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NICE Bites

Depression

NICE CG90/91; 2009

NICE CG90 covers the management of depression in adults in primary and secondary care and NICE CG91 covers the treatment of depression in adults with a chronic physical health problem. These replace NICE CG23 (updated 2007).

Definition of terms

CBT	cognitive behavioural therapy
CCBT	computerised cognitive behavioural therapy
IPT	interpersonal therapy
SSRI	selective serotonin reuptake inhibitor
TCA	tricyclic antidepressant
MAOI	monoamine oxidase inhibitor
ECT	electroconvulsive therapy
NSAID	non-steroidal anti-inflammatory drug

Management follows a stepped-care approach.

Recognition, assessment and initial management

Conduct a comprehensive assessment that does not rely simply on a symptom count.

Severities of depression

This guidance uses the DSM-IV criteria for major depression instead of ICD-10 criteria used in previous guidelines and includes the following categories:

Subthreshold depressive symptoms
Mild depression
Moderate depression
Severe depression

Depression with anxiety

For patients with:

- depression accompanied by symptoms of anxiety - treat the depression first,
- anxiety disorder and depression or depressive symptoms – treat the anxiety disorder first (see NICE CG22; 2007).

Persistent subthreshold depressive symptoms or mild to moderate depression

Sleep hygiene – provide advice on sleep hygiene.

Active monitoring – see full guideline for details.

Low-intensity psychosocial interventions

Offer one or more of the following:

- individual guided self-help based on CBT principles,
- CCBT,
- a structured group physical activity programme,
- † group-based peer support programme.

All interventions for depression should be delivered by competent practitioners.

Antidepressants

Do **NOT** routinely prescribe antidepressants for treatment of persistent subthreshold depressive symptoms or mild depression as the risk-benefit ratio is poor.

Consider an antidepressant 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**
- † mild depression that complicates the care of the physical health problem.

St John's wort

Do **NOT** prescribe or advise treatment with St John's wort.

Explain to patients using St John's wort about the:

- different potencies of available preparations,
- interactions with other medicines (including oral contraceptives, anticoagulants and anticonvulsants).

Persistent subthreshold depressive symptoms or mild to moderate depression with *inadequate response to initial intervention*

Give an antidepressant (usually an SSRI) **OR** a high-intensity psychological intervention.

Moderate and severe depression

Combine an antidepressant (usually an SSRI) with a high-intensity psychological intervention.

High-intensity psychological interventions e.g. CBT, IPT
See full guideline for details.

† Management options for patients with a chronic physical health problem and moderate to severe depression - see full guideline for details.

Complex and severe depression

- Refer to specialist mental health services.
- Consider reintroducing treatments that have been inadequately delivered or adhered to.
- Only start medication under the supervision of a consultant psychiatrist.
- For people who have depression with *psychotic symptoms*, consider augmenting treatment with antipsychotic medication.
- Develop a multidisciplinary care plan.
- Consider crisis resolution and home treatment teams to manage crises.

Electroconvulsive therapy

- Consider for severe, life threatening depression and when a rapid response is required or when other treatments have failed.
- Do not use for people with moderate depression unless their depression has not responded to multiple treatment.
- Fully inform the individual of the risks and benefits associated with ECT.

Do not routinely vary treatment strategies by depression subtype e.g.atypical depression or patient factors.

† *These are additional considerations for people with depression and a chronic physical health problem.*

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Depression
NICE CG90

Pharmacological treatment
Choosing an antidepressant
All antidepressants have similar efficacy. Choice depends on:
- anticipated adverse effects and discontinuation symptoms,
- potential interactions with other medicines or illness; refer to appendix 1 of the BNF and appendix 16 of NICE CG91 (full guideline),
- efficacy and tolerability of other antidepressants tried.

First-line - use a generic SSRI
Consider:
- the increased risk of bleeding with SSRIs; prescribe a gastroprotective drug for older people taking a NSAID or aspirin,
- the high risk of drug interactions with fluoxetine, fluvoxamine and paroxetine,
- the higher incidence of discontinuation symptoms with paroxetine,
- citalopram or sertraline for people with a chronic physical health problem as these cause fewer drug interactions.

Other antidepressants e.g. TCAs, MAOIs, venlafaxine
Consider:
- toxicity in overdose in patients at risk of suicide:
  - the greatest risk in overdose is with TCAs, except for lofepramine,
  - venlafaxine is associated with a greater risk of death from overdose compared to other antidepressants used in primary care.
- the increased likelihood of discontinuation due to adverse effects; increase doses gradually with venlafaxine, duloxetine and TCA,
- the specific cautions, contraindications and monitoring requirements for individual drugs,
- non-reversible MAOIs, combined antidepressants and lithium augmentation of antidepressants should only be prescribed by specialist mental health professionals.

Do **NOT** prescribe dosulepin.

Cautions and counselling
When **starting treatment** inform patients:
- of the gradual development of full antidepressant effect,
- of potential adverse effects and drug interactions,
- about the risk of discontinuation symptoms on stopping,
- to take medication regularly and continue beyond remission to reduce the risk of relapse,
- that antidepressants are **NOT** associated with addiction.

Monitoring
For patients at increased risk of suicide or younger than 30 years, review;
- after one week then frequently until risk no longer significant.

For patients **NOT** at increased risk of suicide, review;
- after two weeks then regularly e.g. every 2 to 4 weeks in the first 3 months.

Response to treatment
- If no improvement is seen after 2 to 4 weeks, check patient compliance.
- If there is minimal or no response after 3 to 4 weeks of treatment with a therapeutic dose, consider:
  - increasing the dose, **OR**
  - switching to another antidepressant.
- If there is some improvement by 4 weeks, continue for another 2 to 4 weeks.

  Consider switching antidepressants if:
  - response is still not adequate, **OR**
  - there are adverse effects, **OR**
  - the person requests a change of drug.
- If adverse effects occur:
  - if mild, monitor symptoms closely, **OR**
  - stop or switch to another antidepressant, **OR**
  - if patient has significant symptoms of anxiety, agitation or insomnia add short-term treatment with a benzodiazepine (max 2 weeks); caution if person is at risk of falls.

Switching antidepressants
CARE is needed when switching between antidepressants.
Consider:
- initially, a different SSRI or a newer-generation antidepressant,
- subsequently an antidepressant of a different class such as venlafaxine, a TCA or an MAOI.

Do **NOT** switch to, or start dosulepin.

§ Editorial note – further guidance on switching can be accessed at www.nelm.nhs.uk (see Medicines Q&A documents; Evidence section).

Combining and augmenting antidepressants
Do **NOT** combine or augment antidepressants in primary care without advice from a consultant psychiatrist.

After providing information about increased adverse effects, consider combining or augmenting an antidepressant with:
- lithium – see full guideline for monitoring requirements,
- an antipsychotic such as aripiprazole*, olanzapine*, quetiapine* or risperidone*,
- another antidepressant such as mianserin or mirtazepine,
- Do **NOT** routinely augment an antidepressant with:
  - buspirone*, carbamazepine*, lamotrigine*, valproate*, pindolol* or thyroid hormones*.
  - a benzodiazepine for more than 2 weeks.

* These agents do not have a UK marketing authorisation for this indication. See individual Summary of Product Characteristics for full prescribing information.

Stopping or reducing antidepressants
- Advise patients that discontinuation symptoms may occur on stopping, missing doses or when reducing the dose; these are usually mild and self-limiting, but can be severe if the drug is stopped abruptly.
- Gradually reduce dose over 4 weeks (this is not necessary with fluoxetine) or over longer periods for drugs with a short half-life (e.g. paroxetine, venlafaxine).

If discontinuation symptoms occur:
- if symptoms are mild, monitor,
- if symptoms are severe, reintroduce the original, antidepressant (or a similar antidepressant with a longer half-life) at the dose that was effective, and reduce dose gradually while monitoring symptoms.

Continuation and prevention of relapse
At remission – patients who have benefited with antidepressant treatment should continue this for at least 6 months.
6 months after remission – review the need to continue medication. If there is a significant risk of relapse or a history of recurrent depression consider the following options:
- continuing medication for another 2 years,
- augmenting medication,
- psychological intervention.

See full guideline for details.