Phase 3b Quality Improvement Project:

Monitoring of SSRI Prescribing in Adults at Richmond Medical Centre

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Introduction

Selective Serotonin Reuptake Inhibitors (SSRIs) are becoming more commonly prescribed, with 16.6% of the adult population being prescribed an antidepressant of some form between 2017 and 2018 compared to 15.8% in 2015-2016, SSRIs being the most commonly prescribed class of antidepressants[1]. Proper prescribing practice is therefore critical to ensure that SSRIs are being used safely and effectively for a large patient population.

Richmond Medical Centre has a greater than average antidepressant prescription rate, with 1274 patients of 5964 adults in the practice population (21.4%) receiving a prescription for an antidepressant within the 2017-2018 timeframe. This is likely partially due to Richmond being the ninth most deprived ward, out of 28, in Sheffield[2], as lower socioeconomic status is a well-established risk factor for developing anxiety and depression[3] [4]. Patients from lower socioeconomic backgrounds are also less likely to make positive decisions regarding their health[5]. Therefore, doctors in these areas must advocate for their patients to make more informed choices regarding their health and wellbeing.

NICE guidance lays out various recommendations on how to safely and effectively prescribe SSRIs to have the best chance of avoiding relapses of anxiety and depression while also minimising the chances of adverse effects. They state that each patient should receive an offer of psychotherapy, often in the form of CBT, to all patients regardless of the severity of their condition. NICE guidance on the treatment and management of depression was also updated during this audit (29/6/22), and new changes to the guidance have been reflected in the discussion.

Method

Patients that fit the audit criteria were identified using SystmOne's clinical reporting tools. The clinical report generated identified patients who had been prescribed an SSRI medication for the first time within the last 12 to 24 months (between 8/6/20 and 7/6/21. A further filter was implemented only to include patients who were registered with the practice and were over 18 years of age at the time of the first SSRI prescription. This identified 237 patients, of which 50 were selected by a random number generator to be included in the audit population.

Each patient's journal was then read for relevant consultations and categorised against four binary criteria, making up the final data used in this audit. All data was then recorded and processed anonymously using Google Sheets.

This time frame of 12 to 24 months was selected to allow time for patients to reach a stage of remission/partial remission to enable the criteria to be assessed in as many patients as possible while still having a discrete amount of time (one year) over which the interventions took place.

Criteria and standards

When formulating criteria and standards, the focus was on creating evidence-based criteria which were also relevant to observed clinical practice. This allowed the audit to be both relevant to national and local practice. These criteria and standards were then discussed with the GP supervising the project to understand whether the criteria and standards were sensible, achievable, and relevant to current practice.

1) Was CBT or other psychological therapy offered or discussed at the initial presentation (90%)

NICE guidance states that all patients requiring SSRI treatment for depression and anxiety should be considered for psychological interventions such as CBT. For depression, psychotherapies are included in the treatment algorithm for all severities, including an SSRI prescription[6]. For anxiety and panic disorders, NICE guidance has CBT as 'step 2' in the stepwise management, with step 3 being an SSRI[7].

All patients with anxiety/depression severe enough to warrant SSRI use have been proven to benefit from psychological therapies such as CBT, as reflected in two recent meta-analyses assessing the efficacy of CBT for anxiety and depression of various severities. Both papers concluded that CBT significantly improved outcomes at all severities of both conditions[8] [9]. Therefore, the standard for this criterion was set at 90% as there is little indication for it not being discussed with the patient.

2) Has a follow-up date been set once the patient has stated remission/partial remission (90%) and 3) Of patients offered follow-up, is the follow-up date met (80%)

NICE guidance strongly suggests that patients, even in partial remission, have follow-up appointments every six months when undergoing therapy for depression. This is to reassess the need for treatment and to optimise therapy to reduce the risk of relapses. The most recent release of the NICE guidance has moved toward treating patients in partial remission the same as 'full' remission, with a view to relapse prevention at this point in treatment[6].

A recent systematic review of follow-up in depression has highlighted the importance of regular reviews in relapse prevention and found using a 'chronic care model' of reviewing patients regularly with an emphasis on 'collaborative care', a model of using

a multidisciplinary approach with “proactive and scheduled patient follow-up” and “enhanced inter-professional communication” was the most effective at preventing relapse[10].

The standards for these criteria were selected as 90% for criteria two as guidance states that regular long-term follow-up is beneficial for all patients in the preventing relapse stage of treatment and 80% for criteria three as there are more factors which may impede the follow-up from taking place such as patients not attending and human error with booking the follow-up appointment.

Not all patients were included in these criteria. Patients were excluded from criteria two if they did not state remission or partial remission during the audit timeframe. Patients were excluded from criteria three if they did not meet criteria two.

4) Was antidepressant continuation/discontinuation risks and benefits discussed at the follow-up appointment (80%)

NICE guidance has recently been updated with more information on how to avoid relapses in patients with depression. It emphasises shared decision-making in the long-term relapse prevention plan. It suggests for patients at low risk of relapse; antidepressant therapies should be considered for discontinuation. They also recommend that patients at higher risk of relapse consider a course of treatment best for them, including continuing medication at remission doses or stopping medication with Mindfulness-Based Cognitive Therapy (MBCT) or group CBT alongside tapering the medication. NICE advises that patients should be informed of the risks of relapse if drug treatment is discontinued and the risks of staying on SSRIs long-term, for example, increased bleeding risk and long-term sexual dysfunction. The decision to continue/discontinue therapy should be constituted of the risk of relapse, risk of long-

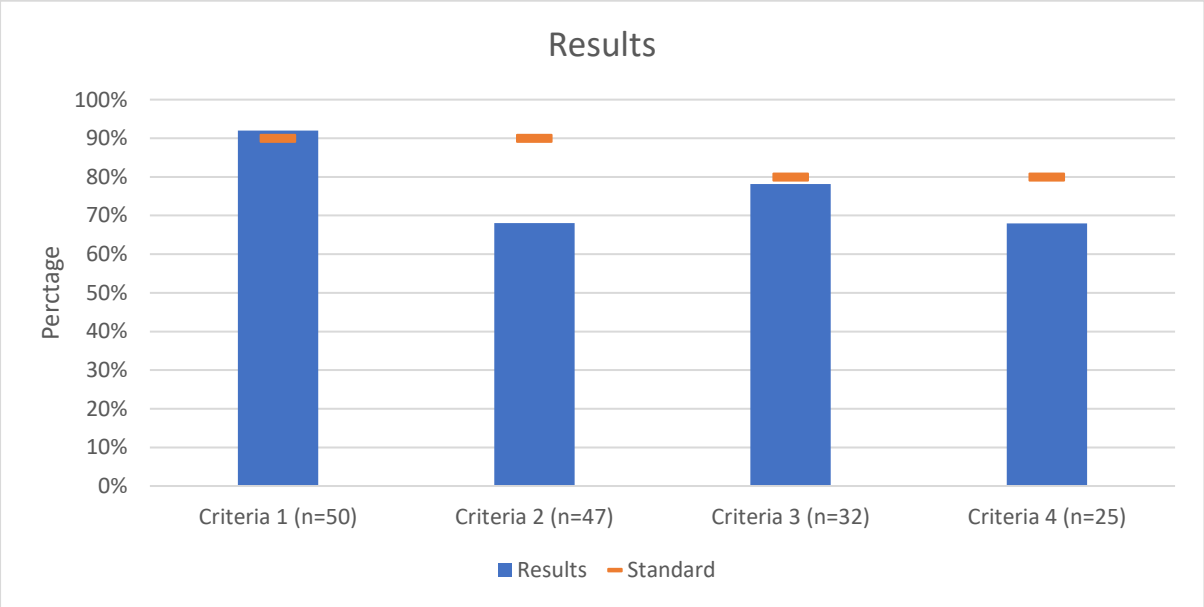
term side effects from medication, risk of increased discontinuation symptoms and the patient's feelings around continuing or discontinuing medication[6] [7].

A recent meta-analysis shows a 70% reduction in relapse for patients at high risk of relapse when staying on the SSRI dose, which achieved long-term remission. The paper did not include many patients at low risk of relapse and suggested that this area requires further research[11]. A randomised control trial with a large sample size of 478 with patients at mixed risks of relapse showed that 39% of patients that stayed on SSRIs relapsed, and 56% relapsed that were not receiving active treatment. While this further illustrates that SSRIs are useful in preventing relapse, it is also important for clinicians to consider that the 39% who stayed on the SSRI and relapsed may have been more challenging to manage as they are already on medication removing a major option for management of the relapses[12]. Furthermore, this trial assessed 'no active treatment' as the alternative to SSRIs. It may have been helpful to compare other interventions to prevent relapses, such as CBT at the time of medication discontinuation or concurrent medication and psychotherapy.

As patients within this audit are all first presentations of anxiety or depression, most would be considered at a lower risk of relapse as many risk factors for relapse are previous anxiety and depression. Other factors that NICE suggest may be a factor when assessing the risk of relapse are coping styles and socioeconomic and personal factors[6]. Therefore, the standard for this criterion was set at 80% because most patients included in this audit should be considered for the risks and benefits of continuing treatment as it is their first presentation of low mood or anxiety; however, there are a small number of cases where the clinician may deem it reasonable not to discuss this with the patient. Therefore, the lower boundary of 80% was considered appropriate. Patients were excluded from criteria four if they did not meet criteria three.

Results

Headings / Criteria (standard)	Number of patients	Number of patients who meet the criteria	Percentage (rounded to nearest whole number)
Criteria 1 (90%)	50	46	92%
Criteria 2 (90%)	47	32	68%
Criteria 3 (80%)	32	25	78%
Criteria 4 (80%)	25	17	68%



Discussion

Of the 50 patients, 92% were offered CBT or psychotherapy, which exceeds the 90% standard set for this criterion. Of the four patients who did not meet the criteria, it was noted that two of these had very brief entries into the notes at the time of the initial consultation. It is possible that CBT or psychotherapy was discussed during the consultation but not documented in the notes for various reasons, such as time constraints on the clinician.

Of the 47 patients documented as being in remission or partial remission, 68% were offered follow-up appointments. A common theme in the patients who did not receive set follow-up was to follow up as needed and continue medication as a plan. While this allows patients to see a clinician if they feel they require it, it often leaves patients taking SSRIs for over 12 months with no follow-up or assessment of the risks and benefits of continuing treatment.

78% of patients who had a follow-up date set at remission or partial remission (n=32) then went on to have the review with a clinician. At the same time, there was no apparent reason for this in many cases, human error with not booking appointments or failure to set a reminder task to the appropriate staff member to book the appointment for when the review is due. Nonetheless, 78% is just one patient away from meeting the standard; therefore, this result is borderline, and a larger patient population would have to be assessed to determine whether this standard is being met.

17 of the 25 patients (68%) who got a follow-up appointment went on to have a recorded discussion about the positives and negatives of the continuation of SSRI treatment. Many patients who did not have this discussion continued to stay on SSRIs and were not subsequently followed up. This means that of the 47 patients who reached partial or complete remission, only 36% went on to discuss the benefits and risks of continued treatment with an SSRI. Clinicians should be making active choices over whether to continue prescribing an SSRI as doing so leads to better control over the relapse risk in patients and ultimately could improve the patient’s quality of life significantly.

The main challenge faced during this audit was changing NICE guidance on depression in adults during the project. The original criteria were created against the old 2009 guidelines as this was the clinical guidance in place when the auditable events for these patients took place. However, they were also checked for relevance against the new guidelines. All recommendations are based on the new guidance to keep this audit as up to date as possible when influencing clinical practice.

Recommendations

After discussion at the Thursday practice meeting, the following recommendations were agreed upon as reasonable and practical:

- Brief relapse prevention plans for patients at the follow-up
- Continue with the advocation for CBT and psychological therapies
- Increase follow-up rate of patients so that they can be regularly assessed for the need for ongoing treatment with possible scope for wider health professionals to be involved in the follow-up process.
- Possibility for an automatic reminder when a patient has not been coded with “mental health review” for over six months or to implement a maximum number of repeat prescriptions of SSRIs for all patients to ensure timely follow-up
- Options for leaflets tailored to low and high-risk patients explaining risks and benefits of continued SSRI treatments available to send via text message to the patient’s phone using AccuRx
- Possibility for Primary Care mental health teams to have input into certain aspects of relapse prevention especially helping patients with the social factors of their condition

Reauditing the prescribing practice of SSRIs in approximately two years would be beneficial to review recommendation implementation and to keep recommendations up to date with current NICE guidelines.

Sustainability impact of the recommendations

These recommendations can potentially increase the sustainability of the treatment of depression and anxiety. Active relapse prevention can help prevent further disease and possibly reduce the need for ongoing appointments and medication. Psychotherapies such as CBT or MBCT have an element of patient empowerment as it allows the patient to control their management, unlike medications.

Stopping unnecessary consultations and prescriptions with solid relapse prevention plans could lead to more streamlined care, save money, and reduce the treatment burden on the patient. Deprescribing and having fewer appointments could also reduce the treatment's carbon footprint as there is less plastic packaging.

Other things clinicians should consider when carrying out anxiety and depression reviews could be optimising the prescribing practice. Often clinicians titrate patients' doses up, such as Sertraline 100mg, given as two 50mg tablets on a trial basis as they may already have a prescription for 50mg tablets. The best practice for sustainability would be to optimise this at review and change this to one tablet of 100mg to reduce the cost, tablet burden for the patient and carbon footprint of additional packaging and tablets.

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