

Depression in adults: treatment and management

NICE guideline

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Your responsibility

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

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the [Yellow Card Scheme](#).

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

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

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This guideline replaces CG90.

This guideline partially replaces CG123.

This guideline is the basis of QS8.

Overview

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.

NICE has also produced a [guideline on depression in adults with a chronic physical health problem](#).

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

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.

Health and social care professionals should follow our general guidelines for people delivering care:

- [decision-making and mental capacity](#)
- [medicines adherence](#)
- [medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults](#)
- [medicines optimisation](#)
- [multimorbidity](#)
- [service user experience in adult mental health](#)
- [shared decision making](#)
- [supporting adult carers](#).

Definitions of depression and severity

Depression refers to a wide range of mental health problems characterised by the absence of a positive affect (a loss of interest and enjoyment in ordinary things and experiences), low mood and a range of associated emotional, cognitive, physical and behavioural symptoms. For more detail, see the [International Classification of Diseases-11 \(ICD-11\)](#) or the [Diagnostic and Statistical Manual of Mental Disorders-5 \(DSM-5\)](#) criteria for depression.

Depression severity exists along a continuum and is essentially composed of 3 elements:

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

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

Traditionally, depression severity has been grouped under 4 categories (subthreshold, mild, moderate and severe) but in the development of this guideline the committee wanted to develop a way of representing the severity of depression which best represents the available evidence on the classification and would help the uptake of the recommendations in routine clinical practice. This guideline has therefore defined new episodes of depression as [less severe](#) or [more severe](#) depression.

Less severe depression encompasses subthreshold and mild depression, and more severe depression encompasses moderate and severe depression. Thresholds on validated scales were used in this guideline as an indicator of severity. For example, a score 16 on the PHQ-9 scale was used, with scores less than 16 defined as less severe depression, and scores of 16 or more defined as more severe depression.

1.1 Principles of care

- 1.1.1 When working with people with depression and their families or carers, ensure steps are taken to reduce stigma, discrimination and barriers for individuals seeking help for depression (for example, reducing judgemental attitudes, showing compassion, parity of esteem between mental illness and physical illness, treating people as individuals). **[2009, amended 2022]**

Providing information and support

- 1.1.2 Provide people with depression with up-to-date and evidence-based verbal and written information about depression and its treatment, appropriate to their language, cultural and communication needs.
- 1.1.3 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 had treatment under the Mental Health Act 2007, in line with the Mental Capacity Act 2005, and review them regularly. 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 2022]**
- 1.1.4 Advise people with depression that they can set up a Health and Welfare Lasting Power of Attorney, and support them to do so if appropriate, so that a trusted person can represent their interests and make decisions on their behalf if they do not have the capacity to make decisions themselves at any point. **[2022]**

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?

See also the [NICE guideline on depression in adults with a chronic physical health problem](#). **[2009, amended 2022]**

- 1.2.2 If a person answers 'yes' to either of the depression identification questions (see recommendation 1.2.1) but the practitioner is not competent to perform a mental health assessment, refer the person to an appropriate professional who can. If this professional is not the person's GP, inform the person's GP about the referral. **[2009]**
- 1.2.3 If a person answers 'yes' to either of the depression identification questions (see recommendation 1.2.1) and the practitioner is competent to perform a mental health assessment, review the person's mental state and associated functional, interpersonal and social difficulties. **[2009]**
- 1.2.4 Consider using a validated measure (for example, for symptoms, functions and/or disability) when assessing a person with suspected depression to inform and evaluate treatment. **[2009]**
- 1.2.5 If a person has language or communication difficulties (for example, sensory or cognitive impairments or autism), to help identify possible depression consider:
- asking the person about their symptoms directly, using an 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)
 - asking a family member or carer about the person's symptoms.

See also the [NICE guidelines on mental health problems in people with learning disabilities](#) and [autism spectrum disorder](#). **[2009, amended 2022]**

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, but also takes into account severity of symptoms, previous history, duration and course of illness. Also, take into account both the degree of functional impairment and/or disability associated with the possible depression and the length of the episode. **[2009, amended 2022]**
- 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
 - personal strengths and resources, including supportive relationships
 - difficulties with previous and current interpersonal relationships
 - current lifestyle (for example, diet, physical activity, sleep)
 - any recent or past experience of stressful or traumatic life events, such as redundancy, divorce, bereavement, trauma (also see the [NICE guideline on post-traumatic stress disorder](#))
 - living conditions, drug (prescribed or illicit) and alcohol use, debt, employment situation, loneliness and social isolation. **[2009, amended 2022]**

Risk assessment and management

- 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 2022]**

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 in-person, video call or telephone contact
- 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**

2022]

Depression with anxiety

- 1.2.13 When depression is accompanied by symptoms of anxiety, which is particularly common in older people, 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, amended 2022]**

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 person's ability to communicate, disability or impairment.

For people with depression who also have dementia, see the [section on depression and anxiety in the NICE guideline on dementia](#). **[2009, amended 2022]**

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 in the section on initial assessment)
- whether they have ideas or preferences about starting treatment, and what treatment options they have previously found helpful or might prefer
- their experience of any prior episodes of depression, or treatments for depression
- what they hope to gain from treatment. **[2022]**

1.3.2 Help 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. **[2022]**

1.3.3 Discuss with people with depression their preferences for treatments (including declining an offer of treatment, or changing their mind once a treatment has started) by providing:

- information on what treatments are NICE-recommended, their potential benefits and harms, any waiting times for treatments, and the expected outcomes (see table 1 and table 2 on the recommended treatments for a new episode of less severe and more severe depression)
- a choice of:
 - the treatments recommended in this guideline
 - how they will be delivered (for example individual or group, in person or remotely) **and**
 - where they will be delivered

- the option to attend with a family member or friend when possible, for some or all of their treatment
- 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. **[2022]**

1.3.4 Commissioners and service managers 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 they are monitored to ensure equality of access, provision, outcomes and experience. **[2022]**

For a short explanation of why the committee made these recommendations and how they might affect practice, 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: patient choice](#).

1.4 Delivery of treatments

All treatments

- 1.4.1 When considering treatments for people with [depression](#):
- carry out an assessment of need
 - develop a treatment plan
 - take into account any physical health problems
 - take into account any coexisting mental health problems
 - discuss what factors would make the person most likely to engage with treatment (including reviewing positive and negative experiences of previous

treatment)

- take into account previous treatment history
- address any barriers to the delivery of treatments because of any disabilities, language or communication difficulties
- ensure 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 [NICE guideline on mental health problems in people with learning disabilities](#).
- who also have autism, see the [NICE guideline on autism spectrum disorder](#)
- who also have dementia, see the [NICE guideline on dementia](#)
- in pregnancy or the postnatal period, or who are breastfeeding, see the [NICE guideline on antenatal and postnatal mental health](#)
- who are menopausal, see the [NICE guideline on menopause](#)
- and physical health problems, see the [NICE guideline on depression in adults with a chronic physical health problem](#) and also see the [recommendations on collaborative care](#). **[2022]**

1.4.2 Match the choice of treatment to meet the needs and preferences of the person with depression. Use the least intrusive and most resource efficient treatment that is appropriate for their clinical needs, or one that has worked for them in the past. **[2022]**

1.4.3 For all people with depression having treatment:

- 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, for example PHQ-9) and follow up. **[2009, amended 2022]**

Psychological and psychosocial interventions

- 1.4.4 Inform people if there are waiting lists for a course of treatment and how long the wait is likely to be (for example, the NHS constitution advises that treatment should be started within 18 weeks). Keep in touch with people at regular intervals, ensure they are aware of how to access help if their condition worsens, ensure they are made aware of who they can contact about their progress on the waiting list. Consider providing self-help materials and addressing social support issues in the interim. **[2022]**
- 1.4.5 Use psychological and psychosocial [treatment manuals](#) to guide the form, duration and ending of interventions. **[2009, amended 2022]**
- 1.4.6 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]**
- 1.4.7 All healthcare professionals delivering interventions for people with depression should:
- receive regular clinical supervision
 - have their competence monitored and evaluated; this could include their supervisor reviewing video and audio recordings of their work (with patient consent). **[2009, amended 2022]**
- 1.4.8 When delivering psychological treatments for people with neurodevelopmental or learning disabilities, consider adapting the intervention as advised in the [NICE guideline on mental health problems in people with learning disabilities](#). **[2022]**

- 1.4.9 When people are nearing the end of a course of psychological treatment, discuss ways in which they can maintain the benefits of treatment and ensure their ongoing wellness. [2022]

Pharmacological treatments

Starting antidepressant medication

- 1.4.10 When offering a person medication for the treatment of depression, discuss and agree a management plan with the person. Include:

- the reasons for offering medication
- the choices of medication (if a number of different antidepressants are suitable)
- the dose, and how the dose may need to be adjusted
- the benefits, covering what improvements the person would like to see in their life and how the medication may help
- 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, effects on sexual function)
- 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 to review that is appropriate for their needs. [2022]

- 1.4.11 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 weeks to check their symptoms are improving and for side effects, or 1 week after starting antidepressant medication if a new prescription is for a person aged 18 to 25 years or if there is a particular concern for risk of suicide (see the [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).

[2022]

Stopping antidepressant medication

- 1.4.12 Advise people taking antidepressant medication to talk with the person who prescribed their medication (for example, their primary healthcare 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. **[2022]**
- 1.4.13 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. Also advise them that withdrawal symptoms do not affect everyone,

and can vary in type and severity between individuals. Symptoms may include:

- unsteadiness, vertigo or dizziness
- altered sensations (for example, electric shock sensations)
- altered feelings (for example, irritability, anxiety, low mood tearfulness, panic attacks, irrational fears, confusion, or very rarely suicidal thoughts)
- restlessness or agitation
- problems sleeping
- sweating
- abdominal symptoms (for example, nausea)
- palpitations, tiredness, headaches, and aches in joints and muscles. **[2022]**

1.4.14 Explain to people taking antidepressant medication that:

- withdrawal symptoms can be mild, may appear within a few days of reducing or stopping antidepressant medication, and usually go away within 1 to 2 weeks
- withdrawal can sometimes be more difficult, with symptoms lasting longer (in some cases several weeks, and occasionally several months)
- withdrawal symptoms can sometimes be severe, particularly if the antidepressant medication is stopped suddenly. **[2022]**

1.4.15 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
- increased support from a clinician or therapist (for example, regular check-in phone calls, seeing them more frequently, providing advice about sleep hygiene). **[2022]**

1.4.16 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 zero in a step-wise fashion, at each step prescribing a proportion of the previous dose (for example, 50% of previous dose)
- consider using smaller reductions (for example, 25%) as the dose becomes lower
- if, once very small doses have been reached, slow tapering cannot be achieved using tablets or capsules, consider using liquid preparations if available
- 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 or are tolerable before making the next dose reduction
- take into account the broader clinical context such as the potential benefit of more rapid withdrawal if there are serious or intolerable side effects (for example, hyponatraemia or upper gastrointestinal tract bleeding)
- take into account that more rapid withdrawal may be appropriate when switching antidepressants
- recognise that withdrawal may take weeks or months to complete successfully. **[2022]**

1.4.17 Monitor and review people taking antidepressant medication while their dose is being reduced, both for withdrawal symptoms and the return of symptoms of depression. Base the frequency of monitoring on the person's clinical and support needs. **[2022]**

1.4.18 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–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 in the following way:
 - 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.
 - allow 1 to 2 weeks to evaluate the effects of dose reduction before considering further dose reductions. **[2022]**

1.4.19 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. **[2022]**

1.4.20 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 primary healthcare or mental health professional) if the

symptoms do not improve, or if they get worse. [2022]

- 1.4.21 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. [2022]

For a short explanation of why the committee made these recommendations and how they might affect practice, see the [rationale and impact section on starting and stopping antidepressants](#).

For full details of the evidence and the committee's discussion, see the [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

- 1.4.22 When prescribing antidepressant medication for people with depression who are aged 18 to 25 years or are thought to be at increased risk of suicide:
- assess their mental state and mood before starting the prescription, ideally in person (or by video call or by telephone call if in-person assessment is not possible, or not preferred)
 - be aware of the possible increased prevalence of suicidal thoughts, self-harm and suicide in the early stages of antidepressant treatment, and ensure that a risk management strategy is in place (see the [section on risk assessment and management](#))
 - 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 these options are not possible or not preferred)
 - review them again 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 2022]**

1.4.23 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 2022]**

Antidepressant medication for older people

1.4.24 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
- be alert to an increased risk of falls and fractures
- be alert to the risks of hyponatraemia (particularly in those with other risk factors for hyponatraemia, such as concomitant use of diuretics).

See also the [NICE guideline on dementia: assessment, management and support for people living with dementia and their carers](#). **[2009, amended 2022]**

Use of lithium as augmentation

1.4.25 For people with depression taking lithium, assess weight, renal and thyroid function and calcium levels before treatment and then monitor at least every 6 months during treatment, or more often if there is evidence of significant renal impairment. **[2009, amended 2022]**

- 1.4.26 For women of reproductive age, in particular if they are planning a pregnancy, discuss the risks and benefits of lithium, preconception planning and the need for additional monitoring. **[2022]**
- 1.4.27 Monitor serum lithium levels 12 hours post dose, 1 week after starting treatment and 1 week after each dose change, and then weekly until levels are stable. 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. **[2022]**
- 1.4.28 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 aged 65 or above)
 - 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 2 receptor blockers,

diuretics and non-steroidal anti-inflammatory drugs [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. **[2022]**

- 1.4.29 Manage lithium prescribing under shared care arrangements. If there are concerns about toxicity or side effects (for example, in older people or people with renal impairment), manage their lithium prescribing in conjunction with specialist secondary care services. **[2022]**
- 1.4.30 Consider electrocardiogram (ECG) monitoring in people taking lithium who have a high risk of, or existing, cardiovascular disease. **[2009]**
- 1.4.31 Provide people taking lithium with information on how to do so safely, including the NHS lithium treatment pack. **[2022]**
- 1.4.32 Only stop lithium in specialist mental health services, or with their advice. When stopping lithium, whenever possible reduce doses gradually over 1 to 3 months. **[2022]**

For a short explanation of why the committee made these consensus recommendations and how they might affect practice, see the [rationale and impact section on use of lithium as augmentation](#).

Use of oral antipsychotics as augmentation

In June 2022, use of antipsychotics for the treatment of depression was an off-label use for some antipsychotics. See [NICE's information on prescribing medicines](#).

- 1.4.33 Before starting an antipsychotic, check the person's baseline pulse and blood pressure, weight, nutritional status, diet, level of physical activity, fasting blood

glucose or HbA1c and fasting lipids. **[2022]**

- 1.4.34 Carry out monitoring as indicated in the summary of product characteristics for individual medicines, for people who take an antipsychotic for the treatment of their depression. This may include:
- monitoring full blood count, urea and electrolytes, liver function tests and prolactin
 - 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
 - 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. **[2022]**
- 1.4.35 Manage antipsychotic prescribing under shared care arrangements. **[2022]**
- 1.4.36 For people with depression who are taking an antipsychotic, consider at each review whether to continue the antipsychotic based on their current physical and mental health risks. **[2022]**
- 1.4.37 Only stop antipsychotics in specialist mental health services, or with their advice. When stopping antipsychotics, reduce doses gradually over at least 4 weeks and

in proportion to the length of treatment. **[2022]**

For a short explanation of why the committee made these consensus recommendations and how they might affect practice, see the [rationale and impact section on use of oral antipsychotics as augmentation](#).

Use of St John's Wort

1.4.38 Although there is evidence that St John's Wort may be of benefit in less severe depression, healthcare professionals 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]**

Physical treatments and activities

Use of light therapy

1.4.39 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]**

Activities to help wellbeing

1.4.40 Advise people that doing any form of physical activity on a regular basis (for example, walking, jogging, swimming, dance, gardening) could help enhance their

sense of wellbeing. The benefits can be greater if this activity is outdoors. [2022]

- 1.4.41 Advise people that maintaining a healthy lifestyle (for example, eating a healthy diet, not over-using alcohol, getting enough sleep) may help improve their sense of wellbeing. See the also the [NHS advice on mental wellbeing](#). [2022]

For a short explanation of why the committee made these consensus recommendations and how they might affect practice, see the [rationale and impact section on activities to help wellbeing](#).

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 to 4 weeks
 - make contact (with repeated attempts if necessary), if the person does not attend follow-up appointments. [2009, amended 2022]

Treatment options

- 1.5.2 Discuss treatment options with people with a new episode of less severe depression, and match their choice of treatment to their clinical needs and preferences:
- use table 1 and the [visual summary on discussing first-line treatments for less severe depression](#) to guide and inform the conversation
 - take into account that all treatments in table 1 can be used as first-line treatments, but consider the least intrusive and least resource intensive treatment first (guided self-help)
 - reach a shared decision on a treatment choice appropriate to the person's clinical needs, taking into account their preferences (see also the [recommendations on choice of treatments](#))
 - recognise that people have a right to decline treatment. **[2022]**
- 1.5.3 Do not routinely offer antidepressant medication as first-line treatment for less severe depression. Only offer it if that is the person's informed preference. **[2022]**

Table 1

Treatment options for less severe depression in order of the committee's interpretation of their clinical and cost effectiveness and consideration of implementation factors

Treatment	How is this delivered?	Key features	Other things to think about
Guided self-help	<ul style="list-style-type: none"> • Printed or digital materials that follow the principles of guided self-help including structured cognitive behavioural therapy (CBT), structured behavioural activation (BA), problem-solving or psychoeducation materials. These can be delivered in person, by telephone, or online. • Support from a trained practitioner who facilitates the self-help intervention, encourages completion and reviews progress and outcomes. • Usually consists of 6 to 8 structured regular sessions. 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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

Treatment	How is this delivered?	Key features	Other things to think about
			<p>than individual psychological treatments.</p> <ul style="list-style-type: none"> • Avoids potential side effects of medication.

Treatment	How is this delivered?	Key features	Other things to think about
<p>Group cognitive behavioural therapy (CBT)</p>	<ul style="list-style-type: none"> • A group intervention delivered by 2 practitioners, at least 1 of whom has therapy-specific training and competence. • Usually consists of 8 regular sessions. • Usually 8 participants in the group. • Delivered in line with current treatment manuals. 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • May be helpful for people who can recognise negative thoughts or unhelpful patterns of 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.

Treatment	How is this delivered?	Key features	Other things to think about
<p>Group behavioural activation (BA)</p>	<ul style="list-style-type: none"> • A group intervention delivered by 2 practitioners, at least 1 of whom has therapy-specific training and competence. • Usually consists of 8 regular sessions. • Usually 8 participants in the group. • Delivered in line with current treatment manuals. 	<ul style="list-style-type: none"> • 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 <u>avoidance</u> 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. 	<ul style="list-style-type: none"> • 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.

Treatment	How is this delivered?	Key features	Other things to think about
Individual CBT	<ul style="list-style-type: none"> • Individual intervention delivered by a practitioner with therapy-specific training and competence. • Usually consists of 8 regular sessions, although additional sessions may be needed for people with comorbid mental or physical health problems or complex social needs, or to address residual symptoms. • Delivered in line with current treatment manuals. 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • May be helpful for people who can recognise negative thoughts or unhelpful patterns of 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

Treatment	How is this delivered?	Key features	Other things to think about
			homework assignments.

Treatment	How is this delivered?	Key features	Other things to think about
Individual BA	<ul style="list-style-type: none"> • Individual intervention delivered by a practitioner with therapy-specific training and competence. • Usually consists of 8 regular sessions, although additional sessions may be needed for people with comorbid mental or physical health problems or complex social needs, or to address residual symptoms. • Delivered in line with current treatment manuals. 	<ul style="list-style-type: none"> • 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 <u>avoidance</u> 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. 	<ul style="list-style-type: none"> • 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

Treatment	How is this delivered?	Key features	Other things to think about
			<p>will need to be willing to complete homework assignments.</p>

Treatment	How is this delivered?	Key features	Other things to think about
Group exercise	<ul style="list-style-type: none"> • A group physical activity intervention provided by a trained practitioner. • Uses a physical activity programme specifically designed for people with depression. • Usually consists of more than 1 session per week for 10 weeks. • Usually 8 participants in the group. 	<ul style="list-style-type: none"> • Includes moderate intensity aerobic exercise. • Does not directly target thoughts and feelings. 	<ul style="list-style-type: none"> • 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 make it difficult to exercise. • May need to be adapted to accommodate psychological aspects, for example anxiety or shame which may act as barriers to engagement. • Needs a considerable time commitment. • Can help with physical health too.

Treatment	How is this delivered?	Key features	Other things to think about
			<ul style="list-style-type: none"> <li data-bbox="1203 300 1445 472">• Avoids potential side effects of medication.

Treatment	How is this delivered?	Key features	Other things to think about
<p>Group mindfulness and meditation</p>	<ul style="list-style-type: none"> • A group intervention provided preferably by 2 practitioners, at least 1 of whom has therapy-specific training and competence. • Uses a programme such as mindfulness-based cognitive therapy specifically designed for people with depression. • Usually consists of 8 regular sessions. • Usually, 8 to 15 participants in the group. 	<ul style="list-style-type: none"> • 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 depression. 	<ul style="list-style-type: none"> • May be helpful for people who want to develop a different perspective on negative thoughts, feelings or bodily 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.

Treatment	How is this delivered?	Key features	Other things to think about
			<ul style="list-style-type: none"> The person will need to be willing to complete homework assignments, including using mindfulness recordings at home in between sessions.

Treatment	How is this delivered?	Key features	Other things to think about
<p>Interpersonal psychotherapy (IPT)</p>	<ul style="list-style-type: none"> • Individual intervention delivered by a practitioner with therapy-specific training and competence. • Usually consists of 8 to 16 regular sessions, although additional sessions may be needed for people with comorbid mental or physical health problems or complex social needs, or to address residual symptoms. • Delivered in line with current treatment manuals. 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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.

Treatment	How is this delivered?	Key features	Other things to think about
<p>Selective serotonin reuptake inhibitors (SSRIs)</p>	<ul style="list-style-type: none"> • A review, usually within 2 weeks, to check the person's symptoms are improving and for side effects. • A review 1 week after starting antidepressant medication if a new prescription is for a person aged 18 to 25 years or if there is a particular concern for risk of suicide. • Typically taken for at least 6 months (including after symptoms remit), with regular reviews. • See the recommendations on starting and stopping antidepressant medication for more details on regular monitoring, when reviews will happen during treatment, continuing treatment after remission to prevent relapse, and tapering over time to help prevent withdrawal symptoms. 	<ul style="list-style-type: none"> • Modify neuronal transmission in the brain. 	<ul style="list-style-type: none"> • 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.

Treatment	How is this delivered?	Key features	Other things to think about
Counselling	<ul style="list-style-type: none"> • Individual intervention delivered by a practitioner with therapy-specific training and competence. • Usually consists of 8 regular sessions, although additional sessions may be needed for people with comorbid mental or physical health problems or complex social needs, or to address residual symptoms. • Uses an empirically validated protocol developed specifically for depression. 	<ul style="list-style-type: none"> • Focus is on emotional processing and finding emotional meaning, 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. 	<ul style="list-style-type: none"> • 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 depression in a group. • Avoids potential side effects of medication.

Treatment	How is this delivered?	Key features	Other things to think about
<p>Short-term psychodynamic psychotherapy (STPP)</p>	<ul style="list-style-type: none"> • Individual sessions delivered by a practitioner with therapy-specific training and competence. • Usually consists of 8 to 16 regular sessions, although additional sessions may be needed for people with comorbid mental or physical health problems or complex social needs, or to address residual symptoms. • Uses an empirically validated protocol developed specifically for depression. 	<ul style="list-style-type: none"> • Focus is on recognising difficult feelings in significant relationships and stressful situations, and identifying how patterns can be repeated. • Both insight-oriented and affect focused. • Relationship between therapist and person with depression is included as a focus to help support working through key current conflicts. 	<ul style="list-style-type: none"> • 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 depression in a group. • Focusing on painful experiences in close and/or family

Treatment	How is this delivered?	Key features	Other things to think about
			<p>relationships could initially be distressing.</p> <ul style="list-style-type: none"> • Avoids potential side effects of medication.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the [rationale and impact section on treatment for a new episode 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](#).

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 options

1.6.1 Discuss treatment options with people who have a new episode of more severe depression, and match their choice of treatment to their clinical needs and preferences:

- use table 2 and the [visual summary on discussing first-line treatments for more severe depression](#) to guide and inform the conversation
- take into account that all treatments in table 2 can be used as first-line treatments

- reach a shared decision on a treatment choice appropriate to the person's clinical needs, taking into account their preferences (see also the [recommendations on choice of treatments](#))
- recognise that people have a right to decline treatment. **[2022]**

Table 2

Treatment options for more severe depression in order of the committee's interpretation of their clinical and cost effectiveness and consideration of implementation factors

Treatment	How is this delivered?	Key features	Other things to think about
<p>Combination of individual cognitive behavioural therapy (CBT) and an antidepressant</p>	<ul style="list-style-type: none"> A combination of individual CBT and a course of antidepressant medication (see details below). 	<ul style="list-style-type: none"> Combines the benefits of regular CBT sessions with a therapist and medication. 	<ul style="list-style-type: none"> Sessions with a therapist provide immediate support while the medication takes time to work or medication can be started immediately, and then CBT started as soon as possible afterwards to obtain combined effects. There may be side effects from the medication, and some people may find it difficult to later stop antidepressant medication.

Treatment	How is this delivered?	Key features	Other things to think about
Individual CBT	<ul style="list-style-type: none"> • Individual intervention delivered by a practitioner with therapy-specific training and competence. • Usually consists of 16 regular sessions, although additional sessions may be needed for people with comorbid mental or physical health problems or complex social needs, or to address residual symptoms. • Delivered in line with current treatment manuals. 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • May be helpful for people who can recognise negative thoughts or unhelpful patterns of behaviour they wish to change. • Avoids potential side effects of medication. • The person will need to be willing to complete homework assignments.

Treatment	How is this delivered?	Key features	Other things to think about
<p>Individual behavioural activation (BA)</p>	<ul style="list-style-type: none"> • Individual intervention delivered by a practitioner with therapy-specific training and competence. • Usually consists of 12 to 16 regular sessions, although additional sessions may be needed for people with comorbid mental or physical health problems or complex social needs, or to address residual symptoms. • Delivered in line with current treatment manuals. 	<ul style="list-style-type: none"> • 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 <u>avoidance</u> 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. 	<ul style="list-style-type: none"> • 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

Treatment	How is this delivered?	Key features	Other things to think about
			assignments.

Treatment	How is this delivered?	Key features	Other things to think about
Antidepressant medication	<ul style="list-style-type: none"> • A review, usually within 2 weeks, to check the person's symptoms are improving and for side effects. • A review 1 week after starting antidepressant medication if a new prescription is for a person aged 18 to 25 years or if there is a particular concern for risk of suicide. • Typically taken for at least 6 months (including after symptoms remit), with regular reviews. • Can be a selective serotonin reuptake inhibitor (SSRI), serotonin–norepinephrine reuptake inhibitor (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 on regular monitoring, when 	<ul style="list-style-type: none"> • SSRIs are generally well tolerated, have a good safety profile and should be considered as the first choice for most people. • Tricyclic antidepressant (TCAs) are dangerous in overdose, although lofepramine has the best safety profile. 	<ul style="list-style-type: none"> • Choice of treatment will depend on preference for specific 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

Treatment	How is this delivered?	Key features	Other things to think about
	<p>reviews will happen during treatment, continuing treatment after remission to prevent relapse, and tapering over time to help prevent withdrawal symptoms.</p>		<p>stop antidepressant medication.</p>
<p>Individual problem-solving</p>	<ul style="list-style-type: none"> • Individual sessions delivered by a practitioner with therapy-specific training and competence. • Usually consists of 6 to 12 regular sessions. • Delivered in line with current treatment manuals. 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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.

Treatment	How is this delivered?	Key features	Other things to think about
Counselling	<ul style="list-style-type: none"> • Individual sessions delivered by a practitioner with therapy-specific training and competence. • Usually consists of 12 to 16 regular sessions, although additional sessions may be needed for people with comorbid mental or physical health problems or complex social needs, or to address residual symptoms. • Uses an empirically validated protocol developed specifically for depression. 	<ul style="list-style-type: none"> • Focus is on emotional processing and finding emotional meaning, 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. 	<ul style="list-style-type: none"> • 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 depression in a group. • Avoids potential side effects of medication.

Treatment	How is this delivered?	Key features	Other things to think about
<p>Short-term psychodynamic psychotherapy (STPP)</p>	<ul style="list-style-type: none"> • Individual sessions delivered by a practitioner with therapy-specific training and competence. • Usually consists of 16 regular sessions, although additional sessions may be needed for people with comorbid mental or physical health problems or complex social needs, or to address residual symptoms. • Uses an empirically validated protocol developed specifically for depression. 	<ul style="list-style-type: none"> • Focus is on recognising difficult feelings in significant relationships and stressful situations, and identifying how patterns can be repeated. • Both insight-oriented and affect focused. • Relationship between therapist and person with depression is included as a focus to help support working through key current conflicts. 	<ul style="list-style-type: none"> • 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 depression in a group. • Focusing on painful experiences in close and/or family relationships could initially be distressing.

Treatment	How is this delivered?	Key features	Other things to think about
			<ul style="list-style-type: none"> • Avoids potential side effects of medication.
<p>Interpersonal psychotherapy (IPT)</p>	<ul style="list-style-type: none"> • Individual sessions delivered by a practitioner with therapy-specific training and competence. • Usually consists of 16 regular sessions, although additional sessions may be needed for people with comorbid mental or physical health problems or complex social needs, or to address residual symptoms. • Delivered in line with current treatment manuals. 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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.

Treatment	How is this delivered?	Key features	Other things to think about
Guided self-help	<ul style="list-style-type: none"> • Printed or digital materials that follow the principles of guided self-help including structured CBT, structured BA, problem-solving or psychoeducation materials. These can be delivered in person, by telephone, or online. • Support from a trained practitioner who facilitates the self-help intervention, encourages completion and reviews progress and outcome. • Support usually consists of 6 to 8 structured, regular sessions. 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • In more severe depression, the potential advantages of providing other treatment choices with more therapist contact should be carefully considered first. • 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

Treatment	How is this delivered?	Key features	Other things to think about
			<p>adaptations than individual psychological treatments.</p> <ul style="list-style-type: none"> • Avoids potential side effects of medication.

Treatment	How is this delivered?	Key features	Other things to think about
Group exercise	<ul style="list-style-type: none"> • A group physical activity intervention provided by a trained practitioner. • Uses a physical activity programme specifically designed for people with depression. • Usually consists of more than 1 session per week for 10 weeks. • Usually 8 participants in the group. 	<ul style="list-style-type: none"> • Includes moderate intensity aerobic exercise. • Does not directly target thoughts and feelings. 	<ul style="list-style-type: none"> • In more severe depression, the potential advantages of providing other treatment choices with more therapist contact should be carefully considered first. • May allow peer support from others who are may be having similar experiences. • May need to be adapted if the person has physical health problems that prevent exercise. • May need to be adapted to accommodate psychological aspects, for example anxiety or shame which may act as barriers to engagement.

Treatment	How is this delivered?	Key features	Other things to think about
			<ul style="list-style-type: none"> • 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 this recommendation and how it might affect practice, see the [rationale and impact section on treatment for a new episode 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. **[2022]**

1.7.2 Deliver behavioural couples therapy for people with depression that:

- follows the behavioural principles for couples therapy
- provides 15 to 20 sessions over 5 to 6 months. **[2009]**

For a short explanation of why the committee made this recommendation and how it might affect practice, 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 Preventing relapse

- 1.8.1 Discuss with people that continuation of treatment (antidepressants or psychological therapies) 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. See the [visual summary on preventing relapse](#). **[2022]**
- 1.8.2 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 (see [recommendation 1.2.7 in the section on initial assessment](#)) and that are still present (for example, relationship problems, ongoing stress, poverty, isolation, unemployment). **[2022]**
- 1.8.3 Discuss with people the potential risks of continuing with antidepressants long

term, and how these balance against the risks of depression relapse. These include:

- possible side effects, such as an increased bleeding risk or long-term effects on sexual function
- difficulty stopping antidepressants. **[2022]**

1.8.4 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. **[2022]**

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 to prevent relapse, maintaining the dose that led to full or partial remission, 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). **[2022]**

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 usually consists of 8 sessions over 2 to 3 months with the option of additional sessions in the next 12 months. **[2022]**

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 personal or social 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. **[2022]**
- 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. **[2022]**
- 1.8.9 Discuss with people who have remitted from depression when treated with a 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. **[2022]**
- 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. **[2022]**
- 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 validated rating scale (see the [recommendations](#)

on delivery of treatments)

- review any side effects
- review any medical, personal, social or environmental factors that may affect their risk of relapse, and encourage them to access help from other agencies
- discuss with them if they wish to continue treatment; if they wish to stop antidepressant treatment, see the recommendations on stopping antidepressant medication. [2022]

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. [2022]

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on preventing relapse.

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

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, social or environmental factors or physical or other mental health conditions that might explain why the treatment is not 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, including how other agencies may be able to help with these factors. See the [visual summary on further-line treatment](#). **[2022]**

- 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 treatment changes to work, review the diagnosis and consider the possibility of alternative or comorbid conditions that may limit response to depression treatments. **[2022]**
- 1.9.3 Reassure the person that although treatment has not worked, other treatments can be tried, and may be effective. **[2022]**
- 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
 - adding an SSRI to the psychological therapy
 - switching to an SSRI alone. **[2022]**
- 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 [section on suggested treatment options for more severe depression](#))
 - continuing antidepressant therapy by either 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 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, or in secondary care a TCA or MAOI); take into account 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 to take place in, or with advice from, secondary care
 - ◇ TCAs are dangerous in overdose, although lofepramine has the best safety profile
- changing to a combination of psychological therapy (for example, CBT, interpersonal psychotherapy [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). **[2022]**

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 another medication (see recommendation 1.9.9). **[2022]**

1.9.7 Vortioxetine is recommended as an option in NICE technology appraisal guidance when there has been no or limited response to at least 2 antidepressants within the current episode. For full details, see the [guidance on vortioxetine for treating major depressive episodes \(TA367, 2015\)](#). **[2022]**

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. **[2022]**

1.9.9 If a person with depression wants to try a combination treatment and is willing to accept the possibility of an increased side-effect burden (see recommendation 1.9.8), consider referral to a specialist mental health setting or consulting a specialist. Treatment options include:

- adding an additional antidepressant medication from a different class (for example, adding mirtazapine or trazodone to an SSRI)
- combining an antidepressant medication with a second-generation antipsychotic (for example, aripiprazole, olanzapine, quetiapine or risperidone) or lithium
- augmenting antidepressants with electroconvulsive therapy (see the [recommendations on electroconvulsive therapy for depression](#)), lamotrigine, or triiodothyronine (liothyronine).

Be aware that some combinations of classes of antidepressants are potentially dangerous and should be avoided (for example, a SSRI, SNRI or TCA with a MAOI), and that when using an antipsychotic the effects of this on depression, including loss of interest and motivation, should be carefully reviewed.

In June 2022, this was an off-label use for some antipsychotics, lamotrigine, and triiodothyronine (liothyronine). See [NICE's information on prescribing medicines](#). **[2022]**

For a short explanation of why the committee made these recommendations and how they might affect practice, 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. See the [visual summary on treatment for chronic depression](#). [2022]
- 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**
 - SNRIs **or**
 - TCAs (be aware that TCAs are dangerous in overdose, although lofepramine has the best safety profile) **or**
 - combination therapy with CBT and either an SSRI or a TCA.

Discuss the 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](#)). [2022]

- 1.10.3 For people with chronic depressive symptoms, offer cognitive behavioural treatment that:

- has a focus on chronic depressive symptoms
 - covers related maintaining processes, including [avoidance](#), [rumination](#) and interpersonal difficulties. **[2022]**
- 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](#). **[2022]**
- 1.10.5 If a person with chronic depressive symptoms that significantly impair personal and social functioning cannot tolerate a particular SSRI, consider treatment with an alternative SSRI. **[2022]**
- 1.10.6 For people with chronic depressive symptoms that significantly impair personal and social functioning, who have not responded to SSRIs or SNRIs, 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:
- TCAs
 - moclobemide
 - irreversible MAOIs such as phenelzine
 - low-dose amisulpride (maximum dose of 50 mg daily, as higher doses may worsen depression and lead to side effects such as hyperprolactinaemia and QT interval prolongation).
- In June 2022, this was an off-label use for amisulpride. See [NICE's information on prescribing medicines](#). **[2022]**
- 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 to 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 2022]**

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 the [sections on further-line treatment](#) and [chronic depressive symptoms](#), offer a referral to specialist mental health services for advice and further treatment. See also the [recommendations on collaborative care](#). **[2022]**

1.10.9 For people with chronic depressive symptoms that have not responded to the treatments recommended in the sections on further-line treatment and chronic depressive symptoms, 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 (including from other agencies) may be helpful. **[2022]**

For a short explanation of why the committee made these recommendations and how they might affect practice, 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 Do not withhold treatment for depression because of a coexisting personality disorder. See the [visual summary on treatment of depression with personality disorder](#). [2022]
- 1.11.2 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](#). [2022]
- 1.11.3 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. [2022]
- 1.11.4 For people with depression and a diagnosis of personality disorder, consider referral to a specialist personality disorder treatment programme. See the [NICE guideline on borderline personality disorder](#) for recommendations on treatment for borderline personality disorder with coexisting depression. [2022]

For a short explanation of why the committee made these recommendations and how they might affect practice, see the [rationale and impact section on depression in people with a diagnosis of personality disorder](#).

Full details of the evidence and the committee's discussion are in [evidence review F: depression with coexisting personality disorder](#).

1.12 Psychotic depression

In June 2022, 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
- an assessment of needs
- 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. See the [visual summary on treatment of psychotic depression](#). **[2022]**

1.12.2 Consider combination treatment for people with depression with psychotic symptoms with antidepressant medication and antipsychotic medication (for example, olanzapine or quetiapine). **[2022]**

1.12.3 If a person with depression with psychotic symptoms does not wish to take antipsychotic medication in addition to an antidepressant, then treat with an antidepressant alone. **[2022]**

1.12.4 Monitor people with depression with psychotic symptoms for treatment response (in particular for unusual thought content and hallucinations). **[2022]**

1.12.5 Consider continuing antipsychotic medication for people with depression with psychotic symptoms for a number of months after remission, if tolerated. The decision about if and when to stop antipsychotic medication should be made by, or in consultation with, specialist services. **[2022]**

1.12.6 For more advice on prescribing and monitoring antipsychotics see the

[recommendations on use of oral antipsychotics as augmentation](#) and the [NICE guideline on psychosis and schizophrenia in adults](#). [2022]

For a short explanation of why the committee made these recommendations and how they might affect practice, 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 experience of ECT 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](#)). [2022]

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. **[2022]**

- 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:
- 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. **[2022]**
- 1.13.4 If a person with depression cannot give informed consent, only give ECT if it does not conflict with a valid advance treatment decision the person made. **[2022]**
- 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. **[2022]**
- 1.13.6 Clinics should only provide ECT if they:
- are Electroconvulsive Therapy Accreditation Service (ECTAS) accredited
 - provide ECT services in accordance with ECTAS standards
 - submit data, including outcomes, on each course of acute and maintenance ECT they deliver as needed for the ECTAS minimum dataset.

Follow the [ECT Accreditation Service Standards for Administering ECT](#).

[2022]

- 1.13.7 Trusts which provide ECT services should ensure compliance with the ECTAS standards for administering ECT through board-level performance management. [2022]
- 1.13.8 Stop ECT treatment for a person with depression:
- immediately, if the side effects outweigh the potential benefits, **or**
 - when stable remission has been achieved. [2022]
- 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 preventing relapse](#))
 - consider lithium augmentation of antidepressant medication (see the [recommendations on further-line treatment](#)). [2022]

For a short explanation of why the committee made these recommendations and how they might affect practice, 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 procedures guidance on repetitive transcranial magnetic stimulation for depression](#).

1.15 Treatment-resistant depression

- 1.15.1 See the [NICE interventional procedures guidance on implanted vagus nerve stimulation for treatment-resistant depression](#).
- 1.15.2 Esketamine nasal spray is not recommended in NICE technology appraisal guidance for treating treatment-resistant depression. For full details, see the [guidance on esketamine nasal spray \(TA854, 2022\)](#).

1.16 Access, coordination and delivery of care

Access to services

- 1.16.1 Commissioners and providers of mental health services should consider using models such as [stepped care or matched care](#) for organising the delivery of care and treatment of people with depression. See the [matched care model visual summary](#).

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. **[2022]**

1.16.2 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 a coordinated primary and secondary care mental health service, as well as community services (for example social care, education, housing, statutory services and the voluntary and social enterprise sector). This should include:

- assessment procedures
- shared decision making
- collaboration between professionals
- delivery of pharmacological, psychological and physical (for example exercise, ECT) interventions
- delivery of interventions for personal, social and environmental factors (for example, housing problems, isolation and unemployment)
- care coordination
- involvement of service users in design, monitoring and evaluation of services
- the effective monitoring and evaluation of services. **[2022]**

1.16.3 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 primary care healthcare professionals), 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, providing advice, consultation and support for primary care mental health staff

- specialist-based mental health teams, for people with severe and complex needs. **[2022]**

1.16.4 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 and retention:

- services available outside normal working hours
- 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. **[2022, amended 2023]**

1.16.5 When promoting access and uptake of services, identify and address the needs of groups who may have difficulty in accessing, or face stigma or discrimination 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
- people who are homeless, refugees and asylum seekers. **[2022]**

For a short explanation of why the committee made these recommendations and how they might affect practice, 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 to services](#).

Collaborative care

1.16.6 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. **[2022]**

1.16.7 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
- involvement of other agencies that provide support
- supervision of practitioners by an experienced mental health professional. **[2022]**

Specialist care

- 1.16.8 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 previous treatments, and **either**
 - have multiple complicating problems, for example unemployment, poor housing or financial problems **or**
 - have significant coexisting mental and physical health conditions. **[2022]**
- 1.16.9 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). **[2022]**

For a short explanation of why the committee made these recommendations and how they might affect practice, 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

- 1.16.10 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. **[2022]**
- 1.16.11 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. **[2022]**
- 1.16.12 Consider inpatient treatment for people with more severe depression who cannot be adequately supported by a CRHT team. See also the [NICE guideline on mental health problems in people with learning disabilities](#). **[2022]**

- 1.16.13 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 secondary care settings (including community and inpatient). **[2022]**
- 1.16.14 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]**
- 1.16.15 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 and how they might affect practice, 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, communication 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 ICD-11, depression is defined as the presence of depressed mood or diminished interest in activities occurring most of the day, nearly every day, for at least 2 weeks, accompanied by other symptoms such as:

- reduced ability to concentrate and sustain attention or marked indecisiveness

- beliefs of low self-worth or excessive or inappropriate guilt
- hopelessness about the future
- recurrent thoughts of death or suicidal ideation or evidence of attempted suicide
- significantly disrupted sleep or excessive sleep
- significant changes in appetite or weight
- psychomotor agitation or retardation
- reduced energy or fatigue

In DSM-5 depression is defined as the presence of 5 or more symptoms from a list of 9 symptoms, during the same 2-week period and where at least 1 of the symptoms is depressed mood or loss of interest or pleasure, most of the day, nearly every day. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. The 9 symptoms are:

- depressed mood – indicated by subjective report or observation by others
- loss of interest or pleasure in almost all activities – indicated by subjective report or observation by others
- significant (more than 5% in a month) unintentional weight loss or gain or decrease or increase in appetite
- sleep disturbance (insomnia or hypersomnia)
- psychomotor changes (agitation or retardation) severe enough to be observable by others
- tiredness, fatigue, or low energy, or decreased efficiency with which routine tasks are completed
- a sense of worthlessness or excessive, inappropriate, or delusional guilt (not merely self-reproach or guilt about being sick)
- impaired ability to think, concentrate, or make decisions – indicated by subjective report or observation by others
- recurrent thoughts of death (not just fear of dying), suicidal ideation, or suicide

attempts.

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, and in this guideline was defined as depression scoring less than 16 on the PHQ-9 scale.

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, and in this guideline was defined as depression scoring 16 or more on the PHQ-9 scale.

Personal and social functioning

Personal functioning represents the ability of an individual to effectively engage in the normal activities of everyday living and react to experiences. Social functioning is the ability to interact with other people, develop relationships and to gain from and develop these interactions.

Routine (sessional) outcome monitoring

This is a system for the monitoring of the outcomes of treatments which involves regular assessment (usually at each contact; referred to as sessional) of symptoms or personal and social 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 I not get better?').

Stepped care or matched 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. Matched care follows the principles of stepped care, but also takes into account other factors such as patient presentation, previous experience of treatment, patient choice and preferences.

See the [matched care model visual summary](#).

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 the recommendation for research, see the [rationale section on starting and stopping antidepressants](#).

For full details of the evidence and the committee's discussion, see the [evidence reviews for the NICE guideline on safe prescribing](#) (evidence review A: patient information and support; evidence review B: prescribing strategies; evidence review C: safe withdrawal; evidence review D: withdrawal interventions; evidence review E: 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 the recommendation for research, see the [rationale section on preventing relapse](#).

Full details of the evidence and the committee's discussion are in [evidence review C: preventing relapse](#).

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 the recommendation for research, see the [rationale 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 the recommendation for research, 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](#).

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 the recommendation for research, see the [rationale section on access to services](#).

Full details of the evidence and the committee's discussion are in [evidence review H: access to services](#).

Other recommendations for research

6 First-line treatment of less severe depression

Is peer support an effective and cost-effective treatment in improving outcomes, including symptoms, personal and social 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? (This question is applicable to less severe and more severe depression.)

For a short explanation of why the committee made these recommendations for research, see the [rationale section on treatment for a new episode 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](#).

7 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 for research, see the [rationale section on treatment for a new episode 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](#).

8 Chronic depression

What is the effectiveness, acceptability and safety of monoamine oxidase inhibitors (MAOIs; for example, phenelzine) compared to alternative SSRI or 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 people with depression, 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 for research, 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](#).

9 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 electroconvulsive therapy [ECT])?

For a short explanation of why the committee made the recommendation for research, see the [rationale section on psychotic depression](#).

Full details of the evidence and the committee's discussion are in [evidence review G: psychotic depression](#).

10 Electroconvulsive therapy

Is maintenance electroconvulsive therapy (ECT) effective and safe for relapse prevention in people with severe and recurring depression whose depression has remitted on ECT?

For a short explanation of why the committee made the recommendation for research, see the [rationale section on preventing relapse](#).

Full details of the evidence and the committee's discussion are in [evidence review C: preventing relapse](#).

Rationale and impact

These sections briefly explain why the committee made the recommendations and how they might affect practice or services.

Choice of treatments

[Recommendations 1.3.1 to 1.3.4](#)

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 1.4.10 to 1.4.21](#)

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 withdrawal 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 on stopping antidepressants](#). 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.

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Use of lithium as augmentation

[Recommendations 1.4.26 to 1.4.29, 1.4.31 and 1.4.32](#)

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 BNF.

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 oral antipsychotics as augmentation

[Recommendations 1.4.33 to 1.4.37](#)

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 BNF 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.

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Activities to help wellbeing

[Recommendations 1.4.40 and 1.4.41](#)

Why the committee made the recommendations

The committee were aware, based on their knowledge and experience, that informal exercise, and particularly exercise outdoors, may lead to an improved sense of wellbeing. They were also aware that a healthy lifestyle may improve a sense of wellbeing. These views were confirmed by stakeholder comments

How the recommendations might affect practice

The recommendations may encourage conversations about the value of informal exercise and a healthy lifestyle, but as this is self-directed exercise and lifestyle changes there will not be resource implications for the NHS.

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Treatment for a new episode of less severe depression

[Recommendations 1.5.2 and 1.5.3](#)

Why the committee made the recommendations

There was good evidence for the effectiveness of group cognitive behavioural therapy (CBT) and group behavioural activation (BA) and these treatments were found to likely 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 guided self-help, and these interventions were also likely to be cost effective. Therefore, these options were provided as alternatives for people who did not wish to participate in group therapy. The committee discussed that, in practice, it was logical to offer the least intrusive and least resource intensive treatments first, and then step up to other treatments if necessary. For this reason, the committee agreed that guided self-help should be considered first for most people with less severe depression.

There was some evidence for the effectiveness of group mindfulness and meditation, group exercise, interpersonal psychotherapy (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 selective serotonin reuptake inhibitors (SSRIs) would be the preferred antidepressants to use in people with less severe depression because of their safety and tolerability. The committee discussed that as the evidence suggested that some psychological therapies were more effective than antidepressants and due to the potential for side effects, 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 short-term psychodynamic psychotherapy (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. Apart from the advice to use guided self-help first for pragmatic reasons, 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 to also take into account factors which may promote implementation, such as the use of least intrusive treatments first. However, 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 on peer support. As there was considerable uncertainty in the evidence for the effectiveness and cost effectiveness of psychological interventions, the committee made a further research recommendation 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.

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Treatment for a new episode of more severe depression

[Recommendation 1.6.1](#)

Why the committee made the recommendation

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

There was some evidence for the effectiveness of counselling and individual problem-solving therapy, both of which also appeared to be 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 on acupuncture and antidepressants](#).

Both guided self-help and group exercise were, on average, shown to be effective and

appeared to be 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 that the potential advantages of providing other treatment choices with more therapist contact should be carefully considered first.

In addition to the evidence reviewed, the committee were aware of large-scale and pragmatic trials that were excluded from the network meta-analysis (because they involved patient populations that did not meet specific search criteria). However, the results of these studies were largely consistent with the evidence reviewed and supported the recommendations.

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 (as well as consideration of implementation factors) 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 recommendation might affect practice

The recommendation reflects 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.

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Behavioural couples therapy

[Recommendation 1.7.1](#)

Why the committee made the recommendation

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 recommendation might affect practice

The recommendation reflects current practice, but may reduce variation in practice across the NHS.

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Preventing relapse

[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 mindfulness-based cognitive therapy (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 or maintenance electroconvulsive therapy (ECT) in preventing relapse, the committee made a [research recommendation on the effectiveness and cost effectiveness of brief courses of psychological treatment](#) and a [research recommendation on maintenance ECT](#).

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.

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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's symptoms may not respond to treatment for depression for a number of reasons, and that these reasons should be explored and addressed 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 further-line treatment options for people whose depression had initially been treated with psychological therapies. As there was no evidence for people whose symptoms did not respond to initial psychological treatments, the committee made a [research recommendation on further-line treatment](#).

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. There was also some

evidence that a combination of psychological therapy and antidepressants was effective so the committee also recommended the use of combination treatment. Based on the evidence from the review of first-line treatment for more severe depression, the committee agreed that the psychological interventions that had been effective and cost effective for first-line treatment of more severe depression could be used for people whose symptoms had not responded to antidepressants and wished to try a psychological therapy instead.

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 when there has been no or inadequate response to other treatment. Based on their knowledge, experience and awareness of the wider evidence base for ECT, the committee were aware that ECT leads to rapid effects and so they advised that it should also be considered in other circumstances (not just as further-line treatment), 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 needed 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 1.9.1 to 1.9.9 and 1.13.1 to 1.13.9](#)

Chronic depressive symptoms

[Recommendations 1.10.1 to 1.10.6, 1.10.8 and 1.10.9](#)

Why the committee made the recommendations

There was some evidence for CBT, SSRIs, SNRIs 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 a [research recommendation on the effectiveness and cost effectiveness of psychological, pharmacological or a combination of these treatments](#).

There was some evidence for the effectiveness of other medications, including TCAs, phenelzine, amisulpride and moclobemide 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 SNRIs. 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 monoamine oxidase inhibitors (MAOIs) for further-line treatment of chronic depression, the committee made a [research recommendation on the effectiveness, acceptability and safety of MAOIs](#).

How the recommendations might affect practice

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

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Depression in people with a diagnosis of personality disorder

[Recommendations 1.11.1 to 1.11.4](#)

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 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 on the most effective and cost-effective interventions for the treatment and management of psychotic depression](#).

How the recommendations might affect practice

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

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Access to services

[Recommendations 1.16.1 to 1.16.5](#)

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 or matched care approach by, good integration between primary and secondary care, ensuring information on services was available and 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 on 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.

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.

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Collaborative care and specialist care

[Recommendations 1.16.5 to 1.16.8](#)

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.

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Crisis care, home treatment and inpatient care

[Recommendations 1.16.10 to 1.16.13](#)

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.

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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 topic page on depression](#).

For full details of the evidence and the guideline committee's discussions, see the [evidence reviews](#). You can also find information about [how the guideline was developed](#), including [details of the committee](#).

NICE has produced [tools and resources to help you put this guideline into practice](#). For general help and advice on putting our guidelines into practice, see [resources to help you put NICE guidance into practice](#).

Update information

June 2022: This guideline updates and replaces NICE guideline CG90 (published October 2009).

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 **[2022]** if the evidence has been reviewed.

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

Some recommendations were deleted from the 2009 guideline. [Appendix 1](#) sets out these recommendations and includes details of replacement recommendations. If there is no replacement recommendation, an explanation for the deletion is given.

For recommendations ending **[2009, amended 2022]** we have made changes without reviewing the evidence. The reasons for the changes are given in [appendix 2](#).

For recommendations 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.

See also the [previous NICE guideline and supporting documents](#).

Minor changes since publication

December 2025: We amended the information on antidepressant medication in tables 1 and 2 to emphasise the need for regular reviews in relation to length of treatment and give details of when the first review should happen.

October 2025: We amended recommendation 1.5.3 to clarify our advice on first-line treatment for less severe depression.

September 2024: We added links to relevant technology appraisal guidance in the [sections on further-line treatment](#) and [treatment-resistant depression](#).

May 2024: We have simplified the guideline by removing recommendations on general principles of care that are covered in other NICE guidelines (for example, the [NICE guideline on service user experience in adult mental health](#)).

This is a presentational change only, and no changes to practice are intended.

April 2023: In recommendation 1.4.11 we clarified the timing of the first review after starting antidepressant medication for people aged 18 to 25 years or where there is a particular concern for risk of suicide.

February 2023: We made a correction to the terms used section for the DSM-5 definition of depression.

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