Appendix A: Summary of evidence from surveillance

2023 surveillance of common mental health problems (2011) NICE guideline CG123

Table 1 comparison of recommendations present in CG123 and NG222.

CG123 – common mental health problems	NG222 – depression in adults
1.3.1.1 Be alert to possible depression (particularly in people with a past history of depression, possible somatic symptoms of depression or a chronic physical health problem with associated functional impairment) and consider asking people who may have depression 2 questions, specifically: • During the last month, have you often been bothered by feeling down, depressed or hopeless? During the last month, have you often been bothered by having little interest or pleasure in doing things? If a person answers 'yes' to either of the above questions, consider depression and follow the recommendations for assessment (see section 1.3.2).	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]

ISBN: 978-1-4731-4929-8

	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]
1.3.2.6 In addition to assessing symptoms and associated functional impairment, consider how the following factors may have affected the development, course and severity of a person's presenting problem: ● a history of any mental health disorder ● a history of a chronic physical health problem ● any past experience of, and response to, treatments ● the quality of interpersonal relationships ● living conditions and social isolation ● a family history of mental illness ● a history of domestic violence or sexual abuse ● employment and immigration status. If appropriate, the impact of the presenting problem on the care of children and young people should also be assessed, and if necessary local safeguarding procedures followed.	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]
1.3.2.9 Always ask people with a common mental health disorder directly about suicidal ideation and intent. If there is a risk of self-harm or suicide:	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 risk (see the section on risk assessment and monitoring) • advise the person to seek further help if the situation deteriorates.	• 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]**
1.3.3.2 If a person with a common mental health disorder presents considerable and immediate risk to themselves or others, refer them urgently to the emergency services or specialist mental health services.	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]**
1.3.3.3 If a person with a common mental health disorder, in particular depression, is assessed to be at risk of suicide: • take into account toxicity in overdose, if a drug is prescribed, and potential interaction with other prescribed medication; if necessary, limit the amount of drugs available • consider increasing the level of support, such as more frequent direct or telephone contacts • consider referral to specialist mental health services.	1.2.12 If a person with depression is assessed to be at risk of suicide: • do not 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
1.4.1.5 When a person presents with symptoms of anxiety and depression, assess the nature and extent of the symptoms, and if the person has: • depression that is accompanied by symptoms of anxiety, the first priority should usually be to treat the depressive disorder, in line with the NICE guideline on depression	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]**

• an anxiety disorder and comorbid depression or depressive symptoms, consult the NICE guidelines for the relevant anxiety disorder and consider treating the anxiety disorder first both anxiety and depressive symptoms, with no formal diagnosis, that are associated with functional impairment, discuss with the person the symptoms to treat first and the choice of intervention	
1.4.1.1 When discussing treatment options with a person with a common mental health disorder, consider: • their past experience of the disorder • their experience of, and response to, previous treatment • the trajectory of symptoms • the diagnosis or problem specification, severity and duration of the problem • the extent of any associated functional impairment arising from the disorder itself or any chronic physical health problem • the presence of any social or personal factors that may have a role in the development or maintenance of the disorder • the presence of any comorbid disorders	1.3.1 Discuss with people with depression: • what, if anything, they think might be contributing to the development of their depression (see recommendation 1.2.7) • whether they have ideas or preferences about starting treatment, and what treatment options they 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]**
1.4.2.1 – subthreshold depressive symptoms or mild to moderate depression – difficult to see how the CBT, physical activity and peer support recommended here fits with the recs in NG222	1.5.2 and table 1 – covers the treatment options for those with a new episode of less severe depression and includes areas like guided self-help, CBT, behavioural activation, group exercise, mindfulness/meditation, SSRIs, IPT, counselling, STPP – notes that choice of treatment should match clinical needs and preferences

1.4.2.3 Do not offer antidepressants routinely for people with persistent subthreshold depressive symptoms or mild depression, but consider them for, or refer for an assessment, people with: • initial presentation of subthreshold depressive symptoms that have been present for a long period (typically at least 2 years) **or** • subthreshold depressive symptoms or mild depression that persist after other interventions **or** • a past history of moderate or severe depression **or** • mild depression that complicates the care of a physical health problem.	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] 1.5.3 Do not routinely offer antidepressant medication as first-line treatment for less severe depression, unless that is the person's preference. **[2022]**
Recs 1.4.3.1-1.4.3.4 – for subthreshold depressive symptoms or mild to moderate depression that has not responded to low-intensity intervention or for those with moderate to severe depressions	1.6.1 and table 2 – treatment options for more severe depression – again notes that choice of treatment should match clinical needs and preferences. Difficult to match to CG123 recommendations.
1.4.4.1 For people with a common mental health disorder who are at significant risk of relapse or have a history of recurrent problems, discuss with the person the treatments that might reduce the risk of recurrence. The choice of treatment or referral for treatment should be informed by the response to previous treatment, including residual symptoms, the consequences of relapse, any discontinuation symptoms when stopping medication, and the person's preference.	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]**
1.4.4.2 For people with a previous history of depression who are currently well and who are considered at risk of relapse despite taking antidepressant medication, or those who are unable to continue or choose not to continue antidepressant medication, offer or refer for 1 of the following:	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:

• individual CBT • mindfulness-based cognitive therapy (for those who have had 3 or more episodes). 1.4.4.3 For people who have had previous treatment for depression but continue to have residual depressive symptoms, offer or refer for 1 of the following: • individual CBT • mindfulness-based cognitive therapy (for those who have had 3 or more episodes).	• 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]** 1.8.8 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]

Table 2 comparison of recommendations present in CG123 and CG31.

CG123 – common mental health problems	**CG31 – obsessive-compulsive disorder and body dysmorphic disorder**
1.4.2.6 For people with mild to moderate OCD: • offer or refer for individual CBT including exposure and response prevention (ERP) of limited duration (typically up to 10 hours), which could be provided using self-help materials or by telephone **or** • refer for group CBT (including ERP) (note, group formats may deliver more than 10 hours of therapy).	1.5.1.1 In the initial treatment of adults with OCD, low intensity psychological treatments (including exposure and response prevention [ERP]; up to 10 therapist hours per patient) should be offered if the patient's degree of functional impairment is mild and/or the patient expresses a preference for a low intensity approach. Low intensity treatments include: • brief individual cognitive behavioural therapy (CBT; including ERP) using structured self-help materials • brief individual CBT (including ERP) by telephone

	• group CBT (including ERP; note, the patient may be receiving more than 10 hours of therapy in this format).
1.4.3.7 For people with OCD and moderate or severe functional impairment, and in particular where there is significant comorbidity with other common mental health disorders, offer or refer for: • CBT (including ERP) or antidepressant medication for moderate impairment CBT (including ERP) combined with antidepressant medication and case management for severe impairment. Offer home-based treatment where the person is unable or reluctant to attend a clinic or has specific problems (for example, hoarding	1.5.1.3 Adults with OCD with moderate functional impairment should be offered the choice of either a course of an SSRI or more intensive CBT (including ERP; more than 10 therapist hours per patient), because these treatments appear to be comparably efficacious. 1.5.1.4 Adults with OCD with severe functional impairment should be offered combined treatment with an SSRI and CBT (including ERP). 1.5.1.8 For children and young people with OCD with mild functional impairment, guided self help may be considered in conjunction with support and information for the family or carers. 1.5.1.9 Children and young people with OCD with moderate to severe functional impairment, and those with OCD with mild functional impairment for whom guided self help has been ineffective or refused, should be offered CBT (including ERP) that involves the family or carers and is adapted to suit the developmental age of the child as the treatment of choice. Group or individual formats should be offered depending upon the preference of the child or young person and their family or carers.

	1.5.2.5 For adults with OCD with more severe functional impairment who are housebound, unable or reluctant to attend a clinic, or have significant problems with hoarding, a period of home-based treatment may be considered.
1.4.3.9 For people with OCD who have not benefitted from 2 courses of CBT (including ERP) combined with antidepressant medication, refer to a service with specialist expertise in OCD	1.5.4.5 For adults with OCD or BDD, if there has been no response to a full trial of at least 1 SSRI alone, a full trial of combined treatment with CBT (including ERP) and an SSRI, and a full trial of clomipramine alone, the patient should be referred to a multidisciplinary team with specific expertise in the treatment of OCD/BDD for assessment and further treatment planning. 1.5.5.1 For a child or young person with OCD or BDD, if there has not been an adequate response within 12 weeks to a full trial of CBT (including ERP) involving the family or carers, a multidisciplinary review should be carried out. 1.5.5.4 For a child or a young person with OCD or BDD, if treatment with an SSRI in combination with CBT (including ERP) involving the family or carers is unsuccessful or is not tolerated because of side effects, the use of another SSRI or clomipramine with careful monitoring may be considered, especially if the child or young person has had a positive response to these alternatives in the past. This should also be in combination with CBT (including ERP). Note that this is an off-label use of clomipramine. See NICE's information on prescribing medicines

Table 3 comparison of recommendations present in CG123 and CG31.

CG123 – common mental health problems	**CG113 – generalised anxiety disorder and panic disorder in adults**

1.3.1.2 Be alert to possible anxiety disorders (particularly in people with a past history of an anxiety disorder, possible somatic symptoms of an anxiety disorder or in those who have experienced a recent traumatic event). Consider asking the person about their feelings of anxiety and their ability to stop or control worry, using the 2-item Generalized Anxiety Disorder scale (GAD-2; see the full guideline). • If the person scores 3 or more on the GAD-2 scale, consider an anxiety disorder and follow the recommendations for assessment (see section 1.3.2). • If the person scores less than 3 on the GAD-2 scale, but you are still concerned they may have an anxiety disorder, ask the following: 'Do you find yourself avoiding places or activities and does this cause you problems?'. If the person answers 'yes' to this question, consider an anxiety disorder and follow the recommendations for assessment (see section 1.3.2).	1.2.3 Consider the diagnosis of GAD in people presenting with anxiety or significant worry, and in people who attend primary care frequently who: • have a chronic physical health problem **or** • do not have a physical health problem but are seeking reassurance about somatic symptoms (particularly older people and people from minority ethnic groups) **or** • are repeatedly worrying about a wide range of different issues. **[2011]** 1.2.5 For people who may have GAD, conduct a comprehensive assessment that does not rely solely on the number, severity and duration of symptoms, but also considers the degree of distress and functional impairment. [2011]
1.4.1.5 When a person presents with symptoms of anxiety and depression, assess the nature and extent of the symptoms, and if the person has: • depression that is accompanied by symptoms of anxiety, the first priority should usually be to treat the depressive disorder, in line with the NICE guideline on depression • an anxiety disorder and comorbid depression or depressive symptoms, consult the NICE guidelines for the relevant anxiety disorder and consider treating the anxiety disorder first • both anxiety and depressive symptoms, with no formal diagnosis, that are associated with functional impairment, discuss with the person the symptoms to treat first and the choice of intervention	1.2.7 For people with GAD and a comorbid depressive or other anxiety disorder, treat the primary disorder first (that is, the 1 that is more severe and in which it is more likely that treatment will improve overall functioning).

1.4.2.4 For people with generalised anxiety disorder that has not improved after psychoeducation and active monitoring, offer or refer for one of the following low-intensity interventions: ● individual non-facilitated self-help ● individual facilitated self-help ● psychoeducational groups.	1.2.11 For people with GAD whose symptoms have not improved after education and active monitoring in step 1, offer 1 or more of the following as a first-line intervention, guided by the person's preference: ● individual non-facilitated self-help ● individual guided self-help ● psychoeducational groups. **[2011]**
1.4.3.5 For people with generalised anxiety disorder who have marked functional impairment or have not responded to a low-intensity intervention, offer or refer for 1 of the following: ● CBT **or** ● applied relaxation **or** ● if the person prefers, drug treatment.	1.2.16 For people with GAD and marked functional impairment, or those whose symptoms have not responded adequately to step 2 interventions: ● Offer either – an individual high-intensity psychological intervention (see recommendations 1.2.17 to 1.2.21) **or** – drug treatment (see recommendations 1.2.22 to 1.2.32). ● Provide verbal and written information on the likely benefits and disadvantages of each mode of treatment, including the tendency of drug treatments to be associated with side effects and withdrawal syndromes. ● Base the choice of treatment on the person's preference as there is no evidence that either mode of treatment (individual high-intensity psychological intervention or drug treatment) is better. **[2011]** 1.2.17 If a person with GAD chooses a high-intensity psychological intervention, offer either CBT or applied relaxation. [2011]

1.4.2.5 For people with mild to moderate panic disorder, offer or refer for 1 of the following low-intensity interventions: • individual non-facilitated self-help • individual facilitated self-help.	1.4.10 For people with mild to moderate panic disorder, offer or refer for 1 of the following low-intensity interventions: • individual non-facilitated self-help • individual facilitated self-help. (This recommendation is taken from the NICE guideline on common mental health problems.)
1.4.3.6 For people with moderate to severe panic disorder (with or without agoraphobia), consider referral for: • CBT **or** • an antidepressant if the disorder is long-standing or the person has not benefitted from or has declined psychological interventions	1.4.13 For people with moderate to severe panic disorder (with or without agoraphobia), consider referral for: • CBT or • an antidepressant if the disorder is long-standing or the person has not benefitted from or has declined psychological intervention. (This recommendation is taken from the NICE guideline on common mental health problems.)

Table 4 comparison of recommendations present in CG123 and CG31.

CG123 – common mental health problems	**NG116 – Post-traumatic stress disorder**
1.4.1.10 If a person with a common mental health disorder needs social, educational or vocational support, consider:	No similar 'do not do' recommendations found in NG116, however there is a recommendation on peer support.

• informing them about self-help groups (but not for people with PTSD), support groups and other local and national resources • befriending or a rehabilitation programme for people with long-standing moderate or severe disorders • educational and employment support services.	**Peer support** 1.4.3 Tell people about and help them access peer support groups if they want to and could benefit. Peer support groups should: • be facilitated by people with mental health training and supervision • be delivered in a way that reduces the risk of exacerbating symptoms • provide information and help to access services. **[2018]**
1.4.2.7 For people with PTSD, including those with mild to moderate PTSD, refer for a formal psychological intervention (trauma-focused CBT or eye movement desensitisation and reprocessing [EMDR]).	1.6.13 Consider eye movement desensitisation and reprocessing (EMDR) for children and young people aged 7 to 17 years with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented more than 3 months after a traumatic event only if they do not respond to or engage with trauma-focused CBT. [2018] 1.6.18 Consider EMDR for adults with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented between 1 and 3 months after a non-combat-related trauma if the person has a preference for EMDR. [2018]
1.4.3.10 For people with PTSD, offer or refer for a psychological intervention (trauma-focused CBT or EMDR). Do not delay the intervention or referral, particularly for people with severe and escalating symptoms in the first month after the traumatic event.	1.6.18 Consider EMDR for adults with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented between 1 and 3 months after a non-combat-related trauma if the person has a preference for EMDR. [2018] 1.6.16 Offer an individual trauma-focused CBT intervention to adults with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented more than 1 month after a traumatic event. These interventions include: • cognitive processing therapy

	• cognitive therapy for PTSD • narrative exposure therapy • prolonged exposure therapy. [2018] 1.6.19 Offer EMDR to adults with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented more than 3 months after a noncombat-related trauma. [2018]
1.4.3.11 For people with PTSD, offer or refer for drug treatment only if a person declines an offer of a psychological intervention or expresses a preference for drug treatment	1.6.14 Do not offer drug treatments for the prevention or treatment of PTSD in children and young people aged under 18 years. [2018] 1.6.25 Consider venlafaxine or a selective serotonin reuptake inhibitor (SSRI), such as sertraline, for adults with a diagnosis of PTSD if the person has a preference for drug treatment. Review this treatment regularly. [2018] In December 2018, this was an off-label use for venlafaxine. See NICE's information on prescribing medicines. In December 2018, only sertraline and paroxetine had a UK marketing authorisation for this indication. See NICE's information on prescribing medicines. 1.6.26 Consider antipsychotics such as risperidone in addition to psychological therapies to manage symptoms for adults with a diagnosis of PTSD if: • they have disabling symptoms and behaviours, for example severe hyperarousal or psychotic symptoms and • their symptoms have not responded to other drug or psychological treatments. Antipsychotic treatment should be started and reviewed regularly by a specialist (see

	recommendations on how to use antipsychotic medication in NICE's guideline on psychosis and schizophrenia in adults). [2018] In December 2018, this was an off-label use of risperidone. See NICE's information on prescribing medicines.