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Cochrane Nursing Care Field – Cochrane Review Summary

Prepared for the

Issues in Mental Health Nursing

Continuation and maintenance treatments for depression in older people

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Background:

This summary is based on a Cochrane review (Wilkinson & Izmeth, 2016) that explores ongoing treatments for depression in older people to prevent relapse and recurrence. With population ageing (United Nations, 2017), it is important to recognise any idiosyncrasies between depression in older and younger individuals, to provide more personalised nursing care. This review focusses on the continuation and maintenance phase of care, as whilst many older people are treated with antidepressants (Percudani, Fortino, & Petrovich, 2005), and the short-term effects of this are thought to be good (Katona & Livingstone, 2002), we also need to consider how best to sustain good mental health after clinical recovery.

Determinants of depression in later life may vary from younger adults (Aziz & Steffens, 2013); therefore assessing the effectiveness of interventions, which have contrasting mechanisms of action, may warrant differential examination for older adults. When considering treatment options with older adults, the potential adverse effects of medications and pharmaceutical interactions when treating multiple morbidities also requires careful consideration. Antidepressant drugs (particularly selective serotonin reuptake inhibitors, SSRIs), have for example been associated with increased risk of falling, multiple falls, and injurious falls (Kerse et al., 2008). These adverse outcomes are important determinants of health in older people, with associated morbidities compounding the disability experienced with depression (Xu & Rivera Drew, 2018).

Objectives:

This review aimed to explore the effectiveness of antidepressants and psychological therapies, on their own or in combination, for preventing relapse and recurrence of depression in older people.

Intervention/Methods:

This review included randomised trials comparing treatments for people 60 years or over (any setting), in which some or all of whom were in remission or

had recovered from depression. Trials including people with bipolar disorder, dementia, and other severe mental disorders were excluded.

The review scope included any antidepressant (any dose), and any structured psychological therapy (any duration/intensity). Interventions could be compared to each other, placebo, or 'treatment as usual'/waiting list control. Studies on electroconvulsive therapy, antipsychotic medication, lithium, or in which some therapy recipients were not the older person (e.g. family therapy), were excluded. Included trials needed to randomise participants at the continuation/maintenance phase of their care. The primary outcomes were recurrence of depression and participant drop-outs at one year.

The authors searched (to July 2015) the specialised register of the Cochrane Common Mental Disorders Group (covering Medline, Embase, PsychINFO, and CENTRAL), clinical trials registries, reference lists, conference abstracts, and hand searched four journals. Authors conducted study selection, data extraction, and risk of bias assessments independently in duplicate, resolving disagreements through discussion. Treatment effects were calculated using risk ratios, 95% confidence intervals, and random effects meta-analysis.

Results:

Seven studies (803 participants; range: 43 to 305 participants) were included. There was low quality evidence that antidepressants alone (RR = 0.67, 95% CI 0.55 to 0.82; 3 trials, 247 participants), or nortriptyline combined with Interpersonal Therapy (RR = 0.42, 95% CI 0.23 to 0.77; 1 trial, 54 participants) is more beneficial than placebo. There were no differences in any of the other active treatment comparisons examined (based on limited studies), nor in Interpersonal Therapy alone versus placebo. Data on number of drop-outs were sparse, and where present showed no difference between treatments.

Conclusions:

The review authors conclude that the benefits and harms of long-term antidepressant continuation for preventing depression recurrence in older

people are not clear. Nurses should be mindful that although there was a beneficial effect for antidepressants at 12 months, and antidepressants appeared no more harmful than placebo, the studies contributing these data were small, with different populations and variations in medications assessed. Data from other treatment comparisons were also too limited to draw firm conclusions. The quality of the evidence summarised in this review was deemed to be low. Faced with no firm conclusions from the research evidence, the most sensible approach for nursing care is to continue as usual (following clinical guidelines) until further evidence becomes available.

Implications for Practice:

The National Institute for Health and Care Excellence (NICE, 2018; further update in progress) offers guidance for adults of all ages. For older people, it highlights that antidepressants should be prescribed at an age-appropriate dose considering general health and concomitant medication interactions, and to monitor side effects (Van Damme, Declercq, Lemey, Tandt, & Petrovic, 2018). The guidance for continuation and maintenance is to encourage continued antidepressant use for at least six months for those who have benefitted from them, and for two years or more if the individual risks relapse, with careful monitoring. NICE (2018) also recommends that those with significant risk of relapse or residual symptoms are offered cognitive behavioural therapy or mindfulness-based cognitive therapy. Nurses remain part of an important shared decision-making process, informing and discussing with patients their treatment options, signposting to wider support networks as required, to determine the best plans for individuals as part of patient-centred care.

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