RANZCP CLINICAL PRACTICE GUIDELINES

Summary of guideline for the treatment of depression

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Depression is common, serious and treatable. The Australian and New Zealand Clinical Practice Guideline for the Treatment of Depression by Specialist Services provides evidence-based treatment guidance across the spectrum of depressive disorders and delineates where specialist treatment and primary care management is indicated. The present summary version covers the key contents of the guideline. It includes assessment, treatment and general management issues by category type and severity of depressive disorder. Algorithms of first-line and subsequent treatment choices are provided for: (i) mild depression without complications; (ii) moderately severe depression (including with comorbid anxiety) and dysthymia; (iii) uncomplicated, melancholic or atypical depression; (iv) moderately severe depression with comorbid substance abuse; (v) moderate to severe depression with physical disorders; (vi) severe depression with melancholia; (vii) recurrent depression or failure to respond to a preferred first-line treatment; and (viii) psychotic depression, and severe depression with risk of suicide. Continuing and maintenance treatments for recurrent depression are discussed. Emerging evidence of the equal value of cognitive behaviour therapy (CBT) and interpersonal psychotherapy (IPT) to pharmacological treatments for some depression is discussed, and the need to ensure that they are provided by suitably trained practitioners. Indications for hospitalization and electroconvulsive therapy (ECT) are also provided.

Key words: *antidepressive agents, depressive disorder, patient care planning, practice guidelines, secondary care.*

Depression is common, serious and treatable. It affects 1 in 25 people in any 1 month. This summary clinical practice guideline (CPG) is an evidence-based guideline for use by those providing specialist mental health care. It has been developed in accordance with National Health and Medical Research Council (NHMRC) criteria for the development of CPG as described in the editorial article in this edition of *Australasian Psychiatry*. The recommendations from our systematic review of the specialist treatment literature are summarized here in a brief format so that they are easier to commit to memory for routine practice where applicable on a case-by-case basis, taking into account patient preferences. They should be read in conjunction with the comprehensive version, which is published in the *Australian and New Zealand Journal of Psychiatry*.

ASSESSMENT

Assessment should include full evaluation and formulation, including particularly:

- risk assessment;
- subtype, severity and duration of depression;
- comorbidity (with medical and/or psychiatric and/or alcohol and drug);
- current stresses, strengths and supports; and

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- relevant personal and family history, and past history of any mental illnesses.

SUMMARY OF TREATMENT EVIDENCE

The evidence supports the following treatments provided as part of an overall clinical management plan. Every person with depression is an individual facing uniquely different circumstances. Their treating clinician should consider the extent to which the available evidence is pertinent to the treatment of this individual.

Components of an effective treatment plan include:

- a therapeutic relationship, which is essential to maximize benefits of treatment;
- treatment alliances with patient, family/friends, primary care providers, other mental health professionals; and
- access to cultural and primary language services.

The greatest contribution to a positive treatment outcome comes from:

- maximizing cooperation of the person with the selected treatment;
- identifying and addressing known risk factors for relapse;
- maintaining a treatment regime for as long as is necessary to allow the person to stabilize (i.e. at least 1 year, and where there is a history or significant risk of recurrence at least monitor and treat proactively for 3 years).

These considerations considerably outweigh the limited advantages of one treatment over another. Figures 1 and 2 outline the stages generally indicated in the process of assessment and treatment.

Research evidence is based on carefully selected subjects in clinical trials. The extent to which the research evidence is applicable to people with complex conditions often encountered in specialist practice, and their circumstances, needs to be considered carefully.

For all depressed people

Provide education about depression and lifestyle changes that will assist recovery, mindful of identified stresses and supports. This should be ongoing to maintain changes achieved, and repeated if life circumstances change. Suicide risk needs to be monitored throughout treatment.

Mild depression without any complications

Treatment should be provided within primary care. It should include education about depression, examine

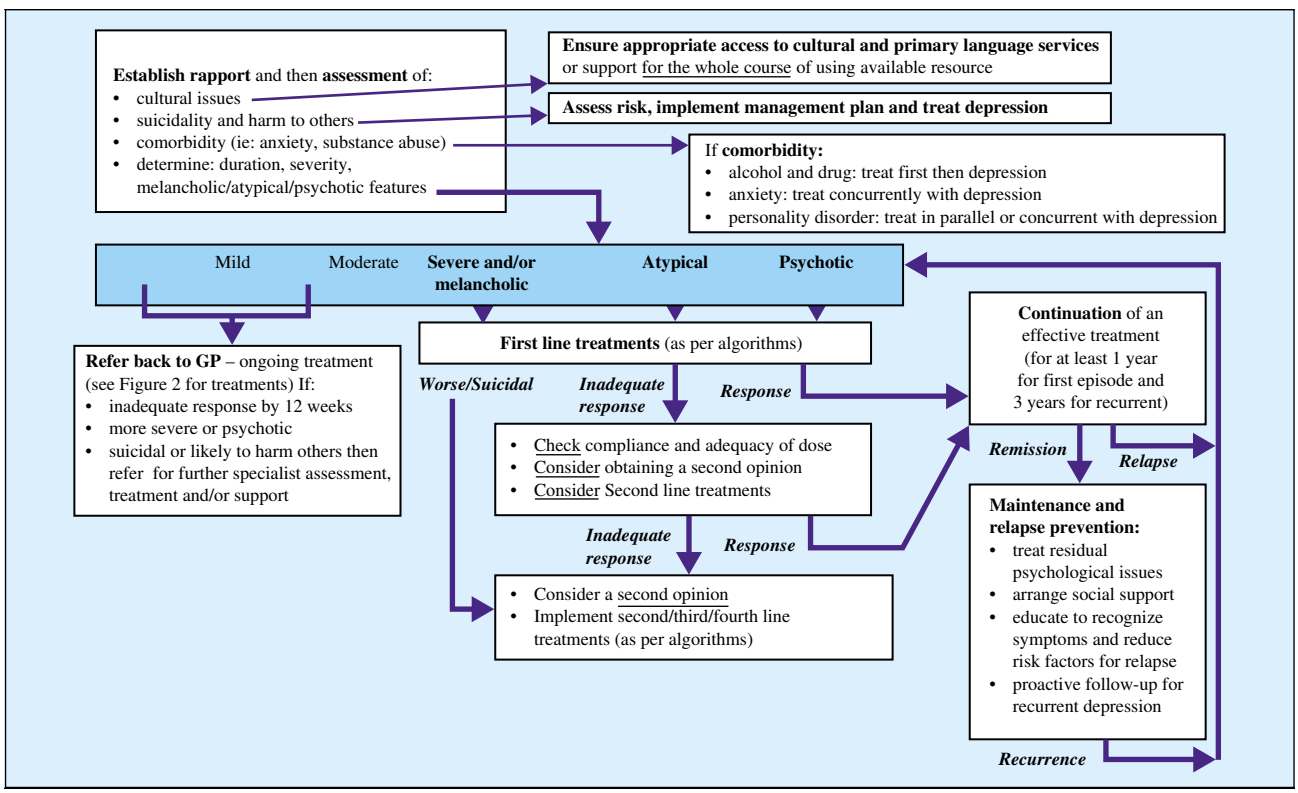

Figure 1: Assessment and treatment of depression in specialist care.

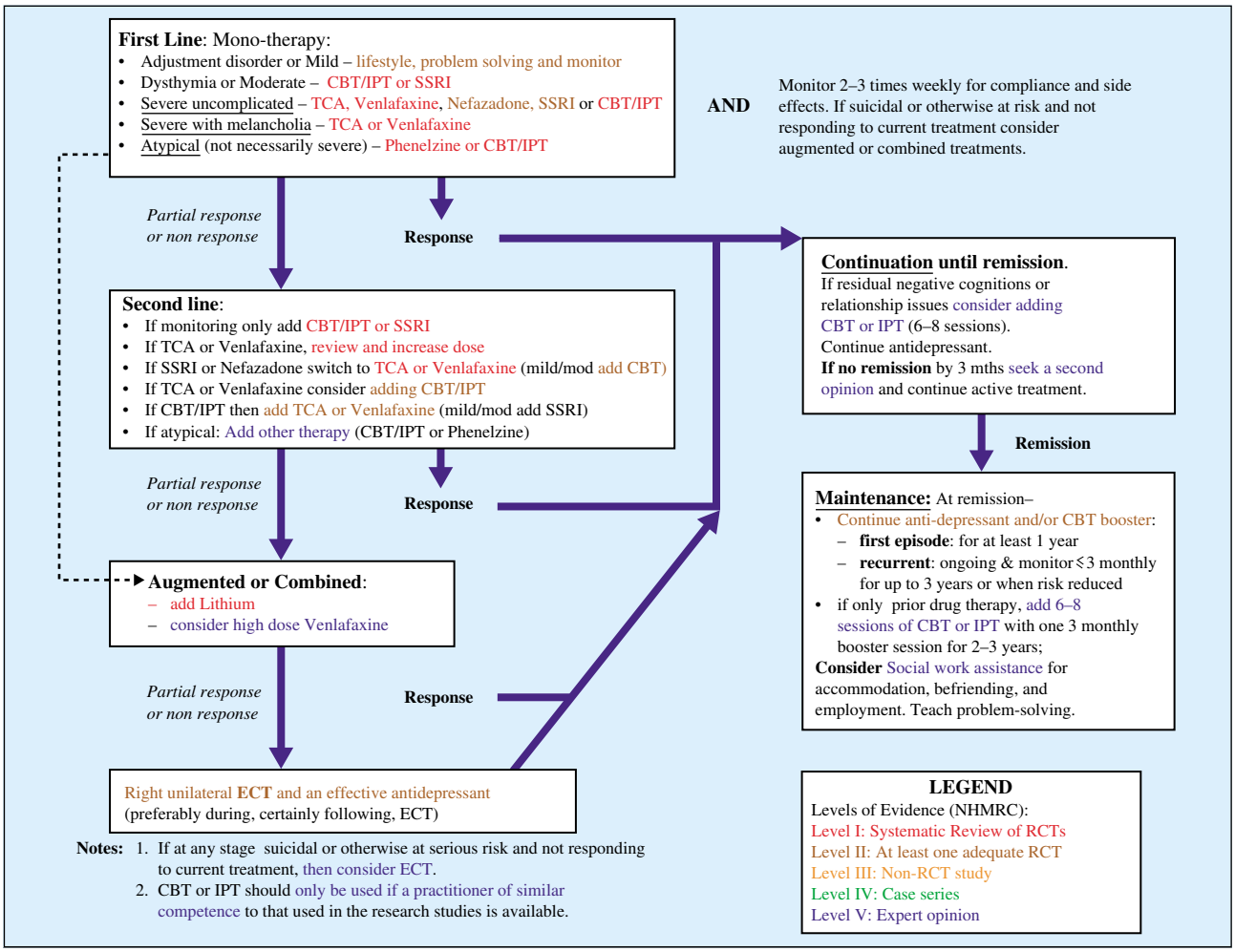

Figure 2: Selection of evidence-based treatment for uncomplicated, melancholic or atypical depression.

the need for lifestyle changes; consider teaching problem-solving techniques; consider relationships with significant others and offer specific assistance as required; and provide supportive monitoring. There is no evidence for the use of pharmacological or psychological treatments for this group unless the symptoms persist beyond 8 weeks – then brief treatment with cognitive behaviour therapy (CBT), interpersonal psychotherapy (IPT) or a selective serotonin reuptake inhibitor (SSRI) in addition to supportive management may assist.

Moderately severe depression (including with comorbid anxiety) and dysthymia

Either an antidepressant or one of the brief psychological therapies (8–12 sessions of CBT or IPT) is indicated. Monitoring should be regular and include review of side-effects, treatment benefits, changes in stresses and circumstances, and encourage compliance. Monitoring should be at a frequency appropriate to the severity of the illness (at least weekly is suggested). At the end of a reasonable trial period, treatment should be reviewed and changed/revised as indicated. It is expected that the input from specialist services will be limited to the initial phases and thereafter will be consultative to primary services, who will manage long-term care.

Moderately severe depression with comorbid substance abuse

Use interventions to reduce alcohol consumption and then treat as if moderate or severe depression. This will require explicit coordination of alcohol and drug, secondary mental health and primary care services.

Moderate to severe depression with physical disorders

Concurrent treatment of the physical disorder and depression in both secondary and primary care services is appropriate.

Severe depression with melancholia

Generally, initiate an antidepressant and once there has been a response, consider adding a psychological therapy (to achieve either a full response and/or reduce risks of relapse).

Recurrent depression or failure to respond to a preferred first-line treatment

If first-line treatment was an SSRI or a psychological therapy, switch to a tricyclic antidepressant (TCA) or venlafaxine; or a higher dose TCA or venlafaxine; or combine a course of one of the brief psychological therapies and an antidepressant.

Psychotic depression, severe depression with risk of suicide

Care should be provided by specialist mental health services until stabilized, and then continuing consultation/liaison with primary care services. Treatment options are outlined in Figure 3.

Continuing treatment

The most important factor in the management of depression is to maintain compliance with an effective treatment. Addition of CBT or IPT to the continuing and maintenance phases has been associated with lower relapse rates.

Maintenance treatment for recurrent depression

Depression is often a relapsing condition, so once the person has responded to treatment, ongoing relapse prevention and early intervention in any recurrence is essential. Indeed, most presentations, even to primary care providers, will be for a second or subsequent episode of depression and the treatments offered should acknowledge this. In this respect

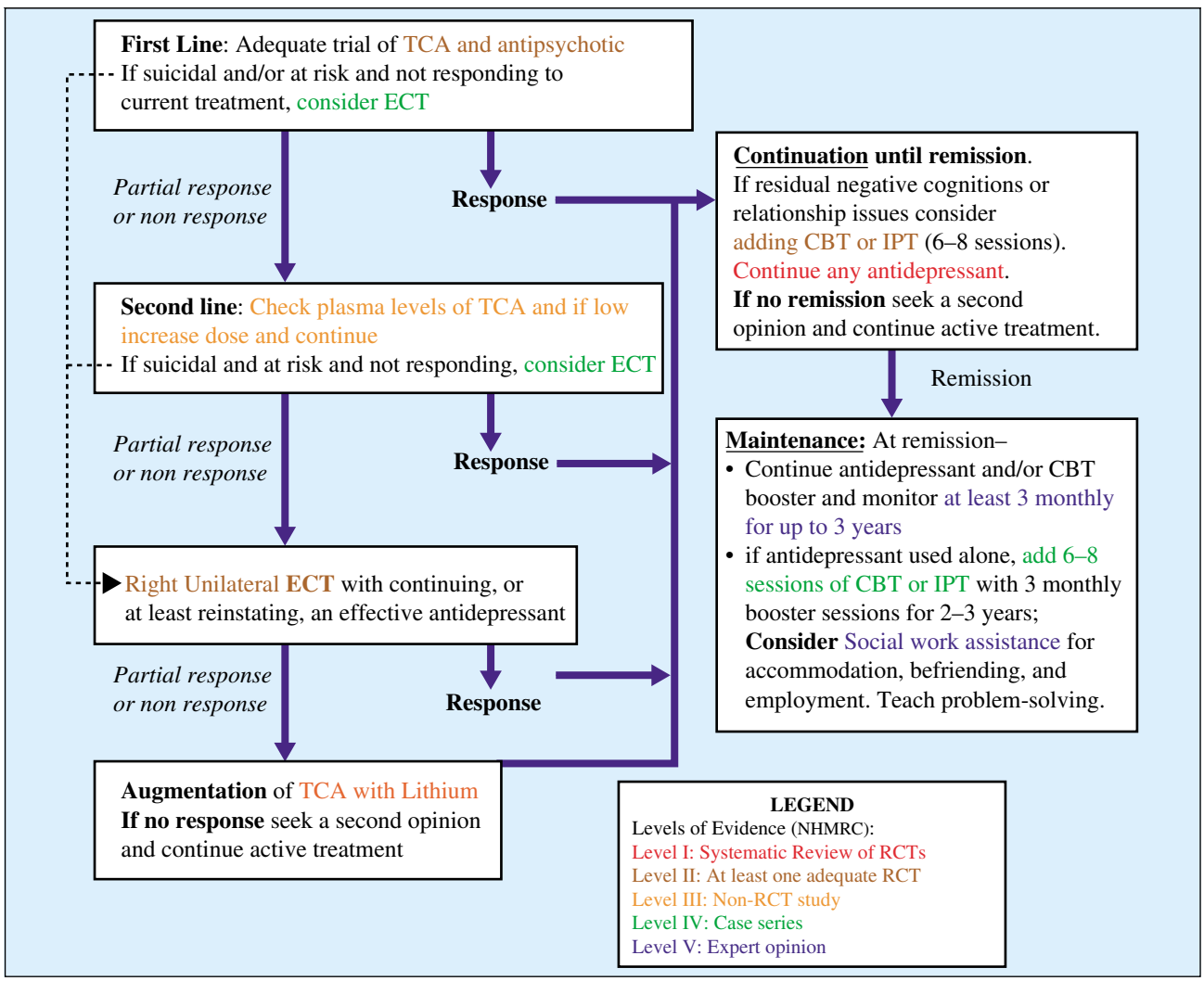

Figure 3: Main options for the treatment of psychotic depression.

depression is similar to many medical conditions such as congestive heart failure or basal cell carcinoma, where risk of relapse is significant and ongoing monitoring is indicated. The key intervention should be continuing with an effective and acceptable treatment. The use of CBT or IPT where there are residual symptoms or inadequate response have been associated with lower rates of relapse after 2 and 3 years.

GENERAL MANAGEMENT ISSUES

In severe depression it is often necessary to proceed to second- and third-line treatments at an earlier stage. For example, ECT is an effective treatment in depression, which may have a place earlier or later in treatment depending on the nature and severity of depression.

While there is increasing evidence that CBT and IPT are as effective as antidepressants in many depressive illnesses, not all therapists are equally experienced or effective. Research studies of these therapies adhere strictly to versions of these therapies that follow treatment manuals and may not reflect the somewhat more eclectic usual practice. Cognitive behaviour therapy and IPT should be considered only if a competent and experienced practitioner is available. There are too few studies of other forms of psychological therapies to make evidence-based recommendations, but clinical experience indicates that they can be valuable for those with major interpersonal difficulties and severe past trauma.

Hospitalization

Treatment away from the depressed person's usual home may be necessary to ensure greater supervision if they are: suicidal; unable to look after themselves; in a setting that is considered to be exacerbating their illness; in need of otherwise unavailable psychological support in severe distress. The setting for this will need to be selected on the basis of the depressed person's needs, the extent and level of expertise or support required and the range of options available. This may include friends and family, respite accommodation, or inpatient hospital care.

The full text of these clinical practice guidelines for depression can be obtained from the College website at http://www.ranzcp.org

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