NICE National Institute for Health and Care Excellence

Depression in adults with a chronic physical health problem

Treatment and management

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Introduction

This guideline is published alongside 'Depression: the treatment and management of depression in adults (update)' (NICE clinical guideline 90), which makes recommendations on the identification, treatment and management of depression in adults aged 18 years and older, in primary and secondary care.

This guideline (and CG90) update recommendations made in NICE technology appraisal guidance 97 for the treatment of depression only. The guidance in TA97 remains unchanged for the use of CCBT in the treatment of panic and phobia and obsessive compulsive disorder.

This guideline makes recommendations on the identification, treatment and management of depression in adults aged 18 years and older who also have a chronic physical health problem (such as cancer, heart disease, diabetes, or a musculoskeletal, respiratory or neurological disorder).

Depression is a broad and heterogeneous diagnosis. Central to it is depressed mood and/or loss of pleasure in most activities. A chronic physical health problem can both cause and exacerbate depression: pain, functional impairment and disability associated with chronic physical health problems can greatly increase the risk of depression in people with physical illness, and depression can also exacerbate the pain and distress associated with physical illnesses and adversely affect outcomes, including shortening life expectancy. Furthermore, depression can be a risk factor in the development of a range of physical illnesses, such as cardiovascular disease. When a person has both depression and a chronic physical health problem, functional impairment is likely to be greater than if a person has depression or the physical health problem alone.

Depression is approximately two to three times more common in patients[†] with a chronic physical health problem than in people who have good physical health and occurs in about 20% of people with a chronic physical health problem.

Severity of depression is determined by both the number and severity of symptoms, as well as the degree of functional impairment. A formal diagnosis using the ICD-10 classification system requires at least four out of ten depressive symptoms, whereas the DSM-IV system requires at least five out of nine for a diagnosis of major depression (referred to in this guideline as 'depression'). Symptoms should be present for at least 2 weeks and each symptom should be

present at sufficient severity for most of every day. Both diagnostic systems require at least one (DSM-IV) or two (ICD-10) key symptoms (low mood[2], loss of interest and pleasure[2] or loss of energy[3]) to be present.

Increasingly, it is recognised that depressive symptoms below the DSM-IV and ICD-10 threshold criteria can be distressing and disabling if persistent. Therefore this guideline covers 'subthreshold depressive symptoms', which fall below the criteria for a diagnosis of major depression, and are defined as at least one key symptom of depression but with insufficient other symptoms and/or functional impairment to meet the criteria for full diagnosis. Symptoms are considered persistent if they continue despite active monitoring and/or low-intensity intervention, or have been present for a considerable time, typically several months. (For a diagnosis of dysthymia, symptoms should be present for at least 2 years[4].)

The presence of a physical illness can complicate the assessment of depression and some symptoms, such as fatigue, are common to both mental and physical disorders.

It should be noted that classificatory systems are agreed conventions that seek to define different severities of depression in order to guide diagnosis and treatment, and their value is 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 rather than ICD-10, which was used in the previous depression guideline (NICE clinical guideline 23). This is because DSM-IV is used in nearly all the evidence reviewed and it provides definitions for 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, clinicians are not expected to switch to DSM-IV but should be aware that the threshold for mild depression is higher than with ICD-10 (five symptoms not four) and that degree of functional impairment should be routinely assessed before making a diagnosis. Using DSM-IV enables the guideline to better target the use of specific interventions, such as antidepressants, for more severe degrees of depression.

In addition to physical illness, a wide range of psychological and social factors, which are not captured well by current diagnostic systems, have a significant impact on the course of depression and the response to treatment. Therefore it is also important to consider both personal past history and family history of depression when undertaking a diagnostic assessment (see appendix C for further details).

Treating depression in people with a chronic physical health problem has the potential to increase their quality of life and life expectancy. Depression often has a remitting and relapsing course, and symptoms may persist between episodes. Where possible, the key goal of an intervention for depression should be complete relief of symptoms (remission) – this is associated with better functioning and a lower likelihood of relapse than lesser degrees of response, as well as potentially better physical health outcomes.

The guideline will assume that prescribers will use a drug's summary of product characteristics (SPC) and the 'British national formulary' (BNF) to inform decisions made with individual patients.

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[1] Throughout this guideline, the term 'patient' is used to denote a person who has both depression and a chronic physical health problem.

[2] In both ICD-10 and DSM-IV.

[3] In ICD-10 only.

[4] Both DSM-IV and ICD-10 have the category of dysthymia, which consists of depressive symptoms that are subthreshold for major depression but that persist (by definition for more than 2 years). There appears to be no empirical evidence that dysthymia is distinct from subthreshold depressive symptoms apart from duration of symptoms, and the term 'persistent subthreshold depressive symptoms' is preferred in this guideline.

Patient-centred care

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

Treatment and care should take into account patient's needs and preferences. People with depression and a chronic physical health problem should have the opportunity to make informed decisions, including advance decisions and advance statements, about their care and treatment, in partnership with their practitioners. If patients do not have the capacity to make decisions, healthcare professionals should follow the Department of Health's advice on consent and the code of practice that accompanies the Mental Capacity Act. In Wales, healthcare professionals should follow advice on consent from the Welsh Government.

Good communication between practitioners 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

- When assessing a patient with a chronic physical health problem who may have depression, conduct a comprehensive assessment that does not rely simply on a symptom count. Take into account both the degree of functional impairment and/or disability associated with the possible depression and the duration of the episode.

Effective delivery of interventions for depression

- All interventions for depression should be delivered by competent practitioners. Psychological and psychosocial interventions should be based on the relevant treatment manual(s), which should guide the structure and duration of the intervention. Practitioners should consider using competence frameworks developed from the relevant treatment manual(s) and for all interventions should:
    - receive regular high-quality supervision
    - use routine outcome measures and ensure that the patient with depression is involved in reviewing the efficacy of the treatment
    - engage in monitoring and evaluation of treatment adherence and practitioner competence – for example, by using video and audio tapes, and external audit and scrutiny where appropriate.

Case identification and recognition

- Be alert to possible depression (particularly in patients with a past history of depression or a chronic physical health problem with associated functional impairment) and consider asking patients who may have depression two questions, specifically:
    - 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?

Low-intensity psychosocial interventions

- For patients with persistent subthreshold depressive symptoms or mild to moderate depression and a chronic physical health problem, and for patients with subthreshold depressive symptoms that complicate the care of the chronic physical health problem, consider offering one or more of the following interventions, guided by the patient's preference:
    - a structured group physical activity programme
    - a group-based peer support (self-help) programme
    - individual guided self-help based on the principles of cognitive behavioural therapy (CBT)
    - computerised cognitive behavioural therapy (CCBT)[5].

Treatment for moderate depression

- For patients with initial presentation of moderate depression and a chronic physical health problem, offer the following choice of high-intensity psychological interventions:
    - group-based CBT **or**
    - individual CBT for patients who decline group-based CBT or for whom it is not appropriate, or where a group is not available **or**
    - behavioural couples therapy for people who have a regular partner and where the relationship may contribute to the development or maintenance of depression, or where involving the partner is considered to be of potential therapeutic benefit.

Antidepressant drugs

- Do not use antidepressants routinely to treat subthreshold depressive symptoms or mild depression in patients with a chronic physical health problem (because the risk–benefit ratio is poor), 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 that have been present for a long period (typically at least 2 years) **or**
  - subthreshold depressive symptoms or mild depression that persist(s) after other interventions.

- When an antidepressant is to be prescribed for a patient with depression and a chronic physical health problem, take into account the following:
  - the presence of additional physical health disorders
  - the side effects of antidepressants, which may impact on the underlying physical disease (in particular, SSRIs may result in or exacerbate hyponatraemia, especially in older people)
  - that there is no evidence as yet supporting the use of specific antidepressants for patients with particular chronic physical health problems
  - interactions with other medications.

Collaborative care

- Consider collaborative care for patients with moderate to severe depression and a chronic physical health problem with associated functional impairment whose depression has not responded to initial high-intensity psychological interventions, pharmacological treatment or a combination of psychological and pharmacological interventions.

[5] This recommendation (and recommendation 1.4.2.1 in CG90) updates the recommendations on depression only in 'Computerised cognitive behaviour therapy for depression and anxiety (review)' (NICE technology appraisal guidance 97).

1 Guidance

The following guidance is based on the best available evidence. The full guideline gives details of the methods and the evidence used to develop the guidance.

Box 1 Depression definitions (taken from DSM-IV)

Subthreshold depressive symptoms: Fewer than 5 symptoms of depression.

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.

Note that a comprehensive assessment of depression should not rely simply on a symptom count, but should take into account the degree of functional impairment and/or disability (see section 1.1.3).

Throughout this guideline, the term 'patient' is used to denote a person who has both depression and a chronic physical health problem.

This guideline is published alongside 'Depression: the treatment and management of depression in adults (update)' (NICE clinical guideline 90), which makes recommendations on the identification, treatment and management of depression in adults aged 18 years and older, in primary and secondary care.

1.1 Care of all people with depression

1.1.1 Providing information and support, and obtaining informed consent

1.1.1.1 When working with patients with depression and a chronic physical health problem and their families or carers:

- build a trusting relationship and work in an open, engaging and non-judgemental manner

- explore treatment options for depression 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 and take into account how this may affect the patient with a chronic physical health problem
- ensure that discussions take place in settings in which confidentiality, privacy and dignity are respected.

1.1.1.2 When working with patients with depression and a chronic physical health problem and their families or carers:

- provide information appropriate to their level of understanding about the nature of depression and the range of treatments available
- 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 (that is, someone who is not known to the patient) if needed.

1.1.1.3 Inform patients with depression and a chronic physical health problem about self-help groups, support groups and other local and national resources for people with depression.

1.1.1.4 Make all efforts necessary to ensure that a patient with depression and a chronic physical health problem can give meaningful and informed consent before treatment starts. This is especially important when a patient has severe depression or is subject to the Mental Health Act.

1.1.1.5 Ensure that consent to treatment is based on the provision of clear information (which should also be available in written form) about the intervention, covering:

- what it comprises

- what is expected of the patient while having it
- likely outcomes (including any side effects).

1.1.2 Supporting families and carers

1.1.2.1 When families or carers are involved in supporting a patient with severe or chronic[6] depression and a chronic physical health problem, consider:

- providing written and verbal information on depression and its management, including how families or carers can support the patient
- offering a carer's assessment of their caring, physical and mental health needs if necessary
- providing information about local family or carer support groups and voluntary organisations, and helping families or carers to access these
- negotiating between the patient and their family or carer about confidentiality and the sharing of information.

1.1.3 Principles for assessment, coordination of care and choosing treatments

1.1.3.1 When assessing a patient with a chronic physical health problem who may have depression, conduct a comprehensive assessment that does not rely simply on a symptom count. Take into account both the degree of functional impairment and/or disability associated with the possible depression and the duration of the episode.

1.1.3.2 In addition to assessing symptoms and associated functional impairment, consider how the following factors may have affected the development, course and severity of a patient's depression:

- any history of depression and comorbid mental health or physical disorders
- any past history of mood elevation (to determine if the depression may be part of bipolar disorder[7])
- any past experience of, and response to, treatments

- the quality of interpersonal relationships
- living conditions and social isolation.

1.1.3.3 Be respectful of, and sensitive to, diverse cultural, ethnic and religious backgrounds when working with patients with depression and a chronic physical health problem, and be aware of the possible variations in the presentation of depression. Ensure competence in:

- culturally sensitive assessment
- using different explanatory models of depression
- addressing cultural and ethnic differences when developing and implementing treatment plans
- working with families from diverse ethnic and cultural backgrounds.

1.1.3.4 When assessing a patient with a chronic physical health problem and suspected depression, be aware of any learning disabilities or acquired cognitive impairments, and if necessary consider consulting with a relevant specialist when developing treatment plans and strategies.

1.1.3.5 When providing interventions for patients with a learning disability or acquired cognitive impairment who have a chronic physical health problem and a diagnosis of depression:

- where possible, provide the same interventions as for other patients with depression
- if necessary, adjust the method of delivery or duration of the intervention to take account of the disability or impairment.

1.1.3.6 Always ask patients with depression and a chronic physical health problem directly about suicidal ideation and intent. If there is a risk of self-harm or suicide:

- assess whether the patient has adequate social support and is aware of sources of help

- arrange help appropriate to the level of risk (see section 1.3.2)
- advise the patient to seek further help if the situation deteriorates.

1.1.4 Effective delivery of interventions for depression

1.1.4.1 All interventions for depression should be delivered by competent practitioners. Psychological and psychosocial interventions should be based on the relevant treatment manual(s), which should guide the structure and duration of the intervention. Practitioners should consider using competence frameworks developed from the relevant treatment manual(s) and for all interventions should:

- receive regular high-quality supervision
- use routine outcome measures and ensure that the patient with depression is involved in reviewing the efficacy of the treatment
- engage in monitoring and evaluation of treatment adherence and practitioner competence – for example, by using video and audio tapes, and external audit and scrutiny where appropriate.

1.1.4.2 Consider providing all interventions in the preferred language of the patient with depression and a chronic physical health problem where possible.

1.1.4.3 Where a patient's management is shared between primary and secondary care, there should be clear agreement between practitioners (especially the patient's GP) on the responsibility for the monitoring and treatment of that patient. The treatment plan should be shared with the patient and, where appropriate, with their family or carer.

1.1.4.4 If a patient's chronic physical health problem restricts their ability to engage with a preferred psychosocial or psychological treatment for depression (see sections 1.4.2, 1.5.1 and 1.5.3), consider alternatives in discussion with the patient, such as antidepressants (see section 1.5.2) or delivery of psychosocial or psychological interventions by telephone if mobility or other difficulties prevent face-to face contact.

1.2 Stepped care

The stepped-care model provides a framework in which to organise the provision of services, and supports patients, carers and practitioners in identifying and accessing the most effective interventions (see figure 1). In stepped care the least intrusive, most effective intervention is provided first; if a patient does not benefit from the intervention initially offered, or declines an intervention, they should be offered an appropriate intervention from the next step.

Figure 1 The stepped-care model

Focus of the intervention	Nature of the intervention
STEP 4: Severe and complex[a] depression; risk to life; severe self-neglect	Medication, high-intensity psychological interventions, electroconvulsive therapy, crisis service, combined treatments, multiprofessional and inpatient care
STEP 3: Persistent subthreshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions; moderate and severe depression	Medication, high-intensity psychological interventions, combined treatments, collaborative care[b] and referral for further assessment and interventions
STEP 2: Persistent subthreshold depressive symptoms; mild to moderate depression	Low-intensity psychosocial interventions, psychological interventions, medication and referral for further assessment and interventions
STEP 1: All known and suspected presentations of depression	Assessment, support, psychoeducation, active monitoring and referral for further assessment and interventions
[a] Complex depression includes depression that shows an inadequate response to multiple treatments, is complicated by psychotic symptoms, and/or is associated with significant psychiatric comorbidity or psychosocial factors [b] Only for depression where the person also has a chronic physical health problem and associated functional impairment (see 'Depression in adults with a chronic physical health problem: treatment and management' [NICE clinical guideline 91]).	

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

The recommendations in this section are primarily for practitioners working in primary care and in general hospital settings. Practitioners should be aware that patients with a chronic physical health problem are at a high risk of depression, particularly where there is functional impairment.

1.3.1 Case identification and recognition

1.3.1.1 Be alert to possible depression (particularly in patients with a past history of depression or a chronic physical health problem with associated functional impairment) and consider asking patients who may have depression two questions, specifically:

- 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 patient with a chronic physical health problem answers 'yes' to either of the depression identification questions (see 1.3.1.1) but the practitioner is not competent to perform a mental health assessment, they should refer the patient to an appropriate professional. If this professional is not the patient's GP, inform the GP of the referral.

1.3.1.3 If a patient with a chronic physical health problem answers 'yes' to either of the depression identification questions (see 1.3.1.1), a practitioner who is competent to perform a mental health assessment should:

- ask three further questions to improve the accuracy of the assessment of depression, specifically:
  - during the last month, have you often been bothered by feelings of worthlessness?
  - during the last month, have you often been bothered by poor concentration?

- during the last month, have you often been bothered by thoughts of death?

- review the patient's mental state and associated functional, interpersonal and social difficulties
- consider the role of both the chronic physical health problem and any prescribed medication in the development or maintenance of the depression
- ascertain that the optimal treatment for the physical health problem is being provided and adhered to, seeking specialist advice if necessary.

1.3.1.4 When assessing a patient with suspected depression, consider using a validated measure (for example, for symptoms, functions and/or disability) to inform and evaluate treatment.

1.3.1.5 For patients with significant language or communication difficulties, for example patients with sensory impairments or a learning disability, consider using the Distress Thermometer[8] and/or asking a family member or carer about the patient's symptoms to identify possible depression. If a significant level of distress is identified, investigate further.

1.3.2 Risk assessment and monitoring

1.3.2.1 If a patient with depression and a chronic physical health problem presents considerable immediate risk to themselves or others, refer them urgently to specialist mental health services.

1.3.2.2 Advise patients with depression and a chronic physical health problem of the potential for increased agitation, anxiety and suicidal ideation in the initial stages of treatment for depression; actively seek out these symptoms and:

- ensure that the patient knows how to seek help promptly
- review the patient's treatment if they develop marked and/or prolonged agitation.

1.3.2.3 Advise a patient with depression and a chronic physical health problem, and their family or carer, to be vigilant for mood changes, negativity and hopelessness, and suicidal ideation, and to contact their practitioner if

concerned. This is particularly important during high-risk periods, such as starting or changing treatment and at times of increased personal stress.

1.3.2.4 If a patient with depression and a chronic physical health problem is assessed to be at risk of suicide:

- take into account toxicity in overdose if an antidepressant is prescribed or the patient is taking other medication; if necessary, limit the amount of drug(s) available
- consider increasing the level of support, such as more frequent direct or telephone contacts
- consider referral to specialist mental health services.

1.4 Step 2: recognised depression in primary care and general hospital settings – persistent subthreshold depressive symptoms or mild to moderate depression

1.4.1 General measures

Depression with anxiety

1.4.1.1 When depression is accompanied by symptoms of anxiety, the first priority should usually be to treat the depression. When the patient has an anxiety disorder and comorbid depression or depressive symptoms, consult the NICE guideline for the relevant anxiety disorder (see section 6) and consider treating the anxiety disorder first (since effective treatment of the anxiety disorder will often improve the depression or the depressive symptoms).

Sleep hygiene

1.4.1.2 Offer patients with depression and a chronic physical health problem advice on sleep hygiene if needed, 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 where this is possible for the patient.

Active monitoring

1.4.1.3 For patients who, in the judgement of the practitioner, may recover with no formal intervention, or patients with mild depression who do not want an intervention, or patients with subthreshold depressive symptoms who request an intervention:

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

1.4.2 Low-intensity psychosocial interventions

1.4.2.1 For patients with persistent subthreshold depressive symptoms or mild to moderate depression and a chronic physical health problem, and for patients with subthreshold depressive symptoms that complicate the care of the chronic physical health problem, consider offering one or more of the following interventions, guided by the patient's preference:

- a structured group physical activity programme
- a group-based peer support (self-help) programme
- individual guided self-help based on the principles of cognitive behavioural therapy (CBT)
- computerised cognitive behavioural therapy (CCBT)[9].

Delivery of low-intensity psychosocial interventions

1.4.2.2 Physical activity programmes for patients with persistent subthreshold depressive symptoms or mild to moderate depression and a chronic physical health problem, and for patients with subthreshold depressive symptoms that complicate the care of the chronic physical health problem, should:

- be modified (in terms of the duration of the programme and frequency and length of the sessions) for different levels of physical ability as a result of the particular chronic physical health problem, in liaison with the team providing care for the physical health problem
- be delivered in groups with support from a competent practitioner
- consist typically of two or three sessions per week of moderate duration (45 minutes to 1 hour) over 10 to 14 weeks (average 12 weeks)
- be coordinated or integrated with any rehabilitation programme for the chronic physical health problem.

1.4.2.3 Group-based peer support (self-help) programmes for patients with persistent subthreshold depressive symptoms or mild to moderate depression and a chronic physical health problem, and for patients with subthreshold depressive symptoms that complicate the care of the chronic physical health problem, should:

- be delivered to groups of patients with a shared chronic physical health problem
- focus on sharing experiences and feelings associated with having a chronic physical health problem
- be supported by practitioners who should:
  - facilitate attendance at the meetings
  - have knowledge of the patients' chronic physical health problem and its relationship to depression
  - review the outcomes of the intervention with the individual patients

- consist typically of one session per week delivered over a period of 8 to 12 weeks.

1.4.2.4 Individual guided self-help programmes based on the principles of CBT (and including behavioural activation and problem-solving techniques) for patients with persistent subthreshold depressive symptoms or mild to moderate depression and a chronic physical health problem, and for patients with subthreshold depressive symptoms that complicate the care of the chronic physical health problem, should:

- include the provision of written materials of an appropriate reading age (or alternative media to support access)
- be supported by a trained practitioner, who typically facilitates the self-help programme and reviews progress and outcome
- consist of up to six to eight sessions (face-to-face and via telephone) normally taking place over 9 to 12 weeks, including follow-up.

1.4.2.5 CCBT for patients with persistent subthreshold depressive symptoms or mild to moderate depression and a chronic physical health problem, and for patients with subthreshold depressive symptoms that complicate the care of the chronic physical health problem, should:

- be provided via a stand-alone computer-based or web-based programme
- include an explanation of the CBT model, encourage tasks between sessions, and use thought-challenging and active monitoring of behaviour, thought patterns and outcomes
- be supported by a trained practitioner, who typically provides limited facilitation of the programme and reviews progress and outcome
- typically take place over 9 to 12 weeks, including follow-up.

1.4.3 Drug treatment

1.4.3.1 Do not use antidepressants routinely to treat subthreshold depressive symptoms or mild depression in patients with a chronic physical health

problem (because the risk–benefit ratio is poor), 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 that have been present for a long period (typically at least 2 years) **or**
- subthreshold depressive symptoms or mild depression that persist(s) after other interventions.

1.4.3.2 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 patients with depression and a chronic physical health problem 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 patients 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 – persistent subthreshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions, and moderate and severe depression

1.5.1 Treatment options

1.5.1.1 For patients with persistent subthreshold depressive symptoms or mild to moderate depression and a chronic physical health problem who have not benefited from a low-intensity psychosocial intervention, discuss the relative merits of different interventions with the patient and provide:

- an antidepressant (normally a selective serotonin reuptake inhibitor [SSRI]) or
- one of the following high-intensity psychological interventions:
  - group-based CBT **or**
  - individual CBT for patients who decline group-based CBT or for whom it is not appropriate, or where a group is not available **or**
  - behavioural couples therapy for people who have a regular partner and where the relationship may contribute to the development or maintenance of depression, or where involving the partner is considered to be of potential therapeutic benefit.

1.5.1.2 For patients with initial presentation of moderate depression and a chronic physical health problem, offer the following choice of high-intensity psychological interventions:

- group-based CBT **or**
- individual CBT for patients who decline group-based CBT or for whom it is not appropriate, or where a group is not available **or**
- behavioural couples therapy for people who have a regular partner and where the relationship may contribute to the development or maintenance of depression, or where involving the partner is considered to be of potential therapeutic benefit.

1.5.1.3 For patients with initial presentation of severe depression and a chronic physical health problem, consider offering a combination of individual CBT and an antidepressant.

1.5.1.4 The choice of intervention should be influenced by the:

- duration of the episode of depression and the trajectory of symptoms
- previous course of depression and response to treatment
- likelihood of adherence to treatment and any potential adverse effects
- course and treatment of the chronic physical health problem

- patient's treatment preference and priorities.

1.5.2 Antidepressant drugs

Choice of antidepressants[10]

1.5.2.1 When an antidepressant is to be prescribed for a patient with depression and a chronic physical health problem, take into account the following:

- the presence of additional physical health disorders
- the side effects of antidepressants, which may impact on the underlying physical disease (in particular, SSRIs may result in or exacerbate hyponatraemia, especially in older people)
- that there is no evidence as yet supporting the use of specific antidepressants for patients with particular chronic physical health problems
- interactions with other medications.

1.5.2.2 When an antidepressant is to be prescribed, be aware of drug interactions and:

- refer to appendix 1 of the BNF[n] and the table of interactions in appendix 16 of the full guideline for information
- seek specialist advice if there is uncertainty
- if necessary, refer the patient to specialist mental health services for continued prescribing.

1.5.2.3 First prescribe an SSRI in generic form unless there are interactions with other drugs; consider using citalopram or sertraline because they have less propensity for interactions.

1.5.2.4 When prescribing antidepressants, be aware that:

- dosulepin should not be prescribed

- non-reversible monoamine oxidase inhibitors (MAOIs; for example, phenelzine), combined antidepressants and lithium augmentation of antidepressants should normally be prescribed only by specialist mental health professionals.

1.5.2.5 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 recommended for routine use in primary care, 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.

Interactions of SSRIs with other medication

See appendix 1 of the BNF and appendix 16 of the full guideline for information on drug interactions.

1.5.2.6 Do not normally offer SSRIs to patients taking non-steroidal anti-inflammatory drugs (NSAIDs) because of the increased risk of gastrointestinal bleeding. Consider offering an antidepressant with a lower propensity for, or a different range of, interactions, such as mianserin, mirtazapine, moclobemide, reboxetine or trazodone.

1.5.2.7 If no suitable alternative antidepressant can be identified, SSRIs may be prescribed at the same time as NSAIDs if gastroprotective medicines (for example, proton-pump inhibitors) are also offered.

1.5.2.8 Do not normally offer SSRIs to patients taking warfarin or heparin because of their anti-platelet effect.

1.5.2.9 Use SSRIs with caution in patients taking aspirin. When aspirin is used as a single agent, consider alternatives that may be safer, such as trazodone, mianserin or reboxetine.

1.5.2.10 If no suitable alternative antidepressant can be identified, SSRIs may be prescribed at the same time as aspirin if gastroprotective medicines (for example, proton-pump inhibitors) are also offered.

1.5.2.11 Consider offering mirtazapine to patients taking heparin, aspirin or warfarin (but note that when taken with warfarin, the international normalised ratio [INR] may increase slightly).

1.5.2.12 Do not offer SSRIs to patients receiving 'triptan' drugs for migraine. Offer a safer alternative such as mirtazapine, trazodone, mianserin or reboxetine.

1.5.2.13 Do not normally offer SSRIs at the same time as monoamine oxidase B (MAO-B) inhibitors such as selegiline and rasagiline. Offer a safer alternative such as mirtazapine, trazodone, mianserin or reboxetine.

1.5.2.14 Do not normally offer fluvoxamine to patients taking theophylline, clozapine, methadone or tizamidine. Offer a safer alternative such as sertraline or citalopram.

1.5.2.15 Offer sertraline as the preferred antidepressant for patients taking flecainide or propafenone, although mirtazapine and moclobemide may also be used.

1.5.2.16 Do not offer fluoxetine or paroxetine to patients taking atomoxetine. Offer a different SSRI.

Starting treatment

1.5.2.17 When prescribing antidepressants, explore any concerns the patient with depression and a chronic physical health problem has about taking medication, explain fully the reasons for prescribing, and provide information about taking antidepressants, including:

- the gradual development of the full antidepressant effect
- the importance of taking medication as prescribed and the need to continue treatment after remission
- potential side effects
- the potential for interactions with other medications

- the risk and nature of discontinuation symptoms with all antidepressants, particularly with drugs with a shorter half-life (such as paroxetine and venlafaxine), and how these symptoms can be minimised
- the fact that addiction does not occur with antidepressants.

Offer written information appropriate to the patient's needs.

1.5.2.18 Prescribe antidepressant medication at a recognised therapeutic dose for patients with depression and a chronic physical health problem (that is, avoid the tendency to prescribe at subtherapeutic doses in these patients).

1.5.2.19 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 thereafter, for example at intervals of 2 to 4 weeks in the first 3 months, and then at longer intervals if response is good.

1.5.2.20 A patient with depression started on antidepressants who is considered to present an increased suicide risk or is younger than 30 years (because of the potential increased prevalence of suicidal thoughts in 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 clinically important.

1.5.2.21 If a patient with depression and a chronic physical health problem develops side effects early in antidepressant treatment, provide appropriate information and consider one of the following strategies:

- monitor symptoms closely where side effects are mild and acceptable to the patient **or**
- stop the antidepressant or change to a different antidepressant if the patient prefers **or**
- in discussion with the patient, consider short-term concomitant treatment with a benzodiazepine if anxiety, agitation and/or insomnia are problematic, but:
  - do not offer benzodiazepines to patients with chronic symptoms of anxiety

- use benzodiazepines with caution in patients at risk of falls
- in order to prevent the development of dependence, do not use benzodiazepines for longer than 2 weeks.

Continuing treatment

1.5.2.22 Support and encourage a patient with a chronic physical health problem who has benefited from taking an antidepressant to continue medication for at least 6 months after remission of an episode of depression. Discuss with the patient that:

- this greatly reduces the risk of relapse
- antidepressants are not associated with addiction.

1.5.2.23 Review with the patient with depression and a chronic physical health problem the need for continued antidepressant treatment beyond 6 months after remission, taking into account:

- the number of previous episodes of depression
- the presence of residual symptoms
- concurrent physical health problems and psychosocial difficulties.

Failure of treatment to provide benefit

More detailed advice on switching, sequencing, augmenting and combining antidepressants can be found in section 1.8 of 'Depression: the treatment and management of depression in adults (update)' (CG90). The recommendations below should be considered alongside recommendations 1.5.2.6 to 1.5.2.16 in the section 'Interactions of SSRIs with other medication' in the current guideline.

1.5.2.24 If the patient's depression shows no improvement after 2 to 4 weeks with the first antidepressant, check that the drug has been taken regularly and in the prescribed dose.

1.5.2.25 If response is absent or minimal after 3 to 4 weeks of treatment with a therapeutic dose of an antidepressant, increase the level of support (for example, by weekly face-to-face or telephone contact) and consider:

- increasing the dose in line with the SPC if there are no significant side effects **or**
- switching to another antidepressant as described in section 1.8 of the Depression guideline (CG90) if there are side effects or if the patient prefers.

1.5.2.26 If the patient's depression shows some improvement by 4 weeks, continue treatment for another 2 to 4 weeks. Consider switching to another antidepressant as described in section 1.8 of the Depression guideline (CG90) if:

- response is still not adequate **or**
- there are side effects **or**
- the patient prefers to change treatment.

1.5.2.27 When switching from one antidepressant to another, be aware of:

- the need for gradual and modest incremental increases in dose
- interactions between antidepressants
- the risk of serotonin syndrome when combinations of serotonergic antidepressants are prescribed[¤].

1.5.2.28 If an antidepressant has not been effective or is poorly tolerated:

- consider offering other treatment options, including high-intensity psychological treatments (see section 1.5.3)
- prescribe another single antidepressant (which can be from the same class) if the decision is made to offer a further course of antidepressants.

Stopping or reducing antidepressants

1.5.2.29 Advise patients with depression and a chronic physical health problem who are taking antidepressants that discontinuation symptoms[13] may occur on stopping, missing doses or, occasionally, on reducing the dose of the drug. Explain that symptoms are usually mild and self-limiting over about 1 week, but can be severe, particularly if the drug is stopped abruptly.

1.5.2.30 When stopping an antidepressant, gradually reduce the dose, normally over a 4-week period, although some patients may require longer periods, particularly with drugs with a shorter half-life (such as paroxetine and venlafaxine). This is not required with fluoxetine because of its long half-life.

1.5.2.31 Inform the patient that they should seek advice from their practitioner if they experience significant discontinuation symptoms. If discontinuation symptoms occur:

- monitor symptoms and reassure the patient if symptoms are mild
- consider reintroducing the original antidepressant at the dose that was effective (or another antidepressant with a longer half-life from the same class) if symptoms are severe, and reduce the dose gradually while monitoring symptoms.

1.5.3 Psychological interventions

Delivering high-intensity psychological interventions

1.5.3.1 For all high-intensity 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:

- reduced if remission has been achieved
- increased if progress is being made, and there is agreement between the practitioner and the patient with depression that further sessions would be beneficial (for example, if there is a comorbid personality disorder or psychosocial factors that impact on the patient's ability to benefit from treatment).

1.5.3.2 Group-based CBT for patients with depression and a chronic physical health problem should be:

- delivered in groups (typically of between six and eight patients) with a common chronic physical health problem
- typically delivered over a period of 6 to 8 weeks.

1.5.3.3 Individual CBT for patients with moderate depression and a chronic physical health problem should be:

- delivered until the symptoms of depression have remitted (over a period that is typically 6 to 8 weeks and should not normally exceed 16 to 18 weeks)
- followed up by two further sessions in the 6 months after the end of treatment, especially if treatment was extended.

1.5.3.4 Individual CBT for patients with severe depression and a chronic physical health problem should be:

- delivered until the symptoms of depression have remitted (over a period that is typically 16 to 18 weeks)
- focused in the initial sessions (which typically should take place twice weekly for the first 2 to 3 weeks) on behavioural activation
- followed up by two or three further sessions in the 12 months after the end of treatment.

1.5.3.5 Behavioural couples therapy for depression should normally be based on behavioural principles, and an adequate course of therapy should be 15 to 20 sessions over 5 to 6 months.

1.5.4 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. The interventions, which involve all sectors of care, require a coordinated approach to mental and physical healthcare, as well as a dedicated

coordinator of the intervention located in and receiving support from a multi-professional team, joint determination of the plan of care, and long-term coordination and follow-up.

1.5.4.1 Consider collaborative care for patients with moderate to severe depression and a chronic physical health problem with associated functional impairment whose depression has not responded to initial high-intensity psychological interventions, pharmacological treatment or a combination of psychological and pharmacological interventions.

1.5.4.2 Collaborative care for patients with depression and a chronic physical health problem 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 and pharmacological interventions, and medication management
- long-term coordination of care and follow-up.

1.6 Step 4: complex and severe depression

1.6.1.1 Practitioners providing treatment in specialist mental health services for patients with complex and severe depression and a chronic physical health problem should:

- refer to the NICE guideline on the treatment of depression[14]
- be aware of the additional drug interactions associated with the treatment of patients with both depression and a chronic physical health problem (see recommendations 1.5.2.6 to 1.5.2.16)
- work closely and collaboratively with the physical health services.

[6] Depression is described as 'chronic' if symptoms have been present more or less continuously for 2 years or more.

[7] Refer if necessary to 'Bipolar disorder' (NICE clinical guideline 38).

[8] The Distress Thermometer is a single-item question screen that 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, Kornblith AB, Batel-Copel L et al. (1998) Rapid screening for psychologic distress in men with prostate carcinoma: a pilot study. Cancer 82: 1904–8)

[9] This recommendation (and recommendation 1.4.2.1 in CG90) updates the recommendations on depression only in 'Computerised cognitive behaviour therapy for depression and anxiety (review)' (NICE technology appraisal guidance 97).

[10] 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 SPCs. For women in the antenatal and postnatal periods, see also NICE clinical guideline 45 'Antenatal and postnatal mental health'.

[11] British National Formulary

[12] Features of serotonin syndrome include confusion, delirium, shivering, sweating, changes in blood pressure and myoclonus.

[13] Discontinuation symptoms include increased mood change, restlessness, difficulty sleeping, unsteadiness, sweating, abdominal symptoms and altered sensations.

[14] 'Depression: the treatment and management of depression in adults (update)' (NICE clinical guideline 90).

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.

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 about how NICE clinical guidelines are developed on the NICE website. A booklet, 'How NICE clinical guidelines are developed: an overview for stakeholders, the public and the NHS' is available.

3 Implementation

NICE has developed tools to help organisations implement this guidance.

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 Combined medication and CBT for patients with moderate to severe depression and a chronic physical health problem

What is the clinical and cost effectiveness of combined medication and CBT compared with antidepressants or CBT alone for patients with moderate to severe depression and a chronic physical health problem?

Why this is important

There is limited evidence for the effectiveness of combined antidepressant treatment and CBT for patients with moderate to severe depression and a chronic physical health problem. Data from studies in patients with depression in the absence of a chronic physical health problem suggest that combined treatment may bring real benefit. However, uncertainty about medium-term outcomes for these patients remains. In addition to uncertainty about the effectiveness of the interventions, the potential for interactions between medication prescribed for depression and for chronic physical health problems is a concern. This needs to be considered in terms of both the difficulties that may arise from drug interactions and the anxieties of individual patients about this, which may reduce the likelihood of them complying with antidepressant medication. The answer to this question has practical implications for service delivery and resource allocation in the NHS.

The outcomes for this proposed study should involve both observer-rated and patient-rated assessments of acute and medium-term outcomes for at least 6 months and an assessment of the acceptability and potential burden of the various treatment options. The study should 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.

4.2 Peer support interventions compared with group-based exercise and treatment as usual for patients with mild to moderate depression and a chronic physical health problem

What is the clinical and cost effectiveness of group peer support and group-based exercise when compared with treatment as usual for patients with mild to moderate depression and a chronic physical health problem?

Why this is important

There is limited evidence for the effectiveness of peer support and exercise in the treatment of patients with depression and a chronic physical health problem. Although the available data suggest that both are practical and potentially acceptable treatments that may bring real benefit, uncertainty remains about medium-term outcomes. The answer to this question has practical implications for service delivery and resource allocation in the NHS.

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-rated and patient-rated assessments for acute and medium-term outcomes for 12 months, and an assessment of the acceptability and potential burden of treatment options. The study should be large enough to determine the presence or absence of clinically important effects using a non-inferiority design with robust health economic measures.

4.3 Antidepressant medication compared with placebo in patients with depression and COPD

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

Why this is important

There is limited evidence for the effectiveness of antidepressant treatment in patients with depression and a chronic physical health problem. Of particular concern to the Guideline Development Group was the high incidence of depression in patients with COPD (which is also known to be associated with a high incidence of anxiety disorders). The Guideline Development

Group considered it important to measure the effectiveness of antidepressant medication in the treatment of COPD. The answer to this question has important practical implications for service delivery, particularly for a patient group with mental health needs that are traditionally under-treated within the NHS.

The question should be answered using a randomised controlled trial in which patients with moderate depression and COPD receive either placebo or antidepressant medication. The outcomes chosen should reflect both observer-rated and patient-rated assessments for acute and medium-term outcomes for at least 6 months and an assessment of the acceptability and burden of treatment. In addition to the assessment of symptoms of depression, the study should also assess the impact of antidepressant medication on symptoms of anxiety. The study should be large enough to determine the presence or absence of clinically important effects using a non-inferiority design together with robust health economic measures.

4.4 Behavioural activation compared with antidepressant medication for patients with moderate to severe depression and a chronic physical health problem

What is the clinical and cost effectiveness of behavioural activation compared with antidepressant medication in the treatment of moderate to severe depression in patients with a chronic physical health problem?

Why this is important

There is limited evidence for the effectiveness of high-intensity psychological interventions in the treatment of moderate to severe depression in patients with a chronic physical health problem; the most substantial evidence base is for CBT. Recent developments 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 than CBT and could potentially contribute to increased treatment choice for patients. The answer to this question would have practical implications for service delivery and resource allocation within the NHS.

This question should be answered using a randomised controlled trial in which patients with moderate to severe depression and a chronic physical health problem receive either behavioural activation or antidepressant medication. The outcomes should be chosen to reflect both observer-rated 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.

4.5 The effects of collaborative care on physical health outcomes for patients with moderate to severe depression and a chronic physical health problem

What is the clinical and cost effectiveness of collaborative care with regard to physical health outcomes for people with moderate to severe depression and a chronic physical health problem?

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 a chronic physical health problem. However, the evidence base regarding the effects of collaborative care on physical health outcomes is more limited. Improved depression care is thought to produce other health benefits, such as improved functioning and physical outcomes[18]; this may be particularly significant for people with depression and a chronic physical health problem. This means that interventions that also improve physical health should result in substantial increases in utility and subsequently result in quality-adjusted life year (QALY) gains. Furthermore, the ability to achieve such health gains can potentially reduce the population burden of illness and morbidity within healthcare budgets. There is an association between depression and increased use of medical services, and so it follows that improved treatment of depression could reduce medical expenditure, partially or fully offsetting the costs of treating the depression[18]. The answer to this question has important practical implications for service delivery and resource allocation within the NHS.

This question should be answered using a randomised controlled trial design that includes people with moderate to severe depression and a chronic physical health problem. In addition to depression-related outcomes, physical health outcomes such as general physical functioning and pain, as well as outcomes specifically related to the condition (such as HbA1c for diabetes), should be assessed. These outcomes should reflect both observer-rated and patient-rated assessments of medium-term and long-term outcomes for at least 18 months. The study should also include an assessment of the acceptability and burden of treatment options and the impact of the intervention on the overall care system. It 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.

4.6 The effectiveness of physical rehabilitation programmes for patients with a chronic physical health problem and depression

What is the effectiveness of rehabilitation programmes for patients with depression and a chronic physical health problem in terms of improved mood?

Why this is important

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

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 patients with a chronic physical health problem) are effective. However, many patients with a chronic physical health problem are also undertaking specifically designed rehabilitation programmes (for example, cardiac rehabilitation programmes after 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, which components of the intervention are effective and which specific patient populations may benefit. Therefore an individual patient meta-analysis to examine the impact of rehabilitation programmes on symptoms of depression in patients with a chronic physical health problem should be undertaken before any further research is conducted.

4.7 The efficacy of counselling compared with low-intensity cognitive and behavioural interventions and treatment as

usual in the treatment of depression in patients with a chronic physical health problem

What is the relative efficacy of counselling compared with low-intensity cognitive and behavioural interventions and treatment as usual in patients with depression and a chronic physical health problem?

Why this is important

There is a limited evidence base for counselling compared with treatment as usual in the treatment of patients with depression and a chronic physical health problem. High-intensity cognitive and behavioural interventions have the best evidence base for efficacy but there is limited evidence on the efficacy of low-intensity cognitive and behavioural interventions in patients with depression and a chronic physical health problem. The evidence on low-intensity cognitive and behavioural interventions for this guideline was largely supplemented by the evidence base in the Depression guideline (CG90)[17]. It is therefore important to establish whether either counselling or low-intensity cognitive and behavioural interventions are effective alternatives to treatment as usual for patients with a chronic physical health problem and should be provided in the NHS. The answer to this question will have important implications for the provision of psychological treatment in the NHS.

This question should be answered using a randomised controlled trial design that reports short-term and medium-term outcomes (including cost-effectiveness outcomes) of at least 18 months' duration. Particular attention should be paid to the reproducibility of the treatment model and the training and supervision of the practitioners providing interventions in order to ensure that the treatments are both robust and generalisable. The outcomes chosen should reflect both observer-rated and patient-rated assessments of improvement and an assessment of the acceptability of the treatment options. Particular attention should be given to physical health and quality-of-life outcomes in addition to depression outcomes. The study needs to be large enough to determine the presence or absence of clinically important effects using a non inferiority design, and mediators and moderators of response should be investigated.

[15] Katon W, Unutzer J, Fan MY et al. (2006) Cost-effectiveness and net benefit of enhanced treatment for depression for older adults with diabetes and depression. Diabetes Care 29: 265–70

[16] Simon GE, Manning WG, Katzelnick DJet al. (2001). Cost-effectiveness of systematic depression treatment for high utilizers of general medical care. Archives of General Psychiatry 58: 181–7

[17] 'Depression: the treatment and management of depression in adults (update)' (NICE clinical guideline 90).

5 Other versions of this guideline

5.1 Full guideline

The full guideline, 'Depression in adults with a chronic physical health problem: treatment and management' 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 our website.

5.2 Information for the public

NICE has produced 'information for the public' explaining this guideline.

We encourage NHS and voluntary sector organisations to use text from this information in their own materials about depression.

6 Related NICE guidance

Published

- Depression: the treatment and management of depression in adults (update). NICE clinical guideline 90 (2009).
- Borderline personality disorder. NICE clinical guideline 78 (2009).
- Medicines adherence. NICE clinical guideline 76 (2009).
- Antenatal and postnatal mental health. NICE clinical guideline 45 (2007).
- Dementia. NICE clinical guideline 42 (2006).
- Bipolar disorder. NICE clinical guideline 38 (2006).
- Obsessive-compulsive disorder. NICE clinical guideline 31 (2005).
- Depression in children and young people. NICE clinical guideline 28 (2005).
- Post-traumatic stress disorder (PTSD). NICE clinical guideline 26 (2005).
- Anxiety (amended). NICE clinical guideline 22 (2004; amended 2007). [Replaced by NICE clinical guideline 113]

7 Updating the guideline

NICE clinical guidelines are updated so that recommendations take into account important new information. New evidence is checked 3 years after publication, and practitioners 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

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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.

Mr Peter Robb (Chair)
Consultant Ear, Nose and Throat Surgeon, Epsom and St Helier University Hospitals and The Royal Surrey County NHS Trusts

Mr John Seddon
Lay member

Dr Christine Hine
Consultant in Public Health (Acute Commissioning), Bristol and South Gloucestershire Primary Care Trusts

Dr Greg Rogers
GP, Kent

Appendix C: Assessing depression and its severity

As set out in the introduction to this guideline, the assessment of depression is based on the criteria in DSM-IV. Assessment should include the number and severity of symptoms, duration of the current episode, and the course of the illness.

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 of depression
- 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:

- inadequate or incomplete response to two or more interventions
- recurrent episode within 1 year of last one
- history suggestive of bipolar disorder
- patient 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 definitions

Subthreshold depressive symptoms: Fewer than 5 symptoms of depression.

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 features.

Appendix D: Recommendations from other NICE clinical guidelines on depression .

This guideline is published alongside 'Depression: the treatment and management of depression in adults (update)' (NICE clinical guideline 90). Because some of the recommendations in that guideline apply to people with depression and a chronic physical health problem, they have also been included in this guideline. The table below lists recommendations that are based on or have been adapted from recommendations in NICE clinical guideline 90.

In addition, some of the recommendations in both this guideline and NICE clinical guideline 90 have been taken from the previous NICE clinical guideline 23 'Management of depression in primary and secondary care'. These recommendations are also indicated in the table below. Note that the evidence for these recommendations has not been updated and any wording changes have been made for clarification only.

Recommendation number in current guideline (NICE clinical guideline 91)	Recommendation number in NICE clinical guideline 90	Recommendation number in NICE clinical guideline 23
1.1.1.1	1.1.1.1	
1.1.1.2	1.1.1.2	1.1.2.1/1.1.3.1/1.1.3.2
1.1.1.3	1.1.1.3	1.1.2.3
1.1.1.4	1.1.1.4	1.1.2.2
1.1.1.5	1.1.1.5	
1.1.2.1	1.1.3.1	
1.1.3.1	1.1.4.1	
1.1.3.2	1.1.4.2	
1.1.3.3	1.1.4.3	
1.1.3.4	1.1.4.4	
1.1.3.5	1.1.4.5	
1.1.3.6	1.1.4.6	1.1.6.4/1.1.6.6

1.1.4.1	1.1.5.1	
1.1.4.2	1.1.5.2	1.1.3.3
1.1.4.3		1.1.6.7
1.3.1.1	1.3.1.1	
1.3.1.2	1.3.1.2	
1.3.1.4	1.3.1.4	
1.3.1.5	1.3.1.5	
1.3.2.1	1.3.2.1	1.5.1.1
1.3.2.2	1.3.2.2	
1.3.2.3	1.3.2.3	1.1.6.5
1.3.2.4	1.3.2.4	1.5.2.6/1.5.2.7
1.4.1.1	1.4.1.1	1.1.1.1
1.4.1.3	1.4.1.3	
1.4.3.2	1.4.4.2	1.5.2.37/1.5.2.38
1.5.2.5	1.5.2.3	
1.5.2.17	1.5.2.5	
1.5.2.19	1.5.2.6	1.5.2.10
1.5.2.20	1.5.2.7	1.5.2.5
1.5.2.22	1.9.1.1	
1.5.2.23	1.9.1.2	
1.5.2.24	1.5.2.10	
1.5.2.25	1.5.2.11	
1.5.2.26	1.5.2.12	
1.5.2.29	1.9.2.1	
1.5.2.30	1.9.2.2	

1.5.2.31	1.9.2.3	
1.5.3.1	1.5.3.1	
1.5.3.5	1.5.3.5	

About this guideline

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

The guideline was developed by the National Collaborating Centre for Mental Health. The Collaborating Centre worked with a group of healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

The methods and processes for developing NICE clinical guidelines are described in The guidelines manual.

This guideline (and CG90) update recommendations made in NICE technology appraisal guidance 97 for the treatment of depression only. The guidance in TA97 remains unchanged for the use of CCBT in the treatment of panic and phobia and obsessive compulsive disorder.

The recommendations from this guideline have been incorporated into a NICE Pathway. We have produced information for the public explaining this guideline. Tools to help you put the guideline into practice and information about the evidence it is based on are also available.

Changes after publication

January 2012: minor maintenance

August 2013: minor maintenance

Your responsibility

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.

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