NICE guidelines for the management of depression

The National Institute for Health and Clinical Excellence (NICE) published depression guidelines in December 2004 (NICE, 2004). Given that depression has a point prevalence in the population of somewhere between 5 and 10% (Katon and Schulberg, 1992), with rates of 30% or more in medical and surgical clinics (Kroenke et al, 1997), and that the illness is the leading cause of disability world wide (Murray and Lopez, 1996), the guidelines are relevant to all doctors. This editorial focuses on the implications of the guidelines for non-mental health specialists.

Stepped care model

The NICE depression guidelines are based on a 'stepped care' approach with five levels (*Table 1*). Patients move to higher steps with increasing severity of illness and increased risk. Step one concerns diagnosis while steps two and three relate to the management of depression in non-specialist settings.

Step 1: Diagnosis and recognition of depression

Diagnosis is the corner-stone of evidence-based medicine. Unfortunately diagnosis of depression is currently rather arbitrary. NICE recommends use of a symptom check list to improve reliability using the *International Classification of Diseases* (10th edition) (ICD-10) criteria (*Table 2*). Patients must have a minimum of four symptoms which have been present for at least 2 weeks. Severity assessment is by means of a symptom count with mild, moderate and severe defined as the presence of four, five or six, and seven plus symptoms from the checklist respectively (all including at least one of the essential three symptoms; *Table 2*).

Depression is a potentially terminal illness in a significant minority of patients (as a result of suicide and increased physical health morbidity and mortality). NICE recommend screening of high-risk groups including women following childbirth and all those with significant physical illnesses, with two simple questions: 'During the last month have you often been bothered by a) feeling down, depressed or hopeless? and b) having little interest or pleasure in doing things?' A positive response to either question necessitates further enquiry about all of the (other eight) symptoms listed in *Table 2* to confirm the diagnosis and assess severity.

Step 2: Mild depression

Antidepressants are not recommended for the routine management of patients with mild depression. This is because mild depression often spontaneously resolves and the vast bulk of evidence for antidepressants relates patients with moderate to severe depression. NICE therefore recommend 'watchful waiting' which includes simple problem solving techniques with active follow-up in the next 1–2 weeks. Simple advice regarding comorbid anxiety and sleep disturbance (both of which are very common) is also advised.

Additional strategies include supervised exercise (45–60 minutes three times weekly for 12 weeks) or guided self-help along cognitive–behaviour lines. However, the resources for such interventions are sparsely available. Antidepressants are only recommended if a patient fails to respond to the above or has a history of more severe depression.

Table 1. National Institute for Health and Clinical Excellence stepped care of depression

Step 1	Recognition of depression
Step 2	Depression in primary care – mild depression
Step 3	Depression in primary care – moderate to severe
Step 4	Mental health services – refractory, recurrent, atypical and psychotic depression
Step 5	Depression requiring inpatient care

Step 3: Moderate to severe depression

The first-line intervention for moderate to severe depression is an antidepressant. There is a clear evidence base to support their use despite arguments to the contrary (Moncreiff and Irving, 2005) that have been considered and dismissed by NICE. A selective serotonin-reuptake inhibitor (SSRI) is recommended, in particular fluoxetine or citalopram. Care needs to be taken with fluoxetine because of possible drug interactions, but its long half-life also means that there is less of a problem if doses are forgotten.

Practitioners are advised to inform patients about potential side-effects, the delay in response, and risk of discontinuation/withdrawal symptoms if the drugs are stopped abruptly. Fluoxetine has little risk of this, but it can be particularly problematic with paroxetine. Antidepressants should be continued for at least 6 months from remission (i.e. full resolution of symptoms). SSRIs can cause akathisia (a subjective experience of uncontrollable motor restlessness) and increased anxiety in the early stages of treatment. Patients should be monitored closely since this is a risk factor for suicide. It can be managed by short-term (2–4 weeks maximum) use of benzodiazepines if simple reassurance is insufficient.

Table 2. International Classification of Diseases-10 symptom check list

Key symptoms	Persistent low mood
	Loss of interest or pleasure
	Fatigue or low energy
Additional symptoms	Disturbed sleep
	Poor concentration or indecisiveness
	Low self confidence
	Poor or increased appetite
	Suicidal thoughts or acts
	Agitation or slowing of movement
	Guilt or self blame
Severity of illness	4 symptoms = mild
	5–6 symptoms = moderate
	7+ symptoms = severe

NICE recommends that if there is any risk of suicide or the patient is under 30 years old, they should be reviewed after 1 week's treatment. Otherwise, patients should be reviewed after 2 weeks and then every 2–4 weeks for 3 months. If a patient fails to respond (after 4–6 weeks' treatment), and lack of concordance is excluded, consider increasing the dose of SSRI to British National Formulary limits. If this is ineffective, the antidepressant should be switched. The problem here is that while this is needed in 30–35% of patients, there are not enough data to guide the choice of second-line agent.

NICE suggests that an alternative SSRI can be considered along with mirtazepine, moclobemide, reboxetine and lofepramine. Mirtazepine is well tolerated but sedative (which can be an advantage or disadvantage) and it can cause significant weight gain. Moclobemide is a monoamine oxidase inhibitor; unlike the older ones it has less extreme food restrictions, but care is needed switching to it because of interactions with SSRIs. Reboxetine selectively acts on noradrenergic transmission so its side-effect profile is very different to SSRIs. Lofepramine is the only tricyclic antidepressant recommended for use by non-specialists because it is the best tolerated and safest in overdose.

Rather controversially, NICE have recommended that venlafaxine, which has developed a reputation as an effective second-line antidepressant, should not be used by non-specialists (along with phenelzine, dosulepin (dothiepin) and lithium augmentation of antidepressants). This recommendation is currently under appeal by the manufacturer Wyeth.

If a patient refuses an antidepressant, fails to respond, or there is a need to avoid side-effects, NICE recommend cognitive behavioural psychotherapy and interpersonal psychotherapy given by trained individuals over 16–20 hourly sessions. Dynamic psychotherapy, counseling and non-specific psychotherapies are not recommended. While many patients would like psychotherapy, there are grossly inadequate resources for the number of patients involved, often with waiting lists of 6–12 months that are unacceptable for what must be re-emphasized is a terminal illness in a significant minority of patients.

Steps 4 and 5: Mental health services

Patients who fail to respond to two different antidepressants, or just one if they have atypical depression (characterized by 'reversed' biological symptoms of over-eating and over-sleeping), should be referred to secondary care mental health services, as should patients with psychotic depression.

Conclusions

Depression is a serious illness that is often not diagnosed and mistreated. The NICE depression guidelines provide simple guidance for non-specialist and specialist mental health practitioners alike. The brief guidance document (12 pages, down-loadable from the NICE web site) should be required reading for all doctors given the prevalence of the illness particularly in medial and surgical clinics and that NICE recommends screening of such groups.

Physicians and surgeons need to be aware of first-line management strategies. However, full implementation of the guidelines, particularly with respect of non-pharmacological treatments, is a major challenge and will require enormous additional resources. **BJHM**

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Katon W, Schulberg H (1992) Epidemiology of depression in primary care. *Gen Hosp Psychiatry* **14:** 237–47
Kroenke K, Jackson JL, Chamberlin J (1997) Depressive and anxiety disorders in patients presenting with physical complaints: clinical predictors and outcome. *Am J Med* **103:** 339–47
Moncreiff J, Irving I (2005) Efficacy of antidepressants in adults. *BMJ* **331**: 155–7 (http://bmj.bmjjournals.com/cgi/eletters/331/7509/155)
Murray C, Lopez A (1996) *The Global Burden of Disease.* Harvard University Press, Harvard, CT
National Institute for Clinical Excellence (2004) *Depression: Management of depression in primary and secondary care.* Clinical Guideline 23, National Institute for Clinical Excellence, London

KEY POINTS

- Depression is a potentially terminal illness that is particularly common in patients with physical health complaints.
- National Institute for Health and Clinical Excellence (NICE) recommend simple screening of such groups.
- Antidepressants are effective treatments of depression and NICE recommend fluoxetine or citalopram first line.
- The brief version of the NICE depression guidelines should be required reading for all doctors.