NHS
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Quick reference guide

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Depression

Treatment and management of depression in adults, including adults with a chronic physical health problem

This is an update of NICE clinical guideline 23

NICE clinical guidelines 90 and 91
Developed by the National Collaborating Centre for Mental Health

About this booklet

This is a quick reference guide that summarises the recommendations NICE has made to the NHS in the following two clinical guidelines:

- Depression: the treatment and management of depression in adults (update) (NICE clinical guideline 90). Note that this guidance partially updates and replaces NICE clinical guideline 23 (published December 2004; revised April 2007).
- Depression in adults with a chronic physical health problem: treatment and management (NICE clinical guideline 91).

Who should read this booklet?

This quick reference guide is for all practitioners who care for adults with depression, including adults with a chronic physical health problem. A separate quick reference guide is also available for healthcare professionals in general hospital settings which focuses on recognising and assessing depression and providing initial treatment for adults who have a chronic physical health problem (see www.nice.org.uk/CG91quickrefguide).

Who wrote the guidelines?

The guidelines were developed by the National Collaborating Centre for Mental Health, which is based at the Royal College of Psychiatrists and the British Psychological Society. For more information on how NICE clinical guidelines are developed, go to www.nice.org.uk
See the inside back cover for more information about these guidelines.

Person-centred care

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

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

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

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

Contents

Introduction

- Depression is a broad and heterogeneous diagnosis, characterised by depressed mood and/or loss of pleasure in most activities. Severity of the disorder is determined by both the number and severity of symptoms and the degree of functional impairment (see Severities of depression box on page 6).
- This updated guideline uses the DSM-IV criteria for major depression (referred to here as 'depression') instead of the ICD-10 criteria used in NICE clinical guideline 23. Using DSM-IV enables specific interventions to be better targeted for more severe degrees of depression; its definition of severity also makes it less likely that a diagnosis will be made solely on symptom counting.
- Symptoms below the threshold for diagnosis can be distressing and disabling; therefore this updated guideline also covers 'subthreshold depressive symptoms' (see box on page 6).

Additional considerations for people with depression and a chronic physical health problem

This quick reference guide includes recommendations for people with depression and a chronic physical health problem. Except where stated, the recommendations in the main body of the text refer to all people with depression, both with and without a chronic physical health problem.

In some cases, however, the interventions best supported by evidence are different for the two groups. Practitioners should also take into account factors such as drug interactions when treating depression in people with a chronic physical health problem. Therefore, recommendations outlined in red advise how to modify or substitute interventions for this group.

Key priorities for implementation

The following key priorities are from 'Depression: the treatment and management of depression in adults (update)' (NICE clinical guideline 90). Key priorities marked with a dagger (†) are also key priorities for implementation in 'Depression in adults with a chronic physical health problem: treatment and management' (NICE clinical guideline 91).

Principles for assessment

- †When assessing a person 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 person 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 people with a past history of depression or a chronic physical health problem with associated functional impairment) and consider asking people 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 people with persistent subthreshold depressive symptoms or mild to moderate depression, consider offering one or more of the following interventions, guided by the person's preference:
  - individual guided self-help based on the principles of cognitive behavioural therapy (CBT)
  - computerised CBT (CCBT)[1]
  - a structured group physical activity programme.

Drug treatment

- Do not use antidepressants routinely to treat persistent subthreshold depressive symptoms or mild depression because the risk–benefit ratio is poor, but consider them for people with:
  - a past history of moderate or severe depression **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] These recommendations update the recommendations on depression only in 'Computerised cognitive behaviour therapy for depression and anxiety (review)' (NICE technology appraisal guidance 97).

Treatment for moderate or severe depression

- For people with moderate or severe depression, provide a combination of antidepressant medication and a high-intensity psychological intervention (CBT or interpersonal therapy [IPT]).

Continuation and relapse prevention

- Support and encourage a person 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 person that:
  - this greatly reduces the risk of relapse
  - antidepressants are not associated with addiction.

Psychological interventions for relapse prevention

- People with depression who are considered to be at significant risk of relapse (including those who have relapsed despite antidepressant treatment or who are unable or choose not to continue antidepressant treatment) or who have residual symptoms, should be offered one of the following psychological interventions:
  - individual CBT for people who have relapsed despite antidepressant medication and for people with a significant history of depression and residual symptoms despite treatment
  - mindfulness-based cognitive therapy for people who are currently well but have experienced three or more previous episodes of depression.

The following key priorities are from 'Depression in adults with a chronic physical health problem: treatment and management' (NICE clinical guideline 91).

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 CBT
  - CCBT[1].

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.

continued

[1] These recommendations update the recommendations on depression only in 'Computerised cognitive behaviour therapy for depression and anxiety (review)' (NICE technology appraisal guidance 97).

Key priorities for implementation *continued*

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.

Severities of depression[2]

Subthreshold depressive symptoms: Fewer than 5 symptoms.

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

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

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

[2] Taken from DSM-IV (see www.nice.org.uk/CG90niceguideline for further details).

The stepped-care model

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

Focus of the intervention	Nature of the intervention
STEP 4: Severe and complex[3] 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[4] and referral for further assessment and interventions
STEP 2: Persistent subthreshold depressive symptoms; mild to moderate depression	Low-intensity psychological and psychosocial 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

[3] 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.
[4] Only for depression where the person also has a chronic physical health problem and associated functional impairment.

Principles of care

Information, support and consent

- When working with people with depression and their families and carers:
  - build a trusting relationship and explore treatment options with hope and optimism, explaining the different courses of depression and that recovery is possible
  - be aware of possible stigma and discrimination associated with depression
  - ensure that confidentiality, privacy and dignity are respected
  - provide information about depression and its treatment, and about self-help groups, support groups and other resources
  - ensure that comprehensive written information is available in the appropriate language and in audio format if possible
  - provide independent interpreters if needed.
- Be sensitive to diverse cultural, ethnic and religious backgrounds, and aware of 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.
- Provide all interventions in the person's preferred language where possible.
- Ensure that the person can give meaningful and informed consent before treatment starts, especially if they have severe depression or are subject to the Mental Health Act. Consent should be based on the provision of clear information (also provided in writing) covering:
  - what the intervention comprises
  - what is expected of the person while having it
  - likely outcomes (including side effects).

Supporting families and carers

- When families or carers are involved in supporting a person with severe or chronic[5] depression, consider:
  - providing written and verbal information on depression and how they can support the person
  - providing information about local family or carer support groups and voluntary organisations, and helping families or carers to access these
  - offering a carer's assessment
  - negotiating confidentiality and the sharing of information between the person and their family or carers.

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

Effective delivery of care

- All interventions should be delivered by competent practitioners. Psychological and psychosocial interventions should be based on the relevant treatment manual(s), which should guide their structure and duration. 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 person with depression is involved in reviewing the efficacy of treatment
  - monitor and evaluate treatment adherence and practitioner competence.

Additional considerations for people with a chronic physical health problem

- If a person's care is shared between primary and secondary care, there should be clear agreement between practitioners (especially the person's GP) on the responsibility for monitoring and treating that person. Share the treatment plan with the person and (if appropriate) with their family or carer.
- If a person's chronic physical health problem restricts their ability to engage with a psychosocial or psychological intervention for depression, discuss alternatives with the person, such as antidepressants or delivering the interventions by telephone if mobility or other difficulties prevent face-to-face contact.

Step 1: Recognition, assessment and initial management

Identifying people with depression

Be alert to possible depression (particularly in people with a past history of depression or a chronic physical health problem with associated functional impairment) and consider asking:

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

If the person answers 'yes' to either question

A practitioner who is competent in mental health assessment should:

- review the person's mental state and associated functional, interpersonal and social difficulties
- consider using a validated measure for symptoms, functions and/or disability
- for people with language or communication difficulties, consider using the Distress Thermometer[6] and/or asking a family member or carer about symptoms; if significant distress is identified, investigate further.

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

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

If the person also has a chronic physical health problem:

- ask three further questions to improve the accuracy of the assessment:
  - during the last month, have you often been bothered by:
    - feelings of worthlessness?
    - poor concentration?
    - thoughts of death?
- consider the role of the physical health problem and any prescribed medication in the depression
- check that the optimal treatment for the physical health problem is being provided and adhered to; seek specialist advice if necessary.

[6] For more information see 'Depression: the treatment and management of depression in adults (update)' (www.nice.org.uk/CG90niceguideline).

Assessment and initial management

- For a person who may have depression, conduct a comprehensive assessment that does not rely simply on a symptom count. Take into account:
  - the degree of associated functional impairment and/or disability
  - the duration of the episode.

- Explore how the following may have affected the development, course and severity of the depression:
  - history of depression and comorbid mental health or physical disorders
  - any past history of mood elevation[7]
  - response to previous treatments
  - the quality of interpersonal relationships
  - living conditions and social isolation.
- If the person has a learning disability or acquired cognitive impairment:
  - consider consulting a relevant specialist when developing treatment plans
  - where possible, provide the same interventions as for other people with depression; adjust the method of delivery or duration if necessary.
- Always ask a person with depression directly about suicidal ideation and intent. If there is a risk of self-harm or suicide:
  - assess whether they have adequate social support and are aware of sources of help
  - arrange help appropriate to the level of risk (see below)
  - advise them to seek help if the situation deteriorates.

Risk assessment and monitoring

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

[7] Refer if necessary to 'Bipolar disorder' (NICE clinical guideline 38; www.nice.org.uk/CG38).

Step 2: Recognised depression – persistent subthreshold depressive symptoms or mild to moderate depression

General measures

Depression with anxiety

- When depression is accompanied by symptoms of anxiety, usually treat the depression first. But if the person has an anxiety disorder and comorbid depression or depressive symptoms, consider treating the anxiety disorder first (refer to the relevant NICE guideline).

Sleep hygiene

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

Active monitoring

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

Drug treatment

- Do not use antidepressants routinely to treat persistent subthreshold depressive symptoms or mild depression, but consider them for people with:
  - a past history of moderate or severe depression **or**
  - initial presentation of subthreshold depressive symptoms present for at least 2 years **or**
  - subthreshold depressive symptoms or mild depression persisting after other interventions.

For people with depression and a chronic physical health problem

- Do not use antidepressants routinely to treat subthreshold depressive symptoms or mild depression, but consider them for people with:
  - mild depression that complicates the care of the physical health problem **or**
  - a past history of moderate or severe depression **or**
  - initial presentation of subthreshold depressive symptoms present for at least 2 years **or**
  - subthreshold depressive symptoms or mild depression persisting after other interventions.

- Do not prescribe or advise use of St John's wort for depression. Explain the different potencies of the preparations available and the potential serious interactions of St John's wort with other drugs (including oral contraceptives, anticoagulants and anticonvulsants).

Psychosocial and psychological interventions

Recommendations on this page refer to people with persistent subthreshold depressive symptoms or mild to moderate depression without a chronic physical health problem. **Turn to page 14 for interventions for people who also have a chronic physical health problem.**

- For people with persistent subthreshold depressive symptoms or mild to moderate depression, consider offering one or more of the low-intensity psychosocial interventions in the first table on this page, guided by the person's preference.
- For people who decline a low-intensity psychosocial intervention, consider group-based cognitive behavioural therapy (CBT) (see the second table on this page).

Delivering low-intensity psychosocial interventions

Type of intervention	Intervention should:
Individual guided self-help based on CBT principles (and including behavioural activation and problem-solving techniques)	• include written materials (or alternative media) • be supported by a trained practitioner who reviews progress and outcome • consist of up to 6–8 sessions (face-to-face and by telephone) over 9–12 weeks, including follow-up
CCBT[8]	• be provided via a stand-alone computer-based or web-based programme • explain 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 reviews progress and outcome • typically take place over 9–12 weeks, including follow-up
A structured group physical activity programme	• be delivered in groups supported by a competent practitioner • typically consist of 3 sessions per week (lasting 45 minutes to 1 hour) over 10–14 weeks

Delivering group-based CBT

Type of intervention	Intervention should:
Group-based CBT	• be based on a model such as 'Coping with depression' • be delivered by two trained and competent practitioners • consist of 10–12 meetings of 8–10 participants • typically take place over 12–16 weeks, including follow-up

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

Low-intensity psychosocial interventions for people with depression and a chronic physical health problem

For people with persistent subthreshold depressive symptoms or mild to moderate depression and a chronic physical health problem, and for people with subthreshold depressive symptoms that complicate the care of the chronic physical health problem, consider offering one or more of the low-intensity psychosocial interventions in the table below, guided by the person's preference.

Type of intervention	Intervention should:
A structured group physical activity programme	• be modified for different abilities according to the physical health problem, in liaison with the team treating the physical health problem • be delivered in groups supported by a competent practitioner • typically consist of 2–3 sessions per week (lasting 45 minutes to 1 hour) over 10–14 weeks • be coordinated with any rehabilitation programme for the physical health problem
A group-based peer support (self-help) programme	• be delivered to groups of people 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, understand the chronic physical health problem and its relationship to depression, and review outcomes • consist typically of 1 session per week over 8–12 weeks
Individual guided self-help based on CBT principles (and including behavioural activation and problem-solving techniques)	• include written materials (or alternative media) • be supported by a trained practitioner who reviews progress and outcome • consist of up to 6–8 sessions (face-to-face and by telephone) over 9–12 weeks, including follow-up
Computerised CBT (CCBT)[9]	• be provided via a stand-alone computer-based or web-based programme • explain 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 reviews progress and outcome • typically take place over 9–12 weeks, including follow-up

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

Step 3: Persistent subthreshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions, and moderate and severe depression

Overview of this section

Choosing treatments

- Choice of intervention should be influenced by the:
  - duration of the episode and trajectory of symptoms
  - previous illness course and response to treatment
  - likelihood of adherence and potential adverse effects
  - person's preference
  - course and treatment of any chronic physical health problem.

Treatment options for people with depression without a chronic physical health problem

- For people with persistent subthreshold depressive symptoms or mild to moderate depression who have not benefited from a low-intensity psychosocial intervention, discuss different interventions with the person and provide:
  - an antidepressant (normally a selective serotonin reuptake inhibitor [SSRI]) **or**
  - a high-intensity psychological intervention, normally one of the following (see table on page 17 for how to deliver these interventions):
    - CBT
    - IPT
    - behavioural activation (but note that the evidence is less robust than for CBT or IPT)
    - 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.

- For people who decline the options above, consider[10]:
  - counselling for people with persistent subthreshold depressive symptoms or mild to moderate depression; offer 6–10 sessions over 8–12 weeks
  - short-term psychodynamic psychotherapy for people with mild to moderate depression; offer 16–20 sessions over 4–6 months.
- For people with moderate or severe depression, combine antidepressants with a high-intensity psychological intervention (CBT or IPT).

Treatment options for people with depression and a chronic physical health problem

- For people with persistent subthreshold depressive symptoms or mild to moderate depression who have not benefited from a low-intensity psychosocial intervention, provide an antidepressant (normally an SSRI) **or** one of the following high-intensity psychological interventions:
  - group-based CBT **or**
  - individual CBT (if group-based CBT is declined, not appropriate or 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.
- For people with initial presentation of moderate depression, offer group-based CBT, individual CBT or behavioural couples therapy.
- For people with severe depression, consider offering both individual CBT and an antidepressant.

[10] Discuss with the person the uncertainty of the effectiveness of counselling and psychodynamic psychotherapy in treating depression.

Delivering high-intensity psychological interventions

For people without a chronic physical health problem

Type of intervention	Delivery[11]
Individual CBT	• Typically 16–20 sessions over 3–4 months • Consider 3–4 follow-up sessions over the next 3–6 months • For moderate or severe depression, consider 2 sessions per week for the first 2–3 weeks
IPT	• Typically 16–20 sessions over 3–4 months • For severe depression, consider 2 sessions per week for the first 2–3 weeks
Behavioural activation	• Typically 16–20 sessions over 3–4 months • Consider 3–4 follow-up sessions over the next 3–6 months • For moderate or severe depression, consider 2 sessions per week for the first 3–4 weeks
Behavioural couples therapy	• Typically 15–20 sessions over 5–6 months

For people with a chronic physical health problem

Type of intervention	Delivery[12]
Group-based CBT	• Typically in groups of 6–8 people with a common physical health problem, over 6–8 weeks
Individual CBT	• Deliver until symptoms have remitted but typically: – 6–8 weeks (no longer than 16–18 weeks) for moderate depression plus 2 follow-up sessions in the next 6 months – 16–18 weeks for severe depression plus 2 or 3 follow-up sessions in the next 12 months; offer twice-weekly sessions for the first 2–3 weeks focusing on behavioural activation
Behavioural couples therapy	• Typically 15–20 sessions over 5–6 months

[11,12] Duration of intervention can be tailored to individual circumstances.

Choosing an antidepressant[13]

Except where stated, recommendations about choosing antidepressants and starting treatment (see page 20) refer to people with depression with or without a chronic physical health problem.

- Discuss choice of antidepressant, covering:
  - anticipated adverse events – for example, side effects and discontinuation symptoms (see page 22)
  - potential interactions with concomitant medication or physical illness[14]
  - the person's perception of the efficacy and tolerability of any antidepressants they have previously taken.
- Normally choose an SSRI in generic form. Take the following into account:
  - SSRIs are associated with an increased risk of bleeding. Consider prescribing a gastroprotective drug in older people who are taking non-steroidal anti-inflammatory drugs (NSAIDs) or aspirin.
  - Fluoxetine, fluvoxamine and paroxetine have a higher propensity for drug interactions[15].
  - For people who also have a chronic physical health problem, consider using citalopram or sertraline as these have a lower propensity for interactions.
  - Paroxetine is associated with a higher incidence of discontinuation symptoms.
- Take into account toxicity in overdose for people at significant risk of suicide. Be aware that:
  - compared with other equally effective antidepressants recommended in primary care, venlafaxine is associated with a greater risk of death from overdose
  - the greatest risk in overdose is with tricyclic antidepressants (TCAs), except for lofepramine.
- When prescribing drugs other than SSRIs, take into account:
  - the increased likelihood of the person stopping treatment because of side effects, and the consequent need to increase the dose gradually, with venlafaxine, duloxetine and TCAs
  - the specific cautions, contraindications and monitoring requirements for some drugs[16]
  - that non-reversible monoamine oxidase inhibitors (MAOIs, such as phenelzine), combined antidepressants (see page 21) and lithium augmentation of antidepressants (see pages 21–22) should normally be prescribed only by specialist mental health professionals
  - that dosulepin should not be prescribed.
- When prescribing antidepressants for older adults:
  - prescribe at an age-appropriate dose taking into account physical health and concomitant medication
  - monitor carefully for side effects.

[13] 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 British national formulary (BNF) and individual drug summaries of product characteristics (SPCs). For women in the antenatal and postnatal periods, see also NICE clinical guideline 45 'Antenatal and postnatal mental health'.

[14–16] Refer to appendix 1 of the BNF and appendix 16 of the full guideline 'Depression in adults with a chronic physical health problem: treatment and management' (www.nice.org.uk/CG91fullguideline) for information on drug interactions.

Additional considerations for people with a chronic physical health problem

- When prescribing antidepressants, be aware of drug interactions[17] and seek specialist advice if uncertain. If needed, refer the person to specialist mental health services for continued prescribing.
- Do not prescribe subtherapeutic doses of antidepressants.
- Take into account:
  - additional physical health problems
  - side effects of antidepressants that may impact on the underlying physical disease
  - that there is currently no evidence to support using specific antidepressants for particular physical health problems.

Interactions of SSRIs with other medications

Medication for chronic physical health problem	Recommended antidepressant(s)
Non-steroidal anti-inflammatory drugs (NSAIDs)	• Do not normally offer SSRIs – but if no suitable alternatives can be identified, offer gastroprotective medicines (for example, proton pump inhibitors) together with the SSRI • Consider mianserin, mirtazapine, moclobemide, reboxetine or trazodone
Warfarin or heparin	• Do not normally offer SSRIs • Consider mirtazapine (note that when taken with warfarin, the international normalised ratio [INR] may increase slightly)
Aspirin	• Use SSRIs with caution – if no suitable alternatives can be identified, offer gastroprotective medicines together with the SSRI • Consider trazodone, mianserin or reboxetine when aspirin is used as a single agent • Consider mirtazapine
'Triptan' drugs for migraine	• Do not offer SSRIs • Offer mirtazapine, trazodone, mianserin or reboxetine
Monoamine oxidase B inhibitors (for example, selegiline and rasagiline)	• Do not normally offer SSRIs • Offer mirtazapine, trazodone, mianserin or reboxetine
Theophylline, clozapine, methadone or tizamidine	• Do not normally offer fluvoxamine • Offer sertraline or citalopram
Flecainide or propafenone	• Offer sertraline as the preferred antidepressant • Mirtazapine and moclobemide may also be used
Atomoxetine	• Do not offer fluoxetine or paroxetine • Offer a different SSRI

[17] Refer to appendix 1 of the BNF and appendix 16 of the full guideline (www.nice.org.uk/CG91fullguideline).

Starting antidepressant treatment

- Explore any concerns the person has about taking medication and provide information, including:
  - the gradual development of the full antidepressant effect
  - the importance of taking medication as prescribed and the need to continue beyond remission
  - potential side effects and drug interactions
  - the risk and nature of discontinuation symptoms (particularly with drugs with a shorter half-life, such as paroxetine and venlafaxine)
  - the fact that addiction does not occur.
- For people who are not considered to be at increased risk of suicide, normally see them after 2 weeks. See them regularly, for example every 2–4 weeks in the first 3 months, and then at longer intervals if response is good.

- For people who are considered to be at increased risk of suicide or are younger than 30 years, normally see them after 1 week and then frequently until the risk is no longer clinically important.

- If a person experiences side effects early in treatment, provide information and consider:
  - monitoring symptoms closely if side effects are mild and acceptable to the person **or**
  - stopping or changing to a different antidepressant if the person prefers **or**
  - short-term concomitant treatment (usually no longer than 2 weeks) with a benzodiazepine if anxiety, agitation and/or insomnia are problematic, except in people with chronic symptoms of anxiety; use with caution in people at risk of falls.
- People who start on low-dose TCAs and have a clear clinical response can be maintained on that dose with careful monitoring.
- If improvement is not occurring on the first antidepressant after 2–4 weeks, check that the drug has been taken as prescribed.
- If response is absent or minimal after 3–4 weeks of treatment with a therapeutic dose of an antidepressant, increase support and consider:
  - increasing the dose in line with the summary of product characteristics (SPC) if there are no significant side effects **or**
  - switching to another antidepressant (see page 21) if there are side effects or if the person prefers.
- If there is some improvement by 4 weeks, continue treatment for another 2–4 weeks. Consider switching antidepressants (see page 21) if:
  - response is still not adequate **or**
  - there are side effects **or**
  - the person prefers to change drug.

Sequencing treatments after an inadequate response

Switching and combining antidepressants

- When reviewing treatment after an inadequate response to initial pharmacological interventions:
  - check adherence to, and side effects from, initial treatment
  - increase the frequency of appointments
  - be aware that using a single antidepressant is usually associated with a lower side-effect burden
  - consider reintroducing treatments that have been inadequately delivered or adhered to, including increasing the dose or switching antidepressants.
- When switching antidepressants, consider:
  - initially, a different SSRI or a better tolerated newer-generation antidepressant
  - subsequently, an antidepressant of a different class that may be less well tolerated (such as venlafaxine, a TCA or an MAOI).
- Do not switch to, or start, dosulepin.
- Normally switch within 1 week for drugs with a short half-life. Consider interactions and exercise caution when switching:
  - from fluoxetine to other antidepressants
  - from fluoxetine or paroxetine to a TCA; use a lower starting dose of the TCA (particularly when switching from fluoxetine)
  - to a new serotonergic antidepressant or MAOI
  - from a non-reversible MAOI: a 2-week washout period is required (do not routinely prescribe other antidepressants during this period).
- Do not normally combine antidepressants in primary care without consulting a consultant psychiatrist. Also:
  - select medications that are safe to use together
  - be aware of the increased side-effect burden
  - document and discuss the rationale with the person, inform them if off-label medication is offered, and monitor for adverse effects
  - ensure familiarity with the primary evidence and consider obtaining a second opinion if the combination is unusual, the evidence for the efficacy of a chosen strategy is limited or the risk–benefit ratio is unclear.

Augmenting antidepressants

- If a person is informed about and prepared to tolerate the increased side-effect burden, consider augmenting an antidepressant with:
  - lithium
  - an antipsychotic such as aripiprazole*, olanzapine*, quetiapine* or risperidone*
  - another antidepressant, such as mianserin or mirtazapine.

* In this guideline, drug names are marked with an asterisk if they do not have UK marketing authorisation for the indication in question at the time of publication (October 2009). Informed consent should be obtained and documented.

- When prescribing lithium:
  - monitor renal and thyroid function before treatment and every 6 months during treatment (more often if there is evidence of renal impairment)
  - consider ECG monitoring in people at high risk of cardiovascular disease
  - monitor serum lithium levels 1 week after treatment starts and every dose change, and then every 3 months.
- When prescribing an antipsychotic, monitor weight, lipid and glucose levels, and relevant side effects.
- Do not routinely augment an antidepressant with:
  - a benzodiazepine for more than 2 weeks
  - buspirone*, carbamazepine*, lamotrigrine*, valproate*, pindolol* or thyroid hormones*.

Combining psychological and drug treatment

- If a person's depression has not responded to either pharmacological or psychological interventions, consider combining antidepressants with CBT.

Referral

- If a person's depression has not responded to various augmentation and combination treatments, consider referral to a specialist practitioner or service.

Stopping or reducing antidepressants

- Advise people that discontinuation symptoms[18] may occur on stopping, missing doses or, occasionally, reducing the dose of the drug. Explain that these are usually mild and self-limiting over about 1 week, but can be severe, particularly if the drug is stopped abruptly.
- Normally, gradually reduce the dose over 4 weeks (this is not necessary with fluoxetine). Reduce the dose over longer periods for drugs with a shorter half-life (for example, paroxetine and venlafaxine).
- Advise the person to see their practitioner if they experience significant discontinuation symptoms. If symptoms occur:
  - monitor them and reassure the person 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.

* In this guideline, drug names are marked with an asterisk if they do not have UK marketing authorisation for the indication in question at the time of publication (October 2009). Informed consent should be obtained and documented.

[18] Such as increased mood change, restlessness, difficulty sleeping, unsteadiness, sweating, abdominal symptoms and altered sensations.

Continuation and relapse prevention

At remission:
Encourage a person who has benefited from taking an antidepressant to continue medication for at least 6 months and inform them that:

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

6 months after remission:
Review with the person the need for continued medication, taking into account:

- number of previous episodes
- residual symptoms
- concurrent physical health problems and psychosocial difficulties

If risk of relapse is significant or there is a history of recurrent depression

- Discuss choice of treatment with the person, and base choice on previous treatment history and the person's preference

Continuing medication

- Advise use of antidepressants for at least 2 years.
- Maintain level of medication at which acute treatment was effective (unless there are adverse effects) if:
  - the person has had two or more recent episodes of depression which caused significant functional impairment
  - they have other risk factors for relapse
  - the consequences of relapse are likely to be severe.

After 2 years

- Re-evaluate treatment with the person, taking into account age, comorbidities and other risk factors; thereafter re-evaluate as regularly as needed.

Augmenting medication

- People who have had multiple episodes of depression and who have a good response to augmentation should remain on this treatment if side effects are acceptable. If one medication is stopped, it should usually be the augmenting agent.
- Do not use lithium alone to prevent recurrence.

Psychological interventions

- Provide individual CBT for people who have relapsed despite antidepressants and for people with a significant history of depression and residual symptoms despite treatment.
  - Typically deliver 16–20 sessions over 3–4 months.
  - If more are needed to achieve remission, deliver 2 sessions per week for the first 2–3 weeks; also include 4–6 follow-up sessions in the next 6 months.

or

- Provide mindfulness-based cognitive therapy for people who are currently well but have had 3 or more episodes of depression. Deliver in groups of 8–15 people in weekly 2-hour meetings over 8 weeks. Also offer 4 follow-up sessions in the next 12 months.

Enhanced care

- Do not routinely provide medication management as a separate intervention for people with depression.
- For people with severe depression, or with moderate depression and complex problems, consider referring to specialist mental health services for a programme of coordinated multiprofessional care.
- If a person with long-standing moderate or severe depression would benefit from additional social or vocational support, consider:
  - befriending as an adjunct to pharmacological or psychological treatments; trained volunteers should provide at least weekly contact for 2–6 months
  - a rehabilitation programme if depression has resulted in long-term loss of work or disengagement from social activities.

Collaborative care for people with a chronic physical health problem

- Consider collaborative care for people 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 these.
- Collaborative care should normally include:
  - case management which is supervised by 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
  - long-term coordination of care and follow-up.

Treatment based on depression subtype and personal characteristics

- Do not routinely vary treatment strategies by depression subtype (for example, atypical depression or seasonal depression) or personal characteristics (for example, sex or ethnicity).
- Advise people with winter depression who wish to try light therapy that the evidence for the efficacy of light therapy is uncertain.

Step 4: Complex and severe depression

Principles of care

- Assess a person referred to specialist mental health services, including:
  - symptom profile, suicide risk, treatment history and comorbidities
  - psychosocial stressors, personality factors and significant relationship difficulties, particularly if the depression is chronic or recurrent.
- Consider reintroducing treatments that have been inadequately delivered or adhered to.
- Use crisis resolution and home treatment teams to manage crises for people with severe depression who present significant risk, and to deliver high-quality acute care. Monitor risk in a way that allows people to continue their lives without disruption.
- Medication in secondary care mental health services should be started under the supervision of a consultant psychiatrist.
- Develop a multidisciplinary care plan with the person (and their family or carer if the person agrees) which:
  - identifies the roles of all professionals involved
  - includes a crisis plan that identifies potential crisis triggers and strategies to manage them
  - is shared with the person, their GP and other relevant people.
- For people with recurrent severe depression or depression with psychotic symptoms and for those who have been treated under the Mental Health Act, consider developing advance decisions and advance statements with the person. Include copies in the person's care plan in primary and secondary care. Give copies to the person and to their family or carer, if the person agrees.

Additional consideration for people with a chronic physical health problem

- When treating people with complex and severe depression and a chronic physical health problem in specialist mental health services, work closely with physical health services and be aware of possible additional drug interactions.

Inpatient care, and crisis resolution and home treatment teams

- Consider inpatient treatment for people who are at significant risk of suicide, self-harm or self-neglect.
- The full range of high-intensity psychological interventions should normally be offered in inpatient settings. However, consider increasing the intensity and duration of the interventions and ensure that they can be provided effectively and efficiently on discharge.
- Consider crisis resolution and home treatment teams for people who might benefit from early discharge from hospital.

Pharmacological management of depression with psychotic symptoms

- For people who have depression with psychotic symptoms, consider augmenting their treatment plan with antipsychotic medication.

Electroconvulsive therapy[19]

- Consider ECT for severe, life-threatening depression and when a rapid response is required, or when other treatments have failed.
- Do not use ECT routinely for people with moderate depression but consider it if their depression has not responded to multiple treatments.
- Ensure the person is fully informed of the risks and benefits associated with having ECT[20]. Document the assessment and consider:
  - the risks associated with a general anaesthetic
  - medical comorbidities
  - potential adverse events, notably cognitive impairment
  - the risks associated with not receiving ECT.
- Make the decision to use ECT jointly with the person if possible, taking into account the Mental Health Act 2007. Also:
  - obtain valid informed consent without pressure or coercion
  - remind the person of their right to withdraw consent at any point
  - adhere to recognised guidelines about consent and involve advocates or carers
  - if informed consent is not possible, give ECT only if it does not conflict with a valid advance directive, and consult the person's advocate or carer.

- For additional recommendations on ECT and the use of transcranial magnetic stimulation for depression, see the NICE guideline at www.nice.org.uk/CG90niceguideline

[19] The recommendations on ECT update the depression aspects only of 'Guidance on the use of electroconvulsive therapy' (NICE technology appraisal guidance 59; www.nice.org.uk/TA59).
[20] The risks may be greater in older people; consider ECT with caution in this group.

Further information

Ordering information

You can download the following documents from www.nice.org.uk/CG90 and www.nice.org.uk/CG91

- NICE guidelines 90 and 91 – all the recommendations.
- This quick reference guide – a summary of the recommendations from both guidelines for healthcare professionals.
- A quick reference guide summarising relevant recommendations from CG91 for healthcare professionals in general hospital settings.
- 'Understanding NICE guidance' – summaries for patients and carers.
- The full guidelines – all the recommendations, details of how they were developed, and reviews of the evidence they were based on.

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

- N2016 (this quick reference guide)
- N2018 (quick reference guide for healthcare professionals in general hospital settings)
- N2017 ('Understanding NICE guidance' for CG90)
- N2019 ('Understanding NICE guidance' for CG91)

Implementation tools

NICE has developed tools to help organisations implement this guidance (see www.nice.org.uk/CG90 and www.nice.org.uk/CG91).

Related NICE guidance

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

Published

- Borderline personality disorder. NICE clinical guideline 78 (2009). www.nice.org.uk/CG78
- Medicines adherence. NICE clinical guideline 76 (2009). www.nice.org.uk/CG76
- Antenatal and postnatal mental health. NICE clinical guideline 45 (2007). www.nice.org.uk/CG45
- Dementia. NICE clinical guideline 42 (2006). www.nice.org.uk/CG42
- Bipolar disorder. NICE clinical guideline 38 (2006). www.nice.org.uk/CG38
- Obsessive-compulsive disorder. NICE clinical guideline 31 (2005). www.nice.org.uk/CG31
- Depression in children and young people. NICE clinical guideline 28 (2005). www.nice.org.uk/CG28
- Post-traumatic stress disorder (PTSD). NICE clinical guideline 26 (2005). www.nice.org.uk/CG26
- Anxiety (amended). NICE clinical guideline 22 (2004; amended 2007). www.nice.org.uk/CG22

Under development

- Vagus nerve stimulation for severe depression. NICE interventional procedure guidance. Publication expected 2009.

Updating the guidelines

These guidelines will be updated as needed, and information about the progress of any updates will be available at www.nice.org.uk/CG90 and www.nice.org.uk/CG91

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