AN AUDIT TO COMPARE DISCHARGE RATES BETWEEN ANTIDEPRESSANT MONOTHERAPIES PRESCRIBED FOR PURE UNIPOLAR DEPRESSION VERSUS DEPRESSION IN THE PRESENCE OF OTHER INDICATIONS

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SUMMARY

Introduction: It has been demonstrated that there are differences in the efficacy and acceptability of commonly prescribed antidepressants (Cipriani et al. 2009). This meta-analysis showed that escitalopram, sertraline, venlafaxine and mirtazapine were the most effective in the acute treatment of unipolar depression in adults. In this audit, these most effective antidepressants will be referred to as 'the four', whilst other antidepressants will be referred to as 'the others'. We aimed to analyse prescribing patterns of antidepressant monotherapies in Bedford East Community Mental Health Team. We also aimed to compare the efficacy of antidepressant monotherapies in patients with unipolar depression or patients with depressed mood and also other psychiatric indications within Bedford East Community Mental Health Team, using discharge rates from the out-patient clinic as the outcome measure. We aimed to compare the efficacy of 'the four' versus 'the others' in patients with unipolar depression patients with depressed mood and also other psychiatric indications at within Bedford East Community Mental Health Team , using discharge rates from the out-patient clinic as the outcome measure.

Subjects and Methods: We included all patients on an antidepressant monotherapy in Bedford East Community Mental Health Team in our analysis (206 patients in total) (Figure 1). We examined the clinical notes for each patient to assess whether they were diagnosed with unipolar depression or another psychiatric condition, and whether they had been discharged from the out-patient clinic after being prescribed the antidepressant. This allowed us to calculate discharge rates for each antidepressant monotherapy.

Results: For patients with unipolar depression, discharge rates were higher when they were prescribed one of 'the four' and highest when prescribed escitalopram. For patients with other indications, discharge rates were higher for 'the others' and highest for fluoxetine .

Discussion: A greater percentage of patients with unipolar depression were discharged from clinic compared with patients treated with antidepressant monotherapy for depressed mood and also other psychiatric indications.

Conclusion: These results suggest that co-morbid undiagnosed other mental illness may be a cause of 'resistant depression'.

Key words: *anti-depressants – prescribing – audit – suicidality - discharge rates*

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INTRODUCTION

It has been demonstrated that there are differences in the efficacy and acceptability of commonly prescribed antidepressants (Cipriani et al. 2009). This meta-analysis showed that escitalopram, sertraline, venlafaxine and mirtazapine were the most effective in the acute treatment of unipolar depression in adults, while escitalopram and sertraline were found to be the antidepressants which were best tolerated. In this audit, these most effective antidepressants will be referred to as 'the four', whilst other antidepressants will be referred to as 'the others'. Few studies have been published in order to study the treatment of depression within the specific context of a British Community Mental Health Team (CMHT). Such a team will deal with cases of depression which have usually not responded to treatment by General Practitioners with anti-depressants, usually SSRIs, and brief psychological therapies, the availability of which does vary from one area of the UK to another. The context of this study is a single CMHT in Bedford, England, which receives referrals from a number of GPs. We wished find out whether we were tending to make the treatment choices suggested by Cipriani, and whether, within our practice, the anti-depressants identified by Cipriani did in practice give better results. In the UK, the choice of anti-depressants is based on the Guidelines for Depression published by the National Institute for Health and Clinical Excellence (NICE 2004, NICE 2009), another important influence is the STAR-D trial (Rush et al. 2004, Rush et al. 2006, Warden et al. 2007, Howland et al. 2008, Huynh et al. 2008).

It is also the case that certain co-morbid conditions, such as Post-traumatic Stress Disorder, Borderline Personality Disorder , and Bipolar II Affective Disorder often are diagnosed by General Practitioners as being 'Depressed', and when they do not improve in Primary care, are referred to CMHTs. These patients have another disorder co-morbid with their depressed mood. We wished to determine , in this study, whether these co-morbidities affected the outcomes, as reflected in the

discharge rate from the CMHT, and how this impacted in the guidelines on antidepressant choice suggested by Cipriani's Metanalysis.

We aimed to analyse prescribing patterns of antidepressant monotherapies in Bedford East Community Mental Health Team.

We also aimed to compare the efficacy of antidepressant monotherapies in patients with unipolar depression or patients with depressed mood and also other psychiatric indications within Bedford East Community Mental Health Team, using discharge rates from the out-patient clinic as the outcome measure.

Finally we wished to compare the efficacy of 'the four' versus 'the others' in patients with unipolar depression patients with depressed mood and also other psychiatric indications at within Bedford East Community Mental Health Team , using discharge rates from the out-patient clinic as the outcome measure.

SUBJECTS AND METHODS

We included all patients on an antidepressant monotherapy in Bedford East Community Mental Health Team in our analysis (206 patients in total) (Figure 1).
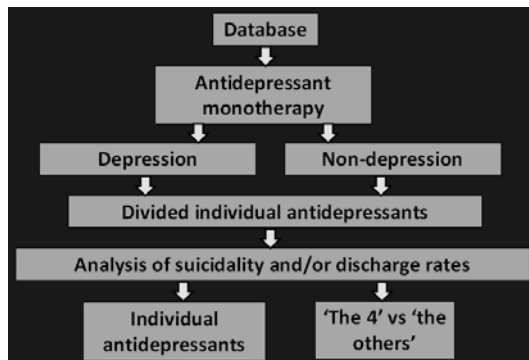

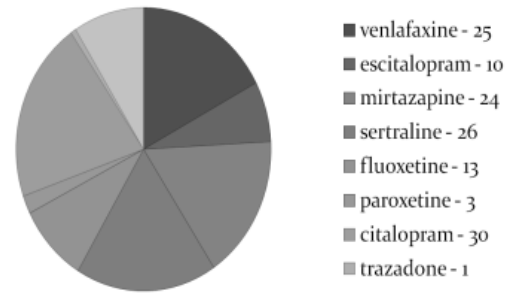**Figure 1.** Flow chart to show patient selection method

Figure 2. Number of patients prescribed an antidepressant monotherapy for unipolar depression

We were able to utilise a database, in the form of a Microsoft Office Excel Spreadsheet, in which the team kept many details of the patients. The database was used in an anonymised form. We examined the clinical notes for each patient to assess whether they were diagnosed with unipolar depression or another psychiatric condition, and whether they had been discharged from the out-patient clinic after being prescribed the antidepressant. This allowed us to calculate discharge rates for each antidepressant monotherapy.
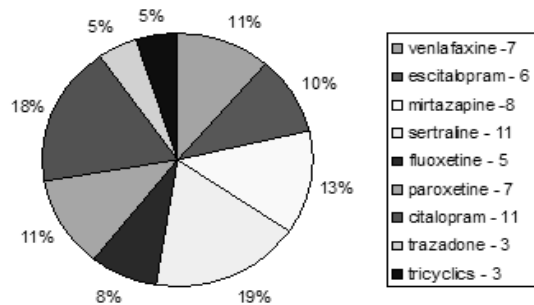

Figure 2b. Number of patients prescribed an antidepressant monotherapy for a psychiatric indication other than depression
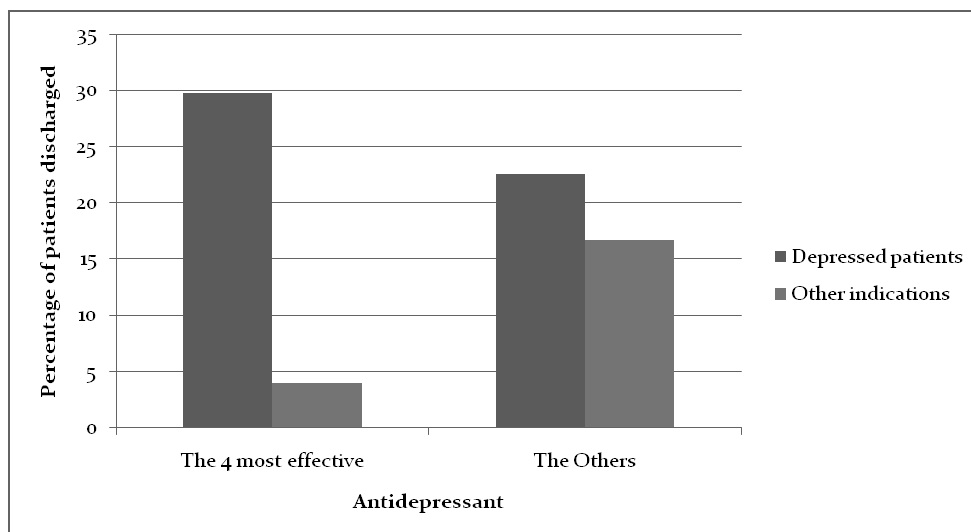

Figure 3. Comparison of the percentage of patients treated for depression or for patients with depressed mood and a psychiatric indication other than depression who were discharged from clinic.

RESULTS

For unipolar depression, the most frequently prescribed antidepressant was citalopram (21%), 59% of patients were prescribed one of 'the four' and 41% were prescribed one of 'the others'. For other psychiatric indications, the most frequently prescribed antidepressant was sertraline (18%), 53% of patients were prescribed 'the four', and 47% of patients were prescribed 'the others'.

For patients with unipolar depression, discharge rates were higher when they were prescribed one of 'the four' and highest when prescribed escitalopram. For patients with other indications, discharge rates were higher for 'the others' and highest for fluoxetine (Figure 3).

A greater percentage of patients with unipolar depression were discharged from clinic compared with patients treated with antidepressant monotherapy for depressed mood and other indications (Figure 4).
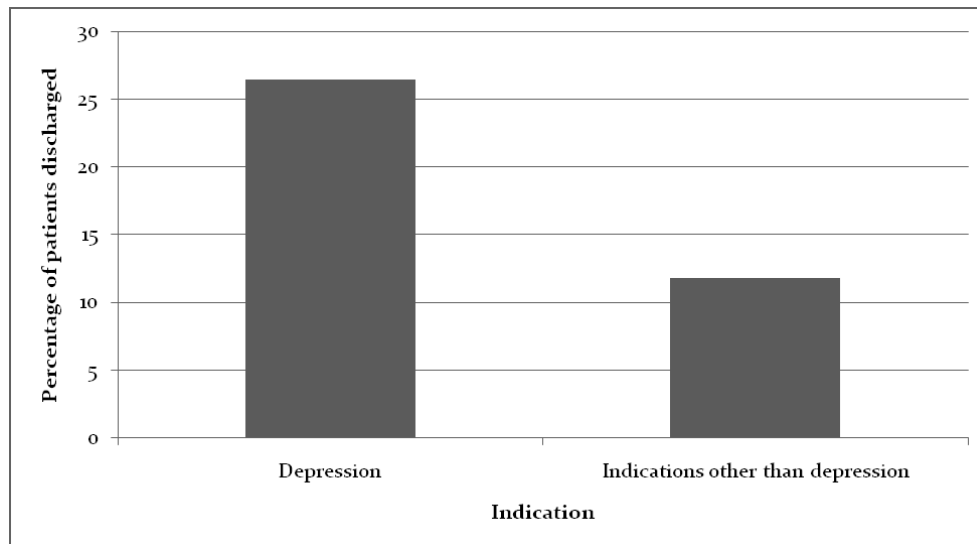

Figure 4. Comparison of the percentage of patients treated for depression or indications other than depression who were discharged from clinic

DISCUSSION

Our results suggest that prescription of 'the four' led to a higher discharge rate than prescription of 'the others' in patients with unipolar depression, but not for those with other psychiatric conditions, where the opposite was true.

A greater percentage of patients with unipolar depression were discharged from clinic compared with people treated for other indications, suggesting that antidepressant monotherapy may be less effective in the treatment of other psychiatric conditions. While patients in this study were known to have other psychiatric conditions , our study illustrates that it is possible that some patients diagnosed with unipolar depression who do not respond to antidepressant monotherapy actually may also have a co-morbid other psychiatric disorder, such as post-traumatic stress disorder, borderline personality disorder, or bipolar affective disorder. Indeed , these were the most common of the other conditions found in the patients we were studying. Hence, co-morbid undiagnosed other mental illness may be a cause of 'resistant depression'.

There are, however, a number of limitations to this study; The number of patients was very small (only 145 in total) so the power of the study is low, however the study was intended to examine prescribing practices in a single CMHT, with the consequent small number of patients.

There were particularly small numbers of patients on escitalopram, and none with suicidal ideation before treatment. The small number of patients on escitalopram was because it had not, at the time of the study, been approved for treatment of depression in the trust formulary.

We did not perform any statistical analyses on the results, so we do not know if the results were statistically significant .

We did not include the dose of the antidepressant, nor did we take into consideration psychosocial therapies which the patients would be receiving concurrently with medication.

CONCLUSIONS

This audit in a small group of patients suggests that when prescribed antidepressant monotherapy, more patients with unipolar depression are discharged from clinic than those who also had other psychiatric conditions. For patients with unipolar depression prescription of 'the four' caused the greatest discharge rate, but for other indications prescription of ' 'the

others' caused the greatest discharge rate. This suggests the most efficacious antidepressant to prescribe depends on the indications which are present. Hence, in our sample, Cipriani's recommendations for anti-depressant choice do not hold good when there is another co-morbid psychiatric condition as well as depressed mood. We recommend that audits such as this on antidepressant prescribing in the CMHT be carried out on a yearly basis in order to ensure best practice in choice of antidepressants. We further recommend that care must be taken in the diagnostic process in order to identify any existing co-morbidities in patients presenting with depressed mood.

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