

Antidepressants use among depressive patients of Hawler psychiatric hospital / Erbil – out patient clinic

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Abstract

Background and objective: Depression is widely recognized as a major public health problem around the world. The mainstay of treatment is the prescription of antidepressants although, psychological treatments have found a place as an alternative to antidepressants in milder forms of depression, this study had been done to identify whether antidepressant use among depressive patients in adult psychiatric consultation of Hawler psychiatric hospital is consistent to the last NICE guidelines of antidepressant prescription.

Methods: Fifty Samples collected between 19.June.2016 to 18.August.2016 from adult psychiatric consultation clinic of Hawler psychiatric hospital/ Erbil. We interviewed the patients with Major Depressive Disorder about how they used antidepressant for their illnesses, in addition to that we look for registered notes in patient's follow up files, and in some conditions we asked responsible psychiatrist for further clarifications. All days of week were included from Saturday to Thursday, to cover all psychiatrists in charge with the service.

Results: We found there were differences in some points of the way of using antidepressants for depressed patients in psychiatric consultation comparing to the NICE guidelines like drug category selection, and discussion with patients, while in another point there were similarities like period of drug use.

Conclusion: Not every point that mentioned by the NICE guidelines is applied on our patients may be for many reasons, we may need to put local guidelines by present care givers on the base evidences from our society, culture, and patients types.

Keywords: Hawler, Antidepressants, Guidelines

Introduction

Mood can be defined as a pervasive and sustained emotion or feeling tone that influences a person's behavior and colors his or her perception of being in the world.¹

Depression is part of normal experience to feel unhappy during times of adversity. The symptom of depressed mood is a component of many psychiatric syndromes, and is also commonly found in certain physical diseases (e.g. in infections such as hepatitis, and some neurological disorders), but with the syndromes known as depressive disorders. The central features of these syndromes are:

- ✓ depressed mood
- ✓ lack of enjoyment
- ✓ Slowness.
- ✓ negative thinking
- ✓ reduced energy

Among all of these, depressed mood is usually, the most prominent symptom.²

Patients are classified as having major depressive disorder, recurrent, who are experiencing at least a second episode of depression.¹

Depression is, of course, widely recognized as a major public health problem around the world. The mainstay of treatment is the prescription of antidepressants although, nowadays psychological treatments have found their role as an alternative to antidepressants in milder forms of depression. Other methods of treating depression remain somewhat experimental and are not widely available like (vagal nerve stimulation [VNS], transcranial magnetic stimulation [TMS], etc.³

Comparing with the tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs), Selective serotonin reuptake inhibitors (SSRIs) are well tolerated and are generally recommended as first-line pharmacological treatment. And all types of antidepressants are associated with a range of side effects, with ability to cause discontinuation symptoms.³

In Hawler Psychiatric Hospital, there is adult psychiatric consultation, where patients above 18 years age-old are seen by psychiatrist, there are many patients with depression prescribed for them antidepressants, here in this study, we will compare prescribing antidepressants for depressive patients in adult psychiatric consultation to last NICE guidelines.

Aim

To identify whether antidepressant use among depressive patients in adult psychiatric consultation of Hawler psychiatric Hospital is consistent with last NICE Guidelines of prescribing antidepressants among depressive patients.

Data Collection Methodology

- Fifty Samples collected between 19.June.2016 to 18.August.2016
- We interviewed with patients about how they used antidepressant for their depression, with looking for registered notes in patient's follow up files, and if necessary we asked responsible psychiatrist for any clarifications.
- Each interview lasts about 10 minutes.

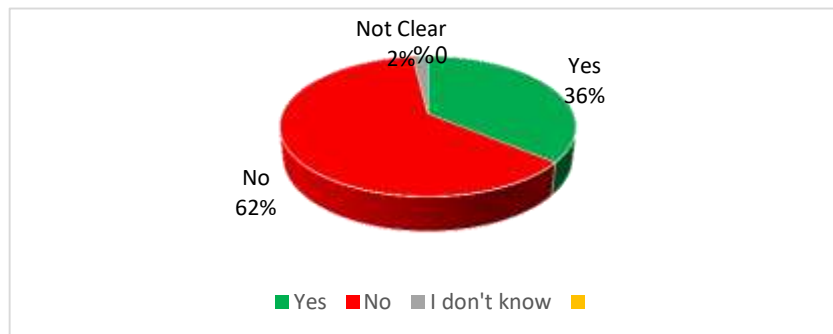
- Other psychiatric illnesses those comorbid with depression had been excluded for example patient with Obsessive compulsive disorder (OCD) comorbid with depression. and psychotic depression were excluded.
- Age above 18 years included.
- All days of week were included from saturday to thursday, to cover all psychiatrists in charge with the service.
- We did interview with all included patients those visited adult psychiatric consultation except:
 - 1-Those who refused to participate after we clarified for them the aim of the study, they excused by many reasons mainly they were on hurry, and they don't have time, some of them didn't have interest to participate.
 - 2- Sometimes our consultation was too crowded we didn't have time to interview with patient and provide privacy for those who included in this study.
- Consent taken verbally from the patients, after clarification of the aim of the study, and we insure the patients that we are not about to change or interfere with their treatment.
- We used the following paper during the interview, in full private and confident environment.

Results

- 1- Discuss with the patient choice of drug and utility/availability of other, non-pharmacological Treatments.



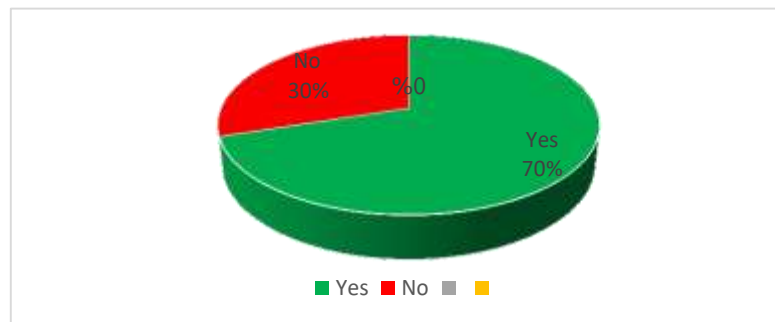
- 2- Discuss with the patient likely outcomes, such as gradual relief from depressive symptoms over several weeks.



- 3- Prescribe a dose of antidepressant (after titration, if necessary) that is likely to be effective.



- 4- For a single episode, continue treatment for at least 6–9 months after resolution of symptoms (multiple episodes may require longer).

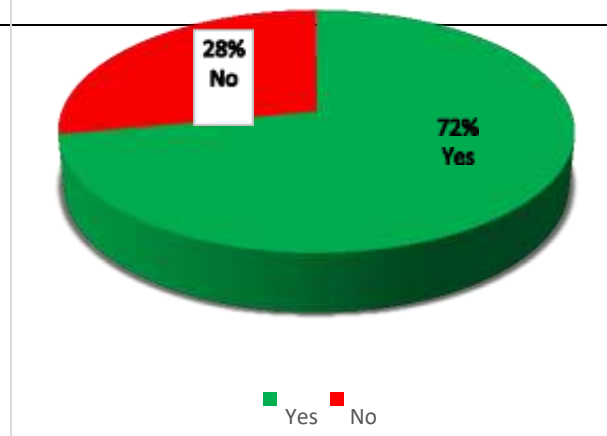


- 5- Withdraw antidepressants gradually; always inform patients of the risk and nature of discontinuation symptoms.
- There were no any patients found that needed his medication to be withdrawn by the psychiatrist.
 - There were no any patients found that had been informed about the risk and nature of discontinuation symptoms.

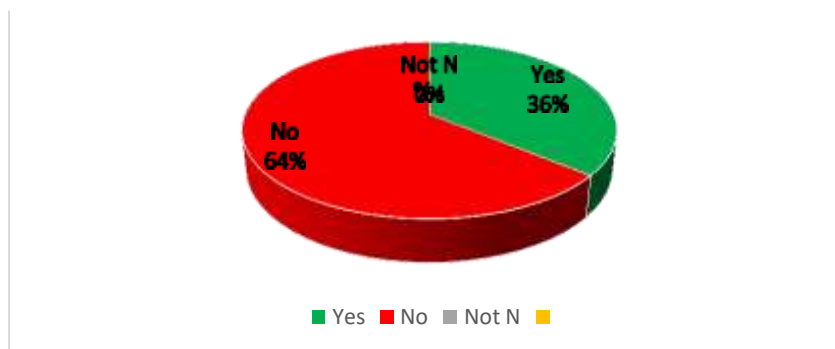
6- Antidepressants are not recommended as a first-line treatment in recent-onset, mild depression. active monitoring, individual guided self-help, cognitive behavioral therapy (CBT) or exercise is preferred.

Antidepressants are recommended for the treatment of moderate to severe depression and for dysthymia. Because the severity of depression is not specified for any one, and we didn't find any patient without treatment with medication even from their first visiting to the consultation, all of them only treated by medications

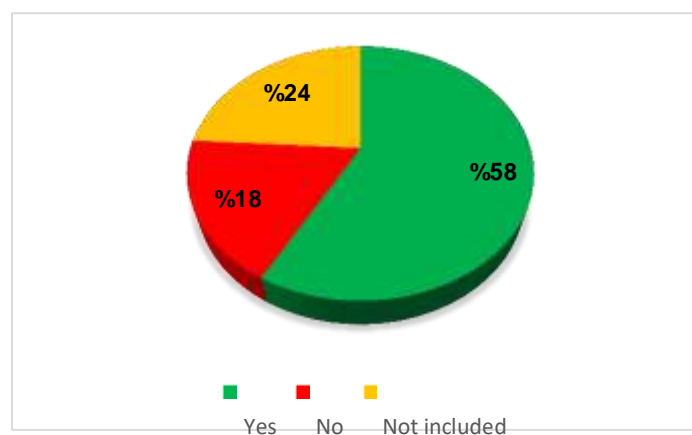
- 7- When an antidepressant is prescribed, a generic selective serotonin reuptake inhibitor (SSRI) is recommended.



8- For treatment-resistant depression, recommended strategies include augmentation with lithium or an antipsychotic or the addition of a second antidepressant.



9 - Patients with two prior episodes and functional impairment should be treated for at least 2 years.



10 - The use of electroconvulsive therapy (ECT) is supported in severe and treatment resistant depression.

Among our 50 Cases only 3 cases receive ECT, only One of them he had resistant depression; the second one has suicidal ideation, while the last one the indication of ECT was not clear.

Discussion

Our study shows that only one case (2%) who participated in our study, the responsible psychiatrist discussed with him the choice of drug and utility/availability of other, non-pharmacological treatments, while 48 cases (96%) this discussion never occurred, one case (2%) was not clear if this discussion occurred or not, because this patient didn't remember exactly whether this discussion was done with him or not, there was no any record in his follow up file. Maybe these results due to insufficient time at the consultation, and/or related to our patient population type those visited the consultation, 40% of them they never entered the primary school, 40% didn't finish from primary school, 16% didn't finish their secondary school, so in such low educational level may be discussions of such issues is difficult.

Eighteen cases (36%) informed by the psychiatrist about the likely outcomes of antidepressant use, such as gradual relief from depressive symptoms over several weeks, while 31 cases (62%) not informed, one case (2%) was not clear, because this patient didn't remember whether he informed about this information or not.

Also in 27 cases (54%) psychiatrist prescribed a dose of antidepressant that is likely to be effective with titration, in 23 cases (46%) titration not done for them and their medications changed while they were on minimal effective doses or less than minimal effective doses.

Thirty five cases (70%) for their first episode continue treatment for at least 6–9 months after resolution of symptoms, but all of them before starting to discontinue their antidepressants they developed another depressive episode. 15 cases (30%) discontinue their treatment before this time in their first depressive episode, they discontinue by themselves when they felt better, and some of them follow the traditional healers' advice to stop receiving medications. Apart from patient and family attitudes toward psychiatric disorder and its treatment, expense of the drug with low income, and reduced productivity among psychiatrically ill patients, in addition to fear from drug dependence.

There were no any patients found that needed his medication to be withdrawn by the psychiatrist, apart those patients who were in their first episode, no any patient reach to the point of need to withdraw his medications, either they discontinue by themselves or they developed new depressive episode.

There were no any patients found that had been informed about the risk and nature of discontinuation symptoms. Antidepressant discontinuation symptoms are important as they can cause morbidity, affect adherence to antidepressant treatment, prevent antidepressants being stopped and can be misdiagnosed, leading to inappropriate treatment. In most patients, discontinuation symptoms are self-limiting; of short duration and mild, but in a minority of cases they can be severe, last several weeks and cause significant morbidity.¹⁴

For example there was report of two patients who developed a severe discontinuation (withdrawal) reaction following stoppage of paroxetine and venlafaxine, respectively. Neurological symptoms were prominent and neither patient could walk unaided. Both patients feared they had suffered a 'stroke' and arranged an emergency medical consultation. One patient was correctly diagnosed, the antidepressant was recommenced and symptoms resolved within 24 h. Failure to recognize the reaction resulted in the other patient being referred to a neurologist, undergoing a computed tomography brain scan and an electroencephalogram and remaining symptomatic for over 8 weeks.⁷

And developing withdrawal symptoms is differ among different antidepressants, for example in a randomized clinical trial done in 1999 about Selective serotonin reuptake inhibitor discontinuation syndrome, they found abrupt interruption of antidepressant therapy for 5-8 days was associated with the emergence of new somatic and psychological symptoms in patients treated with paroxetine and to a lesser degree sertraline, with few symptoms seen with fluoxetine.⁸

Severity of depression is not specified for any one, and we didn't find any patient without treatment with medication even from their first visiting to the consultation, all of them only treated by medications. Small sample size may affect the results, apart from that short period of the consultation with crowded patients, and unavailable other modalities of treatment, made a situation that specification of the severity may be useless and carry no benefits to the patients in the management process in our consultation, except when indicated to be admitted to the hospital or need electroconvulsive therapy ECT, and both of them are available in our hospital, we have bed for admission and ECT unit.

Thirty six cases (72%) a generic selective serotonin reuptake inhibitor (SSRI) is prescribed for them, while 14 cases (28%) they started their treatment with Tricyclic Antidepressants (TCA).

In this study we used NICE guidelines as a standard to be compared and they choose Selective serotonin reuptake inhibitors (SSRIs) as first line.

SSRIs are well tolerated compared with the older tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs), and are generally recommended as first-line pharmacological treatment for depression.³ and in this study Psychotic depression not included. TCAs are probably the drugs of first choice in psychotic depression.³

In one meta-analysis of efficacy and acceptability of SSRIs versus TCA in young patient aged 7 to 25 years done in 2014, they found SSRIs were significantly more effective than TCAs in primary efficacy. Patients taking SSRIs had a significantly greater response to depressive symptoms than patients taking TCAs.¹⁰

In another systemic review and meta-analysis done in 2013, SSRI versus TCA (six RCTs): There was no statistically significant difference between SSRI and TCA for response or remission. SSRI showed significantly lower drop-out and adverse event outcomes compared to TCA.¹¹

In a systematic review of Chinese randomized clinical trials of SSRI treatment of depression done in 2014, In terms of efficacy, SSRIs were statistically significant superior to TCA (response rate, remission rate), which is inconsistent with most western meta-analyses which have indicated comparable efficacy between SSRIs and TCAs, or showed that TCAs were more effective than SSRIs. And no significant differences were observed regarding dropout rates due to side effects, this is not in line with evidence from Western trials suggesting superiority of SSRI over TCA in terms of tolerability and dropout rates. TCA was associated with a higher prevalence of adverse effects in Drowsiness, Anxiety, and Dry mouth etc.¹²

So higher prevalence of adverse effects that cause dropout in TCA comparing to the SSRIs make superiority of the SSRIs as first line of pharmacotherapy, a part from that serious cardiac side effects of TCA, make SSRIs more preferable as first line.

For treatment-resistant depression, 32 cases (64%) treated as resistant depression from the beginning, here we mean they received antidepressants with low dose of antipsychotics from the first psychiatric consultation without giving any chances to antidepressants alone in its therapeutic doses, may be they started their treatment in other areas like private clinics or psychiatric hospitals from another areas, then they came to our

consultation with their treatment just for opening follow up files and receiving medications from the hospital, so they stayed on their old treatment with possibility of their insistence.

18 cases (36%) either treated as resistant depression after diagnosed as a resistant depression or they are in correct process of treatment till now you cannot diagnose them as a resistant depression and neither receiving two antidepressant nor antipsychotic with antidepressant.

29 Cases (58%) had history of prior two episodes continue their treatment for two years and more, 9 Cases (18%) had history prior of two episodes not received treatment as described above , 12 Cases (24%) not included.

Among our 50 Cases only 3 cases receive ECT, One of them he had resistant depression, the second one has suicidal ideation, while the last one the indication of ECT was not clear.

Other factors may explain the results

In a survey of 1878 Canadian physicians, 22% to 26% had concerns about loss of autonomy, the rigidity of guidelines and decreased satisfaction with medical practice.⁵

So when we look to these percentages we realized that guidelines something not constant, therefore frequently these guidelines changed with time because of new and more researches about disorders and their treatments. With taking on consideration the 5 specific areas in developing guidelines, these 5 specific areas are clinical guidelines, social care guidelines, medicines practice guidelines, safe staffing guidelines, guideline development process.¹³

A. Insufficient time

- 1- Hawler psychiatric hospital consultation, received a large number of patient every day within limited time every day, for example daily there are about 30 – 50 cases of different psychiatric presentation coming to the consultation within 3.5 hours, which mean about 4-7 minutes for each patient, so this very short time restrict the psychiatrist to follow these guidelines.
- 2- Absence of professional referral system in Hawler government, make psychiatric consultation received many medical and neurological cases which consume time and sometimes mislead the psychiatrist.

Two studies done in other field than psychiatry about following guidelines in managing the patients, in one study(sample consisted of a random sample of 488 physical therapist in the United States who were members of the American Physical Therapy Association (APTA) in July 2002). 46% percent of the respondents indicated insufficient time was the most important barrier to the use of evidence in practice.⁶this is done in United States although their referral system better than in our country, still they complaining from insufficient time, so what about our consultation with such huge numbers of patients within limited time.

While in another study which is Cabana and associates reviewed 76 articles that investigated barriers to physician use of clinical practice guidelines, they mentioned lack of time is one of the barrier.⁹

So time is important factor to follow guidelines in daily practising and managing the patients, and may be the most important challenge to be solved.

B. Lack of facility

- 1- Availability of antidepressant in our pharmacy is another point that restrict psychiatrist for choosing the antidepressants say nothing of discussion with the patient about the choice of drug and utility/availability of other.
- 2- Non-pharmacological treatment like psychotherapy not available because there are no Clinical Psychotherapist work in hospital to receive patients and make psychotherapy sessions for them, a part from some non-professional social worker present.
- 3- Financial problems of the patients restrict psychiatrist to prescribe what is available in hospital pharmacy. As mentioned in one of descriptive study about ‘Why do GPs not implement evidence- based guidelines? They mentioned financial considerations making the subject a low priority.⁴

C. Patient’s characteristics those visiting our consultation

1-Level of Education

Twenty cases (40%) illiterate, 21 cases (42%) not finished the primary school, 8 cases (16%) not finished the secondary school, and just 2 cases (4%) graduated from the university.

This is another big challenge to follow the guidelines, for example they don’t have any scientific information, so how you can discuss with them about the choice of the treatment way.

2- Patient population

Almost all of our patients want rapid recovery from the depression and during the follow up they frequently blaming their psychiatrist and their prescribed medication not help them, sometimes they discontinue their medications because of they didn’t get benefit from it, and tried to consult traditional healers whose they are present everywhere with easily accessible to their places. So psychiatrist may be obligated to enhance the speed of prescription of medications and shifting from the guidelines to not lose the patient for long time if not for ever.

In one study that done in other medical specialty, approximately 30% of the respondents rated lack of generalizability of research findings to their specific patient population and the inability to apply findings to individual patients with unique characteristics as important barriers.⁶

In descriptive study about ‘Why do GPs not implement evidence-based guidelines?’ several barriers to the implementation of evidence-based guidelines in the management of hypertension in the elderly were identified. They found doubts about the applicability of trial data to particular patients is another barrier to follow the guidelines.⁴

D- Factors related to the psychiatrists (Knowledge, attitudes toward the guidelines)

In this study we didn’t ask psychiatrist about his or her knowledge, attitude or any factor that may prevent psychiatrist avoid to use a guidelines.

Cabana and associates⁹ reviewed 76 articles that investigated barriers to physician use of CPGs. They found 293 barriers that they divided into 3 broad groups, based on physician knowledge (lack of awareness and familiarity with the guidelines), attitudes (resistance to changing prior patterns of practices, lack of agreement with specific guidelines, lack of agreement with guidelines in general, concerns about whether the guidelines would work, and concerns about whether the clinician would be able to implement the guidelines), and external factors (difficulty or complexity of the guidelines, inconvenience of guideline implementation,

patient resistance, and lack of time, reminders, and resources). The authors noted that few studies examined the full variety of barriers that may affect the use of practice guidelines.^{8,9} And Lack of interest was chosen as an important barrier by 11% of the respondents,³ in another study.

Conclusion:

Not every point that mentioned by the NICE guidelines is applied on our patients may be for many reasons, we may need to put local guidelines by present care givers on the base evidences from our society, culture, and patients types.

Recommendations

- 1- Referral system need to be improved, because many cases those visiting psychiatric consultation, either pure neurological, or medical cases that should be referred to neurological or medical consultation, and there are many simple cases that can be treated in primary health care and no need to be seen by psychiatrist at consultation. By this way we may save more time to deal with indicated psychiatric cases.
- 2- Working on developing our guidelines those are more appropriate to our society, population, available facilities, with getting benefits from other international guidelines and recent related studies.
- 3- Looking for the causes why our psychiatrist not follow these guidelines and working on any treatable causes.
- 4- Provide support and different psychotropic medications in our pharmacy to solve the problem of availability of these medications continuously.
- 5- Working on providing Clinical psychotherapist and psychotherapy session.
- 6- Psychoeducation among people about different psychiatric issues by using different available ways including media and social networks.

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