A COMPARISON OF OUTCOMES OF PATIENTS WITH DEPRESSION, RECURRENT DEPRESSION, AND DEPRESSION AND ANXIETY WITHIN PATIENTS IN A BRITISH CMHT

Sophie Butler[2], Mark Agius[1,3] & Rashid Zaman[1,3]

[1]*South Essex University Partnership Foundation Trust, UK*
[2]*School of Clinical Medicine, University of Cambridge, UK*
[3]*Department of Psychiatry, University of Cambridge, UK*

SUMMARY

Introduction: Many patients in Community Mental Health Teams have a diagnosis of depression F32, recurrent depression F33, and depression and anxiety F41.2, and such patients are often considered by team managers as being suitable for discharge to primary care. It is necessary to describe factors that influence outcomes, specifically discharge, in order to identify suitable patients who might continue their treatment in primary care.

We aimed to assess the influence of suicidality, alcohol and drug abuse and augmentation strategies on the discharge status of patients treated by the Bedford East Community Mental Health Team (BECMHT) who have been diagnosed with depression in each of the three groups F32, F33, and F41.2.

Subjects and Methods: Using the team database, we identified 168 patients with depression F32, recurrent depressive disorder F33 and depression and anxiety F41.2. We then established their discharge status (discharged, enhanced CPA and normal CPA) and identified factors that may influence the discharge status (suicidal ideation, alcohol and drug problems and augmentation therapy). Outcome as measured by patient discharge and the prevalence of each factor was compared in the three groups.

Results: The group who had been diagnosed with a depressive episode, F32 , were less likely to be discharged and appeared to be more likely to suffer from alcoholism, illicit drug abuse, and suicidality.

Discussion: Arguably, the F32 group could be a more heterogeneous group of patients, F32 becoming a 'default diagnosis' into which both patients with a discrete 'depressive episode' and patients with a 'depressive episode plus other problematic factors' were put, while the F33 and F42.1 groups were more clear cut.

Conclusion: Suicidality, alcoholism, and illicit drug use clearly impact on the outcomes of patients in the diagnostic groups studied.

Key words: *depressive episode - recurrent depressive disorder - depression with anxiety – suicidality - alcohol abuse - illicit drug abuse*

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INTRODUCTION

Treatment of patients with depression in English Community Mental Health services usually follow the guidelines laid down by the National Institute for Health and Clinical Excellence (NICE 2007). Our team have recently developed guidelines as to how to develop models of shared care between primary and secondary care for such patients (Agius et al. 2009). Depression treatment and outcomes within British Community Mental Health Teams (CMHTs) have not been adequately described. It is generally believed that if possible, one should treat patients in primary care (Agius et al. 2005) and so it is necessary to describe factors that influence outcomes, specifically discharge, in order to identify suitable patients. Many patients in Community Mental Health Teams have a diagnosis of depression F32, recurrent depression F33, and depression and anxiety F41.2, and such patients are often considered by team managers as being suitable for discharge to primary care. We decided to audit the frequency at which patients with these three conditions were discharged to primary care, in order to identify factors which affect this frequency.

We aimed to assess the influence of suicidality, alcohol and drug abuse and augmentation strategies on the discharge status of patients treated by the Bedford East Community Mental Health Team (BECMHT) who have been diagnosed with depression in each of the three groups F32, F33, and F41.2.

SUBJECTS AND METHOD

From an anonymised database of BECMHT patients we identified 168 patients with depression (F32, F33 and F41.2). We then extracted data on patients, firstly on the discharge status (discharged, enhanced CPA and normal CPA) and secondly on factors that may influence the discharge status (suicidal ideation, alcohol and drug problems and augmentation therapy). Outcome as measured by patient discharge and the prevalence of each factor was compared in the three group.

RESULTS

In the F32 groups 12.24% of patients were discharged compared with 30.53% and 29.17% in groups F33 and F42.1 respectively. The F32 group also

had the greatest percentage of patients in the CPA enhanced group 71.43% compared to 58.95% and 58.33% in the F33 and F42.1 groups.

In group F32 55.10% of patients had the factor suicidality compared to 27.37% and 25.00% in F33 respectively. There were more alcohol and drug problems in F32 (32.65% and 14.28%) compared with F33 (9.47% and 1.05%) and F42.1 (8.33% and 8.33%). There was a higher proportion of patients on augmentation therapy in group F42.1 (54.17%) than F32 (38.77%) and F33 (27.37%).

DISCUSSION

Arguably, the F32 group could be a more heterogeneous group of patients, F32 becoming a 'default diagnosis' into which both patients with a discrete 'depressive episode' and patients with a 'depressive episode plus other problematic factors' were put, while the F33 and F42.1 groups were more clear cut.

In the group F32 that has the least discharges there are higher numbers of patients with suicidal ideation, alcohol problems and drug problems (particularly cannabis).

Arguably, patients with a simple diagnosis of a depressive episode F32 who come into secondary care are those with important complicating factors such as suicidality and drug or alcohol abuse, since most patients with a simple depressive episode can be treated in primary care, and are only referred if they present problems.

The highest percentage of patients on augmentation therapy is in the F42.1 group probably because of using a second medication to reduce the anxiety.

Fewer patients are discharged from the F32 group, mirroring the increased suicidality and drug and alcohol use in this group. It does not appear that there is a significant difference in the number of patients using augmentation strategies between the F32 and F33 groups, but the number of discharges are significantly lower in the F32 group, mirroring that there are problems, including drugs and alcohol which need be dealt with in the F32 group. At present, in our series, it does not appear certain that augmentation strategies for treating depression specifically are having a clear influence on outcomes

CONCLUSION

We have identified some of the factors that influence the outcomes of the treatment of depression in CMHT's. Further work is warranted to define these. We aim to produce further data on factors that contribute to effective treatment of suicidality teams, as well as investigating the use of augmentation strategies for treatment of depression.

We recommend that repeated audits of the influence of suicidality , alcohol, and illicit drug use in these three groups of patients are carried out in CMHTs in order that improved treatment strategies be adopted and outcomes of depression treatment be improved.

REFERENCES

1. *Agius M, Martic Biocina S, Alptekin K Rotstein V, Morselli P & Persaud A: Basic Standards for Management of Patients with Common Mental Illnesses in Primary Care. Psychiatria Danubina 2005; 17:205-221.*

2. *Agius M, Zaman R & Klepacka K: Developing guidelines for the treatment of resistant unipolar depression across primary and secondary care European Neuropsycho-pharmacology 2009; 1 9 Supp 3;S428.*

3. *NICE Depression (amended): management of depression in primary and secondary care. NICE clinical guideline 23 (amended). National Institute for Health and Clinical Excellence. 2007.*

Correspondence:

Mark Agius MD
SEPT at Weller Wing, Bedford Hospital
Bedford, Bedfordshire, MK42 9DJ, UK
E-mail: ma393@cam.ac.uk