Depression in adults: appendices 1 and 2 (recommendations that have been deleted, or changed without an evidence review)

Appendix 1. Recommendations that have been deleted (June 2022 update)

Recommendation in 2009 guideline	Comment
1.1.1.2 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.	This recommendation has been deleted as this information is now included in the NICE guideline on Service user experience in adult mental health services, which has been cross-referenced from the guideline.
1.1.1.4 Make every effort to ensure that a person with depression can give meaningful and informed consent before treatment starts. This is especially important when a person has severe depression or their treatment falls under the Mental Health Act or the Mental Capacity Act.	This recommendation has been deleted as this information is now included in the NICE guideline on service user experience in adult mental health services, which has been cross-referenced from the guideline.
1.1.1.5 Ensure that consent to treatment is based on the provision of clear information (which should also be available in written form) about the intervention, covering: • what the intervention is • what is expected of the person while they are having it • likely outcomes (including any side effects).	This recommendation has been deleted as this information is now included in the NICE guideline on service user experience in adult mental health services, which has been cross-referenced from the guideline.
1.1.4.3 Be respectful of, and sensitive to, diverse cultural, ethnic and religious backgrounds when working with people with depression, and be aware of the possible variations in the presentation of depression. Ensure competence in: • culturally sensitive assessment	This recommendation has been deleted as this information is now included in the NICE guideline on service user experience in adult mental health services, which has been cross-referenced from the guideline.

• using different explanatory models of depression • addressing cultural and ethnic differences when developing and implementing treatment plans • working with families from diverse ethnic and cultural backgrounds.	
1.1.5.2 Consider providing all interventions in the preferred language of the person with depression where possible.	This recommendation has been deleted as this information is now included in the NICE guideline on service user experience in adult mental health services, which has been cross-referenced from the guideline.
1.2 Stepped care	This whole section has been deleted as a new evidence review on models of service delivery was carried out (see section 1.15)
1.4.1.2 Offer people with depression advice on sleep hygiene if needed, including: • establishing regular sleep and wake times • avoiding excess eating, smoking or drinking alcohol before sleep • creating a proper environment for sleep taking regular physical exercise.	This recommendation has been deleted and replaced by new recommendations on activities to help wellbeing.
1.4.2.Low intensity psychosocial interventions	This whole section has been replaced by a new evidence review for the first-line treatment of depression (see sections 1.5 and 1.6)
1.4.3 Group cognitive behavioural therapy	This whole section has been replaced by a new evidence review for the first-line treatment of depression (see sections 1.5 and 1.6)
1.4.4.1 Do not use antidepressants routinely to treat persistent subthreshold depressive symptoms or mild depression because the risk–benefit ratio is poor, but consider them for people with: • a past history of moderate or severe depression or	This recommendation has been replaced by a new evidence review for the first-line treatment of depression (see section 1.5)

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

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

Recommendation in 2009 guideline	Recommendation in current guideline	Reason for change
1.1.1.1 When working with people with depression and their families or carers: • 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 When working with people with depression and their families or carers: • build a trusting relationship and work in an open, engaging and non-judgemental manner • explore treatment choices (see recommendations on choice) in an atmosphere of hope and optimism, explaining the different courses of depression, and that recovery is possible • be aware that stigma and discrimination can be associated with a diagnosis of depression • be aware that the symptoms of depression itself and the impact of stigma and discrimination can make it difficult for people to access mental health services or take up offers of treatment • 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) • ensure that discussions take place in settings that respect confidentiality,	An additional bullet point has been added to highlight that the symptoms of depression and stigma can make it difficult to access treatment, and that service providers should take action to overcome this. This evidence was identified in the evidence review on choice.

	privacy and dignity. **[2009, amended 2022]**	
1.1.1.3 Inform people with depression about self-help groups, support groups and other	1.1.2 Make sure people with depression are aware of self-help groups, peer support groups and other local and national resources. Follow the guidance on providing information in the NICE guideline on service user experience in adult mental health. **[2009, amended 2022]**	A link to the NICE guideline on service user experience in adult mental health has been added.
1.1.2.1 For people with recurrent severe depression or depression with psychotic symptoms and for those who have been treated under the Mental Health Act, consider developing advance decisions and advance statements collaboratively with the person. Record the decisions and statements and include copies in the person's care plan in primary and secondary care. Give copies to the person and to their family or carer, if the person agrees.	1.1.4 Consider developing advance decisions about treatment choices (including declining treatment) and advance statements collaboratively with people who have recurrent severe depression or depression with psychotic symptoms, and for those who have been treated under the Mental Health Act 2007, in line with the Mental Capacity Act 2005, 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]**	This recommendation has been amended to cite additional relevant legislation, the Mental Capacity Act, and include the choice to decline treatment.
1.1.3.1 When families or carers are involved in supporting a person with severe or chronic depression, consider: • providing written and verbal information on depression and its management, including how families or carers can support the person • offering a carer's assessment of their caring, physical and mental health needs if necessary	1.1.6 When families or carers are involved in supporting a person with severe or chronic depression, see the recommendations in the NICE guideline on supporting adult carers on identifying, assessing and meeting the caring, physical and mental health needs of families and carers. **[2009, amended 2022]**	The details of the recommendation have been replaced by a link to the NICE guideline on supporting adult carers, which provides greater and more up to date advice on supporting families and carers.

• providing information about local family or carer support groups and voluntary organisations, and helping families or carers to access these • negotiating between the person and their family or carer about confidentiality and the sharing of information.		
1.1.4.1 When assessing a person who may have depression, conduct a comprehensive assessment that does not rely simply on a symptom count. Take into account both the degree of functional impairment and/or disability associated with the possible depression and the duration of the episode.	1.2.6 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]**	The other factors, besides a symptom count, that should be taken into consideration have been added.
1.1.4.2 In addition to assessing symptoms and associated functional impairment, consider how the following factors may have affected the development, course and severity of a person's depression: • any history of depression and comorbid mental health or physical disorders • any past history of mood elevation (to determine if the depression may be part of bipolar disorder) • any past experience of, and response to, treatments • the quality of interpersonal relationships • living conditions and social isolation.	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	The recommendation has been amended to include a link to the NICE guideline on bipolar disorder, the recommendations have been clarified that it is previous and current relationships, and, based on the committee's experience and knowledge and stakeholder feedback the list of other factors that may affect depression has been expanded.

	• 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]**	
1.1.4.4. When assessing a person with suspected depression, be aware of any learning disabilities or acquired cognitive impairments, and if necessary consider consulting with a relevant specialist when developing treatment plans and strategies.	1.2.5 If a person has language or communication difficulties (for example, 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 guideline on mental health problems in people with learning disabilities and the NICE guideline on autism	This recommendation has been updated with more practical advice on how to overcome communication difficulties and a link to the NICE guidelines on mental health problems in people with learning disabilities and autism (see also 1.2.5 below)

	spectrum disorder. **[2009, amended 2022]**	
1.1.4.5 When providing interventions for people with a learning disability or acquired cognitive impairment who have a diagnosis of depression: • where possible, provide the same interventions as for other people with depression • if necessary, adjust the method of delivery or duration of the intervention to take account of the disability or impairment.	1.2.15 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. **[2009]** For people with depression who also have dementia, see the advice in the NICE guideline on dementia. **[2009, amended 2022]**	A link to the NICE guideline on dementia has been added to this recommendation.
1.1.5.1 All interventions for depression should be delivered by competent practitioners. Psychological and psychosocial interventions should be based on the relevant treatment manual(s), which should guide the structure and duration of the intervention. Practitioners should consider using competence frameworks developed from the relevant treatment manual(s) and for all interventions should: • receive regular high-quality supervision • use routine outcome measures and ensure that the person with depression is involved in reviewing the efficacy of the treatment • engage in monitoring and evaluation of treatment adherence and practitioner competence – for example, by using	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]**	This recommendation has been split into 3 for ease of reading and comprehension. The 'ending' of interventions has been added, based on stakeholder feedback that people feel unsure what to do when treatment ends. Supervision has been amended to 'clinical supervision'.

video and audio tapes, and external audit and scrutiny where appropriate.		
1.3.1.1 Be alert to possible depression (particularly in people with a past history of depression or a chronic physical health problem with associated functional impairment) and consider asking people who may have depression two questions, specifically: • During the last month, have you often been bothered by feeling down, depressed or hopeless? • During the last month, have you often been bothered by having little interest or pleasure in doing things?	1.2.1 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]**	A link to the NICE guideline on depression in adults with a chronic physical health problem has been added.
1.3.1.4 When assessing a person with suspected depression, consider using a validated measure (for example, for symptoms, functions and/or disability) to inform and evaluate treatment.	1.4.3 For 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	Based on their experience and knowledge the committee amended the recommendation on measuring outcomes to include when people should be reviewed, that this monitoring should include harms, side effects and suicidal ideation as well as treatment outcomes.

	sessional outcome measures, for example PHQ-9) and follow up. **[2009, amended 2022]**	
1.3.1.5 For people with significant language or communication difficulties, for example people with sensory impairments or a learning disability, consider using the Distress Thermometer and/or asking a family member or carer about the person's symptoms to identify possible depression. If a significant level of distress is identified, investigate further.	1.2.5 If a person has language or communication difficulties (for example, people with sensory or cognitive impairments or autism), to help identify possible depression consider: • asking the person about their symptoms directly using a British Sign Language/English interpreter • asking a family member or carer about the person's symptoms. See also the NICE guideline on mental health problems in people with learning disabilities and the NICE guideline on autism spectrum disorder. **[2009, amended 2022]**	This recommendation has been updated and the reference to use of the Distress Thermometer has been removed as this detail would be superseded by recommendations made in NICE's guideline on mental health problems in people with learning disabilities. Detail has been added about the use of British Sign Language or English interpreter and links to NICE guideline on mental health problems in people with learning disabilities and autism included.
1.3.2.3 Advise a person with depression and their family or carer to be vigilant for mood changes, negativity and hopelessness, and suicidal ideation, and to contact their practitioner if concerned. This is particularly important during high-risk periods, such as starting or changing treatment and at times of increased personal stress.	1.2.11 Advise a person with depression and their family or carer to be vigilant for mood changes, agitation, negativity and hopelessness, and suicidal ideation, and to contact their practitioner if concerned. This is particularly important during high-risk periods, such as starting or changing treatment and at times of increased personal stress. **[2009, amended 2022]**	This recommendation has been amended to include agitation.
1.3.2.4 If a person with depression is assessed to be at risk of suicide: • take into account toxicity in overdose if an antidepressant is prescribed or the person is taking other medication; if necessary,	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	This recommendation has been updated, based on the committee's experience and knowledge, by adding a bullet to state that treatment should not be withheld because

limit the amount of drug(s) available • consider increasing the level of support, such as more frequent direct or telephone contacts • consider referral to specialist mental health services.	prescribed, or the person is taking other medication; (if necessary, limit the amount of medicine available) • consider increasing the level of support provided, such as more frequent in-person, video call or telephone contacts • consider referral to specialist mental health services. For further advice on risk assessment, see the NICE guideline on self-harm. For further advice on medication see the recommendations on antidepressant medication for people at risk of suicide. **[2009, amended 2022]**	they are suicidal, and to clarify that face-to-face support can be provided as well as telephone calls. A link to the NICE guideline on self-harm (in development) has been added, and to the separate section of the guideline on antidepressant medication for people at risk of suicide.
1.4.1.1 When depression is accompanied by symptoms of anxiety, the first priority should usually be to treat the depression. When the person has an anxiety disorder and comorbid depression or depressive symptoms, consult the NICE guideline for the relevant anxiety disorder (see section 6) and consider treating the anxiety disorder first (since effective treatment of the anxiety disorder will often improve the depression or the depressive symptoms).	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]**	The fact that anxiety is particularly common in older people has been added to the recommendation.
1.4.1.3 For people who, in the judgement of the practitioner, may recover with no formal intervention, or people with mild depression who do not want an intervention, or people with subthreshold depressive symptoms who request an intervention: • discuss the presenting problem(s) and any concerns that the person may have about them	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	This recommendation was updated to remove the reference to subthreshold symptoms (as these people are now covered in the less severe depression recommendations), to provide more detail about underlying vulnerabilities, to

• provide information about the nature and course of depression • arrange a further assessment, normally within 2 weeks • make contact if the person does not attend follow-up appointments.	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]**	make sure people know how to seek help if they change their mind, and that repeated attempts should be made it contact people if necessary.
1.5.2.3 Take into account toxicity in overdose when choosing an antidepressant for people at significant risk of suicide. Be aware that: • compared with other equally effective antidepressants recommended for routine use in primary care, venlafaxine is associated with a greater risk of death from overdose • tricyclic antidepressants (TCAs), except for lofepramine, are associated with the greatest risk in overdose.	1.4.25 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]**	Based on the committee's knowledge and experience the warning relating to venlafaxine was removed as the committee agreed that there was no evidence that venlafaxine was associated with any greater risk than any other SSRIs or SNRIs. The 'be aware' recommendation was changed to 'do not routinely start treatment'.
1.5.2.7 A person with depression started on antidepressants who is considered to present an increased suicide risk or is younger than 30 years (because of the potential increased prevalence of suicidal thoughts in the early stages of antidepressant treatment for this group) should normally be seen after 1 week and frequently thereafter as appropriate until the risk is no longer considered clinically important.	1.4.21 When prescribing antidepressant medication for people with depression who are 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	The age limit has been reduced to 25 years as this is in line with the Medicines and Healthcare products Regulatory Agency (MHRA) advice on increased risk of suicide. Advice on assessment before starting a prescription has been added, and the need to have a risk management strategy in place. It has been clarified that the 1 week

	antidepressant treatment, and ensure that a risk management strategy is in place (see the recommendations 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]**	review should ideally be face-to-face or by video call, or can be by telephone, and then another review should take place after 4 weeks, with further reviews depending on their circumstances. The committee used their knowledge to provide examples of factors that may increase their risk of suicide.
1.6.1.3 When prescribing antidepressants for older people: • prescribe at an age-appropriate dose taking into account the effect of general physical health and concomitant medication on pharmacokinetics and pharmacodynamics • carefully monitor for side effects.	1.4.23 When prescribing antidepressant medication for older people: • take into account the person's general physical health, comorbidities and possible interactions with any other medicines they may be taking • carefully monitor the person for side effects (for example, hyponatraemia).	The recommendation has been amended to add in comorbidities, as that may determine the choice of antidepressant. The suggestion to use a reduced dose in the elderly has been removed, as there is no evidence that lower doses are needed and they may not be effective.

	See the NICE guideline on dementia. **[2009, amended 2022]**	An example of an important side-effect has been given, and a link to the NICE guideline on dementia has been included
1.6.1.4 For people with long-standing moderate or severe depression who would benefit from additional social or vocational support, consider: • befriending as an adjunct to pharmacological or psychological treatments; befriending should be by trained volunteers providing, typically, at least weekly contact for between 2 and 6 months • a rehabilitation programme if a person's depression has resulted in loss of work or disengagement from other social activities over a longer term.	1.10.7 For people with chronic depressive symptoms that significantly impair personal and social functioning, who have been assessed as likely to benefit from extra social or vocational support, consider: • befriending in combination with existing antidepressant medication or psychological therapy: this should be done by trained volunteers, typically with at least weekly contact for between 2 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]**	The terminology for the population has been changed to 'chronic depressive symptoms' to reflect the section heading in the guideline.
1.6.13 When prescribing antidepressants for older people: • prescribe at an age-appropriate dose taking into account the effect of general physical health and concomitant medication on pharmacokinetics and pharmacodynamics • carefully monitor for side effects.	1.4.26 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	The recommendation has been expanded, based on stakeholder feedback, to include other factors to take into consideration when prescribing for older people, and to add a link to the NICE guideline on dementia.

	concomitant use of diuretics). See also the NICE guideline on dementia. **[2009, amended 2021]**	
1.8.1.7 When prescribing lithium: • monitor renal and thyroid function before treatment and every 6 months during treatment (more often if there is evidence of renal impairment) • consider ECG monitoring in people with depression who are at high risk of cardiovascular disease • monitor serum lithium levels 1 week after initiation and each dose change until stable, and every 3 months thereafter.	1.4.24 For people with depression taking lithium 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]**	The recommendation has been amended to include weight and calcium levels, to bring the recommendations in line with the monitoring requirements in the BNF

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ISBN: 978-1-4731-4622-8