NICE National Institute for Health and Care Excellence

NICE guideline

Depression in adults: recognition and management

Clinical guideline

Published: 28 October 2009
nice.org.uk/guidance/cg90

Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Contents

This guideline replaces CG23.

This guideline partially replaces TA59 and TA97.

This guideline is the basis of QS23 and QS8.

Introduction

This guideline is a partial update of NICE clinical guideline 23 (published December 2004 revised April 2007) and replaces it. Appendix D has a list of recommendations for which the evidence has not been updated since the original guideline.

This guideline is published alongside 'Depression in adults with a chronic physical health problem: treatment and management' (NICE clinical guideline 91) which makes recommendations on the identification treatment and management of depression in adults aged 18 years and older who also have a chronic physical health problem.

This guideline makes recommendations on the identification, treatment and management of depression in adults aged 18 years and older, in primary and secondary care. This guideline covers people whose depression occurs as the primary diagnosis; the relevant NICE guidelines should be consulted for depression occurring in the context of other disorders (see section 6).

Depression is a broad and heterogeneous diagnosis. Central to it is depressed mood and/or loss of pleasure in most activities. Severity of the disorder is determined by both the number and severity of symptoms, as well as the degree of functional impairment. A formal diagnosis using the ICD-10 classification system requires at least four out of ten depressive symptoms, whereas the DSM-IV system requires at least five out of nine for a diagnosis of major depression (referred to in this guideline as 'depression'). Symptoms should be present for at least 2 weeks and each symptom should be present at sufficient severity for most of every day. Both diagnostic systems require at least one (DSM-IV) or two (ICD-10) key symptoms (low mood,[1] loss of interest and pleasure[1] or loss of energy[2]) to be present.

Increasingly, it is recognised that depressive symptoms below the DSM-IV and ICD-10 threshold criteria can be distressing and disabling if persistent. Therefore this updated guideline covers 'subthreshold depressive symptoms', which fall below the criteria for major depression, and are defined as at least one key symptom of depression but with insufficient other symptoms and/or functional impairment to meet the criteria for full diagnosis. Symptoms are considered persistent if they continue despite active monitoring and/or low-intensity intervention, or have been present

for a considerable time, typically several months. (For a diagnosis of dysthymia, symptoms should be present for at least 2 years[3].)

It should be noted that classificatory systems are agreed conventions that seek to define different severities of depression in order to guide diagnosis and treatment, and their value is determined by how useful they are in practice. After careful review of the diagnostic criteria and the evidence, the Guideline Development Group decided to adopt DSM-IV criteria for this update rather than ICD-10, which was used in the previous guideline (NICE clinical guideline 23). This is because DSM-IV is used in nearly all the evidence reviewed and it provides definitions for atypical symptoms and seasonal depression. Its definition of severity also makes it less likely that a diagnosis of depression will be based solely on symptom counting. In practical terms, clinicians are not expected to switch to DSM-IV but should be aware that the threshold for mild depression is higher than ICD-10 (five symptoms instead of four) and that degree of functional impairment should be routinely assessed before making a diagnosis. Using DSM-IV enables the guideline to target better the use of specific interventions, such as antidepressants, for more severe degrees of depression.

A wide range of biological, psychological and social factors, which are not captured well by current diagnostic systems, have a significant impact on the course of depression and the response to treatment. Therefore it is also important to consider both personal past history and family history of depression when undertaking a diagnostic assessment (see appendix C for further details).

Depression often has a remitting and relapsing course, and symptoms may persist between episodes. Where possible, the key goal of an intervention should be complete relief of symptoms (remission), which is associated with better functioning and a lower likelihood of relapse.

The guideline assumes that prescribers will use a drug's summary of product characteristics (SPC) and the 'British national formulary' (BNF) to inform their decisions made with individual patients.

This guideline recommends some drugs for indications for which they do not have a UK marketing authorisation at the date of publication, if they are already in use in the NHS for that indication, and there is good evidence to support that use. Drugs are marked with an asterisk if they do not have UK marketing authorisation for depression or the indication stated at the time of publication.

Section 1.10.4 of this guideline updates recommendations made in 'Guidance on the use of electroconvulsive therapy' (NICE technology appraisal guidance 59)[4] for the treatment of depression **only**. The guidance in TA59 remains unchanged for the use of ECT in the treatment of catatonia, prolonged or severe manic episodes and schizophrenia.

Recommendation 1.4.2.1 of this guideline updates recommendations made in 'Computerised cognitive behaviour therapy for depression and anxiety (review)' (NICE technology appraisal guidance 97)[5] for the treatment of depression **only**. The guidance in TA97 remains unchanged for the use of CCBT in panic and phobia and obsessive compulsive disorder.

[1] In both ICD-10 and DSM-IV.

[2] In ICD-10 only.

[3] Both DSM-IV and ICD-10 have the category of dysthymia, which consists of depressive symptoms that are subthreshold for major depression but that persist (by definition for more than 2 years). There appears to be no empirical evidence that dysthymia is distinct from subthreshold depressive symptoms apart from duration of symptoms, and the term 'persistent subthreshold depressive symptoms' is preferred in this guideline.

[4] NICE technology appraisal guidance 59

[5] NICE technology appraisal guidance 97

Person-centred care

This guideline offers best practice advice on the care of adults with depression.

Treatment and care should take into account patients' needs and preferences. People with depression should have the opportunity to make informed decisions about their care and treatment, in partnership with their practitioners. If patients do not have the capacity to make decisions, healthcare professionals should follow the Department of Health's advice on consent and the code of practice that accompanies the Mental Capacity Act. In Wales, healthcare professionals should follow advice on consent from the Welsh Government.

Good communication between practitioners and patients is essential. It should be supported by evidence-based written information tailored to the patient's needs. Treatment and care, and the information patients are given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English.

If the patient agrees, families and carers should have the opportunity to be involved in decisions about treatment and care.

Families and carers should also be given the information and support they need.

Key priorities for implementation

Principles for assessment

- When assessing a person who may have depression, conduct a comprehensive assessment that does not rely simply on a symptom count. Take into account both the degree of functional impairment and/or disability associated with the possible depression and the duration of the episode.

Effective delivery of interventions for depression

- All interventions for depression should be delivered by competent practitioners. Psychological and psychosocial interventions should be based on the relevant treatment manual(s), which should guide the structure and duration of the intervention. Practitioners should consider using competence frameworks developed from the relevant treatment manual(s) and for all interventions should:
    - receive regular high-quality supervision
    - use routine outcome measures and ensure that the person with depression is involved in reviewing the efficacy of the treatment
    - engage in monitoring and evaluation of treatment adherence and practitioner competence – for example, by using video and audio tapes, and external audit and scrutiny where appropriate.

Case identification and recognition

- 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 two questions, specifically:
    - During the last month, have you often been bothered by feeling down, depressed or hopeless?
    - During the last month, have you often been bothered by having little interest or pleasure in doing things?

Low-intensity psychosocial interventions

- 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)[6]
    - a structured group physical activity programme.

Drug treatment

- 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.

Treatment for moderate or severe depression

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

Continuation and relapse prevention

- 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.

Psychological interventions for relapse prevention

- 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 one of the following psychological interventions:
    - 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.

[6] This recommendation (and recommendation 1.4.2.1 in CG91) updates the recommendations on depression only in 'Computerised cognitive behaviour therapy for depression and anxiety (review)' (NICE technology appraisal guidance 97).

1 Guidance

The following guidance is based on the best available evidence. The full guideline gives details of the methods and the evidence used to develop the guidance.

Box 1 Depression definitions (taken from DSM-IV)

Subthreshold depressive symptoms: Fewer than 5 symptoms of depression.

Mild depression: Few, if any, symptoms in excess of the 5 required to make the diagnosis, and symptoms result in only minor functional impairment.

Moderate depression: Symptoms or functional impairment are between 'mild' and 'severe'.

Severe depression: Most symptoms, and the symptoms markedly interfere with functioning. Can occur with or without psychotic symptoms.

Note that a comprehensive assessment of depression should not rely simply on a symptom count, but should take into account the degree of functional impairment and/or disability (see section 1.1.4).

This guideline is published alongside 'Depression in adults with a chronic physical health problem: treatment and management' (NICE clinical guideline 91), which makes recommendations on the identification, treatment and management of depression in adults aged 18 years and older who also have a chronic physical health problem.

1.1 Care of all people with depression

1.1.1 Providing information and support, and obtaining informed consent

1.1.1.1 When working with people with depression and their families or carers:

- build a trusting relationship and work in an open, engaging and non-judgemental manner
- explore treatment options in an atmosphere of hope and optimism, explaining 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 in which confidentiality, privacy and dignity are respected.

1.1.1.2 When working with people with depression and their families or carers:

- provide information appropriate to their level of understanding about the nature of depression and the range of treatments available
- avoid clinical language without adequate explanation
- ensure that comprehensive written information is available in the appropriate language and in audio format if possible
- provide and work proficiently with independent interpreters (that is, someone who is not known to the person with depression) if needed.

1.1.1.3 Inform people with depression about self-help groups, support groups and other local and national resources.

1.1.1.4 Make all efforts necessary 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 is subject to the Mental Health Act.

1.1.1.5 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 it comprises
- what is expected of the person while having it
- likely outcomes (including any side effects).

1.1.2 Advance decisions and statements

1.1.2.1 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.

1.1.3 Supporting families and carers

1.1.3.1 When families or carers are involved in supporting a person with severe or chronic[7] depression, consider:

- providing written and verbal 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 necessary
- providing information about local family or carer support groups and voluntary organisations, and helping families or carers to access these
- negotiating between the person and their family or carer about confidentiality and the sharing of information.

1.1.4 Principles for assessment, coordination of care and choosing treatments

1.1.4.1 When assessing a person who may have depression, conduct a comprehensive assessment that does not rely simply on a symptom count. Take into account both the degree of functional impairment and/or disability associated with the possible depression and the duration of the episode.

1.1.4.2 In addition to assessing symptoms and associated functional impairment, 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[8])
- any past experience of, and response to, treatments
- the quality of interpersonal relationships
- living conditions and social isolation.

1.1.4.3 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.

1.1.4.4 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.

1.1.4.5 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.

1.1.4.6 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 risk (see section 1.3.2)
- advise the person to seek further help if the situation deteriorates.

1.1.5 Effective delivery of interventions for depression

1.1.5.1 All interventions for depression should be delivered by competent practitioners. Psychological and psychosocial interventions should be based on the relevant treatment manual(s), which should guide the structure and duration of the intervention. Practitioners should consider using competence frameworks developed from the relevant treatment manual(s) and for all interventions should:

- receive regular high-quality supervision

- use routine outcome measures and ensure that the person with depression is involved in reviewing the efficacy of the treatment
- engage in monitoring and evaluation of treatment adherence and practitioner competence – for example, by using video and audio tapes, and external audit and scrutiny where appropriate.

1.1.5.2 Consider providing all interventions in the preferred language of the person with depression where possible.

1.2 Stepped care

The stepped-care model provides a framework in which to organise the provision of services, and supports patients, carers and practitioners in identifying and accessing the most effective interventions (see figure 1). In stepped care the least intrusive, most effective intervention is provided first; if a person does not benefit from the intervention initially offered, or declines an intervention, they should be offered an appropriate intervention from the next step.

Figure 1 The stepped-care model

Focus of the intervention	Nature of the intervention
STEP 4: Severe and complex[a] depression; risk to life; severe self-neglect	Medication, high-intensity psychological interventions, electroconvulsive therapy, crisis service, combined treatments, multiprofessional and inpatient care
STEP 3: Persistent subthreshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions; moderate and severe depression	Medication, high-intensity psychological interventions, combined treatments, collaborative care[b] and referral for further assessment and interventions
STEP 2: Persistent subthreshold depressive symptoms; mild to moderate depression	Low-intensity psychosocial interventions, psychological interventions, medication and referral for further assessment and interventions
STEP 1: All known and suspected presentations of depression	Assessment, support, psychoeducation, active monitoring and referral for further assessment and interventions

[a] Complex depression includes depression that shows an inadequate response to multiple treatments, is complicated by psychotic symptoms, and/or is associated with significant psychiatric comorbidity or psychosocial factors

[b] Only for depression where the person also has a chronic physical health problem and associated functional impairment (see 'Depression in adults with a chronic physical health problem: treatment and management' [NICE clinical guideline 91]).

1.3 Step 1: recognition, assessment and initial management

1.3.1 Case identification and recognition

1.3.1.1 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 two questions, specifically:

- During the last month, have you often been bothered by feeling down, depressed or hopeless?
- During the last month, have you often been bothered by having little interest or pleasure in doing things?

1.3.1.2 If a person answers 'yes' to either of the depression identification questions (see 1.3.1.1) but the practitioner is not competent to perform a mental health assessment, they should refer the person to an appropriate professional. If this professional is not the person's GP, inform the GP of the referral.

1.3.1.3 If a person answers 'yes' to either of the depression identification questions (see 1.3.1.1), a practitioner who is competent to perform a mental health assessment should review the person's mental state and associated functional, interpersonal and social difficulties.

1.3.1.4 When assessing a person with suspected depression, consider using a validated measure (for example, for symptoms, functions and/or disability) to inform and evaluate treatment.

1.3.1.5 For people with significant language or communication difficulties, for example people with sensory impairments or a learning disability, consider using the Distress Thermometer[b] 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.

1.3.2 Risk assessment and monitoring

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

1.3.2.2 Advise people with depression of the potential for increased agitation, anxiety and suicidal ideation in the initial stages of treatment; actively seek out 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.

1.3.2.3 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.

1.3.2.4 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 drug(s) available
- consider increasing the level of support, such as more frequent direct or telephone contacts
- consider referral to specialist mental health services.

1.4 Step 2: recognised depression – persistent subthreshold depressive symptoms or mild to moderate depression

1.4.1 General measures

Depression with anxiety

1.4.1.1 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 the NICE guideline for the relevant anxiety disorder (see section 6) and consider treating the anxiety disorder first (since effective treatment of the anxiety disorder will often improve the depression or the depressive symptoms).

Sleep hygiene

1.4.1.2 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.

Active monitoring

1.4.1.3 For people who, in the judgement of the practitioner, may recover with no formal intervention, or people with mild depression who do not want an intervention, or people with subthreshold depressive symptoms who request an intervention:

- discuss the presenting problem(s) and any concerns that the person may have about them
- 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.

1.4.2 Low-intensity psychosocial interventions

1.4.2.1 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)[10]
- a structured group physical activity programme.

Delivery of low-intensity psychosocial interventions

1.4.2.2 Individual guided self-help programmes based on the principles of CBT (and including behavioural activation and problem-solving techniques) for people with persistent subthreshold depressive symptoms or mild to moderate depression should:

- include the provision of written materials of an appropriate reading age (or alternative media to support access)
- be supported by a trained practitioner, who typically facilitates the self-help programme and reviews progress and outcome
- consist of up to six to eight sessions (face-to-face and via telephone) normally taking place over 9 to 12 weeks, including follow-up.

1.4.2.3 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.

1.4.2.4 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).

1.4.3 Group cognitive behavioural therapy

1.4.3.1 Consider group-based CBT for people with persistent subthreshold depressive symptoms or mild to moderate depression who decline low-intensity psychosocial interventions (see 1.4.2.1).

1.4.3.2 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 10 to 12 meetings of eight to ten participants
- normally take place over 12 to 16 weeks, including follow-up.

1.4.4 Drug treatment

1.4.4.1 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.

1.4.4.2 Although there is evidence that St John's wort may be of benefit in mild or moderate 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 oral 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.

1.5 Step 3: persistent subthreshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions, and moderate and severe depression

1.5.1 Treatment options

1.5.1.1 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)
  - 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.

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

1.5.1.3 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.

1.5.1.4 For people with depression who decline an antidepressant, CBT, IPT, behavioural activation and behavioural couples therapy, consider:

- counselling for people with persistent subthreshold depressive symptoms or mild to moderate depression
- short-term psychodynamic psychotherapy for people with mild to moderate depression.

Discuss with the person the uncertainty of the effectiveness of counselling and psychodynamic psychotherapy in treating depression.

1.5.2 Antidepressant drugs

Choice of antidepressant[11]

1.5.2.1 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 1.9.2.1), and potential interactions with concomitant medication or physical health problems[12]
- their perception of the efficacy and tolerability of any antidepressants they have previously taken.

1.5.2.2 When an antidepressant is to be prescribed, it should normally be an SSRI in a generic form because SSRIs are equally effective as other antidepressants and have a favourable risk–benefit ratio. Also take the following into account:

- SSRIs are associated with an increased risk of bleeding, especially in older people or in people taking other drugs that have the potential to damage the gastrointestinal mucosa or interfere with clotting. In particular, consider prescribing a gastroprotective drug in older people who are taking non-steroidal anti-inflammatory drugs (NSAIDs) or aspirin.
- Fluoxetine, fluvoxamine and paroxetine are associated with a higher propensity for drug interactions than other SSRIs[10].

- Paroxetine is associated with a higher incidence of discontinuation symptoms than other SSRIs.

1.5.2.3 Take into account toxicity in overdose when choosing an antidepressant for people at significant risk of suicide. Be aware that:

- compared with other equally effective antidepressants recommended for routine use in primary care, venlafaxine is associated with a greater risk of death from overdose
- tricyclic antidepressants (TCAs), except for lofepramine, are associated with the greatest risk in overdose.

1.5.2.4 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
  - 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.[13]
- Non-reversible monoamine oxidase inhibitors (MAOIs), such as phenelzine, should normally be prescribed only by specialist mental health professionals.
- Dosulepin should not be prescribed.

Starting and initial phase of treatment

1.5.2.5 When prescribing antidepressants, explore any concerns the person with depression has about taking medication, explain fully the reasons for prescribing, and provide information about taking antidepressants, including:

- the gradual development of the full antidepressant effect

- the importance of taking medication as prescribed and the need to continue treatment after remission
- potential side effects
- the potential for interactions with other medications
- the risk and nature of discontinuation symptoms with all antidepressants, particularly with drugs with a shorter half-life (such as paroxetine and venlafaxine), and how these symptoms can be minimised
- the fact that addiction does not occur with antidepressants.

Offer written information appropriate to the person's needs.

1.5.2.6 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.

1.5.2.7 A person with depression started on antidepressants who is considered to present an increased suicide risk or is younger than 30 years (because of the potential increased prevalence of suicidal thoughts in the early stages of antidepressant treatment for this group) should normally be seen after 1 week and frequently thereafter as appropriate until the risk is no longer considered clinically important.

1.5.2.8 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.

1.5.2.9 People who start on low-dose TCAs and who have a clear clinical response can be maintained on that dose with careful monitoring.

1.5.2.10 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.

1.5.2.11 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 SPC 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.

1.5.2.12 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 section 1.8 if:

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

1.5.3 Psychological interventions

Delivering high-intensity psychological interventions

1.5.3.1 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).

1.5.3.2 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.

1.5.3.3 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.

1.5.3.4 For all people with depression having behavioural activation, 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 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.

1.5.3.5 Behavioural couples therapy for depression should normally be based on behavioural principles, and an adequate course of therapy should be 15 to 20 sessions over 5 to 6 months.

Delivering counselling

1.5.3.6 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.

Delivering short-term psychodynamic psychotherapy

1.5.3.7 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.

1.6 Treatment choice based on depression subtypes and personal characteristics

There is little evidence to guide prescribing in relation to depression subtypes or personal characteristics. The main issue concerns the impact of other physical disorders on the treatment of depression. Refer to 'Depression in adults with a chronic physical health problem: treatment and management' (NICE clinical guideline 91) for further information.

1.6.1.1 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.

1.6.1.2 Advise people with winter depression that follows a seasonal pattern and who wish to try light therapy in preference to antidepressant or psychological treatment that the evidence for the efficacy of light therapy is uncertain.

1.6.1.3 When prescribing antidepressants for older people:

- prescribe at an age-appropriate dose taking into account the effect of general physical health and concomitant medication on pharmacokinetics and pharmacodynamics
- carefully monitor for side effects.

1.6.1.4 For people with long-standing moderate or severe depression who would benefit from additional social or vocational support, consider:

- befriending as an adjunct to pharmacological or psychological treatments; befriending should be by trained volunteers providing, typically, at least weekly contact for between 2 and 6 months
- a rehabilitation programme if a person's depression has resulted in loss of work or disengagement from other social activities over a longer term.

1.7 Enhanced care for depression

1.7.1.1 Medication management as a separate intervention for people with depression should not be provided routinely by services. It is likely to be effective only when provided as part of a more complex intervention.

1.7.1.2 For people with severe depression and those with moderate depression and complex problems, consider:

- referring to specialist mental health services for a programme of coordinated multiprofessional care
- providing collaborative care if the depression is in the context of a chronic physical health problem with associated functional impairment[14].

1.8 Sequencing treatments after initial inadequate response

Some people have depression that does not respond well to initial treatment. This section describes strategies to adopt if this occurs.

1.8.1 Drug treatments

1.8.1.1 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 inadequately delivered or adhered to, including increasing the dose
- consider switching to an alternative antidepressant.

Switching antidepressants

1.8.1.2 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.

1.8.1.3 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.

1.8.1.4 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[15]
- from a non-reversible MAOI: a 2-week washout period is required (other antidepressants should not be prescribed routinely during this period).

Combining and augmenting medications

'Augmentation' is when an antidepressant is used with a non-antidepressant drug and 'combination' is when two antidepressants are used together.

1.8.1.5 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.

1.8.1.6 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.

1.8.1.7 When prescribing lithium:

- monitor renal and thyroid function before treatment and every 6 months during treatment (more often if there is evidence of renal impairment)
- consider ECG monitoring in people with depression who are at high risk of cardiovascular disease
- monitor serum lithium levels 1 week after initiation and each dose change until stable, and every 3 months thereafter.

1.8.1.8 When prescribing an antipsychotic, monitor weight, lipid and glucose levels, and side effects (for example, extrapyramidal side effects and prolactin-related side effects with risperidone).

1.8.1.9 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[16].

Combined psychological and drug treatment

1.8.1.10 For a person whose depression has not responded to either pharmacological or psychological interventions, consider combining antidepressant medication with CBT.

Referral

1.8.1.11 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.

1.9 Continuation and relapse prevention

1.9.1.1 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.

1.9.1.2 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.

1.9.1.3 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.

Using medication for relapse prevention

1.9.1.4 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 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).

1.9.1.5 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.

1.9.1.6 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.

1.9.1.7 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.

Psychological interventions for relapse prevention

1.9.1.8 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 one of the following psychological interventions:

- 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.

Delivering psychological interventions for relapse prevention

1.9.1.9 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.

1.9.1.10 Mindfulness-based cognitive therapy should normally be delivered in groups of 8 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.

1.9.2 Stopping or reducing antidepressants

1.9.2.1 Advise people with depression who are taking antidepressants that discontinuation symptoms[17] may occur on stopping, missing doses or, occasionally, on reducing the dose of the drug. Explain that symptoms are

usually mild and self-limiting over about 1 week, but can be severe, particularly if the drug is stopped abruptly.

1.9.2.2 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.

1.9.2.3 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.

1.10 Step 4: complex and severe depression

Referral to specialist mental health services should normally be for people with depression who are at significant risk of self-harm, have psychotic symptoms, require complex multiprofessional care, or where an expert opinion on treatment and management is needed.

1.10.1.1 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.

1.10.1.2 In specialist mental health services, after thoroughly reviewing previous treatments for depression, consider reintroducing previous treatments that have been inadequately delivered or adhered to.

1.10.1.3 Use crisis resolution and home treatment teams to manage crises for people with severe depression who present significant risk, and to deliver high-quality 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.

1.10.1.4 Medication in secondary care mental health services should be started under the supervision of a consultant psychiatrist.

1.10.1.5 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.

1.10.2 Inpatient care, and crisis resolution and home treatment teams

1.10.2.1 Consider inpatient treatment for people with depression who are at significant risk of suicide, self-harm or self-neglect.

1.10.2.2 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.

1.10.2.3 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.

1.10.3 Pharmacological management of depression with psychotic symptoms

1.10.3.1 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).

1.10.4 Electroconvulsive therapy (ECT)

The recommendations in this section update the depression aspects only of 'Guidance on the use of electroconvulsive therapy' (NICE technology appraisal guidance 59).

1.10.4.1 Consider ECT for acute treatment of severe depression that is life-threatening and when a rapid response is required, or when other treatments have failed.

1.10.4.2 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.

1.10.4.3 For people whose depression has not responded well to a previous course of ECT, consider a repeat trial of ECT only after:

- reviewing the adequacy of the previous treatment course **and**
- considering all other options **and**
- discussing the risks and benefits with the person and/or, where appropriate, their advocate or carer.

1.10.4.4 When considering ECT as a treatment choice, ensure that the person with depression is fully informed of the risks associated with ECT, and with the risks and benefits specific to them. Document the assessment and consider:

- the risks associated with a general anaesthetic
- current medical comorbidities
- potential adverse events, notably cognitive impairment
- the risks associated with not receiving ECT.

The risks associated with ECT may be greater in older people; exercise particular caution when considering ECT treatment in this group.

1.10.4.5 A decision to use ECT should be made jointly with the person with depression as far as possible, taking into account, where applicable, the requirements of the Mental Health Act 2007. Also be aware that:

- valid informed consent should be obtained (if the person has the capacity to grant or refuse consent) without the pressure or coercion that might occur as a result of the circumstances and clinical setting
- the person should be reminded of their right to withdraw consent at any time
- there should be strict adherence to recognised guidelines about consent, and advocates or carers should be involved to facilitate informed discussions
- if informed consent is not possible, ECT should only be given if it does not conflict with a valid advance decision, and the person's advocate or carer should be consulted.

1.10.4.6 The choice of electrode placement and stimulus dose related to seizure threshold should balance efficacy against the risk of cognitive impairment. Take into account that:

- bilateral ECT is more effective than unilateral ECT but may cause more cognitive impairment
- with unilateral ECT, a higher stimulus dose is associated with greater efficacy, but also increased cognitive impairment compared with a lower stimulus dose.

1.10.4.7 Assess clinical status after each ECT treatment using a formal valid outcome measure, and stop treatment when remission has been achieved, or sooner if side effects outweigh the potential benefits.

1.10.4.8 Assess cognitive function before the first ECT treatment and monitor at least every three to four treatments, and at the end of a course of treatment.

1.10.4.9 Assessment of cognitive function should include:

- 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.

  If there is evidence of significant cognitive impairment at any stage consider, in discussion with the person with depression, changing from bilateral to unilateral electrode placement, reducing the stimulus dose or stopping treatment depending on the balance of risks and benefits.

1.10.4.10 If a person's depression has responded to a course of ECT, antidepressant medication should be started or continued to prevent relapse. Consider lithium augmentation of antidepressants.

1.10.5 Transcranial magnetic stimulation

For guidance on transcranial magnetic stimulation, see the NICE interventional procedure guidance on repetitive transcranial magnetic stimulation for depression.

---

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

[8] Refer if necessary to 'Bipolar disorder' (NICE clinical guideline 38).

[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.)

[10] This recommendation (and recommendation 1.4.2.1 in CG91) updates the recommendations on depression only in 'Computerised cognitive behaviour therapy for depression and anxiety (review)' (NICE technology appraisal guidance 97).

[11] For additional considerations on the use of antidepressants and other medications (including the assessment of the relative risks and benefits) for women who may become pregnant, please refer to the BNF and individual drug SPCs. For women in the antenatal and postnatal periods, see also NICE clinical guideline 45 'Antenatal and postnatal mental health'.

[12] Consult appendix 1 of the BNF for information on drug interactions and 'Depression in adults with a chronic physical health problem: treatment and management' (NICE clinical guideline 91).

[13] Consult the BNF for detailed information.

[14] Refer to 'Depression in adults with a chronic physical health problem: treatment and management' (NICE clinical guideline 91) for the evidence base for this.

[15] Features of serotonin syndrome include confusion, delirium, shivering, sweating, changes in blood pressure and myoclonus.

[16] In this guideline, drug names are marked with an asterisk if they do not have UK marketing authorisation for the indication in question at the time of publication (October 2009). Informed consent should be obtained and documented.

[17] Discontinuation symptoms include increased mood change, restlessness, difficulty sleeping, unsteadiness, sweating, abdominal symptoms and altered sensations.

2 Notes on the scope of the guidance

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover. The scope of this guideline is available.

How this guideline was developed

NICE commissioned the National Collaborating Centre for Mental Health to develop this guideline. The Centre established a guideline development group (see appendix A), which reviewed the evidence and developed the recommendations. An independent guideline review panel oversaw the development of the guideline (see appendix B).

There is more information about how NICE clinical guidelines are developed on the NICE website. A booklet, 'How NICE clinical guidelines are developed: an overview for stakeholders, the public and the NHS' is available.

3 Implementation

NICE has developed tools to help organisations implement this guidance.

4 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future.

4.1 Sequencing antidepressant treatment after inadequate initial response

What is the best medication strategy for people with depression who have not had sufficient response to a first SSRI antidepressant after 6 to 8 weeks of adequate treatment?

Why this is important

Inadequate response to a first antidepressant is a frequent problem but the best way of sequencing treatments is not clear from the available evidence. There is good evidence that the likelihood of eventual response decreases with the duration of depression and number of failed treatment attempts, so maximising the response at an early stage may be an important factor in the final outcome. The results of this study will be generalisable to a large number of people with depression and will inform choice of treatment.

This question should be addressed using a randomised controlled trial design to compare the effects of continuing on the same antidepressant (with dose increase if appropriate) and switching to another SSRI or to an antidepressant of another class. Built into the design should be an assessment of the effect of increased frequency of follow-up and monitoring alone on improvement. The outcomes chosen should reflect both observer and patient-rated assessments of improvement and an assessment of the acceptability of the treatment options. The study needs to be large enough to determine the presence or absence of clinically important effects using a non-inferiority design, and mediators and moderators of response should be investigated.

4.2 The efficacy of short-term psychodynamic psychotherapy compared with cognitive behavioural therapy and antidepressants in the treatment of moderate to severe depression

In well-defined depression of moderate to severe severity, what is the efficacy of short-term psychodynamic psychotherapy compared with CBT and antidepressants?

Why this is important

Psychological treatments are an important therapeutic option for people with depression. CBT has the best evidence base for efficacy but it is not effective for everyone. The availability of alternatives drawing from a different theoretical model is therefore important. Psychotherapy based on psychodynamic principles has historically been provided in the NHS but provision is patchy and a good evidence base is lacking. It is therefore important to establish whether short-term psychodynamic psychotherapy is an effective alternative to CBT and one that should be provided. The results of this study will have important implications for the provision of psychological treatment in the NHS.

This question should be answered using a randomised controlled trial design that reports short-term and medium-term outcomes (including cost-effectiveness outcomes) of at least 18 months' duration. Particular attention should be paid to the reproducibility of the treatment model and training and supervision of those providing interventions in order to ensure that the treatments are both robust and generalisable. The outcomes chosen should reflect both observer and patient-rated assessments of improvement and an assessment of the acceptability of the treatment options. The study needs to be large enough to determine the presence or absence of clinically important effects using a non-inferiority design, and mediators and moderators of response should be investigated.

4.3 The cost effectiveness of combined antidepressants and CBT compared with sequenced treatment for moderate to severe depression

What is the cost effectiveness of combined antidepressants and CBT compared with sequenced medication followed by CBT and vice versa for moderate to severe depression?

Why this is important

There is a reasonable evidence base for the superior effectiveness of combined antidepressants and CBT over either treatment alone in moderate to severe depression. However the practicality, acceptability and cost effectiveness of combined treatment over a sequenced approach is less well-established. The answer has important practical implications for service delivery and resource implications for the NHS.

This question should be answered using a randomised controlled trial design in which people with moderate to severe depression receive either combined treatment from the outset, or single modality treatment with the addition of the other modality if there is inadequate response to initial treatment. The outcomes chosen should reflect both observer and patient-rated assessments for acute and medium-term outcomes to at least 6 months, and an assessment of the acceptability and

burden of the treatment options. The study needs to be large enough to determine the presence or absence of clinically important effects using a non-inferiority design together with robust health economic measures.

4.4 The efficacy of light therapy compared with antidepressants for mild to moderate depression with a seasonal pattern

How effective is light therapy compared with antidepressants for mild to moderate depression with a seasonal pattern?

Why this is important

Although the status of seasonal depression as a separate entity is not entirely clear, surveys have consistently reported a high prevalence of seasonal (predominantly winter) depression in the UK. This reflects a considerable degree of morbidity, predominantly in the winter months, for people with this condition. Light therapy has been proposed as a specific treatment for winter depression but only small, inconclusive trials have been carried out, from which it is not possible to tell whether either light therapy or antidepressants are effective in its treatment. Clarification of whether, and to what degree, treatments are effective would help to inform the decisions that people with seasonal depression and practitioners have to make about the treatment of winter depression.

This question should be answered using a randomised controlled trial design in which people with mild to moderate depression with a seasonal pattern (seasonal affective disorder) receive light therapy or an SSRI antidepressant in a partially placebo-controlled design. The doses of both light and SSRI should be at accepted or proposed therapeutic levels and there should be an initial phase over a few weeks in which a plausible placebo treatment is administered followed by randomisation to one of the active treatments. The outcomes chosen should reflect both observer and patient-rated assessments of improvement and an assessment of the acceptability of the treatment options. The study needs to be large enough to determine the presence or absence of clinically important effects, and mediators and moderators of response should be investigated.

4.5 The efficacy of CBT compared with antidepressants and placebo for persistent subthreshold depressive symptoms

What is the efficacy of CBT compared with antidepressants and placebo for persistent subthreshold depressive symptoms?

Why this is important

Persistent subthreshold depressive symptoms are increasingly recognised as affecting a considerable number of people and causing significant suffering, but the best way to treat it is not known. There are studies of the efficacy of antidepressants for dysthymia (persistent subthreshold depressive symptoms that have lasted for at least 2 years) but there is a lack of evidence for CBT. Subthreshold depressive symptoms of recent onset tend to improve but how long practitioners should wait before offering medication or psychological treatment is not known. This research recommendation is aimed at informing the treatment options available for this group of people with subthreshold depressive symptoms that persist despite low-intensity interventions.

This question should be answered using a randomised controlled trial design that reports short-term and medium-term outcomes (including cost-effectiveness outcomes) of at least 6 months' duration. A careful definition of persistence should be used which needs to include duration of symptoms and consideration of failure of low-intensity interventions and does not necessarily imply a full diagnosis of dysthymia. The outcomes chosen should reflect both observer and patient-rated assessments of improvement and an assessment of the acceptability of the treatment options. The study needs to be large enough to determine the presence or absence of clinically important effects using a non-inferiority design, and mediators and moderators of response should be investigated.

4.6 The efficacy of counselling compared with low-intensity cognitive behavioural interventions and treatment as usual in the treatment of persistent subthreshold depressive symptoms and mild depression

In persistent subthreshold depressive symptoms and mild depression, what is the efficacy of counselling compared with low-intensity cognitive behavioural interventions?

Why this is important

Psychological treatments are an important therapeutic option for people with subthreshold symptoms and mild depression. Low-intensity cognitive and behavioural interventions have the best evidence base for efficacy but the evidence is limited and longer-term outcomes are uncertain, as are the outcomes for counselling. It is therefore important to establish whether either of these interventions is an effective alternative to treatment as usual and should be provided in the NHS. The results of this study will have important implications for the provision of psychological treatment in the NHS.

This question should be answered using a randomised controlled trial design which reports short-term and medium-term outcomes (including cost-effectiveness outcomes) of at least 18 months'

duration. Particular attention should be paid to the reproducibility of the treatment model and training and supervision of those providing interventions in order to ensure that the treatments are both robust and generalisable. The outcomes chosen should reflect both observer and patient-rated assessments of improvement and an assessment of the acceptability of the treatment options. The study needs to be large enough to determine the presence or absence of clinically important effects using a non-inferiority design, and mediators and moderators of response should be investigated.

4.7 The efficacy of behavioural activation compared with CBT and antidepressants in the treatment of moderate to severe depression

In well-defined depression of moderate to severe severity, what is the efficacy of behavioural activation compared with CBT and antidepressants?

Why this is important

Psychological treatments are an important therapeutic option for people with depression. Behavioural activation is a promising treatment but does not have the substantial evidence base that CBT has. The availability of alternatives drawing from a different theoretical model is important because outcomes are modest even with the best supported treatments. It is therefore important to establish whether behavioural activation is an effective alternative to CBT and one that should be provided. The results of this study will have important implications for the provision of psychological treatment in the NHS.

This question should be answered using a randomised controlled trial design which reports short-term and medium-term outcomes (including cost-effectiveness outcomes) of at least 18 months' duration. Particular attention should be paid to the reproducibility of the treatment model and training and supervision of those providing interventions in order to ensure that the treatments are both robust and generalisable. The outcomes chosen should reflect both observer and patient-rated assessments of improvement and an assessment of the acceptability of the treatment options. The study needs to be large enough to determine the presence or absence of clinically important effects using a non-inferiority design, and mediators and moderators of response should be investigated.

4.8 The efficacy and cost effectiveness of different systems for the organisation of care for people with depression

In people with mild, moderate or severe depression, what system of care (stepped care versus matched care) is more clinically effective and cost effective in improving outcomes?

Why this is important

The best structures for the delivery of effective care for depression are poorly understood. Stepped-care models are widely implemented but the efficacy of this model compared with matched care is uncertain. Evidence on the relative benefits of the two approaches and the differential effects by depression severity is needed. The results of this study will have important implications for the structure of depression treatment services in the NHS.

This question should be answered using a randomised controlled trial design which reports short-term and medium-term outcomes (including cost-effectiveness outcomes) of at least 18 months' duration. In stepped care the majority of patients will first be offered a low-intensity intervention by a paraprofessional unless there are significant risk factors dictating otherwise. In matched care a comprehensive mental health assessment will determine which intervention a patient should receive. The full range of effective interventions (both psychological and pharmacological) should be made available in both arms of the trial. The outcomes chosen should reflect both observer and patient-rated assessments of improvement and an assessment of the acceptability of the treatment options. The study needs to be large enough to determine the presence or absence of clinically important effects, and moderators (including the severity of depression) of response should be investigated.

4.9 The efficacy and cost effectiveness of cognitive behavioural therapy, interpersonal therapy and antidepressants in prevention of relapse in people with moderate to severe recurrent depression

In people with moderate to severe recurrent depression, what is the relative efficacy of CBT, interpersonal therapy (IPT) and antidepressants in preventing relapse?

Why this is important

Psychological and pharmacological treatments are important therapeutic options for people with depression, but evidence on the prevention of relapse (especially for psychological interventions) is limited. All of these treatments have shown promise in reducing relapse but the relapse rate

remains high. New developments in the style and delivery of CBT and IPT show some promise in reducing relapse but need to be tested in a large-scale trial. The results of this study will have important implications for the provision of psychological treatment in the NHS.

This question should be answered using a randomised controlled trial design which reports short-term and medium-term outcomes (including cost-effectiveness outcomes) of at least 24 months' duration. Particular attention should be paid to the development and evaluation of CBT, IPT and medication interventions tailored specifically to prevent relapse, including the nature and duration of the intervention. The outcomes chosen should reflect both observer and patient-rated assessments of improvement and an assessment of the acceptability of the treatment options. The study needs to be large enough to determine the presence or absence of clinically important effects using a non-inferiority design, and mediators (including the focus of the interventions) and moderators (including the severity of the depression) of response should be investigated.

4.10 The effectiveness of maintenance ECT for relapse prevention in people with severe and recurring depression that does not respond to pharmacological or psychological interventions

Is maintenance ECT effective for relapse prevention in people with severe and recurring depression that does not respond to pharmacological or psychological interventions?

Why this is important

A small number of people do not benefit in any significant way from pharmacological or psychological interventions but do respond to ECT. However, many of these people relapse and need repeated treatment with ECT. This results in considerable suffering to them and it is also costly, because ECT often necessitates inpatient care. A small number of studies suggest possible benefits from maintenance ECT but it is used little in the NHS. The outcome of the audit and clinical trial should supply information on patient characteristics, outcomes, feasibility and acceptability in relation to the use of maintenance ECT and potentially inform its wider use in the NHS. The results therefore may have important implications for the provision of ECT in the NHS.

This question should be addressed through first establishing a national audit for the collection of data on all people receiving maintenance ECT. The characteristics of the people who are likely to be considered for maintenance ECT make a randomised controlled trial unfeasible, but a clinical trial using alternative methods (for example, mirror image or a carefully characterised non-randomised study) should be undertaken depending on the outcome of the audit.

The number of people receiving maintenance ECT is small, and considerable uncertainty surrounds its use, such as its long-term efficacy and acceptability and possible side effects, which include cognitive impairment. The outcomes chosen for the audit and clinical trial should reflect both observer and patient-rated assessments of improvement, the impact on cognitive function and an assessment of the acceptability of ECT as a maintenance treatment.

5 Other versions of this guideline

5.1 Full guideline

The full guideline, 'Depression: the treatment and management of depression in adults' contains details of the methods and evidence used to develop the guideline. It is published by the National Collaborating Centre for Mental Health, and is available from our website.

5.2 Information for the public

NICE has produced information for the public explaining this guideline.

We encourage NHS and voluntary sector organisations to use text from this information in their own materials about depression.

6 Related NICE guidance

Published

- Depression: the treatment and management of depression in adults (update). NICE clinical guideline 90 (2009).
- Borderline personality disorder. NICE clinical guideline 78 (2009).
- Medicines adherence. NICE clinical guideline 76 (2009).
- Antenatal and postnatal mental health. NICE clinical guideline 45 (2007).
- Bipolar disorder. NICE clinical guideline 38 (2006).
- Obsessive-compulsive disorder. NICE clinical guideline 31 (2005). CG31
- Depression in children and young people. NICE clinical guideline 28 (2005).
- Post-traumatic stress disorder (PTSD). NICE clinical guideline 26 (2005).
- Anxiety (amended). NICE clinical guideline 22 (2004; amended 2007). [Replaced by NICE clinical guideline 113]
- Vagus nerve stimulation for treatment-resistant depression. NICE interventional procedure guidance 330 (2009).

7 Update information

April 2016: Recommendation 1.10.5.1 has been deleted and replaced with a link to the NICE interventional procedure guidance on repetitive transcranial magnetic stimulation for depression.

Appendix A: The Guideline Development Group

Professor Ian Anderson (Chair, Guideline Development Group)
Professor of Psychiatry, University of Manchester

Professor Stephen Pilling
Joint Director, National Collaborating Centre for Mental Health; Director, Centre for Outcomes Research and Effectiveness, University College London.

Ms Alison Barnes
Service user member

Ms Linda Bayliss
Research Assistant (May 2008 to August 2008), National Collaborating Centre for Mental Health

Ms Victoria Bird
Research Assistant, National Collaborating Centre for Mental Health

Ms Rachel Burbeck
Lead Systematic Reviewer, National Collaborating Centre for Mental Health

Dr Carolyn Chew-Graham
General Practitioner, Senior Lecturer in Primary Care, University of Manchester

Mr Jeremy Clarke
Psychological therapist, Lambeth Primary care Trust

Mr Matthew Dyer
Health Economist, National Collaborating Centre for Mental Health

Ms Esther Flanagan
Project Manager (2009), National Collaborating Centre for Mental Health

Ms Catherine Harris
Carer member and Local Councillor

Ms Sarah Hopkins
Project Manager (until 2008), National Collaborating Centre for Mental Health

Dr Mark Kenwright
Consultant Cognitive Behavioural Psychotherapist; Ealing Cognitive Behavioural Therapy Service

Professor Willem Kuyken
Professor of Clinical Psychology and Co-Director Mood Disorders Centre, University of Exeter Psychology

Ms Angela Lewis
Research Assistant, National Collaborating Centre for Mental Health

Professor Glyn Lewis
Professor of Psychiatric Epidemiology, University of Bristol

Mr Ryan Li
Project Manager (2008), National Collaborating Centre for Mental Health

Mr Brendan Masterson
Clinical Nurse Leader, Affective Disorders Unit, Bethlem Royal Hospital

Dr Nick Meader
Systematic Reviewer, National Collaborating Centre for Mental Health

Mr Alan Meudell
Service user member, Healthy Minds at Work

Dr Alex Mitchell
Consultant Psychiatrist and Honorary lecturer in liaison psychiatry, University of Leicester

Dr Richard Moore
Clinical Psychologist, Cambridge

Dr Suffiya Omarjee
Health Economist, National Collaborating Centre for Mental Health

Ms Carol Paton
Chief Pharmacist, Oxleas NHS Foundation Trust

Dr Alejandra Perez
Systematic Reviewer, National Collaborating Centre for Mental Health

Ms Maria Rizzo
Research Assistant, National Collaborating Centre for Mental Health

Ms Peny Retsa
Health Economist (until 2008), National Collaborating Centre for Mental Health

Ms Jennie Robertson
Research Assistant (from September 2008), National Collaborating Centre for Mental Health

Mr Rob Saunders
Research Assistant, National Collaborating Centre for Mental Health (2008)

Ms Christine Sealey
Centre Manager, National Collaborating Centre for Mental Health

Ms Beth Shackleton
Project Manager, National Collaborating Centre for Mental Health (until 2008)

Dr Thomas Shackleton
General Practitioner, Suffolk

Ms Sarah Stockton
Senior Information Scientist, National Collaborating Centre for Mental Health

Dr Clare Taylor
Editor, National Collaborating Centre for Mental Health

Ms Jane Wood
Nurse, Strategic Development Manager, Mental Health, Leeds Primary Care Trust.

Appendix B: The Guideline Review Panel

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring adherence to NICE guideline development processes. In particular, the panel ensures that stakeholder comments have been adequately considered and responded to. The panel includes members from the following perspectives: primary care, secondary care, lay, public health and industry.

Mr Peter Robb (Chair)
Consultant Ear, Nose and Throat Surgeon, Epsom and St Helier University Hospitals and The Royal Surrey County NHS Trusts

Mr John Seddon
Lay member

Dr Christine Hine
Consultant in Public Health (Acute Commissioning), Bristol and South Gloucestershire Primary Care Trusts (PCTs)

Dr Greg Rogers
GP, Kent

Dr John Harley
Clinical Governance and Prescribing Lead and GP, North Tees PCT

Appendix C: Assessing depression and its severity

As set out in the introduction to this guideline, the assessment of depression is based on the criteria in DSM-IV. 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.

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

1. Factors that favour general advice and active monitoring:

- four or fewer of the above symptoms with little associated disability
- 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.

2. 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.

3. 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.

4. 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.

Depression definitions[18]

Subthreshold depressive symptoms: Fewer than 5 symptoms of depression.

Mild depression: Few, if any, symptoms in excess of the 5 required to make the diagnosis, and symptoms result in only minor functional impairment.

Moderate depression: Symptoms or functional impairment are between 'mild' and 'severe'.

Severe depression: Most symptoms, and the symptoms markedly interfere with functioning. Can occur with or without psychotic symptoms.

[18] These are taken from DSM-IV. ICD-10 is similar but the threshold for mild depression is lower at 4 symptoms.

Appendix D: Recommendations from NICE clinical guideline 23

The following recommendations have been taken from the previous NICE clinical guideline 23 'Management of depression in primary and secondary care'. Note that the evidence for these recommendations has not been updated. Any wording changes have been made for clarification only.

Recommendation number in updated NICE clinical guideline 90	Recommendation number in NICE clinical guideline 23
1.1.1.2	1.1.2.1/1.1.3.1/1.1.3.2
1.1.1.3	1.1.2.3
1.1.1.4	1.1.2.2
1.1.4.6	1.1.6.4/1.1.6.6
1.1.5.2	1.1.3.3
1.3.2.1	1.5.1.1
1.3.2.3	1.1.6.5
1.3.2.4	1.5.2.6/1.5.2.7
1.4.1.1	1.1.1.1
1.4.1.2	1.4.1.1
1.4.4.2	1.5.2.37/1.5.2.38
1.5.2.2	1.5.2.13/1.5.2.14
1.5.2.6	1.5.2.10
1.5.2.7	1.5.2.5
1.5.2.9	1.5.2.29
1.6.1.4	1.5.5.3/1.5.5.4
1.8.1.11	1.6.2.14
1.10.1.1	1.6.1.1
1.10.1.2	1.6.1.2
1.10.1.3	1.6.1.3

1.10.2.1	1.7.1.1
1.10.2.3	1.7.1.2
1.10.3.1	1.6.5.1

About this guideline

NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales.

The guideline was developed by the National Collaborating Centre for Mental Health. The Collaborating Centre worked with a group of healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

The methods and processes for developing NICE clinical guidelines are described in The guidelines manual.

This guideline is a partial update of NICE clinical guideline 23 (published December 2004 revised April 2007) and replaces it.

The recommendations from this guideline have been incorporated into a NICE Pathway. We have produced information for the public explaining this guideline. Tools to help you put the guideline into practice and information about the evidence it is based on are also available.

Your responsibility

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

Copyright

Accreditation