Depression in adults: treatment and management

Appendix V3: recommendations that have been deleted of changed from 2009 guideline

1 *Recommendations that have been deleted or changed*

2 Recommendations to be deleted

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

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

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Offer people with depression advice on sleep hygiene if needed, including:

- establishing regular sleep and wake times
- avoiding excess eating, smoking or drinking alcohol before sleep
- creating a proper environment for sleep taking regular physical exercise. (1.4.1.2)

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Replaced by:

First line treatment for less severe depression

Offer group-based cognitive behavioural therapy (CBT) specific to depression as the initial treatment for people with less severe depression. [new 2017] (1.5.1)

Deliver group-based CBT that is:

- based on a cognitive behavioural model
- delivered by 2 competent practitioners
- consists of up to 9 sessions of 90 minutes each, for up to 12 participants
- takes place over 12–16 weeks, including follow-up. [new 2017] (1.5.2)

Offer individual self-help with support for people with less severe depression who do not want group CBT. [new 2017] (1.5.3)

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

- provide age-appropriate, written, audio or digital (computer or online) material
- have support from a trained practitioner who facilitates the self-help intervention, encourages completion and reviews progress and outcome
- consist of up to 6 sessions (face-to-face or by telephone or online), each up to 30 minutes
- take place over 9–12 weeks, including follow-up. [2017] (1.5.4)

Consider a physical activity programme specifically designed for people with depression who do not want group CBT or self-help with support. [new 2017] (1.5.5)

Ensure physical activity programmes for people with less severe depression:

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For people with persistent subthreshold depressive symptoms or mild to moderate depression, consider offering one or more of the following interventions, guided by the person's preference:

- individual guided self-help based on the principles of cognitive behavioural therapy (CBT)
- computerised cognitive behavioural therapy (CCBT)
- a structured group physical activity programme. (1.4.2.1)

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

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

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Physical activity programmes for people with persistent subthreshold depressive

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symptoms or mild to moderate depression should: • be delivered in groups with support from a competent practitioner • consist typically of three sessions per week of moderate duration (45 minutes to 1 hour) over 10 to 14 weeks (average 12 weeks). (1.4.2.4)	• are delivered in groups by a competent practitioner • consist of 45 minutes of aerobic exercise of moderate intensity and duration twice a week for 5 weeks, then once a week for a further 7 weeks • usually have 8 people per group. [new 2017] (1.5.6)
Consider group-based CBT for people with persistent subthreshold depressive symptoms or mild to moderate depression who decline low-intensity psychosocial interventions (1.4.3.1)	Consider a selective serotonin reuptake inhibitor (SSRI) or mirtazapine for people with less severe depression who choose not to have psychological interventions, or based on previous treatment history for confirmed depression had a positive response to SSRIs or mirtazapine or had a poor response to psychological interventions. [new 2017] (1.5.7)
Group-based CBT for people with persistent subthreshold depressive symptoms or mild to moderate depression should: • be based on a structured model such as 'Coping with Depression' • be delivered by two trained and competent practitioners • consist of ten to 12 meetings of eight to ten participants • normally take place over 12 to 16 weeks, including follow-up. (1.4.3.2)	Offer individual CBT or behavioural activation (BA) if a person with less severe depression: • has a history of poor response when they tried group CBT, a physical activity programme, facilitated self-help or antidepressant medication before or • has responded well to CBT or BA before or • is at risk of developing more severe depression, for example they have a history of severe depression or the current assessment suggests a more severe depression is developing. [new 2017] (1.5.8)
Do not use antidepressants routinely to treat persistent subthreshold depressive symptoms or mild depression because the risk–benefit ratio is poor, but consider them for people with: • a past history of moderate or severe depression or • initial presentation of subthreshold depressive symptoms that have been present for a long period (typically at least 2 years) or • subthreshold depressive symptoms or mild depression that persist(s) after other interventions. (1.4.4.1)	Consider interpersonal therapy (IPT) if a person with less severe depression would like help for interpersonal difficulties that focus on role transitions or disputes or grief and: • has had group CBT, exercise or facilitated self-help, antidepressant medication, individual CBT or BA for a previous episode of depression, but this did not work well for them, or • does not want group CBT, exercise or facilitated self-help, antidepressant medication, individual CBT or BA. [new 2017] (1.5.9)
For people with moderate or severe depression, provide a combination of antidepressant medication and a high-intensity psychological intervention (CBT or IPT). (1.5.1.2)	
The choice of intervention should be influenced by the:	

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

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

- The increased likelihood of the person stopping treatment because of side effects (and the consequent need to increase the dose gradually) with venlafaxine, duloxetine and TCAs.
- The specific cautions, contraindications and monitoring requirements for some drugs. For example:
  - the potential for higher doses of venlafaxine to exacerbate cardiac arrhythmias and the need to monitor the person's blood pressure
  - the possible exacerbation of hypertension with venlafaxine and duloxetine
  - the potential for postural hypotension and arrhythmias with TCAs
  - the need for haematological monitoring with mianserin in elderly people.
- Non-reversible monoamine oxidase inhibitors (MAOIs), such as phenelzine, should normally be prescribed only by specialist mental health professionals.
- Dosulepin should not be prescribed. (1.5.2.4)

For people started on antidepressants who are not considered to be at increased risk of suicide, normally see them after 2 weeks. See them regularly thereafter; for example, at intervals of 2 to 4 weeks in the first 3 months, and then

Provide individual CBT, BA or IPT to treat less severe depression over 16 sessions, each lasting 50–60 minutes, over 3–4 months. [new 2017] (1.5.10)

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

- 2 sessions per week for the first 2–3 weeks of treatment for people with less severe depression
- 3–4 follow-up and maintenance sessions over 3–6 months after finishing the course for all people who have had individual CBT, BA or IPT. [new 2017] (1.5.11)

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

- has had group CBT, exercise or facilitated self-help, antidepressant medication, individual CBT or BA for a previous episode of depression, but this did not work well for them, or
- does not want group CBT, exercise or facilitated self-help, antidepressant medication, individual CBT or BA. [new 2017] (1.5.12)

Ensure counselling for people with less severe depression:

- is based on a model developed specifically for depression
- consists of up to 16 individual sessions each lasting up to an hour
- takes place over 12 to 16 weeks, including follow-up. [new 2017] (1.5.13)

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

- has had group CBT, exercise or facilitated self-help, antidepressant medication or individual CBT for a

at longer intervals if response is good (1.5.2.6)	previous episode of depression, but this did not work well for them, or • does not want group CBT, exercise or facilitated self-help, antidepressant medication or individual CBT. [new 2017] (1.5.14)
If a person with depression develops side effects early in antidepressant treatment, provide appropriate information and consider one of the following strategies: • monitor symptoms closely where side effects are mild and acceptable to the person or • stop the antidepressant or change to a different antidepressant if the person prefers or • in discussion with the person, consider short-term concomitant treatment with a benzodiazepine if anxiety, agitation and/or insomnia are problematic (except in people with chronic symptoms of anxiety); this should usually be for no longer than 2 weeks in order to prevent the development of dependence. (1.5.2.8)	Ensure STPT for people with less severe depression: • is based on a model developed specifically for depression • consists of up to 16 individual sessions each lasting up to an hour • takes place over 12 to 16 weeks, including follow-up. [new 2017] (1.5.15) *First line treatment for more severe depression* Offer individual CBT in combination with an SSRI or mirtazapine as the initial treatment for more severe depression. [new 2017] (1.6.1)
People who start on low-dose TCAs and who have a clear clinical response can be maintained on that dose with careful monitoring. (1.5.2.9)	If a person with more severe depression does not want to take medication, offer: • group CBT, or • individual CBT or BA if the person does not want group therapy. [new 2017] (1.6.2)
If the person's depression shows some improvement by 4 weeks, continue treatment for another 2 to 4 weeks. Consider switching to another antidepressant as described in 1.8 if: • response is still not adequate or • there are side effects or • the person prefers to change treatment. (1.5.2.12)	If a person with more severe depression does not want psychological therapy, offer an SSRI or mirtazapine. [new 2017] (1.6.3)
For all high-intensity psychological interventions, the duration of treatment should normally be within the limits indicated in this guideline. As the aim of treatment is to obtain significant improvement or remission the duration of treatment may be: • reduced if remission has been achieved • increased if progress is being made, and there is agreement between the practitioner and the person with depression that further sessions would be beneficial (for example, if there is a comorbid personality	Consider short-term psychodynamic psychotherapy, alone or in combination with an SSRI or mirtazapine, for a person with more severe depression who would like help for emotional and developmental difficulties in relationships and: • has had individual CBT in combination with an SSRI, group CBT, or individual CBT or BA for a previous episode of depression, but this did not work well for them, or • does not want individual CBT in combination with an SSRI, group

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<td>disorder or significant psychosocial factors that impact on the person's ability to benefit from treatment). (1.5.3.1)</td>
<td rowspan="6">CBT, or individual CBT or BA. [new 2017] (1.6.4)

Behavioural couples therapy

Consider behavioural couples therapy for a person with depression who has problems in the relationship with their partner if:

• the relationship problem(s) could be contributing to their depression or
• involving their partner may help in the treatment of their depression. [new 2017] (1.7.1)

Ensure behavioural couples therapy for people with depression:

• follows the behavioural principles for couples therapy
• provides 15–20 sessions over 5–6 months. [2017] (1.7.2)</td>
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<td>For all people with depression having individual CBT, the duration of treatment should typically be in the range of 16 to 20 sessions over 3 to 4 months. Also consider providing:

• two sessions per week for the first 2 to 3 weeks of treatment for people with moderate or severe depression
• follow-up sessions typically consisting of three to four sessions over the following 3 to 6 months for all people with depression. (1.5.3.2)</td>
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<td>For all people with depression having IPT, the duration of treatment should typically be in the range of 16 to 20 sessions over 3 to 4 months. For people with severe depression, consider providing two sessions per week for the first 2 to 3 weeks of treatment. (1.5.3.3)</td>
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<td>For all people with depression having behavioural activation, the duration of treatment should typically be in the range of 16 to 20 sessions over 3 to 4 months. Also consider providing:

• two sessions per week for the first 3 to 4 weeks of treatment for people with moderate or severe depression
• follow-up sessions typically consisting of three to four sessions over the following 3 to 6 months for all people with depression. (1.5.3.4)</td>
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<td>For all people with persistent subthreshold depressive symptoms or mild to moderate depression having counselling, the duration of treatment should typically be in the range of six to ten sessions over 8 to 12 weeks. (1.5.3.6)</td>
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<td>For all people with mild to moderate depression having short-term psychodynamic psychotherapy, the duration of treatment should typically be</td>
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in the range of 16 to 20 sessions over 4 to 6 months. (1.5.3.7)	
Do not routinely vary the treatment strategies for depression described in this guideline either by depression subtype (for example, atypical depression or seasonal depression) or by personal characteristics (for example, sex or ethnicity) as there is no convincing evidence to support such action. (1.6.1.1)	

For people with persistent subthreshold depressive symptoms or mild to moderate depression who have not benefited from a low-intensity psychosocial intervention, discuss the relative merits of different interventions with the person and provide:
• an antidepressant (normally a selective serotonin reuptake inhibitor [SSRI]) or
• a high-intensity psychological intervention, normally one of the following options:
  ○ CBT
  ○ interpersonal therapy (IPT)
  ○ behavioural activation (but note that the evidence is less robust than for CBT or IPT)
  ○ behavioural couples therapy for people who have a regular partner and where the relationship may contribute to the development or maintenance of depression, or where involving the partner is considered to be of potential therapeutic benefit. (1.5.1.1)
	Replaced by:
	If a person with depression has had no response or a limited response to initial treatment (within 3–4 weeks for antidepressant medication or 4–6 weeks for psychological therapy or combined medication and psychological therapy), assess:
	• whether there are any personal or social factors that might explain why the treatment isn't working
	• whether the person has not been adhering to the treatment plan, including any adverse effects of medication.
	Work with the person to try and address any problems raised. [new 2017] (1.9.1)
	If a person has had no response or a limited response to initial treatment after assessing the issues in recommendation 1.9.1, provide more support by increasing the number and length of appointments. Also consider:
	• changing to a combination of psychological therapy and medication if the person is on medication only, or
	• changing to psychological therapy alone, if the person is on medication only and does not want to continue with medication or
	• changing to a combination of 2 different classes of medication, in specialist settings or after consulting a specialist, if the person is on medication only or a combination of medication and psychological therapy and does not want to continue with psychological therapy. [new 2017] (1.9.2)

If the person's depression shows no improvement after 2 to 4 weeks with the first antidepressant, check that the drug has been taken regularly and in the prescribed dose. (1.5.2.10)	
If response is absent or minimal after 3 to 4 weeks of treatment with a therapeutic dose of an antidepressant, increase the level of support (for example, by weekly face-to-face or telephone contact) and consider:	

• increasing the dose in line with the Summary of Product Characteristics if there are no significant side effects or • switching to another antidepressant as described in Section 1.8 if there are side effects or if the person prefers. (1.5.2.11)	When changing treatment for a person with depression who has had no response or a limited response to initial medication, consider: • combining the medication with a psychological therapy (CBT, BA, or IPT), or • switching to a psychological therapy alone (CBT, BA, or IPT) if the person wants to stop taking medication. [new 2017] (1.9.3) If a person has had no response or a limited response to initial medication and does not want to try a psychological therapy, and wants to try a combination of medications, inform them of the likely increase in their side-effect burden (including risk of serotonin syndrome). [new 2017] (1.9.4) If a person wants to try a combination of medications and is willing to accept an increased side-effect burden, consider: • adding an antidepressant of a different class to their initial medication, for example an SSRI with mirtazapine, in specialist settings or after consulting a specialist • combining an antidepressant with an antipsychotic or lithium in specialist settings or after consulting a specialist. [new 2017] (1.9.5) When changing treatment for a person with depression who has had no response or a limited response to initial psychological therapy, consider: • combining the psychological therapy with an SSRI, for example sertraline or citalopram, or mirtazapine, or • switching to an SSRI, for example sertraline or citalopram, or mirtazapine if the person wants to stop the psychological therapy. [new 2017] (1.9.6) If a person has had no response or a limited response to initial medication and does not want a psychological therapy or a combination of medications, consider: • continuing with the current medication, with extra support, close
When reviewing drug treatment for a person with depression whose symptoms have not adequately responded to initial pharmacological interventions: • check adherence to, and side effects from, initial treatment • increase the frequency of appointments using outcome monitoring with a validated outcome measure • be aware that using a single antidepressant rather than combination medication or augmentation (see 1.8.1.5 to 1.8.1.9) is usually associated with a lower side-effect burden • consider reintroducing previous treatments that have been inadequately delivered or adhered to, including increasing the dose • consider switching to an alternative antidepressant. (1.8.1.1)	
When switching to another antidepressant, be aware that the evidence for the relative advantage of switching either within or between classes is weak. Consider switching to: • initially a different SSRI or a better tolerated newer-generation antidepressant • subsequently an antidepressant of a different pharmacological class that may be less well tolerated, for example venlafaxine, a TCA or an MAOI. (1.8.1.2)	
Do not switch to, or start, dosulepin because evidence supporting its tolerability relative to other antidepressants is outweighed by the increased cardiac risk and toxicity in overdose. (1.8.1.3)	
When switching to another antidepressant, which can normally be	

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

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

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

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

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

monitoring and an increased dose if the medication is well tolerated, or

- switching to a medicine of a different class , or
- switching to medication of the same class if there are problems with tolerability. [new 2017] (1.9.7)

If a person's symptoms do not respond to a dose increase or switching to another antidepressant after 2–4 weeks, review the need for care and treatment and consider consulting with, or referring the person to, a specialist service. [new 2017] (1.9.8)

For people with depression whose symptoms have not adequately responded to a combination of medication and a psychological therapy after 12 weeks, consider:

- alternatives to combined treatment (see recommendation 1.10.2)
- switching to a different psychological therapy, such as cognitive behavioural analysis system of psychotherapy (CBASP), CBT or MBCT (see recommendation 1.10.1). [new 2017] (1.9.9)

If a person finds that their antidepressant medication is helping them but they are having side effects, consider switching to another antidepressant with a different side effect profile. [new 2017] (1.9.10)

• lithium or • an antipsychotic such as aripiprazole, olanzapine, quetiapine or risperidone or • another antidepressant such as mirtazapine or mianserin. (1.8.1.6)	
The following strategies should not be used routinely: • augmentation of an antidepressant with a benzodiazepine for more than 2 weeks as there is a risk of dependence • augmentation of an antidepressant with buspirone, carbamazepine, lamotrigine or valproate as there is insufficient evidence for their use • augmentation of an antidepressant with pindolol or thyroid hormones as there is inconsistent evidence of effectiveness. (1.8.1.9)	
For a person whose depression has not responded to either pharmacological or psychological interventions, consider combining antidepressant medication with CBT. (1.8.1.10)	
For a person whose depression has failed to respond to various strategies for augmentation and combination treatments, consider referral to a practitioner with a specialist interest in treating depression, or to a specialist service. (1.8.1.11)	
The assessment of a person with depression referred to specialist mental health services should include: • their symptom profile, suicide risk and, where appropriate, previous treatment history • associated psychosocial stressors, personality factors and significant relationship difficulties, particularly where the depression is chronic or recurrent • associated comorbidities including alcohol and substance misuse, and personality disorders. (1.10.1.1)	
In specialist mental health services, after thoroughly reviewing previous treatments for depression, consider reintroducing previous treatments that have been	

inadequately delivered or adhered to. (1.10.1.2)	
Medication in secondary care mental health services should be started under the supervision of a consultant psychiatrist. (1.10.1.4)	
Discuss antidepressant treatment options with the person with depression, covering: • the choice of antidepressant, including any anticipated adverse events, for example, side effects and discontinuation symptoms (see Section 11.8.7.2) and potential interactions with concomitant medication or physical health problems • their perception of the efficacy and tolerability of any antidepressants they have previously taken. (1.5.2.1)	Replaced by: When offering a person antidepressant medication: • explain the reasons for offering it • discuss the risks and benefits • discuss any concerns they have about taking the medication • ensure they have information to take away that is appropriate for their needs. [2017] (1.4.7) When prescribing antidepressant medication, give people information about: • how long it takes (typically 2–4 weeks) to begin to start to feel better • how important it is to follow the instructions on when to take antidepressant medication • how treatment might need to carry on even after remission • how they may be affected when they first start taking antidepressant medication, and what these effects might be • how they may be affected if they have to take antidepressant medication for a long time and what these effects might be, especially in people over 65 • how taking antidepressant medication might affect their sense of resilience (how strong they feel and how well they can get over problems) and being able to cope • how taking antidepressant medication might affect any other medicines they are taking • how they may be affected when they stop taking antidepressant medication, and how these effects can be minimised

	• the fact that they cannot get addicted to antidepressant medication. [2017] (1.4.8)
Inform the person that they should seek advice from their practitioner if they experience significant discontinuation symptoms. (1.9.2.3)	Issue covered by the new recommendations in section 1.4
For people with severe depression and those with moderate depression and complex problems, consider: • referring to specialist mental health services for a programme of co-ordinated multiprofessional care • providing collaborative care if the depression is in the context of a chronic physical health problem with associated functional impairment. (1.7.1.2)	Replaced by: Refer people to specialist mental health services for a programme of coordinated multidisciplinary care if they have: • more severe depression with multiple complicating problems, for example unemployment, poor housing or financial problems, or • significant coexisting conditions. [new 2017] (1.14.4) Ensure multidisciplinary care plans for people with more severe depression with multiple complicating problems, or significant coexisting conditions: • are developed together with the person, their GP and other relevant people involved in their care (with the person's agreement) • set out the roles and responsibilities of all health and social care professionals involved in delivering the care • include information about 24-hour support services, and how to contact them • include a crisis plan that identifies potential crisis triggers, and strategies to manage those triggers • are updated if there are any significant changes in the person's needs or condition • are reviewed at agreed regular intervals • include medication management (a plan for starting, reviewing and discontinuing medication). [new 2017] (1.14.6)
Support and encourage a person who has benefited from taking an antidepressant to continue medication for at least 6 months after remission of an	Replaced by:

episode of depression. Discuss with the person that: • this greatly reduces the risk of relapse • antidepressants are not associated with addiction. (1.9.1.1)	Discuss the likelihood of having a relapse with people who have recovered from depression. Explain: • that a history of previous relapse increases the chance of further relapses • the potential benefits of relapse prevention. [new 2017] (1.8.1) Take into account that the following may increase the risk of relapse: • how often a person has had episodes of depression, and how recently • any other chronic physical health or mental health problems • any residual symptoms and unhelpful coping styles. for example avoidance and rumination) • how severe their symptoms were, risk to self and if they had functional impairment in previous episodes of depression • the effectiveness of previous interventions for treatment and relapse prevention • personal, social and environmental factors. [new 2017] (1.8.2) For people who have recovered from less severe depression when treated with medication (alone or in combination with a psychological therapy), but are assessed as having a higher risk of relapse, consider: • psychological therapy (CBT) with an explicit focus on relapse prevention, typically 3–4 sessions over 1–2 months • continuing their medication. [new 2017] (1.8.3) For people who have recovered from more severe depression when treated with medication (alone or in combination with a psychological therapy), but are assessed as having a higher risk of relapse, offer: • a psychological therapy [mindfulness-based cognitive therapy (MBCT) or
Review with the person with depression the need for continued antidepressant treatment beyond 6 months after remission, taking into account: • the number of previous episodes of depression • the presence of residual symptoms • concurrent physical health problems and psychosocial difficulties. (1.9.1.2)	
For people with depression who are at significant risk of relapse or have a history of recurrent depression, discuss with the person treatments to reduce the risk of recurrence, including continuing medication, augmentation of medication or psychological treatment (CBT). Treatment choice should be influenced by: • previous treatment history, including the consequences of a relapse, residual symptoms, response to previous treatment and any discontinuation symptoms • the person's preference. (1.9.1.3)	
Advise people with depression to continue antidepressants for at least 2 years if they are at risk of relapse. Maintain the level of medication at which acute treatment was effective (unless there is good reason to reduce the dose, such as unacceptable adverse effects) if: • they have had two or more episodes of depression in the recent past, during which they experienced significant functional impairment • they have other risk factors for relapse such as residual symptoms, multiple previous episodes, or a history of severe or prolonged episodes or of inadequate response • the consequences of relapse are likely to be severe (for example, suicide attempts, loss of functioning, severe life disruption, and inability to work). (1.9.1.4)	

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

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

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

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

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

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

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

group CBT] in combination with medication, or

- psychological therapy (MBCT or group CBT) with a focus on relapse prevention if the person wants to stop taking medication. [new 2017] (1.8.4)

For people who have recovered from depression when treated with a psychological therapy, but are assessed as having a higher risk of relapse, offer further psychological therapy (see recommendation 1.8.3). [new 2017] (1.8.5)

For people who are continuing with medication to prevent relapse, maintain the same dose unless there is good reason to reduce it (such as adverse effects). [new 2017] (1.8.6)

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

- monitor mood state using a formal validated rating scale, for example the PHQ-9
- review side effects
- review any personal, social and environmental factors that may impact on the risk of relapse
- agree the timescale for further review (no more than 12 months). [new 2017] (1.8.7)

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

- assess the risk of relapse
- discuss the need to continue with medication. [new 2017] (1.8.8)

Offer group CBT (or MBCT for those who have had 3 or more previous episodes of depression) for preventing relapse to people who are assessed as being at higher risk of relapse and who recovered with medication but who want to stop taking it. [new 2017] (1.8.9)

When choosing a psychological therapy for preventing relapse for people who

• consist of two sessions per week for the first 2 to 3 weeks of treatment • include additional follow-up sessions, typically consisting of four to six sessions over the following 6 months. (1.9.1.9) Mindfulness-based cognitive therapy should normally be delivered in groups of eight to 15 participants and consist of weekly 2-hour meetings over 8 weeks and four follow-up sessions in the 12 months after the end of treatment. (1.9.1.10)	recovered with initial psychological therapy, offer: • 4 more sessions of the same treatment if it has an explicit relapse prevention component, or • group CBT (or MBCT for those who have had 3 or more previous episodes of depression) if initial psychological therapy had no explicit relapse prevention component. [new 2017] (1.8.10) Re-assess a person's risk of relapse when they finish a psychological relapse prevention intervention. Discuss the need for continuing treatment with the person if necessary. [new 2017] (1.8.11) Deliver MBCT for people assessed as having a higher risk of relapse in groups of up to 15 participants. Meetings should last 2 hours once a week for 8 weeks, with 4 follow-up sessions in the 12 months after treatment ends. [new 2017] (1.8.12) Deliver group CBT for people assessed as having a higher risk of relapse in groups of up to 12 participants. Sessions should last 2 hours once a week for 8 weeks. [new 2017] (1.8.13)
When stopping an antidepressant, gradually reduce the dose, normally over a 4-week period, although some people may require longer periods, particularly with drugs with a shorter half-life (such as paroxetine and venlafaxine). This is not required with fluoxetine because of its long half-life. (1.9.2.2)	When stopping an antidepressant medication, slowly reduce the dose based on how long the person has been taking it. For example: • over several days if the person has been taking it for 2–8 weeks • over several weeks if the person has been taking it for 2–12 months • over several months if the person has been taking it for 12 months or more. [new 2017] (1.4.10)
Inform the person that they should seek advice from their practitioner if they experience significant discontinuation symptoms. If discontinuation symptoms occur: • monitor symptoms and reassure the person if symptoms are mild • consider reintroducing the original antidepressant at the dose that was effective (or another antidepressant with a longer half-life from the same	Replaced by: If a person has discontinuation symptoms when they stop taking antidepressant medication or lower 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 or lower the dose

class) if symptoms are severe, and reduce the dose gradually while monitoring symptoms. (1.9.2.3)	• even if they start taking an antidepressant medication again or increase their dose, the symptoms won't go away immediately. [new 2017] (1.4.11) If a person has mild discontinuation symptoms when they stop taking antidepressant medication: • monitor their symptoms • keep reassuring them that such symptoms are common. [new 2017] (1.4.12) If a person has severe discontinuation symptoms, consider restarting the original antidepressant medication at the dose that was previously effective, or another antidepressant from the same class with a longer half-life. Reduce the dose gradually while monitoring symptoms. [new 2017] (1.4.13)
Use crisis resolution and home treatment teams to manage crises for people with severe depression who present significant risk, and to deliver high-quality acute care. The teams should monitor risk as a high-priority routine activity in a way that allows people to continue their lives without disruption (1.10.1.3) Consider inpatient treatment for people with depression who are at significant risk of suicide, self-harm or self-neglect. (1.10.2.1) The full range of high-intensity psychological interventions should normally be offered in inpatient settings. However, consider increasing the intensity and duration of the interventions and ensure that they can be provided effectively and efficiently on discharge. (1.10.2.2) Consider crisis resolution and home treatment teams for people with depression who might benefit from early discharge from hospital after a period of inpatient care. (1.10.2.3)	Replaced by: Consider crisis and intensive home treatment for people with more severe depression who are at significant risk of: • suicide, in particular for those who live alone • self-harm • harm to others • self-neglect • complications in response to their treatment, for example older people with medical comorbidities. [new 2017] (1.14.6) Ensure teams providing crisis resolution and home treatment (CRHT) interventions to support people with depression: • monitor and manage risk as a high-priority routine activity • establish and implement a treatment programme • ensure continuity of any treatment programme while the person is in contact with the CRHT team, and on discharge or transfer to other services when this is needed • have a crisis management plan in place before the person is discharged

	from the team's care. [new 2017] (1.14.7) Consider inpatient treatment for people with more severe depression who cannot be adequately supported by a CRHT team. [new 2017] (1.14.8) Make the full range of recommended psychological therapies (group CBT, CBT or BA) available for people with depression in inpatient settings. [new 2017] (1.14.9) When providing psychological therapies for people with depression in inpatient settings: • increase the intensity and duration of the interventions • ensure that they continue to be provided effectively and promptly on discharge. [new 2017] (1.14.10) Consider using CRHT teams with people with depression who might benefit from early discharge from hospital after a period of inpatient care. [2017] (1.14.11)
Teams working with people with complex and severe depression should develop comprehensive multidisciplinary care plans in collaboration with the person with depression (and their family or carer, if agreed with the person). The care plan should: • identify clearly the roles and responsibilities of all health and social care professionals involved • develop a crisis plan that identifies potential triggers that could lead to a crisis and strategies to manage such triggers • be shared with the GP and the person with depression and other relevant people involved in the person's care. (1.10.1.5)	Replaced by: Ensure multidisciplinary care plans for people with more severe depression with multiple complicating problems, or significant coexisting conditions: • are developed together with the person, their GP and other relevant people involved in their care (with the person's agreement) • set out the roles and responsibilities of all health and social care professionals involved in delivering the care • include information about 24-hour support services, and how to contact them • include a crisis plan that identifies potential crisis triggers, and strategies to manage those triggers • are updated if there are any significant changes in the person's needs or condition • are reviewed at agreed regular intervals

	• include medication management (a plan for starting, reviewing and discontinuing medication). [new 2017] (1.14.5)
For people who have depression with psychotic symptoms, consider augmenting the current treatment plan with antipsychotic medication (although the optimum dose and duration of treatment are unknown) (1.10.3.1)	Replaced by: Refer people with depression with psychotic symptoms to specialist mental health services for a programme of coordinated multi-disciplinary care, which includes access to psychological interventions.[new 2017] (1.12.1) When treating people with depression with psychotic symptoms, consider adding antipsychotic medication to their current treatment plan. [new 2017] (1.12.2)
Do not use ECT routinely for people with moderate depression but consider it if their depression has not responded to multiple drug treatments and psychological treatment. (1.10.4.2)	Replaced by: Consider electroconvulsive therapy (ECT) for acute treatment of more severe depression if: • the more severe depression is life-threatening and a rapid response is needed, or • multiple pharmacological and psychological treatments have failed. [2017] (1.13.1)

Amended recommendation wording (change to meaning)

Recommendation in 2009 guideline	Recommendation in current guideline	Reason for change
Make all efforts necessary to ensure that a person with depression can give meaningful and informed consent before treatment starts. This is especially important when a person has severe depression or is subject to the Mental Health Act. [2004] (1.1.1.4)	Make every effort to ensure that a person with depression can give meaningful and informed consent before treatment starts. This is especially important when a person has severe depression or their treatment falls under the Mental Health Act or the Mental Capacity Act. [2004, amended 2017] (1.1.4)	Amended to cite additional relevant legislation – the Mental Capacity Act.
For people with recurrent severe depression or depression with psychotic symptoms and for those who have been treated under the Mental Health Act, consider developing advance decisions and advance statements collaboratively with the person. Record the decisions and statements and include copies in the person's care plan in primary and secondary care. Give copies to the person and to their family or carer, if the person agrees. (1.1.2.1	Consider developing advance decisions and advance statements collaboratively with people who have recurrent severe depression or depression with psychotic symptoms, and for those who have been treated under the Mental Health Act, in line with the Mental Capacity Act. 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 2017] (1.1.6)	Amended to cite additional relevant legislation – the Mental Capacity Act.
For people with significant language or communication difficulties, for example people with sensory impairments or a learning disability, consider using the Distress Thermometer [1]and/or asking a family member or carer about the person's symptoms to identify possible depression. If a significant level of distress is identified, investigate further. (1.3.1.5)	If a person has significant language or communication difficulties, (for example people with sensory or cognitive impairments), consider asking a family member or carer about the person's symptoms to identify possible depression. [2004, amended 2017] (See also NICE's guideline on mental health problems in people with learning disabilities.) (1.2.5)	Removed reference to use of the Distress Thermometer as this detail would be superseded by recommendations made in NICE's guideline on mental health problems in people with learning disabilities

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

In addition to assessing symptoms and associated functional impairment, consider how the following factors may have affected the development, course and severity of a person's depression: • any history of depression and comorbid mental health or physical disorders • any past history of mood elevation (to determine if the depression may be part of bipolar disorder) • any past experience of, and response to, treatments • the quality of interpersonal relationships • living conditions and social isolation.	Think about how the factors below may have affected the development, course and severity of a person's depression in addition to assessing symptoms and associated functional impairment: • any history of depression and coexisting mental health or physical disorders • any history of mood elevation (to determine if the depression may be part of bipolar disorder) • any past experience of, and response to, previous treatments • the quality of interpersonal relationships • living conditions, employment situation and social isolation. [2009, amended 2017] (1.2.7)	Added employment situation into the list of factors to consider as this would now be checked as standard
When assessing a person with suspected depression, be aware of any learning disabilities or acquired cognitive impairments, and if necessary consider consulting with a relevant specialist when developing treatment plans and strategies. (1.1.4.4)	When assessing a person with suspected depression: • be aware of any acquired cognitive impairments • if needed, consult with a relevant specialist when developing treatment plans and strategies. [2009, amended 2017] (1.2.8)	Removed reference to learning disabilities as there is now a separate NICE guideline on mental health problems in people with learning disabilities

When providing interventions for people with a learning disability or acquired cognitive impairment who have a diagnosis of depression: • where possible, provide the same interventions as for other people with depression • if necessary, adjust the method of delivery or duration of the intervention to take account of the disability or impairment. (1.1.4.5)	When providing interventions for people with an acquired cognitive impairment who have a diagnosis of depression: • if possible, provide the same interventions as for other people with depression • if needed, adjust the method of delivery or length of the intervention to take account of the disability or impairment. [2009, amended 2017] (1.2.9)	Removed reference to learning disabilities as there is now a separate NICE guideline on mental health problems in people with learning disabilities

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

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