Australian Government
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Veterans' MATES

Therapeutic Brief

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Achieving best outcomes for depression

Depression is common among Australian veterans.[1] Analysis of Australia's Department of Veterans' Affairs (DVA) health claims data indicates duration of antidepressant use is often inconsistent with clinical guidelines and non-pharmacological therapies are underused.[2, 3]

Most people with depression have a mild to moderate form, and with appropriate care, most recover within a year.[4] Up to 80% of people have at least two recurrences during their lifetime, and for a small proportion of people, depression becomes a chronic illness.[4, 5]

Current guidelines recommend using a stepped care approach for treating depression.[4-6] Where the DVA patient is willing and able to participate, non-pharmacological therapies are recommended as first-line treatments for mild to moderate depression.[4-7] For more severe depression, antidepressants are recommended in conjunction with non-pharmacological therapies.[4-6, 8]

Key points

- Encourage all your DVA patients with depression to participate in psychological therapies
- Avoid routinely starting patients with mild to moderate depression on an antidepressant
- Every six months re-evaluate the need for ongoing use of an antidepressant based on your patient's individual circumstances

Offer early referral for psychological support

First-line treatments for mild to moderate depression include individual guided self-help therapies based on the principles of cognitive behavioural therapy (CBT), and education about lifestyle changes, including mood monitoring, exercise and healthy sleep patterns.[6, 7] Behavioural activation used either in a guided self-help format over the telephone with a low intensity coach, such as the *beyondblue NewAccess* program, or face-to-face sessions with a high intensity CBT practitioner, such as a psychologist, is recommended.[9, 10]

Some patients might prefer telephone or electronic interventions; others might prefer face-to-face sessions. **No matter the mode of intervention, reviewing your patient each week or fortnight, and making contact with them if they don't attend follow up appointments, allows you to monitor changes in their mood, encourages adherence and completion of programs, and has an overall positive effect on their recovery.[6, 11]**

For DVA patients with mobility problems, consider arranging psychological interventions, including CBT, problem solving therapy or family therapy, with exercise interventions in their home. Evidence suggests home-based psychological therapies combined with exercise are as effective in reducing symptoms of depression as when the patient attends a clinic.[12] DVA can pay for assessment and treatment by a psychologist or social worker for eligible DVA patients who are not able to travel.[13] www.dva.gov.au/providers/what-you-need-know/rules-providers/rules-allied-health-care-providers

Finding a health professional who can provide support

DVA has expanded eligibility for mental health conditions. Now, anyone who has ever served in the permanent forces of the Australian Defence Force may receive treatment for any mental health condition, regardless of when they served, for how long, or the nature of their service. This is known as non-liability health care. DVA will pay for treatment for DVA patients with depression whatever the cause, even if the condition is not related to service. For further information, go to DVA at: www.dva.gov.au/health-and-treatment/injury-or-health-treatments/mental-health-care/free-mental-health-care-veterans

- One way to find a psychologist is to go to the Australian Psychological Society website at: www.psychology.org.au/FindAPsychologist/
- You can access a registered clinical counsellor via the Australian Counselling Association at: www.theaca.net.au/find-registered-counsellor.php
- An accredited mental health social worker is able to carry out assessments, and provide interventions, including CBT, for DVA patients with depression. An accredited mental health social worker can be found at: www.aasw.asn.au/information-for-the-community/information-for-gps
- Physical exercise plays an important role in helping to prevent, treat and reduce the risk of recurrence of depression, especially when the exercise is supervised by qualified trainers.[14, 15]
  - Refer to the RACGP 'Handbook of Non-Drug Interventions (HANDI)' for mental health to access information about exercise for depression at: www.racgp.org.au/clinical-resources/clinical-guidelines/handi/handi-interventions/mental-health/exercise-depression
  - To find a physiotherapist via the Australian Physiotherapy Association, go to: www.physiotherapy.asn.au/APAWCM/Controls/FindaPhysio.aspx
  - To find an accredited exercise physiologist via Exercise & Sports Science Australia, go to: www.essa.org.au/find-aep/
- **Encourage your DVA patients to contact Open Arms Veterans and Families Counselling for extra support, counselling and group programs:** www.openarms.gov.au/who-we-help can be contacted 24 hours a day, 7 days a week via telephone on 1800 011 046 or via the website at: www.openarms.gov.au/

If access to a psychologist or other healthcare professional trained in non-pharmacological therapies is not possible, consider low intensity guided self-help interventions, such as Mindspot Clinic, moodGYM or other e-mental health resources via the DVA portal for your DVA patients, especially those programs that require GP involvement.

The RACGP has developed 'e-Mental health: A guide for GPs' to assist GPs in using e-mental health interventions in primary care and is available at: www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/e-mental-health

Antidepressants provide little therapeutic benefit for mild to moderate depression

Australia has one of the highest rates of antidepressant use in the world.[16] The benefit of an antidepressant compared with placebo increases with the severity of depression.[17] Antidepressants provide little benefit for most people with mild to moderate depression.[17] They are most beneficial for people with severe depression,[17] especially when used in conjunction with psychological therapies.[5, 8] The UK National Institute of Clinical Excellence's threshold for clinical significance (a Hamilton Depression Rating Scale point difference of ≥3) was only met for HDRS scores of 25 or greater (see Figure 1).[17]

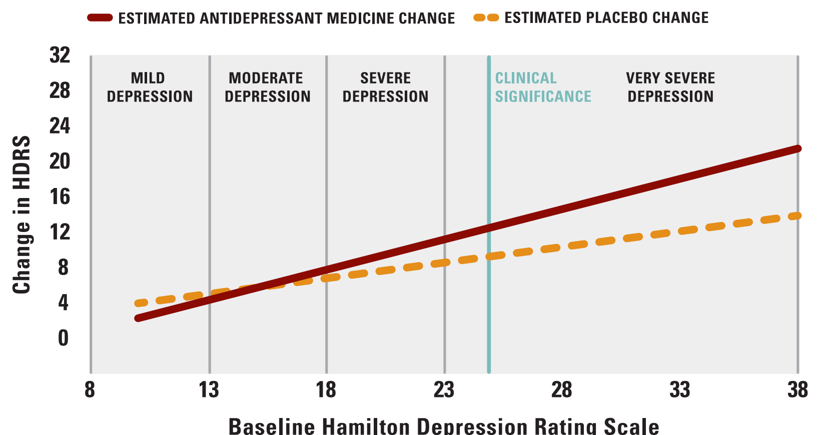

Figure 1: A meta-analysis of six studies indicates the mean change in depressive symptoms according to the Hamilton Depression Rating Scale (HDRS) for antidepressant medicine and placebo for mild, moderate, severe and very severe depression.[17]

In people with mild to moderate depression, the adverse effects associated with antidepressant use might outweigh the benefits. Consider potential adverse effects and drug interactions before starting an antidepressant. See the 'Australian Medicines Handbook'.

Older people are often more susceptible to adverse effects than younger people because of multi-morbidity, other medicines they are taking and frailty.[18] As with younger people, antidepressants are most effective in those with severe depression and when used in conjunction with psychological therapies.[19]

Persistent depressive disorder (dysthymia)[5, 20] & Sub-threshold depression[6, 21-23]

- There are other depressive disorders, including persistent depressive disorder (PDD) and sub-threshold depression, that fall outside the criteria for depression, but are relatively common in DVA patients.
- DVA patients with these disorders might not actively seek help, and may go unrecognised and untreated.
- Early diagnosis and treatment is important as DVA patients with PDD or sub-threshold depression often experience significant morbidity including impairment in social and occupational functioning, and increased physical ailments and risk of suicide.
- When treating DVA patients with PDD or sub-threshold depression, encourage participation in psychological therapies, especially CBT-based self-help interventions before considering medicines.

A combined treatment approach is most effective for more severe depression

For most patients with moderate depression, psychological therapies alone are an effective treatment, especially if provided early in the illness.[19, 24] Patients with more severe depression are likely to benefit the most from an antidepressant in conjunction with face-to-face psychological therapies.[5, 11] Psychological therapies have been found to have an additional positive effect in treating depression, apart from the effects from pharmacotherapy.[8] The combined effect of pharmacotherapy and psychological therapies compared with placebo is estimated to be twice that of pharmacotherapy alone.[8]

Some DVA patients might have complex physical and mental health issues, including post-traumatic stress disorder (PTSD), anxiety, cognitive impairment, substance use disorders or chronic pain.[25] These comorbid disorders require management of their own, if the patient's depression is to respond fully to treatment.[25, 26] Certain antidepressants might be inappropriate for some patients with complex issues due to their adverse effect profile or lack of evidence of effectiveness.[19]

Before starting an antidepressant, patients prefer:[26]

- to talk about realistic treatment options and goals and to know that decisions will be mutually agreed upon
- an explanation of the possible cause of depression and what to expect when taking an antidepressant and how it might help
- to know how long before the antidepressant might start to have an effect and the approximate length of time it will need to be taken for
- to be informed of the possible adverse effects, and to have all reports of adverse events experienced taken seriously.

Review the effect of potential interactions of the antidepressant with other medicines the patient is taking, including oxycodone or tramadol.[19]

Up to two thirds of people with depression will not respond to the first antidepressant they take.[7, 27] If there is no response after at least four weeks of taking an adequate dose of an antidepressant; review the diagnosis, re-check adherence, switch to another antidepressant or refer your patient to a psychiatrist.[5, 7]

Encourage involvement of the DVA patient's family where possible; their involvement and support can provide a sense of connection and belonging for the patient, aid recovery and lessen the risks associated with suicidal behaviour.[25] Because living with a person with depression can affect family members, consider the impact on them and refer as needed.[25]

Review duration of antidepressant use

There is limited research to indicate optimal duration of antidepressant treatment.[5] However, patients who have had full resolution of symptoms might benefit from a review of their antidepressant medicine.[6]

As a general guide, current guidelines recommend:

- Continuation of an antidepressant after full resolution of symptoms for six to 12 months for patients following a single episode of depression.[5, 24]
- Continuation of an antidepressant for at least two to three years for patients with two prior episodes of depression.[5-7]
- Patients with depression who are resistant to antidepressant treatment and psychological therapies, or those with severe depression, should be referred to a psychiatrist for management.[11]
- **Patients with severe depression and suicidal thoughts or psychotic symptoms should have crisis intervention and be managed by a psychiatrist.[18]**

DVA patients with a history of previous episodes of depression, particularly if they have been severe and associated with suicidality, and those with co-morbid disorders, including PTSD and coronary heart disease might benefit from ongoing therapy.[11, 25, 28, 29] Every six months, re-evaluate the need for ongoing use of an antidepressant, based on your patient's individual circumstances.

When considering tapering and ceasing an antidepressant, introduce the concept of stopping the antidepressant with your patient over several visits before you start tapering; some patients might feel anxious about stopping, especially if they have been taking an antidepressant for some time.[27, 30] Abruptly stopping is generally not recommended unless a serious adverse event has occurred, for example a cardiac arrhythmia in a person taking a tricyclic antidepressant (TCA).[7] Almost all antidepressants have the potential to cause discontinuation symptoms when they are stopped or rapidly reduced after being taken for six weeks or longer.[7, 27]

Consider antidepressant cessation carefully in high-risk patients, as relapse in these patients could initiate life-threatening behaviours.[27]

Tapering and ceasing an antidepressant[5, 7, 27, 30]
Discuss and negotiate a tapering plan with your patient and include their partner or close family members if appropriate. Schedule more frequent visits to closely monitor your patient's progress, and to detect any early signs and symptoms of re-emerging depression.
Consider and manage potential drug interactions caused by cessation of the antidepressant.
Inform your patient of potential discontinuation symptoms that might occur as the dose is tapered down. Discontinuation symptoms are usually mild and transient, but for some, they can be more severe and troublesome. Refer to the 'Australian Medicines Handbook' for discontinuation symptoms associated with antidepressants.
Taper the dose slowly over an extended period of time (at least four weeks or even months). Slow the tapering rate towards the end as discontinuation symptoms might not appear until reduction in the total daily dose is substantial.
The patient might experience some discontinuation symptoms from any of the classes of antidepressants, even with gradual tapering, but the risk is greater with higher doses and with longer duration of treatment.
Discontinuation symptoms are most severe with venlafaxine, and frequently occur with duloxetine, desvenlafaxine and short-acting SSRIs, especially paroxetine. Discontinuation symptoms are less likely with fluoxetine, because of its long half-life, especially if the dose is less than 40mg.
If discontinuation symptoms are severe, reintroduce the antidepressant, or another with a longer half-life from the same class, and taper gradually while monitoring for symptoms.
If your patient is taking an SSRI or an SNRI and finding withdrawal symptoms burdensome, switching to fluoxetine might help to alleviate symptoms. It can usually be stopped later without discontinuation symptoms reappearing.
Suddenly stopping a TCA can cause anticholinergic rebound symptoms including Parkinson-like symptoms, balance disturbances, flu-like symptoms, myalgia and gastrointestinal problems.

For further guidance refer to 'Switching and stopping antidepressants' at: https://www.nps.org.au/australian-prescriber/articles/switching-and-stopping-antidepressants

Full reference list available on the website: www.veteransmates.net.au

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