Depression 2: exploring management options for adults with moderate to severe symptoms

As the evidence base on treating depression evolves, it is vital that nurses stay up to date with treatment options for patients with differing degrees of symptoms.

LEARNING OBJECTIVES
- Be familiar with the treatments available for moderate to severe depression.
- Identify the treatment options available for moderate to severe depression that has not responded to treatment.

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The first part of this two part unit covered the identification, assessment and initial management of persistent subthreshold depressive symptoms and mild to moderate depression. This second part looks at the core treatments for moderate to severe depression, as well as mild to moderate depression and persistent subthreshold symptoms that have not responded to low intensity interventions.

MANAGEMENT OPTIONS
The updated guideline on depression (National Institute for Health and Clinical Excellence, 2009) sets out a range of options for people with persistent subthreshold depressive symptoms or mild to moderate depression who have not benefited from a low intensity psychosocial intervention (see part 1 of this unit).

These options could be an antidepressant – normally a selective serotonin reuptake inhibitor (SSRI) – or a high intensity psychological intervention, such as cognitive behavioural therapy (CBT), interpersonal therapy (IPT), behavioural activation, or behavioural couples therapy. The evidence for these four psychological interventions, which were developed specifically for the treatment of depression, is robust. However, the evidence for other psychological interventions, such as counselling or short term psychodynamic therapy, which were not developed specifically for depression, is weaker and the guideline is more circumspect in its recommendations for these.

People with moderate to severe depression should be offered a combination of antidepressants and a high intensity psychological intervention (CBT or IPT).

ANTIDEPRESSANT TREATMENT
The nurse’s role in prescribing antidepressants has expanded significantly over the past decade. First level nurses with the relevant nurse prescriber qualification can now prescribe any licensed medicine as long as it is within their area of competence.

However, for the majority of nurses caring for people with depression, their role is more likely to relate to supporting the administration of antidepressant medication, facilitating informed decision making about treatment, and monitoring response.

Recommendations made by NICE (2004) regarding the choice of antidepressants remain largely unchanged. Clinical evidence for the antidepressant duloxetine was reviewed, but the drug was found to be no more clinically effective than other antidepressants. The review of escitalopram revealed that it had a small advantage over other antidepressants but this was not large enough for this drug to be specifically recommended (NICE, 2009).

The guideline therefore continues to support the conclusion that antidepressants have largely equal efficacy and advises the choice of drug should be guided by side effect profile, propensity to cause discontinuation symptoms, safety in overdose, patient preference and previous experience of treatments. Taking these factors into account, the updated guideline advises that an SSRI in generic form should usually be first choice.

Before patients start taking an antidepressant, NICE (2009) advises that healthcare professionals explore any concerns they may have, explain fully the reasons for prescribing and provide information about the treatment, for example, that concerning potential side effects and interactions with other medicines (see the guideline for full details).

It is important that patients appreciate that antidepressants may take several weeks to achieve their full effect and should be taken on a regular basis for at least six months. For details on specific drugs and specific classes, and how to manage side effects, see NICE (2009).

Lack of response to drug treatment
The updated guideline provides detailed advice about what to do if a patient’s symptoms are not improving after having taken an antidepressant for 2-4 weeks. NICE advises that healthcare professionals should first check that the drug has been taken as prescribed.

There is evidence that frequent assessments in the first six weeks of treatment are associated with better outcomes. If response is minimal after 3-4 weeks, the level of support should be intensified and the dose may be increased or, if there are side effects, the patient could switch to another antidepressant.

TREATMENT OPTIONS FOR PATIENTS WITH POOR RESPONSE
For patients with moderate to severe depression whose response to treatment is poor, options include changing, combining or augmenting antidepressants and combining an antidepressant with CBT.

As evidence for sequencing drug treatments for people whose depression has
not responded adequately to initial medication remains weak, the recommendations in the updated guideline remain largely unchanged.

The STAR*D trial (Rush et al, 2006; 2003) found that some patients will achieve remission with each successive treatment strategy, although the number doing so decreases each time. There was no good objective data to demonstrate the superior efficacy of one strategy over another, but some patients may have a preference for one particular treatment (Rush et al, 2006; 2003).

If there is a poor response to initial treatment, it is important to consider whether the treatment was initiated correctly or adhered to. These factors should be reviewed first and more frequent follow up appointments considered.

When switching medication, the choice of the new drug should be guided by similar principles to those used when choosing the initial medication, for example side effects, toxicity and discontinuation symptoms.

With these factors in mind, the guideline advises first using a different SSRI or a better tolerated newer generation antidepressant, then an antidepressant of a different class that may be less well tolerated (such as venlafaxine, a tricyclic antidepressant or a monoamine oxidase inhibitor). For drugs with a short half life, switching can usually take place within one week.

Combining or augmenting antidepressants should only be started in primary care in consultation with a consultant psychiatrist. When antidepressants are combined or augmented with other medication:

- The medicines used should be known to be safe when used together;
- Healthcare professionals should be aware of a likely increase in side effects;
- Patients should be monitored closely for interactions and side effects.

For recommendations on specific drugs and classes, as well as monitoring, see NICE (2009).

**CONTINUING TREATMENT AND PREVENTING RELAPSE**

If patients benefit from taking an antidepressant, they should continue taking it for at least six months as this greatly reduces the risk of relapse.

After six months, there should be a review to establish whether they need to continue medication, bearing in mind the number of previous episodes of depression and any residual symptoms.

If there is a risk of relapse, there are various options to consider, such as continuing with medication, augmenting medication (see above) and providing psychological interventions (individual CBT or mindfulness based cognitive therapy).

**COMPLEX AND SEVERE DEPRESSION**

A minority of patients will have a depressive illness that is sufficiently complex or severe to need a referral to a specialist mental health service. This would include people at significant risk of self harm, those who have psychotic symptoms, those who require complex multidisciplinary care or those for whom an expert opinion on treatment might be necessary.

Specialist teams are expected to undertake a full assessment considering symptoms, risk, psychosocial factors, significant relationship difficulties and comorbidities, including alcohol and substance use and personality disorder.

The NICE guideline recommends the use of crisis resolution and home treatment teams to safely and effectively manage people with severe depression who presents a significant risk. Specialist nursing staff play an integral role in delivering these services.

Teams working with people with complex and severe depression should ensure that a comprehensive multidisciplinary care plan is agreed, identifying the roles and responsibilities of the various professionals involved in the patient’s care. A crisis plan should also be developed, identifying potential triggers to a crisis and approaches to managing such triggers.

**EFFECTIVE DELIVERY OF INTERVENTIONS**

As there is evidence of considerable variation in the competence of those providing psychological interventions (Brown et al, 2005), the updated guideline places greater emphasis on professional competence. Psychological and psychosocial interventions should be based on the relevant treatment manuals, which should guide the structure and length of the intervention. However, the guideline also sets out treatment duration parameters that are based on evidence.

The guideline advises that competence frameworks may be used for all interventions for depression and that practitioners should have regular supervision, use routine outcome measures and ensure patients are involved in reviewing the efficacy of the treatment. Treatment adherence should be monitored, as should practitioner competence (this may involve external audit and scrutiny).

These recommendations are intended to support the results of clinical trials being applied to routine practice and to underpin the delivery of psychological interventions in the Improving Access to Psychological Therapies Programme (IAPT) (www.iapt.nhs.uk). Results from this pilot suggest it is possible to replicate the results of clinical trials in routine practice (Clark et al, 2009).

**CONCLUSION**

The updated NICE (2009) guideline represents an evolutionary development from its 2004 predecessor. Part 2 of this unit has noted that much of the advice on antidepressant medication remains the same but, in terms of all interventions – particularly psychological and psychosocial treatment – a greater emphasis is placed on practitioners’ competence and the use of treatment manuals in delivering these interventions.

Nurses in almost every area of practice have a role in the assessment and treatment of depression. By understanding and implementing the key recommendations of the NICE (2009) guideline, they can ensure that patients who are depressed have the opportunity to receive effective, evidence based treatment and support.

**NURSING Learning**

Nursing Times Learning offers cost effective, high quality online learning. For the psychiatric crisis response unit go to www.nursingtimes.net/crisis

**REFERENCES**


