Depression in adults: treatment and management

NICE guideline: short version

Draft for second consultation, May 2018

This guideline covers identifying, treating and managing depression in people aged 18 and over. It recommends tailoring care and treatment based on the severity of a person's depression. It also includes advice on preventing relapse and managing complex and severe depression.

Who is it for?

- Healthcare professionals
- Other professionals who have direct contact with, or provide health and other public services for, people with depression
- Commissioners and providers of services for people with depression and their families and carers
- Adults with depression, their families and carers

This guideline will update and replace NICE guideline CG90 (published October 2009).

We have updated or added new recommendations on the treatment of new depressive episodes, further treatment, treatment of chronic, psychotic and complex depression, preventing relapse and the organisation of and access to services.

You are invited to comment on the new and updated recommendations in this guideline. These are marked as:

- **[new 2018]** if the evidence has been reviewed and the recommendation has been added or updated **or**
- **[2018]** if the evidence has been reviewed but no change has been made to the recommended action.

You are also invited to comment on recommendations that NICE proposes to delete from the 2009 guideline.

We have not updated recommendations shaded in grey, and cannot accept comments on them. In some cases, we have made minor wording changes for clarification.

See Update information for a full explanation of what is being updated.

This version of the guideline contains the draft recommendations, context and recommendations for research. Information about how the guideline was developed is on the guideline's page on the NICE website. This includes the guideline committee's discussion and the evidence reviews (in the full guideline), the scope, and details of the committee and any declarations of interest.

Contents

Contents 3
Recommendations 4
1.1 Experience of care 4
1.2 Recognition, assessment and initial management 5
1.3 Access to services 9
1.4 General principles of care 11
1.5 First-line treatment for less severe depression 20
1.6 First-line treatment for more severe depression 24
1.7 Behavioural couples therapy for depression 25
1.8 Relapse prevention 26
1.9 No or limited response to initial treatment 29
1.10 Treating chronic depressive symptoms 32
1.11 Treating complex depression 34
1.12 Treating psychotic depression 34
1.13 Electroconvulsive therapy 34
1.14 Coordination and delivery of care 37
Terms used in this guideline 40
Putting this guideline into practice 45
Context 47
Reason for the update 48
More information 48
Recommendations for research 48
1 Effectiveness of peer support for different severities of depression 48
2 Mechanisms of action of psychological interventions 49
3 Rate of relapse 50
4 Group based psychological treatments for preventing relapse 50
5 Increased access to services 51
Update information 52
Recommendations that have been deleted or changed 53

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

1.1 Experience of care

Providing information and support

1.1.1 Make sure people with depression are aware of self-help groups, support groups and other local and national resources. [2004]

Advance decisions and statements

1.1.2 Consider developing advance decisions and advance statements collaboratively with people who have recurrent severe depression or depression with psychotic symptoms, and for those who have been treated under the Mental Health Act 2007, in line with the Mental Capacity Act 2005. Record the decisions and statements and include copies in the person's care plan in primary and secondary care, and give copies to the person and to their family or carer if the person agrees. [2009, amended 2018]

Supporting families and carers

1.1.3 When families or carers are involved in supporting a person with severe or chronic[1] depression, think about:

[1] Depression is described as 'chronic' if symptoms have been present more or less continuously for 2 years or more.

- providing written and verbal spoken information on depression and its management, including how families or carers can support the person
- offering a carer's assessment of their caring, physical and mental health needs if needed
- providing information about local family or carer support groups and voluntary organisations, and helping families or carers to access them
- discussing with the person and their family or carer about confidentiality and the sharing of information. [2009]

1.2 Recognition, assessment and initial management

1.2.1 Be alert to possible depression (particularly in people with a past history of depression or a chronic physical health problem with associated functional impairment) and consider asking people who may have depression if:

- during the last month, have they often been bothered by feeling down, depressed or hopeless?
- during the last month, have they often been bothered by having little interest or pleasure in doing things? [2009]

1.2.2 If a person answers 'yes' to either of the depression identification questions (see recommendation 1.2.1) but the practitioner is not competent to perform a mental health assessment, refer the person to an appropriate professional who can. If this professional is not the person's GP, inform the person's GP about the referral. [2009]

1.2.3 If a person answers 'yes' to either of the depression identification questions (see recommendation 1.2.1) and the practitioner is competent to perform a mental health assessment, review the person's mental state and associated functional, interpersonal and social difficulties. [2009]

1.2.4 Consider using a validated measure (for example, for symptoms, functions and/or disability) when assessing a person with suspected depression to inform and evaluate treatment. [2009]

1.2.5 If a person has significant language or communication difficulties, (for example people with sensory or cognitive impairments), consider asking a family member or carer about the person's symptoms to identify possible depression. [2004, amended 2018]

(See also NICE's guideline on mental health problems in people with learning disabilities.)

1.2.6 Conduct a comprehensive assessment that does not rely simply on a symptom count when assessing a person who may have depression. Take into account both the degree of functional impairment and/or disability associated with the possible depression and the length of the episode. [2009]

1.2.7 Think about how the factors below may have affected the development, course and severity of a person's depression in addition to assessing symptoms and associated functional impairment:

- any history of depression and coexisting mental health or physical disorders
- any history of mood elevation (to determine if the depression may be part of bipolar disorder[2])
- any past experience of, and response to, previous treatments
- the quality of interpersonal relationships
- living conditions, employment situation and social isolation. [2009, amended 2018]

[2] If needed, refer to NICE's guideline on bipolar disorder: assessment and management.

Acquired cognitive impairments

1.2.8 When assessing a person with suspected depression:

- be aware of any acquired cognitive impairments
- if needed, consult with a relevant specialist when developing treatment plans and strategies. [2009, amended 2018]

1.2.9 When providing interventions for people with an acquired cognitive impairment who have a diagnosis of depression:

- if possible, provide the same interventions as for other people with depression
- if needed, adjust the method of delivery or length of the intervention to take account of the disability or impairment. [2009, amended 2018]

Depression with anxiety

1.2.10 When depression is accompanied by symptoms of anxiety, the first priority should usually be to treat the depression. When the person has an anxiety disorder and comorbid depression or depressive symptoms, consult NICE guidance for the relevant anxiety disorder if available and consider treating the anxiety disorder first. [2004]

Risk assessment and monitoring

1.2.11 Always ask people with depression directly about suicidal ideation and intent. If there is a risk of self-harm or suicide:

- assess whether the person has adequate social support and is aware of sources of help
- arrange help appropriate to the level of need
- advise the person to seek further help if the situation deteriorates. [2004]

1.2.12 If a person with depression presents considerable immediate risk to themselves or others, refer them urgently to specialist mental health services. [2004]

1.2.13 Advise people with depression of the potential for increased agitation, anxiety and suicidal ideation in the initial stages of treatment. Check if they have any of these symptoms and:

- ensure that the person knows how to seek help promptly
- review the person's treatment if they develop marked and/or prolonged agitation. [2004]

1.2.14 Advise a person with depression and their family or carer to be vigilant for mood changes, negativity and hopelessness, and suicidal ideation, and to contact their practitioner if concerned. This is particularly important during high-risk periods, such as starting or changing treatment and at times of increased personal stress. [2004]

1.2.15 If a person with depression is assessed to be at risk of suicide:

- take into account toxicity in overdose if an antidepressant is prescribed or the person is taking other medication; (if necessary, limit the amount of medicine available)
- consider increasing the level of support, such as more frequent direct or telephone contacts
- consider referral to specialist mental health services. [2004]

Active monitoring

1.2.16 For people who do not want an intervention with less severe depression, in particular those whose depressive symptoms are improving, or people with subthreshold depressive symptoms:

- discuss the presenting problem(s) and any concerns that the person may have
- provide information about the nature and course of depression

- arrange a further assessment, normally within 2 weeks
- make contact if the person does not attend follow-up appointments. [2004]

1.3 Access to services

1.3.1 Commissioners and providers of mental health services should consider using stepped care models for organising the delivery of care and treatment of people with depression. Stepped care pathways should:

- be accessible and acceptable to people using the services
- support the integrated delivery of services across primary and secondary care
- have clear criteria for entry to all levels of the service
- have multiple entry points and ways to access the service, including self-referral
- have agreed protocols for sharing information. [new 2018]

1.3.2 Commissioners and providers of mental health services should ensure that accessible information about the pathways into treatment and different explanatory models of depression is available, for example in different languages and formats. [new 2018]

1.3.3 Commissioners and providers of mental health services should ensure pathways are in place to support coordinated care and treatment of people with depression. Pathways should:

- promote easy access to, and uptake of, the interventions covered
- allow for prompt assessment of adults with depression, including assessment of severity and risk
- ensure coordination and continuity of care
- have routine collection of data on access to, uptake of, and outcomes of the interventions in the pathway. [new 2018]

1.3.4 Commissioners and providers of mental health services for people with depression should ensure the effective delivery of interventions is supported across primary and secondary care. These procedures should build on the key functions of a catchment-area-based community mental health service and be provided in the context of an integrated primary and secondary care mental health service. Key functions include:

- assessment and engagement
- shared decision making
- collaboration between professionals
- delivery of pharmacological, psychological and social interventions
- care coordination including care provided by physical health services
- the effective monitoring and evaluation of services. [new 2018]

1.3.5 Commissioners and providers of primary and secondary care mental health services should ensure support is in place so integrated services can be delivered by:

- individual practitioners (including GPs and practice nurses), providing interventions, support or supervision
- mental health staff, for team-based interventions in primary care for the majority of people with depression
- mental health specialists, for advice, consultation and support for primary care mental health staff
- specialist-based mental health teams, for severe and complex disorders. [new 2018]

1.3.6 Commissioners and providers of mental health services should ensure pathways have the following in place for people with depression to promote access and increased uptake of services:

- information about the pathway provided in a non-stigmatising way, using age and culturally appropriate language and formats
- services available outside normal working hours
- a range of different methods to engage with and deliver interventions, for example text messages, email, telephone and online
- services provided in community-based settings, for example in a person's home, community centres, leisure centres, care homes, social centres and integrated clinics within primary care
- bilingual therapists or independent translators
- procedures to support active involvement of families, partners and carers. [new 2018]

1.3.7 When promoting access and uptake of services, be aware of the needs of the following groups who may have difficulty in accessing, or face stigma when taking up, some or all mental health services:

- men
- older people
- lesbian, gay, bisexual and transgender people
- people from black, Asian and minority ethnic communities
- people with learning disabilities or acquired cognitive impairments
- asylum seekers. [new 2018]

1.4 General principles of care

All interventions

1.4.1 Support people with depression to decide on their preferences for interventions (including declining an offer of treatment) by giving them:

- information on what interventions might be available, their harms and benefits, and the expected outcomes
- choice of the interventions recommended in this guideline, how they will be delivered (for example face to face or digitally), and where they will be delivered
- the option, if possible, to choose the gender of the practitioner
- information on what the next steps will be if the initial intervention is not helpful. [new 2018]

1.4.2 Make decisions about what treatment might be suitable, and discuss the likelihood of developing more severe depression, in collaboration with the person. Take into account the person's experience of any prior episodes of depression or depression treatments. [new 2018]

1.4.3 When developing interventions for people with depression, make sure the following are covered:

- assessing need
- developing a treatment plan
- taking account of any physical health problems
- regular liaison between healthcare professionals in specialist and non-specialist settings (see recommendations 1.3.3 and 1.3.4)
- routine outcome monitoring (using validated measures) and follow-up. [new 2018]

1.4.4 Use psychological and psychosocial treatment manuals[3] to guide the form and length of interventions. [2018]

1.4.5 Consider using competence frameworks developed from treatment manual(s) for psychological and psychosocial interventions to

[3] Treatment manuals are those that were used in the trials that provided the evidence for the efficacy of interventions recommended in this guideline.

support effective training, delivery and supervision of interventions. [2018]

1.4.6 For interventions for people with depression:

- review how well the treatment is working with the person
- monitor and evaluate treatment adherence
- monitor for harms of pharmacological and psychological treatment
- consider routinely using validated sessional outcome measures. [2018]

1.4.7 Healthcare professionals delivering interventions for people with depression should:

- receive regular high-quality supervision
- have their competence monitored and evaluated, for example by reviewing video and audio recordings of their work. [2018]

Pharmacological interventions

1.4.8 When offering a person antidepressant medication:

- explain the reasons for offering it
- discuss the harms and benefits
- discuss any concerns they have about taking or stopping the antidepressant medication
- make sure they have information to take away that is appropriate for their needs. [2018]

1.4.9 When prescribing antidepressant medication, give people information about:

- how long it takes to start to feel better (typically within 3 weeks)

- how to seek a review from the prescriber if there has been no improvement within 3-4 weeks
- how important it is to follow the instructions on when to take antidepressant medication
- how treatment might need to carry on after remission and how that need will be assessed
- how they may be affected when they first start taking antidepressant medication, and what these effects might be
- how they may be affected if they have to take antidepressant medication for a long time and what these effects might be, especially in older people
- how taking antidepressant medication might affect their sense of resilience (how strong they feel and how well they can get over problems) and being able to cope
- how taking antidepressant medication might affect any other medicines they are taking
- how they may be affected when they stop taking antidepressant medication, and how these effects can be minimised
- the fact that they cannot get addicted to antidepressant medication. [2018]

1.4.10 Advise people taking antidepressant medication that although it is not addictive, if they stop taking it, miss doses or do not take a full dose, they may have discontinuation symptoms such as:

- restlessness
- problems sleeping
- unsteadiness
- sweating
- abdominal symptoms
- altered sensations
- altered feelings (for example irritability, anxiety or confusion).

Explain that these discontinuation symptoms are usually mild and go away after a week but can sometimes be severe, particularly if the antidepressant medication is stopped suddenly. [2018]

1.4.11 When stopping antidepressant medication, take into account the pharmacokinetic profile (for example, the half-life of the medication) and slowly reduce the dose at a rate proportionate to the duration of treatment. For example, this could be over some months if the person has been taking antidepressant medication for several years. [new 2018]

1.4.12 Monitor people taking antidepressant medication while their dose is being reduced. If needed, adjust the speed and duration of dose reduction according to symptoms. [new 2018]

1.4.13 When reducing a person's dose of antidepressant medication, be aware that:

- discontinuation symptoms can be experienced with a wide range of antidepressant medication
- paroxetine and venlafaxine are more likely to be associated with discontinuation symptoms, so particular care is needed with them
- fluoxetine's prolonged duration of action means that it can usually be safely stopped without dose reduction. [new 2018]

1.4.14 If a person has discontinuation symptoms when they stop taking antidepressant medication or reduce their dose, reassure them that they are not having a relapse of their depression. Explain that:

- these symptoms are common
- relapse does not usually happen as soon as you stop taking an antidepressant medication or lower the dose

- even if they start taking an antidepressant medication again or increase their dose, the symptoms may take up to 2-3 days to disappear. [new 2018]

1.4.15 If a person has mild discontinuation symptoms when they stop taking antidepressant medication:

- monitor their symptoms
- keep reassuring them that such symptoms are common. [new 2018]

1.4.16 If a person has severe discontinuation symptoms, consider restarting the original antidepressant medication at the dose that was previously effective, or another antidepressant medication from the same class with a longer half-life. Reduce the dose gradually while monitoring symptoms. [new 2018]

1.4.17 When prescribing antidepressant medication for people with depression who are under 30 years or are thought to be at increased risk of suicide:

- see them 1 week after starting the antidepressant medication
- review them as often as needed, but no later than 4 weeks after the first appointment
- base the frequency of review on their circumstances (for example, the availability of support, break-up of a relationship, loss of employment), and any changes in suicidal ideation or assessed risk of suicide. [2018]

1.4.18 Take into account toxicity in overdose when prescribing an antidepressant medication for people at significant risk of suicide, and do not routinely initiate treatment with:

- tricyclic antidepressants (TCAs), except lofepramine, as they are associated with the greatest risk in overdose

- venlafaxine as compared with other equally effective antidepressant medication recommended for routine use in primary care, it is associated with a greater risk of death from overdose. [2018]

1.4.19 When prescribing antidepressant medication for older people:

- consider prescribing them at a lower dose
- take into account the person's general physical health and possible interactions with any other medicines they may be taking
- carefully monitor the person for side effects. [2018]

1.4.20 For people with depression taking lithium, in particular older people:

- monitor renal and thyroid function and calcium levels before treatment and every 3-6 months during treatment, or more often if there is evidence of renal impairment
- monitor serum lithium levels 1 week after starting treatment and at each dose change until stable, and every 3 months after that
- set the dose according to response and tolerability: plasma lithium levels should not exceed 1.0 mmol/L (therapeutic levels for augmentation of antidepressant medication are usually at or above 0.4 mmol/L)
- do not start repeat prescriptions until lithium levels and renal function are stable
- take into account a person's overall physical health when reviewing test results (including possible dehydration or infection)
- review polypharmacy (in particular, seek specialist advice on the use of ACE inhibitors/angiotensin II receptor blockers, diuretics and NSAIDs, all of which may increase lithium levels (see recommendations 1.3.3 and 1.3.4))

- monitor at each review for signs of lithium toxicity, including diarrhoea, vomiting, coarse tremor, ataxia, confusion, and convulsions
- seek specialist advice if there is uncertainty about the interpretation of any test results (see recommendations 1.3.3 and 1.3.4). [new 2018]

1.4.21 Manage lithium prescribing under shared care arrangements. If there are concerns about older people, manage their lithium prescribing in specialist secondary care services. [new 2018]

1.4.22 Consider ECG monitoring in people taking lithium who have a high risk of or existing cardiovascular disease. [2018]

1.4.23 Give people who are going to be taking lithium information on how to do so safely[4]. [new 2018]

1.4.24 For people who receive an antipsychotic for the treatment of their depression:[5],

- assess their weight, fasting blood glucose or HbA1c and fasting lipids before they start taking antipsychotics
- monitor their weight weekly for the first 6 weeks, then at 12 weeks, 1 year and annually
- monitor their fasting blood glucose or HbA1c and fasting lipids at 12 weeks, and then annually
- consider ECG monitoring (at baseline and when final dose is reached) for people with established cardiovascular disease and for those taking other medicines known to

[4] A lithium treatment pack should be given to patients when starting treatment with lithium, see the BNF for further information.

[5] At the time of publication (March 2018), not all antipsychotics have a UK marketing authorisation for this indication. If this is the case the prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information. See individual SPCs for full list of monitoring requirements.

prolong the cardiac QT interval (for example, citalopram or escitalopram)

- at each review, monitor for adverse effects, including extrapyramidal and prolactin-related side effects
- if there is rapid or excessive weight gain, or abnormal lipid or blood glucose levels, investigate and treat as needed. [new 2018]

1.4.25 For people with depression who are treated with an antipsychotic medication:

- monitor their treatment in specialist mental health services for the first 12 months or until optimal treatment has been reached (whichever is longer)
- after 12 months, transfer the responsibility for monitoring to primary care under a shared-care agreement. [new 2018]

1.4.26 For people with depression who are taking an antipsychotic medication:

- consider at each review whether to continue the antipsychotic medication in light of current physical and mental health risks
- if it is decided to stop taking the antipsychotic medication, do this gradually and in proportion to the length of use, supervised by or in consultation with specialist mental health services (see recommendations 1.3.3 and 1.3.4). [new 2018]

1.4.27 For advice on the safe and effective use of medicines for people taking 1 or more medicines, and medicines reconciliation and medication review, see NICE's guideline on medicines optimisation. [2018]

1.4.28 Advise people with winter depression that follows a seasonal pattern and who wish to try light therapy in preference to antidepressant

medication or psychological treatment that the evidence for the efficacy of light therapy is uncertain. [2009]

1.4.29 Although there is evidence that St John's wort may be of benefit in less severe depression, practitioners should:

- not prescribe or advise its use by people with depression because of uncertainty about appropriate doses, persistence of effect, variation in the nature of preparations and potential serious interactions with other drugs (including hormonal contraceptives, anticoagulants and anticonvulsants)
- advise people with depression of the different potencies of the preparations available and of the potential serious interactions of St John's wort with other drugs [2004].

1.5 First-line treatment for less severe depression

In this guideline the term less severe depression includes the traditional categories of subthreshold symptoms, mild depression, and the lower half of moderate depression.

Lower intensity psychological interventions

1.5.1 Offer individual self-help with support as an initial treatment for people with less severe depression. [new 2018]

1.5.2 Follow the principles of CBT when providing self-help with support. Self-help should:

- include age-appropriate, written, audio or digital (computer or online) material
- have support from a trained practitioner who facilitates the self-help intervention, encourages completion and reviews progress and outcome

- typically consist of up to 10 sessions (face-to-face or by telephone or online), with an initial session of up to 30 minutes and further sessions being up to 15 minutes.
- take place over 9–12 weeks, including follow-up. [2018]

1.5.3 Consider a physical activity programme specifically designed for people with depression as an initial treatment for people with less severe depression. [new 2018]

1.5.4 Deliver physical activity programmes for people with less severe depression that:

- are given in groups by a competent practitioner
- typically consist of 45 minutes of aerobic exercise of moderate intensity and duration twice a week for 4–6 weeks, then weekly for a further 6 weeks
- usually have 8 people per group. [new 2018]

Higher intensity psychological interventions

1.5.5 Offer individual cognitive behavioural therapy (CBT) or behavioural activation (BA) if a person with less severe depression:

- has a history of poor response when they tried self-help with support, exercise, or antidepressant medication before **or**
- has responded well to CBT or BA before **or**
- is at risk of developing more severe depression, for example if they have a history of severe depression or the current assessment suggests a more severe depression is developing **or**
- does not want self-help with support, exercise or antidepressant medication. [new 2018]

1.5.6 Consider interpersonal therapy (IPT) if a person with less severe depression would like help for interpersonal difficulties that focus on role transitions or disputes or grief **and**:

- has had exercise or self-help with support, antidepressant medication, individual CBT or BA for a previous episode of depression, but this did not work well for them, **or**
- does not want self-help with support, exercise, antidepressant medication, individual CBT or BA. [new 2018]

1.5.7 Provide individual CBT, BA or IPT to treat less severe depression in up to 16 sessions, each lasting 50–60 minutes, over 3–4 months. [new 2018]

1.5.8 When giving individual CBT, BA or IPT, also consider providing:

- 2 sessions per week for the first 2–3 weeks of treatment for people with less severe depression
- 3–4 follow-up and maintenance sessions over 3–6 months for all people who have recovered or have had clinically significant improvement following individual CBT, BA or IPT. [new 2018]

1.5.9 Consider group-based CBT specific to depression for people with less severe depression if:

- they have had self-help with support, exercise, antidepressant medication, individual CBT or BA or IPT for a previous episode of depression, but this did not work well for them, **or**
- they do not want self-help, exercise, antidepressant medication, individual CBT or BA or IPT. [new 2018]

1.5.10 Deliver group-based CBT that is:

- based on a cognitive behavioural model
- delivered by 2 competent practitioners
- typically consists of up to 12 weekly sessions of up to 2 hours each, for up to 6–8 participants [new 2018]

1.5.11 Consider counselling if a person with less severe depression would like help for significant psychosocial, relationship or employment problems **and**:

- has had self-help with support, exercise, antidepressant medication, individual CBT or BA or IPT for a previous episode of depression, but this did not work well for them, **or**
- does not want self-help with support, exercise, antidepressant medication, individual CBT or BA or IPT. [new 2018]

1.5.12 Deliver counselling for people with less severe depression that:

- is based on a model developed specifically for depression
- consists of up to 16 individual sessions each lasting up to an hour
- takes place over 16 weeks. [new 2018]

1.5.13 Consider short-term psychodynamic therapy (STPT) if a person with less severe depression would like help for emotional and developmental difficulties in relationships **and**:

- has had self-help with support, exercise, antidepressant medication, individual CBT or BA or IPT for a previous episode of depression, but this did not work well for them, **or**
- does not want self-help with support, exercise, antidepressant medication, individual CBT or BA or IPT. [new 2018]

1.5.14 Deliver STPT for people with less severe depression that:

- is based on a model developed specifically for depression
- consists of up to 16 individual sessions each lasting up to an hour
- takes place over 16 weeks. [new 2018]

Pharmacological interventions

1.5.15 Consider a selective serotonin reuptake inhibitor (SSRI) for people with less severe depression who:

- choose not to have high or low intensity psychological interventions or exercise, **or**
- based on previous treatment history for confirmed depression had a positive response to SSRIs, **or**
- had a poor response to psychological interventions, **or**
- are at risk of developing more severe depression (for example, if they have a history of severe depression or the current assessment suggests a more severe depression is developing). [new 2018]

1.6 First-line treatment for more severe depression

In this guideline the term more severe depression includes the traditional categories of the upper half of moderate depression and severe depression.

1.6.1 For people with more severe depression, offer:

- an individual high intensity psychological intervention (CBT, BA or IPT) **or**
- antidepressant medication (see recommendation 1.6.3). [new 2018]

1.6.2 Offer a combination of high intensity psychological intervention (CBT, BA or IPT) and antidepressant medication (see recommendation 1.6.3) for people with more severe depression if:

- they have a history of poor response to a high intensity psychological intervention or antidepressant medication alone **or**
- they have responded well to combination treatment before **or**
- the current assessment suggests a limited response to a high intensity psychological intervention or antidepressant medication alone. [new 2018]

1.6.3 When deciding on antidepressant medication for people with more severe depression, either alone or in combination with a psychological intervention:

- start treatment with an SSRI or mirtazapine
- consider a TCA such as lofepramine or nortriptyline if the person has a history of poor response to SSRIs or mirtazapine. [new 2018]

1.6.4 Consider short-term psychodynamic therapy, alone or in combination with antidepressant medication, for a person with more severe depression who would like help for emotional and developmental difficulties in relationships and who:

- has had individual CBT, IPT or BA alone, antidepressant medication alone or a combination of the two for a previous episode of depression, but this did not work well for them, **or**
- does not want individual CBT, IPT or BA alone, antidepressant medication alone or a combination of the two. [new 2018]

1.7 Behavioural couples therapy for depression

1.7.1 Consider behavioural couples therapy for a person with less or more severe depression who has problems in the relationship with their partner if:

- the relationship problem(s) could be contributing to their depression **or**
- involving their partner may help in the treatment of their depression. [new 2018]

1.7.2 Deliver behavioural couples therapy for people with depression that:

- follows the behavioural principles for couples therapy
- provides 15–20 sessions over 5–6 months. [2018]

1.8 Relapse prevention

1.8.1 Discuss the likelihood of having a relapse with people who have recovered from depression. Explain:

- that a history of previous relapse, and the presence of residual symptoms, increases the chance of relapses
- the importance of them seeking help as soon as possible if the symptoms of depression return or worsen in the case of residual symptoms
- the potential benefits of relapse prevention. [new 2018]

1.8.2 Take into account that the following may increase the risk of relapse in people who have recovered from depression:

- how often a person has had episodes of depression, and how recently
- any other chronic physical health or mental health problems
- any residual symptoms and unhelpful coping styles (for example avoidance and rumination)
- how severe their symptoms were, risk to self and if they had functional impairment in previous episodes of depression
- the effectiveness of previous interventions for treatment and relapse prevention

- personal, social and environmental factors. [new 2018]

1.8.3 For people who have recovered from less severe depression when treated with antidepressant medication (alone or in combination with a psychological therapy), but are assessed as having a higher risk of relapse, consider:

- continuing with antidepressant medication to prevent relapse, maintaining the same dose unless there is good reason to reduce it (such as adverse effects), **or**
- psychological therapy (CBT) with an explicit focus on relapse prevention, typically 3–4 sessions over 1–2 months. [new 2018]

1.8.4 For people who have recovered from more severe depression when treated with antidepressant medication (alone or in combination with a psychological therapy), but are assessed as having a higher risk of relapse, offer:

- a psychological therapy [group CBT or mindfulness-based cognitive therapy (MBCT) for those who have had 3 or more previous episodes of depression] in combination with antidepressant medication, **or**
- psychological therapy (group CBT or MBCT for those who have had 3 or more previous episodes of depression) if the person wants to stop taking antidepressant medication. [new 2018]

1.8.5 When choosing a psychological therapy for preventing relapse for people who recovered with initial psychological therapy, but are assessed as having a higher risk of relapse, offer:

- 4 more sessions of the same treatment if it has an explicit relapse prevention component, **or**
- group CBT or MBCT (for those who have had 3 or more previous episodes of depression) if the initial psychological

therapy had no explicit relapse prevention component. [new 2018]

1.8.6 Deliver group CBT for people assessed as having a higher risk of relapse in groups of up to 12 participants. Sessions should last 2 hours once a week for 8 weeks. [new 2018]

1.8.7 Deliver MBCT for people assessed as having a higher risk of relapse in groups of up to 15 participants. Meetings should last 2 hours once a week for 8 weeks, with 4 follow-up sessions in the 12 months after treatment ends. [new 2018]

1.8.8 For people continuing with medication to prevent relapse, hold reviews at 3, 6 and 12 months after maintenance treatment has started. At each review:

- monitor mood state using a formal validated rating scale,
- review side effects
- review any personal, social and environmental factors that may impact on the risk of relapse
- agree the timescale for further review (no more than 12 months). [new 2018]

1.8.9 At all further reviews for people continuing with antidepressant medication to prevent relapse:

- assess the risk of relapse
- discuss the need to continue with antidepressant medication. [new 2018]

1.8.10 Re-assess a person's risk of relapse when they finish a psychological relapse prevention intervention, and assess the need for any further follow up. Discuss continuing treatment with the person if it is needed. [new 2018]

1.9 No or limited response to initial treatment

1.9.1 If a person with depression has had no response or a limited response to treatment (typically within 3 weeks for antidepressant medication or 4–6 weeks for psychological therapy or combined medication and psychological therapy), assess:

- whether there are any personal or social factors or physical health conditions that might explain why the treatment isn't working
- whether the person has not been adhering to the treatment plan, including any adverse effects of medication.

Work with the person to try and address any problems raised. [new 2018]

1.9.2 If a person has had no response or a limited response to treatment for depression after assessing the issues in recommendation 1.9.1, provide more support by increasing the number and length of appointments. [new 2018]

1.9.3 If a person has had no response or a limited response to treatment for depression, has not benefitted from more support (see recommendation 1.9.2), and is on antidepressant medication only and does not want to continue with it, consider switching to a psychological therapy alone (CBT, BA or IPT). [new 2018]

1.9.4 If a person has had no response or a limited response to treatment, has not benefitted from more support (see recommendation 1.9.2), and is on antidepressant medication only and wants to continue with antidepressant medication, consider providing additional support and monitoring and:

- continuing with the current medication and increasing the dose if the medication is well tolerated, **or**

- switching to a medicine of a different class (including SSRIs, SNRIs, TCAs or MAOI)[6], **or**
- switching to a medication of the same class if there are problems with tolerability, **or**
- changing to a combination of psychological therapy (CBT, BA, or IPT) and medication. [new 2018]

1.9.5 If a person's symptoms do not respond to a dose increase or switching to another antidepressant medication after a further 2–4 weeks:

- review the need for care and treatment, **and**
- consider consulting with, or referring the person to, a specialist service if their symptoms impair personal and social functioning (see recommendations 1.3.4 and 1.3.5). [new 2018]

1.9.6 If a person has had no response or a limited response to treatment for depression after 2 lines of treatment and wants to continue with antidepressant medication, see the NICE guidance on the use of vortioxetine. [new 2018]

1.9.7 If a person on antidepressant medication only or a combination of antidepressant medication and psychological therapy, has had no response or a limited response to treatment, and does not want to continue with psychological therapy, consider changing to a combination of 2 different classes of medication. Consult a specialist if the symptoms significantly impair personal and social functioning (see recommendations 1.3.4 and 1.3.5). [new 2018]

1.9.8 If a person has had no response or a limited response to initial antidepressant medication and does not want to try a psychological therapy, and wants to try a combination of medications, explain the

[6] There is limited evidence to support routine increases in dose of antidepressants or switching in people who have not responded to initial treatment.

likely increase in their side-effect burden (including risk of serotonin syndrome). [new 2018]

1.9.9 If a person wants to try a combination of medications and is willing to accept an increased side-effect burden:

- consider adding an antidepressant medication of a different class to their initial medication (for example an SSRI with mirtazapine), in specialist settings or after consulting a specialist if the symptoms impair personal and social functioning (see recommendations 1.3.3 and 1.3.4),
- be aware that some combinations are potentially dangerous and should be avoided (for example, an SSRI, SNRI or TCA with MAOI)
- consider combining an antidepressant medication with an antipsychotic[7] or lithium, in specialist settings or after consulting a specialist, if the symptoms impair personal and social functioning (see recommendations 1.3.4 and 1.3.5)
- be aware that escitalopram and citalopram are associated with QTc prolongation. [new 2018]

1.9.10 When changing treatment for a person with depression who has had no response or a limited response to initial psychological therapy, consider:

- combining the psychological therapy with an SSRI, for example sertraline or citalopram, or mirtazapine, **or**
- switching to an SSRI, for example sertraline or citalopram, or mirtazapine if the person wants to stop the psychological therapy. [new 2018]

[7] At the time of publication (March 2018), not all antipsychotics have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.

1.9.11 For people with depression whose symptoms have not adequately responded to a combination of medication and a psychological therapy after 12 weeks, consider a different combination of medication and psychological therapy. [new 2018]

1.10 Treating chronic depressive symptoms

1.10.1 For people with chronic depressive symptoms that significantly impair personal and social functioning, consider cognitive behavioural treatments (CBASP and CBT) in combination with antidepressant medication. The cognitive behavioural treatment should:

- have a focus on chronic depressive symptoms
- cover related maintaining processes, for example avoidance, rumination and interpersonal difficulties. [new 2018]

1.10.2 If a person with chronic depressive symptoms that significantly impair personal and social functioning chooses not to have combined treatment, offer:

- an SSRI alone, **or**
- cognitive behavioural treatments (CBASP and CBT) alone. [new 2018]

1.10.3 If a person with chronic depressive symptoms that significantly impair personal and social functioning cannot tolerate an SSRI, consider treatment with an alternative SSRI. [new 2018]

1.10.4 For people with chronic depressive symptoms that significantly impair personal and social functioning, who have not responded to 1 or more SSRIs, consider alternative medication in specialist settings, or after consulting a specialist (see recommendations 1.3.3 and 1.3.4). Alternatives include:

- tricyclic antidepressants, **or**

- moclobemide, **or**
- amisulpride[8]. [new 2018]

1.10.5 For people with chronic depressive symptoms that significantly impair personal and social functioning who have been assessed as likely to benefit from extra social or vocational support, consider:

- befriending in combination with existing antidepressant medication or psychological therapy: this should be done by trained volunteers, typically with at least weekly contact for between 2–6 months
- a rehabilitation programme, if their depression has led to loss of work or their withdrawing from social activities over the longer term. [2018]

1.10.6 For people with no or limited response to treatment or chronic depressive symptoms that significantly impair personal and social functioning who have not responded to the interventions recommended in section 1.9 and 1.10, consider referral to a specialist mental health services for advice and further treatment. [new 2018]

1.10.7 For people with chronic depressive symptoms that have not responded to the interventions recommended in section 1.9 and 1.10, and who are on long term antidepressant medication:

- review the benefits of treatment with the person
- consider stopping the medication, as set out in recommendations 1.4.10, 1.4.11 and 1.4.12 [new 2018]

[8] At the time of publication (March 2018), amisulpride did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.

1.11 Treating complex depression

1.11.1 For people with complex depression (depression comorbid with a personality disorder), consider referral to a specialist personality disorder treatment programme. See NICE guidance on borderline personality disorder for recommendations on treatment for personality disorder with coexisting depression. [new 2018]

1.11.2 For people with complex depression who have not been able to access, not been helped by or chosen not to be treated in a specialist personality disorder programme, consider a combination of antidepressant medication and CBT. [new 2018]

1.11.3 When delivering antidepressant medication and CBT combination treatment for people with complex depression:

- give the person support and encourage them to carry on with the treatment
- provide the treatment in a structured, multidisciplinary setting
- extend the duration of treatment if needed, up to a year. [new 2018]

1.12 Treating psychotic depression

1.12.1 Refer people with depression with psychotic symptoms to specialist mental health services for a programme of coordinated multi-disciplinary care, which includes access to psychological interventions. [new 2018]

1.12.2 When treating people with depression with psychotic symptoms, consider adding antipsychotic medication to their current treatment plan. [new 2018]

1.13 Electroconvulsive therapy

1.13.1 Consider electroconvulsive therapy (ECT) for acute treatment of severe depression if:

- the severe depression is life-threatening and a rapid response is needed, **or**
- multiple pharmacological and psychological treatments have failed. [2018]

1.13.2 For people whose depression has not responded well to ECT previously, only consider a repeat trial of ECT after:

- reviewing the adequacy of the previous treatment course
- considering all other options
- discussing the risks and benefits with the person or, if appropriate, their advocate or carer. [2018]

1.13.3 Make sure people with depression who are going to have ECT are fully informed of the risks, and with the risks and benefits specific to them. Take into account:

- the risks associated with a general anaesthetic
- any medical comorbidities
- potential adverse events, in particular cognitive impairment
- if the person is older, the possible increased risk associated with ECT treatment for this age group
- the risks associated with not having ECT.

Document the assessment. [2018]

1.13.4 Make the decision to use ECT together with the person with depression if they have the capacity to give consent. Take into account the requirements of the Mental Health Act 2007 (if applicable), and make sure:

- valid, informed consent is given without pressure or coercion from the circumstances or clinical setting
- the person is aware of their right to change their mind and withdraw consent at any time

- there is strict adherence to recognised guidelines on consent, and advocates or carers are involved to help informed discussions. [2018]

1.13.5 If a person with depression cannot give informed consent, only give ECT if it does not conflict with an advance treatment decision the person made. [2018]

1.13.6 For a person with depression who is going to have ECT, assess their cognitive function:

- before the first treatment
- at least every 3–4 treatments
- at the end of the treatment course. [2018]

1.13.7 Check for the following in cognitive function assessments for people having ECT:

- orientation, and time to reorientation after each treatment
- measures of new learning, retrograde amnesia and subjective memory impairment, carried out at least 24 hours after a treatment. [2018]

1.13.8 If a person shows signs of significant cognitive impairment at any stage of ECT treatment, consider:

- changing from bilateral to unilateral electrode placement, **or**
- reducing the stimulus dose, **or**
- stopping treatment. [2018]

1.13.9 When giving ECT to a person with depression:

- base the electrode placement and stimulus dose, related to seizure threshold, on a balance of effectiveness against the risk of cognitive impairment

- be aware that bilateral ECT is more effective than unilateral ECT, but may cause more cognitive impairment
- be aware that with unilateral ECT a higher stimulus dose can be more effective, but can also increase cognitive impairment. [2018]

1.13.10 Assess a person's clinical status after each ECT treatment using a formal valid outcome measure (HRDS or MDRAS). [2018]

1.13.11 Stop ECT treatment for a person with depression:

- straightaway, if the side effects outweigh the potential benefits, **or**
- when remission has been achieved. [2018]

1.13.12 If a person's depression has responded to a course of ECT:

- start (or continue) antidepressant medication to prevent relapse
- consider lithium augmentation of antidepressant medication. [2018]

1.14 Coordination and delivery of care

Collaborative care

1.14.1 Consider collaborative care for all older people with depression, in particular if they have significant physical health problems or social problems. [new 2018]

1.14.2 Consider collaborative care as a method for delivering care for people with more severe depression. [new 2018]

1.14.3 Deliver collaborative care for people with more severe depression that includes:

- patient-centred assessment and engagement
- symptom measurement and monitoring

- medication management (a plan for starting, reviewing and discontinuing medication)
- active follow-up by a designated case manager
- delivery of psychological and psychosocial interventions within a structured protocol, for example stepped care
- taking any relevant physical health problems into account
- regular liaison with primary and secondary care colleagues
- supervision of practitioner(s) by an experienced mental health professional. [new 2018]

Specialist care planning

1.14.4 Refer people with more severe depression or chronic depressive symptoms, either of which significantly impairs personal and social functioning, to specialist mental health services for coordinated multidisciplinary care if:

- they have not benefitted from or have chosen not to have initial treatment, **and either**
- have multiple complicating problems, for example unemployment, poor housing or financial problems, **or**
- have significant coexisting mental and physical health conditions. [new 2018]

1.14.5 Deliver multidisciplinary care plans for people with more severe depression or chronic depressive symptoms (either of which significantly impairs personal and social functioning) and multiple complicating problems, or significant coexisting conditions that:

- are developed together with the person, their GP and other relevant people involved in their care (with the person's agreement)
- set out the roles and responsibilities of all health and social care professionals involved in delivering the care

- include information about 24-hour support services, and how to contact them
- include a crisis plan that identifies potential crisis triggers, and strategies to manage those triggers
- are updated if there are any significant changes in the person's needs or condition
- are reviewed at agreed regular intervals
- include medication management (a plan for starting, reviewing and discontinuing medication). [new 2018]

Crisis care and home treatment and inpatient care

1.14.6 Consider crisis and intensive home treatment for people with more severe depression who are at significant risk of:

- suicide, in particular for those who live alone
- self-harm
- harm to others
- self-neglect
- complications in response to their treatment, for example older people with medical comorbidities. [new 2018]

1.14.7 Ensure teams providing crisis resolution and home treatment (CRHT) interventions to support people with depression:

- monitor and manage risk as a high-priority routine activity
- establish and implement a treatment programme
- ensure continuity of any treatment programme while the person is in contact with the CRHT team, and on discharge or transfer to other services when this is needed
- put a crisis management plan in place before the person is discharged from the team’s care. [new 2018]

1.14.8 Consider inpatient treatment for people with more severe depression who cannot be adequately supported by a CRHT team. [new 2018]

1.14.9 Make psychological therapies recommended for the treatment of more severe depression, relapse prevention, chronic depressive symptoms and complex depression available for people with depression in inpatient settings. [new 2018]

1.14.10 When providing psychological therapies for people with depression in inpatient settings:

- increase the intensity and duration of the interventions
- ensure that they continue to be provided effectively and promptly on discharge. [new 2018]

1.14.11 Consider using CRHT teams for people with depression having a period of inpatient care who might benefit from early discharge from hospital. [2018]

Terms used in this guideline

Chronic depressive symptoms

People with chronic depressive symptoms includes those who continually meet criteria for the diagnosis of a major depressive episode for at least 2 years; or have persistent sub-threshold symptoms for at least 2 years; or who have persistent low mood with or without concurrent episodes of major depression for at least 2 years. People with depressive symptoms may also have a number of social and personal difficulties that contribute to the maintenance of their chronic depressive symptoms.

Collaborative care

Collaborative care requires that the service user and healthcare professional jointly identify problems and agree goals for interventions, and normally comprises:

- case management which is supervised and supported by a senior mental health professional
- close collaboration between primary and secondary physical health services and specialist mental health services in the delivery of services
- the provision of a range of evidence-based interventions
- the long term coordination of care and follow-up.

Depression severity

In this guideline the terms ‘less severe depression’ and ‘more severe depression’ are used. Depression severity exists along a continuum and is essentially composed of three elements:

- symptoms (which may vary in frequency and intensity)
- duration of the disorder
- the impact on personal and social functioning.

Severity of depression is therefore a consequence of the contribution of all of these elements.

Traditionally, depression severity has been grouped under 4 categories:

- ‘severe depression’, characterised by a large number of symptoms with a major negative impact on personal and social functioning
- ‘moderate depression’, which has a smaller number of symptoms with a more limited negative impact on personal and social functioning
- ‘mild depression’, which has a small number of symptoms with a limited impact on personal and social functioning, and
- ‘sub-threshold depressive symptoms’, which do not meet criteria for a diagnosis of depression and which typically have little impact on personal and social functioning.

In the development of the recommendations for this guideline the committee wanted to develop a way of representing the severity of depression in the recommendations which best represents the available evidence on the classification and would help the uptake of the recommendations in routine clinical practice. They therefore decided to use the terms ‘less severe depression’, which includes the traditional categories of subthreshold symptoms, mild depression, and the lower half of moderate depression; and ‘more severe depression’, which includes the traditional categories of the upper half of moderate depression and severe depression.

Assessment of depression

This is based on the criteria in the Diagnostic and Statistical Manual, 5th edition (DSM-5). Assessment should include the number and severity of symptoms, duration of the current episode, and course of illness.

Key symptoms:

- persistent sadness or low mood; and/or
- marked loss of interests or pleasure.

At least one of these, most days, most of the time for at least 2 weeks.

If any of above present, ask about associated symptoms:

- disturbed sleep (decreased or increased compared to usual)
- decreased or increased appetite and/or weight
- fatigue or loss of energy
- agitation or slowing of movements
- poor concentration or indecisiveness
- feelings of worthlessness or excessive or inappropriate guilt
- suicidal thoughts or acts.

The Patient Health Questionnaire (PHQ-9, Kroenke et al., 2001) asks about these nine DSM symptoms, and can be used to count symptoms, but the number of symptoms is not sufficient in itself to define severity, as patients vary in their readiness to volunteer symptoms. Further enquiry is essential.

Then, ask about duration and associated disability, past and family history of mood disorders, and availability of social support.

Less severe depression

This is typically depression with fewer than 7 symptoms and minor or moderate functional impairment.

More severe depression

This is typically depression with 7 or more symptoms and moderate to severe functional impairment.

Factors that favour general advice and active monitoring

- four or fewer of the above symptoms with little associated disability ('sub-threshold depression')
- symptoms intermittent, or less than 2 weeks' duration
- recent onset with identified stressor
- no past or family history of depression
- social support available
- lack of suicidal thoughts.

Active monitoring can be aided by use of a validated questionnaire such as the PHQ-9, as it has been shown to be sensitive to change at the individual patient level (Lowe et al., 2004).

Factors that favour more active treatment in primary care

- five or more symptoms with associated disability
- persistent or long-standing symptoms
- personal or family history of depression
- low social support
- occasional suicidal thoughts.

Factors that favour referral to mental health professionals

- inadequate or incomplete response to two or more interventions
- recurrent episode within 1 year of last one
- history suggestive of bipolar disorder
- the person with depression or relatives request referral
- more persistent suicidal thoughts
- self-neglect.

Factors that favour urgent referral to specialist mental health services

- actively suicidal ideas or plans

- psychotic symptoms
- severe agitation accompanying severe symptoms
- severe self-neglect.

References

Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression measure. J Gen Intern Med 2001, 16:606-613.

Löwe B, Kroenke K, Herzog W Grafe K. Measuring depression outcome with a brief self-report instrument: sensitivity to change of the Patient Health Questionnaire (PHQ-9). J Affective Dis 81 (2004) 61–66.

Medication management

Medication management is giving a person advice on how to keep to a regime for the use of medication (for example, how to take it, when to take it and how often). The focus in such programmes is only on the management of medication and not on other aspects of depression.

Routine (sessional) outcome monitoring

This is a system for the monitoring of the outcomes of treatments which involves regular (usually at each contact: referred to as sessional) assessment of symptoms or functioning using a valid scale. It can inform both service user and practitioner of progress in treatment. It is often supported by computerised delivery and scoring of the measures which ensures better completion of the questionnaires and service level audit and evaluation. Alternative terms such as “sessional outcome monitoring” or sessional outcomes” may also be used which emphasise that outcomes should be recorded at each contact.

Stepped care

This is a system of delivering and monitoring treatments, so that the most effective, least intrusive and least resource intensive treatments are delivered first. Stepped care has a built in ‘self-correcting’ mechanism so that people who do not benefit from initial interventions can be ‘stepped up’ to more intensive interventions as needed.

Putting this guideline into practice

[This section will be completed after consultation]

NICE has produced tools and resources [link to tools and resources tab] to help you put this guideline into practice.

[Optional paragraph if issues raised] Some issues were highlighted that might need specific thought when implementing the recommendations. These were raised during the development of this guideline. They are:

- [add any issues specific to guideline here]
- [Use 'Bullet left 1 last' style for the final item in this list.]

Putting recommendations into practice can take time. How long may vary from guideline to guideline, and depends on how much change in practice or services is needed. Implementing change is most effective when aligned with local priorities.

Changes recommended for clinical practice that can be done quickly – like changes in prescribing practice – should be shared quickly. This is because healthcare professionals should use guidelines to guide their work – as is required by professional regulating bodies such as the General Medical and Nursing and Midwifery Councils.

Changes should be implemented as soon as possible, unless there is a good reason for not doing so (for example, if it would be better value for money if a package of recommendations were all implemented at once).

Different organisations may need different approaches to implementation, depending on their size and function. Sometimes individual practitioners may be able to respond to recommendations to improve their practice more quickly than large organisations.

Here are some pointers to help organisations put NICE guidelines into practice:

1. **Raise awareness** through routine communication channels, such as email or newsletters, regular meetings, internal staff briefings and other communications with

all relevant partner organisations. Identify things staff can include in their own practice straight away.

2. **Identify a lead** with an interest in the topic to champion the guideline and motivate others to support its use and make service changes, and to find out any significant issues locally.

3. **Carry out a baseline assessment** against the recommendations to find out whether there are gaps in current service provision.

4. **Think about what data you need to measure improvement** and plan how you will collect it. You may want to work with other health and social care organisations and specialist groups to compare current practice with the recommendations. This may also help identify local issues that will slow or prevent implementation.

5. **Develop an action plan**, with the steps needed to put the guideline into practice, and make sure it is ready as soon as possible. Big, complex changes may take longer to implement, but some may be quick and easy to do. An action plan will help in both cases.

6. **For very big changes** include milestones and a business case, which will set out additional costs, savings and possible areas for disinvestment. A small project group could develop the action plan. The group might include the guideline champion, a senior organisational sponsor, staff involved in the associated services, finance and information professionals.

7. **Implement the action plan** with oversight from the lead and the project group. Big projects may also need project management support.

8. **Review and monitor** how well the guideline is being implemented through the project group. Share progress with those involved in making improvements, as well as relevant boards and local partners.

NICE provides a comprehensive programme of support and resources to maximise uptake and use of evidence and guidance. See our into practice pages for more information.

Also see Leng G, Moore V, Abraham S, editors (2014) Achieving high quality care – practical experience from NICE. Chichester: Wiley.

Context

Each year 6% of adults in England will experience an episode of depression, and more than 15% of people will experience an episode of depression over the course of their lifetime. For many people the episode will not be severe, but for more than 20% the depression will be more severe and have a significant impact on their daily lives. Recurrence rates are high: there is a 50% chance of recurrence after a first episode, rising to 70% and 90% after a second or third episode, respectively.

Women are between 1.5 and 2.5 times more likely to be diagnosed with depression than men. However, although men are less likely to be diagnosed with depression, they are more likely to die by suicide, have higher levels of substance misuse, and are less likely to seek help than women.

The symptoms of depression can be disabling and the effects of the illness pervasive. Depression can have a major detrimental effect on a person's personal, social and work life. This places a heavy burden on the person and their carers and dependents, as well as placing considerable demands on the healthcare system. Depression is expected to become the second most common cause (after ischaemic heart disease) of loss of disability-adjusted life years in the world by 2020.

Depression is the leading cause of suicide, accounting for two-thirds of all deaths by suicide.

Under-treatment of depression is widespread, because many people are unwilling to seek help for depression and detection of depression by professionals is variable. For example, of the 130 people with depression per 1,000 population, only 80 will consult their GP. Of these 80 people, 49 are not recognised as having depression. This is mainly because they have contacted their GP because of a somatic symptom and do not consider themselves as having a mental health problem (despite the presence of symptoms of depression).

Reason for the update

This update of NICE clinical guideline CG90 was commissioned because a review identified new evidence that might potentially change the recommendations for:

- service delivery (collaborative care)
- lower intensity psychological interventions for depression
- higher intensity psychological interventions for depression
- pharmacological interventions for moderate to severe depression.

More information

[The following sentence is for post-consultation versions only – editor to update hyperlink with guideline number]You can also see this guideline in the NICE pathway on [pathway title].

To find out what NICE has said on topics related to this guideline, see our web page on [developer to add and link topic page title or titles; editors can advise if needed].

[The following sentence is for post-consultation versions only – editor to update hyperlink with guideline number]See also the guideline committee's discussion and the evidence reviews (in the full guideline), and information about how the guideline was developed, including details of the committee.

Recommendations for research

The guideline committee has made the following recommendations for research. The committee's full set of research recommendations is detailed in the full guideline.

1 Effectiveness of peer support for different severities of depression

Is peer support an effective and cost effective intervention in improving outcomes, including symptoms, personal functioning and quality of life in adults as a stand-

alone intervention in people with less severe depression and as an adjunct to other evidence based interventions in more severe depression?

Why this is important

Not all people with depression respond well to first-line treatments and for some people the absence of good social support systems may account for the limited response to first line interventions. A number of models for the provision of peer support have been developed in mental health which aim to provide direct personal support and help with establishing and maintaining supportive social networks. Peer support is provided by people who themselves have personal experience of a mental health problem. However, to date few studies have established and tested peer support models for people with depression. Peer support models, including both individual and group interventions, should be tested in a series of randomised controlled trials which examine the effectiveness of peer support for different severities of depression alone or in combination with evidence-based interventions for the treatment of depression. The trials should report outcomes for a minimum of 24 months post completion of the intervention.

2 Mechanisms of action of psychological interventions

What are the mechanisms of action of effective psychological interventions for acute episodes of depression in adults?

Why this is important

Depression is a debilitating and highly prevalent condition in adults. Despite significant investment, the most effective and well-established treatments have only modest effects on depressive symptoms, and the majority of treatment is for recurrent depressive episodes. Psychological interventions are complex interventions involving many interacting components and delivery elements. Research is required to identify the mechanisms of action of the effective individual psychological treatments for depression, which would allow for the isolation of the most effective components and the development of more potent, cost-effective and acceptable treatments. This includes examining both generic therapeutic components (for example therapeutic relationship, rationale; remoralization), therapy structure (for example session duration, frequency), and specific ingredients. The

determination of the active components depends on testing the presence or absence of individual therapeutic elements in rigorous study designs for example, factorial designs. The research will need to be able to fully characterise the nature and range of depressive symptoms experienced by people and relate these to any proposed underlying neuropsychological mechanisms. The studies will also need to take into account the impact of any moderators of treatment effect including therapist, patient and environment factors. This research is necessary to improve clinical outcomes and quality of life for patients, as well as to reduce the financial burden upon the NHS.

3 Rate of relapse

What is the rate of relapse in people with depression who present, and are treated, in primary and secondary care, and what factors are associated with increased risk of relapse?

Why this is important

The current understanding of the rate of relapse in depression is that it is high and may be up to 50% after a first episode, rising to 80% in people who have had three or more episodes of depression. However, most studies have been undertaken in the secondary care setting and whether these figures represent the actual rate of relapse in primary care populations is uncertain. In addition, beyond the number of previous episodes and the presence of residual symptoms there is also considerable uncertainty about what other factors (biological, psychological or social) might be associated with an increased risk of relapse. This cohort study will enable clinicians to more accurately identify those at risk of relapse, and provide relapse prevention strategies for these people. Accordingly, this would improve clinical outcomes and quality of life in patients as well as facilitating more targeted use of NHS resources.

4 Group based psychological treatments for preventing relapse

What is the comparative effectiveness and cost effectiveness of group based psychological treatments in preventing relapse in people with depression (compared to each other and antidepressant medication) for people who have had a successful course of treatment with antidepressants or psychological therapies?

Why this is important

Depressive relapse is a frequent occurrence with implications for the wellbeing and quality of life for the individual and financial implications for the NHS. Antidepressants can be effective in preventing relapse but not all service users can tolerate them or wish to take them long-term. Two, group based psychological interventions (group CBT and mindfulness based cognitive therapy) have been developed and shown to be effective primarily in trials when compared to treatment as usual. However, they have not been compared with each other and only in a limited way against antidepressants. The randomised controlled trial should be designed to identify both moderators and mediators of treatment effect, have a minimum follow up period of 24 months, assess any adverse events and the relative cost-effectiveness of the interventions.

5 Increased access to services

What are the most effective and cost effective methods to promote increased access to, and uptake of, interventions for people with depression who are under-represented in current services?

Why this is important

There is general under-recognition of depression but the problem is more marked in certain populations. In addition, even where depression is recognised by the person with depression or by health professionals, access to treatment can still be difficult. A number of factors may relate to this limited access including a person's view of their problems, the information available on services and the location, design and systems for referral to services. A number of studies have addressed this issue and a number of strategies have been developed to address it but no consistent picture has emerged from the research which can inform the design and delivery of services to promote access. Little is also known about how these systems might be tailored to the needs of particular groups such as older people, people from black, Asian and minority ethnic communities, and people with disabilities who may have additional difficulties in accessing services.

Update information

This guideline is an update of NICE guideline CG90 (published October 2009) and will replace it.

New recommendations have been added on treatment of new depressive episodes, further line treatment, treatment of chronic, psychotic and complex depression, preventing relapse and the organisation of and access to services.

These are marked as:

- **[new 2018]** if the evidence has been reviewed and the recommendation has been added or updated
- **[2018]** if the evidence has been reviewed but no change has been made to the recommended action.

NICE proposes to delete some recommendations from the 2009 guideline, because either the evidence has been reviewed and the recommendations have been updated, or NICE has updated other relevant guidance and has replaced the original recommendations. Recommendations that have been deleted or changed sets out these recommendations and includes details of replacement recommendations. Where there is no replacement recommendation, an explanation for the proposed deletion is given.

Where recommendations end [2009 or 2004], the evidence has not been reviewed since the original guideline.

Where recommendations end [2009 or 2004, amended 2018], the evidence has not been reviewed but changes have been made to the recommendation wording that change the meaning (for example, because of equalities duties or a change in the availability of medicines, or incorporated guidance has been updated).

See also the original NICE guideline and supporting documents.

1 *Recommendations that have been deleted or changed*

2 Recommendations to be deleted

Recommendation in 2009 guideline	Comment
When working with people with depression and their families or carers: build a trusting relationship • work in an open, engaging and non-judgemental manner • explore treatment options in an atmosphere of hope and optimism • explain the different courses of depression, and that recovery is possible • be aware that stigma and discrimination can be associated with a diagnosis of depression • ensure that discussions take place in settings that respect confidentiality, privacy and dignity. (1.1.1.1)	The concepts in these recommendations are now covered by NICE guidance on Service user experience in adult mental health services
When working with people with depression and their families or carers: • provide information suited to their level of understanding about the nature of depression and the range of treatments available • avoid clinical language and if it has to be used make sure it is clearly explained • ensure that comprehensive written information is available in an appropriate language (and also in audio format if possible) • provide, and work with, independent interpreters (that is, someone who is not known to the person with depression) if needed. (1.1.1.2)	
Make every effort to ensure that a person with depression can give meaningful and informed consent before treatment starts. This is especially important when a person has severe depression or their treatment falls under the Mental Health Act or the Mental Capacity Act. (1.1.1.4)	
Ensure that consent to treatment is based on the provision of clear information (which should also be	

available in written form) about the intervention, covering: • what the intervention is • what is expected of the person while they are having it • likely outcomes (including any side effects). (1.1.1.5)	
Be respectful of, and sensitive to, diverse cultural, ethnic and religious backgrounds when working with people with depression, and be aware of the possible variations in the presentation of depression. Ensure competence in: • culturally sensitive assessment • using different explanatory models of depression • addressing cultural and ethnic differences when developing and implementing treatment plans • working with families from diverse ethnic and cultural backgrounds. (1.1.4.3) Consider providing all interventions in the preferred language of the person with depression where possible. (1.1.5.2)	Replaced by: *Access to services* Commissioners and providers of mental health services should consider using stepped care models for organising the delivery of care and treatment of people with depression. Stepped care pathways should: • be accessible and acceptable to people using the services • support the integrated delivery of services across primary and secondary care • have clear criteria for entry to all levels of the service • have multiple entry points and ways to access the service, including self-referral • have agreed protocols for sharing information. [2018] (1.3.1) Commissioners and providers of mental health services should ensure that accessible information about the pathways into treatment and different explanatory models of depression is available, for example in different languages and formats. [2018] (1.3.2) Commissioners and providers of mental health services should ensure pathways have the following in place for people with depression to promote access and increased uptake of services: • information about the pathway provided in a non-stigmatising way, using age and culturally appropriate language and formats • services available outside normal working hours • a range of different methods to engage with and deliver interventions, for

	example text messages, email, telephone and online • services provided in community-based settings, for example in a person's home, community centres, leisure centres, care homes, social centres and integrated clinics within primary care • bilingual therapists or independent translators • procedures to support active involvement of families, partners and carers. [2018] (1.3.6) When promoting access and uptake of services, be aware of the needs of the following groups who may have difficulty in accessing, or face stigma when taking up, some or all mental health services: • men • older people • lesbian, gay, bisexual and transgender people • people from black, Asian and minority ethnic communities • people with learning disabilities or acquired cognitive impairments • asylum seekers. [2018] (1.3.7)
Offer people with depression advice on sleep hygiene if needed, including: • establishing regular sleep and wake times • avoiding excess eating, smoking or drinking alcohol before sleep • creating a proper environment for sleep taking regular physical exercise. (1.4.1.2)	Replaced by: *First line treatment for less severe depression* Offer individual self-help with support as an initial treatment for people with less severe depression. [2018] (1.5.1) Follow the principles of CBT when providing self-help with support. Self-help should: • include age-appropriate, written, audio or digital (computer or online) material • have support from a trained practitioner who facilitates the self-help intervention, encourages completion and reviews progress and outcome • typically consist of up to 10 sessions (face-to-face or by telephone or online), with an initial session of up to
For people with persistent subthreshold depressive symptoms or mild to moderate depression, consider offering one or more of the following interventions, guided by the person's preference: • individual guided self-help based on the principles of cognitive behavioural therapy (CBT) • computerised cognitive behavioural therapy (CCBT)	

- a structured group physical activity programme. (1.4.2.1)

CCBT for people with persistent subthreshold depressive symptoms or mild to moderate depression should:

- be provided via a stand-alone computer-based or web-based programme
- include an explanation of the CBT model, encourage tasks between sessions, and use thought-challenging and active monitoring of behaviour, thought patterns and outcomes
- be supported by a trained practitioner, who typically provides limited facilitation of the programme and reviews progress and outcome
- typically take place over 9 to 12 weeks, including follow-up. (1.4.2.3)

Physical activity programmes for people with persistent subthreshold depressive symptoms or mild to moderate depression should:

- be delivered in groups with support from a competent practitioner
- consist typically of three sessions per week of moderate duration (45 minutes to 1 hour) over 10 to 14 weeks (average 12 weeks). (1.4.2.4)

Consider group-based CBT for people with persistent subthreshold depressive symptoms or mild to moderate depression who decline low-intensity psychosocial interventions (1.4.3.1)

Group-based CBT for people with persistent subthreshold depressive symptoms or mild to moderate depression should:

- be based on a structured model such as 'Coping with Depression'
- be delivered by two trained and competent practitioners
- consist of ten to 12 meetings of eight to ten participants
- normally take place over 12 to 16 weeks, including follow-up. (1.4.3.2)

30 minutes and further sessions being up to 15 minutes.

- take place over 9–12 weeks, including follow-up. [2018] (1.5.2)

Consider a physical activity programme specifically designed for people with depression as an initial treatment for people with less severe depression. 2018] (1.5.3)

Deliver physical activity programmes for people with less severe depression that:

- are given in groups by a competent practitioner
- typically consist of 45 minutes of aerobic exercise of moderate intensity and duration twice a week for 4–6 weeks, then weekly for a further 6 weeks
- usually have 8 people per group. [2018] (1.5.4)

Offer individual cognitive behavioural therapy (CBT) or behavioural activation (BA) if a person with less severe depression:

- has a history of poor response when they tried self-help with support, exercise, or antidepressant medication before or
- has responded well to CBT or BA before or
- is at risk of developing more severe depression, for example if they have a history of severe depression or the current assessment suggests a more severe depression is developing or
- does not want self-help with support, exercise or antidepressant medication. [2018] (1.5.5)

Consider interpersonal therapy (IPT) if a person with less severe depression would like help for interpersonal difficulties that focus on role transitions or disputes or grief and:

- has had exercise or self-help with support, antidepressant medication, individual CBT or BA for a previous episode of depression, but this did not work well for them, or

Do not use antidepressants routinely to treat persistent subthreshold depressive symptoms or mild depression because the risk–benefit ratio is poor, but consider them for people with:

- a past history of moderate or severe depression or
- initial presentation of subthreshold depressive symptoms that have been present for a long period (typically at least 2 years) or
- subthreshold depressive symptoms or mild depression that persist(s) after other interventions. (1.4.4.1)

For people with moderate or severe depression, provide a combination of antidepressant medication and a high-intensity psychological intervention (CBT or IPT). (1.5.1.2)

The choice of intervention should be influenced by the:

- duration of the episode of depression and the trajectory of symptoms
- previous course of depression and response to treatment
- likelihood of adherence to treatment and any potential adverse effects
- person's treatment preference and priorities. (1.5.1.3)

When prescribing drugs other than SSRIs, take the following into account:

- The increased likelihood of the person stopping treatment because of side effects (and the consequent need to increase the dose gradually) with venlafaxine, duloxetine and TCAs.
- The specific cautions, contraindications and monitoring requirements for some drugs. For example:
  - the potential for higher doses of venlafaxine to exacerbate cardiac arrhythmias and the need to monitor the person's blood pressure

- does not want self-help with support, exercise, antidepressant medication, individual CBT or BA. [2018] (1.5.6)

Provide individual CBT, BA or IPT to treat less severe depression in up to 16 sessions, each lasting 50–60 minutes, over 3–4 months. [2018] (1.5.7)

When giving individual CBT, BA or IPT, also consider providing:

- 2 sessions per week for the first 2–3 weeks of treatment for people with less severe depression
- 3–4 follow-up and maintenance sessions over 3–6 months for all people who have recovered or have had clinically significant improvement following individual CBT, BA or IPT. [2018] (1.5.8)

Consider group-based CBT specific to depression for people with less severe depression if:

- they have had self-help with support, exercise, antidepressant medication, individual CBT or BA or IPT for a previous episode of depression, but this did not work well for them, or
- they do not want self-help, exercise, antidepressant medication, individual CBT or BA or IPT. [2018] (1.5.9)

Deliver group-based CBT that is:

- based on a cognitive behavioural model
- delivered by 2 competent practitioners
- typically consists of up to 12 weekly sessions of up to 2 hours each, for up to 6–8 participants. [2018] (1.5.10)

Consider counselling if a person with less severe depression would like help for significant psychosocial, relationship or employment problems and:

- has had self-help with support, exercise, antidepressant medication, individual CBT or BA or IPT for a previous episode of depression, but this did not work well for them, or
- does not want self-help with support, exercise, antidepressant medication,

– the possible exacerbation of hypertension with venlafaxine and duloxetine – the potential for postural hypotension and arrhythmias with TCAs – the need for haematological monitoring with mianserin in elderly people. • Non-reversible monoamine oxidase inhibitors (MAOIs), such as phenelzine, should normally be prescribed only by specialist mental health professionals. • Dosulepin should not be prescribed. (1.5.2.4)	individual CBT or BA or IPT. [2018] (1.5.11) Deliver counselling for people with less severe depression that: • is based on a model developed specifically for depression • consists of up to 16 individual sessions each lasting up to an hour • takes place over 16 weeks. [2018] (1.5.12) Consider short-term psychodynamic therapy (STPT) if a person with less severe depression would like help for emotional and developmental difficulties in relationships and: • has had self-help with support, exercise, antidepressant medication, individual CBT or BA or IPT for a previous episode of depression, but this did not work well for them, or • does not want self-help with support, exercise, antidepressant medication, individual CBT or BA or IPT. [new 2018] (1.5.13) Deliver STPT for people with less severe depression that: • is based on a model developed specifically for depression • consists of up to 16 individual sessions each lasting up to an hour • takes place over 16 weeks. [new 2018] (1.5.14) Consider a selective serotonin reuptake inhibitor (SSRI) for people with less severe depression who: • choose not to have high or low intensity psychological interventions or exercise, or • based on previous treatment history for confirmed depression had a positive response to SSRIs, or • had a poor response to psychological interventions, or • are at risk of developing more severe depression (for example, if they have a history of severe depression or the current assessment suggests a more severe depression is developing). [2018] (1.5.15)
For people started on antidepressants who are not considered to be at increased risk of suicide, normally see them after 2 weeks. See them regularly thereafter; for example, at intervals of 2 to 4 weeks in the first 3 months, and then at longer intervals if response is good (1.5.2.6)	
If a person with depression develops side effects early in antidepressant treatment, provide appropriate information and consider one of the following strategies: • monitor symptoms closely where side effects are mild and acceptable to the person or • stop the antidepressant or change to a different antidepressant if the person prefers or • in discussion with the person, consider short-term concomitant treatment with a benzodiazepine if anxiety, agitation and/or insomnia are problematic (except in people with chronic symptoms of anxiety); this should usually be for no longer than 2 weeks in order to prevent the development of dependence. (1.5.2.8)	
People who start on low-dose TCAs and who have a clear clinical response can be maintained on that dose with careful monitoring. (1.5.2.9)	

If the person's depression shows some improvement by 4 weeks, continue treatment for another 2 to 4 weeks. Consider switching to another antidepressant as described in 1.8 if:

- response is still not adequate or
- there are side effects or
- the person prefers to change treatment. (1.5.2.12)

For all high-intensity psychological interventions, the duration of treatment should normally be within the limits indicated in this guideline. As the aim of treatment is to obtain significant improvement or remission the duration of treatment may be:

- reduced if remission has been achieved
- increased if progress is being made, and there is agreement between the practitioner and the person with depression that further sessions would be beneficial (for example, if there is a comorbid personality disorder or significant psychosocial factors that impact on the person's ability to benefit from treatment). (1.5.3.1)

For all people with depression having individual CBT, the duration of treatment should typically be in the range of 16 to 20 sessions over 3 to 4 months. Also consider providing:

- two sessions per week for the first 2 to 3 weeks of treatment for people with moderate or severe depression
- follow-up sessions typically consisting of three to four sessions over the following 3 to 6 months for all people with depression. (1.5.3.2)

For all people with depression having IPT, the duration of treatment should typically be in the range of 16 to 20 sessions over 3 to 4 months. For people with severe depression, consider providing two sessions per week for the first 2 to 3 weeks of treatment. (1.5.3.3)

For all people with depression having behavioural activation, the duration of

First line treatment for more severe depression

For people with more severe depression, offer:

- an individual high intensity psychological intervention (CBT, BA or IPT) or
- antidepressant medication (see recommendation 1.6.3). [2018] (1.6.1)

Offer a combination of high intensity psychological intervention (CBT, BA or IPT) and antidepressant medication (see recommendation 1.6.3) for people with more severe depression if:

- they have a history of poor response to a high intensity psychological intervention or antidepressant medication alone or
- they have responded well to combination treatment before or
- the current assessment suggests a limited response to a high intensity psychological intervention or antidepressant medication alone. [2018] (1.6.2)

When deciding on antidepressant medication for people with more severe depression, either alone or in combination with a psychological intervention:

- start treatment with an SSRI or mirtazapine
- consider a TCA such as lofepramine or nortriptyline if the person has a history of poor response to SSRIs or mirtazapine. [2018] (1.6.3)

Consider short-term psychodynamic therapy, alone or in combination with antidepressant medication, for a person with more severe depression who would like help for emotional and developmental difficulties in relationships and who:

- has had individual CBT, IPT or BA alone, antidepressant medication alone or a combination of the two for a previous episode of depression, but this did not work well for them, or
- does not want individual CBT, IPT or BA alone, antidepressant medication

<table>
<tr>
<td>treatment should typically be in the range of 16 to 20 sessions over 3 to 4 months. Also consider providing:
• two sessions per week for the first 3 to 4 weeks of treatment for people with moderate or severe depression
• follow-up sessions typically consisting of three to four sessions over the following 3 to 6 months for all people with depression. (1.5.3.4)</td>
<td rowspan="4">alone or a combination of the two. [2018] (1.6.4)
Behavioural couples therapy
Consider behavioural couples therapy for a person with less or more severe depression who has problems in the relationship with their partner if:
• the relationship problem(s) could be contributing to their depression or
• involving their partner may help in the treatment of their depression. [2018] (1.7.1)
Deliver behavioural couples therapy for people with depression that:
• follows the behavioural principles for couples therapy
• provides 15–20 sessions over 5–6 months. [2018] (1.7.2)</td>
</tr>
<tr>
<td>For all people with persistent subthreshold depressive symptoms or mild to moderate depression having counselling, the duration of treatment should typically be in the range of six to ten sessions over 8 to 12 weeks. (1.5.3.6)</td>
</tr>
<tr>
<td>For all people with mild to moderate depression having short-term psychodynamic psychotherapy, the duration of treatment should typically be in the range of 16 to 20 sessions over 4 to 6 months. (1.5.3.7)</td>
</tr>
<tr>
<td>Do not routinely vary the treatment strategies for depression described in this guideline either by depression subtype (for example, atypical depression or seasonal depression) or by personal characteristics (for example, sex or ethnicity) as there is no convincing evidence to support such action. (1.6.1.1)</td>
</tr>
<tr>
<td>For people with persistent subthreshold depressive symptoms or mild to moderate depression who have not benefited from a low-intensity psychosocial intervention, discuss the relative merits of different interventions with the person and provide:
• an antidepressant (normally a selective serotonin reuptake inhibitor [SSRI]) or
• a high-intensity psychological intervention, normally one of the following options:
○ CBT
○ interpersonal therapy (IPT)</td>
<td>Replaced by:
If a person with depression has had no response or a limited response to treatment (typically within 3 weeks for antidepressant medication or 4–6 weeks for psychological therapy or combined medication and psychological therapy), assess:
• whether there are any personal or social factors or physical health conditions that might explain why the treatment isn’t working
• whether the person has not been adhering to the treatment plan, including any adverse effects of medication.</td>
</tr>
</table>

<table>
<tr>
<td>

behavioural activation (but note that the evidence is less robust than for CBT or IPT)
behavioural couples therapy for people who have a regular partner and where the relationship may contribute to the development or maintenance of depression, or where involving the partner is considered to be of potential therapeutic benefit. (1.5.1.1)

</td>
<td rowspan="4">Work with the person to try and address any problems raised. [2018] (1.9.1)

If a person has had no response or a limited response to treatment for depression after assessing the issues in recommendation 1.9.1, provide more support by increasing the number and length of appointments. [2018] (1.9.2)

If a person has had no response or a limited response to treatment for depression, has not benefitted from more support (see recommendation 1.9.2), and is on antidepressant medication only and does not want to continue with it, consider switching to a psychological therapy alone (CBT, BA or IPT). [2018] (1.9.3)

If a person has had no response or a limited response to treatment, has not benefitted from more support (see recommendation 1.9.2), and is on antidepressant medication only and wants to continue with antidepressant medication, consider providing additional support and monitoring and:

• continuing with the current medication and increasing the dose if the medication is well tolerated, or

• switching to a medicine of a different class (including SSRIs, SNRIs, TCAs or MAOI) , or

• switching to a medication of the same class if there are problems with tolerability, or

• changing to a combination of psychological therapy (CBT, BA, or IPT) and medication. [2018] (1.9.4)

If a person’s symptoms do not respond to a dose increase or switching to another antidepressant medication after a further 2–4 weeks:

• review the need for care and treatment, and

• consider consulting with, or referring the person to, a specialist service if their symptoms impair personal and social functioning (see recommendations 1.3.3 and 1.3.4). [2018] (1.9.5)</td>
</tr>
<tr>
<td>If the person’s depression shows no improvement after 2 to 4 weeks with the first antidepressant, check that the drug has been taken regularly and in the prescribed dose. (1.5.2.10)</td>
</tr>
<tr>
<td>If response is absent or minimal after 3 to 4 weeks of treatment with a therapeutic dose of an antidepressant, increase the level of support (for example, by weekly face-to-face or telephone contact) and consider:

• increasing the dose in line with the Summary of Product Characteristics if there are no significant side effects or
• switching to another antidepressant as described in Section 1.8 if there are side effects or if the person prefers. (1.5.2.11)</td>
</tr>
<tr>
<td>When reviewing drug treatment for a person with depression whose symptoms have not adequately responded to initial pharmacological interventions:

• check adherence to, and side effects from, initial treatment
• increase the frequency of appointments using outcome monitoring with a validated outcome measure
• be aware that using a single antidepressant rather than combination medication or augmentation (see 1.8.1.5 to 1.8.1.9) is usually associated with a lower side-effect burden
• consider reintroducing previous treatments that have been</td>
</tr>
</table>

inadequately delivered or adhered to, including increasing the dose

- consider switching to an alternative antidepressant. (1.8.1.1)

When switching to another antidepressant, be aware that the evidence for the relative advantage of switching either within or between classes is weak. Consider switching to:

- initially a different SSRI or a better tolerated newer-generation antidepressant
- subsequently an antidepressant of a different pharmacological class that may be less well tolerated, for example venlafaxine, a TCA or an MAOI. (1.8.1.2)

Do not switch to, or start, dosulepin because evidence supporting its tolerability relative to other antidepressants is outweighed by the increased cardiac risk and toxicity in overdose. (1.8.1.3)

When switching to another antidepressant, which can normally be achieved within 1 week when switching from drugs with a short half-life, consider the potential for interactions in determining the choice of new drug and the nature and duration of the transition. Exercise particular caution when switching:

- from fluoxetine to other antidepressants, because fluoxetine has a long half-life (approximately 1 week)
- from fluoxetine or paroxetine to a TCA, because both of these drugs inhibit the metabolism of TCAs; a lower starting dose of the TCA will be required, particularly if switching from fluoxetine because of its long half-life
- to a new serotonergic antidepressant or MAOI, because of the risk of serotonin syndrome
- from a non-reversible MAOI: a 2-week washout period is required (other antidepressants should not be prescribed routinely during this period). (1.8.1.4)

If a person has had no response or a limited response to treatment for depression after 2 lines of treatment and wants to continue with antidepressant medication, see the NICE guidance on the use of vortioxetine. [2018] (1.9.6)

If a person on antidepressant medication only or a combination of antidepressant medication and psychological therapy, has had no response or a limited response to treatment, and does not want to continue with psychological therapy, consider changing to a combination of 2 different classes of medication. Consult a specialist if the symptoms significantly impair personal and social functioning (see recommendations 1.3.3 and 1.3.4). [2018] (1.9.7)

If a person has had no response or a limited response to initial antidepressant medication and does not want to try a psychological therapy, and wants to try a combination of medications, explain the likely increase in their side-effect burden (including risk of serotonin syndrome). [2018] (1.9.8)

If a person wants to try a combination of medications and is willing to accept an increased side-effect burden:

- consider adding an antidepressant medication of a different class to their initial medication (for example an SSRI with mirtazapine), in specialist settings or after consulting a specialist if the symptoms impair personal and social functioning (see recommendations 1.3.3 and 1.3.4),
- be aware that some combinations are potentially dangerous and should be avoided (for example, an SSRI, SNRI or TCA with MAOI)
- consider combining an antidepressant medication with an antipsychotic or lithium, in specialist settings or after consulting a specialist, if the symptoms impair personal and social functioning (see recommendations 1.3.3 and 1.3.4)

When using combinations of medications (which should only normally be started in primary care in consultation with a consultant psychiatrist):

- select medications that are known to be safe when used together
- be aware of the increased side-effect burden this usually causes
- discuss the rationale for any combination with the person with depression, follow GMC guidance if off-label medication is prescribed, and monitor carefully for adverse effects
- be familiar with primary evidence and consider obtaining a second opinion when using unusual combinations, the evidence for the efficacy of a chosen strategy is limited or the risk–benefit ratio is unclear
- document the rationale for the chosen combination. (1.8.1.5)

If a person with depression is informed about, and prepared to tolerate, the increased side-effect burden, consider combining or augmenting an antidepressant with:

- lithium or
- an antipsychotic such as aripiprazole, olanzapine, quetiapine or risperidone or
- another antidepressant such as mirtazapine or mianserin. (1.8.1.6)

The following strategies should not be used routinely:

- augmentation of an antidepressant with a benzodiazepine for more than 2 weeks as there is a risk of dependence
- augmentation of an antidepressant with buspirone, carbamazepine, lamotrigine or valproate as there is insufficient evidence for their use
- augmentation of an antidepressant with pindolol or thyroid hormones as there is inconsistent evidence of effectiveness. (1.8.1.9)

For a person whose depression has not responded to either pharmacological or psychological interventions, consider

- be aware that escitalopram and citalopram are associated with QTc prolongation. [2018] (1.9.9)

When changing treatment for a person with depression who has had no response or a limited response to initial psychological therapy, consider:

- combining the psychological therapy with an SSRI, for example sertraline or citalopram, or mirtazapine, or
- switching to an SSRI, for example sertraline or citalopram, or mirtazapine if the person wants to stop the psychological therapy. [2018] (1.9.10)

For people with depression whose symptoms have not adequately responded to a combination of medication and a psychological therapy after 12 weeks, consider a different combination of medication and psychological therapy. [2018] (1.9.11)

combining antidepressant medication with CBT. (1.8.1.10)	
For a person whose depression has failed to respond to various strategies for augmentation and combination treatments, consider referral to a practitioner with a specialist interest in treating depression, or to a specialist service. (1.8.1.11)	
The assessment of a person with depression referred to specialist mental health services should include: • their symptom profile, suicide risk and, where appropriate, previous treatment history • associated psychosocial stressors, personality factors and significant relationship difficulties, particularly where the depression is chronic or recurrent • associated comorbidities including alcohol and substance misuse, and personality disorders. (1.10.1.1)	
In specialist mental health services, after thoroughly reviewing previous treatments for depression, consider reintroducing previous treatments that have been inadequately delivered or adhered to. (1.10.1.2)	
Medication in secondary care mental health services should be started under the supervision of a consultant psychiatrist. (1.10.1.4)	
Discuss antidepressant treatment options with the person with depression, covering: • the choice of antidepressant, including any anticipated adverse events, for example, side effects and discontinuation symptoms (see Section 11.8.7.2) and potential interactions with concomitant medication or physical health problems • their perception of the efficacy and tolerability of any antidepressants they have previously taken. (1.5.2.1)	Replaced by: When offering a person antidepressant medication: • explain the reasons for offering it • discuss the harms and benefits • discuss any concerns they have about taking or stopping the antidepressant medication • make sure they have information to take away that is appropriate for their needs. [2018] (1.4.8)

	When prescribing antidepressant medication, give people information about: • how long it takes to start to feel better (typically within 3 weeks) • how to seek a review from the prescriber if there has been no improvement within 3-4 weeks • how important it is to follow the instructions on when to take antidepressant medication • how treatment might need to carry on after remission and how that need will be assessed • how they may be affected when they first start taking antidepressant medication, and what these effects might be • how they may be affected if they have to take antidepressant medication for a long time and what these effects might be, especially in older people • how taking antidepressant medication might affect their sense of resilience (how strong they feel and how well they can get over problems) and being able to cope • how taking antidepressant medication might affect any other medicines they are taking • how they may be affected when they stop taking antidepressant medication, and how these effects can be minimised • the fact that they cannot get addicted to antidepressant medication. [2018] (1.4.9)
Inform the person that they should seek advice from their practitioner if they experience significant discontinuation symptoms. (1.9.2.3)	Replaced by: Advise people taking antidepressant medication that although it is not addictive, if they stop taking it, miss doses or do not take a full dose, they may have discontinuation symptoms such as: • restlessness • problems sleeping • unsteadiness • sweating • abdominal symptoms

	• altered sensations • altered feelings (for example irritability, anxiety or confusion). Explain that these discontinuation symptoms are usually mild and go away after a week but can sometimes be severe, particularly if the antidepressant medication is stopped suddenly. [2018] (1.4.10) When stopping antidepressant medication, take into account the pharmacokinetic profile (for example, the half-life of the medication) and slowly reduce the dose at a rate proportionate to the duration of treatment. For example, this could be over some months if the person has been taking antidepressant medication for several years. [2018] (1.4.11) Monitor people taking antidepressant medication while their dose is being reduced. If needed, adjust the speed and duration of dose reduction according to symptoms. [2018] (1.4.12) When reducing a person's dose of antidepressant medication, be aware that: • discontinuation symptoms can be experienced with a wide range of antidepressant medication • paroxetine and venlafaxine are more likely to be associated with discontinuation symptoms, so particular care is needed with them • fluoxetine's prolonged duration of action means that it can usually be safely stopped without dose reduction. [2018] (1.4.13) If a person has discontinuation symptoms when they stop taking antidepressant medication or reduce their dose, reassure them that they are not having a relapse of their depression. Explain that: • these symptoms are common • relapse does not usually happen as soon as you stop taking an antidepressant medication or lower the dose • even if they start taking an antidepressant medication again or increase their dose, the symptoms may

	take up to 2-3 days to disappear. [2018] (1.4.14) If a person has mild discontinuation symptoms when they stop taking antidepressant medication: • monitor their symptoms • keep reassuring them that such symptoms are common. [2018] (1.4.15) If a person has severe discontinuation symptoms, consider restarting the original antidepressant medication at the dose that was previously effective, or another antidepressant medication from the same class with a longer half-life. Reduce the dose gradually while monitoring symptoms. [2018] (1.4.16)
For people with severe depression and those with moderate depression and complex problems, consider: • referring to specialist mental health services for a programme of co-ordinated multiprofessional care • providing collaborative care if the depression is in the context of a chronic physical health problem with associated functional impairment. (1.7.1.2)	Replaced by: *Specialist care planning* Refer people with more severe depression or chronic depressive symptoms, either of which significantly impairs personal and social functioning, to specialist mental health services for coordinated multidisciplinary care if: • they have not benefitted from or have chosen not to have initial treatment, and either • have multiple complicating problems, for example unemployment, poor housing or financial problems, or • have significant coexisting mental and physical health conditions. [2018] (1.14.4) Deliver multidisciplinary care plans for people with more severe depression or chronic depressive symptoms (either of which significantly impairs personal and social functioning) and multiple complicating problems, or significant coexisting conditions that: • are developed together with the person, their GP and other relevant people involved in their care (with the person's agreement) • set out the roles and responsibilities of all health and social care professionals involved in delivering the care • include information about 24-hour support services, and how to contact them

<table>
<tr><td></td><td>• include a crisis plan that identifies potential crisis triggers, and strategies to manage those triggers
• are updated if there are any significant changes in the person's needs or condition
• are reviewed at agreed regular intervals
• include medication management (a plan for starting, reviewing and discontinuing medication). [new 2018] (1.14.5)</td></tr>
<tr><td>Support and encourage a person who has benefited from taking an antidepressant to continue medication for at least 6 months after remission of an episode of depression. Discuss with the person that:
• this greatly reduces the risk of relapse
• antidepressants are not associated with addiction. (1.9.1.1)</td><td rowspan="4">Replaced by:
Discuss the likelihood of having a relapse with people who have recovered from depression. Explain:
• that a history of previous relapse, and the presence of residual symptoms, increases the chance of relapses
• the importance of them seeking help as soon as possible if the symptoms of depression return or worsen in the case of residual symptoms
• the potential benefits of relapse prevention. [2018] (1.8.1)
Take into account that the following may increase the risk of relapse in people who have recovered from depression:
• how often a person has had episodes of depression, and how recently
• any other chronic physical health or mental health problems
• any residual symptoms and unhelpful coping styles (for example avoidance and rumination)
• how severe their symptoms were, risk to self and if they had functional impairment in previous episodes of depression
• the effectiveness of previous interventions for treatment and relapse prevention
• personal, social and environmental factors. [2018] (1.8.2)
For people who have recovered from less severe depression when treated with antidepressant medication (alone or in combination with a psychological</td></tr>
<tr><td>Review with the person with depression the need for continued antidepressant treatment beyond 6 months after remission, taking into account:
• the number of previous episodes of depression
• the presence of residual symptoms
• concurrent physical health problems and psychosocial difficulties. (1.9.1.2)</td></tr>
<tr><td>For people with depression who are at significant risk of relapse or have a history of recurrent depression, discuss with the person treatments to reduce the risk of recurrence, including continuing medication, augmentation of medication or psychological treatment (CBT). Treatment choice should be influenced by:
• previous treatment history, including the consequences of a relapse, residual symptoms, response to previous treatment and any discontinuation symptoms
• the person’s preference. (1.9.1.3)</td></tr>
<tr><td>Advise people with depression to continue antidepressants for at least 2 years if they are at risk of relapse. Maintain the level of medication at which acute treatment was effective (unless</td></tr>
</table>

there is good reason to reduce the dose, such as unacceptable adverse effects) if:

- they have had two or more episodes of depression in the recent past, during which they experienced significant functional impairment
- they have other risk factors for relapse such as residual symptoms, multiple previous episodes, or a history of severe or prolonged episodes or of inadequate response
- the consequences of relapse are likely to be severe (for example, suicide attempts, loss of functioning, severe life disruption, and inability to work). (1.9.1.4)

When deciding whether to continue maintenance treatment beyond 2 years, re-evaluate with the person with depression, taking into account age, comorbid conditions and other risk factors. (1.9.1.5)

People with depression on long-term maintenance treatment should be regularly re-evaluated, with frequency of contact determined by:

- comorbid conditions
- risk factors for relapse
- severity and frequency of episodes of depression. (1.9.1.6)

People who have had multiple episodes of depression, and who have had a good response to treatment with an antidepressant and an augmenting agent, should remain on this combination after remission if they find the side effects tolerable and acceptable. If one medication is stopped, it should usually be the augmenting agent. Lithium should not be used as a sole agent to prevent recurrence. (1.9.1.7)

People with depression who are considered to be at significant risk of relapse (including those who have relapsed despite antidepressant treatment or who are unable or choose not to continue antidepressant treatment) or who have residual symptoms, should be offered the following psychological interventions:

therapy), but are assessed as having a higher risk of relapse, consider:

• continuing with antidepressant medication to prevent relapse, maintaining the same dose unless there is good reason to reduce it (such as adverse effects), or

• psychological therapy (CBT) with an explicit focus on relapse prevention, typically 3–4 sessions over 1–2 months. [new 2018] (1.8.3)

For people who have recovered from more severe depression when treated with antidepressant medication (alone or in combination with a psychological therapy), but are assessed as having a higher risk of relapse, offer:

• a psychological therapy [group CBT or mindfulness-based cognitive therapy (MBCT) for those who have had 3 or more previous episodes of depression] in combination with antidepressant medication, or

• psychological therapy (group CBT or MBCT for those who have had 3 or more previous episodes of depression) if the person wants to stop taking antidepressant medication. [2018] (1.8.4)

When choosing a psychological therapy for preventing relapse for people who recovered with initial psychological therapy, but are assessed as having a higher risk of relapse, offer:

• 4 more sessions of the same treatment if it has an explicit relapse prevention component, or

• group CBT or MBCT (for those who have had 3 or more previous episodes of depression) if the initial psychological therapy had no explicit relapse prevention component. [new 2018] (1.8.5)

Deliver group CBT for people assessed as having a higher risk of relapse in groups of up to 12 participants. Sessions should last 2 hours once a week for 8 weeks. [2018] (1.8.6)

Deliver MBCT for people assessed as having a higher risk of relapse in groups

<table>
<tr>
<td>

individual CBT for people who have relapsed despite antidepressant medication and for people with a significant history of depression and residual symptoms despite treatment
mindfulness-based cognitive therapy for people who are currently well but have experienced three or more previous episodes of depression. (1.9.1.8)

For all people with depression who are having individual CBT for relapse prevention, the duration of treatment should typically be in the range of 16 to 20 sessions over 3 to 4 months. If the duration of treatment needs to be extended to achieve remission it should:

consist of two sessions per week for the first 2 to 3 weeks of treatment
include additional follow-up sessions, typically consisting of four to six sessions over the following 6 months. (1.9.1.9)

Mindfulness-based cognitive therapy should normally be delivered in groups of eight to 15 participants and consist of weekly 2-hour meetings over 8 weeks and four follow-up sessions in the 12 months after the end of treatment. (1.9.1.10)
</td>
<td>
of up to 15 participants. Meetings should last 2 hours once a week for 8 weeks, with 4 follow-up sessions in the 12 months after treatment ends. [2018] (1.8.7)
For people continuing with medication to prevent relapse, hold reviews at 3, 6 and 12 months after maintenance treatment has started. At each review:
• monitor mood state using a formal validated rating scale,
• review side effects
• review any personal, social and environmental factors that may impact on the risk of relapse
• agree the timescale for further review (no more than 12 months). [2018] (1.8.8)
At all further reviews for people continuing with antidepressant medication to prevent relapse:
• assess the risk of relapse
• discuss the need to continue with antidepressant medication. [2018] (1.8.9)
Re-assess a person’s risk of relapse when they finish a psychological relapse prevention intervention, and assess the need for any further follow up. Discuss continuing treatment with the person if it is needed. [2018] (1.8.10)
</td>
</tr>
<tr>
<td>When stopping an antidepressant, gradually reduce the dose, normally over a 4-week period, although some people may require longer periods, particularly with drugs with a shorter half-life (such as paroxetine and venlafaxine). This is not required with fluoxetine because of its long half-life. (1.9.2.2)</td>
<td>
Replaced by:
When stopping antidepressant medication, take into account the pharmacokinetic profile (for example, the half-life of the medication) and slowly reduce the dose at a rate proportionate to the duration of treatment. For example, this could be over some months if the person has been taking antidepressant medication for several years. [2018] (1.4.11)
Monitor people taking antidepressant medication while their dose is being reduced. If needed, adjust the speed and
</td>
</tr>
</table>

	duration of dose reduction according to symptoms. [2018] (1.4.12) When reducing a person's dose of antidepressant medication, be aware that: • discontinuation symptoms can be experienced with a wide range of antidepressant medication • paroxetine and venlafaxine are more likely to be associated with discontinuation symptoms, so particular care is needed with them • fluoxetine's prolonged duration of action means that it can usually be safely stopped without dose reduction. [2018] (1.4.13)
Inform the person that they should seek advice from their practitioner if they experience significant discontinuation symptoms. If discontinuation symptoms occur: • monitor symptoms and reassure the person if symptoms are mild • consider reintroducing the original antidepressant at the dose that was effective (or another antidepressant with a longer half-life from the same class) if symptoms are severe, and reduce the dose gradually while monitoring symptoms. (1.9.2.3)	Replaced by: If a person has discontinuation symptoms when they stop taking antidepressant medication or reduce their dose, reassure them that they are not having a relapse of their depression. Explain that: • these symptoms are common • relapse does not usually happen as soon as you stop taking an antidepressant medication or lower the dose • even if they start taking an antidepressant medication again or increase their dose, the symptoms may take up to 2-3 days to disappear. [2018] (1.4.14) If a person has mild discontinuation symptoms when they stop taking antidepressant medication: • monitor their symptoms • keep reassuring them that such symptoms are common. [2018] (1.4.15) If a person has severe discontinuation symptoms, consider restarting the original antidepressant medication at the dose that was previously effective, or another antidepressant medication from the same class with a longer half-life. Reduce the dose gradually while monitoring symptoms. [2018] (1.4.16)
Use crisis resolution and home treatment teams to manage crises for people with severe depression who present significant risk, and to deliver high-quality	Replaced by: *Crisis care and home treatment and inpatient care*

acute care. The teams should monitor risk as a high-priority routine activity in a way that allows people to continue their lives without disruption (1.10.1.3) Consider inpatient treatment for people with depression who are at significant risk of suicide, self-harm or self-neglect. (1.10.2.1) The full range of high-intensity psychological interventions should normally be offered in inpatient settings. However, consider increasing the intensity and duration of the interventions and ensure that they can be provided effectively and efficiently on discharge. (1.10.2.2) Consider crisis resolution and home treatment teams for people with depression who might benefit from early discharge from hospital after a period of inpatient care. (1.10.2.3)	Consider crisis and intensive home treatment for people with more severe depression who are at significant risk of: • suicide, in particular for those who live alone • self-harm • harm to others • self-neglect • complications in response to their treatment, for example older people with medical comorbidities. [2018] (1.14.6) Ensure teams providing crisis resolution and home treatment (CRHT) interventions to support people with depression: • monitor and manage risk as a high-priority routine activity • establish and implement a treatment programme • ensure continuity of any treatment programme while the person is in contact with the CRHT team, and on discharge or transfer to other services when this is needed • put a crisis management plan in place before the person is discharged from the team's care. [2018] (1.14.7) Consider inpatient treatment for people with more severe depression who cannot be adequately supported by a CRHT team. [2018] (1.14.8) Make psychological therapies recommended for the treatment of more severe depression, relapse prevention, chronic depressive symptoms and complex depression available for people with depression in inpatient settings. [new 2018] (1.14.9) When providing psychological therapies for people with depression in inpatient settings: • increase the intensity and duration of the interventions • ensure that they continue to be provided effectively and promptly on discharge. [2018] (1.14.10) Consider using CRHT teams for people with depression having a period of inpatient care who might benefit from

	early discharge from hospital. [2018] (1.14.11)
Teams working with people with complex and severe depression should develop comprehensive multidisciplinary care plans in collaboration with the person with depression (and their family or carer, if agreed with the person). The care plan should: • identify clearly the roles and responsibilities of all health and social care professionals involved • develop a crisis plan that identifies potential triggers that could lead to a crisis and strategies to manage such triggers • be shared with the GP and the person with depression and other relevant people involved in the person's care. (1.10.1.5)	Replaced by: Deliver multidisciplinary care plans for people with more severe depression or chronic depressive symptoms (either of which significantly impairs personal and social functioning) and multiple complicating problems, or significant coexisting conditions that: • are developed together with the person, their GP and other relevant people involved in their care (with the person's agreement) • set out the roles and responsibilities of all health and social care professionals involved in delivering the care • include information about 24-hour support services, and how to contact them • include a crisis plan that identifies potential crisis triggers, and strategies to manage those triggers • are updated if there are any significant changes in the person's needs or condition • are reviewed at agreed regular intervals • include medication management (a plan for starting, reviewing and discontinuing medication). [2018] (1.14.5)
For people who have depression with psychotic symptoms, consider augmenting the current treatment plan with antipsychotic medication (although the optimum dose and duration of treatment are unknown) (1.10.3.1)	Replaced by: Refer people with depression with psychotic symptoms to specialist mental health services for a programme of coordinated multi-disciplinary care, which includes access to psychological interventions.[2018] (1.12.1) When treating people with depression with psychotic symptoms, consider adding antipsychotic medication to their current treatment plan. [2018] (1.12.2)
Do not use ECT routinely for people with moderate depression but consider it if their depression has not responded to multiple drug treatments and psychological treatment. (1.10.4.2)	Replaced by: Consider electroconvulsive therapy (ECT) for acute treatment of more severe depression if: • the more severe depression is life-threatening and a rapid response is needed, or

	• multiple pharmacological and psychological treatments have failed. [2018] (1.13.1)

1

2 **Amended recommendation wording (change to meaning)**

Recommendation in 2009 guideline	Recommendation in current guideline	Reason for change
For people with recurrent severe depression or depression with psychotic symptoms and for those who have been treated under the Mental Health Act, consider developing advance decisions and advance statements collaboratively with the person. Record the decisions and statements and include copies in the person's care plan in primary and secondary care. Give copies to the person and to their family or carer, if the person agrees. (1.1.2.1	Consider developing advance decisions and advance statements collaboratively with people who have recurrent severe depression or depression with psychotic symptoms, and for those who have been treated under the Mental Health Act 2007, in line with the Mental Capacity Act 2005. Record the decisions and statements and include copies in the person's care plan in primary and secondary care, and give copies to the person and to their family or carer if the person agrees. [2009, amended 2018] (1.1.2)	Amended to cite additional relevant legislation – the Mental Capacity Act.
For people with significant language or communication difficulties, for example people with sensory impairments or a learning disability, consider using the Distress Thermometer [9]and/or asking a family member or carer about the person's symptoms to identify possible depression. If a significant level of distress is identified, investigate further. (1.3.1.5)	If a person has significant language or communication difficulties, (for example people with sensory or cognitive impairments), consider asking a family member or carer about the person's symptoms to identify possible depression. [2004, amended 2018] (See also NICE's guideline on mental health problems in people with learning disabilities.) (1.2.5)	Removed reference to use of the Distress Thermometer as this detail would be superseded by recommendations made in NICE's guideline on mental health problems in people with learning disabilities
In addition to assessing symptoms and associated functional impairment,	Think about how the factors below may have affected the development, course and	Added employment situation into the list of factors to consider

[9] The Distress Thermometer is a single-item question screen that will identify distress coming from any source. The person places a mark on the scale answering: 'How distressed have you been during the past week on a scale of 0 to 10?' Scores of 4 or more indicate a significant level of distress that should be investigated further. (Roth AJ, Kornblith AB, Batel-Copel L, et al. (1998) Rapid screening for psychologic distress in men with prostate carcinoma: a pilot study. Cancer 82: 1904–8.) 1904–8.)

consider how the following factors may have affected the development, course and severity of a person's depression: • any history of depression and comorbid mental health or physical disorders • any past history of mood elevation (to determine if the depression may be part of bipolar disorder) • any past experience of, and response to, treatments • the quality of interpersonal relationships • living conditions and social isolation.	severity of a person's depression in addition to assessing symptoms and associated functional impairment: • any history of depression and coexisting mental health or physical disorders • any history of mood elevation (to determine if the depression may be part of bipolar disorder) • any past experience of, and response to, previous treatments • the quality of interpersonal relationships • living conditions, employment situation and social isolation. [2009, amended 2018] (1.2.7)	as this would now be checked as standard
When assessing a person with suspected depression, be aware of any learning disabilities or acquired cognitive impairments, and if necessary consider consulting with a relevant specialist when developing treatment plans and strategies. (1.1.4.4)	When assessing a person with suspected depression: • be aware of any acquired cognitive impairments • if needed, consult with a relevant specialist when developing treatment plans and strategies. [2009, amended 2018] (1.2.8)	Removed reference to learning disabilities as there is now a separate NICE guideline on mental health problems in people with learning disabilities
When providing interventions for people with a learning disability or acquired cognitive impairment who have a diagnosis of depression: • where possible, provide the same interventions as for other people with depression • if necessary, adjust the method of delivery or duration of the intervention to take account of the disability or impairment. (1.1.4.5)	When providing interventions for people with an acquired cognitive impairment who have a diagnosis of depression: • if possible, provide the same interventions as for other people with depression • if needed, adjust the method of delivery or length of the intervention to take account of the disability or impairment. [2009, amended 2018] (1.2.9)	Removed reference to learning disabilities as there is now a separate NICE guideline on mental health problems in people with learning disabilities

1
2

Changes to recommendation wording for clarification only (no change to meaning)

Recommendation numbers in current guideline	Comment
All recommendations except those labelled [new 2017]	Recommendations have been edited into the direct style (in line with current NICE style for recommendations in guidelines) where possible. Yellow highlighting has not been applied to these changes.

ISBN: