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AN AUDIT TO IDENTIFY FACTORS THAT ARE MORE COMMONLY ASSOCIATED WITH DEPRESSED PATIENTS ON AUGMENTATION THERAPY UNDER THE BEFORDSHIRE EAST COMMUNITY MENTAL HEALTH TEAM (BECMHT)

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SUMMARY

Background: *Whilst it is important that we treat patients with depression in primary care if possible there are many patients with depression who will need the more expert support provided in secondary care.*

Aims and Methods: *An Anonymised Database held by the Bedford East Community Mental Health Team was studied to assess what factors were related to the use of Augmentation Strategies to treat resistant depression.*

Results: *Of the total 282 patients 109 (38.7%) were on augmentation therapy. In the F32 and F33 group just over a third of the patients (35.8% and 37.1%) were on augmentation therapy and in the F41.2 group over a half of patients (56.7%) were on augmentation therapy.*

Discussion: *There does seem to be a relationship between the number of risk factors a patient has and the likelihood that they are on augmentation. Particularly strong factors are another psychiatric diagnosis and 'other suicide risk factors'.*

Conclusion: *Generally the patients coming to secondary care with more of the specified risk factors are more likely to need augmentation.*

Key words: *resistant depression - augmentation therapies*

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Introduction

Whilst it is important that we treat patients with depression in primary care if possible (Agius et al. 2005) there are many patients with depression who will need the more expert support provided in secondary care.

A previous audit of depressed patients under the BECMHT (Butler et al. 2010) identified that there were a significant number of patients on treatment combinations not included in NICE guidance. Secondary care is appropriate for these patients since specialist care and a wider experience is required to optimize treatment decisions.

The aim of this audit was to identify factors more common in the group of patients on complex treatment combinations. This would then help clinicians to identify patients that would be more likely to need atypical treatment and thus management in secondary care.

Subjects and method

From an anonymised database of BECMHT patients we identified 282 patients with depression, of which 120 had a diagnosis of F32 (Depressive Episode), 132 of F33 (Recurrent Depressive Disorder) and 30 of F41.2(Depression and Anxiety). We then split these into groups of patients that were either on augmentation (A) or on no augmentation (N). The patients in group N were either on no antidepressant (D), antimanic (M) or antipsychotic (P) or just one D. The patients on group A included any other combination of D, M and P.

From the data available on the database we identified some factors that may influence augmentation therapy. These factors were (1) other psychiatric diagnosis, (2) suicide attempt, (3) suicidal ideation, (4) alcohol use, (5) drug use and (6) other risk factors for suicide. The other risk factors for suicide used were anger/aggression, hopelessness, childhood abuse, financial troubles, self harm, current abuse/violence, forensic history and family problems such as child protection issues (Oquendo et al. 2004).

The factors present in group A and N were then compared. The severity of depression for the F32 group only was also compared between the A and N groups. (Only 1.3% patients in the F33 group had a severity stated.)

Results

Of the total 282 patients 109 (38.7%) were on augmentation therapy. In the F32 and F33 group just over a third of the patients (35.8% and 37.1%) were on augmentation therapy and in the F41.2 group over a half of patients (56.7%) were on augmentation therapy.

In terms of severity of disease in the F32 group, 20.9% of the A group and 28.6% of the N group had an unknown severity. Of the F32 A group the largest proportion (46.5% vs 11.7% N) of patients had depression classified as severe, whereas in the F32 N group the largest proportion of people had depression classified as moderate (57.1% vs 27.9% A). There were

few patients with mild depression in both groups; A 4.7% and N 2.6%.

Group N had a greater percentage of patients with zero specified factors than group A (39.9% vs 20.2%). Group A had a greater percentage of patients with any number of factors than group N. The highest percentage of group A patients had 1 factor (36.7% vs 31.8% of N) and 43% of patients had two or more factors compared to 28.3% of group N.

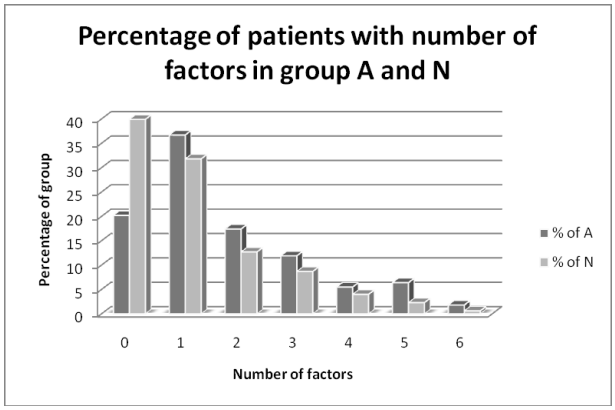

Figure 1. Percentage of patients with number of risk factors in group A and N

For every specified factor that could influence augmentation therapy group A had a greater percentage of patients than group N. The biggest difference was with an other psychiatric diagnosis (50.5% vs 28.9%), although other suicide RF also showed a comparatively large difference (35.8% vs 22.5%). Suicide attempts and ideation were slightly higher amongst group A (14.7% vs 10.4% and 24.8% vs 22.5%) as was alcohol and drug use (15.6% vs 11% and 7.4% vs 6.4%).

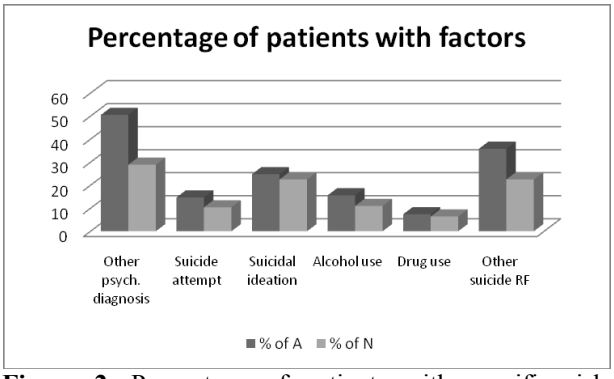

Figure 2. Percentage of patients with specific risk factors in group A and N

The most common augmentation combination was an antipsychotic with an antidepressant with 47.7% (52) of group A on this. Including other combinations there are a total of 80 patients on an antipsychotic, 59 of these did not have documented psychotic symptoms recorded on the database and 13 had no specified factors at all. 17 of the antipsychotic augmentation strategies had an evidence base known to us; fluoxetine and olanzapine (Shelton et al. 2001) or augmentation with quetiapine (Thase et al. 2006). This leaves 78.8% of the 80 patients on an antipsychotic that are on treatment regimes without a reason for such treatment recorded on the database. We will later discuss possible reasons for the use of anti-psychotics in these patients.

Discussion

It would not be surprising that more patients on augmentation therapy have a more severe grade of depression than those not requiring augmentation. However there are a significant proportion of patients whose severity of illness is not known and so to confirm this relationship we need to establish the severity by looking through the notes.

We can see that there does seem to be a relationship between the number of risk factors a patient has and the likelihood that they are on augmentation. Particularly strong factors are another psychiatric diagnosis and 'other suicide risk factors'. Included in the 'other psychiatric diagnosis' are psychotic and somatic symptoms. We included these as factors in the audit because although they are symptoms of depression that can complicate treatment and thus might increase the chance of using augmentation. It would be interesting to see if when they were excluded there would be such a difference between groups A and N. 'Other risk factors' is a very broad category including some factors which may be considered 'softer' risk factors e.g. anger, however there is over a 10% difference between group A and N suggesting that those on augmentation do have more life problems than those not on augmentation.

It is very interesting that 73.8% of patients on an antipsychotic for augmentation have no psychotic symptoms and that it is difficult from the database alone to explain the rationale for these choices in therapy. Reasons for the lack of psychotic symptoms could be that these have been treated successfully and patients remain on anti-psychotic medication to prevent re-occurrence or that these patients are on anti-psychotics as a form of tranquilisation, which has been a common strategy in the past.

This is certainly an area that needs more investigation, we need to review the literature to see if any information has been overlooked and to look into the concerned patients notes to see if an alternative explanation is found e.g. undocumented psychotic symptoms or very resistant depression. A further point of investigation is to look into the prescribing patterns of BECMHT over time to see if there is increasing use of specific augmentation regimes such as those recommended by NICE (NICE 2007) and by the STAR D study (Rush 2006) since audits like such as this one have been conducted. It will also be of interest to study the impact of the licencing of atypical antipsychotics such as Quetiapine (Thase et al. 2001) for the treatment of Bipolar Depression will have on prescribing practice. It is intended that these issues will be the subject of future reports.

One of the main limitations of this audit is that the factors we were able to investigate were limited to the information entered onto the database and so some information that may have been relevant e.g. subjective rating of severity of depression was not included. The sample size was reasonably large however due to the nature of the database we could not look into changes in patient's symptoms or medications over time. Therefore we cannot determine whether the augmentation strategies which patients are on are successful. It should also be commented that because it is not standard practice for rating scales to be used systematically in British patients, it is at present difficult to quantify from the notes the severity of depressive symptoms and how this changes over time. This is an important issue in the evaluation of the treatment of depression, and one which we are aiming to remedy.

Despite these limitations we have found that generally the patients coming to secondary care with more of the specified risk factors are more likely to need augmentation. This enables clinicians to identify patients whom they need to think carefully about and thus the patient may benefit from earlier recognition and initiation onto augmentation combinations. We have also identified further areas that need investigation such as antipsychotic augmentation combinations and changing prescribing patterns.

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