

The treatment of depression in adults

Understanding NICE guidance – information for people with depression, their advocates and carers, and the public

In April 2007, NICE issued a new version of this information to take account of some changes in the recommendations in the NICE guideline. NICE made these changes after new advice was issued by the Medicines and Healthcare products Regulatory Agency on prescribing a drug called venlafaxine.

December 2004,
with amendments
April 2007



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Issue date: April 2007

To order copies

Copies of this booklet can be ordered from the NHS Response Line; telephone 0870 1555 455 and quote reference number N1238.

A version in English and Welsh is also available, reference number N1245. Mae fersiwn yn Gymraeg ac yn Saesneg ar gael hefyd, rhif cyfeirnod N1245. The NICE clinical guideline on which this information is based, 'Depression: management of depression in primary and secondary care', is available from the NICE website (www.nice.org.uk/CG023NICEguideline). A quick reference guide for healthcare professionals is also available from the website (www.nice.org.uk/CG023NICEquickrefguide), and the NHS Response Line (reference number N1237).

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ISBN: 1-84629-403-7

Published by the National Institute for Health and Clinical Excellence
April 2007

Artwork by LIMA Graphics Ltd, Frimley, Surrey
Printed by Alderson Brothers Printers Limited, Surrey

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About this information

This information describes the guidance that the National Institute for Health and Clinical Excellence (called NICE for short) has issued to the NHS on depression. It is based on 'Depression: management of depression in primary and secondary care' (NICE Clinical Guideline No. 23), which is a clinical guideline produced by NICE for doctors, nurses and others working in the NHS in England and Wales. Although the information in this booklet has been written mainly for people with depression, it may also be useful for family members, advocates or those who care for people with depression, and anyone with an interest in depression or in healthcare in general.

Short explanations of some of the medical words and terms used in this booklet are provided on pages 48–57.

Clinical guidelines

Clinical guidelines are recommendations for good practice. The guidelines produced by NICE are prepared by groups of healthcare professionals, patients, carers and their representatives, and scientists. The groups look at the evidence available

on the best way of treating a condition and make recommendations based on this evidence.

There is more about NICE and the way that the NICE guidelines are developed on the NICE website (www.nice.org.uk). You can download the booklet 'The guideline development process – an overview for stakeholders, the public and the NHS' from the website, or you can order a copy by phoning 0870 1555 455 and quoting reference number N1113.

What the recommendations cover

NICE clinical guidelines can look at different areas of diagnosis, treatment, care, self-help or a combination of these. The recommendations in 'Depression: management of depression in primary and secondary care', which are described here, cover:

- the care you can expect to receive from your GP or other healthcare professionals, whether you receive treatment in or out of hospital
- the information you can expect to receive about your problem and its treatment
- what you can expect from treatment, including psychological therapies, drug treatment and electroconvulsive therapy

- the kinds of services that help people with depression, including your GP, specialist mental health services and hospital care.

The guideline looks at depression in people aged 18 years and older, and covers mild to severe depression.

It does not specifically look at:

- depression in children
- a type of mental health problem called dysthymia (for more information, see page 52)
- postnatal depression (see page 54)
- seasonal affective disorder (see page 56)
- people with depression who have a separate physical or mental illness.

The information that follows tells you about the NICE guideline on depression. It doesn't attempt to explain depression in detail. If you want to find out more about depression, ask your doctor or another member of your healthcare team. Alternatively, NHS Direct may be a good starting point. You can call NHS Direct on 0845 46 47 or view the NHS Direct website (www.nhsdirect.nhs.uk or www.nhsdirect.wales.nhs.uk).

How guidelines are used in the NHS

In general, healthcare professionals working in the NHS are expected to follow NICE's clinical guidelines. But there will be times when the treatments recommended will not be suitable for some people for reasons including their specific medical condition, their general health, their wishes, or a combination of these.

If you think that the treatment or care that you receive (or someone you care for receives) does not match the treatment or care described in the pages that follow, you should discuss your concerns with your GP or other members of your healthcare team, or with your advocate.

If you want to read the other versions of this guideline

There are four versions of this guideline:

- this one
- the NICE guideline, 'Depression: management of depression in primary and secondary care' (NICE Clinical Guideline 23)

- the quick reference guide, which is a summary of the main recommendations in the NICE guideline and has been issued to people working in the NHS
- the full guideline, which contains all the details of the guideline recommendations, how they were developed and information about the evidence on which they are based.

All versions of the guideline are available from the NICE website (www.nice.org.uk/CG023). This version and the quick reference guide are also available from the NHS Response Line – phone 0870 1555 455 and give the reference number(s) of the booklets you want (N1238 for this version, N1245 for this version in English and Welsh, and N1237 for the quick reference guide). The full guideline was produced by the National Collaborating Centre for Mental Health and is available from www.bps.org.uk/depression and the NICE website (www.nice.org.uk/CG023fullguideline).

About depression

Depression is one of the most common mental illnesses, affecting nearly 1 in 6 people in the UK at some point in their lives.

Symptoms of depression

Depression varies from person to person. It can be difficult to distinguish between depression and everyday feelings of sadness, which affect most people from time to time. But in general, if you are depressed, you will feel a loss of pleasure in things you used to enjoy, and a loss of interest in people and what is going on around you.

If you have depression, you might experience some of the following symptoms: you might feel tearful, irritable, and tired most of the time; you might also have a poor appetite (sometimes leading to weight loss), sleep badly, and have a lack of interest in sex; it is also common to not feel like doing anything, and to withdraw from social activities.

Depression can also lead to poor concentration and poor memory. You may also have lots of negative thoughts and feelings of guilt and worthlessness, or be self-critical and lack confidence. People with depression might also harm themselves or have thoughts of suicide, or sometimes may make attempts at suicide.

Types of depression

Depression can arise out of the blue or can be set off for a variety of reasons (such as serious physical illness, dementia, difficult things that have happened in childhood or are happening now, bereavement, family problems, or unemployment). Some people will have depression just once. However, about half of people who have had an episode of depression will get depressed more than once. How long depression lasts also varies from person to person. Most will feel better within 4 to 6 months, whereas some can experience symptoms for much longer (depression lasting more than 2 years is called chronic depression).

The severity of depression varies a great deal. Some people have only a few symptoms, which affect daily life in a limited way. This is called mild depression. Other people may have more symptoms that can make daily life very difficult – this is called severe depression.

Depression is also often accompanied by anxiety (for an explanation, see page 49). NICE has also issued a guideline on anxiety disorders if you want more information. This is available from the NICE website (www.nice.org.uk/CG022). The information for the public and the quick reference guide are also available from the NHS Response Line – phone 0870 1555 455 and give the reference number(s) of the booklets you want (N1236 for information for the public in English, N1244 for a version in English and Welsh, and N1235 for the quick reference guide).

What you can expect if you have depression

The information in the rest of this booklet tells you about the NICE guideline on depression. There are short explanations of some of the medical words and terms used in this booklet on pages 48 to 57.

Information and support

If you have depression, healthcare professionals should provide you with information and support that can help you and your family or carers understand your illness better. This should include information on the nature, course and treatment of depression, and information about self-help groups and support groups for people with depression and their family and carers.

When you are offered any treatment, you should be given information about the illness and the treatment before the treatment starts. This should include information on the use and side effects of medication. Your doctor should also make sure that you are able to give properly informed consent before treatment starts. This is especially important if you have severe depression. It is very important that you feel

involved in any decision about your treatment, and feel that the healthcare professional is always listening to what you have to say and that your views really do influence the type of treatment you receive.

Language

When healthcare professionals discuss your depression with you, they should do so clearly, and avoid using lots of medical terms. If these terms are used they should be explained to you.

When a person with depression has difficulty speaking and understanding English, his or her healthcare team should use an interpreter. If possible, all healthcare services should provide written information that is clear and that you can understand. Where possible, psychological treatments and information about medicines should be provided in a language you can understand.

Confidentiality

People with depression can be concerned that the involvement of their relatives may affect their rights to confidentiality. Discussions between people with depression and doctors

are bound by rules about confidentiality and you should know that these will only be broken if you or others are at significant risk of harm or neglect, and if informing a family member or carer is likely to reduce that risk. You should be told if confidentiality has been broken.

Support from your GP

Your GP is likely to be the first person in the health service you will see about your depression. This first contact can be difficult because it may be hard for you to talk about your symptoms. There are certain things that you can expect your GP to discuss with you, or ask you.

Your GP will ask you questions about your depression in order to help you to talk about it. These might include questions about your physical and psychological health, your family and friendships, any cultural issues, any recent changes in your life, and any family history of mental illness.

You will also be asked if you have had thoughts about harming yourself. Your GP should advise you (and your family or carer) to watch for negative thinking and behaviour, hopelessness, changes in mood, and thoughts about suicide – particularly during very stressful periods.

If you have had thoughts about suicide, your doctor should give you information about where you can get further help and support. He or she should advise you to seek help if the situation gets worse.

Your GP may suggest that you see a specialist, such as a psychiatrist, psychologist or a mental health nurse. If this happens, there should be a clear agreement about who is responsible for looking after the various aspects of your health and progress. You, and if appropriate your family or carer, should be informed about this agreement.

If you are at significant risk of harming yourself, or are of risk to others, then urgent referral to a specialist mental health team or hospital will be considered.

Recognising depression

Because the symptoms of depression can sometimes be mostly physical, you may not realise that you are suffering from depression. If you visit your GP with physical symptoms, such as fatigue or weight loss, he or she might ask you questions about depression, such as: 'During the last month, have you often been bothered by feeling down, depressed or

hopeless?’ and ‘During the last month, have you often been bothered by having little interest or pleasure in doing things?’

Although it is not always clear what causes depression, for many people it can be related to difficult and painful experiences in their life, and these can be difficult or embarrassing to talk about. This is not uncommon and healthcare professionals know about this. If you can, it is important to be as open as possible about things that you think might be important in helping yourself and others understand your depression.

Asking questions about your condition

This booklet gives you a general introduction to the kind of support and treatment you can expect if you, or a family member, have depression. Having read the parts of this booklet that seem important to you, you may find it helpful to ask your GP, or others caring for you, for more information so that you are better able to make decisions about your own care and treatment.

Many people get anxious when talking to a doctor, and it is easy to forget to ask important questions. The box on this page has some suggestions of the kinds of questions you could ask. There are other suggestions later on in this booklet. It might help to write them down and take them with you when you see your doctor, or you could take this booklet with you.

Questions you might like to ask about depression

You may not understand the type of depression you have, or how it could affect you. If that is the case, you could ask one or more of the following:

- What makes you think I am suffering from depression?
- Is this kind of depression common?
- What does it mean for my health/daily life/work?

Finding the right care for you

Depression can have a number of different causes and symptoms. For this reason, each person with depression is treated as an individual. Although some people will have a very specific problem or set of problems, others can have a wider range of difficulties that may include financial, social and other health problems. If this is the case, you might need help from both your GP and the specialist mental health services. However, most people with depression are cared for by their GP.

Your GP might involve a number of other community-based healthcare professionals, such as nurses and counsellors, in your care. If you need specialist care, you could be referred to a psychiatrist, clinical psychologist, mental health nurse, or psychiatric nurse. Of those patients who receive specialist care, most, if not all, continue to receive care from their GP. Very occasionally, people with depression are admitted to hospital.

Your choice

There are different kinds of treatments for depression, including psychological treatments, medication, and simple measures such as exercise programmes. Some of these treatments may be combined.

Your own preference for a particular treatment is important in deciding the choice of treatment.

Treatment and care from your GP

Most treatments for depression will be provided by your GP, and for many people, a simple brief treatment can help them overcome their depression. Your doctor and others involved in your care will try to make sure that you get the treatment that will best help you. The next few pages are about treatments for mild depression. If you do not benefit from these treatments, or your doctor feels that your depression is more severe, you will be offered other treatments explained later in the booklet.

Questions you might ask about your treatment or care

This guideline is about making sure you get the best treatment for you. This means that you should know about the kind of treatments you are being offered. You might want to ask your GP one or more of the following questions:

- What kind of treatment do you think will best help me?
- How long will the treatment take?
- Do you think I will have any problems with this treatment?

Mild depression

Mild depression can get better by itself with no treatment at all, or with some simple advice on coping with problems and improving sleep. If you do not want treatment, or if your GP thinks you will recover with no treatment, you should usually be offered another appointment within 2 weeks to see how you are. Your GP might contact you if you do not attend your follow-up appointment.

There are a number of treatments that can help if you have mild depression; these are described below.

Exercise

Exercise can improve your health and lift your mood. Your GP may advise you to follow an exercise programme. A programme usually consists of up to 3 sessions per week (lasting 45 minutes to 1 hour) for between 10 and 12 weeks.

Psychological treatments

There are a number of helpful psychological treatments for depression, and there are explanations of the different types on pages 50 to 55. These include problem-solving therapy, short-term cognitive behavioural therapy, and guided self-help. Alternatively, counselling or a computer-based system (computerised cognitive behavioural therapy) may help.

Short-term treatments can help with milder forms of depression. The aims of all psychological treatments are to reduce symptoms related to depression.

If you have depression and another problem (such as drug or alcohol misuse or significant personality problems), then your treatment for depression may last longer. You may also be offered other treatments that focus specifically on the other problem.

All psychological treatments should be provided by healthcare professionals who have experience of people with depression and are skilled in giving the treatment. In all psychological therapies, your therapist should work with you to focus on what is helpful in overcoming depression.

Questions you might ask about psychological treatment

If you are offered a particular psychological treatment, you might want to know more about it, so you could ask one or more of these questions:

- Can you tell me in more detail what the treatment will involve?
- Can you tell me why you have decided to offer me this type of treatment?
- Are there other treatments that might suit me?

Antidepressants

Antidepressants are not usually recommended for people with mild depression. But they may help you in certain circumstances – for example, if your depression has lasted a long time, or if you have had severe depression before and now have milder symptoms.

St John's wort

St John's wort may be of benefit for people with milder depression, but your GP should not prescribe it or advise you to take it, because it is not certain what is the right dose for depression, different preparations vary in exactly what they contain, and St John's wort can cause serious problems when taken with other medicines. If you are taking it you should be careful if you are taking any other medicines – particularly the contraceptive pill, anticoagulants or anticonvulsants – and ask your doctor or pharmacist for advice. See page 56 for further information.

Anxiety and depression

If you have both anxiety and depression, your doctor will usually treat your depression first. Treatments for depression, such as psychological therapies and antidepressant medication, can often help to reduce symptoms of anxiety, so while your depression lifts, your anxiety may also get better.

Moderate or severe depression

Although depression often responds quickly to treatment, for some people it may be more severe or take longer for their treatment to work. Antidepressant medication and psychological treatments that have been specifically designed for people with depression can help. If you have moderate depression, you should normally be offered antidepressants before trying psychological treatments.

Antidepressant medication

Antidepressants work by increasing the activity and levels of certain chemicals in the brain that help to lift your mood. There are several different types of antidepressant, which include:

- selective serotonin reuptake inhibitors (SSRIs)
- tricyclic antidepressants
- monoamine oxidase inhibitors.

There are details about the different types of antidepressants on pages 49 to 57.

Your doctor will usually offer you an SSRI. SSRIs are as effective as other types of antidepressants and they usually have less side effects.

There are, however, many different antidepressants commonly used. If you would like to find out more about the medication offered to you, you could ask your doctor or pharmacist. You may, for instance, want to know about the side effects associated with the antidepressant and whether you can take it with other medication.

General points about antidepressants

You should be given enough information about the different antidepressant medications so that you are able to make an informed choice as to which one you would prefer. Your doctor will also take into account your experience of any previous treatment.

Your doctor will take into account the fact that some drugs may have different effects in men and women.

You may be worried about taking antidepressant medication – and your doctor should talk to you about your concerns. For example, you will not crave antidepressants or need to take more of the medication to feel the same effect as time goes on. Also, taking antidepressants does not mean that you are a weak person.

You should also be given advice on how antidepressants react with other medicines, foods and alcohol.

Before you start taking antidepressants, you should be told that the medication might take some time to work. You should also be asked to follow the instructions about taking your medicine carefully even if you have some doubts about it working at the beginning.

Your doctor should tell you about any side effects associated with your medication and symptoms that may occur when you stop taking it (see pages 30–31).

Your doctor should ask you to take the medication for a month to find out whether it is helping you. If you feel a little better, but not much better, it is worth waiting another 2 weeks before increasing the dose, stopping the medication, or changing to another kind of antidepressant. (See page 28 for additional advice for older people.)

If you are aged 30 or older, your doctor should see you 2 weeks after you start an antidepressant. You should then usually see him or her every 2 to 4 weeks for the first 3 months, with fewer appointments after that (depending on how you are feeling). However, if you are younger than 30 you should usually be seen 1 week after starting an antidepressant, and then as many times as needed after that. If you have had suicidal thoughts and are thought to be at risk, you should also be seen 1 week after starting an antidepressant and then as many times as needed, whatever your age.

Once you have started taking an SSRI your doctor should check whether you are anxious, agitated, having thoughts about suicide or feel restless and like you can't sit or stand still (called 'akathisia'). Your doctor should advise you that there is a risk of these symptoms in the early stages of treatment with an SSRI, and tell you to

seek help immediately if they are at all distressing. If you feel very restless and agitated over a long period of time your doctor should give you information and review your medication.

Your doctor should tell you (and your family or carer) to watch for negative thinking and behaviour, hopelessness, changes in mood, and thoughts about suicide when you first start taking antidepressants and if you change from one antidepressant to another. You (and your family or carer) should contact your doctor if you are at all concerned.

If you have thoughts about suicide, you should get extra support and advice from your doctor about taking your medication. This may include extra appointments or help over the phone.

You should be advised to take antidepressants for at least 6 months after you feel better because this reduces the risk of your depression coming back. Your doctor should check to see if you need to stay on medication after this.

Additional advice for older people

- If you are aged 65 or over you should be offered a dose of antidepressants appropriate for your age. For most antidepressants, this is usually half the standard dose. You should be advised to try the medication for at least 6 weeks to see whether it helps. If you do feel a little better you should be advised to continue with the treatment for a further 6 weeks before deciding whether to stop or change to a different antidepressant.
- Your doctor should take into account any other medication you may be taking when offering an antidepressant.
- Your doctor should carefully monitor you for side effects, particularly if you are taking tricyclic antidepressants.

A note about depression and dementia

If you have depression and dementia, you should be treated in exactly the same way as other older people, because antidepressants help depression even if a person has dementia.

Tricyclic antidepressants

If you are offered a tricyclic antidepressant, you should be carefully monitored for side effects and to find out whether the medication is working. If your symptoms have improved, then you can stay on the same dose with careful

monitoring. The dose will be gradually increased if the medication is not working very well and there are no unpleasant side effects. Before you are prescribed a tricyclic antidepressant, you should have an electrocardiograph test (or ECG for short) to check your heart and a blood pressure check if you are at significant risk of heart and circulation problems.

Tricyclic antidepressants (with the exception of lofepramine) should not be prescribed for anyone who:

- has recently had a heart attack, or
- is at high risk of serious 'cardiac arrhythmias' (an irregular heart beat).

Venlafaxine

Your doctor may consider offering you treatment with an antidepressant called venlafaxine. You should have your blood pressure checked when you start the drug and regularly during treatment. If your blood pressure persistently increases, your doctor should reduce the dose of the drug or consider stopping treatment. You should also have checks for heart problems; this is particularly important if it is known that you have heart or circulation problems ('cardiovascular disease'). If you are offered a high dose of venlafaxine (300 mg per day or more) your doctor should be advised or supervised by a specialist mental health medical practitioner.

Venlafaxine should not be prescribed for anyone who:

- has high blood pressure (hypertension) that is not being treated
- has recently had a heart attack, or
- is at high risk of serious 'cardiac arrhythmias' (an irregular heart beat).

Stopping or reducing antidepressants, and discontinuation (or withdrawal) symptoms

The length of time people take antidepressant medication varies from person to person. You might be advised by your GP to stop or reduce your antidepressant medication because you are feeling better, or because you are experiencing unpleasant side effects and wish to stop or try a different kind of antidepressant.

Whichever medication you are taking, you should be told that, although antidepressants are not addictive, in the way alcohol and cigarettes can be, you might experience unpleasant symptoms when you stop the medication, miss doses or reduce the dose of the medication. These symptoms are referred to as discontinuation (or withdrawal) symptoms, and they can include dizziness, feeling nauseous, unusual bodily sensations, anxiety and headaches. These symptoms are usually mild, but

can sometimes be severe, especially if the antidepressant is stopped abruptly.

If your antidepressant medication is being stopped, your GP should usually reduce the dose over a 4-week period.

If you experience severe problems while reducing your medication, your GP might try you again on the original dose or try a similar antidepressant, and reduce again gradually while monitoring your symptoms.

If you experience symptoms that concern you while coming off your medication, you should seek advice from your GP immediately.

Changing to another antidepressant

If you are offered a different kind of antidepressant to the one you first tried, your doctor should increase the dose of the new antidepressant very gradually. If you start feeling confused, restless or start sweating, shaking, shivering and have hallucinations (strange visions or sounds) and sudden jerks of your muscles then you may have a condition called serotonin syndrome and you should contact your doctor or go to a hospital straight away.

Questions you might ask if you have been offered antidepressant medication

If you are offered antidepressant medication you might want to know more about it and so you could ask one or more of the following questions:

- How long will it take before I start to feel better?
- How long will I have to take antidepressant medication?
- Will it be easy to stop taking antidepressant medication?

You should be informed about the side effects associated with antidepressants. If you are unsure, you might consider asking the following questions.

- Does this medication have any side effects that could affect my physical or mental health or daily life?
- What should I do if I get any of these side effects?
- How long do the side effects last?

Psychological treatment

You may be offered treatments that have been specifically designed to help people with depression including cognitive behavioural therapy (CBT), interpersonal therapy (IPT) and couples therapy. CBT focuses on thoughts and feelings and how to cope with problems. People with moderate to severe depression usually have 16 to 20 sessions of CBT over 6 to 9 months (although it could be longer or shorter depending on individual circumstances or needs). IPT focuses on specific problems, such as how depression affects your ability to relate to other people. This therapy may last for 16 to 20 sessions over a 6- to 9-month period. If having psychological therapy on your own has not helped your depression, and you have a spouse or partner, you should be offered couples therapy, which involves both of you. If you are 65 or over, you should be offered the full range of psychological treatments. See pages 50 to 55 for further information on the treatments.

Psychodynamic psychotherapy (see page 55) should not be offered ordinarily, but it may be of some benefit if you have a number of complicated personal problems.

Combining antidepressants with psychological treatments

If your depression is severe you might be offered a combination of antidepressant medication with cognitive behavioural therapy (CBT) or interpersonal therapy (IPT).

Ongoing treatment for depression that lasts for 2 years or more

If your depression lasts for 2 years or more (chronic depression), you will typically be offered a combination of treatments, such as cognitive behavioural therapy and antidepressant medication. You may also be offered further telephone support.

Befriending

If this is available in your area, your doctor may offer you social support through a 'befriending' service, in addition to any antidepressant or psychological treatment you may be receiving. This should be provided by trained volunteers who will visit you at least once a week for between 2 and 6 months. They will talk and listen to you, and offer practical advice and support.

Further social support

If your depression has lasted for a long time you may need some help to regain your confidence and get back on your feet. For example, if you have been out of work for some time, you may need help with returning to work. Your healthcare professional should be able to tell you about the programmes to help you address these difficulties.

Support and treatment if you are referred to a specialist mental health service

This section is relevant to you if your depression is severe, does not respond to treatment, or comes back again. If your depression falls under any of these categories, your GP might refer you to a specialist mental health professional, such as a psychiatrist, psychologist or mental health nurse.

Once you are referred you should be assessed and your previous treatment thoroughly reviewed. Your doctor may offer you different treatments or suggest a treatment that you have already tried if there is a reason that could explain why it had not worked before.

The kinds of treatments and support you can expect to receive are similar to those that you may receive from your GP but the treatments may also be more long-term and intensive. If you have very severe depression, it is recommended that your healthcare professional makes sure that there are written instructions about your treatment that you set out in advance (these are called advance directives). These instructions should say what treatments you prefer, and what treatments you do not wish to receive.

Medication

All of the treatments described in this section (pages 36 to 38) should be started by a consultant psychiatrist or a doctor working closely with a consultant psychiatrist.

Lithium

If you have tried several different types of antidepressant and have experienced no improvement, your doctor may offer you a drug called lithium in addition to your current treatment. You should be told about the side effects of lithium, and you should have an electrocardiograph (ECG) to check your heart.

Antidepressants

If you have tried several different types of antidepressant and have experienced no improvement, your doctor may suggest venlafaxine if you have not tried it before (see pages 29-30), or one of a group of antidepressants called monoamine oxidase inhibitors (such as phenelzine).

If you are offered a monoamine oxidase inhibitor, you may need to have your blood pressure monitored. Your doctor should advise you that there can be serious side effects if you eat certain foods while taking the medication, and tell you what foods to avoid.

If you have experienced two or more episodes of depression in the recent past, and can tolerate antidepressants, your doctor may advise you to continue treatment with antidepressants for at least 2 years. You should have regular checks during and after this time.

Combination antidepressant treatments

If your healthcare professional thinks that you may benefit from combining one kind of antidepressant with another, you will be offered a meeting with a specialist who will start these treatments. Your treatment should be carefully monitored and discussed with you. There are likely to be more side effects with combined treatment and this should be explained to you.

Other medication

If you are suffering from hallucinations and/or delusions (called psychotic depression), you might be offered antipsychotic medication as well as the drugs being used to treat your depression.

Psychological treatments

Research has shown that psychological therapies that have been specifically designed to treat depression, such as cognitive behavioural therapy (CBT), interpersonal therapy (IPT) or couples therapy, can be effective and may reduce the likelihood of your depression coming back. Your specialist should consider offering you one of these.

If you are currently feeling well, but have experienced three or more previous episodes of depression, you may be offered another kind of cognitive behavioural therapy called mindfulness CBT. You may receive this kind of therapy in a group with other people.

Combining antidepressant medication with psychological treatments

If your depression is severe or has not responded to various different treatments, your specialist should consider combining antidepressant medication with CBT or IPT.

Questions you might ask if your depression is not getting better or comes back after a previous episode

If you feel that the treatment is not working as you had expected, you might want to raise this with the doctor providing the treatment by asking the following questions:

- I am not getting better as I expected. Is it worth continuing with this treatment?
- Is there any other treatment that could help me?

If your depression comes back after the first episode, you might want to consider asking these questions:

- Is there a reason for my depression coming back?
- Will I be offered different treatment(s) this time?

Crisis resolution and home treatment teams

These specialist teams (made up of doctors and nurses) will help you to cope with a crisis if you are judged to be very unwell and at risk of neglecting yourself, or harming yourself or others. They will check on you regularly, providing intensive care and support in your own home. They can help to see you through the crisis.

Support and treatment if you need care in hospital

Most patients with depression are never admitted to hospital. However, if it is thought that you are at risk of harming yourself, you have severe depression that does not respond to treatment, or you are being treated under the Mental Health Act, you can be admitted to hospital. (See page 53 for more details on the Mental Health Act.) While in hospital, you will be offered similar treatments to those described earlier in this booklet, but being in hospital means that you will be in a safe place and may be able to have more intensive treatment.

Electroconvulsive therapy (ECT)

ECT is sometimes used as a treatment for severe depression that has not responded to previous treatment to achieve rapid and short-term improvement. ECT will be used only if other forms of therapy have failed to reduce your symptoms, or if you are at serious risk of harming yourself. ECT is always given in hospital under general anaesthetic and works by passing a small electric current through the brain. You may experience some limited loss of memory. A course of ECT usually involves between 6 and 12 sessions (2 sessions a week), although for some patients, symptoms improve after fewer than 6 sessions. If you have ECT:

- You should be given full and clear information on how it works, and an explanation of the advantages and disadvantages.
- If you are older than 65, younger than 18, or pregnant, your doctor should take into account the increased risk of having ECT.
- You should give your consent for any such treatment freely and without feeling obliged or forced into making a decision. You should also be reminded that you can withdraw your consent at any time. Your doctor should ideally involve your advocate and/or carer when discussing consent with you.

- If you are not well enough to give your consent, your doctor should take into account any written instructions agreed between you and your doctor about treatment (usually called advance directives), and your advocate or carer should be consulted.
- Your health will be monitored after each session of ECT, and the treatment will stop as soon as you feel better, or if the treatment is making you feel worse.

This advice on ECT is the same as that given in another piece of NICE guidance, which looked at how ECT should be used. 'The use of electroconvulsive therapy: understanding NICE guidance – information for service users, their advocates and carers, and the public' is available from the NICE website (www.nice.org.uk/TA059publicinfo), or you can order a copy by phoning 0870 1555 455 and quoting reference number N0207.

Making decisions about your care

You have the right to be fully informed and to share in decision-making about your healthcare. If you need further information about any aspects of your depression or treatment, ask your GP, specialist mental health professional, or other member of your health team. You can discuss this guideline with them if you wish.

For carers of someone with depression

Supporting someone with depression

As a family member or carer, you might consider asking for assistance from a doctor or support group in order to understand what role you might play in helping the person with depression. You should be given adequate information about the treatments available.

You may also be offered support as a family in order to best understand and cope with the problems, not because you or your family may have caused or contributed to the

development of the problem, but because you could help your family member recover. If you are finding coping with your family member's depression difficult, then you are also entitled to help in your own right. If this is the case, you can speak to your doctor or a healthcare professional involved in the care of your family member.

Confidentiality

Healthcare professionals should give carers full, clear information. Respecting a patient's right to confidentiality should not be accepted as an excuse for not listening to or communicating with carers. Carers have the same rights to confidentiality as do patients.

Support for yourself

When a family member has depression, it can be difficult for all other members of the family. It is important therefore that you, as a family member or carer, receive emotional support and help from the professionals with whom you come into contact, particularly if you are feeling distressed or worried. You can find useful information about the important role of carers from local support groups and from the website www.carers.gov.uk

Questions for families and carers to ask

Families and other carers need to be well informed and supported. If, as a family member or carer, you are unsure about your role in helping and supporting a person with depression, consider asking one or more of the following questions:

- Can you explain to us what you think the problem is about?
- Can you advise us on the kind of support that you think we might benefit from as a family?
- What can we do to help [person with depression] with their problem?

If confidentiality is not an issue, you may want to ask the following:

- Can you please let us know how the treatment of [person with depression] is progressing?

Further information

For further information about the National Institute for Health and Clinical Excellence (NICE) or the Clinical Guidelines Programme, or for other versions of this guideline (including the sources of evidence used to inform the recommendations for treatment and care) or the quick reference guide, visit the NICE website at www.nice.org.uk

NICE has issued guidelines on the treatment and care of children and young people with depression, and of women with mental health problems in the antenatal and postnatal periods. Information about these guidelines is available from the NICE website:

- Depression in children and young people.
NICE clinical guideline 28.
www.nice.org.uk/CG028
- Antenatal and postnatal mental health.
NICE clinical guideline 45.
www.nice.org.uk/CG045

Words and terms used in this booklet

Advance directives: written instructions agreed before treatment starts in which the patient specifies his or her preferred treatments and those he or she does not wish to receive. These are sometimes used for patients with more severe depression to guide healthcare professionals if the patient becomes unable to make decisions for him- or herself. The patient should understand the nature of the condition for which treatment may be required, the need for treatment, the expected benefits of the proposed treatment, and possible side effects and risks. Advance directives cannot be used to refuse treatment altogether when a person is being treated under the Mental Health Act (see page 53 for an explanation of the Mental Health Act).

Advocates: people who make sure that your wishes are made clear to mental health services. Advocates may speak on your behalf if you would like their help, or if you are not able to do so yourself. They will also make sure that you receive the information and level of care to which you are entitled.

Antidepressants: medicines used to relieve the symptoms of depression. They may work by increasing the activity and levels of certain chemical messengers in the brain (such as one called serotonin) that affect mood. There are several types of antidepressant, including selective serotonin reuptake inhibitors (SSRIs), monoamine oxidase inhibitors (MAOIs), and tricyclic antidepressants (see separate entries for further explanation of the different types). There are also other, newer types of antidepressant, which include mirtazapine, reboxetine and venlafaxine.

Antipsychotics: medicines used in the treatment of psychosis (the symptoms of which include hallucinations and delusions).

Anxiety: a condition in which a person has uncontrollable and/or intense feelings of unease (such as worry or fear). These feelings are different from everyday worries, and are often experienced physically. Common symptoms are butterflies or pain in the stomach, trembling, increased heartbeat and/or sweating.

Befriending: a community-based support system that provides activities and social contact to help people with depression on a one-to-one basis.

Bipolar disorder: this condition is also known as manic depression. It is an illness that affects mood, causing a person to switch between feeling very low (depression) and very high (mania).

Chronic depression: continuous symptoms of depression lasting for 2 years or more.

Cognitive behavioural therapy (CBT): a psychological treatment based on the idea that the way we feel is affected by our thoughts (or 'cognitions') and beliefs, and by how we behave. People with depression tend to have negative thoughts (such as 'I am a failure' or 'I will never get better'), which can lead to negative behaviour (such as stopping doing things that used to be pleasurable, or putting things off). CBT encourages people to engage in activities and to write down their thoughts and problems. It helps them to develop their ability to identify and counteract negative thoughts, and to re-evaluate their perceptions, beliefs or reasoning about their symptoms. An adequate course of CBT may be 6 to 8 sessions for mild depression but is usually 16 to 20 sessions over 6 to 9 months for moderate to severe depression. If you find CBT helpful then you will usually be offered follow-up treatments, which consist of 2 to 4 sessions over 12 months. People with very severe depression might benefit from more intensive treatment for the first month (typically 2 sessions a week).

Computerised cognitive behavioural therapy (CCBT): CCBT is a form of psychological treatment based on cognitive behavioural therapy (CBT). The person works through a computer programme that aims to help people understand depression and develop skills to deal with problems. CCBT usually lasts for 6 to 8 weeks.

Counselling: a short-term psychological therapy that allows people to explore their symptoms and problems with a trained individual. Counsellors will not usually give advice or treatment, but will offer support and guide people to help themselves. Counselling usually consists of 6 to 8 sessions over 6 to 10 weeks.

Couples therapy: a longer-term psychological treatment that enables couples to look at the way they behave with one another, and understand the link between this behaviour and the symptoms of depression. The aim of the therapy is to change the way couples interact so that they may develop a more supportive relationship. A course of couples therapy should be 15 to 20 sessions over 5 to 6 months.

Crisis resolution and home treatment teams: services that aim to provide support in the home and community to people who are very unwell.

Dementia: a term that describes a number of symptoms, including loss of memory and confusion, which usually affect older people and may be caused by Alzheimer's disease and other conditions.

Dysthymia: an illness related to depression. It differs from depression in that the symptoms are milder, and may not significantly affect daily life. Dysthymia is usually a long-term condition.

Electroconvulsive therapy (ECT): a procedure sometimes used to treat severe depression and other conditions in which an electric current is briefly applied to the brain. ECT is only offered if other kinds of treatments have not helped to relieve the depression.

Electrocardiograph (ECG): a test that records the electrical activity of the heart. It can measure the rate and regularity of the heartbeats, the presence of any damage to the heart, or the effects of drugs used to regulate the heart.

Guided self-help: a form of psychological therapy in which the patient is given books, often called self-help manuals, and works through them while being monitored by a healthcare professional. The best programmes are based on cognitive behavioural therapy. This kind of programme usually takes 6 to 8 weeks.

Interpersonal psychotherapy (IPT): a longer-term psychological therapy specifically designed to help people with depression identify and address current problems in their relationships with family, friends, partners, and other people. Treatment usually consists of 16 to 20 sessions over 6 to 9 months. If IPT has been helpful, 2 to 4 more sessions over 12 months may be offered.

Lithium: a form of medication used mainly in the treatment of bipolar disorder (manic depression), which can also be used to treat severe depression. Side effects are common. You should have regular blood tests if you are taking lithium to make sure that the medication is being prescribed at the right dose and to check for some side effects.

Mental Health Act: a law that allows for the treatment of a person with a mental disorder against their will, or without their consent, if without such action the person would be judged to be at serious risk to themselves or others. This is sometimes called 'being sectioned'. If you are treated under the Mental Health Act, you will receive your care in hospital, where you can expect as much care and support as anyone else. Time will be taken to explain what is happening. You should also be advised that you have a legal right to appeal.

Mindfulness CBT: a therapy that helps people with depression to be aware of negative thoughts but not to react to them. With this approach, it is hoped that the person will feel differently about their negative thoughts rather than aim to change the content of their thoughts.

Monoamine oxidase inhibitors (MAOIs): antidepressant medicines, such as phenelzine or moclobemide, which are used less than other antidepressants because there can be serious side effects if you eat certain foods when taking an MAOI. Your doctor should advise you about what these are before you are prescribed an MAOI. Side effects include drowsiness, dizziness, dry mouth and constipation.

Postnatal depression: a type of depression affecting women after childbirth. It may be short term and not significantly affect daily life, but it can also be more severe and last for a longer period of time.

Problem-solving therapy: a short-term psychological treatment offering direct and practical support. The therapist and patient work together to identify and isolate key problem areas that might be contributing to the patient's depression, to break these down into specific, manageable tasks, and to problem solve and develop coping strategies for particular problems. Treatment usually involves 5 to 6 sessions over 10 to 12 weeks.

Psychodynamic psychotherapy: a kind of psychological treatment, which is called dynamic because it focuses on the different forces (or dynamics) that are present in a person's relationships and everyday life, and may be causing them difficulties. The patient explores those thoughts and feelings of which he or she is aware (conscious) or not aware (unconscious). The aim is to examine, understand and work through the forces and difficulties, which may have begun in childhood.

St John's wort: a plant extract that has been used for centuries for medicinal purposes including the treatment of depression. It can be bought from health food shops, herbalists and pharmacies. In common with all herbal preparations, the quantity and proportions of each ingredient varies among individual brands and batches. Taking St John's wort with other medicines – such as anticonvulsants, anticoagulants, antidepressants and the contraceptive pill – can cause serious problems.

Seasonal affective disorder: a form of depression that is linked to the change of seasons. Symptoms are usually most severe during the winter months when the days are shorter.

Selective serotonin reuptake inhibitors (SSRIs): a type of antidepressant medicine that includes sertraline, paroxetine, fluoxetine, citalopram, escitalopram and fluvoxamine. They have fewer of the side effects associated with tricyclics and MAOIs, and are less likely to cause drowsiness and dizziness. They can, however, cause nausea and headaches.

Serotonin syndrome: a very serious condition that can occur when changing from one antidepressant to another, or when taking two antidepressants at the same time (one of which is usually an SSRI). Symptoms include confusion, restlessness, sweating, shaking, shivering, hallucinations (strange visions or sounds) and sudden jerks of the muscles.

Tricyclic antidepressants: medicines such as imipramine, desulepin and lofepramine. They can cause unpleasant side effects, which vary in severity from person to person, but may include dry mouth, blurred vision, constipation, problems passing urine, sweating, light-headedness and excessive drowsiness. There is also a group of antidepressants related to tricyclics, which includes mianserin.

Venlafaxine: a newer antidepressant, of a type called a serotonin and noradrenaline reuptake inhibitor (SNRI). People prescribed venlafaxine should have their blood pressure checked regularly and have checks for heart problems.



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