NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Guideline

Depression in adults

Draft for consultation, November 2021

This guideline covers identifying, treating and managing depression in people aged 18 and over. It recommends treatments for first episodes of depression, further-line treatments and provides advice on preventing relapse and managing chronic depression, psychotic depression and depression with a coexisting diagnosis of personality disorder.

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

Who is it for?

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

What does it include?

- the recommendations
- recommendations for research
- rationale and impact sections that explain why the committee made the 2021 recommendations and how they might affect practice
- the guideline context.

Information about how the guideline was developed is on the guideline's webpage. This includes the evidence reviews, the scope, details of the committee and any declarations of interest.

New and updated recommendations

We have reviewed the evidence on the treatment of new depressive episodes, further-line treatment, treatment of chronic depression, psychotic depression, and depression with a coexisting diagnosis of personality disorder, preventing relapse, patient choice and the organisation of and access to services. You are invited to comment on the new and updated recommendations in this guideline. These are marked as **[2021]**.

You are also invited to comment on recommendations that we propose to delete from the 2009 guideline.

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

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

Full details of the evidence and the committee's discussion on the 2021 recommendations are in the evidence reviews. Evidence for the 2009 recommendations is in the full version of the 2009 guideline.

The recommendations in this guideline were mainly developed before the COVID-19 pandemic. Please tell us if there are any particular issues relating to COVID-19 that we should take into account when finalising the guideline for publication.

Contents

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

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

1.1 Principles of care

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 choices (see recommendations on choice of treatments) 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
- be aware that the symptoms of depression itself, and the impact of stigma, can make it difficult for people to access mental health services or take up offers of treatment. Ensure steps are taken to reduce stigma and barriers for individuals seeking help for depression.
- ensure that discussions take place in settings in which confidentiality, privacy and dignity are respected. **[2009, amended 2021]**

Providing information and support

1.1.2 Make sure people with depression are aware of self-help groups, support groups and other local and national resources. Follow the guidance on

providing information in the NICE guideline on service user experience in adult mental health. **[2009, amended 2021]**

1.1.3 Provide people with depression with up to date and evidence-based verbal and written information. Follow the NICE guideline on patient experience in adult NHS services. **[2021]**

Advance decisions and statements

1.1.4 Consider developing advance decisions about treatment choices (including declining treatment) and advance statements collaboratively with people who have recurrent severe depression or depression with psychotic symptoms, and for those who have been treated under the Mental Health Act 2007, in line with the Mental Capacity Act 2005. Record the decisions and statements and include copies in the person's care plan in primary and secondary care, and give copies to the person and to their family or carer, if the person agrees. **[2009, amended 2021]**

1.1.5 Advise people with depression that they can set up a Health and Welfare Lasting Power of Attorney, so that a trusted person can represent their interests and make decisions on their behalf if, at any stage, they do not have the capacity to make decisions themselves. **[2021]**

Supporting families and carers

1.1.6 When families or carers are involved in supporting a person with severe or chronic depression, see the recommendations in the NICE guideline on supporting adult carers on identifying, assessing and meeting the caring, physical and mental health needs of families and carers. **[2009, amended 2021]**

1.2 Recognition and assessment

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

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

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

1.2.3 If a person answers 'yes' to either of the depression identification questions (see recommendation **Error! Reference source not found.**) and the practitioner is competent to perform a mental health assessment, review the person's mental state and associated functional, interpersonal and social difficulties. **[2009]**

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

1.2.5 If a person has language or communication difficulties (for example, people with sensory or cognitive impairments or autism), to help identify possible depression consider:

- asking a family member or carer about the person's symptoms
- asking the person about their symptoms directly, using the appropriate method of communication depending on the person's needs (for example, using a British Sign Language interpreter, English interpreter, or augmentative and alternative communication).

See also the NICE guidelines on mental health problems in people with learning disabilities and autism spectrum disorder in adults. **[2009, amended 2021]**

Initial assessment

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

1.2.7 Discuss with the person how the factors below may have affected the development, course and severity of their depression in addition to assessing symptoms and associated functional impairment:

- any history of depression and coexisting mental health or physical disorders
- any history of mood elevation (to determine if the depression may be part of bipolar disorder). See the NICE guideline on bipolar disorder.
- any past experience of, and response to, previous treatments
- difficulties with previous and current interpersonal relationships
- living conditions, drug and alcohol use, debt, employment situation and social isolation. **[2009, amended 2021]**

Risk assessment

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

- assess whether the person has adequate social support and is aware of sources of help
- arrange help appropriate to the level of need
- advise the person to seek further help if the situation deteriorates. **[2009]**

1.2.9 If a person with depression presents considerable immediate risk to themselves or others, refer them urgently to specialist mental health services. **[2009]**

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

- ensure that the person knows how to seek help promptly
- review the person's treatment if they develop marked and/or prolonged agitation. **[2009]**

1.2.11 Advise a person with depression and their family or carer to be vigilant for mood changes, agitation, 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. **[2009, amended 2021]**

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

- do not withhold treatment for depression on the basis of their suicide risk
- take into account toxicity in overdose if an antidepressant is prescribed, or the person is taking other medication, and if necessary limit the amount of medicine available
- consider increasing the level of support provided, such as more frequent face-to-face or telephone contacts
- consider referral to specialist mental health services.

For further advice on risk assessment see the NICE guideline on self-harm. For further advice on medication see the recommendations on Antidepressant medication for people at risk of suicide. **[2009, amended 2021]**

Depression with anxiety

1.2.13 When depression is accompanied by symptoms of anxiety, the first priority should usually be to treat the depression. When the person has an anxiety disorder and comorbid depression or depressive symptoms, consult NICE guidance for the relevant anxiety disorder if available and consider treating the anxiety disorder first. **[2009]**

Depression in people with acquired cognitive impairments

1.2.14 When assessing a person with suspected depression:

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

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

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

1.3 Choice of treatments

1.3.1 Discuss with people with depression:

- what, if anything, they think might be contributing to the development of their depression (see recommendation 1.2.7)
- whether they have ideas or preferences about starting treatment, and what treatment options they might prefer
- the person's experience of any prior episodes of depression or treatments for depression
- what they would expect to gain from treatment. **[2021]**

1.3.2 Allow adequate time for the initial discussion about treatment options, and involve family members, carers or other supporters if requested by the person with depression. **[2021]**

1.3.3 Build a trusting relationship with the person with depression and facilitate continuity of care by:

- ensuring they can see the same healthcare professional wherever possible

- recording their views and preferences so that other practitioners are aware of these details. **[2021]**

1.3.4 Discuss with people with depression their preferences for treatments (including declining an offer of treatment) by providing:

- information on what treatments are available, their potential benefits and harms, any waiting times for treatments, and the expected outcomes
- a choice of:
  - the treatments recommended in this guideline
  - how they will be delivered (for example individual or group, face-to-face or remotely) **and**
  - where they will be delivered
- the option to express a preference for the gender of the healthcare professional, to see a professional they already have a good relationship with, or to change professional if the relationship is not working. **[2021]**

1.3.5 Make a shared decision with the person about their treatment. See the NICE guideline on shared decision making. **[2021]**

1.3.6 Commissioners and services should ensure that people can express a preference for NICE-recommended treatments, that those treatments are available in a timely manner, particularly in severe depression, and that access to them is monitored. **[2021]**

For a short explanation of why the committee made this recommendation/these recommendations see the rationale and impact section on choice of treatments.

Full details of the evidence and the committee's discussion are in evidence review I: Choice of treatments.

1.4 Delivery of treatments

All treatments

1.4.1 When considering treatments for people with depression, make sure the following are carried out:

- an assessment of need
- the development of a treatment plan
- consideration of any physical health problems
- consideration of any coexisting mental health problems
- regular liaison between healthcare professionals in specialist and non-specialist settings, if the person is receiving specialist support or treatment.

For people with depression who also have learning disabilities, see the advice in the NICE guideline on mental health problems in people with learning disabilities. For people with depression who also have autism, see the advice in the NICE guideline on autism spectrum disorder. For people with depression who also have dementia, see the advice in the NICE guideline on dementia. **[2021]**

1.4.2 For all treatments for people with depression:

- review how well the treatment is working with the person between 2 and 4 weeks after starting treatment
- monitor and evaluate treatment concordance
- monitor for side effects and harms of treatment
- monitor suicidal ideation particularly in the early weeks of treatment (see also the recommendations on antidepressant medication for people at risk of suicide and recommendations on risk assessment)
- consider routine outcome monitoring (using appropriate validated sessional outcome measures) and follow up. **[2009, amended 2021]**

Psychological and psychosocial interventions

1.4.3 Inform people if there are waiting lists and how long the wait is likely to be. Ensure people are kept informed, are aware of how to access help if their condition worsens, and consider providing self-help material in the interim. **[2021]**

1.4.4 Use psychological and psychosocial treatment manuals to guide the form and length of interventions. **[2009]**

1.4.5 Consider using competence frameworks developed from treatment manual(s) for psychological and psychosocial interventions to support the effective training, delivery and supervision of interventions. **[2009]**

1.4.6 All healthcare professionals delivering interventions for people with depression should:

- receive regular supervision
- have their competence monitored and evaluated. This could include their supervisor reviewing video and audio recordings of their work (with patient consent). **[2009]**

Pharmacological treatments

Starting antidepressant medication

1.4.7 When offering a person medication for the treatment of depression:

- explain the reasons for offering medication
- discuss the benefits, covering what improvements the person would like to see in their life and how the medication may help
- discuss the harms, covering both the possible side effects and withdrawal effects, including any side effects they would particularly like to avoid (for example, weight gain, sedation)
- discuss any concerns they have about taking or stopping the medication (also see the recommendations on stopping medication)

- make sure they have written information to take away and review that is appropriate for their needs. **[2021]**

1.4.8 When prescribing antidepressant medication, ensure people have information about:

- how they may be affected when they first start taking antidepressant medication, and what these effects might be
- how long it takes to see an effect (usually, if the antidepressant medication is going to work, within 4 weeks)
- when their first review will be - this will usually be within 2 to 4 weeks to check their symptoms are improving and for side effects, or after 1 week if a new prescription for a person under 25 years old or if there is a particular concern for risk of suicide (see recommendations on antidepressant medication for people at risk of suicide)
- the importance of following instructions on how to take antidepressant medication (for example, time of day, interactions with other medicines and alcohol)
- why regular monitoring is needed, and how often they will need to attend for review
- how they can self-monitor their symptoms, and how this may help them feel involved in their own recovery
- that treatment might need to be taken for at least 6 months after the remission of symptoms, but should be reviewed regularly
- how some side effects may persist throughout treatment
- withdrawal symptoms and how these withdrawal effects can be minimised. See also the recommendations on stopping antidepressant medication. **[2021]**

1.4.9 For further advice on safe prescribing of antidepressants, see the NICE guideline on safe prescribing (forthcoming). For further advice on the safe and effective use of medicines for people taking 1 or more medicines see the NICE guideline on medicines optimisation. **[2021]**

Stopping antidepressant medication

1.4.10 Advise people taking antidepressant medication to talk with the person who prescribed their medication (for example, their GP or mental health professional) if they want to stop taking it. Explain that it is usually necessary to reduce the dose in stages over time (called 'tapering') but that most people stop antidepressants successfully. **[2021]**

1.4.11 Advise people taking antidepressant medication that if they stop taking it abruptly, miss doses or do not take a full dose, they may have withdrawal symptoms such as:

- restlessness or agitation
- problems sleeping
- altered feelings (for example, suicidal thoughts, irritability, anxiety, low mood tearfulness, panic attacks, irrational fears, or confusion)
- unsteadiness, vertigo or dizziness
- sweating
- abdominal symptoms (for example, nausea)
- altered sensations (for example, electric shock sensations)
- palpitations, tiredness, headaches, and aches in joints and muscles. **[2021]**

1.4.12 Explain that withdrawal symptoms can be mild, appear within a few days of reducing or stopping antidepressant medication, and go away within 1 to 2 weeks. However, they can last longer (in some cases, several weeks, occasionally several months) and can sometimes be severe, particularly if the antidepressant medication is stopped suddenly. **[2021]**

1.4.13 Recognise that people may have fears and concerns about stopping their antidepressant medication (for example, the withdrawal effects they may experience, or that their depression will return) and may need support to withdraw successfully, particularly if previous attempts have led to withdrawal symptoms or have not been successful. This could include:

- details of online or written resources that may be helpful

- support from a clinician or therapist (for example, regular check-in phone calls, seeing them more frequently, providing advice about sleep hygiene). **[2021]**

1.4.14 When stopping a person's antidepressant medication:

- take into account the pharmacokinetic profile (for example, the half-life of the medication as antidepressants with a short half-life will need to be tapered more slowly) and the duration of treatment
- slowly reduce the dose to a proportion of the previous dose (for example, prescribe 75% or 50% of the previous dose), rather than by a fixed dose reduction
- use liquid preparations if necessary to allow slow tapering, once small doses have been reached
- ensure the speed and duration of withdrawal is led by and agreed with the person taking the prescribed medication, ensuring that any withdrawal symptoms have resolved before making the next dose reduction
- take into account the broader clinical context such as the potential benefit of more rapid withdrawal where there are significant side effects
- recognise that withdrawal may take weeks or months to complete successfully. **[2021]**

1.4.15 Monitor and review people taking antidepressant medication while their dose is being reduced. Base the frequency of monitoring on the person's clinical and support needs. **[2021]**

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

- withdrawal symptoms can be experienced with a wide range of antidepressant medication [including tricyclic antidepressants (TCAs), selective serotonin reuptake inhibitors (SSRIs), serotonin

and norepinephrine reuptake inhibitors (SNRIs), and monoamine oxidase inhibitors (MAOIs)]

- some commonly used antidepressants such as paroxetine and venlafaxine, are more likely to be associated with withdrawal symptoms, so particular care is needed with them
- fluoxetine's prolonged duration of action means that it can sometimes be safely stopped over a shorter period
  - in people taking 20 mg fluoxetine a day, a period of alternate day dosing can provide a suitable dose reduction
  - in people taking higher doses (40 mg to 60 mg fluoxetine a day), use a gradual withdrawal schedule. **[2021]**

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

- these symptoms are common
- relapse does not usually happen as soon as you stop taking an antidepressant medication or lower the dose
- even if they start taking an antidepressant medication again or increase their dose, the withdrawal symptoms may take a few days to disappear. **[2021]**

1.4.18 If a person has mild withdrawal symptoms when they stop taking antidepressant medication:

- monitor their symptoms
- reassure them that such symptoms are common and usually time-limited
- advise them to contact the person who prescribed their medication (for example, their GP or mental health professional) if the symptoms do not improve, or if they get worse. **[2021]**

1.4.19 If a person has more severe withdrawal symptoms, consider restarting the original antidepressant medication at the previous dose, and then attempt

dose reduction at a slower rate with smaller decrements after symptoms have resolved. **[2021]**

1.4.20 For further advice on stopping antidepressants see also the NICE guideline on safe prescribing (forthcoming).

For a short explanation of why the committee made these recommendations see the rationale and impact section on starting and stopping antidepressant medication.

Full details of the evidence are in evidence reviews for the NICE guideline on safe prescribing (evidence review A: patient information; evidence review B: prescribing strategies; evidence review C: safe withdrawal; evidence review D: withdrawal symptoms; evidence review F: monitoring).

Antidepressant medication for people at risk of suicide

1.4.21 When prescribing antidepressant medication for people with depression who are under 25 years or are thought to be at increased risk of suicide:

- be aware of the possible increased prevalence of suicidal thoughts, self-harm and suicide in the early stages of antidepressant treatment
- review them 1 week after starting the antidepressant medication or increasing the dose for suicidality (ideally in-person, or by video call, or by telephone if in-person or video are not possible or not preferred)
- review them after this as often as needed, but no later than 4 weeks after the appointment at which the antidepressant was started
- base the frequency and method of ongoing review on their circumstances (for example, the availability of support, unstable housing, new life events such as bereavement, break-up of a relationship, loss of employment), and any changes in suicidal ideation or assessed risk of suicide. **[2009, amended 2021]**

1.4.22 Take into account toxicity in overdose when prescribing an antidepressant medication for people at significant risk of suicide. Do not routinely start treatment with TCAs, except lofepramine, as they are associated with the greatest risk in overdose. **[2009, amended 2021]**

Antidepressant medication for older people

1.4.23 When prescribing antidepressant medication for older people:

- take into account the person's general physical health, comorbidities and possible interactions with any other medicines they may be taking
- carefully monitor the person for side effects (for example, hyponatraemia).

See also the NICE guideline on dementia. **[2009, amended 2021]**

Use of lithium

1.4.24 For people with depression taking lithium, in particular older people assess weight, renal and thyroid function and calcium levels before treatment and then monitor every 3 to 6 months during treatment, or more often if there is evidence of renal impairment. **[2009, amended 2021]**

1.4.25 Monitor serum lithium levels 12 hours post dose, 1 week after starting treatment and after each dose change. Adjust the dose according to serum levels until the target level is reached.

- when the dose is stable, monitor every 3 months for the first year
- after the first year, measure plasma lithium levels every 6 months, or every 3 months for people in any of the following groups:
  - older people
  - people taking medicines that interact with lithium
  - people who are at risk of impaired renal or thyroid function, raised calcium levels or other complications
  - people who have poor symptom control
  - people with poor adherence

- people whose last plasma lithium level was 0.8 mmol per litre or higher. **[2021]**

1.4.26 Determine the dose of lithium according to response and tolerability:

- plasma lithium levels should not exceed 1.0 mmol/l (therapeutic levels for augmentation of antidepressant medication are usually at or above 0.4 mmol/l; consider levels 0.4 to 0.6 mmol/l for older people)
- do not start repeat prescriptions until lithium levels and renal function are stable
- take into account a person's overall physical health when reviewing test results (including possible dehydration or infection)
- take into account any changes to concomitant medication (for example, angiotensin-converting enzyme inhibitors, angiotensin II receptor blockers, diuretics and NSAIDs, or over-the-counter preparations) which may affect lithium levels, and seek specialist advice if necessary
- monitor at each review for signs of lithium toxicity, including diarrhoea, vomiting, coarse tremor, ataxia, confusion, and convulsions
- seek specialist advice if there is uncertainty about the interpretation of any test results. **[2021]**

1.4.27 Manage lithium prescribing under shared care arrangements. If there are concerns about older people, manage their lithium prescribing in specialist secondary care services. **[2021]**

1.4.28 Consider ECG monitoring in people taking lithium who have a high risk of, or existing, cardiovascular disease. **[2009]**

1.4.29 Provide people taking lithium with information on how to do so safely, including the NHS lithium treatment pack. **[2021]**

1.4.30 Only start lithium withdrawal in specialist mental health services, or under their supervision. Reduce doses gradually and in proportion to the length of use. **[2021]**

For a short explanation of why the committee made these recommendations see the rationale and impact section on use of lithium.

Use of antipsychotics

In November 2021, use of antipsychotics for the treatment of depression was an off-label use for some antipsychotics. See NICE's information on prescribing medicines.

1.4.31 For people who receive an antipsychotic for the treatment of their depression consider what monitoring is needed. This may include:

- assessing their pulse and blood pressure, weight, nutritional status, diet, level of physical activity, fasting blood glucose or HbA1c and fasting lipids before they start taking antipsychotics
- considering monitoring full blood count, urea and electrolytes, liver function tests and prolactin, as specified for individual drugs
- monitoring their weight weekly for the first 6 weeks, then at 12 weeks, 1 year and annually
- monitoring their fasting blood glucose or HbA1c and fasting lipids at 12 weeks, 1 year, and then annually
- considering ECG monitoring (at baseline and when final dose is reached) for people with established cardiovascular disease or a specific cardiovascular risk (such as diagnosis of high blood pressure) and for those taking other medicines known to prolong the cardiac QT interval (for example, citalopram or escitalopram)
- at each review, monitoring for adverse effects, including extrapyramidal effects (for example, tremor, parkinsonism) and prolactin-related side effects (for example, sexual or menstrual disturbances) and reducing the dose if necessary

- being aware of any possible drug interactions which may increase the levels of some antipsychotics, and monitoring and adjusting doses if necessary
- if there is rapid or excessive weight gain, or abnormal lipid or blood glucose levels, investigating and managing as needed. **[2021]**

1.4.32 Manage antipsychotic prescribing under shared care arrangements**.** **[2021]**

1.4.33 For people with depression who are taking an antipsychotic medication, consider at each review whether to continue the antipsychotic medication based on current physical and mental health risks. **[2021]**

1.4.34 Only start antipsychotic withdrawal in specialist mental health services, or under their supervision. Reduce doses gradually and in proportion to the length of treatment. **[2021]**

For a short explanation of why the committee made these recommendations see the rationale and impact section on use of antipsychotics.

Use of light therapy

1.4.35 Advise people with winter depression that follows a seasonal pattern and who wish to try light therapy in preference to antidepressant medication or psychological treatment that the evidence for the efficacy of light therapy is uncertain. **[2009]**

1.5 Treatment for a new episode of less severe depression

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

Active monitoring in people who do not want treatment

1.5.1 For people with less severe depression who do not want treatment or people who feel that their depressive symptoms are improving:

- discuss the presenting problem(s) and any underlying vulnerabilities and risk factors, as well as any concerns that the person may have
- make sure the person knows they can change their mind and how to seek help
- provide information about the nature and course of depression
- arrange a further assessment, normally within 2 weeks
- make contact (with repeated attempts if necessary), if the person does not attend follow-up appointments. **[2009, amended 2021]**

Treatment for people with a new episode of less severe depression

1.5.2 Discuss treatment options with people who have a new episode of less severe depression, and:

- use Table 1 and the visual summary to guide and inform the conversation
- reach a shared decision on treatment choice, based on their clinical needs and preferences (see also the recommendations on choice of treatments)
- take into account that all treatments in Table 1 can be used as first-line treatments
- recognise that people have a right to decline treatment. **[2021]**

1.5.3 Do not routinely offer antidepressant medication as first-line treatment for less severe depression, unless that is the person's preference. **[2021]**

Table 1. Treatment options for less severe depression listed in order of recommended use, based on the committee's interpretation of their clinical and cost effectiveness.

Treatment	How is this delivered?	Key features	Other things to think about
Group cognitive behavioural therapy (CBT)	• A group intervention delivered by 2 practitioners with therapy-specific	• Focuses on how thoughts, beliefs, attitudes, feelings and behaviour	• May be helpful for people who can recognise negative thoughts or unhelpful patterns of

Treatment	How is this delivered?	Key features	Other things to think about
	training and competence • Usually consists of 8 weekly sessions of 90 minutes each • Usually 8 participants in the group • Delivered in line with current treatment manuals	interact, and teaches coping skills to deal with things in life differently • Goal-oriented and structured • Focuses on resolving current issues	behaviour they wish to change • May allow peer support from others who may be having similar experiences • Avoids potential side effects of medication • The person will need to be willing to complete homework assignments • May help prevent future episodes of depression for 1 to 2 years after treatment
Group behavioural activation (BA)	• A group intervention delivered by 2 practitioners with therapy-specific training and competence • Usually consists of 8 weekly sessions of 90 minutes each • Usually 8 participants in the group • Delivered in line with current treatment manuals	• Focuses on identifying the link between an individual's activities and their mood. Helps the person to recognise patterns and plan practical changes that reduce avoidance and focus on behaviours that are linked to improved mood. • Goal-oriented and structured • Focuses on resolving current issues • Does not directly target thoughts and feelings	• May be helpful for people whose depression has led to social withdrawal, doing fewer things, inactivity, or has followed a change of circumstances or routine • May allow peer support from others who may be having similar experiences • Avoids potential side effects of medication • The person will need to be willing to complete homework assignments
Individual CBT	• Individual intervention delivered by a practitioner with therapy-specific	• Focuses on how thoughts, beliefs, attitudes, feelings and	• May be helpful for people who can recognise negative thoughts or unhelpful patterns of

Treatment	How is this delivered?	Key features	Other things to think about
	training and competence • Usually consists of 8 weekly or bi-weekly sessions of 60 minutes each • Delivered in line with current treatment manuals	behaviour interact, and teaches coping skills to deal with things in life differently • Goal-oriented and structured • Focuses on resolving current issues	behaviour they wish to change • May suit people who do not like talking about their depression in a group • No opportunity to receive peer support from others who may be having similar experiences • Avoids potential side effects of medication • The person will need to be willing to complete homework assignments • May help prevent future episodes of depression for 1 to 2 years after treatment
Individual BA	• Individual intervention delivered by a practitioner with therapy-specific training and competence • Usually consists of 8 weekly or bi-weekly sessions of 60 minutes each • Delivered in line with current treatment manuals	• Focuses on identifying the link between an individual's activities and their mood. Helps the person to recognise patterns and plan practical changes that reduce avoidance and focus on behaviours that	• May be helpful for people whose depression has led to social withdrawal, doing fewer things, inactivity, or has followed a change of circumstances or routine • May suit people who do not like talking about their depression in a group • No opportunity to receive peer support from others who may be having similar experiences • Avoids potential side effects of medication • The person will need to be willing to

Treatment	How is this delivered?	Key features	Other things to think about
		are linked to improved mood. • Goal-oriented and structured • Focuses on resolving current issues • Does not directly target thoughts and feelings	complete homework assignments
Self-help with support	• Printed or digital materials that follow the principles of structured CBT • Support from a trained practitioner who facilitates the self-help intervention, encourages completion and reviews progress and outcomes • Usually consists of 8 structured sessions (face-to-face or by telephone or online), with an initial session of up to 30 minutes and further sessions of up to 15 minutes • Usually takes place over 16 weeks	• Focuses on how thoughts, beliefs, attitudes, feelings and behaviour interact, and teaches coping skills to deal with things in life differently • Goal-oriented and structured • Focuses on resolving current issues	• May suit people who do not like talking about their depression in a group • Needs self-motivation and willingness to work alone (although regular support is provided) • Allows flexibility in terms of fitting sessions in around other commitments • Need to consider access, and ability to engage with computer programme for digital formats • Less capacity for individual adaptations than individual psychological treatments • Avoids potential side effects of medication
Group exercise	• A group physical activity intervention provided by a trained practitioner • Uses a physical activity programme	• Includes moderate intensity aerobic exercise • Does not directly target thoughts and feelings	• May allow peer support from others who may be having similar experiences • May need to be adapted if the person has physical health problems that

Treatment	How is this delivered?	Key features	Other things to think about
	specifically designed for people with depression • Usually consists of 60 minute sessions, usually 3 times a week for 10 weeks • Usually 8 participants in the group		make it difficult to exercise • Needs a considerable time commitment • Can help with physical health too • Avoids potential side effects of medication
Group mindfulness or meditation	• A group intervention provided by 2 trained practitioners • Uses a programme such as mindfulness-based cognitive therapy specifically designed for people with depression • Usually consists of 8 weekly sessions of 2 hours each • Usually 8 participants in the group	• Focus is on concentrating on the present, observing and sitting with thoughts and feelings and bodily sensations, and breathing exercises • Involves increasing awareness and recognition of thoughts and feelings, rather than on changing them • Does not directly help with relationship, employment or other stressors that may contribute to your depression	• May be helpful for people who want to develop a different relationship or perspective on negative thoughts, feelings or body sensations • May be difficult for people experiencing intense or highly distressing thoughts, or who find focusing on the body difficult • May allow peer support from others who may be having similar experiences • Avoids potential side effects of medication • The person will need to be willing to complete homework assignments, including using mindfulness recordings from home in between sessions
Interpersonal psychotherapy (IPT)	• Individual sessions delivered by a	• Focus is on identifying how interpersonal relationships or circumstances are related to feelings of	May be helpful for people with depression associated with interpersonal difficulties, especially

Treatment	How is this delivered?	Key features	Other things to think about
	trained practitioner • Usually consists of up to 16 weekly sessions, of 60 minutes each • Delivered in line with current treatment manuals	depression, exploring emotions and changing interpersonal responses • Structured approach • Focuses on resolving current issues • The goal is to change relationship patterns rather than directly targeting associated depressive thoughts	adjusting to transitions in relationships, loss, or changing interpersonal roles • May suit people who do not like talking about their depression in a group • Needs a willingness to examine interpersonal relationships • Avoids potential side effects of medication
Selective serotonin reuptake inhibitors (SSRIs)	• A course of antidepressant medication • Usually taken for at least 6 months (including after symptoms remit) • See the recommendations on starting and stopping antidepressant medication for more details	• Increases levels of chemical transmitters in the brain • Does not directly target thoughts	• Minimal time commitment although regular reviews needed (especially when starting and stopping treatment) • Benefits should be felt within 4 weeks • There may be side effects from the medication, and some people may find it difficult to later stop antidepressant medication
Counselling	• Individual sessions delivered by a practitioner with therapy-specific training and competence • Usually consists of 8 weekly sessions, of 60 minutes each • Uses an empirically	• Focus is on emotional processing and finding emotional meaning as the route to lasting change, to help people find their own solutions and develop	• May be useful for people with psychosocial, relationship or employment problems contributing to their depression • May suit people who do not like talking about their

Treatment	How is this delivered?	Key features	Other things to think about
	validated protocol developed specifically for depression	coping mechanisms • Provides empathic listening, facilitated emotional exploration and encouragement • Collaborative use of emotion focused activities to increase self-awareness, to help people gain greater understanding of themselves, their relationships, and their responses to others, but not specific advice to change behaviour	depressionin a group • Avoids potential side effects of medication
Short-term psychodynamic psychotherapy (STPP)	• Individual sessions delivered by a practitioner with therapy-specific training and competence • Usually consists of up to 16 weekly sessions of 50-60 minutes each • Uses an empirically validated protocol developed specifically for depression	• Focus is on recognising difficult feelings in significant relationships and stressful situations, and identifying how patterns can be repeated. Creates a safe space to explore painful feelings, and engender possibilities for change • Both insight-oriented and affect focused • Relationship between therapist and patient is included as a	• May be useful for people with emotional and developmental difficulties in relationships contributing to their depression • May be less suitable for people who do not want to focus on their own feelings, or who do not wish or feel ready to discuss any close and/or family relationships • May suit people who do not like talking about their

Treatment	How is this delivered?	Key features	Other things to think about
		focus to help support working through key current conflicts	depressionin a group • Focusing on painful experiences in close and/or family relationships could initially be distressing • Avoids potential side effects of medication

For a short explanation of why the committee made these recommendations see the rationale and impact section on treatment of less severe depression.

Full details of the evidence and the committee's discussion are in evidence review B: Treatment of a new episode of depression.

Treatments not recommended for less severe depression

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

- 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.
- not prescribe or advise its use by people with depression because of uncertainty about appropriate doses, persistence of effect, variation in the nature of preparations and potential serious interactions with other drugs (including hormonal contraceptives, anticoagulants and anticonvulsants). **[2009]**

1.6 Treatment for a new episode of more severe depression

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

Treatment for people with a new episode of more severe depression

1.6.1 Discuss treatment options with people who have a new episode of more severe depression, and:

- use table 2 and the visual summary to guide and inform the conversation
- reach a shared decision on treatment choice, based on their clinical needs and preferences (see also the recommendations on choice of treatments)
- take into account that all treatments in table 2 can be used as first-line treatments
- recognise that people have a right to decline treatment. **[2021]**

Table 2. Treatment options for more severe depression listed in order of recommended use, based on the committee's interpretation of their clinical and cost effectiveness.

Treatment	How is this delivered?	Key features	Other things to think about
Combination of individual cognitive behavioural therapy (CBT) and an antidepressant	• A combination of individual CBT and a course of antidepressant medication (see details below)	• Combines the benefits of regular CBT sessions with a therapist and medication	• Sessions with a therapist provide immediate support while the medication takes time to work • There may be side effects from the medication, and some people may find it difficult to later stop antidepressant medication
Individual CBT	• Individual intervention delivered by a practitioner with therapy-specific training and competence • Usually consists of 12 to 16 weekly or	• Focuses on how thoughts, beliefs, attitudes, feelings and behaviour interact, and teaches coping skills to deal with	• May be helpful for people who can recognise negative thoughts or unhelpful patterns of

Treatment	How is this delivered?	Key features	Other things to think about
	bi-weekly sessions of 60 minutes each • Delivered in line with current treatment manuals	things in life differently. • Goal-oriented and structured • Focuses on resolving current issues	behaviour they wish to change • Avoids potential side effects of medication • The person will need to be willing to complete homework assignments • May help prevent future episodes of depression for 1 to 2 years after treatment
Individual behavioural activation (BA)	• Individual intervention delivered by a practitioner with therapy-specific training and competence • Usually consists of 12 to 16 weekly or bi-weekly sessions, of 60 minutes each • Delivered in line with current treatment manuals	• Focuses on identifying the link between an individual's activities and their mood. Helps the person to recognise patterns and plan practical changes that reduce avoidance and focus on behaviours that are linked to improved mood. • Goal-oriented and structured • Focuses on resolving current issues • Does not directly target thoughts and feelings	• May be helpful for people whose depression has led to social withdrawal, doing fewer things, inactivity, or has followed a change of circumstances or routine • May suit people who do not like talking about their depression in a group • No opportunity to receive peer support from others who may be having similar experiences • Avoids potential side effects of medication • The person will need to be willing to complete homework assignments
Antidepressant medication	• Usually taken for at least 6 months (and for some time	• SSRIs are generally well tolerated and safe in overdose and should be	• Choice of treatment will depend on preference for specific

Treatment	How is this delivered?	Key features	Other things to think about
	after symptoms remit) • Can be a SSRI, SNRI, or other antidepressant if indicated based on previous clinical and treatment history • See the recommendations on starting and stopping antidepressant medication for more details	considered as the first choice for most patients • TCAs (particularly amitriptyline and dosulepin) have safety concerns, and lofepramine has the best safety profile • Does not directly target thoughts	medication effects such as sedation, concomitant illnesses or medications, suicide risk and previous history of response to antidepressant medicines • Minimal time commitment, although regular reviews needed (especially when starting and stopping treatment) • Benefits should be felt within 4 weeks • There may be side effects from the medication, and some people may find it difficult to later stop antidepressant medication
Individual problem-solving	• Individual sessions delivered by a practitioner with therapy-specific training and competence • Usually first session is 1 hour and then 8 weekly sessions of 30 minutes each • Delivered in line with current treatment manuals	• Focus is on identifying problems, generating alternative solutions, selecting the best option, developing a plan and evaluating whether it has helped solve the problem • Goal-oriented and structured • Focuses on resolving current issues	• May be helpful for people who want to tackle current difficulties and improve future experiences • Avoids potential side effects of medication • The person will need to be willing to complete homework assignments
Counselling	• Individual sessions delivered by a	• Focus is on emotional	• May be useful for people with

Treatment	How is this delivered?	Key features	Other things to think about
	practitioner with therapy-specific training and competence • Usually consists of 12 to 16 weekly sessions of 60 minutes each • Uses an empirically validated protocol developed specifically for depression	processing and finding emotional meaning as the route to lasting change, to help people find their own solutions and develop coping mechanisms • Provides empathic listening, facilitated emotional exploration and encouragement • Collaborative use of emotion focused activities to increase self-awareness, to help people gain greater understanding of themselves, their relationships, and their responses to others, but not specific advice to change behaviour	psychosocial, relationship or employment problems contributing to their depression • May suit people who do not like talking about their depression in a group • Avoids potential side effects of medication
Short-term psychodynamic psychotherapy (STPP)	• Individual sessions delivered by a practitioner with therapy-specific training and competence • Usually consists of 16 weekly sessions of 50-60 minutes each • Uses an empirically validated protocol developed specifically for depression	• Focus is on recognising difficult feelings in significant relationships and stressful situations, and identifying how patterns can be repeated. Creates a safe space to explore painful feelings, and engender	• May be useful for people with emotional and developmental difficulties in relationships contributing to their depression • May be less suitable for people who do not want to focus on their own feelings, or who do not wish or feel ready to discuss any close

Treatment	How is this delivered?	Key features	Other things to think about
		possibilities for change • Both insight-oriented and affect focused • Relationship between therapist and patient is included as a focus to help support working through key current conflicts	and/or family relationships • May suit people who do not like talking about their depression in a group • Focusing on painful experiences in close and/or family relationships could initially be distressing • Avoids potential side effects of medication
Interpersonal psychotherapy (IPT)	• Individual sessions delivered by a practitioner with therapy-specific training and competence • Usually consists of 16 sessions of 60 minutes each • Delivered in line with current treatment manuals	• Focus is on identifying how interpersonal relationships or circumstances are related to feelings of depression, exploring emotions and changing interpersonal responses • Structured approach • Focuses on resolving current issues • The goal is to change relationship patterns rather than directly targeting associated depressive thoughts	• May be helpful for people with depression associated with interpersonal difficulties, especially adjusting to transitions in relationships, loss, or changing interpersonal roles • May suit people who do not like talking about their depression in a group • Needs a willingness to examine interpersonal relationships • Avoids potential side effects of medication
Self-help with support	• Printed or digital materials which follow the	• Focuses on how thoughts, beliefs, attitudes, feelings and behaviour	• In more severe depression, the potential advantages of providing more

Treatment	How is this delivered?	Key features	Other things to think about
	principles of structured CBT • Support from a trained practitioner who facilitates the self-help intervention, encourages completion and reviews progress and outcome • Support usually consists of 8 sessions (face-to-face or by telephone or online), with an initial session of up to 30 minutes and further sessions being up to 15 minutes • Usually takes place over 16 weeks	interact, and teaches coping skills to deal with things in life differently • Goal-oriented and structured • Focuses on resolving current issues	intensive treatment should be carefully considered • Needs self-motivation and willingness to work alone (although regular support is provided) • Allows flexibility in terms of fitting sessions in around other commitments • Need to consider access, and ability to engage with computer programme for digital formats • Less capacity for individual adaptations than individual psychological treatments • Avoids potential side effects of medication
Group exercise	• A group intervention provided by a trained practitioner • Uses a physical activity programme specifically designed for people with depression • Usually consists of 60 minutes sessions, usually 3 times a week for 10 weeks • Usually 8 participants in the group	• Includes moderate intensity aerobic exercise • Does not directly target thoughts and feelings	• In more severe depression, the potential advantages of providing more intensive treatment should be carefully considered • May allow peer support from others who are may be having similar experiences • May need to be adapted if the person has physical health

Treatment	How is this delivered?	Key features	Other things to think about
			problems that prevent exercise • Needs a considerable time commitment • Can help with physical health too • Avoids potential side effects of medication

For a short explanation of why the committee made these recommendations see the rationale and impact section on treatment of more severe depression.

Full details of the evidence and the committee's discussion are in evidence review B: Treatment of a new episode of depression.

1.7 Behavioural couples therapy for depression

1.7.1 Consider behavioural couples therapy for people with either less severe or more severe depression who have problems in the relationship with their partner if:

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

[2021]

1.7.2 Deliver behavioural couples therapy for people with depression that:

- follows the behavioural principles for couples therapy
- provides 15–20 sessions of 50 to 60 minutes over 5 to 6 months.

[2009, amended 2021]

For a short explanation of why the committee made these recommendations see the rationale and impact section on behavioural couples therapy.

Full details of the evidence and the committee's discussion are in evidence review B: Treatment of a new episode of depression.

1.8 Continuation of treatment for relapse prevention

1.8.1 Discuss with people that continuation of treatment after full or partial remission may reduce their risk of relapse and may help them stay well. Reach a shared decision on whether or not to continue a treatment for depression based on their clinical needs and preferences. **[2021]**

1.8.2 If a person chooses not to continue antidepressant medication for relapse prevention, advise them:

- how to stop their antidepressant medication (see the recommendations on stopping antidepressant medication), and
- to seek help as soon as possible if the symptoms of depression return or residual symptoms worsen. **[2021]**

1.8.3 Discuss with people that the likelihood of having a relapse may be increased if they have:

- a history of recurrent episodes of depression, particularly if these have occurred frequently or within the last 2 years
- a history of incomplete response to previous treatment, including residual symptoms
- unhelpful coping styles (for example avoidance and rumination)
- a history of severe depression (including people with severe functional impairment)
- other chronic physical health or mental health problems
- personal, social and environmental factors that contributed to their depression and that are still present (for example, ongoing stress, poverty, isolation, unemployment). **[2021]**

1.8.4 Discuss with people the potential risks of continuing with antidepressants long term (for example, increased bleeding risk, long-term effects on sexual function, difficulty of stopping antidepressants), and how these balance against the risks of depression relapse. **[2021]**

1.8.5 For people who have remitted from depression when treated with antidepressant medication alone, but who have been assessed as being at higher risk of relapse, consider:

- continuing with their antidepressant medication for up to 2 years to prevent relapse, maintaining the same dose unless there is good reason to reduce it (such as side effects), **or**
- a course of psychological therapy [group CBT or mindfulness-based cognitive therapy (MBCT)] for people who do not wish to continue on antidepressants (follow the recommendations on stopping antidepressants), **or**
- continuing with their antidepressant medication and a course of psychological therapy (group CBT or MBCT). **[2021]**

1.8.6 For people starting group CBT or MBCT for relapse prevention, offer a course of therapy with an explicit focus on the development of relapse prevention skills and what is needed to stay well. This should typically consist of 8 sessions over 2 to 3 months, then 4 follow-up sessions in the next 12 months. **[2021]**

1.8.7 Relapse prevention components of psychological interventions may include:

- reviewing what lessons and insights were learnt in therapy and what was helpful in therapy
- making concrete plans to maintain progress beyond the end of therapy including plans to consolidate any changes made to stay well and to continue to practice useful strategies
- identifying stressful circumstances, triggering events, warning signs (such as anxiety or poor sleep), or unhelpful behaviours (such as

avoidance or rumination) that have preceded worsening of symptoms and functioning, and making detailed contingency plans of what to do if each of these re-occur

- making plans for any anticipated challenging events over the next 12 months, including life changes and anniversaries of difficult events. **[2021]**

1.8.8 Discuss with people who have remitted from depression when treated with a psychological therapy alone, but who have been assessed as being at higher risk of relapse, whether they wish to continue with their psychological therapy for relapse prevention. Reach a shared decision on further treatment. **[2021]**

1.8.9 Discuss with people who have remitted from depression when treated with combination of an antidepressant medication and psychological therapy, but who have been assessed as being at higher risk of relapse, whether they wish to continue 1 or both treatments. Reach a shared decision on further treatment. **[2021]**

1.8.10 Continue the same therapy for people who wish to stay on a psychological therapy for relapse prevention (either alone or in combination with an antidepressant), adapted by the therapist for relapse prevention. This should include at least 4 more sessions of the same treatment with a focus on a relapse prevention component (see recommendation 1.8.7) and what is needed to stay well. **[2021]**

1.8.11 Review treatment for people continuing with antidepressant medication to prevent relapse at least every 6 months. At each review:

- monitor their mood using a formal validated rating scale
- review any side effects
- review any medical, personal, social or environmental factors that may affect their risk of relapse

- discuss with them if they wish to continue treatment. If they wish to stop antidepressant treatment, see the recommendations on stopping antidepressant medication. **[2021]**

1.8.12 Reassess the risk of relapse for people who continue with psychological therapy to prevent relapse, when they are finishing the relapse prevention treatment, and assess the need for any further follow up. **[2021]**

For a short explanation of why the committee made these recommendations see the rationale and impact section on continuation of treatment for relapse prevention.

Full details of the evidence and the committee's discussion are in evidence review C: Relapse prevention.

1.9 Further-line treatment

1.9.1 If a person's depression has not responded at all after 4 weeks of antidepressant medication at a recognised therapeutic dose, or after 4 to 6 weeks for psychological therapy or combined medication and psychological therapy, discuss with them:

- whether there are any personal or social factors or physical or other mental health conditions that might explain why the treatment isn't working
- whether they have had problems adhering to the treatment plan (for example, stopping or reducing medication because of side effects, or missing sessions with their therapist).

If any of these are the case, make a shared decision with the person about the best way to try and address any problems raised. **[2021]**

1.9.2 If a person's depression has not responded to treatment after addressing any problems raised (see recommendation 1.9.1), and allowing an adequate time for treatments to work, review the diagnosis and consider

the possibility of alternative or comorbid conditions that may limit response to depression treatments. **[2021]**

1.9.3 Reassure the person that although treatment has not worked, other treatments can be tried, and may be effective. **[2021]**

1.9.4 If a person's depression has had no or a limited response to treatment with psychological therapy alone, and no obvious cause can be found and resolved, discuss further treatment options with the person (including what other treatments they have found helpful in the past) and make a shared decision on how to proceed based on their clinical need and preferences. Options include:

- switching to an alternative psychological treatment
- changing to a combination of psychological therapy with an SSRI or mirtazapine
- switching to an SSRI or mirtazapine alone. **[2021]**

1.9.5 If a person's depression has had no or a limited response to treatment with antidepressant medication alone, and no obvious cause can be found and resolved, discuss further treatment options with the person and make a shared decision on how to proceed based on their clinical need and preferences. Options include:

- adding a group exercise intervention
- switching to a psychological therapy (see the suggested treatment options for more severe depression)
- continuing antidepressant therapy either by increasing the dose or changing the drug. For example by:
  - increasing the dose of the current medication (within the licensed dose range) if the medication is well tolerated. Be aware that higher doses of antidepressants may not be more effective and can increase the frequency and severity of side effects. Ensure follow-up and more frequent monitoring of symptoms and side effects after dose increases.

  - switching to another medication in the same class (for example, another SSRI)
  - switching to a medication of a different class (for example, an SSRI, SNRI, TCA or MAOI). Take into consideration that:
    - ◊ switching medication may mean cross-tapering is needed. See the NICE clinical knowledge summary on switching antidepressants
    - ◊ switching to or from an MAOI, or from one MAOI to another, will need particular care
    - ◊ TCAs (particularly amitriptyline and dosulepin) have safety concerns, and lofepramine has the best safety profile
- changing to a combination of psychological therapy (for example, CBT, IPT or STPP) and medication.

Consider whether some of these decisions and treatments need other services to be involved (for example, specialist mental health services for advice on switching antidepressants). **[2021]**

1.9.6 If a person's depression has had no or a limited response to treatment with a combination of antidepressant medication and psychological therapy, discuss further treatment options with the person and make a shared decision on how to proceed based on their clinical need and preferences. Options include:

- switching to another psychological therapy
- increasing the dose or switching to another antidepressant (see recommendation 1.9.5)
- adding in an another medication (see recommendation 1.9.9). **[2021]**

1.9.7 Only consider vortioxetine when there has been no or limited response to at least 2 previous antidepressants. See the NICE guidance on the use of vortioxetine. **[2021]**

1.9.8 If a person whose depression has had no response or a limited response to antidepressant medication does not want to try a psychological therapy, and instead wants to try a combination of medications, explain the possible increase in their side-effect burden. **[2021]**

1.9.9 If a person with depression wants to try a combination of medications and is willing to accept the possibility of an increased side-effect burden (see recommendation 1.9.8):

- consider adding an additional antidepressant medication with a complementary mechanism of action
- be aware that some combinations are potentially dangerous and should be avoided (for example, a SSRI, SNRI or TCA with a MAOI)
- consider combining an antidepressant medication with an atypical antipsychotic (for example, aripiprazole, olanzapine, quetiapine or risperidone) or lithium. When using an antipsychotic carefully review the effects of this on depression, including loss of interest and motivation.
- consider augmenting antidepressants with ECT (see the recommendations on ECT therapy), lamotrigine, or triiodothyronine (liothyronine).

Combination therapy should be initiated in specialist mental health settings or after consulting a specialist.

In November 2021, this was an unlicensed use for some antipsychotics, lamotrigine, and triiodothyronine (liothyronine). See NICE's information on prescribing medicines. **[2021]**

For a short explanation of why the committee made these recommendations see the rationale and impact section on further-line treatment.

Full details of the evidence and the committee's discussion are in evidence review D: Further-line treatment.

1.10 Chronic depressive symptoms

1.10.1 Be aware that people presenting with chronic depressive symptoms may not have sought treatment for depression previously and may be unaware that they have depression. Discussions about their mood and symptoms initiated by a healthcare practitioner may help them access treatment and services. **[2021]**

1.10.2 For people who present with chronic depressive symptoms that significantly impair personal and social functioning and who have not received previous treatment for depression, treatment options include:

- CBT **or**
- SSRIs **or**
- TCAs (be aware that TCAs, particularly amitriptyline and dosulepin have safety concerns, and lofepramine has the best safety profile) **or**
- combination therapy with CBT and either an SSRI or a TCA.

Discuss treatment options with the person and reach a shared decision on treatment choice, based on their clinical needs and preferences (see also the recommendations on choice of treatments). **[2021]**

1.10.3 Offer cognitive behavioural treatment for people with chronic depressive symptoms that:

- has a focus on chronic depressive symptoms
- covers related maintaining processes, including avoidance, rumination and interpersonal difficulties. **[2021]**

1.10.4 For people who have had, or are still receiving, treatment for depression and who present with chronic depressive symptoms, see the recommendations on further-line treatment. **[2021]**

1.10.5 If a person with chronic depressive symptoms that significantly impair personal and social functioning cannot tolerate an SSRI, consider treatment with an alternative SSRI. **[2021]**

1.10.6 For people with chronic depressive symptoms that significantly impair personal and social functioning, who have not responded to a TCA or 1 or more SSRIs, consider alternative medication in specialist settings, or after consulting a specialist. Take into account that switching medication may mean that an adequate wash-out period is needed, particularly when switching to or from irreversible MAOIs or moclobemide. See the NICE clinical knowledge summary on switching antidepressants. Alternatives include:

- SNRIs
- moclobemide
- irreversible MAOIs such as phenlezine
- low-dose amisulpride (max 50 mg daily, as higher doses may worsen depression and lead to side effects such as hyperprolactinaemia and QT interval prolongation).

In November 2021, this was an off-label use for amisulpride. See NICE's information on prescribing medicines. **[2021]**

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

- befriending in combination with existing antidepressant medication or psychological therapy: this should be done by trained volunteers, typically with at least weekly contact for between 2–6 months
- a rehabilitation programme, if their depression has led to loss of work or their withdrawing from social activities over the longer term. **[2009, amended 2021]**

1.10.8 For people with no or limited response to treatment for chronic depressive symptoms that significantly impair personal and social functioning who have not responded to the treatments recommended in section 1.9 and 1.10, offer a referral to specialist mental health services for advice and further treatment. **[2021]**

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

- review the benefits of treatment with the person
- consider stopping the medication (see the recommendations on stopping antidepressants)
- discuss with the person possible reasons for non-response and what other treatments and support may be helpful. **[2021]**

For a short explanation of why the committee made these recommendations see the rationale and impact section on chronic depressive symptoms.

Full details of the evidence and the committee's discussion are in evidence review E: Chronic depression.

1.11 Depression in people with a diagnosis of personality disorder

1.11.1 For people with depression and a diagnosis of personality disorder consider a combination of antidepressant medication and a psychological treatment (for example, BA, CBT, IPT or STPP). To help people choose between these psychological treatments, see the information on them provided in Table 1 and Table 2. **[2021]**

1.11.2 When delivering antidepressant medication in combination with psychological treatment for people with depression and a diagnosis of personality disorder:

- give the person support and encourage them to carry on with the treatment
- provide the treatment in a structured, multidisciplinary setting
- use a validated measure of prospective mood monitoring or a symptom checklist or chart to assess response, or any exacerbation of emotional instability
- extend the duration of treatment if needed, up to a year. **[2021]**

1.11.3 For people with depression and a diagnosis of personality disorder, consider referral to a specialist personality disorder treatment programme. See the NICE guidance on borderline personality disorder for recommendations on treatment for borderline personality disorder with coexisting depression. **[2021]**

> For a short explanation of why the committee made these recommendations see the rationale and impact section on depression with personality disorder.
>
> Full details of the evidence and the committee's discussion are in evidence review F: Depression with personality disorder.

1.12 Psychotic depression

In November 2021, use of antipsychotics for the treatment of depression was an off-label use for some antipsychotics. See NICE's information on prescribing medicines.

1.12.1 Offer referral to specialist mental health services for people with depression with psychotic symptoms, where the treatment should include:

- a risk assessment
- a programme of coordinated multidisciplinary care
- access to psychological treatments, after improvement of acute psychotic symptoms.

Discuss treatment options and, for those people who have capacity, reach a shared decision based on their clinical needs and preferences. **[2021]**

1.12.2 Consider combination treatment for people with depression with psychotic symptoms with antidepressant medication and antipsychotic medication (for example, olanzapine or quetiapine). **[2021]**

1.12.3 If a person does not wish to take antipsychotic medication, then treat with an antidepressant alone. **[2021]**

1.12.4 Monitor the person for treatment response (in particular for unusual thought content and hallucinations). **[2021]**

1.12.5 Consider continuing antipsychotic medication for a number of months after remission, if tolerated. The decision when to stop antipsychotic medication should be made by, or in consultation with, specialist services. **[2021]**

1.12.6 For more advice on prescribing and monitoring antipsychotics see the recommendations on use of antipsychotics and the NICE guideline on psychosis and schizophrenia in adults. **[2021]**

For a short explanation of why the committee made these recommendations see the rationale and impact section on psychotic depression.

Full details of the evidence and the committee's discussion are in evidence review G: Psychotic depression.

1.13 Electroconvulsive therapy for depression

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

- the person chooses ECT in preference to other treatments based on their past history and what has previously worked for them, **or**
- a rapid response is needed (for example, if the depression is life-threatening because the person is not eating or drinking), **or**
- other treatments have been unsuccessful (see the recommendations on further-line treatment). **[2021]**

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

- the risks associated with a general anaesthetic
- any medical comorbidities
- potential adverse events, in particular cognitive impairment
- if the person is older, the possible increased risk associated with ECT treatment for this age group

- the risks associated with not having ECT.

Document the assessment and discussion. **[2021]**

1.13.3 Discuss the use of ECT as a treatment option with the person with depression, and reach a shared decision on its use based on their clinical needs and preferences, if they have capacity to give consent. Take into account the capacity of the person and the requirements of the Mental Health Act 2007 (if applicable), and make sure:

- valid, informed consent is given without pressure or coercion from the circumstances or clinical setting
- the person is aware of their right to change their mind and withdraw consent at any time
- there is strict adherence to recognised guidelines on consent, and advocates or carers are involved to help informed discussions. **[2021]**

1.13.4 If a person with depression cannot give informed consent, only give ECT if it does not conflict with an advance treatment decision the person made. **[2021]**

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

- reviewing the adequacy of the previous treatment course
- considering all other options
- discussing the risks and benefits with the person or, if appropriate, their advocate or carer. **[2021]**

1.13.6 Clinics providing ECT should:

- be ECTAS-accredited
- provide ECT services in accordance with ECTAS standards
- submit data on each course of acute and maintenance ECT they deliver as required for the ECTAS minimum dataset.

See the ECT Accreditation Service Standards for Administering ECT. **[2021]**

1.13.7 Trusts which provide ECT services should ensure compliance with the ECTAS standards for administering ECT through board-level performance management. **[2021]**

1.13.8 Stop ECT treatment for a person with depression:

- immediately, if the side effects outweigh the potential benefits, or
- when remission has been achieved. **[2021]**

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

- start (or continue) antidepressant medication or a psychological intervention to prevent relapse and to provide ongoing care for their depression (see the recommendations on relapse prevention)
- consider lithium augmentation of antidepressant medication (see the recommendations on further-line treatment). **[2021]**

For a short explanation of why the committee made these recommendations see the rationale and impact section on further-line treatment.

Full details of the evidence and the committee's discussion are in evidence review D: Further-line treatment.

1.14 Transcranial magnetic stimulation for depression

1.14.1 See the NICE Interventional Procedure Guidance on Repetitive transcranial magnetic stimulation for depression.

1.15 Access, coordination and delivery of care

Access to services

1.15.1 Commissioners and providers of mental health services should consider using models such as stepped care or collaborative care for organising

the delivery of care and treatment of people with depression. Pathways should:

- promote easy access to, and uptake of, the treatments covered
- allow for prompt assessment of adults with depression, including assessment of severity and risk
- ensure coordination and continuity of care, with agreed protocols for sharing information
- support the integrated delivery of services across primary and secondary care, to ensure individuals do not fall into gaps in service provision
- have clear criteria for entry to all levels of a stepped care service
- have multiple entry points and ways to access the service, including self-referral
- have routine collection of data on access to, uptake of, and outcomes of the specific treatments in the pathway. **[2021]**

1.15.2 Commissioners and providers of mental health services for people with depression should ensure the effective delivery of treatments. This should build on the key functions of a catchment-area-based community mental health service and be provided in the context of an integrated primary and secondary care mental health service, as well as community services (for example social care, education and housing). This should include:

- assessment procedures
- shared decision making
- collaboration between professionals
- delivery of pharmacological, psychological, physical (for example exercise, ECT) and social interventions
- care coordination
- involvement of service users in design of services
- the effective monitoring and evaluation of services. **[2021]**

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

- individual practitioners (including GPs and practice nurses), providing treatments, support or supervision
- mental health staff, for team-based treatments in primary care for the majority of people with depression
- mental health specialists, for advice, consultation and support for primary care mental health staff
- specialist-based mental health teams, for people with severe and complex disorders. **[2021]**

1.15.4 Commissioners and providers of mental health services should ensure that accessible and culturally adapted information about the pathways into treatment and different explanatory models of depression is available, for example in different languages and formats and in line with NHS England's Accessible Information Standard. **[2021]**

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

- services delivered in culturally appropriate or culturally adapted language and formats
- services available outside normal working hours
- a range of different methods to engage with and deliver treatments in addition to face-to-face meetings, such as text messages, email, telephone and online or remote consultations (for people who wish to access and are able to access services in this way)
- services provided in community-based settings, for example in a person's home, community centres, leisure centres, care homes, social centres and integrated clinics within primary care (particularly for older people)
- services delivered jointly with charities or the voluntary sector

- bilingual therapists or independent translators
- procedures to support active involvement of families, partners and carers. **[2021]**

1.15.6 When promoting access and uptake of services, identify and address the needs of groups who may have difficulty in accessing, or face stigma when using some or all mental health services. This may include:

- men
- older people
- lesbian, gay, bisexual and trans people
- people from black, Asian and minority ethnic communities
- people with learning disabilities or acquired cognitive impairments (see the NICE guideline on mental health problems in people with learning disabilities)
- people with physical or sensory disabilities, who may need reasonable adjustments to services as defined by legislation to enable this access. See the Equality Act 2010.
- people who have conditions which compromise their ability to communicate
- asylum seekers. **[2021]**

For a short explanation of why the committee made these recommendations see the rationale and impact section on access to services.

Full details of the evidence and the committee's discussion are in evidence review H: Access.

Collaborative care

1.15.7 Consider collaborative care for people with depression, particularly older people, those with significant physical health problems or social isolation, or those with more chronic depression not responding to usual specialist care. **[2021]**

1.15.8 Collaborative care for people with depression should comprise:

- patient-centred assessment and engagement
- symptom measurement and monitoring
- medication management (a plan for starting, reviewing and discontinuing medication)
- active care planning and follow up by a designated case manager
- delivery of psychological and psychosocial treatments within a structured protocol
- integrated care of both physical health and mental health
- joint working with primary and secondary care colleagues
- supervision of practitioners by an experienced mental health professional. **[2021]**

Specialist care

1.15.9 Refer people with more severe depression or chronic depressive symptoms, to specialist mental health services for coordinated multidisciplinary care if:

- their depression significantly impairs personal and social functioning and
- they have not benefitted from initial treatment, and either
  - have multiple complicating problems, for example unemployment, poor housing or financial problems, **or**
  - have significant coexisting mental and physical health conditions. **[2021]**

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

- are developed together with the person, their GP and other relevant people involved in their care (with the person's agreement), and that a copy in an appropriate format is offered to the person

- set out the roles and responsibilities of all health and social care professionals involved in delivering the care
- include information about 24-hour support services, and how to contact them
- include a crisis plan that identifies potential crisis triggers, and strategies to manage those triggers and their consequences
- are updated if there are any significant changes in the person's needs or condition
- are reviewed at agreed regular intervals
- include medication management (a plan for starting, reviewing and discontinuing medication). **[2021]**

For a short explanation of why the committee made these recommendations see the rationale and impact section on collaborative care and specialist care.

Full details of the evidence and the committee's discussion are in evidence review A: Service delivery.

Crisis care, home treatment and inpatient care

1.15.11 Consider crisis resolution and home treatment (CRHT) for people with more severe depression who are at significant risk of:

- suicide, in particular for those who live alone
- self-harm
- harm to others
- self-neglect
- complications in response to their treatment, for example older people with medical comorbidities. **[2021]**

1.15.12 Ensure teams providing CRHT interventions to support people with depression:

- monitor and manage risk as a high-priority routine activity
- establish and implement a treatment programme

- ensure continuity of any treatment programme while the person is in contact with the CRHT team, and on discharge or transfer to other services when this is needed
- put a crisis management plan in place before the person is discharged from the team's care. **[2021]**

1.15.13 Consider inpatient treatment for people with more severe depression who cannot be adequately supported by a CRHT team. **[2021]**

1.15.14 Make psychological therapies recommended for the treatment of more severe depression, relapse prevention, chronic depressive symptoms and depression with a diagnosis of personality disorder available for people with depression in inpatient settings. **[2021]**

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

- increase the intensity and duration of the interventions
- ensure that they continue to be provided effectively and promptly on discharge. **[2009]**

1.15.16 Consider using CRHT teams for people with depression having a period of inpatient care who might benefit from early discharge from hospital. **[2009]**

For a short explanation of why the committee made these recommendations see the rationale and impact section on crisis care, home treatment and inpatient care.

Full details of the evidence and the committee's discussion are in evidence review A: Service delivery

Terms used in this guideline

This section defines terms that have been used in a particular way for this guideline. For other definitions see the NICE glossary and the Think Local, Act Personal Care and Support Jargon Buster.

Acquired cognitive impairments

Cognitive impairments are neurological disorders that affect cognitive abilities (for example, learning, memory and problem-solving). Acquired disorders may be because of medical conditions that affect mental function (for example, dementia, Parkinson's disease or traumatic brain injury).

Avoidance

An unhelpful form of coping behaviour in which a person changes their behaviour to avoid thinking about, feeling, or doing difficult things. This includes putting things off, reducing activities, not tackling problems, not speaking up for oneself, distraction, and using alcohol or substances to numb feelings.

Chronic depressive symptoms

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

Collaborative care

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

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

Depression

In this guideline the term ‘people with depression’ is used. This includes people with a clinical diagnosis of depression and those who feel themselves to be experiencing

depression or depressive symptoms, and recognises that people experience, describe and label their experiences of depression in very individual ways.

Less severe depression

Less severe depression encompasses subthreshold and mild depression.

Medication management

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

More severe depression

More severe depression encompasses moderate and severe depression.

Routine (sessional) outcome monitoring

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

Rumination

Repetitive and prolonged negative thinking about the depression, feelings and symptoms, the self, problems or difficult life events and about their causes, consequences, meanings and implications (for example ‘Why did this happen to me?’, ‘Why can’t I get better?’).

Stepped care

This is a system of delivering and monitoring treatments, so that the most effective, least intrusive and least resource intensive treatments are delivered first. Stepped

care has a built in 'self-correcting' mechanism so that people who do not benefit from initial treatments can be 'stepped up' to more intensive treatments as needed.

Treatment manuals

Treatment manuals are based on those that were used in the trials that provided the evidence for the efficacy of treatments recommended in this guideline.

Recommendations for research

The guideline committee has made the following recommendations for research.

Key recommendations for research

1. Stopping antidepressants

What is the incidence and severity of withdrawal symptoms for antidepressant medication?

> For a short explanation of why the committee made this recommendation see the rationale and impact section on starting and stopping antidepressant medication.
>
> Full details of the evidence are in evidence reviews for the NICE guideline on safe prescribing (evidence review A: patient information; evidence review B: prescribing strategies; evidence review C: safe withdrawal; evidence review D: withdrawal symptoms; evidence review F: monitoring).
>
> Full details of the research recommendation have been added to evidence review B: Treatment of a new episode of depression.

2. Relapse prevention

What is the effectiveness and cost effectiveness of brief courses of psychological treatment in preventing relapse for people who have had a successful course of treatment with antidepressants or psychological therapies but remain at high risk of relapse?

For a short explanation of why the committee made this recommendation see the rationale and impact section on continuation of treatment for relapse prevention.

Full details of the evidence and the committee's discussion are in evidence review C: Relapse prevention.

3. Further-line treatment

What are the relative benefits and harms of further-line psychological, psychosocial, pharmacological and physical treatments (alone or in combination), for adults with depression showing an inadequate response to an initial psychological treatment for the current episode?

For a short explanation of why the committee made this recommendation see the rationale and impact section on further-line treatment.

Full details of the evidence and the committee's discussion are in evidence review D: Further-line treatment.

4. Chronic depression

Are psychological, pharmacological or a combination of these treatments effective and cost effective for the treatment of older adults with chronic depressive symptoms?

For a short explanation of why the committee made these recommendations see the rationale and impact section on chronic depressive symptoms.

Full details of the evidence and the committee's discussion are in evidence review E: Chronic depression.

5. Access

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

For a short explanation of why the committee made this recommendation see the rationale section on access to services.

Full details of the evidence and the committee's discussion are in evidence review H: Access.

Other recommendations for research

First-line treatment of less severe depression

Is peer support an effective and cost-effective treatment in improving outcomes, including symptoms, personal functioning and quality of life in adults as a stand-alone treatment in people with less severe depression and as an adjunct to other evidence-based treatments in more severe depression?

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

For a short explanation of why the committee made these recommendations see the rationale and impact section on treatment of less severe depression.

Full details of the evidence and the committee's discussion are in evidence review B: Treatment of a new episode of depression.

First-line treatment of more severe depression

What is the effectiveness and cost effectiveness of combination treatment with acupuncture and antidepressants in people with more severe depression in the UK?

For a short explanation of why the committee made these recommendations see the rationale and impact section on treatment of more severe depression.

Full details of the evidence and the committee's discussion are in evidence review B: Treatment of a new episode of depression.

Chronic depression

What is the effectiveness, acceptability and safety of Monoamine Oxidase Inhibitors (MAOIs) (for example, phenelzine) compared to alternative SSRI/SNRI options in treatment resistant chronic depression with anhedonia?

How can identifying and focusing on the social determinants of chronic depression, and on the outcomes that matter to patients, enable greater precision for targeting the relevant causal factors and mechanisms that contribute to sustained recovery?

> For a short explanation of why the committee made these recommendations see the rationale section on chronic depressive symptoms.
>
> Full details of the evidence and the committee's discussion are in evidence review E: Chronic depression.

Psychotic depression

What are the most effective and cost-effective interventions for the treatment and management of psychotic depression (including consideration of pharmacological, psychological, psychosocial interventions and ECT)?

> For a short explanation of why the committee made this recommendation see the rationale section on psychotic depression.
>
> Full details of the evidence and the committee's discussion are in evidence review G: Psychotic depression.

Rationale and impact

Choice of treatments

Recommendations 1.3.1 to 1.3.6

Why the committee made the recommendations

The evidence showed that both people with depression and healthcare professionals want time to engage in meaningful discussions and to build trusting relationships with healthcare professionals who they feel comfortable with, so that people with

depression can be actively involved in decision-making about treatment options and choices. There was evidence that people's involvement in making choices about their treatment may be impacted by preconceptions about different treatment options, the depression symptoms themselves, and the resources available.

How the recommendations might affect practice

Offering people choice of treatments and discussing treatment options may mean longer consultation times are needed, and this may have a resource impact for the NHS. However, providing information about choices is likely to lead to improved adherence with therapy and better outcomes for people with depression, offsetting any costs associated with longer consultations.

Return to recommendations

Starting and stopping antidepressants

Recommendations 1.4.7 to 1.4.20

Why the committee made the recommendations

The committee reviewed the evidence on antidepressants identified as part of the development of the NICE guideline on safe prescribing, and used this together with their knowledge and experience to develop recommendations.

There was some limited evidence that people with depression wanted information about how and when they would be monitored when prescribed antidepressants, and that they appreciated being able to self-monitor their symptoms as this was empowering. There was also some limited evidence that, when planning to stop medication, tapering antidepressants may reduce adverse effects. The committee used their knowledge to add more detail to the recommendations on techniques for tapering, drugs that may be associated with more withdrawal symptoms, and those which could be tapered more quickly such as fluoxetine.

There was evidence on the range of adverse effects that people experienced when withdrawing from antidepressants, but the committee agreed that more detailed information on incidence and severity for specific interventions would be useful to inform patient choice and so they made a research recommendation. There was

evidence on the information needs and support needs of people with depression, that showed that people would like to receive realistic information about the potential benefits and harms of antidepressants, how long they will take to work, the length of treatment and the process of withdrawal. The evidence also showed they value support from healthcare professionals when withdrawing from medication, including a recognition of their fears and concerns about the withdrawal process.

How the recommendations might affect practice

The recommendations reflect current practice, but may reduce variation in practice across the NHS.

Return to recommendations

Use of lithium

Recommendations 1.4.25 to 1.4.27 and 1.4.29 to 1.4.30

Why the committee made the recommendations

The committee made the recommendations on the use of lithium by informal consensus and based on their knowledge and experience and in line with the monitoring requirements specified in the British National Formulary.

How the recommendations might affect practice

The recommendations reflect current practice, but may reduce variation in practice across the NHS.

Return to recommendations

Use of antipsychotics

Recommendations 1.4.31 to 1.4.34

Why the committee made the recommendations

The committee made the recommendations on the use of antipsychotics by informal consensus and based on their knowledge and experience and in line with the monitoring requirements for antipsychotics specified in the British National Formulary and the NICE guideline on psychosis and schizophrenia

How the recommendations might affect practice

The recommendations reflect current practice, but may reduce variation in practice across the NHS.

Return to recommendations

Treatment for a new episode of less severe depression

Recommendations 1.5.2 to 1.5.3

Why the committee made the recommendations

There was good evidence for the effectiveness of group CBT and group BA and these treatments were found to be the most cost effective, on average, for adults with less severe depression. There was also good evidence for the effectiveness of individual BA, individual CBT and some evidence for the effectiveness of self-help with support and these interventions were also cost effective so these were provided as alternatives for people who did not wish to participate in group therapy.

There was some evidence for the effectiveness of group mindfulness and meditation, group exercise, IPT and antidepressants and they were also cost effective so these were recommended as alternative treatments for people who did not wish to receive CBT or BA (in a group, individual or self-help format). The committee advised that SSRIs would be the preferred antidepressants to use in people with less severe depression because of their tolerability. The committee discussed that as the evidence suggested that some psychological therapies were more effective than antidepressants, medication should not be the default treatment for people with less severe depression, unless it was the person's preference to take antidepressants rather than engage in a psychological intervention.

There was some evidence that counselling and STPP may be effective, but these treatments did not appear to be as cost effective, on average, at improving the symptoms of less severe depression. However the committee recognised that these treatments may be helpful for some people and so included them as options as well.

The committee provided details of the treatments in a table to allow a discussion between healthcare professionals and people with depression about treatment

options. This table is arranged in order of the committee's consensus on the average effectiveness and cost effectiveness of the treatments in adults with less severe depression, with the most effective and cost effective listed at the top of the table, but the committee agreed that choice of therapy should be a personalised decision and that some people may prefer to use a treatment further down the table and that this is a valid choice.

As there was a lack of evidence on the effectiveness of peer support the committee made a research recommendation. As there was considerable uncertainty in the evidence for the effectiveness and cost effectiveness of psychological interventions the committee made a further research recommendations to find out if identifying the mode of action of psychological interventions would allow greater differentiation between the interventions and aid patient choice.

How the recommendations might affect practice

The recommendations reflect current practice, but may reduce variation in practice across the NHS. Commissioners and services will need to ensure that a meaningful choice of all NHS-recommended therapies is available, and depending on current availability, this may need an increase in resource use. Initial consultations and assessment may need longer because of the need for detailed discussions to support informed choice, but a positive choice may improve engagement and outcomes.

Return to recommendations

Treatment for a new episode of more severe depression

Recommendation 1.6.1

Why the committee made the recommendations

There was good evidence for the effectiveness of combination of CBT with antidepressants, individual CBT and individual behavioural therapies and these treatments were also cost effective, on average, for adults with more severe depression. There was good evidence for the effectiveness and cost effectiveness of antidepressants (SSRIs, SNRIs, TCAs and mirtazapine) and the committee agreed that SSRIs and SNRIs should be recommended as first line because of their

tolerability, but for people who had responded well to a TCA in the past and who had no contraindications, a TCA might be preferred. The committee agreed that mirtazapine should not be included as a first-line option, but the committee decided to reserve it for use for further-line treatment. In addition to the evidence reviewed, the committee were aware of large-scale and pragmatic trials of CBT and BA that were excluded from the network meta-analysis (because they involved patient populations that did not meet specific search criteria), but which were also consistent with this evidence and supported the recommendations.

There was some evidence for the effectiveness of counselling and individual problem-solving therapy, both of which were also cost effective.

There was some evidence for the effectiveness of IPT and STPP but these treatments did not appear to be as cost effective, on average, at improving the symptoms of depression. However the committee recognised that these treatments may be helpful for some people and so included them as options as well.

There was some evidence of effectiveness and cost effectiveness for the combination of acupuncture and antidepressants but the committee were aware this evidence was based on Chinese acupuncture which is different to Western acupuncture and so these results may not be applicable to the UK population, so the committee made a research recommendation.

Both self-help with support and group exercise were, on average, shown to be effective and cost effective, but the committee were concerned that in clinical practice these interventions may be offered to people with severe depression in whom regular contact with a healthcare professional may be of benefit, and so advised they should not usually be used as the sole interventions in people with more severe depression.

The committee provided details of the treatments in a table to allow a discussion between healthcare professionals and people with depression about treatment options. This table is arranged in order of the committee’s consensus on the average effectiveness and cost effectiveness of the treatments, with the most effective and cost effective listed at the top of the table, but the committee agreed that choice of

therapy should be a personalised decision and that some people may prefer to use a treatment further down the table and that this is a valid choice.

How the recommendations might affect practice

The recommendations reflect current practice, but may reduce variation in practice across the NHS. Commissioners and services will need to ensure that a meaningful choice of all recommended therapies is available, and depending on current availability, this may need an increase in resource use. Initial consultations and assessment may need longer because of the need for detailed discussions to support informed choice, but a positive choice may improve engagement and outcomes.

Return to recommendations

Behavioural couples therapy

Recommendation 1.7.1

Why the committee made the recommendations

There was some very limited evidence for the effectiveness of behavioural couples therapy for people with depression and who had problems in their relationship, but the committee agreed this was a treatment that was available through the Improving Access to Psychological Therapy (IAPT) services and should be included as an option in the guideline.

How the recommendations might affect practice

The recommendations reflect current practice, but may reduce variation in practice across the NHS.

Return to recommendations

Continuation of treatment for relapse prevention

Recommendations 1.8.1 to 1.8.12

Why the committee made the recommendations

The committee highlighted a number of risk factors, based on their knowledge of the wider literature and experience, which increase the likelihood of relapse. They agreed that people with a higher risk of relapse should be considered for continuation of treatment, but recognised that not all people would wish to take relapse prevention treatment. They also agreed those who wished to continue on antidepressant medication should be warned about the possible long-term effects.

There was good evidence that SSRIs, SNRIs and TCAs, group CBT and MBCT were effective for relapse prevention and were, on average, cost-effective treatments for people at a high risk of relapse, with data for treatment periods up to 2 years. The committee therefore recommended continuation antidepressant treatment or group CBT or MBCT, with their advice framed to take into account the therapy the person had already received. The committee agreed that psychological therapies used for relapse prevention should explicitly focus on relapse prevention skills.

The committee used their knowledge and experience to recommend follow-up arrangements for people on relapse prevention therapy, to ensure that people did not remain on therapy indefinitely.

As there was little evidence for the use of brief courses of psychotherapy in preventing relapse the committee made a research recommendation.

How the recommendations might affect practice

The recommendations reflect current practice, but may reduce variation in practice across the NHS. Commissioners and services will need to provide therapies with an explicit relapse prevention component.

Return to recommendations

Further-line treatment

Recommendations 1.9.1 to 1.9.9 and 1.13.1 to 1.13.9

Why the committee made the recommendations

The committee made recommendations based on their knowledge and experience that people may not respond to treatment for depression for a number of reasons, and that these reasons should be explored before considering further-line treatment.

No evidence was identified for people whose depression had not responded to the use of psychological therapies as first-line treatment, but the committee used their experience to recommend treatment options both for people who had initially been treated with psychological therapies. As there was no evidence for people who did not respond to initial psychological treatments the committee made a research recommendation.

For people whose depression had not responded to antidepressants, there was some evidence that augmenting antidepressant regimens with group exercise was effective. There was also some very limited evidence that switching to a different antidepressant or increasing the dose of the antidepressant may be effective. Based on the evidence from the review of first-line treatment for more severe depression that a combination of psychological therapy and antidepressants was effective, the committee also recommended the use of combination treatment.

There was evidence that combinations of antidepressants, or combinations of an antidepressant with other treatments (ECT, antipsychotics, lithium, lamotrigine and triiodothyronine), were effective, but the committee agreed these combinations would need specialist advice.

There was some limited evidence for the use of ECT as further-line treatment, alone or in combination with exercise, so the committee agreed ECT should remain available as an option for the further-line treatment of depression in certain situations where there has been no or inadequate response to other treatment. Based on their knowledge and experience, the committee were aware that ECT leads to rapid effects and so they advised that it should also be considered when a rapid response was needed, and provided some examples of situations where this might be appropriate. The committee were also aware that there may be people with depression who have had ECT in the past, know it is effective, and express a preference for it. Based on their knowledge and experience, and to ensure better

patient experience, the committee reinforced the recommendations about taking into account patient preferences when considering ECT as a treatment option, in line with their recommendations for other treatment options.

The committee discussed the existing recommendations on the delivery of ECT and agreed these were still correct and so retained them. However, the committee agreed that there were now recognised up to date standards produced by the Royal College of Psychiatrists which covered the standards of service provision required for a safe and effective ECT service, and a recognised ECT accreditation service (ECTAS), and so the committee recommended that clinics and Trusts delivering ECT should be accredited and should adhere to these standards..

How the recommendations might affect practice

The recommendations for further-line treatment reflect current practice, but may reduce variation in practice across the NHS. The recommendations for ECT should ensure the availability of ECT for people if it is an appropriate treatment option for them, but reinforce that it is only a treatment option in certain circumstances.

Return to recommendations

Chronic depressive symptoms

Recommendations 1.10.1 to 1.10.6 and 1.10.8 to 1.10.9

Why the committee made the recommendations

There was some evidence for CBT, SSRIs and TCAs for the treatment of chronic depressive symptoms and some very limited evidence that combinations of psychological therapies and antidepressants may be more effective, on average, than either alone. As there was such limited evidence, particularly for older people who may be more susceptible to chronic depression, and for those whose chronic depression may be because of the impact of social determinants, the committee made 2 research recommendations.

There was some evidence for the effectiveness of other medications, including phenelzine, amisulpride, moclobemide and SNRIs for people with chronic depression, so the committee considered these could be used as alternatives with

specialist advice in people whose symptoms did not respond to SSRIs or TCAs. However, this was an extrapolation of the evidence which was for the first-line treatment of chronic depression (not further-line). As there was no evidence for the use of MAOIs for further-line treatment of chronic depression the committee made a research recommendation.

How the recommendations might affect practice

The recommendations reflect current practice, but may reduce variation in practice across the NHS.

Return to recommendations

Depression in people with a diagnosis of personality disorder

Recommendations 1.11.1 to 1.11.3

Why the committee made the recommendations

There was some limited evidence for the effectiveness of psychological therapies in combination with antidepressants for the treatment of depression in people with a personality disorder, and the committee were aware that extended duration of use and multidisciplinary support may be beneficial to improve uptake and adherence. However, the evidence base was very limited, with small studies of low to very low quality. As a result, the committee were not able to recommend a specific antidepressant or psychological therapy, but agreed that the choice should be guided by the person's preference. The committee were also limited by the available data when making recommendations for different types of personality disorders, as that the evidence was for mixed or non-specified types of personality disorder.

Based on their knowledge and experience, and in accordance with existing NICE guidelines, the committee were aware that in people with depression and personality disorder, treatment of the personality disorder by specialist services may lead to an improvement in depression.

How the recommendations might affect practice

The recommendations may reduce variation in the treatment offered to people presenting with depression and personality disorder, and will reinforce current practice to treat people with personality disorder in a specialist programme.

Return to recommendations

Psychotic depression

Recommendations 1.12.1 to 1.12.6

Why the committee made the recommendations

There was some limited evidence that the combination of an antidepressant and an antipsychotic may provide some benefits in the treatment of psychotic depression. There was some evidence for olanzapine and quetiapine, and the committee knew that quetiapine has antidepressant actions as well as antipsychotic actions and is therefore widely used for psychotic depression. The committee discussed that combination therapy would not usually be started in primary care and therefore people who wished to start an antipsychotic, would need a referral to specialist mental health services. Based on their experience the committee agreed the effectiveness of this combination should be monitored and that people should be reviewed regularly, not left on the combination longer than necessary, and that specialist advice would be needed to determine when the antipsychotic medication could be stopped. As there was limited evidence the committee made a research recommendation.

How the recommendations might affect practice

The recommendations reflect current practice, but may reduce variation in practice across the NHS.

Return to recommendations

Access to services

Recommendations 1.15.1 to 1.15.6

Why the committee made the recommendations

For recommendations on access to services for all people with depression, the committee used their knowledge and experience of how access to services could be improved using a stepped care approach, by good integration between primary and secondary care, by ensuring information on services was available, and by using a variety of different methods to deliver services.

There was some evidence that modifying the way interventions to treat depression were delivered, such as the co-location of physical and mental health services, use of telephone or online video interventions, collaborative care, and culturally adapted services, led to increased uptake and engagement with services for some men, older people, and those from black, Asian and minority ethnic groups with depression. However, as there was limited evidence the committee made a research recommendation.

How the recommendations might affect practice

Modifying the way treatments are delivered to improve access for certain groups may mean modifications to services are needed, and may have resource implications. However, prompt and effective treatment of depression may lead to reduced health and social care costs in the longer term.

Return to recommendations

Collaborative care and specialist care

Recommendations 1.15.7 to 1.15.10

Why the committee made the recommendations

There was good evidence that simple collaborative care improved outcomes in people with depression, and that overall it was cost effective in people with depression, including older people with depression.

There was some evidence that certain components of collaborative care led to benefits, and this was supplemented by the committee's expertise.

The committee did not specifically review evidence for specialist care for people with severe depression with multiple complicating problems or significant coexisting

conditions. However, based on their in-depth understanding of the evidence base the committee were aware of studies suggesting benefits for this group of people, and together with their knowledge and expertise, the committee recommended specialist care .

How the recommendations might affect practice

The recommendations on collaborative care may increase resource use but there is evidence that this is cost effective. Specialist care is likely to increase resource use, but will only be necessary for a small number of people, and may offset future costs for long-term care and treatment.

Return to recommendations

Crisis care, home treatment and inpatient care

Recommendations 1.15.11 to 1.15.14

Why the committee made the recommendations

There was some evidence that crisis resolution and home treatment (CHRT) teams improved symptoms in people with severe non-psychotic mental illness, and that this was a cost-effective option compared to standard inpatient care. However, based on their experience, the committee recognised that people with more severe depression may need inpatient care.

Based on their knowledge and experience, the committee agreed that psychological therapies should be available for people with depression in inpatient settings.

How the recommendations might affect practice

There may be some reduction in costs as CRHT is less costly than inpatient care, and it may prevent longer and more costly inpatient admissions. If used effectively it may also prevent readmission after inpatient stays.

Return to recommendations

Context

Each year 6% of adults in England will experience an episode of depression, and more than 15% of people will experience an episode of depression over the course

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

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

The symptoms of depression can be disabling and the effects of the illness pervasive. Depression can have a major detrimental effect on a person's personal, social and work life. This places a heavy burden on the person and their carers and dependents, as well as placing considerable demands on the healthcare system.

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

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

Finding more information and committee details

To find NICE guidance on related topics, including guidance in development, see the NICE webpage on depression.

For details of the guideline committee see the committee member list.

Update information

May 2022

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

We have reviewed the evidence on access to services, service delivery, treatment of new episodes of depression, prevention of relapse, further-line treatment, chronic depression, depression with personality disorder, psychotic depression and patient choice.

Recommendations are marked **[2021]** if the evidence has been reviewed.

Recommendations that have been deleted, or changed without an evidence review

We propose to delete some recommendations from the 2009 guideline. Table 1 sets out these recommendations and includes details of replacement recommendations. If there is no replacement recommendation, an explanation for the proposed deletion is given.

For recommendations shaded in grey and ending **[2009, amended 2021]** we have made changes that could affect the intent without reviewing the evidence. Yellow shading is used to highlight these changes, and reasons for the changes are given in table 2.

For recommendations shaded in grey and ending **[2009]**, we have not reviewed the evidence. In some cases minor changes have been made – for example, to update links, or bring the language and style up to date – without changing the intent of the recommendation. Minor changes are listed in table 3.

See also the previous NICE guideline and supporting documents.

Table 1 Recommendations that have been deleted

Recommendation in 2009 guideline	Comment
1.1.1.2 When working with people with depression and their families or carers:	This recommendation has been deleted as this information is now included in the

• provide information suited to their level of understanding about the nature of depression and the range of treatments available • avoid clinical language and if it has to be used make sure it is clearly explained • ensure that comprehensive written information is available in an appropriate language (and also in audio format if possible) • provide, and work with, independent interpreters (that is, someone who is not known to the person with depression) if needed.	NICE guideline on Service user experience in adult mental health services, which has been cross-referenced from the guideline.
1.1.1.4 Make every effort to ensure that a person with depression can give meaningful and informed consent before treatment starts. This is especially important when a person has severe depression or their treatment falls under the Mental Health Act or the Mental Capacity Act.	This recommendation has been deleted as this information is now included in the NICE guideline on Service user experience in adult mental health services, which has been cross-referenced from the guideline.
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 the intervention is • what is expected of the person while they are having it • likely outcomes (including any side effects).	This recommendation has been deleted as this information is now included in the NICE guideline on Service user experience in adult mental health services, which has been cross-referenced from the guideline.
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.	This recommendation has been deleted as this information is now included in the NICE guideline on Service user experience in adult mental health services, which has been cross-referenced from the guideline.

1.1.5.2 Consider providing all interventions in the preferred language of the person with depression where possible.	This recommendation has been deleted as this information is now included in the NICE guideline on Service user experience in adult mental health services, which has been cross-referenced from the guideline.
1.2 Stepped care	This whole section has been deleted as a new evidence review on models of service delivery was carried out (see section 1.15)
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.	This recommendation has been deleted as the committee agreed this would be included in self-help materials, which were reviewed as a treatment option for the first-line treatment of depression.
1.4.2.Low intensity psychosocial interventions	This whole section has been replaced by a new evidence review for the first-line treatment of depression (see sections 1.5 and 1.6)
1.4.3 Group cognitive behavioural therapy	This whole section has been replaced by a new evidence review for the first-line treatment of depression (see sections 1.5 and 1.6)
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.	This recommendation has been replaced by a new evidence review for the first-line treatment of depression (see section 1.5)
1.5 Persistent subthreshold depressive symptoms or mild to moderate	This whole section has been replaced by a new evidence review for the first-line

depression with inadequate response to initial interventions, and moderate and severe depression	treatment of depression (see sections 1.5 and 1.6)
1.6 Treatment choice based on depression subtypes and personal characteristics	This whole section has been replaced by a new evidence review for the first-line treatment of depression (see sections 1.5 and 1.6) with the exception of recommendations 1.6.1.2 on light therapy and 1.6.1.3 on antidepressants for older people which have been retained.
1.7 Enhanced care for depression	This whole section has been deleted as a new evidence review on models of service delivery was carried out (see section 1.15)
1.8 Sequencing treatments after initial inadequate response	This whole section has been deleted as a new evidence review on further-line treatment was carried out (see section 1.9)
1.9 Continuation and relapse prevention	This whole section has been deleted as new evidence reviews on relapse preventions and stopping antidepressants were carried out (see section 1.8 and 1.4)
1.10 Complex and severe depression (all of 1.10.1, 1.10.2, 1.10.3)	These whole sections have been deleted as new evidence reviews on psychotic depression and settings for care were carried out (see section 1.12 and 1.15)
1.10.4.	This whole section has been deleted and replaced with new recommendations on ECT.

Table 2 Amended recommendation wording (change to intent) without an evidence review (this table is ordered by numerical order of the recommendations in the 2009 guideline)

Recommendation in 2009 guideline	Recommendation in current guideline	Reason for change
1.1.1.1 When working with people with depression and their families or carers:	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 choices (see recommendations on choice) in an atmosphere of hope and optimism,	An additional bullet point has been added to highlight that the symptoms of depression and stigma can make it difficult to access treatment, and that service providers should take action to overcome this. This evidence was

• build a trusting relationship • work in an open, engaging and non-judgemental manner • explore treatment options in an atmosphere of hope and optimism • explain the different courses of depression, and that recovery is possible • be aware that stigma and discrimination can be associated with a diagnosis of depression • ensure that discussions take place in settings that respect confidentiality, privacy and dignity.	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 • be aware that the symptoms of depression itself and the impact of stigma can make it difficult for people to access mental health services or take up offers of treatment. Ensure steps are taken to reduce stigma and barriers for individuals seeking help for depression • ensure that discussions take place in settings that respect confidentiality, privacy and dignity. (2009, amended 2021)	identified in the evidence review on choice.
1.1.1.3 Inform people with depression about self-help groups, support groups and other	1.1.2 Make sure people with depression are aware of self-help groups, support groups and other local and national resources. Follow the guidance on providing information in the NICE guideline on service user experience in adult mental health. [2009, amended 2021]	A link to the NICE guideline on service user experience in adult mental health has been added.
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.	1.1.4 Consider developing advance decisions about treatment choices (including declining treatment) and advance statements collaboratively with people who have recurrent severe depression or depression with psychotic symptoms, and for those who have been treated under the Mental Health Act 2007, in line with the Mental Capacity Act 2005. Record the decisions and statements and include copies in the person's care plan in primary and	This recommendation has been amended to cite additional relevant legislation – the Mental Capacity Act - and include the choice to decline treatment.

	secondary care, and give copies to the person and to their family or carer if the person agrees. [2009, amended 2021]	
1.1.3.1 When families or carers are involved in supporting a person with severe or chronic 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.	1.1.6 When families or carers are involved in supporting a person with severe or chronic depression, see the recommendations in the NICE guideline on supporting adult carers on identifying, assessing and meeting the caring, physical and mental health needs of families and carers. [2009, amended 2021]	The details of the recommendation have been replaced by a link to the NICE guideline on supporting adult carers, which provides greater and more up to date advice on supporting families and carers.
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	1.2.7 Discuss with the person how the factors below may have affected the development, course and severity of their depression in addition to assessing symptoms and associated functional impairment: • any history of depression and coexisting mental health or physical disorders • any history of mood elevation (to determine if the depression may be part of bipolar disorder). See the NICE guideline on bipolar disorder.	The recommendation has been amended to include a link to the NICE guideline on bipolar disorder, to clarify that it is pervious and current relationships, and, based on the committee's experience and knowledge, to add drug and alcohol use, debt and employment to the list of social factors that may affect depression.

the depression may be part of bipolar disorder) • any past experience of, and response to, treatments • the quality of interpersonal relationships • living conditions and social isolation.	• any past experience of, and response to, previous treatments • difficulties with previous and current interpersonal relationships • living conditions, drug and alcohol use, debt, employment situation and social isolation. [2009, amended 2021]	
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.	1.2.5 If a person has language or communication difficulties (for example, people with sensory or cognitive impairments or autism), to help identify possible depression consider: • asking a family member or carer about the person's symptoms • asking the person about their symptoms directly using the appropriate method of communication depending on the person's needs (for example, using a British Sign Language interpreter, /English interpreter, or augmentative and alternative communication).See also the NICE guideline on mental health problems in people with learning disabilities and the NICE guideline on autism spectrum disorder . [2009, amended 2021]	This recommendation has been updated with more practical advice on how to overcome communication difficulties and a link to the NICE guidelines on mental health problems in people with learning disabilities and autism (see also 1.2.5 below)
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.	1.4.2 For all treatments for people with depression: • review how well the treatment is working with the person between 2 and 4 weeks after starting treatment • monitor and evaluate treatment concordance • monitor for side effects and harms of treatment • monitor suicidal ideation particularly in the early weeks of treatment (see	Based on their experience and knowledge the committee amended the recommendation on measuring outcomes to include when people should be reviewed, that this monitoring should include harms, side effects and suicidal ideation as well as treatment outcomes.

	also the recommendations on antidepressant medication for people at risk of suicide and recommendations on risk assessment) • consider routine outcome monitoring (using appropriate validated sessional outcome measures) and follow up. [2009, amended 2021]	
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 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.	1.2.5 If a person has language or communication difficulties (for example, people with sensory or cognitive impairments or autism), to help identify possible depression consider: • asking a family member or carer about the person's symptoms • asking the person about their symptoms directly using a British Sign Language/English interpreter. See also the NICE guideline on mental health problems in people with learning disabilities and the NICE guideline on autism spectrum disorder . [2009, amended 2021]	This recommendation has been updated and the reference to use of the Distress Thermometer has been removed as this detail would be superseded by recommendations made in NICE's guideline on mental health problems in people with learning disabilities. Detail has been added about the use of British Sign Language or English interpreter and links to NICE guideline on mental health problems in people with learning disabilities and autism included.
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.	1.2.11 Advise a person with depression and their family or carer to be vigilant for mood changes, agitation, 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. [2009, amended 2021]	This recommendation has been amended to include agitation,

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.	1.2.12 If a person with depression is assessed to be at risk of suicide: • do not withold treatment for depression on the basis of their suicide risk • take into account toxicity in overdose if an antidepressant is prescribed, or the person is taking other medication; (if necessary, limit the amount of medicine available) • consider increasing the level of support provided, such as more frequent face-to-face or telephone contacts • consider referral to specialist mental health services. For further advice on risk assessment, see the NICE guideline on self-harm. For further advice on medication see the recommendations on Antidepressant medication for people at risk of suicide. [2009, amended 2021]	This recommendation has been updated, based on the committee's experience and knowledge, by adding a bullet to state that treatment should not be withheld because they are suicidal, and to clarify that face-to-face support can be provided as well as telephone calls. A link to the NICE guideline on self-harm (in development) has been added, and to the separate section of the guideline on antidepressant medication for people at risk of suicide.
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	1.5.1 For people with less severe depression who do not want treatment or people who feel that their depressive symptoms are improving: • discuss the presenting problem(s) and any underlying vulnerabilities and risk factors, as well as any concerns that the person may have • make sure the person knows they can change their mind and how to seek help • provide information about the nature and course of depression • arrange a further assessment, normally within 2 weeks • make contact (with repeated attempts if	This recommendation was updated to remove the reference to subthreshold symptoms (as these people are now covered in the less severe depression recommendations), to provide more detail about underlying vulnerabilities, to make sure people know how to seek help if they change their mind, and that repeated attempts should be made it contact people if necessary.

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.	necessary), if the person does not attend follow-up appointments. [2009, amended 2021]	
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.	1.4.22 Take into account toxicity in overdose when prescribing an antidepressant medication for people at significant risk of suicide. Do not routinely start treatment with TCAs, except lofepramine, as they are associated with the greatest risk in overdose. [2009, amended 2021]	Based on the committee's knowledge and experience the warning relating to venlafaxine was removed as the committee agreed that there was no evidence that venlafaxine was associated with any greater risk than any other SSRIs or SNRIs. The 'be aware' recommendation was changed to 'do not routinely start treatment'.
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.	1.4.21 When prescribing antidepressant medication for people with depression who are under 25 years or are thought to be at increased risk of suicide: • be aware of the possible increased prevalence of suicidal thoughts, self-harm and suicide in the early stages of antidepressant treatment • review them 1 week after starting the antidepressant medication or increasing the dose for suicidality (ideally in-person, or by video call, or by telephone if in-person or	The age limit has been reduced to 25 years as this is in-line with the MHRA advice on increased risk of suicide. It has been clarified that the 1 week review should ideally be face-to-face or by video call, or can be by telephone, and then another review should take place after 4 weeks, with further reviews depending on their circumstances. The committee used their knowledge to provide examples of factors

	video are not possible or not preferred.) • review them after this as often as needed, but no later than 4 weeks after the appointment at which the antidepressant was started • base the frequency and method of ongoing review on their circumstances (for example, the availability of support, unstable housing, new life events such as bereavement, break-up of a relationship, loss of employment), and any changes in suicidal ideation or assessed risk of suicide. [2009, amended 2021]	that may increase their risk of suicide.
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.	1.7.2 Deliver behavioural couples therapy for people with depression that: • follows the behavioural principles for couples therapy provides 15–20 sessions of 50 to 60 minutes over 5 to 6 months. [2009, amended 2021]	The committee added the usual duration of each session to the recommendation.
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.	1.4.23 When prescribing antidepressant medication for older people: • take into account the person's general physical health, comorbidities and possible interactions with any other medicines they may be taking • carefully monitor the person for side effects (for example, hyponatraemia). See the NICE guideline on dementia. [2009, amended 2021]	The recommendation has been amended to add in comorbidities, as that may determine the choice of antidepressant. The suggestion to use a reduced dose in the elderly has been removed, as there is no evidence that lower doses are required and they may not be effective. An example of an important side-effect has been given, and a link to the NICE guideline on

		dementia has been included
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.	1.10.7 For people with chronic depressive symptoms that significantly impair personal and social functioning, who have been assessed as likely to benefit from extra social or vocational support, consider: • befriending in combination with existing antidepressant medication or psychological therapy: this should be done by trained volunteers, typically with at least weekly contact for between 2–6 months • a rehabilitation programme, if their depression has led to loss of work or their withdrawing from social activities over the longer term. [2009, amended 2021]	The terminology for the population has been changed to 'chronic depressive symptoms' to reflect the section heading in the guideline.
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.	1.4.24 For people with depression taking lithium, in particular older people assess weight, renal and thyroid function and calcium levels before treatment and then monitor every 3 to 6 months during treatment, or more often if there is evidence of renal impairment. [2009, amended 2021]	The recommendation has been amended to include weight and calcium levels, and to highlight the importance of monitoring in older people, to bring the recommendations in line with the monitoring requirements in the BNF

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Table 3 to be completed by the NICE guideline editor

Table 3 Minor changes to recommendation wording (no change to intent)

Recommendation numbers in current guideline	Comment
All recommendations except those labelled [20XX] (year of expected publication) [Do not include this row if recs in previous guideline were already in direct style]	Recommendations have been edited into the direct style (in line with current NICE style for recommendations in guidelines) where possible. Yellow highlighting has not been applied to these changes.

[Add month and year of update or post-publication change]: [If the original guideline has information about earlier updates or post-publication changes listed that are still relevant, leave them here with the most recent at the top. Delete any 'minor maintenance' changes. Repeat for each major change]

Minor changes since publication

[Month year]: [list minor changes that are still relevant here]