EDITORIAL

NICE updates guidance on tackling depression

AUTHOR
Dr Phillip Bland
BA BM BCh MRCGP
DRCOG
GP, Dalton-in-Furness

THE REVISED NICE GUIDELINE ON DEPRESSION IN ADULTS,[1] ALTHOUGH BASED ON THE SAME stepped care model, differs substantially from the previous guidance both in its definition of depression and the range of treatments recommended.

If followed, the guidance will significantly change the way in which we manage depressed patients. Whereas currently we treat most patients ourselves using watchful waiting, brief psychological interventions and targeted antidepressant therapy, most patients will now need referral to the IAPT programme or elsewhere.

There are four principal strategies for improving outcomes: case finding; enhanced doctor education; improved targeting of treatment and case management programmes. NICE acknowledges the arguments against screening, i.e. the low PPV, high number needed to screen and lack of evidence of benefit. Nevertheless, selective case finding in high-risk groups is still advocated. However, it does not recommend routine enhanced care despite evidence that case finding is only effective when linked to a case management programme.[2]

The importance of GP communication skills is recognised. A Dutch study is cited which found skills training improved outcomes but not detection.

NICE's decision to switch from ICD-10 to DSM IV is welcome as the latter defines more precisely the clinically important boundary above which antidepressants become more effective than placebo.[3] Somewhat confusingly, however, the boundary has been moved to an imprecise point between mild and moderate major depression. The justification given is that, while antidepressants are equally effective for all grades of major depression, the placebo contribution and hence likelihood of spontaneous recovery diminishes with increasing severity.[4]

Computerised CBT, guided self-help or a group exercise programme are recommended for persistent subthreshold symptoms or mild depression. Antidepressants should only be considered if these prove ineffective, or if there is a history of moderate or severe depression.

None of the proposed psychosocial interventions are recommended as routine treatments in the British Association for Psychopharmacology guidelines.[3] The effect size for CCBT is small;[5] the evidence for bibliotherapy comes mainly from small US studies which recruited highly motivated and educated participants;[6] and exercise therapy only shows a moderate, non-significant effect if methodologically flawed trials are excluded from the analysis.[7]

For patients who do not respond to low-intensity psychosocial interventions, NICE recommends a choice of antidepressant treatment or a high-intensity psychological intervention as an alternative to antidepressant treatment. For moderate to severe depression, antidepressants should be combined with either CBT or IPT. The additional benefit gained from psychotherapy, however, is modest (NNT = 8) and may partly result from a reduction in the dropout rate.[8]

If we are to offer CBT as an alternative/complement to antidepressant treatment, there must be rapid access to therapy, with 16-20 sessions provided. IAPT centres are likely to be swamped with referrals, particularly as the PHQ-9 overestimates severity.[9]

It is disappointing that NICE no longer recommends enhanced care. A key reason for poor outcomes is that less than half those receiving treatment complete a minimum course.[10] A meta-analysis found that case management significantly improved both medication adherence and remission at 6-12 months (effect size = 0.40, NNT = 5).[11] If the main benefit of combining CBT with antidepressant treatment is to improve adherence, it could be argued that case management is a more cost-effective way of achieving this.[8]

The guidance should help to reduce overprescribing of antidepressants and improve access to psychological treatments. However, the fragmentation of care is a concern, and I would advocate that the new range of therapies should be linked to a practice-based case management programme.

REFERENCES

1 National Institute for Health and Clinical Excellence. CG 90. Depression: the treatment and management of depression in adults (update). NICE. London 2009
2 Gilbody S, Sheldon T, Wessely S. Should we screen for depression? *BMJ* 2006; 332:1027-30
3 Anderson IM, Ferrier IN, Baldwin RC et al. Evidence-based guidelines for treating depressive disorders with antidepressants. A revision of the 2000 British Association for Psychopharmacology guidelines. *J Psychopharmacol* 2008; 22: 343-96
4 Kirsch I, Decon B, Huedo-Medina TB et al. Initial severity and antidepressant benefits: a meta-analysis of data submitted to the food and drug administration. *PloS Med* 2008;5:e45. doi:10.1371/journal. Pmed.0050045
5 Spek V, Cuijpers PIM, Nyklicek I et al. Internet-based cognitive behaviour therapy for symptoms of depression and anxiety: a meta-analysis. *Psychol Med* 2007;37:319-28
6 Anderson L, Lewis G, Araya R et al. Self-help books for depression: how can practitioners and patients make the right choice? *Br J Gen Pract* 2005;55: 387-92
7 Mead GE, Morley W, Campbell P et al. Exercise for depression. Cochrane Database of Systematic Reviews 2009, Issue 3. Art. No.:CD004366. DOI: 10.1002/14651858. CD004366.pub4
8 Pampallona S, Bollini P, Tibaldi G et al. Combined pharmacotherapy and psychological treatment for depression. A systematic review. *Arch Gen Psych* 2004; 61:714-9
9 Cameron IM, Crawford JR, Lawton K et al. Psychometric comparison of PHQ-9 and HADS for measuring depression severity in primary care. *Br J Gen Pract* 2008;58: 32-6
10 Hepner KA, Rowe M, Rost K et al. The effect of adherence to practice guidelines on depression outcomes. *Ann Intern Med* 2007;147: 320-9
11 Gensichen J, Beyer M, Muth C et al. Case management to improve major depression in primary health care: a systematic review. *Psychol Med* 2006;36:7-14