

Managing depression in primary care

Increased awareness of depression and the availability of more tolerable drugs mean that more prescriptions are being written for antidepressant drugs in Australia than ever before. But are these prescriptions being used to full advantage? How effective are antidepressants? Are the benefits similar across all grades of depression? What else is effective? *NPS News* considers some of these issues.

How effective are antidepressants in depression?

Antidepressants have a statistically significant effect compared with placebo in clinical trials but a reasonable proportion of patients improve with placebo alone.

In pooled trials of moderate to severe major depression, about 60% of patients taking antidepressants and about 40% of those taking placebo had their symptoms halved in the first 6–8 weeks of therapy.¹

The limitations of these data are worth noting:

- The evidence does not apply to mild or minor depression (see Box 1, page 2).
- At least 80% of the efficacy data for antidepressants are from specialist psychiatric care and may not be relevant to primary care.¹
- In trials submitted to the US Food and Drug Administration, 70–90% of the symptom improvement seen with newer antidepressants also occurred with placebo.² In many trials there was no significant difference between placebo and antidepressants in symptomatic improvement.³ Because such 'negative' trials are seldom published, effectiveness can be overestimated. This is known as 'publication bias'.^{*}
- In individual trials, placebo response rates have ranged from 13% to 52% while for antidepressants the range was 32–70%. Placebo response rates increased by 7% per decade in the 1980s and 90s.⁵
- Rating scales used to measure response include both somatic and mood symptoms.[†] Improvement in physical symptoms can reduce scores without significantly improving core mood symptoms.⁷

Possible explanations for high rates of response to placebo include:

- spontaneous improvement
- high patient expectations of treatment predisposing them to respond well initially⁸
- the increasing recruitment of trial patients with less severe depression (perhaps through the media); these are more likely to improve spontaneously or with placebo.^{5,8–10}

What does this mean for clinicians treating depression?

Antidepressants do have efficacy in moderate to severe major depression and are more likely to help than harm. However:

- in mild depression the evidence for using antidepressants is weak and non-drug treatments are first line⁸
- be aware that individual response to antidepressants varies — only 50% of patients respond to the first drug chosen¹¹ (see Option 2: Maximise antidepressant therapy, page 2)
- most efficacy trials are based on response (i.e. improvement) not remission, and residual symptoms are possible even after 6 weeks.

The short-term efficacy trials discussed above were not designed to guide best practice management of depression. Use antidepressants as part of the overall management of depression and be aware of non-drug treatments and their availability.

* In the future, all trials will be entered in a public register to improve transparency about unpublished data.⁴

† For example, on the Hamilton Rating Scale of Depression half the items relate to somatic symptoms such as insomnia and weight loss; several items relate to anxiety.⁶

Box 1: DSM-IV criteria for diagnosis of major and minor depression¹²

Diagnosis	Symptoms	Functioning	Severity [†]
Major depression At least 5 symptoms for 2 weeks (symptoms I or II must be present)	I Depressed mood II Loss of interest or pleasure III Significant change in appetite or weight IV Insomnia or hypersomnia V Psychomotor agitation or retardation VI Fatigue, loss of energy VII Feelings of worthlessness or excessive guilt	Clinically significant distress or impairment in social, occupational or other important areas of functioning	May be mild, moderate or severe, depending on: <ul style="list-style-type: none"> — the number and intensity of symptoms — degree of functional impairment — risk of suicide.
Minor depression A total of 2–4 symptoms for 2 weeks (symptoms I or II must be present)	VIII Impaired thinking or concentration; indecisiveness IX Suicidal thoughts/thoughts of death		

† Severity in trials is graded using rating scales such as the Hamilton Rating Scale of Depression but this is rarely used in clinical practice.

Options for enhancing management of depression

The goals of depression management are to resolve acute symptoms, maintain treatment for an adequate duration (at least 6 months) and prevent relapse or recurrence.

Note that in severe depression with high suicide risk or psychotic symptoms, prompt psychiatric assessment and treatment are required.

Management of depression is multifaceted; consider some of the options below.

Option 1: Consider non-drug treatments in the management plan

Consider non-drug treatments that are appropriate to the severity of the depression, even when antidepressants are prescribed (see Table 1, page 4).

Cognitive behavioural therapy (CBT), interpersonal therapy (IPT) and problem-solving therapy can be effective with fewer sessions than other forms of psychotherapy. These depression-specific psychological therapies may be provided by GPs, psychiatrists or psychologists. Other psychological therapies have less evidence but may have a limited role, according to most guidelines.^{8,11}

In patients with severe depression, combined therapy is more likely to be effective than either antidepressants or psychological treatment alone.⁸ Antidepressants may be needed initially to improve functioning to a level where patients can engage in psychological therapy.

Option 2: Maximise antidepressant therapy — ensure an adequate drug, dose and duration

When an antidepressant is prescribed:

- Explain the role of antidepressants and discuss non-drug treatment options. A person's beliefs and expectations about their condition and treatments can influence compliance (see Box 2).
- Advise patients what to expect from antidepressant drug therapy. This is crucial in encouraging compliance (see Boxes 2 and 3).
- Discuss the need for regular visits, then ensure follow-up to monitor therapeutic effects, adverse effects and compliance.

If response to an antidepressant is poor, partial or is not sustained after 4–6 weeks:

- check compliance and diagnosis[§]
- consider increasing the dose (if indicated) or changing to another class of antidepressant.

In patients who do respond to drug treatment, continuing treatment for 6–12 months reduces the risk of relapse by about 50%.^{8,13}

Option 3: Improve the process of care

Improving the process of care can improve outcomes.^{8,14}

Commonwealth Government provisions to support improved care are available through the Better

§ For example, bipolar disorder can be confused with depression — mood stabilisers, rather than antidepressants, may be indicated.

Outcomes in Mental Health Care initiative (BOIMHC). These include:

- Improved access for GPs to psychiatrist opinions. Reimbursement to psychiatrists through new MBS item numbers (291 and 293) allows GPs to refer patients for a one-off psychiatric assessment and management plan that the GP implements (293 is a follow-up assessment). GPs can also access a non-emergency psychiatrist opinion within 24 hours by phone, fax or email through GP Psych Support. See www.psychsupport.com.au or call 1800 200 588.
- A service incentive payment (SIP) for completing a cycle of care (3 Step Mental Health Process — can be completed in 2 long consultations).

- Funding of psychologists and other allied health professionals through divisions of general practice, specifically for GP referral (Access to Allied Health Services component).
- Training for GPs who wish to upskill in psychological strategies. MBS item numbers apply for GPs providing Focussed Psychological Strategies.

GPs must undertake some training and registration formalities to access the SIP for the 3 Step Mental Health Process or to undertake training in focussed psychological strategies. Information about training, registration forms and useful links are available from the RACGP website www.racgp.org.au/mentalhealth, the ADGP website www.adgp.com.au or local divisions of general practice.

Box 2: What do people think about treatment for depression?

People with depression:

- value GPs who listen
- like to be given information about depression
- like to be told about the range of options available.^{8,15}

When prescribed antidepressants, people with depression:

- do not expect adverse effects
- expect antidepressants to work quickly
- expect the first antidepressant prescribed to be effective
- usually stop taking them in the first few months
- may feel stigmatised or weak for 'needing' antidepressants.^{15,16}

Box 3: What to tell patients when prescribing an antidepressant

Explain about depression, its symptoms and the process of treatment and recovery. Discuss treatment options including non-drug therapies. Tell the patient that:

- Some adverse effects are likely (describe what these are⁹), but most will go away after 1–2 weeks. If you are concerned about the side effects you are experiencing, talk to your doctor rather than stopping treatment. It may be possible to reduce side effects or to find another drug that suits you better.
- You may not feel better immediately. For some people it can take 4–6 weeks to see an effect, so don't give up too soon.
- You may have to try more than one treatment to find one that works for you.
- Don't stop taking antidepressants as soon as you start to feel better. You will need to take them for at least 6 months. Studies suggest that people who stop treatment too early are more likely to relapse.
- Don't stop taking antidepressants abruptly, especially after you've been taking them for a month or more. Stopping suddenly can cause unpleasant side effects. Talk to your GP or pharmacist about how to reduce the dose gradually to prevent side effects.

¶ See the *Australian Medicines Handbook* for quick reference.

Box 4: Watchful waiting — as good as placebo?

Placebo treatment in clinical trials is not the same as doing nothing. The clinical management that accompanies placebo treatment includes:

- regular, frequent visits (for example, 6 visits in 8 weeks)
- symptom assessment
- a review of adverse effects
- general support, listening
- (in some trials) reassurance about the effectiveness of treatment.

The frequency of follow-up exceeds what is currently common in general practice. However, it is worth reflecting on the therapeutic value of regular contact and discussion with a trained health professional.

Watchful waiting coupled with education about the nature and course of depression, advice about healthy sleep practices and supportive counselling may be sufficient therapy in milder forms of depression.¹⁷ Provide follow-up to monitor for worsening of symptoms or functioning that might need more intensive treatment.⁸

Table 1: Non-drug therapy options in depression

EVIDENCE FOR TREATMENT AND WHEN TO USE IT	ACCESS AND RESOURCES
Mild depression and minor depression**	
Watchful waiting, education and information about depression	
<p>Education about depression, information-giving and supportive monitoring are helpful for all severities of depression, and may be sufficient in minor depression and mild depression (see Box 4).</p> <p>Monitor for worsening severity — added measures may be needed.</p>	<p>Websites provide information, personal experiences of other people with depression and details of support organisations. Some supply information leaflets.</p> <p>These include:</p> <ul style="list-style-type: none"> — www.bluepages.anu.edu.au — www.beyondblue.org.au — www.crufad.unsw.edu.au — www.blackdoginstitute.org.au — www.depressionnet.com.au — www.sane.org
Brief cognitive behavioural therapy (CBT) or interpersonal therapy (IPT) (up to 6 sessions)	
<p>Short-duration treatment (4–6 sessions) can be effective. If patients are slow to engage with therapist, more sessions may be needed. Skills can be learnt by GPs.</p>	<p>For a guide to CBT-based strategies in general practice see:</p> <ul style="list-style-type: none"> — Blashki G, et al. Cognitive behavioural strategies for general practice. <i>Aust Fam Physician</i> 2003;32:910–7 (available from: www.racgp.org.au). — Tiller J. Cognitive behaviour therapy in medical practice. <i>Aust Prescr</i> 2001;24:33–7 (available from: www.australianprescriber.com). <p>For GP training providers see the RACGP website www.racgp.org.au/mentalhealth or your local division of general practice.</p> <p>For treatment providers see the Australian Psychological Society (www.psychology.org.au) or RACGP websites (details above)</p>
Problem-solving therapy	
<p>Uses a structured approach to help the person generate solutions to specific problems.</p> <p>Has efficacy greater than placebo and similar to antidepressants in mild depression.^{18,19}</p> <p>Possibly less effective in older people with minor depression.²⁰</p>	<p>For a practical guide to problem-solving treatment in general practice see:</p> <ul style="list-style-type: none"> — Blashki G, et al. Structured problem solving in general practice. <i>Aust Fam Physician</i> 2003;32:836–42 (available from: www.racgp.org.au). <p>For GP training providers see the RACGP website www.racgp.org.au/mentalhealth or your local division of general practice.</p>
Guided self-help based on CBT principles	
<p>Patients work through a series of written exercises based on CBT.</p> <p>Some evidence for reducing symptoms in the short term.⁸</p>	<p>Specific books are available.²¹</p>
Computer-based CBT via a website	
<p>Reduces symptoms in the short term.^{22,23}</p> <p>Regular contact with clinicians to monitor progress may aid compliance.²²</p>	<p>www.moodgym.anu.edu.au (free, provided by the Centre for Mental Health Research at the Australian National University). Originally designed for young people.</p> <p>www.climate.tv (small fee, GP referral needed, provided by St Vincent's Hospital and the University of NSW).</p>

** See Box 1 for definitions.

Physical exercise	
<p>May help with symptoms in minor depression and mild depression. Less evidence in moderate to severe depression but may be a helpful lifestyle change.^{8,21} Several trials have been conducted in older people:</p> <ul style="list-style-type: none"> One well-conducted study in mild major depression found a similar proportion of people in remission after 4 months with both exercise (3 classes per week) and sertraline (50–200mg daily). Relapse rates were lower in those who recovered with exercise.^{24,25} 	<p>Consider a structured, supervised exercise program 2–3 times per week. Anticipate barriers such as fatigue and lack of motivation. Be realistic about expectations — some patients may feel guilty if unable to comply. Emphasise pleasurable aspects, choose an exercise the patient enjoys. For older people, a class specifically tailored to their needs may be more acceptable, provide social interaction and improve compliance.^{24,26}</p>
Non-directive counselling (empathic, active listening, allowing patient to air problems)	
<p>There is weak evidence for short-term benefits when non-directive counselling is provided by a professional counsellor.²⁷</p>	<p>Telephone help lines provide non-directive counselling but treatment is episodic. Many GPs provide some counselling as part of their management of depression and this may contribute to the therapeutic relationship.</p>
Behavioural techniques, e.g. relaxation therapy, activity scheduling	
<p>Little evidence, especially in major depression. May be helpful when combined with other treatments.²¹</p>	<p>Relaxation therapy involves progressive muscle relaxation exercises. Activity scheduling involves identifying activities the person usually enjoys (e.g. social or recreational activities) or that give a sense of achievement, and encouraging them to set a time to do these.</p>
Moderate depression	
CBT or IPT for 16–20 weeks	
<p>Can be as effective as antidepressants in moderate depression. Adding to antidepressants may be helpful in more severe depression. Evidence of reduced relapse rates after treatment, either with continued treatment or a small number of 'booster' sessions.^{8,28–30}</p>	<p>The Royal Australian and New Zealand College of Psychiatrists provides a referral database list of private psychiatrists through the RACGP website (www.racgp.org.au/psychiatristdatabase). The Australian Psychological Society provides a referral service according to therapeutic needs and treatment approaches. website: www.psychology.org.au email: referral@psychology.org.au phone: 1800 333 497</p>
Severe depression (severe functional impairment, suicidal risk)	
Prompt psychiatric assessment of acute need for hospitalisation, other therapies.	



Complementary update

St John's wort

The evidence for the use of St John's wort (*Hypericum perforatum*) in depression remains problematic. Trials with larger treatment effects have been in poorly defined depressive states, while better-conducted trials in major depression show weak evidence of efficacy compared with placebo. Some trials suggest similar efficacy to that of antidepressants but conclusions are hampered by a lack of placebo controls to show a specific treatment effect.³¹

A further problem is that clinical trial evidence relates to specific extracts and may not apply to products available in Australia.^{31,32} Variation between and within brands means that efficacy, interactions and adverse effects may also vary.

St John's wort has several potentially serious drug interactions. It is an inducer of hepatic P450 enzymes and lowers blood concentrations of warfarin, anticonvulsants, antiretrovirals, oral contraceptives, cyclosporin and tacrolimus. It may cause serotonin syndrome when used with other serotonergic agents (e.g. 'triptans' for migraine, tramadol, selective serotonin reuptake inhibitors [SSRIs]).³³

These factors make it difficult to recommend St John's wort for depression. Recent UK guidelines have recommended against its use for the same reasons.⁸

When prescribing an antidepressant ask patients about their use of complementary medicines, including St John's wort.

Postnatal depression

Depressive symptoms post partum range from normal 'baby blues' to more serious postnatal depression (PND). Postpartum 'blues' are common after delivery and resolve quickly, while PND occurs in around 13% of women.³⁴ Prompt psychiatric intervention is required for the small percentage of women with psychotic symptoms, those who are suicidal, or where there is a possibility of harm or serious neglect to the child.

Screening tools such as the Edinburgh Postnatal Depression Scale (available in some prescribing software) can help identify women who require more thorough assessment.

Treat PND in the same way as major depression, with a choice of drug and non-drug treatments. Weigh up the risks and benefits of treatment and untreated depression for both mother and child.

Psychosocial treatments are integral — effective interventions address issues such as parenting and childcare advice, support from others and realistic role expectations in early motherhood.³⁵ Resources and patient support organisations for doctors and consumers can be found on the beyondblue website (www.beyondblue.org.au/postnataldepression). Mother and baby units attached to hospitals may also provide useful services.

Antidepressants are considered appropriate for moderate to severe PND. Evidence from the single randomised controlled trial (n = 87) in community care found that

antidepressants and psychological therapies were equally effective in reducing symptoms, with no additional benefit when CBT and antidepressant therapy were combined.³⁶

Using antidepressants when breastfeeding

Most SSRIs and tricyclic antidepressants (TCAs) are considered compatible with breastfeeding.^{11,33} **Avoid fluoxetine** (this has a long half-life and accumulates in infants) **and doxepin** (this has been associated with respiratory depression).¹¹ Consider the risks of postural hypotension and greater toxicity in overdose with TCAs.

General principles of antidepressant use in lactating women include:

- Use the lowest effective dose of a non-sustained-release formulation that allows once-daily dosing (i.e. avoid venlafaxine sustained release; Efexor XR).
- For non-sustained-release formulations, take the medicine immediately after breastfeeding and delay the next feed for 2–3 hours to minimise infant exposure (for most antidepressants).³⁴
- Adverse effects have occasionally been reported in infants; monitor for excessive crying, irritability, sleep disturbance and gastrointestinal upset.¹¹

Individual circumstances vary and consulting a specialist drug information service is suggested (e.g. Therapeutic Advice and Information Service: 1300 138 677).

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The information contained in this material is derived from a critical analysis of a wide range of authoritative evidence. Any treatment decisions based on this information should be made in the context of the clinical circumstances of each patient.



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