

key points

SELECTED BY

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The point prevalence rates for ICD-10 depressive episode and ICD-10 mixed anxiety and depressive disorder were 2.3% and 9.0% respectively, according to the 2007 household survey of adult psychiatric morbidity in England. Adults in the UK with these diagnoses were estimated to have taken more than a quarter (9% and 20% respectively) of the total number of days' sickness absence in one year. Few patients receive effective treatment and between one- and two-thirds of primary care patients with major depression have not fully recovered 12 months later.

The NHS Outcomes Framework has identified 'Enhancing quality of life for people with mental illness' as a key improvement area. The NICE quality standard on depression in adults is intended to facilitate this by providing a definition of high quality care. If the standard is followed, patients will benefit from: reduced prescribing of antidepressants to those who will not benefit; increased access to psychological interventions; increased support through structured monitoring and active follow-up and reduced risk of chronic relapsing depression.

People who may have depression should receive an assessment that identifies the severity of symptoms, the degree of associated functional impairment and the duration of the episode. Health outcomes at each appointment should be recorded and the findings used to adjust delivery of interventions.

In persistent subthreshold depressive symptoms or mild depression we should only consider antidepressants for patients who have not responded to a low-intensity intervention, or who have: a previous history of moderate or severe depression; dysthymia (subthreshold depression of ≥ 2 years' duration); or mild depression complicating the care of a chronic condition.

The risk of relapse is highest during the first six months, and antidepressants decrease the odds of relapse by about 70%. The key quality measure is the proportion of patients benefiting from antidepressants who remain on them for at least six months after remission. We should review patients regularly at intervals of between two and four weeks during the first three months of antidepressant treatment. This is in order to: monitor depression symptoms and drug side effects; identify patients at risk of suicide; encourage medication adherence and self-management activities; and identify nonresponders and adjust their treatment.