Depression ranges from mild to severe, and treatment varies according to level. Recognition and skilled assessment are therefore vital for effective management of physical health problems. Subthreshold symptoms mean having several, typically 2-4 symptoms, but not meeting the full diagnostic criteria of five for a depressive episode (American Psychiatric Association, 1994) (see Part 1 of this unit for diagnostic criteria).

For people with persistent subthreshold symptoms or mild to moderate depression who have not benefited from a low intensity psychosocial intervention, the NICE guideline recommends either:
- An antidepressant (see section below); or
- A psychological intervention, such as group based cognitive behavioural therapy (CBT), individual CBT or behavioural couples therapy.

NICE recommends that people who initially present with a long term condition and moderate depression should be offered a choice of psychological interventions. The strongest evidence of effect has been identified for group based CBT and individual CBT (for those who decline group based CBT, for whom it is not appropriate, or where a group is not available), and also, where indicated, for behavioural couples therapy.

For those who present with severe depression, NICE recommends considering a combination of individual CBT and an antidepressant (see below).

**PSYCHOLOGICAL INTERVENTIONS**

Evidence based psychological therapies (CBT and behavioural couples therapy) are delivered by trained staff based in primary care or specialist settings.

Although most nurses will not be involved in the direct delivery of these treatments, it is important they understand the principles, indications and means of accessing them locally. They also need to know about the...
likely waiting times and some detail about the length and demands on patients of these types of therapy (for further details, see the NICE guidance).

When choosing a treatment, it is important to take into account patients' preferences, how long the episode of depression has lasted, whether they have suffered from it before and whether symptoms responded to previous treatment.

Discussion and review should consider whether patients are likely to adhere to treatment, anticipate possible side effects, and take into account the relationship and effects of treatment on the course and treatment of the physical health problem(s). For instance, for people with mobility problems or a demanding schedule of other appointments or activities, the requirements of attending regular therapy sessions and engaging in "homework" tasks need to be carefully considered.

Williams and Garland (2002) give more detailed information on psychological therapies.

**ANTIDEPRESSANT TREATMENT**

Antidepressant drugs have a clear evidence base in the treatment of depression, and the new NICE guideline includes a rigorous review of their effectiveness for people with depression and long term conditions. Although NICE (2009a) confirms that antidepressants are effective in this group, it highlights important considerations in the choice of drug in relation to interactions and side effects.

Nurses have a range of roles in the care of patients with long term conditions who may benefit from antidepressants. Some nurses may prescribe them independently, some may be supplementary prescribers, while others discuss and monitor patients' treatment. As antidepressants are a standard treatment for this common condition, it is important that nurses understand the main principles and risks surrounding their use in this group.

Many people are anxious about the potential effects and side effects of antidepressants, which may partly explain why many discontinue taking their prescribed medication before completing an adequate course. Surveys have indicated that people are often concerned about a risk of addiction (possibly confusing antidepressants with benzodiazepines, which were widely prescribed for emotional problems in previous decades). Providing evidence based information about antidepressants may allay some of these fears and enable clearer decision making about treatment options.

The primary evidence concerning antidepressants derived from the reviews conducted for NICE guidelines and elsewhere (Arroll et al, 2009) is that:

- They are effective in treating major depression;
- There is little difference in the effectiveness of particular drugs;
- There are clear differences in the side effects of different classes and types of antidepressant;
- Selective serotonin reuptake inhibitors (SSRIs) are far safer in overdose than the older class of tricyclic antidepressants (TCAs);
- Treatment should be continued for at least six months after symptom response – and longer if there is a history of recurrent episodes of depression;
- Careful consideration of antidepressant side effects and interactions is needed when prescribing to people who have long term conditions.

When prescribing antidepressants to this patient group, it is particularly important to consider any other physical health disorders, side effects and drug interactions. Healthcare professionals should refer to Appendix 1 of the British National Formulary and seek specialist advice about interactions and side effects. The increased risk of gastrointestinal bleeding associated with SSRIs, and hence avoiding them in patients taking non-steroidal anti-inflammatory drugs (NSAIDs), is particularly relevant. The NICE guideline makes specific recommendations about drug interactions (Table 1).

Before patients start taking any medication that affects the central nervous system, their pulse rate and blood pressure should be recorded, and this monitoring should continue at regular intervals during

<table>
<thead>
<tr>
<th>TABLE 1. DRUG INTERACTIONS (NICE, 2009a)</th>
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<td><strong>MEDICATION FOR PHYSICAL LONG TERM CONDITION</strong></td>
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<td>Non-steroidal anti-inflammatory drugs (NSAIDs)</td>
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<td>Warfarin and heparin</td>
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<td>“Triptan” drugs for migraine</td>
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<tr>
<td>Monoamine oxidase-B (MAO-B) inhibitors (such as selegiline and rasagiline)</td>
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<tr>
<td>Theophylline, clozapine, methadone or tizanidine</td>
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<td>Flecainide or propafenone</td>
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<td>Atomoxetine</td>
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treatment. This is particularly important in those with hypertension, or if the antidepressant prescribed is specifically linked to increases in blood pressure (such as venlafaxine at higher doses).

In general, an SSRI antidepressant in generic form, such as citalopram or sertraline, should be prescribed first because of low tendency for interactions (unless there are specific interactions with other drugs).

Before they start taking antidepressants, NICE advises that patients should have the opportunity to explore any concerns and be given a full explanation as to why they have been prescribed antidepressants and relevant information including the points listed in Box 1. It is particularly important that they appreciate that antidepressants may take several weeks to achieve a response, and should be taken regularly for at least six months. Understanding this and having prior knowledge of potential side effects will help to reduce the risk of patients inappropriately stopping treatment.

Nurses are often well placed to monitor and support those taking antidepressants, and this education provision and ongoing review is an important element of overall management for depression. Providing clear information about the potential for unpleasant reactions if antidepressants are stopped abruptly – such as gastrointestinal and sleep disturbances, headache, anxiety, dizziness, and influenza-like symptoms – is similarly useful. It is helpful to clarify that the potential for unpleasant discontinuation symptoms does not mean that people become addicted to, or dependent on, antidepressants; dependency presents with additional features of tolerance and cravings that are not associated with antidepressants.

Non-reversible monoamine oxidase inhibitors (such as phenelzine), combined antidepressants, and the use of medications such as lithium in combination with antidepressants should normally be prescribed only by specialist mental health professionals. Dosulepin should not be prescribed.

For patients at significant risk of suicide, toxicity in overdose should be considered when choosing an antidepressant. Many tricyclic antidepressants are toxic in overdose and, with the exception of lofepramine, they should be used with great caution. If there are reasons for prescribing these drugs – for instance because of previous use and patients’ preferences – then vigilance concerning the frequency of prescriptions and regular monitoring of response is essential.

There has been a tendency to prescribe antidepressants at subtherapeutic levels. This is particularly noticeable in the treatment of people with comorbid medical conditions and relates to concerns about tolerability and interactions. NICE emphasises that antidepressants should be initiated at a recognised therapeutic dose.

**Monitoring**

Patients under 30 years or those with an increased risk of suicide should be seen one week after starting antidepressants. Those who are not considered to be at an increased risk of suicide should be seen after two weeks and then every 2-4 weeks in the first three months and at longer intervals after that if the response is good.

If side effects develop early on, several options can be considered. If they are mild and reasonably acceptable to patients, the side effects can be monitored. Alternatively, the antidepressant can be stopped or changed to a different one if the patient prefers.

If anxiety, agitation and/or insomnia are causing difficulties, short term (no longer than two weeks) concomitant treatment with a benzodiazepine may be considered, but not for those with chronic symptoms of anxiety or for those at risk of falls.

The need for continued treatment for longer than six months after remission should be reviewed with patients, taking into account the number of previous episodes of depression, the presence of residual symptoms, and concurrent physical health problems and psychosocial difficulties.

**POOR RESPONSE TO TREATMENT**

For patients with moderate to severe depression whose response to treatment is poor, options include changing the antidepressant dose or type, augmenting with other medications (this approach requires specialist involvement: medications most commonly used are antipsychotic drugs, lithium or an additional antidepressant), and combining drug treatment with CBT. NICE (2009b) offers further advice on this.

There is evidence that combining antidepressants with psychological treatment may be more effective than either approach used alone. However, while combined treatments are recommended in the scenario described above, and in severe and complex depression, the strength of this evidence in people with depression and long term conditions is such that NICE does not recommend combined treatment as a standard approach for moderate depression.

**ORGANISATIONAL APPROACHES**

As well as standard treatments for depression – pharmacological or psychological interventions, or a combination of these – the way in which services are organised has an important influence on outcomes. In particular, the development of staff roles and improved ways of collaborating between services, disciplines and providers has been identified as a promising direction for managing depression.

An important part of this type of service restructuring involves a focus on long term conditions (physical health problems) (Wagner, 2001), and the development of case management roles, both of which frequently involve nurses. Nurse case management was initially developed in the US, and much of
the evidence for its usefulness in depression care derives from there. However, the approach has been widely used across a range of long term conditions, and has been developed as a key part of The NHS Improvement Plan (Department of Health, 2004), and further articulated and evaluated in the NHS and social care long term conditions model (DH, 2007).

Within this approach, the case management role – involving specialist clinicians who are usually community matrons – is used to systematically identify people with highly complex long term conditions, and to plan and coordinate health and social care. On the basis of this policy initiative, over 3,000 community matron roles have been developed in primary care trusts throughout England.

This approach is clearly relevant to managing the needs of people with depression and long term conditions. The NICE guideline reviewed evidence for this way of working and identified that collaborative or enhanced care involving a case manager appears effective for depression. It is recommended as an approach for patients with long term conditions whose depression has not responded to initial psychological treatment, an antidepressant or a combination of these interventions.

Collaborative care should involve a case manager who can direct and coordinate care and either deliver or organise the interventions recommended by NICE. The case manager systematically monitors progress and enables close collaboration between primary and acute physical health services and specialist mental health services. The guidelines indicate that case managers should be supported and supervised by a senior mental healthcare professional.

CONCLUSION

Nurses’ roles in the care of people with long term conditions are expanding, and there is increasing recognition that long term illness is commonly accompanied by psychological problems.

Nurses are typically an initial point of healthcare contact and often maintain ongoing follow up care. This therapeutic involvement enables the range of difficulties associated with long term conditions to be individually managed.

Although nurses in hospital or intermediate care settings have less opportunity for ongoing care, nurses in all areas have a vital function in the initial recognition and support of depression, and those in primary care and community settings will usually have a clear involvement in continuing care. Even though many nurses do not have specialist mental health training, they nonetheless have a role in detecting depression, guiding and supporting evidence-based management and referring patients to specialist mental health services where appropriate.

Understanding the extent of heightened risk of depression in people with long term conditions is fundamental to the need for prompt recognition in this patient group. Healthcare professionals such as nurses play an important role in supporting patients in their response to health problems and, for depression, this involves a sound knowledge of the approaches that are appropriate and effective for particular patients.

Performing this role of patient education and helping to coordinate and maintain treatments is particularly important for depression and long term conditions: not only may patients be concerned about disclosing and taking treatment for a mental health problem, but also the range of possible complications caused by coexisting medical treatments requires skilled consideration.

Approaches to healthcare need to be based on clear evidence. This latest NICE guideline provides an important, accessible and comprehensive resource on which to base service developments and clinical decisions.

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REFERENCES


NICE (2009a) Depression in Adults with a Chronic Physical Health Problem: Treatment and Management. London: NICE. www.nice.org.uk/CG091

