

**Quick reference guide for healthcare professionals
in general hospital settings**

Issue date: October 2009

**Depression in adults with a chronic
physical health problem**

Treatment and management

About this booklet

This quick reference guide summarises the recommendations NICE has made to the NHS in 'Depression in adults with a chronic physical health problem: treatment and management' (NICE clinical guideline 91) that are relevant to healthcare professionals in general hospital settings. Note that not all recommendations from the guideline are included, so please refer to the guideline if further details are needed (see www.nice.org.uk/CG91niceguideline).

A quick reference guide to the treatment and management of depression in adults, including adults with a chronic physical health problem, is also available (at www.nice.org.uk/CG90quickrefguide). This summarises the recommendations from both NICE clinical guideline 91 and 'Depression: the treatment and management of depression in adults (update)' (NICE clinical guideline 90). See the back page for further details.

Patient-centred care

Treatment and care should take into account patients' individual needs and preferences. Good communication is essential, supported by evidence-based information, to allow patients to reach informed decisions about their care. Follow Department of Health advice on seeking consent if needed. If the patient agrees, families and carers should have the opportunity to be involved in decisions about treatment and care.

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NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales.

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

Introduction

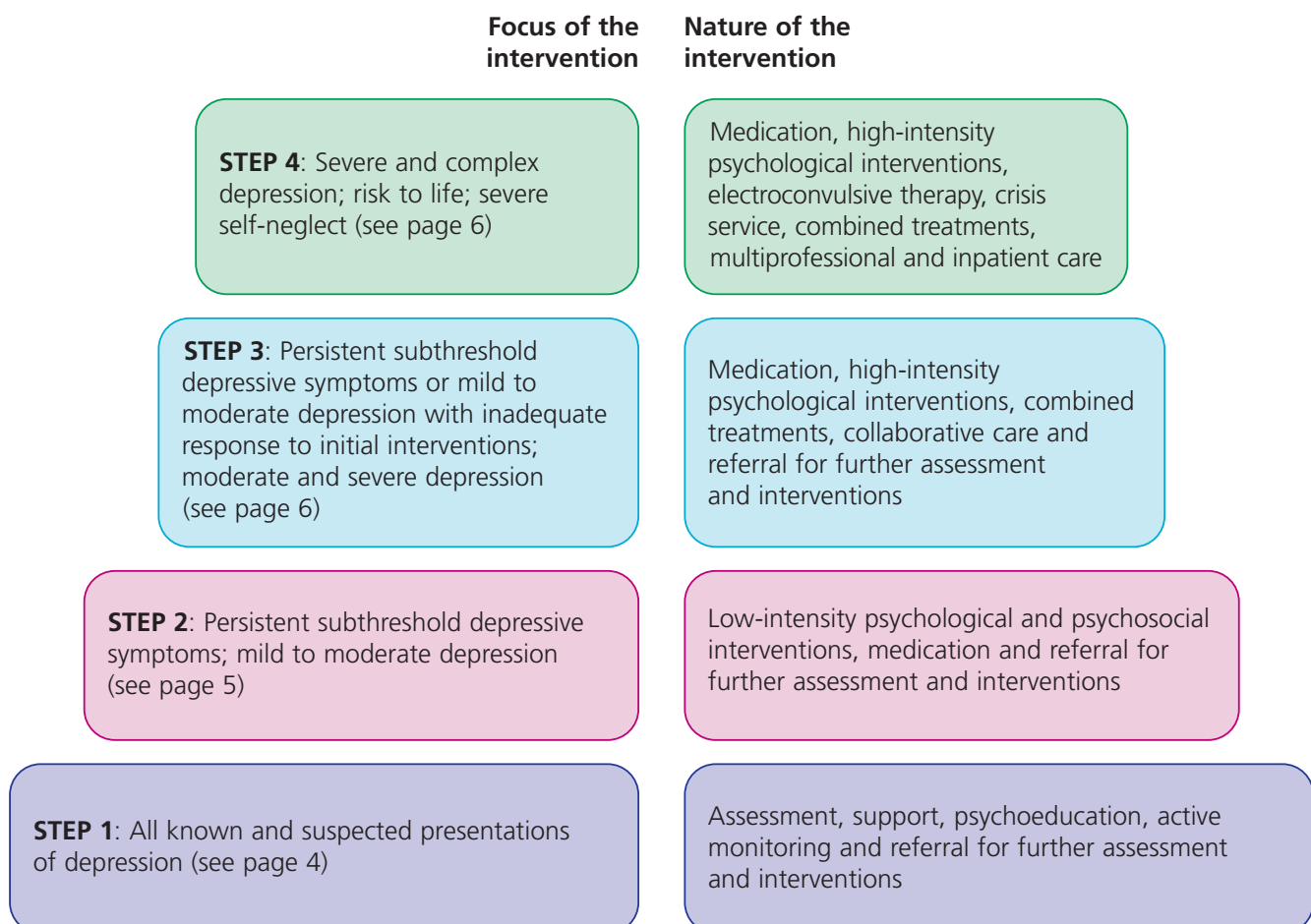
Depression is approximately two to three times more common in patients with a chronic physical health problem (such as cancer, heart disease or diabetes) than in people who have good physical health. A chronic physical health problem can both cause and exacerbate depression, and treating depression in these patients has the potential to increase their quality of life and life expectancy.

The presence of a physical illness can complicate the recognition and assessment of depression, because some symptoms are common to both mental and physical disorders. Symptoms below the threshold for a diagnosis of depression can be distressing and disabling, especially in patients with a physical health problem. Therefore this guideline also covers 'subthreshold depressive symptoms' (see 'Severities of depression' box on page 4).

Key priorities for implementation are highlighted with **KPI**

The stepped-care model

This model provides a framework for organising the provision of services, and helps patients, carers and practitioners to identify and access the most effective interventions. The least intrusive, most effective intervention is provided first. If a person does not benefit from that intervention, or declines an intervention, they should be offered an appropriate intervention from the next step.



Step 1

Identifying depression

Ask a patient who may have depression:

- During the last month, have you often been bothered by:
 - feeling down, depressed or hopeless?
 - having little interest or pleasure in doing things? *KPI*

If the patient answers 'yes' to either question

A practitioner who is not competent in mental health assessment should:

- refer the patient to an appropriate professional – if this is not the patient's GP, inform the GP.

A practitioner who is competent in mental health assessment should:

- | | |
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| <ul style="list-style-type: none"> • Ask three further questions to improve the accuracy of the assessment: <ul style="list-style-type: none"> – During the last month, have you often been bothered by: <ul style="list-style-type: none"> ◆ feelings of worthlessness? ◆ poor concentration? ◆ thoughts of death? • Conduct a comprehensive assessment that does not rely simply on a symptom count, taking into account: <ul style="list-style-type: none"> – the degree of associated functional impairment and/or disability – the duration of the episode. <i>KPI</i> • Consider the role of the physical health problem and any prescribed medication in the depression. | <ul style="list-style-type: none"> • Check that optimal treatment for the physical health problem is being provided, seeking specialist advice if necessary. • Explore how the following may have affected the development, course and severity of depression: <ul style="list-style-type: none"> – any history of depression (including previous treatments), comorbid mental health or physical disorders, and mood elevation – interpersonal relationships, living conditions and social isolation. • For patients with language or communication difficulties, consider using the Distress Thermometer and/or asking a family member or carer about symptoms; if significant distress is identified, investigate further. |
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Severities of depression¹

Subthreshold depressive symptoms: Fewer than 5 symptoms.

Mild depression: Few, if any, symptoms in excess of the 5 required to make the diagnosis, and symptoms result in only minor functional impairment.

Moderate depression: Symptoms or functional impairment are between 'mild' and 'severe'.

Severe depression: Most symptoms, and the symptoms markedly interfere with functioning. Can occur with or without psychotic symptoms.

¹ Taken from DSM-IV (see www.nice.org.uk/CG91niceguideline for further details).

Step 2

Sleep hygiene

- Offer advice on sleep hygiene, including:
 - establishing regular sleep and wake times
 - avoiding excess eating, smoking or drinking alcohol before sleep
 - creating a proper environment for sleep
 - taking regular physical exercise if possible.

Active monitoring

- For patients who may recover with no formal intervention, have mild depression and do not want an intervention, or have subthreshold depressive symptoms and request an intervention:
 - discuss the presenting problem(s) and any concerns
 - provide information about depression
 - arrange a further assessment, normally within 2 weeks
 - make contact if the patient does not attend appointments.

Low-intensity psychosocial interventions

- Consider offering one or more of the following to patients with persistent subthreshold depressive symptoms or mild to moderate depression, and to patients with subthreshold depressive symptoms that complicate the care of their chronic physical health problem:
 - a physical activity programme (modified for the particular physical health problem)
 - a peer support programme in a group of patients with a shared physical health problem
 - individual guided self-help based on cognitive behavioural therapy (CBT) principles
 - computerised CBT (CCBT)². **KPI**
- For details of delivery of interventions, see section 1.4.2 of the NICE guideline (www.nice.org.uk/CG91niceguideline).

Drug treatment

- Do not use antidepressants routinely to treat subthreshold depressive symptoms or mild depression, but consider them for patients with:
 - a past history of moderate or severe depression **or**
 - mild depression that complicates the care of the physical health problem **or**
 - initial presentation of subthreshold depressive symptoms present for at least 2 years **or**
 - subthreshold depressive symptoms or mild depression persisting after other interventions. **KPI**
- Do not prescribe or advise use of St John's wort. Explain about the different potencies of the preparations available and potential serious interactions with other drugs.

² This recommendation updates the recommendations on depression only in 'Computerised cognitive behaviour therapy for depression and anxiety (review)' (NICE technology appraisal guidance 97).

Step 3

Treatment options

Target population	Treatment options
<ul style="list-style-type: none"> Patients with persistent subthreshold depressive symptoms or mild to moderate depression who have not benefited from a low-intensity psychosocial intervention 	<ul style="list-style-type: none"> An antidepressant (see pages 8–9) or A high-intensity psychological intervention (group CBT, individual CBT or behavioural couples therapy)³.
<ul style="list-style-type: none"> Patients who present initially with moderate depression 	<ul style="list-style-type: none"> A high-intensity psychological intervention (group CBT, individual CBT or behavioural couples therapy)³. KPI
<ul style="list-style-type: none"> Patients who present initially with severe depression 	<ul style="list-style-type: none"> Consider offering both individual CBT³ and an antidepressant (see pages 8–9).

³ For details of delivery, see section 1.5.3 of the NICE guideline (www.nice.org.uk/CG91niceguideline).

- When choosing an intervention, take into account:
 - duration of episode and trajectory of symptoms
 - previous course of depression and response to treatment
 - likelihood of adherence to treatment and potential adverse effects
 - course and treatment of the chronic physical health problem
 - patient's treatment preference.

Patients with moderate or severe depression who have not responded to initial interventions

- Consider collaborative care for patients whose depression has not responded to initial high-intensity psychological interventions, pharmacological treatment or a combination of psychological and pharmacological interventions. **KPI**
- Collaborative care should include case management supervised by a senior mental health professional, close collaboration between physical health services and specialist mental health services, interventions as described above, and long-term coordination of care and follow-up.
- For details of treatment options, see www.nice.org.uk/CG90quickrefguide

Step 4

- Interventions may include medication, high-intensity psychological interventions, electroconvulsive therapy and other physical treatments, combined treatments, crisis resolution and home treatment teams, and inpatient care (for further details, see www.nice.org.uk/CG90niceguideline).
- If treatment is provided by specialist mental health services for patients with complex and severe depression, there should be close collaboration with services treating the physical health problem.

Care of people with depression

Principles of care

- Be aware that stigma and discrimination can be associated with a diagnosis of depression, and ensure that the patient's confidentiality, privacy and dignity are respected.
- Be sensitive to diverse cultural, ethnic and religious backgrounds, and aware of possible variations in presentation.
- Be aware of any learning disabilities or acquired cognitive impairments – if necessary consider consulting with a relevant specialist.
- Where a patient's management is shared between primary and secondary care, agree responsibility for monitoring and treatment – involve the patient's GP. Share the treatment plan with the patient and (if appropriate) their family or carer.
- If a patient's chronic physical health problem restricts their ability to engage with a preferred psychosocial or psychological treatment, consider alternatives in discussion with them, such as antidepressants or delivery of interventions by telephone (if face-to-face contact isn't possible).
- Be aware of potential interactions of antidepressants with medication prescribed for the physical health problem (see pages 8–9).
- All interventions should be delivered by competent practitioners (for further details, see the NICE guideline at www.nice.org.uk/CG91niceguideline). **KPI**

Risk assessment and monitoring

- If a patient presents considerable immediate risk to themselves or others, refer them urgently to specialist mental health services.
- Advise the patient and their family or carer of the following, and ensure that they know how to seek help promptly if required:
 - the potential for increased agitation, anxiety and suicidal ideation early in treatment; actively seek out these symptoms and review the patient's treatment if they develop marked and/or prolonged agitation
 - the need to be vigilant for mood changes, negativity and hopelessness, and suicidal ideation, particularly when starting or changing treatment and at times of increased stress – advise them to contact their practitioner if concerned.
- Always ask a patient with depression and a chronic physical health problem directly about suicidal ideation and intent.
- If the patient is assessed to be at risk of suicide, consider:
 - providing increased support such as more frequent contact
 - referral to specialist mental health services.

Antidepressants

Choice of antidepressants⁴

- When prescribing an antidepressant, take into account:
 - the presence of other physical health problems
 - side effects (which may impact on the underlying physical disease)
 - that there is currently no evidence supporting using specific antidepressants for patients with particular physical health problems. **KPI**
- Be aware of drug interactions and:
 - refer to appendix 1 of the British national formulary (BNF) and the table of interactions in appendix 16 of the full guideline (see www.nice.org.uk/CG91fullguideline)
 - seek specialist advice if there is uncertainty
 - if necessary, refer the patient to specialist mental health services for continued prescribing.
- First prescribe a selective serotonin reuptake inhibitor (SSRI) in generic form unless there are interactions with other drugs – consider citalopram or sertraline.
- Dosulepin should not be prescribed.
- Non-reversible monoamine oxidase inhibitors (MAOIs; for example, phenelzine), combined antidepressants and lithium augmentation should normally be prescribed only by specialist mental health professionals.
- Take into account toxicity in overdose when choosing an antidepressant for patients at significant risk of suicide. Be aware that:
 - compared with other equally effective antidepressants, venlafaxine is associated with a greater risk of death from overdose
 - tricyclic antidepressants (TCAs), except for lofepramine, are associated with the greatest risk in overdose.

Treatment

- Explore any concerns the patient has about taking medication and provide information, including:
 - the gradual development of the full antidepressant effect
 - the importance of taking medication as prescribed and the need to continue beyond remission
 - potential side effects and drug interactions
 - the risk and nature of discontinuation symptoms
 - the fact that addiction does not occur.
- Do not prescribe antidepressants at subtherapeutic doses.
- For patients started on antidepressants who are not considered to be at increased risk of suicide, normally see them after 2 weeks. See them regularly, for example every 2 to 4 weeks in the first 3 months, and then at longer intervals if response is good.
- See high-risk patients (at increased risk of suicide or younger than 30 years) started on antidepressants after 1 week, and then frequently until the risk is no longer considered clinically important.

⁴ For additional considerations on the use of antidepressants and other medications (including the assessment of the relative risks and benefits) for women who may become pregnant, please refer to the BNF and individual drug summaries of product characteristics (SPCs). For women in the antenatal and postnatal periods, see also NICE clinical guideline 45 'Antenatal and postnatal mental health'.

- If the patient develops side effects early on, provide information and consider:
 - monitoring symptoms closely if side effects are mild and acceptable to the patient **or**
 - stopping or changing to a different antidepressant if the patient prefers **or**
 - short-term concomitant treatment (no longer than 2 weeks) with a benzodiazepine if anxiety, agitation and/or insomnia are problematic, except in patients with chronic symptoms of anxiety; use with caution in patients at risk of falls.
- If the patient has benefited from taking an antidepressant, encourage them to continue medication for at least 6 months after remission; review the need to continue treatment beyond 6 months.

Stopping antidepressants

- Normally, gradually reduce the dose over 4 weeks (this is not necessary with fluoxetine). Reduce the dose over longer periods for drugs with a shorter half-life (for example, paroxetine and venlafaxine).
- Advise the patient to see their practitioner if they experience significant discontinuation symptoms.

Interactions of SSRIs with other medication

Medication for chronic physical health problem	Recommended antidepressant(s)
Non-steroidal anti-inflammatory drugs (NSAIDs)	<ul style="list-style-type: none"> ● Do not normally offer SSRIs – but if no suitable alternatives can be identified, offer gastroprotective medicines (for example, proton pump inhibitors) together with the SSRI ● Consider mianserin, mirtazapine, moclobemide, reboxetine or trazodone
Warfarin and heparin	<ul style="list-style-type: none"> ● Do not normally offer SSRIs ● Consider mirtazapine (note that when taken with warfarin, the international normalised ratio [INR] may increase slightly)
Aspirin	<ul style="list-style-type: none"> ● Use SSRIs with caution – if no suitable alternatives can be identified, offer gastroprotective medicines together with the SSRI ● When aspirin is used as a single agent, consider trazodone, mianserin or reboxetine ● Consider mirtazapine
'Triptan' drugs for migraine	<ul style="list-style-type: none"> ● Do not offer SSRIs ● Offer mirtazapine, trazodone, mianserin or reboxetine
MAO-B inhibitors (for example, selegiline and rasagiline)	<ul style="list-style-type: none"> ● Do not normally offer SSRIs ● Offer mirtazapine, trazodone, mianserin or reboxetine
Theophylline, clozapine, methadone or tizamide	<ul style="list-style-type: none"> ● Do not normally offer fluvoxamine ● Offer sertraline or citalopram
Flecainide or propafenone	<ul style="list-style-type: none"> ● Offer sertraline as the preferred antidepressant ● Mirtazapine and moclobemide may also be used
Atomoxetine	<ul style="list-style-type: none"> ● Do not offer fluoxetine or paroxetine ● Offer a different SSRI

Further information

Ordering information

You can download the following documents from www.nice.org.uk/CG91

- The NICE guideline – all the recommendations.
- A quick reference guide summarising relevant recommendations for healthcare professionals in general hospital settings (this document).
- A quick reference guide summarising the recommendations on the treatment and management of depression in adults, including adults with a chronic physical health problem ('combined' quick reference guide).
- 'Understanding NICE guidance' – a summary for patients and carers.
- The full guideline – all the recommendations, details of how they were developed, and reviews of the evidence they were based on.

For printed copies of the quick reference guides or 'Understanding NICE guidance', phone NICE publications on 0845 003 7783 or email publications@nice.org.uk and quote:

- N2018 (this quick reference guide)
- N2016 ('combined' quick reference guide)
- N2019 ('Understanding NICE guidance').

Implementation tools

NICE has developed tools to help organisations implement this guidance (see www.nice.org.uk/CG91).

Related NICE guidance

- Depression: the treatment and management of depression in adults (update). NICE clinical guideline 90 (2009). www.nice.org.uk/CG90
- Antenatal and postnatal mental health. NICE clinical guideline 45 (2007). www.nice.org.uk/CG45
- Depression in children and young people. NICE clinical guideline 28 (2005). www.nice.org.uk/CG28
- Anxiety (amended). NICE clinical guideline 22 (2004; amended 2007). www.nice.org.uk/CG22

For information about NICE guidance that has been issued or is in development, see www.nice.org.uk

Updating the guideline

This guideline will be updated as needed, and information about the progress of any update will be available at www.nice.org.uk/CG91

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