

## Depression Treatment Pathway

Screen for depression and diagnose using ICD-10 criteria  
Assess suicidal risk

Patients at risk of suicide/ under 30 years should be seen after 1 week and more frequently until risk is no longer clinically significant

Offer non pharmacological interventions e.g. CBT where appropriate - see [NICE CG90](#), [Wiltshire IPAT](#) or [LIFT Psychology](#) services may be a good place to start for psychological intervention.

Do not offer antidepressants first line for mild first episodes.

Where an antidepressant is required e.g. moderate or severe depression or mild with previous moderate/ severe episode(s):

For patients who have previous history of successful treatment with a particular antidepressant, re-try it in the first instance if appropriate. Otherwise/ first presentation:

- Consider monotherapy with generic **SSRI** as first line. Sertraline and escitalopram are effective and relatively better tolerated and should be considered first line choices. Note [QT prolongation](#) warning with escitalopram.
- Start at a low dose and titrate as necessary to a recognised, therapeutic dose. See patient regularly to assess improvement e.g. every 2-4 weeks (one week if under the age of 30 years) for the first 3 months.
- Monitor for adverse effects including gastro-intestinal upset, bleeding (consider gastro protection for susceptible/ high risk patients) and hyponatraemia (common in elderly)

**Mirtazapine** may be an option if sedation is desired or where hyponatraemia or an increased bleeding risk is a concern

- Assess response at 4 weeks for adults; 6 weeks for the elderly (> 65 years)

No effect

Partial response

Effective & well tolerated

Poorly tolerated

Check compliance and confirm diagnosis

Switch to different antidepressant

Check compliance

Increase dose

Reassess after a further 2-4 weeks

Maintenance - Continue for *at least*

- 6 months at *full treatment dose* after 1st episode.
- 2-3 years for 2<sup>nd</sup> episode
- 5 years for 3<sup>rd</sup> episode (longer for the elderly)
- Lifelong for 4 or more episodes to reduce risk of relapse.

See [BCAP](#) for **Traffic Light Status of drugs**

No improvement

Switch to a different antidepressant **SECOND LINE** (see notes)

- Try an alternative SSRI e.g. fluoxetine
- **Mirtazapine** – (If not already used - see first line treatment)
- **Venlafaxine** - less risk of discontinuation symptoms with MR formulation. 75mg dose acts as an SSRI so little benefit. BP should be measured in patients on doses above 150mg. Associated with greater risk of death from overdose [*prescribe as 'venlalic'*]
- Titrate to therapeutic dose. Assess efficacy over 3 -4 weeks, **↑**dose as necessary.

Ineffective

Consider **THIRD LINE options**

- **Tricyclic antidepressants** e.g. Lofepramine is less sedating, less cardiotoxic and low risk in overdose.
- **Duloxetine** – also used for generalised anxiety disorder and neuropathic pain  
Titrate to therapeutic dose. Assess efficacy over 3 -4 weeks. **↑** dose as necessary.
- **Vortioxetine**, a new multi-model agent (NICE [TA367](#)) is AMBER - for specialist initiation only

Effective & well tolerated

Poorly tolerated or no effect

Maintenance as above

Refer to Primary Care Liaison Service

**NB:** Antidepressants have a fairly prompt onset of action and no response at 2-6 weeks is a good predictor of overall non-response. Absence of any improvement at all at 3-4 weeks should provoke change in treatment. If there are some improvement at this time, continue and assess for a further 2-4 weeks.

### Additional notes:

- Antidepressants are not recommended as first line treatment in recent-onset, mild depression; active monitoring, psychosocial interventions, CBT and/or exercise are preferred (see NICE CG90)
- Discuss the choice of drug and local availability of non-pharmacological options. Direct the service user to the choice and medication website (<http://www.choiceandmedication.org/awp/conditions/17/>) for further information to help them make an informed decision.
- Discuss likely outcomes e.g. gradual relief from depressive symptoms over several weeks; and adverse effects which are usually transient.
- Withdraw antidepressants gradually; always inform the service user of the risk and nature of discontinuation symptoms – see [guidance on stopping and swapping of antidepressants](#).
- Separate additional guidance is given on depression in adults with a chronic physical health problems (see NICE CG91)

### Additional notes on choice of antidepressant

- **Fluoxetine** (long half-life) and **paroxetine** have a higher propensity for drug interactions and are not first line choices due to these problems.
- **Citalopram and escitalopram** – contra-indicated for use with other drugs that can prolong the QT interval. See warning [here](#)
- Dual re-uptake inhibitors such as **venlafaxine** and **duloxetine** tend to be less well tolerated than SSRIs but better than tricyclics (TCAs)
- Tools such as the Montgomery-Asberg Depression Rating Scale and the Hamilton Depression Rating scale can be used to assess drug effect. The **PHQ-9** is simple to use and is recommended for assessing symptom change in depression.
- Switching between drug classes in cases of poor tolerability is not clearly supported in studies but in practice, patients who cannot tolerate one SSRI will readily tolerate another.
- In cases of non-response, there is some evidence that switching within a drug class is effective, but switching between classes is, in practice, the most common option and supported by NICE and the American Psychological Association.

### Reference sources/ useful links:

1. Depression in adults: recognition and management NICE [CG90](#)
2. [Guidance on stopping and swapping antidepressants](#) April 2016
3. **Vortioxetine** for treating major depressive episodes NICE [TA367](#)
4. Maudsley Prescribing Guidelines in Psychiatry 12<sup>th</sup> Edition
5. Depression in adults with a chronic physical health problem: recognition and management NICE CG91
6. Psychotropic Drug Directory 2014
7. Choice and Medication: Depression [www.choiceandmedication.org/awp/conditions/17/](http://www.choiceandmedication.org/awp/conditions/17/)
8. Depression alliance [www.depressionalliance.org](http://www.depressionalliance.org)
9. Self-help: Living Life to the Full [www.lltff.com/index.php?section=page&page\\_seq=8selfhelp.co.uk/selfhelp.htm](http://www.lltff.com/index.php?section=page&page_seq=8selfhelp.co.uk/selfhelp.htm)
10. Self-help: <http://www.getselfhelp.co.uk/selfhelp.htm>