

Depression: the treatment and management of depression in adults with chronic physical health problems

NICE guideline

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If you wish to comment on this version of the guideline, please be aware that all the supporting information and evidence is contained in the full version.

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Recommendations highlighted in grey are from NICE clinical guideline 23 (available from www.nice.org.uk/CG23). Yellow shading in these recommendations indicates where wording changes have been made for the purposes of clarification only.

A partial update of NICE clinical guideline 23 is under way that will replace it – recommendations highlighted in blue are from the consultation draft of that update (out for consultation between 24 February and 21 April 2009). See [Depression in adults \(update\)](#) for more information on how to contribute to that consultation.

Introduction

This guideline makes recommendations for the identification, treatment and management of depression for adults aged 18 years and older with associated chronic physical health problems. Depression is a broad and heterogeneous diagnostic grouping, central to which is depressed mood or loss of pleasure in most activities. In patients with chronic physical health problems depression is approximately two to three times more common than in healthy controls.

Symptoms of depression occur on a continuum of severity and there is no natural threshold when depression becomes clinically important. A diagnosis of depression in ICD-10 requires at least four out of ten depressive symptoms whereas DSM-IV (major depression) requires at least five out of nine. Symptoms should be present for at least 2 weeks and every symptom should be present at sufficient severity for most of every day. Both diagnostic symptoms require at least one (DSM-IV) or two (ICD-10) core symptoms to be present (low mood, loss of enjoyment and interest in both ICD-10 and DSM-IV and, in ICD-10, loss of energy). Severity of depression is determined both by symptom number and severity as well as degree of impairment. It is now increasingly recognised that depression below the thresholds in DSM-IV and ICD-10 can be distressing and disabling, particularly if persistent. Therefore this updated guideline covers 'subthreshold' or 'minor' depression (requiring at

least one core symptom of depression with insufficient other symptoms and/or impairment to meet the full diagnosis). It should be noted that classificatory systems are agreed conventions that seek to define different severities of depression in order to guide description and treatment, with their value determined by how useful they are in practice.

After careful review of the diagnostic criteria and the evidence, the Guideline Development Group decided to adopt DSM-IV criteria for this update rather than ICD-10, which had been used in the previous depression guideline (NICE clinical guideline 23). This is because DSM-IV criteria are used in nearly all the evidence reviewed and DSM-IV provides definitions for minor depression, atypical symptoms and seasonal depression. Its definition of severity also makes it less likely that a diagnosis of depression will be based solely on symptom counting. In practical terms, the change will not affect clinical practice except at the margins where it is intended to better target the use of specific interventions such as antidepressants for more severe degrees of depression. The term 'depression' in this guideline refers to DSM-IV major depression, unless qualified by 'minor' when it refers to depression below the threshold for major depression.

A wide range of biological, psychological and social factors have a significant impact on the course of the disorder and response to treatment, and are not captured well by the current diagnostic systems. Therefore family and previous history, as well as the degree of associated disability, are important when undertaking a diagnostic assessment of depression (see appendix C for further details).

For the purposes of this guideline, the diagnosis of depression requires assessment of a) severity, b) duration of episode and c) course of illness. This guideline uses the following categories of severity, drawing on the classification of depression as set out in DSM-IV:

- minor depression (2 to 4 symptoms with maintained function)
- mild (major) depression (few, if any, symptoms in excess of those required to make the diagnosis and resulting in only minor functional impairment)

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- moderate (major) depression (symptoms or functional impairment between mild and severe)
- severe (major) depression (several symptoms in excess of those required to make the diagnosis and markedly interfering with functioning).

The guideline draws on the best current available evidence for the treatment and management of depression. However, there are some significant limitations to the current evidence base, which have implications for this guideline. These include limited data on both long-term outcomes for most, if not all, interventions, and outcomes generally for severe depression.

All effective treatments for depression are associated with a reduction in suicide; this guideline makes recommendations about how the increased suicidality that might be observed in some patients early in treatment can be managed.

The guideline will assume that prescribers will use a drug's summary of product characteristics (SPC) to inform their decisions for individual patients.

Patient-centred care

This guideline offers best practice advice on the care of adults with depression and chronic health problems.

Treatment and care should take into account patient's needs and preferences. People with depression and chronic health problems should have the opportunity to make informed decisions, including advance decisions and advance statements, about their care and treatment, in partnership with their healthcare professionals. If patients do not have the capacity to make decisions, healthcare professionals should follow the Department of Health guidelines – 'Reference guide to consent for examination or treatment' (2001) (available from www.dh.gov.uk). Healthcare professionals should also follow the code of practice that accompanies the Mental Capacity Act (summary available from www.publicguardian.gov.uk).

Good communication between healthcare professionals and patients is essential. It should be supported by evidence-based written information tailored to the patient's needs. Treatment and care, and the information patients are given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English.

If the patient agrees, families and carers should have the opportunity to be involved in decisions about treatment and care.

Families and carers should also be given the information and support they need.

Key priorities for implementation

Principles for assessment, coordination of care, and choosing treatments

- When assessing a person who may be depressed, practitioners should conduct a comprehensive assessment which takes into account the degree of impairment and/or disability associated with the possible depression, the duration of the episode, and does not rely simply on a symptom count.

[1.1.4.1]

Effective delivery of interventions for depression

- All interventions for depression should be delivered by practitioners who are competent to deliver the intervention. Psychological and psychosocial interventions should be based on the relevant treatment manual(s), which practitioners should follow with regard to the structure and duration of the intervention. Staff should:
 - use competence frameworks developed from the relevant treatment manual(s)
 - receive regular high quality supervision
 - use routine outcome measures and ensure that the person with depression is involved in reviewing the efficacy of the treatment
 - monitor and evaluate adherence and competence, for example, through the use of video and audio tapes and external audit and scrutiny where appropriate. [1.1.5.1]

Step 1: recognition, assessment and initial management in primary care and general hospital settings

- Healthcare professionals should ask two questions to identify possible depression. This should be at a person's first and subsequent contacts with services (that is at least once per year and usually in line with medical reviews), and after the completion of any rehabilitation programme:
 - During the last month, have you often been bothered by feeling down, depressed or hopeless?

- During the last month, have you often been bothered by having little interest or pleasure in doing things? **[1.3.1.1]**

Low intensity psychosocial interventions

- For people with minor and mild to moderate depression and chronic physical health problems, and for those with minor depression that complicates the care of the chronic physical health problem, healthcare professionals should consider:
 - structured physical activity programmes
 - group-based peer support programmes
 - individual guided self-help based on cognitive behavioural therapy principles
 - computerised cognitive behavioural therapy (CCBT).

The choice of intervention should be guided by the patient's preference.

[1.4.3.1]

Drug treatment

- Antidepressants are not recommended for the initial treatment of minor and mild depression in patients with chronic physical health problems, because the risk–benefit ratio is poor, but should be considered where:
 - minor and mild to moderate depression persists after other interventions
 - the patient has a past history of moderate or severe depression
 - minor and mild to moderate depression complicates care and management of the physical health problem. **[1.4.4.1]**
- When an antidepressant is to be prescribed it should be individually tailored to the person with depression and a chronic physical health problem, and the following factors should be taken into account:
 - presence of other physical health disorders
 - side effects of antidepressants (which may impact on the underlying physical disease, including hyponatraemia particularly with SSRIs in older people)

- interactions with other medications.

Practitioners should refer to the table of interactions in appendix 16 of the full guideline and appendix 1 of the BNF¹ for information on drug interactions. **[1.5.2.1]**

Failure of treatment to provide benefit

- If a patient has taken the antidepressant as prescribed and the response to a therapeutic dose is inadequate after 4 weeks, consider:
 - a gradual increase in dose in line with the schedule suggested by the Summary of Product Characteristics if there are no significant side effects
 - switching to another antidepressant if there is still no response after a further 2 weeks, if there are side effects, or the person expresses a preference for changing treatment.

If there has been a partial response, a decision to switch to another antidepressant can be postponed until 6 weeks. **[1.5.2.17]**

Cognitive behavioural therapies – choice of psychological treatment

- For people with moderate depression and chronic physical health problems who are offered psychological interventions, the choice of treatment should include:
 - group-based cognitive behavioural therapy (CBT)
 - individual CBT for those who decline group-based CBT or for whom it is not appropriate, or where a group is not available.

[1.5.3.1]

Step 4: Collaborative care

- For patients with moderate or severe depression, chronic physical health problems and associated functional impairment, and who have not responded to initial psychological or pharmacological treatment, collaborative care should be considered. **[1.6.1.1]**

¹ Available from: www.bnf.org

1 Guidance

The following guidance is based on the best available evidence. The full guideline ([add hyperlink]) gives details of the methods and the evidence used to develop the guidance.

1.1 *Care of all people with depression*

1.1.1 Providing good information, informed consent and mutual support

1.1.1.1 When working with people with depression and their families and carers practitioners should:

- build a trusting relationship and work in an open, engaging and non-judgemental manner
- explore treatment options in an atmosphere of hope and optimism, explaining the different courses of depression and that recovery is possible
- be aware that stigma and discrimination can be associated with a diagnosis of depression.

1.1.1.2 When working with people with depression and their carers practitioners should:

- avoid clinical language without adequate explanation
- ensure that comprehensive written information is available in the appropriate language and in audio format if possible
- provide and work proficiently with independent interpreters where needed.

1.1.1.3 Patients and, where appropriate, families and carers should be provided with information on the nature, course and treatment of depression including the use and likely side-effect profile of medication.

1.1.1.4 Practitioners should be aware of, and inform people with depression and their families and carers about, self-help groups, support groups and other local resources.

1.1.1.5 Practitioners should make all efforts necessary to ensure that a person with depression can give meaningful and informed consent before treatment is initiated. This is especially important when a person with depression has a more severe depression or is subject to the Mental Health Act.

1.1.2 Providing information and informed consent, and ensuring continuity of care

1.1.2.1 Healthcare professionals should be respectful of diversity, and be sensitive to the cultural and religious needs of the diverse communities that they serve and ensure that they have the requisite cultural competences to be able to deliver effective interventions for depression to these communities.

1.1.3 Supporting families and carers

1.1.3.1 When families and carers are involved in supporting a person with severe or persistent depression, practitioners should consider offering:

- written and verbal information on depression and its management, including how families and carers can support the person
- a carers' assessment of their caring, physical and mental health needs where necessary
- information about and facilitate access to local carer and family support groups and relevant voluntary organisations

They should be able to negotiate confidentiality and the sharing of information between the person with depression and their carers.

1.1.4 Principles for assessment, coordination of care and choosing treatments

The effective assessment of a person with depression (including, where appropriate, a comprehensive review of physical, psychological and social needs and a risk assessment) and the subsequent coordination of his or her care may contribute significantly to improved outcomes.

1.1.4.1 When assessing a person who may be depressed, practitioners should conduct a comprehensive assessment which takes into account the degree of impairment and/or disability associated with the possible depression, the duration of the episode, and does not rely simply on a symptom count.

1.1.4.2 In older adults with depression, their physical state, living conditions and social isolation should be assessed. The involvement of more than one agency is recommended where appropriate.

1.1.4.3 When assessing need, practitioners should seek to understand how the factors set out below may have affected the development, course and severity of a person's depression:

- the quality of interpersonal relationships
- the history of depression and other comorbid mental or physical disorders
- the past experience of, and response to, treatments
- the living conditions and degree of social isolation
- a review of any past history of mood elevation to determine if the depression may be part of a bipolar disorder (in which case they should refer to 'Bipolar disorder', NICE clinical guideline 38)

Along with the person's preference they should guide the content of any treatment.

1.1.4.4 Healthcare professionals should be aware that some people with depression and other mental disorders will find discussion and

exploration of these problems difficult because of the shame or stigma that may arise. Therefore it is important that care is taken to ensure that any discussion takes place in settings in which the confidentiality, privacy and dignity of the patient are respected.

1.1.4.5 Practitioners working with people with depression from diverse ethnic and cultural backgrounds should ensure they are competent in:

- culturally appropriate assessment skills
- using different explanatory models of depression
- addressing cultural and ethnic differences in the formulation of treatment plans and the expectations of and adherence to treatment
- working with families from diverse ethnic and cultural backgrounds.

1.1.4.6 Practitioners should always ask a person with depression directly about suicidal ideas and intent. Where the risk of self harm or suicide is present practitioners should assess whether the person has adequate social support and is aware of sources of help. They should arrange help appropriate to the level of risk and advise the person to seek further help if the situation deteriorates.

1.1.4.7 Practitioners should advise a person with depression and their carers to be vigilant for changes in mood, negativity and hopelessness, and suicidal ideas, particularly during high-risk periods, such as during initiation of, and changes to, any treatment plan and increased personal stress. They should be advised to contact the appropriate healthcare practitioner if concerned.

1.1.5 Effective delivery of interventions for depression

1.1.5.1 All interventions for depression should be delivered by practitioners who are competent to deliver the intervention. Psychological and psychosocial interventions should be based on the relevant

treatment manual(s), which practitioners should follow with regard to the structure and duration of the intervention. Staff should:

- use competence frameworks developed from the relevant treatment manual(s)
- receive regular high quality supervision
- use routine outcome measures and ensure that the person with depression is involved in reviewing the efficacy of the treatment
- monitor and evaluate adherence and competence, for example, through the use of video and audio tapes and external audit and scrutiny where appropriate.

1.1.5.2 Where available, consideration should be given to providing all interventions in the preferred language of the person with depression.

1.1.5.3 Where a patient's management is shared between primary and secondary care, there should be clear agreement between individual healthcare professionals on the responsibility for the monitoring and treatment of that patient, and the treatment plan should be shared with the patient and, where appropriate, with families and carers.

1.2 Stepped care

The stepped-care model of depression draws attention to the different needs that people with depression have – depending on the characteristics of their depression and their personal and social circumstances – and the responses that are required from services. It provides a framework in which to organise the provision of services supporting both patients and carers, and healthcare professionals in identifying and accessing the most effective interventions (see figure 1). The aim of a stepped care programme is to provide the least intrusive, most effective intervention first and to promote the organisation and delivery of care in a way which is understandable to patients and carers, and professionals.

Figure 1. The stepped care model

Focus of the intervention	Nature of the intervention
<p>STEP 5: Severe and complex* depression, risk to life, severe self-neglect</p>	<p>Medication, high intensity psychological interventions, ECT, crisis service, combined treatments, multi-professional and in-patient care</p>
<p>STEP 4: Moderate depression with limited response to initial interventions, and severe depression</p>	<p>Collaborative care</p>
<p>STEP 3: Mild to moderate depression with limited response to initial interventions, and moderate depression</p>	<p>Medication, high intensity psychological interventions, combined treatments, referral</p>
<p>STEP 2: Minor, mild to moderate depression</p>	<p>Low intensity psychological and psychosocial interventions, medication, referral</p>
<p>STEP 1: All known and suspected presentations of depression</p>	<p>Assessment, referral, psychoeducation, active monitoring and support</p>

*** Complex includes depression with a poor response to multiple treatments, complicated by psychosis, and/or significant psychiatric comorbidity or psychosocial factors.**

Collaborative care, which should form part of a well-developed stepped care programme, will normally be provided at the primary care level but the interventions should span all sectors of care thereby providing a coordinated approach to mental healthcare, which involves:

- a dedicated co-ordinator of the intervention located in and receiving support from a multi-professional team (including specialist mental health supervision)
- joint determination of the plan of care
- long-term coordination and follow up
- coordination of both mental and physical health care.

1.3 Step 1: recognition, assessment and initial management in primary care and general hospital settings

The following recommendations are for healthcare professionals working in primary care and general hospital settings. Healthcare professionals in primary and secondary care settings should be aware that certain groups of people are at high risk of developing depression, including people with a history of depression and those with chronic physical health problems, particularly where there is functional impairment.

1.3.1 Case identification and recognition

1.3.1.1 Healthcare professionals should ask two questions to identify possible depression. This should be at a person's first and subsequent contacts with services (that is, at least once per year and usually in line with medical reviews), and after the completion of any rehabilitation programme:

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

1.3.1.2 If a person answers 'yes' to either of the depression identification questions, healthcare professionals, when competent in basic mental health assessment, should:

- undertake a detailed clinical assessment including assessment of depressive symptoms, function and disability
- review and consider the role of both the current physical problem and any prescribed medication in the development or maintenance of the depression.

1.3.1.3 Healthcare professionals should also check to see if the optimal treatment for the physical health problem is being provided, where necessary seeking specialist advice.

1.3.1.4 If a person answers 'yes' to either of the depression identification questions and the healthcare professional is not competent in basic mental health assessment, a referral should be made to an appropriate professional. Where this is not the patient's GP, the GP should be informed of the referral.

1.3.1.5 When undertaking an assessment of someone with suspected depression, practitioners should consider the use of a validated measure (for example, for symptoms, functions and/or disability) in order to inform and evaluate treatment.

1.3.1.6 For people with significant language or communication difficulties, for example those with post-stroke aphasia, healthcare professionals should consider the use of the Distress Thermometer² and/or asking a family member or carer about their possible depressive symptoms to identify possible depression.

1.3.2 Risk assessment and monitoring

1.3.2.1 Where a person with depression presents considerable immediate risk to self or others, urgent referral to a specialist mental health service should be arranged.

1.3.2.2 Practitioners should advise patients of the potential for increased agitation, anxiety, suicidal ideation (and for people taking antidepressants, akathisia) in the initial stages of treatment. They should actively seek out these symptoms and ensure that the person with depression knows how to seek help promptly if these are at all distressing. In the event that a patient develops marked and/or prolonged agitation (or akathisia while taking an antidepressant), the treatment should be reviewed.

² Distress thermometer is a single-item question screen, which will identify distress coming from any source. The patient places a mark on the scale answering: 'How distressed have you been during the past week on a scale of 0 to 10?' .Scores of 4 or more indicate a significant level of distress that should be investigated further. (Roth AJ et al. (1998). Rapid screening for psychological distress in men with prostate carcinoma. Cancer 82: 904–1908.)

1.3.2.3 When a person with depression is assessed to be at risk of suicide, practitioners should consider:

- toxicity in overdose where an antidepressant is prescribed and when determining the quantity supplied at any one time; where necessary, implement strategies to limit the amount of drug available
- the use of additional support such as more frequent direct or telephone contacts
- referral to specialist mental health services.

1.4 *Step 2: recognised depression in primary care and general hospital settings – persistent minor and mild to moderate depression*

The large majority of patients with depression (more than 80%) are cared for solely in primary care. Of those who use secondary care services, most – if not all – continue to receive much of their care from the primary care team.

1.4.1 Coordination of care

1.4.1.1 The management of depression in patients with physical health problems should be carefully coordinated between the healthcare professionals involved. This is particularly important when antidepressant medication is prescribed. Prescribers should be aware of potential interactions with medication prescribed for physical problems; where there is uncertainty about potential interactions, specialist advice should be sought and it may be necessary for prescribing to be continued by specialist services.

1.4.2 General measures

Depression with anxiety

1.4.2.1 When depression is accompanied by symptoms of anxiety, the first priority should usually be to treat the depression. Treatment for depression often reduces anxiety symptoms. When the patient has

an anxiety disorder without depression, the NICE guideline for the relevant anxiety disorder should be followed.

Sleep hygiene

1.4.2.2 Patients with depression may benefit from advice on sleep hygiene including:

- establishing regular sleep and wake times
- avoiding excess eating, smoking or drinking before sleep
- creating a proper environment for sleep.

Active monitoring

1.4.2.3 For people with persistent minor and mild depression who do not want an intervention or who, in the opinion of the healthcare professional, may recover with no intervention, practitioners should:

- discuss the presenting problem(s) and any concerns that the person may have about them
- provide information about the nature and course of depression
- arrange a further assessment, normally within 2 weeks
- make contact with people who do not attend follow-up appointments.

1.4.3 Low intensity psychosocial interventions

This section is primarily concerned with those with an established diagnosis of mild to moderate depression, but may also apply to those who have minor depression or minor depression that complicates the care of the chronic physical health problem.

1.4.3.1 For people with minor and mild to moderate depression and chronic physical health problems, and for those with minor depression that complicates the care of the chronic physical health problem, healthcare professionals should consider:

- structured physical activity programmes
- group-based peer support programmes

- individual guided self-help based on cognitive behavioural therapy principles
- computerised cognitive behavioural therapy (CCBT).

The choice of intervention should be guided by the patient's preference.

1.4.3.2 Physical activity programmes for people with mild to moderate depression and chronic physical health problems, and for those with minor depression that complicates the care of the chronic physical health problem, should normally be:

- modified for different levels of physical ability and where necessary the particular chronic physical health problem
- delivered individually or in structured groups under the supervision of a competent professional
- typically consist of weekly sessions over a 10- to 14-week period (average 12 weeks).

1.4.3.3 Group peer support (self-help) programmes for people with mild to moderate depression and chronic physical health problems, and for those with minor depression that complicates the care of the chronic physical health problem, should be:

- delivered to groups of individuals with a shared chronic health problem
- delivered over a period of 8 to 12 weeks
- focused on sharing experiences and feelings of having a chronic physical health problem
- supported by healthcare professionals who should, where necessary, facilitate attendance at the meetings and review the outcomes of the intervention with the individual patients.

1.4.3.4 Individual guided self-help programmes based on cognitive behavioural principles for patients with mild to moderate depression and chronic physical health problems, and for those with minor

depression that complicates the care of the chronic physical health problem, should normally take place over 9 to 12 weeks, including follow up, and consist of:

- the provision of appropriate written materials
- support from a healthcare professional, who typically facilitates the self-help programme and reviews progress and outcome.

1.4.3.5 For patients with mild to moderate depression and chronic physical health problems, and for those with minor depression that complicates the care of the chronic physical health problem, CCBT based on cognitive behavioural therapy (CBT) should be provided via a stand-alone computer or a web-based programme. Programmes should run for 9 to 12 weeks, including follow up, and should:

- include an explanation of the CBT model, encourage tasks between sessions, and use thought challenging, active monitoring of behaviour, thought patterns and outcomes
- be supported by an appropriately trained practitioner, who typically provides limited facilitation of the programme and reviews progress and outcome.

1.4.3.6 Patients with mild to moderate depression and chronic physical health problems, and those with persistent minor depression that complicates the care of the chronic physical health problem, who have not benefited from a low intensity psychosocial intervention should be considered for formal psychological treatment or antidepressant medication. The choice of intervention should be influenced by:

- patient preference for a psychological or pharmacological intervention
- the duration of the episode and the past and current trajectory of symptoms
- past experience of and response to treatment.

1.4.4 Drug treatment

1.4.4.1 Antidepressants are not recommended for the initial treatment of minor and mild depression in patients with chronic physical health problems, because the risk–benefit ratio is poor, but should be considered where:

- minor and mild to moderate depression persists after other interventions
- the patient has a past history of moderate or severe depression
- minor and mild to moderate depression complicates care and management of the physical health problem.

1.4.4.2 Although there is evidence that St John's wort may be of benefit in mild or moderate depression, practitioners should:

- not prescribe or advise its use by people with depression because of uncertainty about appropriate doses, persistence of effect, variation in the nature of preparations and potential serious interactions with other drugs (including oral contraceptives, anticoagulants and anticonvulsants)
- advise people with depression of the different potencies of the preparations available and of the potential serious interactions of St John's wort with other drugs.

1.5 ***Step 3: recognised depression in primary care and general hospital settings – mild to moderate depression with poor response to initial interventions, and moderate and severe depression***

1.5.1 Treatment options

1.5.1.1 For people with persistent minor and mild to moderate depression who have not benefited from a low intensity psychosocial intervention, and those with moderate and severe depression, practitioners should consider a high intensity psychological

treatment or initiation or review of antidepressant medication (normally an SSRI). The choice of intervention should be influenced by:

- the person's treatment preference
- the duration of the episode and the trajectory of symptoms
- the previous illness course and response to treatment.

1.5.1.2 Discuss the relative merits of different interventions with the person with depression and offer:

- antidepressant drugs (normally SSRIs)
- psychological interventions (normally CBT and interpersonal therapy)
- combination of antidepressants and CBT

The choice should be based on patient preference, the likelihood of adherence to the treatment, and the likely side effects.

1.5.2 Antidepressant drugs

The choice of antidepressants

1.5.2.1 When an antidepressant is to be prescribed it should be individually tailored to the person with depression and a chronic physical health problem, and the following factors should be taken into account:

- presence of other physical health disorders
- side effects of antidepressants (which may impact on the underlying physical disease, including hyponatraemia particularly with SSRIs in older people)
- interactions with other medications

Practitioners should refer to the table of interactions in appendix 16 of the full guideline and appendix 1 of the BNF³ for information on drug interactions.

³ Available from: www.bnf.org

1.5.2.2 Where interactions do not preclude the use of an SSRI they should be first choice, because SSRIs are as effective as tricyclic antidepressants and are less likely to be discontinued because of side effects.

1.5.2.3 When prescribing an SSRI, consideration should be given to using a product in a generic form. Citalopram and sertraline, for example, would be reasonable choices because they are generally associated with lower potential for interactions.

1.5.2.4 When prescribing antidepressants, healthcare professionals should be aware that:

- dosulepin should not be routinely initiated
- non-reversible MAOIs (such as phenelzine), combined antidepressants, and lithium augmentation of antidepressants should only be routinely initiated by specialist mental health professionals.

1.5.2.5 Where SSRIs are cautioned against (for example, bleeding disorders, NSAIDs) consider the use of medications with a lower propensity for, or a different range of, interactions including (see appendix 16 of the full guideline and appendix 1 of the BNF for information on drug interactions):

- mianserin
- mirtazapine
- moclobemide
- reboxetine.

1.5.2.6 Consider toxicity in overdose when choosing an antidepressant for people at significant risk of suicide. Be aware of the greater risk of death from overdose with tricyclic antidepressants (with the exception of lofepramine) and venlafaxine, than other equally effective drugs recommended for routine use in primary care.

1.5.2.7 If a depressed patient develops agitation following prescription of an SSRI early in treatment, the prescriber should provide appropriate information and in discussion with the patient:

- consider continuing with the same drug **or**
- stop or change to a different antidepressant if the patient prefers **or**
- consider a brief period of concomitant treatment with a benzodiazepine, followed by a clinical review within 2 weeks.

Symptoms should be monitored closely in all patients.

1.5.2.8 If a depressed patient on any antidepressant develops increased adverse effects early in treatment, the prescriber should provide appropriate information, and if the patient prefers the drug should be stopped or changed to a different antidepressant.

Starting treatment

1.5.2.9 When prescribing antidepressant medication for patients with moderate depression and chronic physical health problems prescribers should provide information (in writing where appropriate) about antidepressants, including:

- the delay in development of the full antidepressant effect
- the importance of taking medication as prescribed and the need to continue treatment after remission
- information on any potential side effects
- the potential for interactions with other medications
- the risk of discontinuation symptoms and how these can be minimised, particularly with a shorter half-life drugs, such as paroxetine and venlafaxine
- the fact that physical dependence does not occur with antidepressants.

Written information appropriate to the person's needs should be made available.

1.5.2.10 Prescribers should be aware that antidepressant medication for patients with depression and chronic physical health problems should be prescribed within a recognised therapeutic dose.

1.5.2.11 People started on antidepressants who are not considered to be at increased risk of suicide should normally be seen after 2 weeks. Thereafter they should be seen on an appropriate and regular basis, for example, at intervals of 2 to 4 weeks in the first 3 months and at longer intervals thereafter, if response is good.

1.5.2.12 Patients started on antidepressants who are considered to present an increased suicide risk or are younger than 30 years (because of the potential increased risk of suicidal thoughts associated with the early stages of antidepressant treatment for this group) should normally be seen after 1 week and frequently thereafter as appropriate until the risk is no longer considered significant.

1.5.2.13 When a patient with depression and a chronic physical health problem is assessed to be at a high risk of suicide, healthcare professionals should consider:

- the use of additional support such as more frequent direct or telephone contacts
- the prescription of a limited quantity of antidepressants
- referral to a specialist mental health service.

1.5.2.14 Particularly in the initial stages of SSRI treatment, healthcare professionals should actively seek out signs of suicidal ideation, increased agitation, anxiety and akathisia. They should also advise patients of the risk of these symptoms in the early stages of treatment and advise them to seek help promptly if these are at all distressing. In the event that a patient develops marked and/or prolonged agitation or akathisia while taking an antidepressant, the use of the drug should be reviewed.

Continuing treatment

1.5.2.15 Patients should be supported and encouraged to take antidepressants for 6 months after remission of an episode of depression as this greatly reduces the risk of relapse. Healthcare professionals should review with the patient the need for continued antidepressant treatment. This review should include consideration of the number of previous episodes, presence of residual symptoms, concurrent physical health problems and psychosocial difficulties.

Failure of treatment to provide benefit

1.5.2.16 When a patient's depression fails to respond to the first antidepressant within 2 to 4 weeks, the prescriber should first check that the drug has been taken regularly and in the prescribed dose.

1.5.2.17 If a patient has taken the antidepressant as prescribed and the response to a therapeutic dose is inadequate after 4 weeks, consider:

- a gradual increase in dose in line with the schedule suggested by the Summary of Product Characteristics if there are no significant side effects
- switching to another antidepressant if there is still no response after a further 2 weeks, if there are side effects, or the person expresses a preference for changing treatment.

If there has been a partial response, a decision to switch to another antidepressant can be postponed until 6 weeks.

1.5.2.18 If the person's depression shows some improvement, continue treatment for another 2 to 4 weeks and, then, if response is still not adequate, if there are side effects or the person expresses a preference for changing treatment, consider switching to another antidepressant.

- 1.5.2.19 If an antidepressant has not been effective or is poorly tolerated and – after consideration of a range of other treatment options, including psychological therapies – the decision is made to offer a further course of antidepressants, then another single antidepressant (including within the same class) should be prescribed.
- 1.5.2.20 When switching from one antidepressant to another, prescribers should be aware of the need for gradual and modest incremental increases of dose, of interactions between antidepressants and the risk of serotonin syndrome when combinations of serotonergic antidepressants are prescribed. Features of serotonin syndrome include confusion, delirium, shivering, sweating, changes in blood pressure and myoclonus.

Stopping and reducing antidepressants

- 1.5.2.21 All people prescribed antidepressants should be informed that:
- antidepressant drugs are not associated with tolerance and craving
 - discontinuation/withdrawal symptoms may occur on stopping, missing doses or, occasionally, on reducing the dose of the drug
 - discontinuation/withdrawal symptoms are usually mild and self-limiting but can occasionally be severe, particularly if the drug is stopped abruptly
 - they should take the drug as prescribed, particularly with drugs with a shorter half-life, such as paroxetine and venlafaxine, in order to avoid discontinuation/withdrawal symptoms.
- 1.5.2.22 Practitioners should normally gradually reduce the doses of the drug over a 4-week period although some people may require longer periods. This is not required with fluoxetine because of its long half-life.

1.5.2.23 If discontinuation/withdrawal symptoms occur, practitioners should:

- monitor symptoms and reassure the person if symptoms are mild
- inform the person that they should seek advice from their medical practitioner if they experience significant discontinuation/withdrawal symptoms.
- consider reintroducing the original antidepressant at the dose that was effective (or another antidepressant with a longer half-life from the same class) and reduce gradually while monitoring symptoms if symptoms are severe.

1.5.3 Psychological treatments

Cognitive behavioural therapies – choice of psychological treatment

1.5.3.1 For people with moderate depression and chronic physical health problems who are offered psychological interventions, the choice of treatment should include:

- group-based CBT
- individual CBT for those who decline group-based CBT or for whom it is not appropriate, or where a group is not available.

1.5.3.2 For people with severe depression and chronic physical health problems individual CBT in combination with antidepressant medication should be considered.

Delivering psychological interventions

1.5.3.3 For all psychological interventions the duration of treatment should normally be within the limits indicated in this guideline. As the aim of treatment is to obtain significant improvement or remission:

- the duration of treatment may be shorter if remission has been achieved
- the duration of treatment may be longer if progress is being made, and there is agreement between the practitioner and the person with depression that further sessions would be beneficial,

for example if there is comorbid personality disorder or psychosocial factors.

1.5.3.4 Group-based CBT for depression and chronic physical health problems should be:

- delivered in groups (typically between 6 and 8 people) with a common chronic health problem
- typically delivered over a period of 6 to 8 weeks
- focused on identifying and restructuring dysfunctional cognitions and behavioural activation
- delivered by healthcare professionals.

1.5.3.5 Individual CBT for moderate depression and chronic physical health problems should be:

- delivered until the symptoms have remitted (typically this should be over a period of 6 to 8 weeks and should not normally exceed 16 to 18 weeks)
- focused on identifying and restructuring dysfunctional cognitions
- followed up by two further sessions in the 6 months following the end of treatment, in particular where the treatment was extended.

1.5.3.6 Individual CBT for severe and chronic physical health problems should be:

- delivered until the symptoms have remitted (typically this should not normally exceed 16 to 18 weeks)
- focused in the initial sessions (which typically should be twice weekly for the first 2 to 3 weeks) on behavioural activation
- focused on identifying and restructuring dysfunctional cognitions
- followed up by two to three sessions in the 12 months following the end of treatment.

1.6 Step 4: Collaborative care

Collaborative care, which should form part of a well-developed stepped care programme, could be provided at the primary or secondary care level, but the interventions, which involve all sectors of care, require a coordinated approach to mental healthcare, and:

- a dedicated co-ordinator of the intervention located in and receiving support from a multi-professional team
- joint determination of the plan of care
- long-term coordination and follow up
- coordination of both mental and physical health care.

1.6.1.1 For patients with moderate or severe depression, chronic physical health problems and associated functional impairment, and who have not responded to initial psychological or pharmacological treatment, collaborative care should be considered.

1.6.1.2 Collaborative care for people with depression and chronic physical health problems should normally include:

- case management which is supervised and has support from a senior mental health professional
- close collaboration between primary and secondary physical health services and specialist mental health services
- a range of interventions consistent with those recommended in this guideline, including patient education, psychological interventions and medication management.

1.7 Step 5: complex and severe depression

1.7.1.1 Healthcare professionals providing treatment in specialist mental health services for people with depression and chronic physical health problems should:

- refer to the NICE guideline on the treatment of depression⁴
- be aware of the additional drug interactions associated with treatment of people with depression and chronic physical health problems
- work closely and collaboratively with the physical health services.

⁴ This refers to 'Depression (amended): management of depression in primary and secondary care' (NICE clinical guideline 23), which is currently being updated.

2 Notes on the scope of the guidance

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover. The scope of this guideline is available from <http://www.nice.org.uk/guidance/index.jsp?action=download&o=42261>

How this guideline was developed

NICE commissioned the National Collaborating Centre for Mental Health to develop this guideline. The Centre established a Guideline Development Group (see appendix A), which reviewed the evidence and developed the recommendations. An independent Guideline Review Panel oversaw the development of the guideline (see appendix B).

There is more information in the booklet: 'The guideline development process: an overview for stakeholders, the public and the NHS' (third edition, published April 2007), which is available from www.nice.org.uk/guidelinesprocess or from NICE publications (phone 0845 003 7783 or email publications@nice.org.uk and quote reference N1233).

3 Implementation

The Healthcare Commission assesses how well NHS organisations meet core and developmental standards set by the Department of Health in 'Standards for better health' (available from www.dh.gov.uk). Implementation of clinical guidelines forms part of the developmental standard D2. Core standard C5 says that NHS organisations should take into account national agreed guidance when planning and delivering care.

NICE has developed tools to help organisations implement this guidance (listed below). These are available on our website (www.nice.org.uk/CGXXX).
[NICE to amend list as needed at time of publication]

- Slides highlighting key messages for local discussion.
- Costing tools:
 - costing report to estimate the national savings and costs associated with implementation

- costing template to estimate the local costs and savings involved.
- Implementation advice on how to put the guidance into practice and national initiatives that support this locally.
- Audit support for monitoring local practice.

4 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future.

4.1 *Clinical and cost effectiveness of combined medication and cognitive behavioural therapy for moderate to severe depression in people with chronic physical health problems*

What is the clinical and cost effectiveness of combined medication and cognitive behavioural treatment compared with antidepressants or cognitive behavioural treatments alone?

The benefits of combined cognitive behavioural treatment and antidepressant treatment for people with moderate and severe depression in the absence of a chronic physical health problem is established. However, the evidence for combined treatments in people with depression and chronic physical health problems is not so well established. In addition to the uncertainty about the effectiveness of the interventions the potential interactions between antidepressant medication and medication prescribed for individuals with chronic physical health problems presents further problems both in terms of the difficulties that may arise from drug interactions and individual patients' anxieties about this which may reduce the likelihood of them complying with antidepressant medication. The outcomes for this study should involve both observer and patient rated assessments of acute and medium term outcomes for at least six months and an assessment of the acceptability and burden of the various treatment options. The study needs to be large enough to

determine the presence or absence of any clinically important effects using a non-inferiority design together with robust health economic measures.

Why this is important

There is a limited evidence base for combined cognitive behavioural treatment and antidepressant treatment for people with moderate and severe depression. However the data from depression in the absence of chronic health problems suggests both may bring real benefit. However uncertainty about their medium-term outcomes remains. The answer to this question has practical implications for service delivery and resource allocation in the NHS.

4.2 *The effectiveness of peer support interventions compared with group based exercise and treatment as usual for people with low to moderate depression and chronic physical health problems*

What is the efficacy of group peer support and group based exercise when compared to treatment as usual?

This question should be answered in an adequately powered three arm randomised controlled trial that examines medium-term outcomes, including cost effectiveness. The outcomes should reflect both observer and patient rated assessments for acute and medium-term outcome for 12 months and an assessment of the acceptability and potential burden of treatment options. The study needs to be large enough to determine the presence or absence of clinically important effects using a non-inferiority design with robust health economic measures.

Why this is important

There is a limited evidence base for peer support and exercise in the treatment of people with depression and chronic physical health problems. However the data so far available suggest both are practical and potentially acceptable measures which may bring real benefit. However uncertainty about their medium-term outcomes remains. The answer to this question has practical implications for service delivery and resource allocation in the NHS.

4.3 *Clinical and cost effectiveness of antidepressant medication compared with placebo in people with depression and chronic physical health problems*

What is the clinical and cost effectiveness of antidepressant medication compared to placebo in people with depression and chronic obstructive pulmonary disease (COPD)?

The question should be answered using a randomised controlled trial in which moderately depressed people with COPD should receive either placebo or antidepressant medication. The outcomes chosen should reflect both observer and patient rated assessments for acute and medium-term outcomes for at least six months and an assessment of the acceptability and burden of treatment. In addition to the assessment of depressive symptoms the study should also assess the impact of antidepressant medication on anxiety symptoms. The study needs to be large enough to determine the presence or absence of clinically important effects using a non-inferiority design together with robust health economic measures.

Why this is important

There is a limited evidence base for antidepressant treatment in people with chronic physical health problems. Particularly of concern to the Guideline Development Group was the high incidence of depression in COPD, (already known to be related to high incidence of anxiety disorders). In spite of this the group considered it important to measure the effectiveness of antidepressant medication in the treatment of COPD but also thought it would be helpful to manage the co-morbid anxiety symptoms as well. The answer to this question is important for the practical implications for service delivery particularly with a group whose mental health needs are traditionally under-treated within the NHS.

4.4 *Clinical and cost effectiveness of behavioural activation compared with antidepressant medication for individuals with depression and chronic physical health problems*

What is the clinical and cost effectiveness of behavioural activation compared with antidepressant medication in the treatment of depression in people with chronic physical health problems?

This question should be answered using a randomised controlled trial in which people with moderate to severe depression receive either behavioural activation or antidepressant medication. The outcomes should be chosen to reflect both observer and patient rated assessments for acute and medium-term outcomes for at least 12 months and also assessment of the acceptability and burden of the treatment options. The study needs to be large enough to determine the presence or absence of clinically important effects using a non-inferiority design and robust health economic measures.

Why this is important

There is a limited evidence base for high intensity psychological interventions in the treatment of depression and chronic physical health problems; the most substantial evidence base is for cognitive behavioural therapy. However recent developments in the broader field of cognitive and behavioural therapies suggest that behavioural activation may be an effective intervention for depression. In principle this may be a more feasible treatment to deliver in routine care and potentially contribute to increased treatment choice for patients. The answer would have practical implications for the service delivery and resource allocation within the NHS.

4.5 *Clinical and cost effectiveness of collaborative care for people with depression and chronic respiratory disorders*

What is the effectiveness of collaborative care for people with depression and chronic respiratory disorders?

This question should be answered using a randomised controlled trial design in people with moderate to severe depression and a chronic respiratory disorder. Outcomes should reflect both observer and patient rated assessments of medium- and long-term outcomes for at least 18 months. It should also include an assessment of the acceptability and burden of treatment options and the impact of the intervention on the overall care system. This study should be large enough to determine the presence or absence of clinically important effects using a non-inferiority design together with robust health outcome measures.

Why this is important

There is a reasonable evidence base to support the use of collaborative care in people with moderate to severe depression and chronic physical health problems. However the evidence base for people with respiratory disorders is more limited and given the relatively high incidence of depression in this group a trial is required. The answer has important practical implications for service delivery and resource allocation within the NHS.

4.6 *The effectiveness of physical rehabilitation programmes for people with chronic physical health problems and depression on depressive symptomatology*

What is the effectiveness in terms of improved mood of rehabilitation programmes for people with acute and chronic physical health problems?

This question should be answered by an individual patient meta-analysis.

There is an existing evidence base showing that programmes specifically designed to treat depression, for example psychosocial and pharmacological interventions in people with chronic physical health problems, are effective. However many people with chronic physical health problems are also in receipt of specifically designed rehabilitation programmes (for example cardiac rehabilitation programmes following myocardial infarction). These interventions are multi-modal and reports indicate that they can have an

impact on mental health outcomes, in particular depression. However, it is unclear what the size of this effect may be, the components of the intervention that are effective and the specific patient populations that may benefit.

Therefore it is suggested that before any further research is conducted an individual patient meta-analysis be undertaken to examine the impact of rehabilitation programmes on depressive symptoms in people with chronic physical health problems.

Why this is important

Many people with chronic physical health problems undergo rehabilitation programmes. There is some suggestion in the literature that these have a beneficial effect on mental health. Understanding and/or enhancing the potentially psychological benefits of these interventions has potentially important cost and service design implications for the NHS. Given the large data set that already exists on these, before embarking on any individual studies it is important to determine the potential effects of these programmes to date. The answer has important practical implications for service delivery and resource allocation within the NHS.

5 Other versions of this guideline

5.1 Full guideline

The full guideline, 'Depression: the treatment and management of depression in adults with chronic physical health problems' contains details of the methods and evidence used to develop the guideline. It is published by the National Collaborating Centre for Mental Health, and is available from <http://www.nccmh.org.uk> and our website (www.nice.org.uk/CGXXXfullguideline). **[Note: these details will apply to the published full guideline.]**

5.2 Quick reference guide

A quick reference guide for healthcare professionals is available from www.nice.org.uk/CGXXXquickrefguide

For printed copies, phone NICE publications on 0845 003 7783 or email publications@nice.org.uk (quote reference number N1XXX). **[Note: these details will apply when the guideline is published.]**

5.3 'Understanding NICE guidance'

A summary for patients and carers ('Understanding NICE guidance') is available from www.nice.org.uk/CGXXXpublicinfo

For printed copies, phone NICE publications on 0845 003 7783 or email publications@nice.org.uk (quote reference number N1XXX). **[Note: these details will apply when the guideline is published.]**

We encourage NHS and voluntary sector organisations to use text from this booklet in their own information about depression and chronic physical health problems.

6 Related NICE guidance

Published

Depression (amended): management of depression in primary and secondary care. NICE clinical guideline 23 (2007). Available from www.nice.org.uk/CG23

Under development

NICE is developing the following guidance (details available from www.nice.org.uk):

Depression: the treatment and management of depression in adults (update). NICE clinical guideline (publication expected September 2009)

7 Updating the guideline

NICE clinical guidelines are updated as needed so that recommendations take into account important new information. New evidence is checked 3 years after publication, and healthcare professionals and patients are asked for their views; we use this information to decide whether all or part of a guideline needs updating. If important new evidence is published at other times, we may decide to do a more rapid update of some recommendations.

Appendix A: The Guideline Development Group

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Appendix B: The Guideline Review Panel

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring adherence to NICE guideline development processes. In particular, the panel ensures that stakeholder comments have been adequately considered and responded to. The panel includes members from the following perspectives: primary care, secondary care, lay, public health and industry.

[NICE to add]

Appendix C: Assessing depression and its severity

Key symptoms:

- persistent sadness or low mood **and/or**
- marked loss of interests or pleasure.

At least one of these, most days, most of the time for at least 2 weeks.

If any of above present, ask about associated symptoms:

- disturbed sleep (decreased or increased compared to usual)
- decreased or increased appetite and/or weight
- fatigue or loss of energy
- agitation or slowing of movements
- poor concentration or indecisiveness
- feelings of worthlessness or excessive or inappropriate guilt
- suicidal thoughts or acts.

Then ask about duration and associated disability, past and family history of mood disorders, and availability of social support

1. Factors that favour general advice and active monitoring:

- four or fewer of the above symptoms with little associated disability
- symptoms intermittent, or less than 2 weeks' duration
- recent onset with identified stressor
- no past or family history
- social support available
- lack of suicidal thoughts.

2. Factors that favour more active treatment in primary care:

- five or more symptoms with associated disability
- persistent or long-standing symptoms
- personal or family history of depression
- low social support
- occasional suicidal thoughts.

3. Factors that favour referral to mental health professionals:

- poor or incomplete response to two or more interventions
- recurrent episode within 1 year of last one
- history suggestive of bipolar disorder
- person with depression or relatives request referral
- more persistent suicidal thoughts
- self-neglect.

4. Factors that favour urgent referral to specialist mental health services

- actively suicidal ideas or plans
- psychotic symptoms
- severe agitation accompanying severe symptoms
- severe self-neglect.

Depression definitions⁵

Minor depression: 2 to 4 symptoms with maintained function.

Mild depression: Few, if any, symptoms in excess of 5 with only minor functional impairment

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

Severe depression: Several symptoms in excess of 5 and symptoms markedly interfere with functioning. With or without psychotic features.

⁵ These are taken from DSM-IV. ICD-10 is similar but the threshold for mild depression is lower at 4 symptoms.