beliefs and interpretations on current problem areas, and develop the patient's skills to identify, monitor and counteract problem thoughts, beliefs and interpretations. The patient learns a repertoire of appropriate coping skills.

Problem Solving Therapy

PST is a structured intervention focusing on identifying specific problem areas and working collaboratively to prioritise problems, break them down into specific manageable tasks, choose solutions and develop appropriate coping behaviours. PST can be readily learnt by a member of the primary care team and can be delivered in short sessions within a feasible time frame.

Interpersonal Therapy

IPT is a structured intervention that focuses on interpersonal and relationship issues. Therapist and patient work collaboratively to identify the effects of key problem areas associated with interpersonal conflicts, role transitions, grief and loss, and social skills. Symptoms reduce when strategies are developed to cope with or resolve these problem areas.

Current examples of e-therapy resources

– also see Appendix F of the New Zealand Guidelines

The National Depression Initiative

www.depression.org.nz

The National Depression Initiative has a recently updated interactive website which has a focus on self management. It provides a self test and detailed information about depression and NZ options for management and treatment in the form of a "journey" that users can take to "get through" depression. It features video clips of New Zealanders who talk about their experience and what they found helpful.

The low down

www.thelowdown.co.nz

An interactive website for young people featuring a self test, fact sheets, a moderated message board to enable peer support, and video clips from popular musicians and high profile young sports people talking about their experiences of depression. The site enables access to a team of counsellors who provide email, phone, webcam and text-based support services for young people.

Recovery via the Internet from Depression (RID)

www.otago.ac.nz/rid

The RID trial (2006-2010) will test whether a set of web-based self-help programmes work for reducing depression in New Zealand. The programmes are designed to help people manage their depression by providing relevant information and/or working through a number of exercises on the internet. The aim of this site is to explain the RID trial and invite people to take part in it.

Moodgym

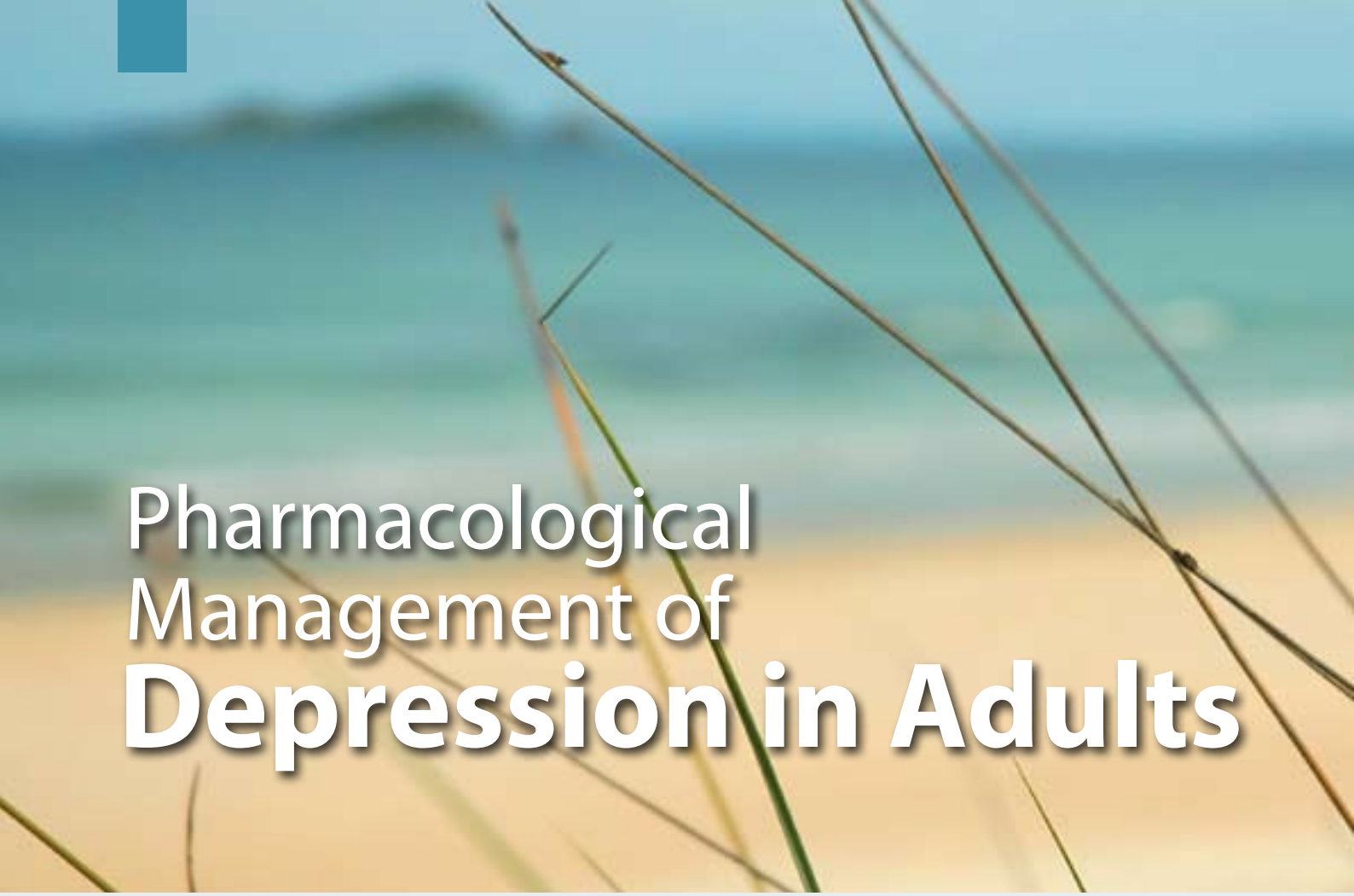
moodgym.anu.edu.au/welcome

Moodgym is based on Cognitive Behaviour Therapy and Interpersonal Therapy. It may be useful in reducing depressive symptoms and dysfunctional thoughts.

Climate.tv

www.climate.tv

Gives access to a group of websites which includes information and courses that can be used by primary care clinicians and their patients, by school teachers and their students, and by health science educators and their staff members. They are a not-for-profit initiative of the Clinical Research Unit for Anxiety and Depression at St Vincent's Hospital, Sydney, Australia. Registration and payment is required to access the course modules.



Pharmacological Management of Depression in Adults

Drug treatment in adults – general principles[1]

- First-line treatment for an adult with moderate depression is either a selective serotonin reuptake inhibitor (SSRI) or a psychological therapy (e.g., 6–8 sessions of problem-solving or cognitive behavioural therapy over 10–12 weeks)
- An adult starting antidepressant treatment who is not considered at increased risk of suicide should be reviewed by the health practitioner within 1–2 weeks and monitored at least 2 weekly until there is clear improvement
- An adult considered at risk of suicide should be followed up more frequently based on assessment of risk and the likelihood of this changing
- Practitioners should consider the use of a tool such as the Patient Health Questionnaire for Depression (PHQ-9) to assist monitoring treatment response in depressed adults
- If an adult on antidepressant medication has had only a partial response after 3–4 weeks, consider increasing the dose
- If an adult on antidepressant medication has not responded to treatment by 4–6 weeks, review the diagnosis and the treatment plan and, if the diagnosis is unchanged, consider either increasing the dose, changing the antidepressant, or changing or adding a psychological therapy
- An adult with depression who is responding to antidepressant treatment should normally continue to take the antidepressant for at least 6 months after remission in order to reduce the risk of relapse
- Patients who have had two or more depressive episodes in the recent past, and who have experienced significant functional impairment during the episodes, should be advised to continue antidepressants for 2 years
- Depressed adults who have not shown an adequate response to two full courses of treatment (psychological or pharmacological) should be referred for review by mental health services while continuing treatment

Antidepressant Choice

All antidepressant drugs are approximately equal in effectiveness, although individual patient response may vary markedly.[10]

For most indications the SSRIs are considered first-line as they are better tolerated and have a wider safety margin than the tricyclic antidepressants (TCAs) and irreversible nonselective monoamine oxidase inhibitors (MAOIs).[11]

MAOIs (phenelzine, tranylcypromine) are now rarely used because of their severe, and potentially fatal, interactions with some foods and medications. They should only be initiated by psychiatrists familiar with their use.

Moclobemide may be useful, particularly in patients who are intolerant of the adverse effects of other antidepressants. The evidence suggests that it works at least in moderate depression but maybe less effective in severe depression. It provides an option when the patient is unable to tolerate anything else.

Choice of antidepressant is also based on individual patient factors. If a patient has responded well to an antidepressant in the past then that drug should be considered first choice. Concurrent medical and psychiatric illnesses e.g. epilepsy, cardiovascular disease and bipolar disorder will also influence choice.

Other factors to consider include:

- adverse effect profile of the drug or drug class e.g. activating effects of an SSRI may be useful when hypersomnia is a presenting symptom
- potential for drug interactions
- toxicity in overdose, as well as the likelihood that the patient will attempt a deliberate overdose

For more information see Table 3 over page.

Dose titration and response

SSRIs can often be started with a 20 mg daily dose (for citalopram, fluoxetine and paroxetine) with no further dose increases. This will be sufficient for many adults.

When using TCAs, start with a low dose and increase slowly e.g. start with 25–50 mg of nortriptyline and increase by 25 mg every third night to 100 mg.

It is usual to take SSRIs in the morning due to the risk of insomnia and TCAs at night because they may be sedative.

Dose titration for both SSRIs and TCAs is usually slower for anxious patients as they appear more sensitive to side effects. It is not unusual for anxious patients to have more anxiety during the titration of SSRIs. Starting dose can be 10 mg of citalopram, fluoxetine or paroxetine. After a week, if the patient tolerates the medication, the dose can be increased.

Regular symptom review and monitoring of suicide risk are essential adjuncts to drug treatment. An assessment tool such as the Patient Health Questionnaire for Depression (PHQ-9) can be used to assist in the monitoring of treatment response in an adult with depression.[1]

Table 3: Comparison of antidepressants most commonly used in general practice in New Zealand.

Tolerability considerations	
Sedation	SSRIs tend to be less sedating than TCAs. However all antidepressants may impair ability to drive or operate machinery.
Anticholinergic effects	Common problem with TCAs and paroxetine
Orthostatic hypotension	Least likely with SSRIs, venlafaxine and moclobemide
Toxicity	TCAs and venlafaxine are more toxic in overdose than SSRIs.
Sexual dysfunction	Less common with moclobemide
Weight gain	TCAs and paroxetine are associated with weight gain
Withdrawal	Some people experience withdrawal effects after missing 1 or 2 doses, especially when using a drug with a short half-life (e.g. paroxetine, venlafaxine). At the end of a treatment course, taper antidepressant over several weeks and monitor for withdrawal symptoms.

Class considerations	
SSRIs	SSRIs are generally considered first-line agents. SSRIs are relatively activating and usually best given as a single daily dose each morning. Routine use of doses above those recommended rarely increases antidepressant effect. Higher doses are necessary for treatment of obsessive compulsive disorder.
TCAs	Nortriptyline is less sedating, and less likely to cause hypotension or anticholinergic effects than amitriptyline, dothiepin, doxepin and trimipramine. TCAs are very toxic in overdose – 700 mg can be lethal in adults.
MAOIs	Moclobemide, a reversible, selective MAOI (RIMA), has far less potential for interactions than irreversible MAOIs (phenelzine and tranylcypromine)
SNRI **(Venlafaxine)**	Venlafaxine has efficacy and tolerability comparable to the other classes of antidepressants. May increase blood pressure, particularly with high doses. Caution required with cardiovascular disease.

An adult with depression who is responding to antidepressant treatment should normally continue to take the antidepressant for at least 6 months after remission (not just after the initial response) of an episode of depression in order to reduce the risk of relapse.[1]

Patients who have had two or more depressive episodes in the recent past, and who have experienced significant functional impairment during the episodes, should be advised to continue antidepressants for 2 years.

When withdrawing treatment on completion or otherwise, reduce the dose gradually over at least 4 weeks to avoid discontinuation symptoms.

Treatment with SSRIs

SSRIs are better tolerated and are safer in overdose than other classes of antidepressants.No single SSRI has a significantly better safety or effectiveness.

If the first SSRI tried is not tolerated or does not work it is reasonable to try another SSRI.

When selecting an SSRI factors that influence patient tolerability become important such as drug interaction potential, severity of withdrawal syndrome and side effects.

Interaction potential

SSRIs are metabolised by different isoenzymes, hence their potential for interaction varies which may influence drug choice.[11] Citalopram is a relatively weak inhibitor of CYP2D6 compared with the other SSRIs, and thus it interacts with a more limited range of drugs than fluoxetine and paroxetine.

The most important interactions are those with other drugs that affect serotonergic neurotransmission as these can lead to serotonin toxicity and, in severe cases, serotonin syndrome

Response to antidepressants[1]

Some improvement is usually seen within two weeks of starting antidepressant treatment at a therapeutic dose.

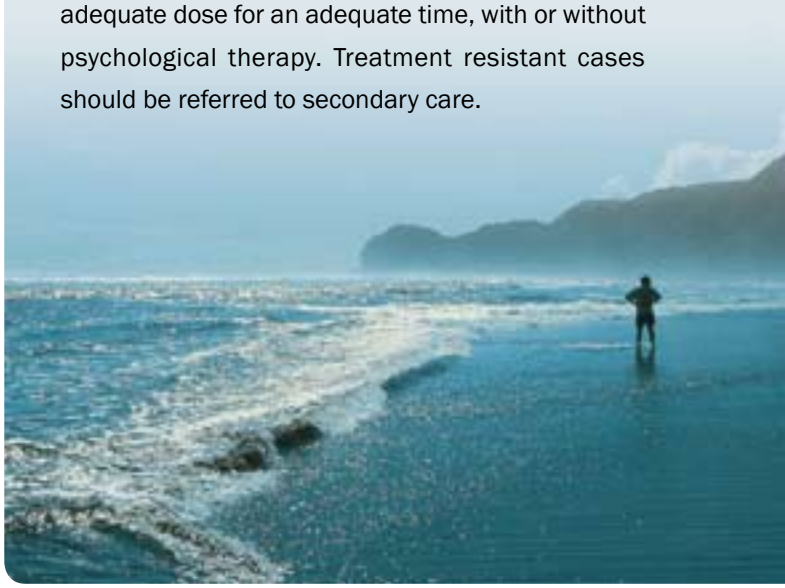
At 3–4 weeks, if there is no improvement or minimal response the practitioner should re-evaluate the treatment plan and consider changing to a different antidepressant, changing to a psychological therapy or adding a psychological therapy.

If there is insufficient response by 4–6 weeks review the diagnosis; if confirmed, review the treatment plan and consider either increasing the dose, changing the antidepressant, changing to a psychological therapy or adding a psychological therapy. A different medication often works even if the first option has been unsuccessful.

Up to a third of patients have a relatively slow response to antidepressants. Continuation of the same antidepressant can also be considered in patients who show a partial response at 6 weeks.

Treatment resistance

This is defined as a lack of satisfactory response after a trial of two antidepressants given sequentially at an adequate dose for an adequate time, with or without psychological therapy. Treatment resistant cases should be referred to secondary care.



Features of serotonin toxicity (see Table 4) may be relatively mild, such as tremor and low grade restlessness. This may indicate the need to modify drug therapy. Serotonin syndrome is the most severe form of serotonin toxicity characterised by a recognised cluster of prominent and severe clinical features that usually require supportive management and stopping the causative agent(s). **If severe, refer immediately to an emergency department**

A number of drugs and herbal products (principally St John's Wort) have serotonergic activity and can cause serotonin toxicity or the syndrome if given alone, especially in high doses. The potential for toxicity is increased if these agents are given in combination (Table 5). For example there is the potential for a toxic interaction if St John's Wort is given with Fluoxetine, or if paroxetine is given with tramadol.

SSRIs can interfere with haemostasis, due to action on serotonin release from platelets, and may increase the risk of bleeding. Risk of upper gastrointestinal tract bleeding in patients taking SSRIs is significantly increased when an SSRI is combined with a nonsteroidal anti-inflammatory drug or low dose aspirin. Patients vulnerable to GI bleeding (e.g. those with a history of peptic ulcer disease, oesophageal varices or who are undergoing surgery) should be observed carefully, considered for an alternative class of antidepressant or given a protective drug.[11]

For further information on interactions refer: BPJ Special Edition, March 2007. Paroxetine Medication Brand change: Drug Interactions with Antidepressants.[12]

Adverse Effects

The SSRIs have a similar adverse effect profile (Table 6).

Gastrointestinal effects and insomnia are generally mild and transient, and can often be minimised by taking the SSRI in the morning, with food. SSRIs are usually activating but if sedation is predominant they can be given at night instead of the morning.

Table 4: Features of Serotonin Toxicity[10]

Clinical Features	Contributing factors
Abdominal cramps, agitation, diarrhoea, myoclonus, tremulousness, coma, tachycardia, hypotension, disorientation, profuse sweating, hyperpyrexia	Overdosage Drug interaction, especially SSRI + MAOI or SSRI + serotonergic TCA (e.g. clomipramine, amitriptyline, imipramine) Inadequate drug-free interval in changing medications Idiosyncratic reaction

Table 5: Drugs that may cause serotonin toxicity[10]

Class	Drugs
antidepressants	TCAs (especially clomipramine), MAOIs (including moclobemide), SSRIs, mirtazapine, venlafaxine, St John's Wort
opioids	tramadol, pethidine, dextromethorphan
stimulants	amphetamines, sibutramine
5HT1 agonists	sumatriptan, naratriptan, zolmitriptan
others	Ecstasy, LSD, cocaine. Selegiline, tryptophan, buspirone, lithium, linezolid

Table 6: Relative frequency of common adverse effects.[10]

SSRI or newer antidepressant	Agitation	Gastro-intestinal	Insomnia	Sedation	Sexual dysfunction	Weight gain
Citalopram	+	++	++	++	+++	+
Fluoxetine	+	++	++	++	+++	+
Paroxetine	+	++	++	++	+++	+
Venlafaxine	++	+++	++	++	+++	+

Approximate frequencies of adverse effects: +(>2%) = infrequent; ++(>10%) = moderately frequent; +++(>30%) = frequent.

Note: this is the frequency of occurrence of adverse effects, not the intensity with which they occur.

Sexual problems, such as decreased libido and difficulty achieving orgasm, occur in around 40% of people taking SSRIs, and in around 30% of cases the problem is likely to be drug-related, though estimates vary widely. A temporary dose reduction or a trial of specific phosphodiesterase inhibitors could be considered.[1]

All SSRIs can cause agitation, therefore in people in whom anxiety is a factor it is advisable to start with a low dose (about half the usual starting dose) and increase the dose slowly. Paroxetine appears to cause more anticholinergic effects (dry mouth, blurred vision, constipation) and for this reason it may be less suitable in elderly patients.

Suicidal ideation

Early contact in the first week of treatment is important to enquire about suicidal ideation and about any increase in symptoms.[1]

In the first few days of treatment with an SSRI an increase in anxiety, restlessness or agitation may occur. This can be very distressing and may be associated with increased suicidality. Patients should be advised to contact the practitioner if this happens. A change of medication could be discussed in these circumstances if the cause appears to be related to medication rather than other stressors.

Discontinuation syndrome

After cessation of an SSRI the most commonly reported discontinuation symptoms include dizziness, nausea, anxiety, vivid dreams and headache (Table 7). Occasionally, electric shock-like sensations are reported. Usually these symptoms are mild, last one to two weeks, and are rapidly reversed with reinstitution of the SSRI.[11]

SSRIs with shorter half-lives, such as paroxetine, have a higher incidence of withdrawal symptoms. Fluoxetine is the SSRI least likely to be associated with a discontinuation syndrome due to its long half-life.

Discontinuation symptoms usually begin within one to three days after abrupt cessation of the SSRI. To avoid discontinuation symptoms a continuous supply of medication and good compliance is necessary. When the decision is made to stop therapy, gradual withdrawal over at least four weeks is recommended. Generally, the higher the dose, the longer the withdrawal period.

Cautions

There are situations when an SSRI is not the first choice for clinical reasons or should be used with caution.

Previous response to a drug is a good predictor of response to treatment of later episodes. Hence when a patient has responded well to an agent such as a TCA in the past it makes sense to consider that drug as first choice.

If the patient has experienced unacceptable side effects to an SSRI e.g. agitation, then it is best to avoid that agent. However it may be worth trying another SSRI before switching to another class.

Caution is recommended when using an SSRI with co-morbid conditions such as epilepsy or diabetes.

All psychotropics lower the seizure threshold, but if the person is well controlled on antiepileptic medication then SSRIs are very unlikely to affect seizure control. SSRIs are considered the antidepressants of choice in patients with concurrent cardiac disorders as TCAs have a greater risk of cardiotoxicity.

In patients with diabetes SSRIs may affect glycemic control. Hypoglycaemia has occurred during therapy and hyperglycaemia has developed following discontinuation. Insulin and/or oral hypoglycaemic dosage may need to be adjusted when an SSRI is initiated or discontinued.

SSRIs are generally contraindicated if the patient enters a manic phase. Manic phase should lead to psychiatric review.

Tricyclic antidepressants

Tricyclic antidepressants (TCAs) are appropriate as a second-line treatment if there has been an unsatisfactory response to an SSRI. They can also be considered in those who have previously responded to a TCA.

All TCAs cause anticholinergic side effects (such as dry mouth, blurred vision, constipation, urinary retention and sweating), sedation and postural hypotension. Usual recommendations are to start with a low dose and titrate up to the full therapeutic dose as quickly as the patient can tolerate this.

TCAs can cause ventricular arrhythmias in the absence of adequate oxygenation of heart muscle (e.g., with ischaemic heart disease) and in overdose. TCAs are very toxic in overdose and seizures can occur.[1]

Nortriptyline is less sedating, and less likely to cause hypotension or anticholinergic effects, than amitriptyline, dothiepin, doxepin and imipramine.[10]

Venlafaxine

Venlafaxine is a SNRI (serotonin and noradrenaline reuptake inhibitor) and is subsidised by PHARMAC for treating depression that has failed to respond to adequate trials of two other antidepressants.

Table 7: Discontinuation symptoms[10]

Class	Symptoms	Comments
TCAs	cholinergic rebound: hypersalivation, runny nose, abdominal cramping, diarrhoea, sleep disturbance	more common on stopping amitriptyline, doxepin, imipramine
SSRIs	dizziness, nausea, paraesthesia, anxiety, agitation, tremor, sweating, confusion, electric shock-like sensations	more common on stopping paroxetine and least likely with fluoxetine
SNRI	venlafaxine may cause a syndrome similar to that seen with SSRIs	particularly likely on stopping venlafaxine because of its short elimination half-life

Comparison of SSRIs and venlafaxine

SSRI/SNRI	Advantages	Disadvantages
Citalopram	Interacts with fewer drugs compared with other SSRIs. Short half-life allows minimal washout period when switching to another drug.	Moderate discontinuation symptoms on stopping.
Fluoxetine	Long half-life which may allow for less frequent administration in poorly compliant patients and less troublesome discontinuation effects.	Longer delay required before switching to other antidepressants. Interacts with more drugs compared with citalopram.
Paroxetine	Short half-life allows minimal washout period when switching to another drug.	High incidence of discontinuation reactions. Interacts with more drugs compared with citalopram.
Venlafaxine	May be a useful option for resistant depression.	May increase blood pressure, particularly with high doses. Caution required with cardiovascular disease. Higher withdrawal rates due to adverse effects.

The reuptake effects of venlafaxine are dose dependent. At low doses (<150 mg/day), the drug acts like the SSRIs. At intermediate to high doses, the additional effects on noradrenaline reuptake become important.

Nausea, agitation, sexual dysfunction and insomnia at low doses of venlafaxine are probably mediated by effects on postsynaptic serotonergic receptors.

At intermediate to high doses, additional adverse effects such as raised blood pressure and headache are observed in some patients, these effects are probably due to an action on adrenergic receptors.

Venlafaxine has not been evaluated in patients with a recent history of myocardial infarction or unstable heart disease and needs to be used with caution in these patients. Increase in blood pressure and serum cholesterol can occur with venlafaxine and monitoring is recommended. Like the SSRIs, venlafaxine has been associated with increased bleeding, including upper gastrointestinal bleeding.[13]

Vocationally trained GPs can prescribe extended release venlafaxine (Efexor-XR) under special authority for people who have trialed and failed to respond to two antidepressants for an adequate time (usually at least 4 weeks).

Refer: BPJ, Oct 2006. Venlafaxine: how and when to use.

Other antidepressants are they still an option?

Mianserin and maprotiline should be avoided due to the significant risk of serious adverse effects and there are very limited indications for the use of the irreversible MAOIs.

Mianserin

Mianserin use in New Zealand was associated with a series of deaths from agranulocytosis which led to its use being restricted under special authority to patients who also had cardiovascular disease or bladder neck obstruction. SSRIs were not available at that time and are suitable for most indications when mianserin would have been used.

Maprotiline

Seizures have been reported in patients receiving maprotiline and have occurred principally in those with no previous history of seizures. It has generally been suggested that maprotiline may be associated with a higher incidence of seizures than the tricyclic antidepressants.

Maprotiline has been withdrawn in some countries, including Australia.

Tranylcypromine/Phenelzine

There are limited indications for the use of these agents. If an irreversible MAOI is being considered then the patient probably requires specialist review. GPs need to remain aware of the major and potentially fatal interactions with other drugs, including some analgesics

Changing from one antidepressant to another

Some patients do not respond to the first antidepressant prescribed and need to be changed to another drug. There are no hard and fast rules to guide which drug to switch to. Similar factors that governed the initial drug choice may be relevant and there may be some logic in trying a drug from a different class. However, a response or better tolerability is often seen by changing to another drug from the same class, (e.g. switching from fluoxetine to citalopram). This may be explained by subtle differences in pharmacology or differences in drug metabolism and genetic polymorphism.

When switching drugs, consider the need for washout periods, cross tapering and the management of discontinuation syndrome.An appropriate interval when changing from one antidepressant to another is recommended to avoid interactions. General recommendations are given in the Table 8, based on the pharmacokinetics of the parent drug and of active metabolites where appropriate. However, this is only a guide and strategies may vary according to individual factors.

Higher doses of medication should be tapered before commencing a change of drug and the new drug should be started at a low dose.

Stopping drug therapy

Antidepressants that have been taken regularly for at least six weeks must not be discontinued abruptly, unless a serious adverse effect has occurred. Stopping treatment quickly can sometimes cause discontinuation symptoms. It is best to reduce the dose gradually over at least four weeks, but slower withdrawal may be necessary after longer periods, for example, over six weeks after a six month course.

Table 8: Antidepressant-free intervals recommended when changing from one antidepressant to another.[11]

		Changing to					
		citalopram paroxetine	**fluoxetine**	**moclobemide**	**venlafaxine**	**TCAs**	**tranylcypromine phenelzine**
Changing from	**citalopram paroxetine**	nil	nil	2 to 4 days[a]	2 to 4 days	2 to 4 days[c]	1 week
	fluoxetine[d]	1 week	-	1 week	1 week	2 weeks[c]	5 weeks
	Moclobemide[a] (if moderate or lower doses of both drugs)	1 to 2 days	1 to 2 days	-	1 to 2 days	1 to 2 days	nil
	venlafaxine	1 to 2 days	1 to 2 days	1 to 2 days	-	1 to 2 days	1 week
	TCAs	2 to 4 days	2 to 4 days	2 to 4 days[e] (1 week for clomipramine)	2 to 4 days	nil	1 week
	tranylcypromine[b] phenelzine[b]	2 weeks	2 weeks	Nil (for moderate or low doses of both drugs)	2 weeks	2 weeks	2 weeks

Notes

- The risk of adverse effects needs to be weighed against the risk of undue delay in response to treatment.
- Monitor closely to detect adverse effects, particularly serotonin toxicity
- Nil = start the new drug on the next day

a. If changing from the short acting SSRIs (citalopram, paroxetine) moclobemide dose should be held at 300 mg/day for the first week. Dose may be subsequently increased if necessary. This recommendation is only for changing from low or moderate doses of SSRIs. High doses of SSRIs should be gradually reduced and then stopped before starting moclobemide.

b. Irreversible nonselective MAOIs (phenelzine, tranylcypromine) should be commenced with caution after all other antidepressants because of the risk of severe hypertension, stroke and serotonin toxicity. Allowance should be made for the washout period.

c. When changing from an SSRI to a TCA, the TCA concentration may be elevated for at least several weeks due to persisting SSRI-induced cytochrome P450 inhibition.

d. Care is required when changing from fluoxetine to another antidepressant as it has a longer half-life than other SSRIs, leading to meaningful concentrations of fluoxetine or its active metabolite being present for about 5 weeks after cessation.

e. When changing from a TCA to moclobemide, the moclobemide dose should be held at 300 mg/day for the first week. Dose may be subsequently increased if necessary. This recommendation is only for changing from low or moderate doses of TCA (e.g. up to 150 mg imipramine).

Pregnancy

Note: The treatment of depression in pregnancy, breastfeeding and postnatal depression will be covered in detail in a subsequent publication.

Decisions about management must be individualised and should be guided by life history of depression (number and severity of episodes), prior occurrence of depression during pregnancy or postpartum, and severity of symptoms at the time of conception and throughout the pregnancy.

Close monitoring by a psychiatrist may be required.

When antidepressants are the treatment of choice, SSRIs, except paroxetine, are recommended as an appropriate first-line therapy for most women.

Paroxetine should be avoided in pregnancy due to teratogenic risk, in accordance with Medsafe advice.[14] Some practitioners may recommend shorter-acting SSRIs such as citalopram, but the longer half-life of fluoxetine means that any neonatal withdrawal effects are likely to be more gradual. For women at risk of preterm birth, the practitioner may wish to consider the use of a TCA in preference to an SSRI, as there is some evidence that SSRIs may increase the risk of premature labour.[1]

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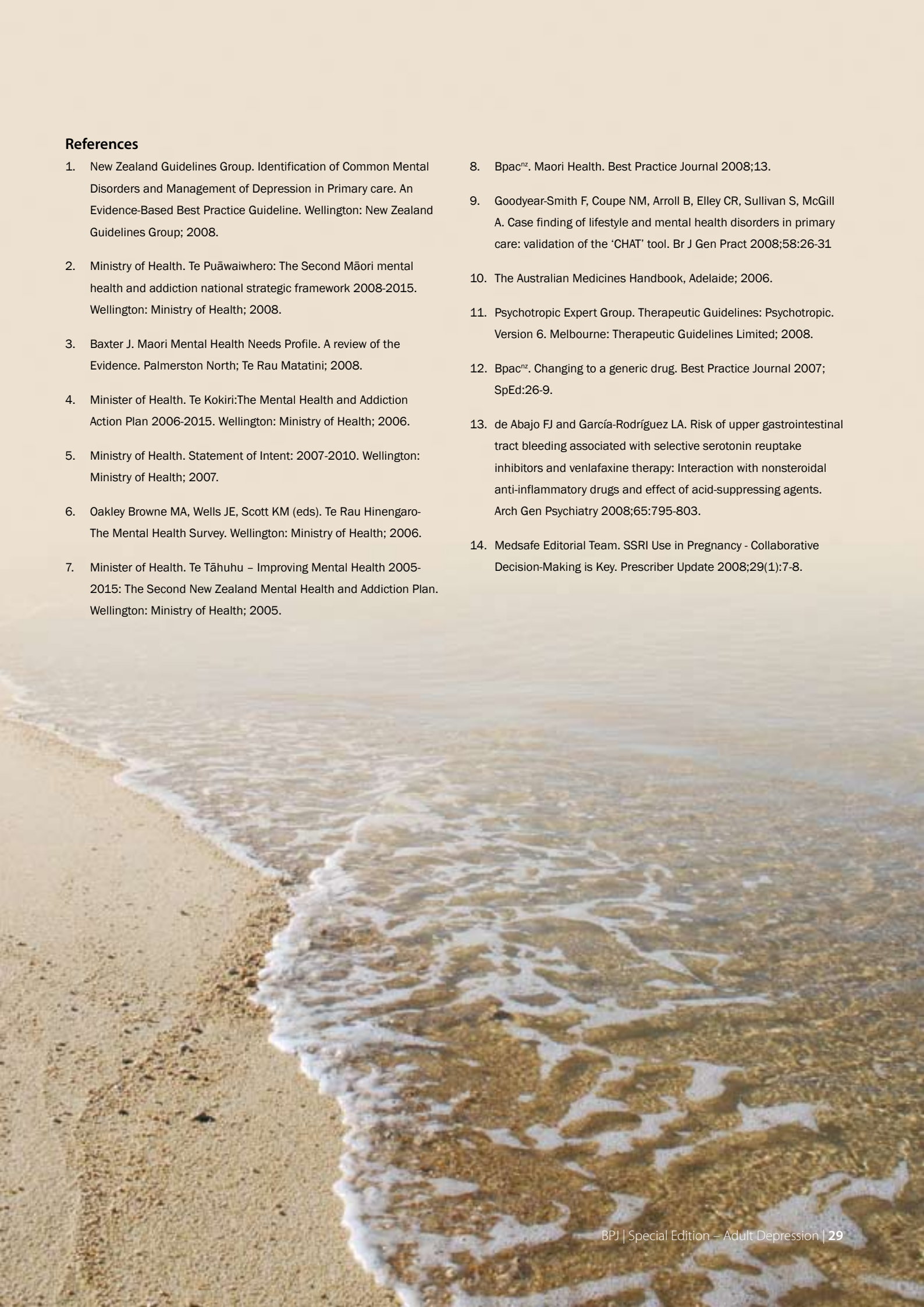


Appendix 1 Management of depression in adults in primary care[1]

Immediate referral* !

Refer at any stage if:

- serious suicidal intent
- psychotic symptoms
- severe self-neglect.

* **Immediate referral:** referral is to be made by the primary care practitioner that day with the expectation of a same-day response to the referral

Urgent referral†

Refer at any stage if:

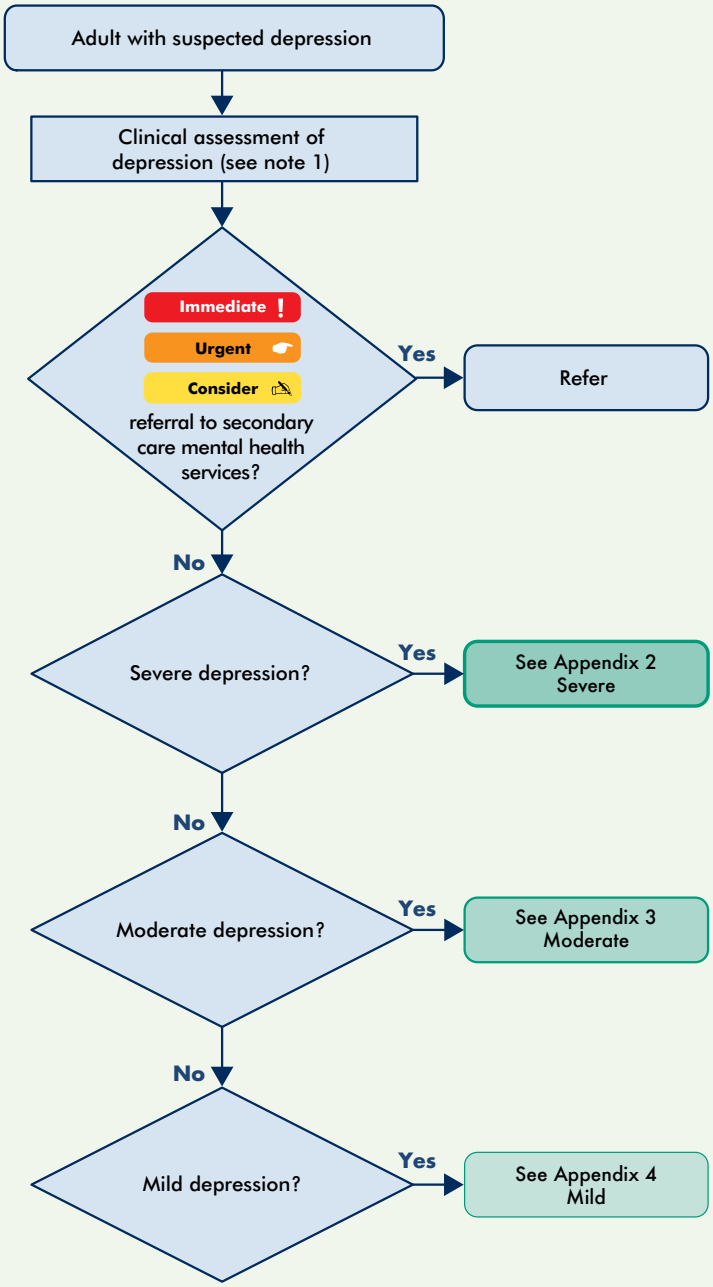
- significant but not immediate risk of harm to self/others
- suspected new-onset bipolar disorder
- treatment resistant.

† **Urgent referral:** referral is to be made by the primary care practitioner within 24 hours, with the expectation that the person referred will be seen within 7–10 days, or sooner depending on secondary care service availability

Consider referral

Refer at any stage if:

- comorbid medical condition that impacts on antidepressant use
- recurrent depression
- atypical depression resistant to initial treatment
- diagnostic uncertainty.



Note 1

Accurate assessment of acuity and severity is important for appropriate management and referral. In addition to the practitioner's clinical assessment, consideration should be given to the use of assessment tools. Tools such as the Patient Health Questionnaire for Depression (PHQ-9) will enable the practitioner to appropriately attribute the degree of severity.

PHQ-9 score for Major Depression

PHQ-9 score	Provisional diagnosis
10–14*	Mild depression
15–19*	Moderate depression
≥20*	Severe depression

Management of severe depression in adults in primary care[1]

Appendix 2

Immediate referral*

Refer at any stage if:

- serious suicidal intent
- psychotic symptoms
- severe self-neglect.

* **Immediate referral:** referral is to be made by the primary care practitioner that day with the expectation of a same-day response to the referral

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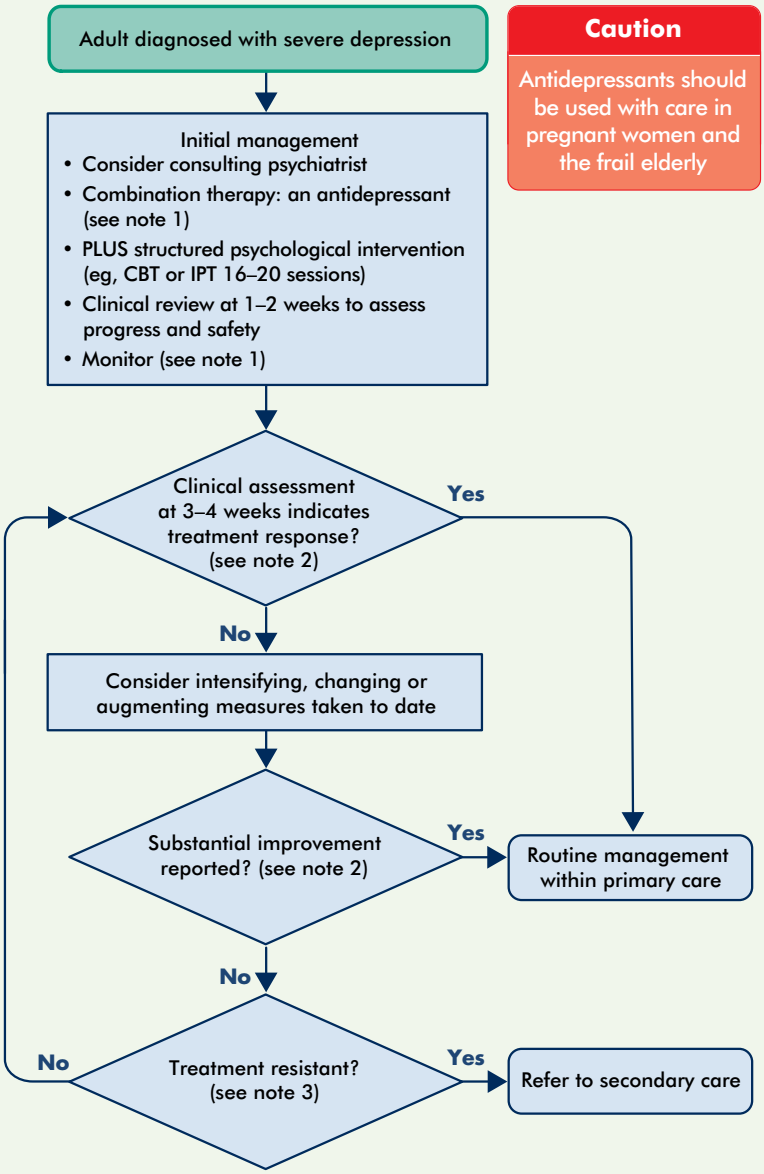


Caution

Antidepressants should be used with care in pregnant women and the frail elderly

Note 1: Monitoring after initiation of an antidepressant

If at increased risk of suicide:

see at 1 week, monitor 1–2 weekly, preferably face-to-face, until the risk is not significant, then at least 2-weekly until clear improvement.

If not at increased risk of suicide:

review within 1–2 weeks, then monitor at least 2-weekly until clear improvement.

Note 2: Antidepressants

At 3–4 weeks

If only a partial response, consider increasing the dose.

If no response or minimal response, or unacceptable side effects, consider changing antidepressant, or changing to or adding a psychological therapy.

At 4–6 weeks

If the person has not responded to treatment, consider increasing the dose, changing antidepressant, or changing to or adding a psychological therapy.

Antidepressants should normally be continued for at least 6 months after remission, to reduce the risk of relapse.

Note 3: Treatment resistance

Treatment resistance is defined as lack of a satisfactory response after trial of two antidepressants given sequentially at an adequate dose for an adequate time (with or without psychological therapy).

Appendix 3 Management of moderate depression in adults in primary care[1]

Immediate referral* !

Refer at any stage if:
- serious suicidal intent
- psychotic symptoms
- severe self-neglect.

* **Immediate referral:** referral is to be made by the primary care practitioner that day with the expectation of a same-day response to the referral

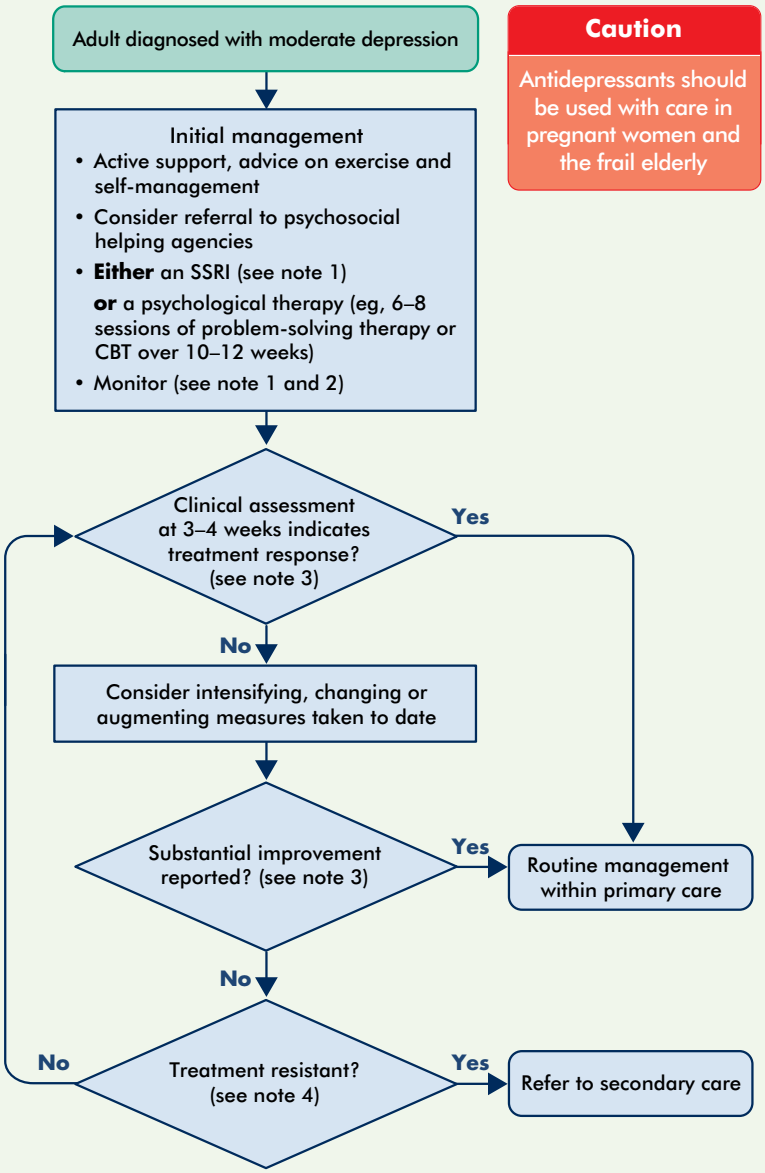
Urgent referral†

Refer at any stage if:
- significant but not immediate risk of harm to self/others
- suspected new-onset bipolar disorder
- treatment resistant.

† **Urgent referral:** referral is to be made by the primary care practitioner within 24 hours, with the expectation that the person referred will be seen within 7–10 days, or sooner depending on secondary care service availability

Consider referral

Refer at any stage if:
- comorbid medical condition that impacts on antidepressant use
- recurrent depression
- atypical depression resistant to initial treatment
- diagnostic uncertainty.



Caution

Antidepressants should be used with care in pregnant women and the frail elderly

Note 1: Monitoring

Initial monitoring

Monitor at 1–2 weeks by face-to-face/phone/text/email to:
- check severity
- gauge progress
- encourage treatment adherence
- take remedial action.

Note 2: Monitoring after initiation of an antidepressant

If at increased risk of suicide:

see at 1 week, monitor 1–2 weekly, preferably face-to-face, until the risk is not significant, then at least 2-weekly until clear improvement.

If not at increased risk of suicide:

review within 1–2 weeks, then monitor at least 2-weekly until clear improvement.

Note 3: Antidepressants

At 3–4 weeks

If only a partial response, consider increasing the dose.

If no response or minimal response, or unacceptable side effects, consider changing antidepressant, or changing to or adding a psychological therapy.

At 4–6 weeks

If the person has not responded to treatment, consider increasing the dose, changing antidepressant, or changing to or adding a psychological therapy.

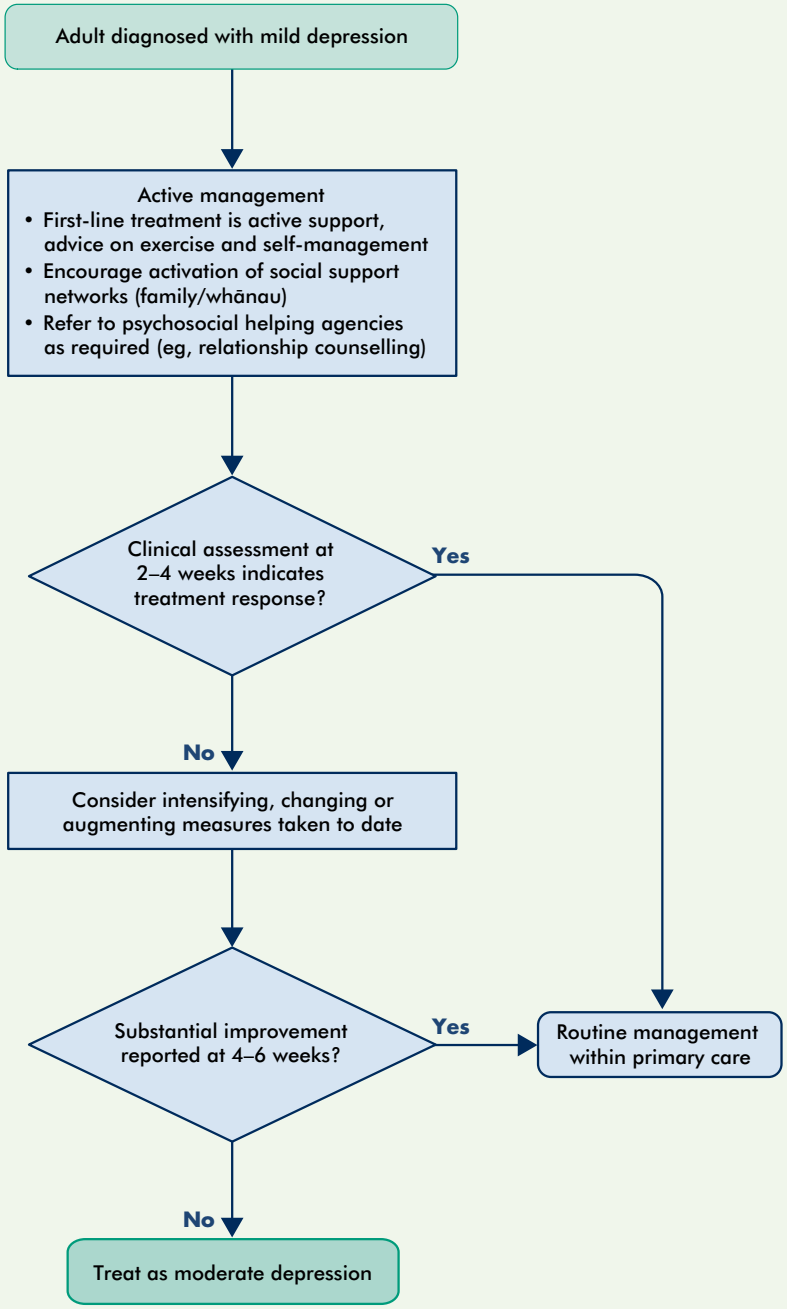
Antidepressants should normally be continued for at least 6 months after remission, to reduce the risk of relapse.

Note 4: Treatment resistance

Treatment resistance is defined as lack of a satisfactory response after trial of two antidepressants given sequentially at an adequate dose for an adequate time (with or without psychological therapy).

Management of mild depression in adults in primary care[1]

Appendix 4



Appendix 5

KESSLER 10 (K10)

KESSLER 10 Questionnaire					
The following ten questions ask about how you have been feeling in the **last four weeks**. For each question, select the option that best describes the amount of time you felt that way.					
In the last four weeks...	None of the time	A little of the time	Some of the time	Most of the time	All of the time
	1	2	3	4	5
1. About how often did you feel tired out for no good reasons?	○	○	○	○	○
2. About how often did you feel nervous?	○	○	○	○	○
3. About how often did you feel so nervous that nothing could calm you down?	○	○	○	○	○
4. About how often did you feel hopeless?	○	○	○	○	○
5. About how often did you feel restless or fidgety?	○	○	○	○	○
6. About how often did you feel so restless you could not sit still?	○	○	○	○	○
7. About how often did you feel depressed?	○	○	○	○	○
8. About how often did you feel that everything was an effort?	○	○	○	○	○
9. About how often did you feel so sad that nothing could cheer you up?	○	○	○	○	○
10. About how often did you feel worthless?	○	○	○	○	○

K10 provisional diagnosis

Scoring — add up answers to questions on K10

None of the time = 1; A little of the time = 2; Some of the time = 3; Most of the time = 4; All of the time = 5

Score between 10 and 19	This score indicates that the patient may currently not be experiencing significant feelings of distress.
Score between 20 and 24	The patient may be experiencing mild levels of distress consistent with the diagnosis of mild depression and/or anxiety disorder.
Score between 25 and 30	The patient may be experiencing moderate levels of distress consistent with the diagnosis of moderate depression and/or anxiety disorder.
Score between 30 and 50	The patient may be experiencing severe levels of distress consistent with the diagnosis of severe depression and/or anxiety disorder.

See **www.nzgg.org.nz/CMD-assessmenttools** for more information

Appendix 6

Patient health questionnaire for depression				
Over the last 2 weeks, how often have you been bothered by any of the following problems? For each question select the option that best describes the amount of time you felt that way.				
In the last 2 weeks	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1. Little interest or pleasure in doing things	○	○	○	○
2. Feeling down, depressed, or hopeless	○	○	○	○
3. Trouble falling or staying asleep, or sleeping too much	○	○	○	○
4. Feeling tired or having little energy	○	○	○	○
5. Poor appetite or overeating	○	○	○	○
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	○	○	○	○
7. Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	○	○	○	○
9. Thoughts that you would be better off dead, or of hurting yourself in some way	○	○	○	○

PHQ-9 provisional diagnosis

Scoring — add up answers to questions on PHQ-9

Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3

Total Score	Depression Severity
10–14	Mild
15–19	Moderate depression
≥ 20	Severe depression

See **www.nzgg.org.nz/CMD-assessmenttools** for more information

Appendix 7 GAD-7

Designed primarily as a screening and severity measure for generalised anxiety disorder, the GAD-7 also has moderately good operating characteristics for three other common anxiety disorders - panic disorder, social anxiety disorder, and post-traumatic stress disorder

Generalised Anxiety Disorder Scale (GAD-7)

Over the **last two weeks** how often have you been bothered by any of the following problems?
For each question, select the option that best describes the amount of time you felt that way.

In last 2 weeks...	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1. Feeling nervous, anxious or on edge	◯	◯	◯	◯
2. Not being able to stop worrying	◯	◯	◯	◯
3. Worrying too much about different things	◯	◯	◯	◯
4. Having trouble relaxing	◯	◯	◯	◯
5. Being so restless it is hard to sit still	◯	◯	◯	◯
6. Becoming easily annoyed or irritable	◯	◯	◯	◯
7. Feeling afraid as if something awful might happen	◯	◯	◯	◯

GAD-7 provisional diagnosis

Scoring — add up answers to questions on GAD-7
Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3

Mild anxiety Score 5 - 9

A score of 5 represents a cutpoint for mild anxiety.

A recommended cutpoint for further evaluation is a score of 10 or greater.

Moderate anxiety Score 10 - 14

A score of 10 represents a cutpoint for moderate anxiety.

A recommended cutpoint for further evaluation is a score of 10 or greater.

Severe anxiety Score 15 - 21

A score of 15 represents a cutpoint for severe anxiety.

A recommended cutpoint for further evaluation is a score of 10 or greater.

See **www.nzgg.org.nz/CMD-assessmenttools** for more information

Appendix 8

Alcohol Use Disorders Identification Test (AUDIT)		
PLEASE TICK THE ANSWER THAT IS NEAREST TO CORRECT FOR YOU		
1.	**How often do you have a drink containing alcohol?** ◯ Never ◯ Monthly or less ◯ 2 – 4 times a month ◯ 2 – 3 times a week ◯ 4 or more times per week	
2.	**How many drinks containing alcohol do you have on a typical day when you are drinking? (code number of standard drinks)** ◯ One to two ◯ 3 or 4 ◯ 5 or 6 ◯ 7 to 9 ◯ 10 or more	
3.	How often do you have six or more drinks on one occasion? ◯ Never ◯ Less than monthly ◯ Monthly ◯ Weekly ◯ Daily or almost daily	
4.	**How often during the last year have you found that you were not able to stop drinking once you had started?** ◯ Never ◯ Less than monthly ◯ Monthly ◯ Weekly ◯ Daily or almost daily	
5.	**How often during the last year have you failed to do what was normally expected from you because of drinking?** ◯ Never ◯ Less than monthly ◯ Monthly ◯ Weekly ◯ Daily or almost daily	
6.	**How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?** ◯ Never ◯ Less than monthly ◯ Monthly ◯ Weekly ◯ Daily or almost daily	
7.	**How often during the last year have you had a feeling of guilt or remorse after drinking?** ◯ Never ◯ Less than monthly ◯ Monthly ◯ Weekly ◯ Daily or almost daily	
8.	**How often during the last year have you been unable to remember what happened the night before because you had been drinking?** ◯ Never ◯ Less than monthly ◯ Monthly ◯ Weekly ◯ Daily or almost daily	
9.	**Have you or someone else been injured as a result of your drinking?** ◯ No ◯ Yes, but not in the last year ◯ Yes, during the last year	
10.	**Has a relative, friend or doctor, or other health worker been concerned about your drinking or suggested that you should cut down?** ◯ No ◯ Yes, but not in the last year ◯ Yes, during the last year	

Scores range from 0 to 4 for each question. See NZGG website below for more details.

AUDIT provisional diagnosis

A score of 8 or more for the whole questionnaire suggests your patient has a harmful pattern of drinking.

Section A: (questions 1, 2, 3) enquires about "at risk" alcohol consumption.
A score of **4 (or more) for women**, or **5 (or more) for men** suggests a level of drinking that places the person at risk of harm.

Section B: (questions 4, 5, 6) enquires about symptoms of dependence.
A score 4 (or more) indicates that person may be psychologically or physically dependent on alcohol.

Section C: (questions 7, 8, 9, 10) enquires about problems relating to drinking.
A score of 4 (or more) indicates significant problems already.

See **www.nzgg.org.nz/CMD-assessmenttools** for more information

Appendix 9

Case-finding and Help Assessment Tool (CHAT)
PLEASE TICK THE ANSWER THAT IS NEAREST TO CORRECT FOR YOU
How many cigarettes do you smoke on average a day?
◯ None ◯ Less than 1 a day ◯ 1–10 ◯ 11–20 ◯ 21–30 ◯ 31 or more
Do you ever feel the need to cut down or stop your smoking? (Tick no if you do not smoke)
◯ No ◯ Yes
Do you want help with your smoking?
◯ No ◯ Yes but not today ◯ Yes
Do you ever feel the need to cut down on your drinking alcohol? (Tick no if you do not drink alcohol OR do not feel the need to cut down)
◯ No ◯ Yes
In the last year, have you ever drunk more alcohol than you meant to?
◯ No ◯ Yes
Do you want help with your drinking?
◯ No ◯ Yes but not today ◯ Yes
Do you ever feel the need to cut down on your non-prescription or recreational drug use? (Tick no if you do not use other drugs OR do not feel the need to cut down)
◯ No ◯ Yes
In the last year, have you ever used non-prescription or recreational drugs more than you meant to?
◯ No ◯ Yes
Do you want help with your drug use?
◯ No ◯ Yes but not today ◯ Yes
Do you sometimes feel unhappy or worried after a session of gambling? (Tick no if you do not gamble OR do not feel unhappy about gambling)
◯ No ◯ Yes
Does gambling sometimes cause you problems?
◯ No ◯ Yes
Do you want help with your gambling?
◯ No ◯ Yes but not today ◯ Yes

Over the last 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?

◯ Not at all ◯ Several days ◯ More than half the days ◯ Nearly every day

Over the last 2 weeks, how often have you been bothered by feeling down, depressed, or hopeless?

◯ Not at all ◯ Several days ◯ More than half the days ◯ Nearly every day

Do you want help with this?

◯ No ◯ Yes but not today ◯ Yes

Over the last 2 weeks have you been worrying a lot about everyday problems?

◯ No ◯ Yes

Do you want help with your anxiety or worrying?

◯ No ◯ Yes but not today ◯ Yes

Is there anyone in your life of whom you are afraid or who hurts you in any way?

◯ No ◯ Yes

Is there anyone in your life who controls you and prevents you doing what you want?

◯ No ◯ Yes

Do you want help with any abuse or violence that you are experiencing?

◯ No ◯ Yes but not today ◯ Yes

Is controlling your anger sometimes a problem for you?

◯ No ◯ Yes

Do you want help with controlling your anger?

◯ No ◯ Yes but not today ◯ Yes

As a rule, do you do less than 30 minutes of moderate or vigorous exercise (such as walking or a sport) on 5 days of the week?

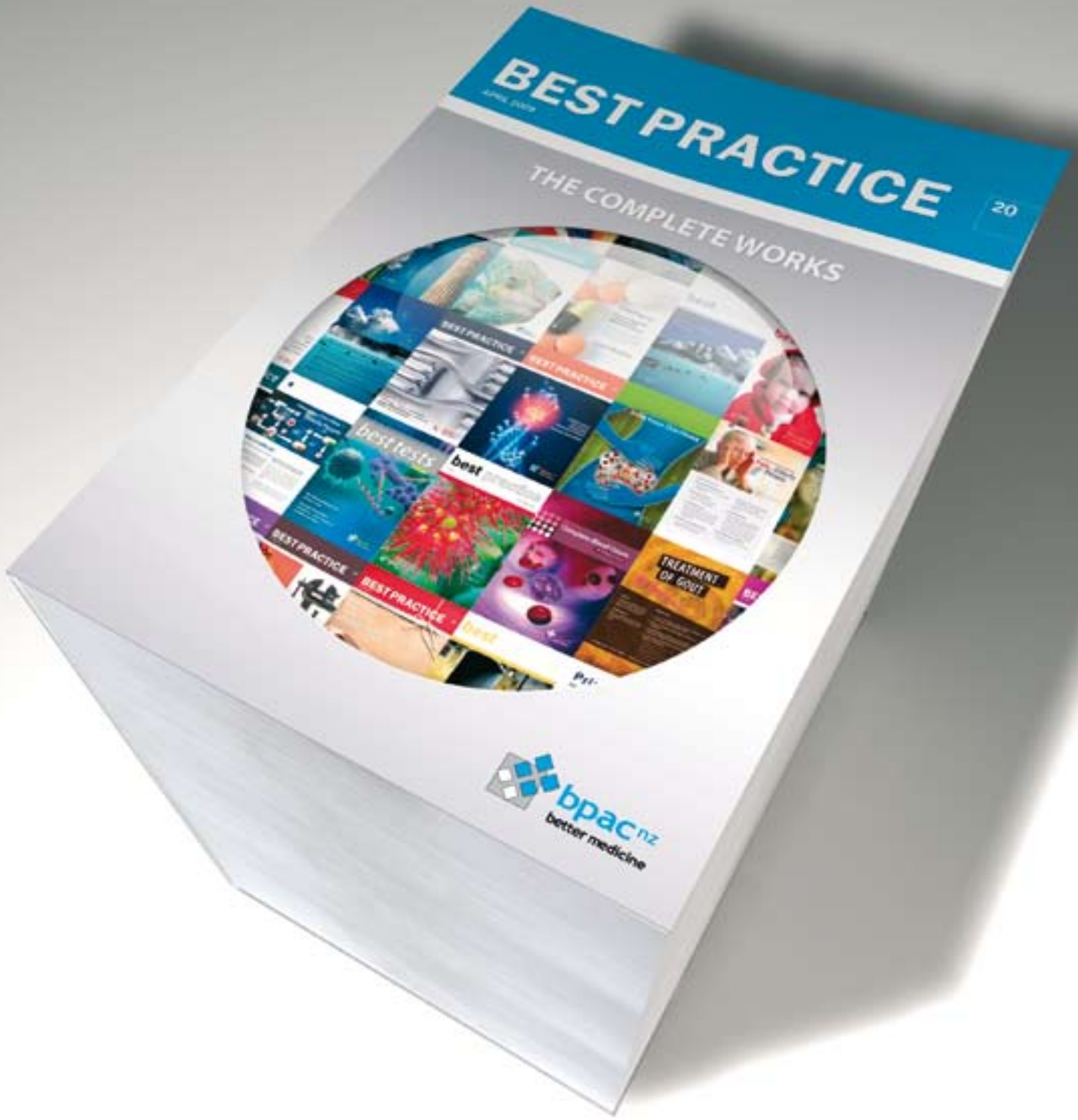
◯ No ◯ Yes

Do you want help with getting more exercise?

◯ No ◯ Yes but not today ◯ Yes

See **www.nzgg.org.nz/CMD-assessmenttools** for more information

for **BEST PRACTICE** online



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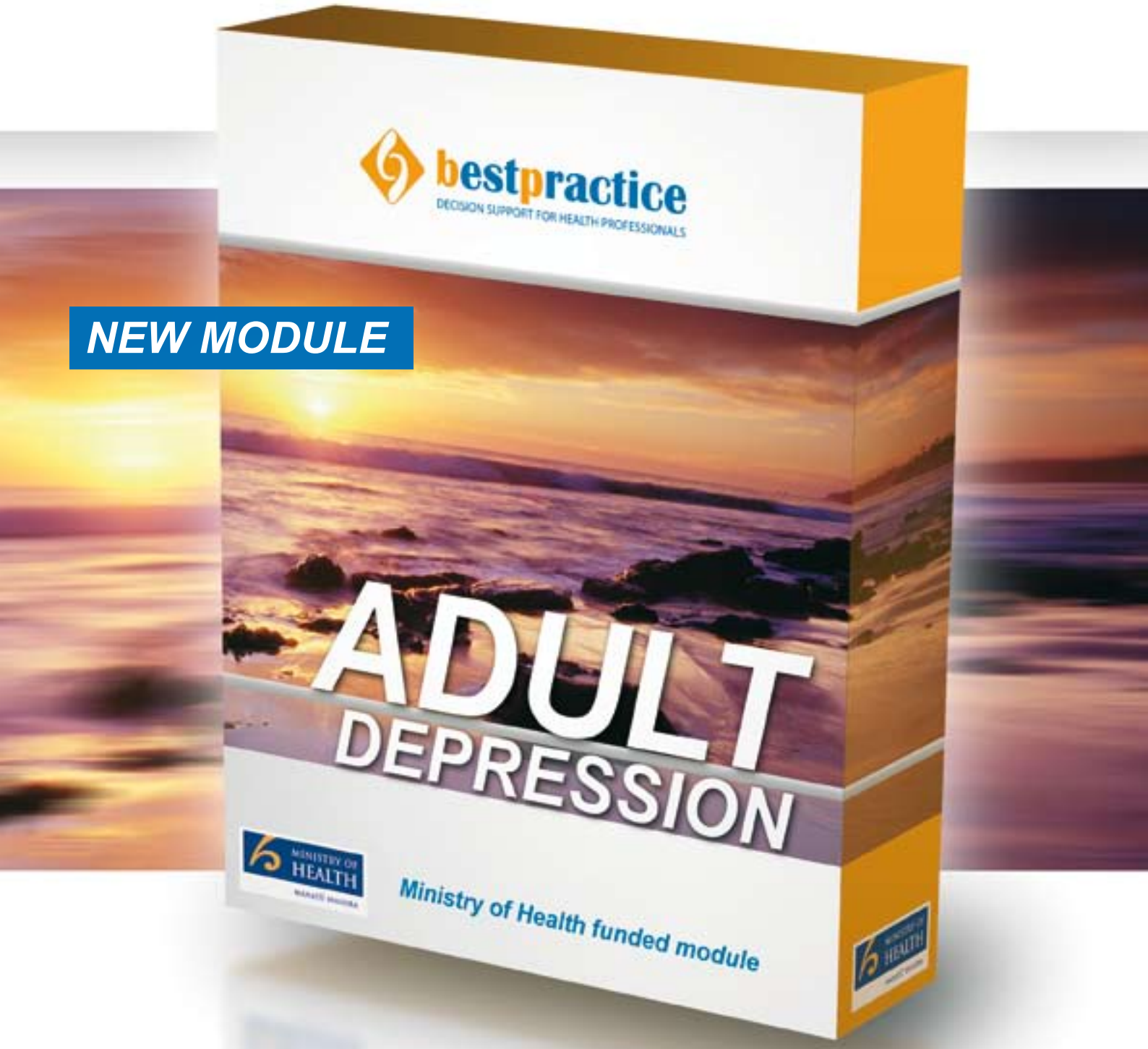

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