

Issue date: December 2004

## **Quick reference guide**

# **Depression: management of depression in primary and secondary care**

**Clinical Guideline 23**

Developed by the National Collaborating Centre for Mental Health

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### This guidance is written in the following context:

This guidance represents the view of the Institute, which was arrived at after careful consideration of the evidence available. Health professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of health professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

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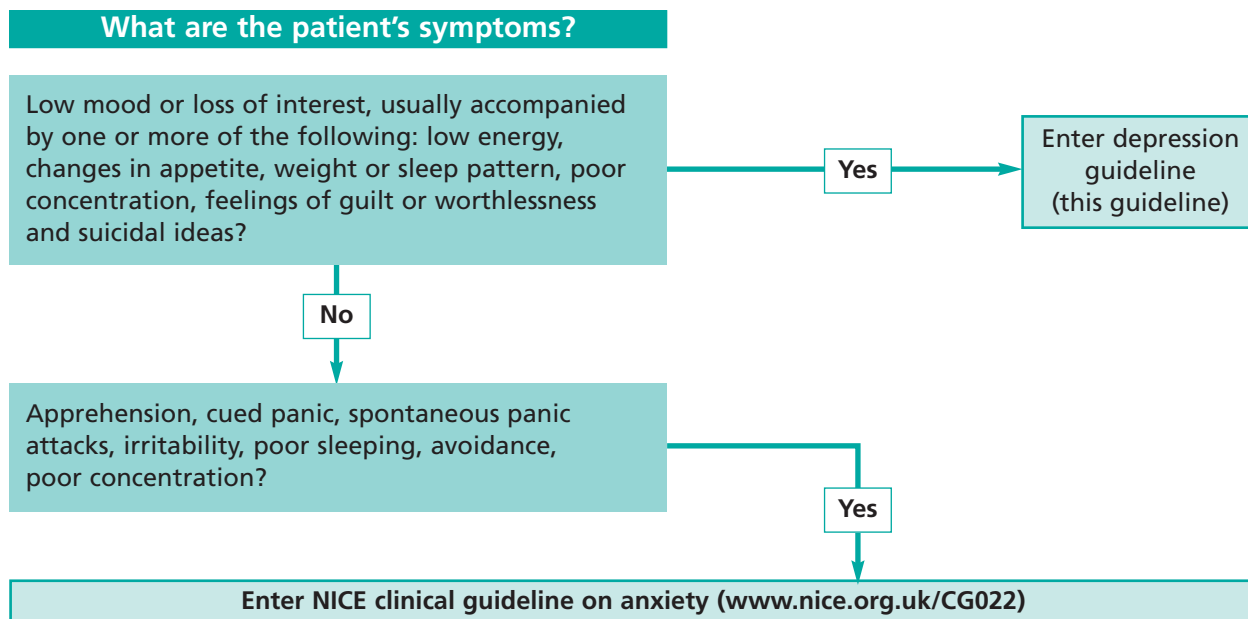
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ISBN: 1-84257-850-2  
Published by the National Institute for Clinical Excellence  
December 2004  
Artwork by LIMA Graphics Ltd, Frimley, Surrey  
Printed by Abba Litho Sales Limited, London

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## Which NICE guideline?



### The stepped care model

The recommendations in this guideline are presented within a stepped care framework that aims to match the needs of people with depression to the most appropriate services, depending on the characteristics of their illness and their personal and social circumstances. Each step represents increased complexity of intervention, with higher steps assuming interventions in previous steps.

**Step 1:** Recognition in primary care and general hospital settings

**Step 2:** Treatment of mild depression in primary care

**Step 3:** Treatment of moderate to severe depression in primary care

**Step 4:** Treatment of depression by mental health specialists

**Step 5:** Inpatient treatment for depression

	Who is responsible for care?	What is the focus?	What do they do?
<b>Step 5:</b>	Inpatient care, crisis teams	Risk to life, severe self-neglect	Medication, combined treatments, ECT
<b>Step 4:</b>	Mental health specialists, including crisis teams	Treatment-resistant, recurrent, atypical and psychotic depression, and those at significant risk	Medication, complex psychological interventions, combined treatments
<b>Step 3:</b>	Primary care team, primary care mental health worker	Moderate or severe depression	Medication, psychological interventions, social support
<b>Step 2:</b>	Primary care team, primary care mental health worker	Mild depression	Watchful waiting, guided self-help, computerised CBT, exercise, brief psychological interventions
<b>Step 1:</b>	GP, practice nurse	Recognition	Assessment

## Key priorities for implementation

### Screening in primary care and general hospital settings

- Screening should be undertaken in primary care and general hospital settings for depression in high-risk groups – for example, those with a past history of depression, significant physical illnesses causing disability, or other mental health problems such as dementia.

### Watchful waiting

- For patients with mild depression who do not want an intervention or who, in the opinion of the healthcare professional, may recover with no intervention, a further assessment should be arranged, normally within 2 weeks ('watchful waiting').

### Antidepressants in mild depression

- Antidepressants are not recommended for the initial treatment of mild depression, because the risk–benefit ratio is poor.

### Guided self-help

- For patients with mild depression, healthcare professionals should consider recommending a guided self-help programme based on cognitive behavioural therapy (CBT).

### Short-term psychological treatment

- In both mild and moderate depression, psychological treatment specifically focused on depression (such as problem-solving therapy, brief CBT and counselling) of 6 to 8 sessions over 10 to 12 weeks should be considered.

### Prescription of an SSRI

- When an antidepressant is to be prescribed in routine care, it should be a selective serotonin reuptake inhibitor (SSRI), because SSRIs are as effective as tricyclic antidepressants and are less likely to be discontinued because of side effects.

### Tolerance and craving, and discontinuation/withdrawal symptoms

- All patients prescribed antidepressants should be informed that, although the drugs are not associated with tolerance and craving, discontinuation/withdrawal symptoms may occur on stopping, missing doses or, occasionally, on reducing the dose of the drug. These symptoms are usually mild and self-limiting but can occasionally be severe, particularly if the drug is stopped abruptly.

### Initial presentation of severe depression

- When patients present initially with severe depression, a combination of antidepressants and individual CBT should be considered as the combination is more cost-effective than either treatment on its own.

### Maintenance treatment with antidepressants

- Patients who have had two or more depressive episodes in the recent past, and who have experienced significant functional impairment during the episodes, should be advised to continue antidepressants for 2 years.

### Combined treatment for treatment-resistant depression

- For patients whose depression is treatment resistant, the combination of antidepressant medication with CBT should be considered.

### CBT for recurrent depression

- CBT should be considered for patients with recurrent depression who have relapsed despite antidepressant treatment, or who express a preference for psychological interventions.

## General principles of care – all steps

### Depression and anxiety

- In comorbid depression and anxiety, treat the depression as a priority. **GPP**

### Patient preference

- Consider patient preference and the experience and outcome of previous treatment(s) when deciding on treatment. **GPP**

### Information

- Give patients and carers appropriate information on the nature, course and treatment of depression, including the use and likely side effects of medication. **GPP**
- Inform patients, families and carers about self-help and support groups, and encourage them to participate where appropriate. **GPP**
- Keep use of clinical language to a minimum and, where possible, provide interventions in a language understood by the patient. **GPP**

### Consent

- Ensure that a patient can give meaningful and properly informed consent, especially when he or she has a more severe depression or is subject to the Mental Health Act. **GPP**

### Management of care

- Where management is shared between primary and secondary care, establish a clear agreement between all professionals on the responsibility for monitoring and treatment; this should be shared with the patient and, where appropriate, with families and carers. **GPP**
- Consider advance directives, especially for people who have recurrent severe or psychotic depressions, and for those who have been treated under the Mental Health Act. **GPP**

## General principles of care

### Assessment

- Consider the psychological, social and physical characteristics of the patient and the quality of interpersonal relationships. Assess impact on: **GPP**
  - depression
  - choice of treatment
  - monitoring.
- Consider alternatives when discussing treatment options. Factors influencing choice include past or family history of depression, response to previous interventions, and the presence of associated problems in social or interpersonal relationships. **GPP**
- In older patients, consider their physical health, their living conditions, and their social situation. **GPP**

### Risk

- Always ask patients with depression directly about suicidal ideas and intent, and advise patients and carers to be vigilant for changes in mood, negativity and hopelessness, and suicidal intent, particularly during high-risk periods such as during initiation of and changes to medication and increased personal stress. Advise patients and carers to contact the appropriate healthcare practitioner if concerned. **GPP**
- Assess whether patients with suicidal ideas have adequate social support and are aware of appropriate sources of help, and advise them to seek appropriate help if the situation deteriorates. **GPP**
- Where a patient presents considerable immediate risk to self or others, consider urgent referral to a specialist mental health service. **GPP**
- Make contact with patients with depression who do not attend follow-up. **C**

## Step 1: Recognition of depression in primary care and general hospital settings

- In primary care and general hospital settings, screen patients with: **C**
  - a past history of depression
  - significant physical illnesses causing disability
  - other mental health problems, such as dementia.
- Bear in mind the potential physical causes of depression and the possibility that depression can be caused by medication. **C**
- Use two screening questions, such as: **B**
  - “During the last month, have you often been bothered by feeling down, depressed or hopeless?”  
*and*
  - “During the last month, have you often been bothered by having little interest or pleasure in doing things?”

## Step 2: Treatment of mild depression in primary care

### Watchful waiting

- In mild depression, if the patient does not want treatment or may recover with no intervention, arrange further assessment – normally within 2 weeks. **C**

### Sleep and anxiety management

- Consider advice on sleep hygiene and anxiety management. **C**

### Exercise

- Advise patients of all ages with mild depression of the benefits of following a structured and supervised exercise programme. Effective duration of such programmes is up to 3 sessions per week of moderate duration (45 minutes to 1 hour) for between 10 and 12 weeks. **C**

### Guided self-help

- For patients with mild depression, consider a guided self-help programme that consists of the provision of appropriate written materials and limited support over 6 to 9 weeks, including follow up, from a professional who typically introduces the self-help programme and reviews progress and outcome. **C**

### Computerised cognitive behavioural therapy

- Computerised CBT should be considered for the treatment of mild depression. **GPP**

### Psychological interventions

- In mild and moderate depression, consider psychological treatment specifically focused on depression (problem-solving therapy, brief CBT and counselling) of 6 to 8 sessions over 10 to 12 weeks. **B**
- Offer the same range of treatments to older people as to younger people. **C**
- In psychological interventions, therapist competence and therapeutic alliance have significant bearing on the outcome of intervention. **C**
- Where significant comorbidity exists, consider extending treatment duration or focusing specifically on comorbid problems. **C**

### Antidepressants

- Antidepressants are not recommended for the initial treatment of mild depression, because the risk–benefit ratio is poor. **C**
- Where mild depression persists after other interventions, or is associated with psychosocial and medical problems, consider use of an antidepressant. **C**
- If a patient with a history of moderate or severe depression presents with mild depression, consider use of an antidepressant (see Step 3 on pages 8 to 11). **C**

### Review in mild depression

- Consider contacting all patients with mild depression who do not attend follow-up appointments. **C**

## Step 3: Treatment of moderate to severe depression in primary care

### Starting treatment

- In moderate depression, offer antidepressant medication to all patients routinely, before psychological interventions. **B**
- Discuss the patient's fears of addiction or other concerns about medication. For example, explain that craving and tolerance do not occur. **GPP**
- When starting treatment, tell patients about: **C**
  - the risk of discontinuation/withdrawal symptoms
  - potential side effects.
- Inform patients about the delay in onset of effect, the time course of treatment and the need to take medication as prescribed. Make available written information appropriate to the patient's needs. **GPP**

### Monitoring risk

- See patients who are considered to be at increased risk of suicide or who are younger than 30 years old 1 week after starting treatment. Monitor frequently until the risk is no longer significant. **C**
- If there is a high risk of suicide, prescribe a limited quantity of antidepressants. **C**
- If there is a high risk of suicide consider additional support such as more frequent contacts with primary care staff, or telephone contacts. **C**
- Monitor for signs of akathisia, suicidal ideas, and increased anxiety and agitation, particularly in the early stages of treatment with an SSRI. **C**
- Advise patients of the risk of these symptoms, and that they should seek help promptly if these are at all distressing. **C**
- If a patient develops marked and/or prolonged akathisia or agitation while taking an antidepressant, review the use of the drug. **C**

### Continuing treatment

- See patients who are not considered to be at increased risk of suicide 2 weeks after starting treatment and regularly thereafter – for example, every 2–4 weeks in the first 3 months – reducing the frequency if response is good. **C**
- For patients with a moderate or severe depressive episode, continue antidepressants for at least 6 months after remission. **A**
- Once a patient has taken antidepressants for 6 months after remission, review the need for continued antidepressant treatment. This review may include consideration of the number of previous episodes, presence of residual symptoms, and concurrent psychosocial difficulties. **C**

### Choice of antidepressants

- For routine care, use an SSRI because they are as effective as tricyclic antidepressants and less likely to be discontinued because of side effects. **A**
- Consider using a generic form of SSRI. Fluoxetine or citalopram, for example, would be reasonable choices because they are generally associated with fewer discontinuation/withdrawal symptoms. Note the higher propensity of fluoxetine for drug interactions. **C**
- Treatments such as dosulepin, phenelzine, combined antidepressants, and lithium augmentation of antidepressants should be routinely initiated only by specialist mental healthcare professionals (including General Practitioners with a Special Interest in Mental Health). **C**
- Venlafaxine should be initiated only by specialist mental health medical practitioners, including General Practitioners with a Special Interest in Mental Health. **C**
- Venlafaxine should be managed only under the supervision of specialist mental health medical practitioners, including General Practitioners with a Special Interest in Mental Health. **C**
- Consider toxicity in overdose; note that tricyclics (with the exception of lofepramine) are more dangerous in overdose. **C**

- If increased agitation develops early in treatment with an SSRI, provide appropriate information and, if the patient prefers, either change to a different antidepressant or consider a brief period of concomitant treatment with a benzodiazepine followed by a clinical review within 2 weeks. **C**
- St John's wort may be of benefit in mild or moderate depression, but its use should not be prescribed or advised because of uncertainty about appropriate doses, variation in the nature of preparations, and potential serious interactions with other drugs. **C**
- Tell patients taking St John's wort about the different potencies of the preparations available and the uncertainty that arises from this, and about the interactions of St John's wort with other drugs (including oral contraceptives, anticoagulants and anticonvulsants). **C**

### Pharmacological treatment of atypical depression

- Treat patients with features of atypical depression with an SSRI. **C**
- If there is no response to an SSRI and there is significant functional impairment, consider referral to a mental health specialist. **GPP**

### Stopping or reducing antidepressants

- Inform patients about the possibility of discontinuation/withdrawal symptoms on stopping or missing doses or reducing the dose. These symptoms are usually mild and self-limiting but can occasionally be severe, particularly if the drug is stopped abruptly. **C**
- Advise patients to take their drugs as prescribed, particularly drugs with a shorter half-life (such as paroxetine). **C**
- Reduce doses gradually over a 4-week period; some people may require longer periods, and fluoxetine can usually be stopped over a shorter period. **C**
- For mild discontinuation/withdrawal symptoms, reassure the patient and monitor symptoms. **C**
- For severe symptoms, consider reintroducing the original antidepressant at the effective dose (or another antidepressant with a longer half-life from the same class) and reduce gradually while monitoring symptoms. **C**
- Ask patients to seek advice from their medical practitioner if they experience significant discontinuation/withdrawal symptoms. **GPP**

### Special patient characteristics

#### Gender

- Note that women have a poorer toleration of imipramine. **B**

#### Age

- For older adults with depression, give antidepressant treatment at an age-appropriate dose for a minimum of 6 weeks before considering that it is ineffective. If there is a partial response within this period, treatment should be continued for a further 6 weeks. **C**
- When prescribing antidepressants for older adults, consider:
  - the increased risk of drug interactions **GPP**
  - careful monitoring of side effects, particularly with tricyclic antidepressants. **C**

#### Patients with dementia

- Treat depression in people with dementia in the same way as depression in other older adults. **C**

#### Patients with cardiovascular disease

- When initiating antidepressant treatment in patients with ischaemic heart disease, note that sertraline has the best evidence base. **B**
- Consider the increased risks associated with tricyclic antidepressants in patients with cardiovascular disease. **GPP**
- Perform an ECG before prescribing a tricyclic antidepressant for a depressed patient at significant risk of cardiovascular disease. **GPP**
- Venlafaxine should not be prescribed for patients with pre-existing heart disease. **C**

## Limited response to initial treatment in moderate and severe depression

### Pharmacological approaches

- When a patient fails to respond to the first antidepressant prescribed, check that the drug has been taken regularly and at the prescribed dose. **GPP**
- If response to a standard dose of an antidepressant is inadequate, and there are no significant side effects, consider a gradual increase in dose in line with the schedule suggested by the Summary of Product Characteristics. **C**
- Consider switching to another antidepressant if there has been no response after a month. If there has been a partial response, a decision to switch can be postponed until 6 weeks. **C**
- If an antidepressant has not been effective or is poorly tolerated and, after considering a range of other treatment options, the decision is made to offer a further course of antidepressants, then switch to another single antidepressant. **C**
- Choices for a second antidepressant include a different SSRI or mirtazapine; alternatives include moclobemide, reboxetine and tricyclic antidepressants (except dosulepin) (but see below). **B**
- When switching from one antidepressant to another, be aware of the need for gradual and modest incremental increases of dose, of interactions between antidepressants, and the risk of serotonin syndrome when combinations of serotonergic antidepressants are prescribed. Features include confusion, delirium, shivering, sweating, changes in blood pressure, and myoclonus. **C**

### Special considerations when switching to a new antidepressant other than a tricyclic

- If switching to mirtazapine, be aware that it can cause sedation and weight gain. **A**
- If switching to moclobemide, be aware of the need to wash out previously prescribed antidepressants. **A**
- If switching to reboxetine, be aware of its relative lack of data on side effects, and monitor carefully. **B**

### Special considerations when switching to a new tricyclic antidepressant

- Consider their poorer tolerability compared with other equally effective antidepressants, and the increased risk of cardiotoxicity and toxicity in overdose. **B**
- Start on a low dose and, if there is a clear clinical response, maintain on that dose with careful monitoring. **C**
- Gradually increase dose if there is lack of efficacy and no major side effects. **GPP**
- Lofepamine is a reasonable choice because of its relative lack of cardiotoxicity. **C**

## Psychological treatments

- CBT is the psychological treatment of choice. Consider interpersonal psychotherapy (IPT) if the patient expresses a preference for it or if you think the patient may benefit from it. **B**
- CBT and IPT should be delivered by a healthcare professional competent in their use – treatment typically consists of 16 to 20 sessions over 6 to 9 months. **B**
- Consider CBT (or IPT) for patients with moderate or severe depression who do not take or refuse antidepressant treatment. **B**
- For patients who have not made an adequate response to other treatments for depression (for example, antidepressants and brief psychological interventions), consider giving a course of CBT of 16 to 20 sessions over 6 to 9 months. **C**
- Consider CBT for patients with severe depression for whom avoiding the side effects often associated with antidepressants is a clinical priority or personal preference. **B**
- For patients with severe depression, consider providing 2 sessions of CBT per week for the first month of treatment. **C**
- Where patients have responded to a course of individual CBT or IPT, consider offering follow-up sessions – typically 2 to 4 sessions over 12 months. **C**

## Initial presentation of severe depression

- When patients present initially with severe depression, a combination of antidepressants and individual CBT should be considered as it is more cost-effective than either treatment on its own. **B**

## Couple-focused therapy

- Consider couple-focused therapy for people with depression who have a regular partner and who have not benefited from a brief individual intervention. An adequate course is 15 to 20 sessions over 5 to 6 months. **B**

## Chronic depression

- In chronic depression, offer a combination of individual CBT and antidepressant medication. **A**
- For men with chronic depression who have not responded to an SSRI, consider a tricyclic antidepressant, as men tolerate the side effects of tricyclic antidepressants reasonably well. **C**
- Consider offering befriending (by trained volunteers offering weekly meetings for 2 to 6 months) as an adjunct to pharmacological or psychological treatments to people with chronic depression. **C**
- Consider a rehabilitation programme for patients who are unemployed, or have been disengaged from social activities over a longer term. **C**

## Enhanced care in primary care

- For all patients, consider telephone support from the primary care team, informed by clear treatment protocols, particularly for monitoring antidepressant medication regimes. **B**
- Primary care organisations should consider establishing multi-faceted care programmes, which integrate through clearly specified protocols the delivery and monitoring of appropriate psychological and pharmacological interventions for the care of people with depression. **C**

## Step 4: Treatment of depression by mental health specialists including crisis teams

- Assess patients with depression referred to specialist care, including their symptom profile and suicide risk and, where appropriate, previous treatment history. Where the depression is chronic or recurrent, assess psychosocial stressors, personality factors and significant relationship difficulties as well. **GPP**
- Consider re-introducing any previous treatments that were inadequately delivered or adhered to. **GPP**
- Crisis resolution teams should be used as a means of managing crises for patients who have severe depression and are assessed as presenting significant risk. **C**
- Medication in specialist services should be initiated under the supervision of a consultant psychiatrist. **GPP**

### Treatment-resistant depression

- For all people whose depression is treatment resistant, consider the combination of antidepressant medication with individual CBT of 16 to 20 sessions over 6 to 9 months. **B**
- For patients with treatment-resistant moderate depression who have relapsed while taking, or after finishing, a course of antidepressants, consider the combination of antidepressant medication with CBT. **B**
- Consider a trial of lithium augmentation for patients whose depression has failed to respond to several antidepressants and who are prepared to tolerate the burdens associated with its use. **B**
- Before initiating lithium augmentation carry out an ECG. **C**
- Venlafaxine may be considered for patients who have failed two adequate trials of alternative antidepressants. The dose can be increased up to *BNF* limits if required, provided patients can tolerate the side effects. **C**
- When prescribing venlafaxine, be aware of:
  - the increased likelihood of patients stopping treatment because of side effects, compared with equally effective SSRIs **A**
  - its higher cost **C**
  - its high propensity for discontinuation/withdrawal symptoms if stopped abruptly **C**
  - its toxicity in overdose. **C**
- Before prescribing venlafaxine carry out an ECG and measure blood pressure. **C**
- For patients prescribed venlafaxine, consider monitoring cardiac function. Undertake regular monitoring of blood pressure, particularly for patients on higher doses. **C**
- Consider augmenting an antidepressant with another antidepressant (there is evidence for benefits of adding mianserin or mirtazapine to SSRIs). **C**
- When augmenting one antidepressant with another, monitor carefully (particularly for the symptoms of serotonin syndrome), and explain the importance of this to the patient. **GPP**
- When augmenting an antidepressant with mianserin be aware of the risk of agranulocytosis, particularly in older adults. **C**
- Re-evaluate the adequacy of previous treatments and consider seeking a second opinion if considering using combinations of antidepressants other than mianserin or mirtazapine with SSRIs. Document the content of any discussion in the notes. **C**
- Consider phenelzine for patients who have failed to respond to alternative antidepressants and who are prepared to tolerate the side effects and dietary restrictions associated with its use. Consider its toxicity in overdose when prescribing for patients at high-risk of suicide. **C**
- Augmentation of an antidepressant with carbamazepine, lamotrigine, buspirone, pindolol, valproate or thyroid supplementation is not recommended in the routine management of treatment-resistant depression. **B**

- Consider referring patients who have failed to respond to various strategies for augmentation and combination treatments to a clinician with a specialist interest in treating depression. **GPP**
- Dosulepin should not be used routinely because the evidence supporting its tolerability relative to other antidepressants is outweighed by the increased cardiac risk and its toxicity in overdose. **C**
- There is insufficient evidence to recommend augmentation of antidepressants with benzodiazepines. **C**

## Recurrent depression and relapse prevention

### Pharmacological treatments

- Continue antidepressants for 2 years for people who have had two or more depressive episodes in the recent past and who have experienced significant functional impairment during the episodes. **B**
- Re-evaluate patients on maintenance treatment, taking into account age, comorbid conditions and other risk factors in the decision to continue the treatment beyond 2 years. **GPP**
- Maintain the antidepressant dose used for relapse prevention at the level at which acute treatment was effective. **C**
- Patients who have had multiple episodes of depression, and who have had a good response to treatment with an antidepressant and lithium augmentation, should remain on the combination for at least 6 months. **B**
- When patients are taking an antidepressant with lithium augmentation, if one drug is to be discontinued, this should be lithium in preference to the antidepressant. **C**

### Psychological treatments

- CBT should be considered for:
  - patients with recurrent depression, who have relapsed despite antidepressant treatment, or who express a preference for psychological interventions **C**
  - patients with a history of relapse and poor or limited response to other interventions **B**
  - patients who have responded to another intervention but are unable or unwilling to continue with that intervention, and are assessed as being at significant risk of relapse **B**
- Mindfulness-based CBT should be considered for patients with recurrent depression. **B**

## Special considerations

### Psychotic depression

- For patients with psychotic depression, consider augmentation of the current treatment plan with antipsychotic medication. **C**

### Atypical depression

- Consider prescribing phenelzine for women whose depression has atypical features, and who have not responded to, or who cannot tolerate, an SSRI. Consider its toxicity in overdose when prescribing for patients at high risk of suicide. **C**
- All patients receiving phenelzine require careful monitoring (including taking blood pressure) and advice on interactions with other medicines and foodstuffs, and should have their attention drawn to the product information leaflet. **C**

## Step 5: Inpatient treatment for depression

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### Inpatient care

- Inpatient treatment should be considered for people with depression where the patient is at significant risk of suicide or self-harm. **C**
- Crisis resolution teams should be considered for patients with depression who might benefit from an early discharge from hospital after a period of inpatient care. **C**

### Electroconvulsive therapy

- Electroconvulsive therapy (ECT) should only be used to achieve rapid and short-term improvement of severe symptoms after an adequate trial of other treatments has proven ineffective, and/or when the condition is considered to be potentially life-threatening, in a severe depressive illness. **N**
- When considering ECT, review risks and potential benefits to the individual, including: the risks associated with the anaesthetic; current comorbidities; anticipated adverse events, particularly cognitive impairment; and the risks of not having treatment. **N**
- Particular care is needed when considering ECT treatment during pregnancy, in older people, and in children and young people, because the risks may be increased. **N**
- Valid consent should be obtained in all cases where the individual has the ability to grant or refuse consent. The decision to use ECT should be made jointly by the individual and the clinician(s) responsible for treatment, on the basis of an informed discussion. This discussion should be enabled by the provision of full and appropriate information about the general risks associated with ECT and about the risks and potential benefits specific to that individual. **N**
- Advance directives should be taken fully into account and the individual's advocate and/or carer should be consulted. **N**
- Clinical status should be assessed after each ECT session and treatment should be stopped when a response has been achieved, or sooner if there is evidence of adverse effects. Cognitive function should be monitored on an ongoing basis, and at a minimum at the end of each course of treatment. **N**
- A repeat course of ECT should be considered under the circumstances indicated above only for individuals who have severe depressive illness, and who have previously responded well to ECT. **N**
- In patients who are experiencing an acute episode but have not previously responded, a repeat trial of ECT should be undertaken only after all other options have been considered and following discussion of the risks and benefits with the individual and/or where appropriate their carer/advocate. **N**
- As the longer-term benefits and risks of ECT have not been clearly established, it is not recommended as a maintenance therapy in depressive illness. **N**

## Grading of the recommendations

This guidance is evidence based and the recommendations are graded as follows.

- A** Based on level I evidence (meta-analysis of randomised controlled trials [RCTs] or at least one RCT)
- B** Based on level II or level III evidence (well-conducted clinical studies but no RCTs) or extrapolated from level I evidence
- C** Based on level IV evidence (expert committee reports or opinions and/or clinical experience of respected authorities)
- GPP** Recommended good practice based on clinical experience of the Guideline Development Group
- N** Evidence from NICE technology appraisal guidance

**For further information, see the NICE guideline ([www.nice.org.uk/CG023NICEguideline](http://www.nice.org.uk/CG023NICEguideline)) or the full guideline ([www.nice.org.uk/CG023fullguideline](http://www.nice.org.uk/CG023fullguideline))**

## Implementation

Local health communities should review their existing practice in the treatment and management of depression against this guideline. The review should consider the resources required to implement the recommendations set out in the NICE guideline ([www.nice.org.uk/CG023NICEguideline](http://www.nice.org.uk/CG023NICEguideline)), the people and processes involved and the timeline over which full implementation is envisaged. It is in the interests of patients that the implementation timeline is as rapid as possible.

Relevant local clinical guidelines, care pathways and protocols should be reviewed in light of this guidance and revised accordingly.

Information on the cost impact of this guideline in England is available on the NICE website

and includes a template that local communities can use ([www.nice.org.uk/CG023costtemplate](http://www.nice.org.uk/CG023costtemplate)).

The implementation of this guideline will build on the National Service Frameworks for Mental Health in England and Wales and should form part of the service development plans for each local health community in England and Wales. The National Service Frameworks are available for England from [www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/MentalHealth/fs/en](http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/MentalHealth/fs/en), and for Wales from [www.wales.nhs.uk/sites/home.cfm?orgid=438](http://www.wales.nhs.uk/sites/home.cfm?orgid=438)

Suggested audit criteria are listed in Appendix D of the NICE guideline. These can be used as the basis for local clinical audit, at the discretion of those in practice.

## Further information

### Distribution

The distribution list for this quick reference guide is available from [www.nice.org.uk/CG023distributionlist](http://www.nice.org.uk/CG023distributionlist)

### NICE guideline

The NICE guideline, 'Depression: management of depression in primary and secondary care', is available from the NICE website ([www.nice.org.uk/CG023NICEguideline](http://www.nice.org.uk/CG023NICEguideline)).

The NICE guideline contains the following sections: Key priorities for implementation; 1 Guidance; 2 Notes on the scope of the guidance; 3 Implementation in the NHS; 4 Key research recommendations; 5 Other versions of this guideline; 6 Related NICE guidance; 7 Review date. It also gives details of the grading scheme for the evidence and recommendations, the Guideline Development Group, the Guideline Review Panel and technical detail on the criteria for audit.

### Information for the public

NICE has produced a version of this guidance for people with depression, their advocates and carers, and the public. The information is available, in English and Welsh, from the NICE website ([www.nice.org.uk/CG023publicinfo](http://www.nice.org.uk/CG023publicinfo)). Printed versions are also available – see below for ordering information.

### Full guideline

The full guideline includes the evidence on which the recommendations are based, in addition to the information in the NICE guideline. It is published by

the National Collaborating Centre for Mental Health. It is available from [www.bps.org.uk/depression](http://www.bps.org.uk/depression), from [www.nice.org.uk/CG023fullguideline](http://www.nice.org.uk/CG023fullguideline) and on the website of the National Electronic Library for Health ([www.nelh.nhs.uk](http://www.nelh.nhs.uk)).

### Related guidance

For information about NICE guidance that has been issued or is in development, see the website ([www.nice.org.uk](http://www.nice.org.uk)).

Anxiety: management of generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults in primary, secondary and community care. *NICE Clinical Guideline* No. 22 (2004). Available from: [www.nice.org.uk/CG022](http://www.nice.org.uk/CG022)

Guidance on the use of computerised cognitive behavioural therapy for anxiety and depression. *NICE Technology Appraisal Guidance* No. 51 (2002). Available from: [www.nice.org.uk/TA051](http://www.nice.org.uk/TA051)

Guidance on the use of electroconvulsive therapy. *NICE Technology Appraisal Guidance* No.59 (2003). Available from: [www.nice.org.uk/TA059](http://www.nice.org.uk/TA059)

NICE is in the process of developing a clinical guideline on depression in children and young people (publication expected August 2005).

### Review date

The process of reviewing the evidence is expected to begin 4 years after the date of issue of this guideline. Reviewing may begin earlier than 4 years if significant evidence that affects the guideline recommendations is identified sooner. The updated guideline will be available within 2 years of the start of the review process.

### Ordering information

Copies of this quick reference guide can be obtained from the NICE website at [www.nice.org.uk/CG023quickrefguide](http://www.nice.org.uk/CG023quickrefguide) or from the NHS Response Line by telephoning 0870 1555 455 and quoting reference number N0766. Information for the public is also available from the NICE website or from the NHS Response Line (quote reference number N0767 for a version in English and N0768 for a version in English and Welsh).