GUIDELINES

Depression in adults, including those with a chronic physical health problem: summary of NICE guidance

Stephen Pilling joint director¹, professor of clinical psychology and clinical effectiveness², Ian Anderson professor of psychiatry³, David Goldberg professor emeritus⁴, Nicholas Meader systematic reviewer⁵, Clare Taylor editor⁵, On behalf of the two guideline development groups

¹National Collaborating Centre for Mental Health, University College London, London WC1E 7HB; ²Research Department of Clinical, Educational and Health Psychology, University College London, London WC1E 7HB; ³University of Manchester, Manchester M13 9PL; ⁴Institute of Psychiatry, King’s College London, London SE5 8AF; ⁵National Collaborating Centre for Mental Health, Royal College of Psychiatrists’ Research and Training Unit, London E1 8AA

This is one of a series of BMJ summaries of new guidelines, which are based on the best available evidence; they highlight important recommendations for clinical practice, especially where uncertainty or controversy exists.

Why read this summary?

Each year 6% of adults will experience an episode of depression, and over the course of a person’s lifetime more than 15% of the population will have an episode.¹ ² Depression (as defined by the American Psychiatric Association⁵) is the leading cause of suicide and currently the fourth highest disease burden on society in terms of its treatment costs, its effect on families and carers, and its impact on productivity in the workplace.

Depression can be disabling and distressing and for many people can become a chronic disorder, especially if inadequately treated. It is about two to three times more common in people with a chronic physical health problem than in people who are in good physical health.⁶ Chronic physical health problems can precipitate and exacerbate depression, but depression can also adversely affect outcomes of coexisting physical illnesses, including increased mortality. Furthermore, depression can be a risk factor for some physical illnesses, such as cardiovascular disease.⁷

This article summarises the most recent recommendations on depression from the National Institute for Health and Clinical Excellence (NICE): an updated guideline on the management and treatment of depression in adults⁸ and a new guideline on depression focusing on adults with a chronic physical health problem.⁹ In both guidelines diagnosis was based on the criteria of the Diagnostic and statistical manual of mental disorders, fourth edition (DSM-IV), which require the presence of at least five symptoms and of impaired function persisting for at least two weeks.⁵

Recommendations

NICE recommendations are based on systematic reviews of the best available evidence. When minimal evidence is available, recommendations are based on the experience and opinion of the Guideline Development Group (GDG) of what constitutes good practice. Evidence levels for the recommendations are given in italic in square brackets.

Identification and assessment

- Be alert to possible depression (particularly in people with a history of depression or a chronic physical health problem with associated functional impairment) and consider asking the following two questions:
  - “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?”

[Based on moderate quality validation studies]

- 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 to determine severity (as defined in DSM-IV) and establish the duration of the episode. [Based on moderate quality observational studies and the experience and opinion of the GDG]
Persistent subthreshold depressive symptoms or mild to moderate depression

- For people with persistent “subthreshold symptoms of depression” (symptoms that are below the DSM-IV criteria for major depression) or mild to moderate depression (with or without a chronic physical health problem) and for those with subthreshold depressive symptoms that complicate the care of the physical health problem, consider offering one or more of the following low intensity psychosocial interventions, guided by the person’s preference:
  - Individual, guided self help based on principles of cognitive behavioural therapy (CBT)
  - Computerised cognitive behavioural therapy
  - A structured, group based physical activity programme.

For people with a chronic physical health problem, also offer group based peer support (self help) programmes.

[All the above recommendations are based on moderate quality randomised controlled trials]

- Do not use antidepressants routinely to treat persistent subthreshold depressive symptoms or mild depression in people without a chronic physical health problem, but consider antidepressants for those with:
  - A history of moderate or severe depression, or
  - Subthreshold depressive symptoms that have been present for at least two years, or
  - Subthreshold depressive symptoms or mild depression persisting after other interventions.

[Based on moderate quality randomised controlled trials and the experience and opinion of the GDG]

Starting antidepressants in people with depression and chronic physical health problem

- When prescribing an antidepressant, take into account:
  - Any additional physical health disorders
  - The side effects of antidepressants, which may affect the underlying physical disease (in particular, selective serotonin reuptake inhibitors may result in or exacerbate hyponatraemia, especially in older people)
  - The absence of evidence to support the use of specific antidepressants for people with particular chronic physical health problems
  - Interactions with other medications.

[Based on moderate quality randomised controlled trials and observational studies]

- Prescribe a selective serotonin reuptake inhibitor in generic form first, unless there are interactions with other drugs; consider using citalopram or sertraline as they are less likely to lead to interactions. [Based on moderate quality randomised controlled trials and observational studies]

Moderate or severe depression

- For people with moderate or severe depression without a chronic physical health problem, provide antidepressant medication combined with high intensity psychological treatment (CBT or interpersonal therapy). [Based on moderate quality randomised controlled trials and health economic modelling]

- For people who first present with moderate depression and a chronic physical health problem, offer group based CBT (or individual CBT for those who decline group based CBT or for whom it is not appropriate, or where a group is not available) or behavioural couples therapy. [Based on moderate quality randomised controlled trials in people with depression and chronic physical health problems and on extrapolation from moderate quality randomised controlled trials in people with depression]

- For people who first present with severe depression and a chronic physical health problem, consider offering individual CBT combined with antidepressant medication. [Based on moderate quality randomised controlled trials on people with depression and chronic physical health problems]

Sequencing treatments after initial inadequate response

- When reviewing drug treatment for a person with depression whose symptoms have not adequately responded to initial pharmacological interventions:
  - Check adherence to, and side effects from, initial treatment
  - Increase the frequency of appointments, monitoring outcomes with a validated outcome measure (such as the hospital anxiety and depression scale) or the patient health questionnaire-9 (PHQ-9)
  - Be aware that using a single antidepressant rather than combination medication (two antidepressants used together) or augmentation (a non-antidepressant such as lithium or an atypical antipsychotic used with an antidepressant) is usually associated with fewer side effects
  - Consider reintroducing previous treatments that have been inadequately delivered or adhered to, including increasing the dose
  - Consider switching to an alternative antidepressant.

[All the above recommendations are based on high quality observational studies]

- When switching to another antidepressant, be aware that the evidence for the relative advantage of switching either within or between classes is weak. Consider switching to:
  - First, a different selective serotonin reuptake inhibitor or a better tolerated, newer generation antidepressant
  - Subsequently, an antidepressant of a different pharmacological class that may be less well tolerated—for example, venlafaxine, a tricyclic antidepressant, or a monoamine oxidase inhibitor
  - In people with a chronic physical health problem be aware of drug interactions.
[Both the above recommendations are based on moderate quality non-randomised trials]

**Continuation and relapse prevention**

- Support and encourage people who have benefited from taking an antidepressant to continue medication for at least six months after remission of an episode. [Based on moderate quality randomised controlled trials]
- Offer people with depression (without a chronic physical health problem) who are considered to be at substantial risk of relapse or who have residual symptoms one of the following psychological interventions:
  - Individual CBT (for those who have relapsed despite antidepressants or who have a history of depression and residual symptoms despite treatment)
  - Mindfulness based cognitive therapy (for those who are currently well but have experienced three or more previous episodes of depression)

[Both the above recommendations are based on moderate quality randomised controlled trials]

**People with chronic physical health problem and moderate to severe depression not responding to treatment**

- 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 psychological interventions (CBT or behavioural couples therapy), pharmacological treatment, or a combination of both of these. [Based on high quality randomised controlled trials]
- Such care should include case management supervised by a senior mental health professional, close collaboration between primary and secondary physical health services, a range of interventions consistent with those recommended in this guideline (including patient education, psychological and pharmacological interventions, and medication management), and long term coordination of care and follow-up. [Based on high quality randomised controlled trials]

**Effective delivery of interventions for depression**

- All interventions for depression should be delivered by competent practitioners.
- Base psychological and psychosocial interventions on the relevant treatment manuals, which should guide the structure and duration of the intervention.
- Practitioners should consider using competence frameworks from the relevant treatment manuals, and for all interventions they should:
  - Receive regular, high quality supervision
  - Use routine outcome measures and involve the person with depression in reviewing treatment efficacy
  - Monitor and evaluate adherence to treatment and practitioner competence.

[All the above recommendations are based on moderate quality randomised controlled trials, observational studies, and the experience and opinion of the GDG]

**Overcoming barriers**

Under-recognition of depression remains a major problem, as does the assessment of depression in the presence of chronic physical health problems. The new guidelines offer specific advice on how to overcome these problems, including modification to assessment procedures in people with chronic physical health problems. Evidence also exists of limited uptake of psychological interventions, and this problem is addressed by the recommendation of low intensity psychosocial interventions for mild to moderate depression as part of a stepped care framework. As evidence exists of considerable variation in the competence of those providing psychological interventions both guidelines include a key recommendation for effective delivery of interventions for depression.

The new guidelines also confront the considerable pessimism that may exist about the effective treatment of depression, in particular for those with a chronic physical health problem, by identifying effective psychological and pharmacological interventions. Uncertainty about drug interactions (in particular between the drugs used to treat depression and those used for a physical health problem) may lead to inappropriate or inadequate prescribing of antidepressants, therefore the guideline places special emphasis on being aware of drug interactions and offers advice about minimising risk. Prescribers who have concerns are advised to consult the British National Formulary (www.bnf.org) and the table of interactions in appendix 16 of the full guideline or to seek specialist advice or referral.

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Areas for future research and remaining uncertainties

- The most effective strategy for sequencing antidepressant treatment after inadequate initial response
- The efficacy of short term psychodynamic psychotherapy compared with cognitive behavioural therapy and antidepressants in treating moderate to severe depression
- The efficacy of CBT compared with antidepressants and placebo for persistent subthreshold depressive symptoms
- The efficacy of counselling compared with low intensity cognitive behavioural interventions and treatment as usual in treating persistent subthreshold depressive symptoms and mild depression
- The efficacy of behavioural activation (an intervention that focuses on identifying effects of behaviours on current symptoms and seeks to reduce the symptoms by using behavioural tasks such as reducing avoidance, scheduling activity, ensuring gradual exposure, and initiating positively reinforced behaviours) compared with CBT and antidepressants in treating moderate to severe depression
- The efficacy and cost effectiveness of different systems for the organisation of care for people with depression
- The efficacy and cost effectiveness of cognitive behavioural therapy, interpersonal therapy, and antidepressants in preventing relapse in moderate to severe recurrent depression
- The efficacy of 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

Further information on the guidance

A separate guideline for depression in people with a chronic physical health problem was developed because of the distinct needs of that population (such as the challenges in identifying depression and engaging people in treatment, and some uncertainties surrounding the evidence base in this population).

Despite the increased prevalence of depression in people with a chronic physical health problem, depression in this population is under-recognised. Therefore the guidelines recommend that clinicians be alert to depression in people with a chronic physical health problem. The diagnosis of depression in DSM-IV includes cognitive, mood, and somatic symptoms (substantial weight change, sleep disturbance, fatigue or loss of energy, and psychomotor retardation or agitation). However, somatic symptoms may arise not because of depression but because of the comorbid physical problem. Questions focused specifically on non-somatic symptoms could improve detection of depression and reduce false positives in people with a chronic physical health problem.

What’s new

The two new guidelines act together as an update of an earlier guideline on depression. The depression in adults guideline also updates recommendations for the treatment of depression included in a NICE technology appraisal of electroconvulsive therapy and in a NICE review of its earlier technology appraisal of computerised cognitive behavioural therapy for depression and anxiety.

The new guidelines adopt DSM-IV criteria because nearly all of the evidence is based on studies in which depression is defined by these criteria. The requirement for five symptoms—rather than four, as in ICD-10 (international classification of diseases, 10th revision)—to make the diagnosis is complicating the diagnosis and emphasis on clinically important functional impairment may increase the threshold for more intensive interventions. The new guidelines cover subthreshold depressive symptoms because these are recognised as potentially distressing and disabling if they are persistent and/or the treatment of a chronic physical health problem is complicated by such symptoms.

The new guidelines together provide more extensive recommendations on low intensity psychological interventions and suggest the use of collaborative care for people with persistent depression and chronic physical health problems. Recommendations on ensuring competence in all practitioners, in particular psychological practitioners, are also included. New information on drug interactions relevant to the treatment of depression and chronic physical health problems is also provided.

Brief methodology for these guidelines

The new guidelines were developed according to NICE guideline methodology (www.nice.org.uk/aboutnice/howwework/developingniceclinicalguidelines) by the National Collaborating Centre for Mental Health. Two groups of healthcare professionals and service user and carer representatives were convened to oversee the work and develop the recommendations for both guidelines. The groups conducted extensive systematic reviews of the clinical and health economic literature.

Although the guidelines were developed by two distinct groups, both groups collaborated during the development process. Firstly, the literature review and recommendations about case identification were the product of collaboration from both guideline development groups. Secondly, as there was a substantially more limited evidence base for people with depression and chronic physical health problems, the guideline development group considered the evidence from the depression in adults (update) group and extrapolated on the basis of this evidence when considered appropriate. Extrapolation was based on several principles including (a) supplementing evidence for people with a chronic physical illness with that from the general population where this was consistent in both populations, and (b) not extrapolating when evidence for people with chronic physical illness and the general population was contradictory.

The guidelines went through an external consultation with stakeholders. The development groups assessed the comments, reanalysed the data where necessary, and modified the guidelines. NICE has produced four different versions of each guideline: a full version; a quick reference guide (which combines both guidelines); a version known as the “NICE guideline” that summarises the recommendations; and a version for service users and the public (“Understanding NICE Guidance”). All these versions are available from the NICE website (www.nice.org.uk). Future updates of the guidelines will be produced as part of the NICE guideline development programme.

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