Healthier Together

Improving health and care in Bristol, North Somerset and South Gloucestershire

Guideline for the management of depression in adults in BNSSG

Step 1 - Screening questions:

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

If the answer is **yes** to either of these questions, move onto step 2

Step 2 - Assessment of mental health:

Diagnostic criteria: DSM-V or ICD-11 criteria

- Symptoms present for at least 2 weeks
- Answers yes to one or both screening questions above, and symptoms occur most of the day, nearly every day
- Accompanied by other symptoms e.g. sleep disruption, appetite/weight change, impaired concentration, suicidal/self harm thoughts, anergia, anhedonia, low self worth

Consider using a validated tool such as ***PHQ-9***

- Use in consultation via EMIS template or online at Patient UK here
- Use as a pre-consultation questionnaire via the AccuRx template

See NICE CKS guidelines for further information on assessment

Assess ***risk of suicide, self harm and harm to others (see Remedy)***

If immediate risk then refer urgently to specialist mental health services (find contact details on Remedy here)

Step 3 - Diagnosis:

Consider differential diagnoses -

Could this be a chronic physical health condition (including neurological disease)? *If high suspicion, consider bloods: FBC, B12/folate, U+Es, LFTs, TFTs, glucose, Ca*

See NICE guideline on depression in adults with a chronic physical health condition

Are they menopausal? Consider HRT in management of low mood (see local menopause guidelines)

PHQ-9 score less than 16, or clinical impression of subthreshold or mild depression

Less severe depression

PHQ-9 score 16 or more, or clinical impression of moderate or severe depression

More severe depression

When to consider involving specialist mental health services - see Remedy page for referral/contact details

- **Urgent** referral if patient is at immediate risk to themselves or others (see assessment section)
- **Urgent** referral (or discussion) if depression with psychotic symptoms - see Remedy and AWP pages on psychosis and early intervention
- Routine referral or discussion for complex, chronic and severe depression
- Antidepressant augmentation with lithium or anti-psychotics should be under shared care protocols (see BNSSG formulary page)

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Step 4—Management

Less severe depression

Antidepressant medication should not routinely be offered as first line treatment, unless that is the patient's preference

More severe depression

Consider antidepressant medication and/or non-pharmacological therapies as first line, depending on patient preference

Pharmacological therapies:

1. Choose antidepressant - *see below*

Find resources on drug interactions from NICE here

2. Antidepressant drug counselling including:
   - Potential harms/benefits
   - Discontinuation symptoms and advice not to abruptly stop medication
   - Time to see effect (usually 2- 4 weeks)
   - Increased risk of anxiety and suicidal thoughts soon after starting (especially under age 25 years)
3. Follow up - reviewing and stopping *(see next page)*

Non-pharmacological therapies:

- Signpost to this local wellbeing toolkit
- Patients can self refer to local IAPT services—Vitaminds. Professionals can make an assisted referral but this is not routine.
- Consider referral to social prescribing via your PCN (further information on Remedy here)
- Other support organisations in BNSSG found here
- In some areas you can refer to Recovery Navigators and Second Step Wellbeing Services - find information here

NICE Patient Decision Support Tool: Making Decisions About Managing Depression

A) Choosing the antidepressant

Is the episode less severe or more severe?

If **less severe**, only SSRIs are recommended.

If **more severe**, consider an SSRI or SNRI first line.

Formulary first line drugs

SSRIs: Sertraline, Citalopram, Fluoxetine

SNRIs: Venlafaxine

NaSSA: Mirtazapine

Second line drugs and drugs on specialist recommendation only - see local formulary

In **comorbid alcohol or opioid dependence**, consider using **non SSRI as first line** (SSRIs appear to be less effective) - refer to BAP guidance (p32-34)

Side effects of all SSRIs/SNRIs:

headache, GI symptoms, sexual dysfunction, hyponatraemia (see risk factors here), bleeding risk (further information here)

During pregnancy and post natal period: please refer to AWP perinatal prescribing guideline

Key points:

- For previously untreated patients, consider sertraline
- If previously treated, consider response to medications in the past
- For patients already established on an antidepressant, consider continuing same drug at same dose
- Outcomes may be better for babies born to mothers treated with antidepressants than to those with untreated depression

Other useful resources: SPS advice, bumps website

Drug profiles (first line) - *refer to BNF or SPC for more information*

Drug	Considerations	Usual starting dose (see BNF)
Sertraline	Fewer drug interactions, safe in unstable angina/recent MI, more associated with diarrhoea.	50mg OD
Citalopram	Fewer drug interactions, causes QT prolongation and is off-label if used with other QT prolonging drugs, may be unsafe in overdose. **See BNF on max. dose in over 65s and MHRA for further detail** . If not well tolerated or poor adherence, consider switch to escitalopram.	20mg OD (10mg OD in elderly tablets, note maximum dose)
Fluoxetine	Preferred in young adults. Increased agitation on starting. Long half life (slow onset and slow to clear, but fewer discontinuation symptoms if infrequent administration etc).	20mg OD
Venlafaxine	Toxic in overdose. Can cause hypertension. Often poorly tolerated on initiation - headaches and nausea common, consider using modified release formulation if not well tolerated or poor adherence.	37.5mg BD (immediate release)
Mirtazapine	Toxic in overdose. Causes sedation and stimulation of appetite/weight gain (may be desired effects).	15-30mg OD

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B) Reviewing the antidepressant

Initial review usually within 2 weeks to check their symptoms are improving and for side effects, or at 1 week after starting the antidepressant medication or increasing the dose for a person aged 18 to 25 years or if there is a particular concern for risk of suicide

If good response at 4 weeks → **Ongoing review** on individual basis, but minimum 6 monthly

Continue antidepressants for **at least 6 months** after remission.

If concern about relapse, continuation should be based on shared decision making

Patients with 2 prior episodes and functional impairment should be treated for at least 2 years

If **no or limited response** at 4 weeks (at therapeutic dose) → Check adherence

Address any additional factors where possible e.g. other physical health conditions, social/environmental/ personal circumstances → If still **no or limited response** →

Review diagnosis

Consider:

- Increase the dose (within licensed dose range) - *particularly if limited response*
- Switch to another medication in the same class
- Switch to a medication in a different class
- Add in or switch to a psychological therapy

For information on switching antidepressants, see NICE guidance and this useful table

If poorly tolerated at any time (and side effects intolerable or not self limiting) →

Reduce dose if possible

Switch to different antidepressant (see above) and restart review process

C) Stopping the antidepressant

1

Consider:

Has the patient been in remission for at least 6 months? If they have had 2 or more previous episodes, have they been treated for at least 2 years?

What is the risk of relapse? See NICE Preventing Relapse flowchart on indicators of high relapse risk and preventing relapse

2

Discuss:

Risks v benefits of continuing antidepressants (particularly important if high risk of relapse) -

- Continuing treatment can reduce risk of relapse
- Risks of longer term side effects with continuation of medication
- Stopping antidepressants can be difficult

Discontinuation symptoms e.g. agitation, sleep disturbance, mood changes, headaches, dizziness, nausea, electric shock sensations, suicidal thoughts (rarely)

3

Do:

Taper the medication in a stepwise approach—look here for further information and example plans from RPsych; find handy patient information leaflets on stopping SSRIs here.

- Speed of tapering depends on: the drug (considering half life), dose and duration of treatment, and discontinuation symptoms
- Generally, you could consider starting with reducing the dose by 25% or 50% every 2 to 4 weeks (with a more gradual reduction if long duration or high dose antidepressant use)

Review regularly during this tapering period

If severe withdrawal symptoms are experienced, consider restarting the antidepressant at original dose, and restart dose reduction more slowly and in smaller increments

References

[1] Overview | Depression in adults: treatment and management | Guidance | NICE

[2] Recommendations | Menopause: diagnosis and management | Guidance | NICE

[3] Depression | Health topics A to Z | CKS | NICE

[4] Guidelines for choice of selective serotonin reuptake inhibitor in depressive illness | Advances in Psychiatric Treatment | Cambridge Core

[5] Which first-line antidepressant? | British Journal of General Practice (bjgp.org)

[6] Depression and Anxiety Disorders (wiley.com), The Maudsley Prescribing Guidelines in Psychiatry (access via OpenAthens)

[7] Pharmacy service :: Avon and Wiltshire Mental Health Partnership NHS Trust (awp.nhs.uk)

[8] BAPaddictionEBG_2012.pdf (BAP addiction guidelines)

[9] Stopping antidepressants | Royal College of Psychiatrists (rcpsych.ac.uk)

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