Depression: Management of Moderate to Severe Depression

Key Highlights from the Recommended Guideline

- Assess patients with moderate to severe depression carefully for risk of suicide or self-harm.
- Antidepressants (generally SSRIs) should be offered routinely; cognitive-behavioural therapy is the psychological therapy of choice.
- Consider augmentation and combination therapies where appropriate.

Scope: This guideline is intended for health professionals involved in the care of adults in primary and secondary care.

How should I use antidepressant medications for moderately to severely depressed patients?

- Offer antidepressants routinely to all such patients before psychological interventions. [Level of evidence: B]
- Reassess patients under 30 years old or at increased suicidal risk after 1 week, and frequently thereafter until suicidal risk is no longer significant. [Level of evidence: C]
  - Ask specifically about suicidal ideation, increased anxiety and agitation and akathisia (especially with SSRIs)
- Inform patients when antidepressant treatment starts that: [Level of evidence: C]
  - These drugs are not associated with tolerance or craving
  - However, if they stop or miss doses (and sometimes when the dose is reduced), they may have discontinuation/withdrawal symptoms
  - These symptoms are usually mild and self-limiting
  - They may occasionally be severe if the drug is stopped abruptly
- Among those with elevated risk of suicide or self-harm:
  - Prescribe only a limited quantity of antidepressant [Level of evidence: C]
  - Consider the use of additional support such as more frequent direct contacts with primary care staff or telephone contacts, or if beneficial, inpatient treatment. [Level of evidence: C]
- Continue the antidepressant for at least 6 months after remission to reduce the risk of relapse. [Level of evidence: A]

How do I decide which antidepressant to choose?

- For routine care, use SSRIs, which are as effective as tricyclics but less likely to be discontinued because of side effects. [Level of evidence: A]
- For patients at higher suicidal risk, consider the toxicity of an antidepressant in overdose. [Level of evidence: C]
  - Note that tricyclics and venlafaxine are more toxic in overdose than other equally effective antidepressants. [Level of evidence: C]
When and how do I switch antidepressants?

- Consider switching after 1 month when there has been no response, and after 6 weeks when there has been a partial response. [Level of evidence: C]
- Taper the dose of the original antidepressant over 4 weeks if the patient has cardiovascular disease (fluoxetine usually needs less tapering time). [Level of evidence: C]
- Consider other treatment options besides antidepressants. [Level of evidence: C]
- If you continue with antidepressant treatment, offer another antidepressant monotherapy. [Level of evidence: C]

Which psychological treatments should I consider for patients with moderate to severe or treatment-resistant depression?

- Offer cognitive-behavioural therapy (CBT) to patients who refuse, are non-adherent to, or intolerant of antidepressant treatment, or who prioritize avoiding antidepressant side effects. [Level of evidence: B]
- Offer CBT combined with antidepressants to:
  - Those with severe depression [Level of evidence: B]
  - Those with chronic depression [Level of evidence: A]
- Select CBT as a first-line choice, or interpersonal therapy (IPT) if the patient prefers it or you think the patient may benefit from it. [Level of evidence: B]
- Consider couple-focused therapy for patients with a regular partner who have not benefited from individual therapy. [Level of evidence: B]
- Typically, treat individuals for 16-20 sessions over 6-9 months and couples for 15-20 sessions over 5-6 months. [Level of evidence: B]

How should I manage my patients with treatment-resistant depression?

- Consider combining CBT with antidepressants, especially if the patient relapses during or after a course of antidepressants alone. [Level of evidence: B]
- For patients who have not responded to several antidepressants, consider adding lithium. [Level of evidence: B]
  - Perform an ECG before starting lithium. [Level of evidence: C]
- Do not augment antidepressants with carbamazepine, lamotrigine, buspirone, pindolol, valproate or thyroid hormone in routine care. [Level of evidence: B]

How should I decrease the risk of relapse in patients with recurrent depression?

- Continue antidepressants for 2 years if the patient has had at least 2 episodes of significantly impairing depression. [Level of evidence: B]
- Continue antidepressant + lithium for at least 6 months if a patient who has had multiple depressive episodes has responded well to this combination. [Level of evidence: B]
- Consider maintenance CBT if a patient has responded to an intervention but cannot or will not continue it. [Level of evidence: B]
- Consider CBT if the patient has a history of relapse and limited response to other interventions. [Level of evidence: B]
- Consider mindfulness-based (usually group) CBT for currently euthymic patients with at least 3 previous depressive episodes as this reduces the risk of relapse. [Level of evidence: B]
How can system improvements enhance the management of patients with depression?

- At the primary level of care:
  - Consider having trained team members support patients by telephone with the aid of clear treatment protocols, especially for monitoring antidepressant treatment. [Level of evidence: B]
  - Consider establishing programs that integrate psychological and pharmacological treatment using clear protocols for delivery and monitoring of treatment. [Level of evidence: C]

- At the specialist level of care,
  - Make use of crisis teams and home treatment teams, focusing on monitoring risk. [Level of evidence: C]

Levels of Evidence

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
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<tbody>
<tr>
<td>Grade A</td>
<td>At least one randomized controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence level-I) without extrapolation</td>
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<tr>
<td>Grade B</td>
<td>Well-conducted clinical studies but no randomized clinical trials on the topic of recommendation (evidence levels II or III); or extrapolated from level-I evidence</td>
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<tr>
<td>Grade C</td>
<td>Expert committee reports or opinions and/or clinical experiences of respected authorities (evidence level IV). This grading indicates that directly applicable clinical studies of good quality are absent or not readily available</td>
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The above recommendations were derived from the following GAC endorsed guideline:


Rating (out of 4): 🍀🍀🍀🍀

Note: This guideline was released by guideline developers as an update to its previous guideline and as such was also reviewed and endorsed by the GAC as an update to the existing GAC endorsed guideline. Please note that a new literature search was not conducted on this topic at this time.

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