Depression: Management of depression in primary and secondary care

Record Status
This is a bibliographic record of a published health technology assessment. No evaluation of the quality of this assessment has been made for the HTA database.

Citation

Authors' objectives
This report provides guidelines on the management of depression in primary and secondary care.

Authors' conclusions
Key priorities for implementation
Screening in primary care and general hospital settings:
- Screening should be undertaken in primary care and general hospital settings for depression in high-risk groups for example, those with a past history of depression, significant physical illnesses causing disability, or other mental health problems, such as dementia.

Watchful waiting:
- For patients with mild depression who do not want an intervention or who, in the opinion of the healthcare professional, may recover with no intervention, a further assessment should be arranged, normally within 2 weeks (watchful waiting).

Antidepressants in mild depression:
- Antidepressants are not recommended for the initial treatment of mild depression, because the risk-benefit ratio is poor.

Guided self-help:
- For patients with mild depression, healthcare professionals should consider recommending a guided self-help programme based on cognitive behavioural therapy (CBT).

Short-term psychological treatment:
- In both mild and moderate depression, psychological treatment specifically focused on depression (such as problem-solving therapy, brief CBT and counselling) of 6 to 8 sessions over 10 to 12 weeks should be considered.

Prescription of an SSRI:
- When an antidepressant is to be prescribed in routine care, it should be a selective serotonin reuptake inhibitor (SSRI), because SSRIs are as effective as tricyclic antidepressants and are less likely to be discontinued because of side effects.

Tolerance and craving, discontinuation/withdrawal symptoms:
- All patients prescribed antidepressants should be informed that, although the drugs are not associated with tolerance and craving, discontinuation/withdrawal symptoms may occur on stopping, missing doses or, occasionally, on reducing the dose of the drug. These symptoms are usually mild and self-limiting but can occasionally be severe, particularly if the drug is stopped abruptly.

Initial presentation of severe depression:
- When patients present initially with severe depression, a combination of antidepressants and individual CBT should be considered as the combination is more cost-effective than either treatment on its own.

Maintenance treatment with antidepressants:
- Patients who have had two or more depressive episodes in the recent past, and who have experienced significant functional impairment during the episodes, should be advised to continue antidepressants for 2 years.

Combined treatment for treatment-resistant depression:
- For patients whose depression is treatment resistant, the
combination of antidepressant medication with CBT should be considered.

CBT for recurrent depression: - CBT should be considered for patients with recurrent depression who have relapsed despite antidepressant treatment, or who express a preference for psychological interventions.

**Project page URL**
http://www.nice.org.uk/page.aspx?o=235213

**Indexing Status**
Subject indexing assigned by CRD

**MeSH**
Depression; Depressive Disorder

**Language Published**
English

**Country of organisation**
England

**Address for correspondence**
MidCity Place, 71 High Holborn, London WC1V 6NA, UK Tel: +44 020 7067 5800 Fax: +44 020 7067 5801 Email: nice@nice.nhs.uk

**AccessionNumber**
32005000056

**Date bibliographic record published**
17/01/2005

**Date abstract record published**
17/01/2005