

## Guideline Summary NGC-10760

### Guideline Title

**Clinical practice guideline on the management of depression in adults.**

### Bibliographic Source(s)

Working Group of the Clinical Practice Guideline on the Management of Depression in Adults. Clinical practice guideline on the management of depression in adults. Madrid: Ministry of Health, Social Services and Equality, Galician Health Technology Assessment Agency (HTA) (avalia-t); 2014. 232 p. [408 references]

### Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Working Group on the Management of Major Depression in Adults. Clinical practice guideline on the management of major depression in adults. Madrid: Ministry of Health and Consumer Affairs, Galician Health Technology Assessment Agency (HTA) (avalia-t); 2008. 120 p.

This guideline meets NGC's 2013 (revised) inclusion criteria.

## Scope

### Disease/Condition(s)

Major depression (major depressive disorder)

### Guideline Category

Counseling  
Diagnosis  
Evaluation  
Management  
Risk Assessment  
Screening  
Treatment

### Clinical Specialty

Family Practice  
Psychiatry  
Psychology

### Intended Users

Advanced Practice Nurses  
Allied Health Personnel  
Health Care Providers  
Nurses  
Patients  
Physician Assistants  
Physicians  
Psychologists/Non-physician Behavioral Health Clinicians

### Guideline Objective(s)

- To improve the healthcare given to patients with depression in the field of primary and secondary care in the Spanish National Health System
- To provide updated recommendations for the healthcare professionals involved in caring for patients with depression
- To promote rationality and effectiveness in choosing the different treatment options
- To propose a therapeutic algorithm
- To discuss indicators to evaluate quality of care
- To help patients, families and friends, by preparing information specifically addressed to them; thus contributing to informed decision-making and communication between patients and professionals
- To identify priority areas for future research

### Target Population

Adults diagnosed with depression

**Note:** Areas not addressed by the clinical practice guideline (CPG) include:

- Depression in childhood and adolescence
- Depression in older people
- Postnatal depression
- Dysthymic disorder, bipolar and adaptive disorder

## Interventions and Practices Considered

### Screening/Diagnosis/Evaluation/Risk Assessment

1. Consideration of sociodemographic and cultural factors that may affect depression and treatment
2. Clinical interview using the International Statistical Classification of Diseases and Related Health Problems (ICD) or Diagnostic and Statistical Manual of Mental Disorders (DSM)
3. Hamilton Rating Scale for Depression (HRSD), the Montgomery Asberg Depression Rating Scale (MADRS), the Brief Patient Health Questionnaire (PHQ-9) and the Beck Depression Inventory (BDI)

### Treatment/Management

1. Consideration of perspectives of patients and their families
2. Treatment according to a stepped care and collaboration model between primary care and mental health
3. Psychotherapy provided by expert professionals, including cognitive behavioural therapy, behavioural activation, problem-solving therapy, couples therapy, interpersonal therapy, counselling, short-term psychodynamic therapy, and other psychotherapeutic interventions (computerised cognitive behavioural therapy and guided self-help)
4. Pharmacological treatment with antidepressant drugs such as selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants (TCAs), benzodiazepines, and venlafaxine
5. Informing patients about benefits/side effects/duration of treatment before beginning treatment
6. Monitoring of patients taking antidepressant drugs
7. Combination antidepressant drug treatment and psychotherapy
8. Management of partial or no improvement
9. Possible use of monoamine oxidase inhibitors (MAOIs) in the event of resistance to various treatments
10. Consideration of electroconvulsive therapy in patients with severe major depression
11. Exercise programmes
12. Psychoeducation, individual and family support, coordination with other professionals, care of comorbidity and regular monitoring of mental and physical status

**Note:** The following interventions and practices were considered but not recommended:

- Routine screening for depression
- Treatment augmentation with valproate, carbamazepine, lamotrigine, gabapentin or topiramate, pindolol, benzodiazepines, buspirone, methylphenidate
- Use of St. John's wort as a treatment for major depression
- Vagus nerve stimulation
- Transcranial magnetic stimulation

## Major Outcomes Considered

- Depression symptoms, perception, and care experience
- Effectiveness of evaluation assessments and screening tools
- Effectiveness of stepped care and collaborative models
- Recovery from depression
- Remission of depression
- Response to treatment
- Relapse after remission
- Recurrence of depression
- Frequency of side effects to treatment
- Rate of treatment dropout due to adverse effects

## Methodology

### Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

### Description of Methods Used to Collect/Select the Evidence

#### Literature Database Search

1. Specialising in systematic reviews, such as the Cochrane Library Plus and the National Health Service (NHS) Centre for Reviews and Dissemination database (Galician Health Technology Assessment Agency [HTA], Database of Abstracts of Reviews of Effects [DARE] and National Health Service Economic Evaluation Database [NHS EED])
2. Specialising in clinical practice guidelines and other summarised resources, such as Turning Research into Practice (TRIP), the National Guideline Clearinghouse (NGC) and GuíaSalud
3. General, such as Medline (PubMed), EMBASE (Ovid), ISI WEB, Bibliographic Index of Health Sciences (IBECS) and the Spanish Medical Index (IME); as well as specialist, such as PsycINFO. Languages: English, French, Spanish, Italian and Portuguese.

In updating the clinical practice guideline (CPG), the original search strategies were used, with redesigning in some cases. For updated clinical questions, the searches were carried out from January 2007 to February 2014. For new questions, the searches were made without any time limit. In the first phase, the searches were directed toward

secondary information sources, such as CPGs and systematic reviews, which were followed by searches for primary studies limited to the most relevant studies published after the search date of the systematic reviews identified.

## Number of Source Documents

The studies in the evidence tables (see the Methodological Material) represent the number of studies included for each key question, after application of the inclusion and exclusion criteria.

## Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

## Rating Scheme for the Strength of the Evidence

### Scottish Intercollegiate Guidelines Network (SIGN) Levels of Evidence

<b>1++</b>	High quality meta-analyses, systematic reviews of clinical trials or high-quality clinical trials with very low risk of bias
<b>1+</b>	Well-conducted meta-analyses, systematic reviews of clinical trials, or well-conducted clinical trials with little risk of bias
<b>1-</b>	Meta-analyses, systematic reviews of clinical trials or clinical trials with high risk of bias
<b>2++</b>	High quality systematic reviews of case control or cohort studies. High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal
<b>2+</b>	Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal
<b>2-</b>	Cohort or case-control studies with a high risk of bias and a significant risk that the relationship is not causal
<b>3</b>	Non-analytical studies such as case reports and case series
<b>4</b>	Expert opinion

**Note:** Studies classified as 1- and 2- must not be used in the preparation of recommendations due to their high potential for bias.

Source: Scottish Intercollegiate Guidelines Network. Forming guideline recommendations. In: SIGN 50: A guideline developers' handbook: Edinburgh: SIGN; 2008.

## Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

## Description of the Methods Used to Analyze the Evidence

Assessment of the quality of quantitative studies and the summary of evidence for each question was done using the methodology proposed by the Scottish Intercollegiate Guidelines Network (SIGN). Although there is a growing tendency to use the Grading of Recommendations Assessment, Development and Evaluation (GRADE) method in Clinical Practice Guidelines (CPGs), the development group decided to continue with the SIGN method, as this was an update. This decision was taken primarily because a change in methodology would have required at least a partial re-evaluation of the studies included in the previous version. The qualitative studies were evaluated by following the Critical Appraisal Skills Programme (CASP) checklist, as proposed by Goldsmith et al. (2007).

All the information on the CPG methodology applied (e.g., literature search strategies and summary tables from the selected studies) is available in detailed form at <http://portal.guiasalud.es> .

## Methods Used to Formulate the Recommendations

Expert Consensus

## Description of Methods Used to Formulate the Recommendations

The Working Group to update the clinical practice guideline (CPG) was formed, comprising of two experts in methodology from the Galicia Health Technology Assessment Agency (avalía-t) and an interdisciplinary group of health professionals, composed of three psychiatrists, two clinical psychologists, a family doctor and a mental health specialist nurse.

The formulation of recommendations was based on the Scottish Intercollegiate Guidelines Network (SIGN) "formal evaluation" or "reasoned judgment" criteria. Controversial recommendations or those with an absence of evidence were resolved by informal consensus of the development group. Recommendations based on qualitative evidence are marked with a "Q".

## Rating Scheme for the Strength of the Recommendations

### Scottish Intercollegiate Guidelines Network (SIGN) Grades of Recommendation

<b>A</b>	At least one meta-analysis, systematic review or clinical trial rated as 1++ and directly applicable to the target population; or a body of evidence consisting of studies rated as 1+ and showing overall consistency of results
<b>B</b>	A body of evidence consisting of studies rated as 2++, directly applicable to the target population of the guideline and showing overall consistency of results; or evidence extrapolated from studies rated as 1++ or 1+
<b>C</b>	A body of evidence consisting of studies rated as 2+, directly applicable to the target population of the guideline and showing overall consistency of results; or evidence extrapolated from studies rated as 2++
<b>D</b>	Evidence level 3 or 4; or evidence extrapolated from studies rated as 2+
<b>Q</b>	Evidence taken from relevant qualitative studies of appropriate quality. This category is not considered by SIGN.
<b>√<sup>1</sup></b>	Recommended practice based on clinical experience and consensus of the editorial team

<sup>1</sup>Sometimes the development group wishes to highlight an important practical aspect for which there is probably no supporting evidence. In general, these cases are related to an aspect of treatment generally accepted to be good clinical practice, and are evaluated as a point of good clinical practice. These messages are not an alternative to the recommendations based on evidence, but should be considered only when there is no other way of highlighting that aspect.

The recommendations adapted from a clinical practice guideline (CPG) are indicated with the superscript<sup>CPG</sup>.

Source: Scottish Intercollegiate Guidelines Network. Forming guideline recommendations. In: SIGN 50: A guideline developers' handbook: Edinburgh: SIGN; 2008.

## Cost Analysis

The guideline developers reviewed published cost analyses.

## Method of Guideline Validation

External Peer Review

## Description of Method of Guideline Validation

The expert collaborators participated in the review and advice on specific sections of the guideline and its recommendations. The external reviewers were involved in reviewing the full draft of the guideline, with representatives proposed by the various scientific organisations and associations related with depression, as well as renowned professionals

proposed by the update development group.

## Recommendations

### Major Recommendations

The levels of evidence (1-4) and strength of the recommendations (A-D, Q, and √) are defined at the end of the Major Recommendations field.

The recommendations adapted from a clinical practice guideline (CPG) are indicated with the superscript "CPG".

#### **Perspectives and Experiences of Patients with Depression and of their Relatives**

*What are the perspectives of patients and of their relatives about depression and their experiences with the health care provided?*

**Q:** When assessing depression, it is recommended to consider the heterogeneity of its presentation as well as the perception patients have about their symptoms and the disorder.

**Q:** It is recommended to pay special attention to issues that affect the daily lives of patients with depression which may have a greater functional impact.

**Q:** The assessment should consider the sociodemographic and cultural factors that may affect the development or maintenance of depressive symptoms and influence treatment, such as sex, family, social network and perceived stigma.

**Q:** The meaning and impact of depression on the patient's family and any needs that may arise should be explored; especially regarding children, adolescents and family dependent upon the depressed patient.

**Q:** It is recommended to encourage the communication of feelings and emotions in an empathetic and respectful environment.

**Q:** When a diagnosis of depression is made, all the necessary information about the disorder and treatment options, as well as explanations to reduce the guilt and stigma attached, must be promoted and provided.

**Q:** It is recommended that patients and, with their consent, their families and relatives, take an active role in making decisions about treatment and the implementation of the care plan.

**Q:** When drug treatment is prescribed, the patient's perception of it must be explored and a positive attitude promoted towards it. Any side effects and the evolution of both symptoms and functional capacity must also be monitored. In addition, with the patient's authorisation, any doubts the family has must be clarified, to engage their support during treatment.

**Q:** Any decision to use electroconvulsive therapy (ECT) should be made jointly with the patient and/or family, taking into account factors such as diagnosis, type and severity of symptoms, medical history, risk/benefit ratio, alternative options and patient preferences.

**Q:** Should ECT be required, it is recommended to place special emphasis on providing all necessary information about the aim of the procedure, its side effects and the treatment plan.

**Q:** Support for patients and relatives should be offered to develop coping strategies. They must be informed of any patient associations and resources which can provide help.

#### **Evaluation and Screening for Depression**

##### **Evaluation of Depression**

*How should depression be evaluated?*

√: The clinical interview is the essential procedure for the diagnosis of depression. The International Classification of Diseases (ICD) and Diagnostic and Statistical Manual of Mental Disorders (DSM) provide a set of agreed criteria to rely on.

**C:** Due to the existence of different factors that may affect the progress, course and severity of depression, it is recommended to evaluate the following areas:

- Features of the episode: duration, number and intensity of symptoms, comorbidity
- Psychosocial assessment (social support and interpersonal relationships)
- Degree of associated dysfunction and/or disabilities
- Risk of suicide
- Response to previous treatment

**C:** It is recommended to assess the risk of suicide in patients with depression, considering the following factors:

- Presence of previous suicide attempts, other comorbid mental disorders and substance abuse
- Specific symptoms such as hopelessness, anxiety, agitation or suicidal ideation
- Other risk factors such as physical illness, chronicity, pain or disability, family history of suicide, social factors and a history of suicide in the environment

**Q:** When assessing depression, it is recommended to consider the heterogeneity of its presentation as well as the perception patients have about their symptoms and the disorder.

**Q:** It is recommended to pay special attention to issues that affect the daily lives of patients with depression which may have a greater functional impact.

**Q:** The assessment should consider the sociodemographic and cultural factors that may affect the development or maintenance of depressive symptoms and influence treatment, such as sex, family, social network and perceived stigma.

**Q:** The meaning and impact of depression on the patient's family and any needs that may arise should be explored; especially regarding children, adolescents and family dependent upon the depressed patient.

**Q:** It is recommended to encourage the communication of feelings and emotions in an empathetic and respectful environment.

**Q:** When a diagnosis of depression is made, all the necessary information about the disorder and treatment options, as well as explanations to reduce the guilt and stigma attached, must be promoted and provided.

##### **Assessment Instruments**

*Which scales have the best psychometric properties for the assessment of depression in adults?*

√: The scales provide additional information in the evaluation, but cannot replace the clinical interview.

**D:** Some of the scales that may be useful in assessing depression are the Hamilton Rating Scale for Depression (HRSD), the Montgomery Asberg Depression Rating Scale (MADRS), the 9-item (Brief) Patient Health Questionnaire (PHQ-9) and the Beck Depression Inventory (BDI).

##### **Depression Screening**

*Does screening improve health outcomes in depression?*

**B:** Routine screening for depression is not recommended for the general population, as there are reasonable doubts about its effectiveness.

**B:** Clinicians should be alert to the possibility of depression, especially in patients with risk factors who also have symptoms such as insomnia, low mood, anhedonia and suicidal

ideation.

**B:** In primary care, when an indicator for depression is observed in a routine examination, it is recommended to use two questions about mood and the ability to enjoy to assess for the presence of depressive disorders. If the response is positive, an appropriate psychopathological assessment is recommended.

## **Treatment**

### **Depression Care Models and General Management Principles**

*How effective are stepped-care and collaborative models?*

#### Care Models

**B:** The management of depression in adults should be performed as a stepped care and collaboration model between primary care and mental health, so that interventions and treatments are tailored to the status and evolution of the patient.

#### General Treatment Recommendations

✓: The treatment of depression in adults should be comprehensive and cover all psychotherapeutic, psychosocial and pharmacological interventions which may improve well-being and functional capacity.

✓: The management of depression should include psychoeducation, individual and family support, coordination with other professionals, care of comorbidity and regular monitoring of mental and physical status.

✓: The initial selection of the mode and scope of treatment should be based on clinical findings and other factors, such as previous history, the availability of treatment, patient preference and the ability to provide support and containment in the environment.

**D<sup>CPG</sup>:** A structured patient monitoring plan should be established. The assessment and monitoring frequency of symptoms should be according to severity, comorbidity, cooperation with treatment, social support and the frequency and severity of side effects of the prescribed treatment.

**Q:** With the consent of the patients, both they and their relatives should take an active role in making decisions about the treatment and care plan development.

**Q:** Patients and their relatives should be offered support to develop coping strategies, and should be informed of the existence of patient associations and resources which can be of help.

**D<sup>CPG</sup>:** Verbal information should be backed up with written documents whenever possible.

### **Psychotherapeutic Treatment**

*How effective are different psychological interventions in patients with depression?*

✓: The availability of psychotherapeutic treatment should be ensured for patients who need it.

**B:** In mild-moderate depression, a brief psychological treatment (such as cognitive behavioural therapy or problem-solving therapy) of 6 to 8 sessions over 10 to 12 weeks should be considered.

**B:** The psychological treatment of choice for moderate to severe depression is cognitive behavioural therapy or interpersonal therapy, of 16 to 20 sessions over 5 months.

**B:** Cognitive behavioural therapy should be considered for patients with inadequate response to other interventions or a prior history of relapses and/or residual symptoms.

**C:** Other psychological interventions should be considered when addressing comorbidity or the complexity of family or marital relationships, often associated with depression.

**B:** Patients with chronic and/or recurrent depression are recommended a combination of drug therapy and cognitive behavioural therapy.

### **Pharmacotherapy**

*How long and at what dose should drug treatment be maintained after remission of depressive symptoms?*

✓: Before starting antidepressant treatment, patients must be adequately informed of the expected benefits, side effects and possible delay in the therapeutic effect.

**A:** The initial selection of drug therapy should be based mainly on the side effect profile and tolerability, safety and pharmacological properties, as well as other factors such as previous response to treatment, cost and patient preferences.

**A:** Selective serotonin reuptake inhibitors (SSRIs) are antidepressants with the most evidence and better risk/benefit ratio, and should be considered as the first choice of treatment.

✓: All patients with moderate depression treated with drugs should be re-assessed within 15 days of the treatment start, and within 8 days in the case of severe depression.

**D<sup>CPG</sup>:** Benzodiazepine treatment may be considered for patients with anxiety, insomnia and/or agitation, although they should not be used for longer than 2 to 3 weeks to prevent the development of dependence.

✓: Patients undergoing drug therapy must be closely monitored, at least for the first 4 weeks.

**D:** Antidepressant treatment should be maintained for at least 6 months after remission of the episode, and aspects such as previous episodes, comorbidity and the presence of other risk factors should be evaluated before deciding on withdrawal of treatment.

**A:** It is recommended that maintenance treatment be performed with the same dose at which the response was achieved.

**D<sup>CPG</sup>:** To avoid withdrawal symptoms, the antidepressant treatment dose should be reduced gradually, usually over a period of 4 weeks; particularly for drugs with short half-lives like paroxetine or venlafaxine.

**D<sup>CPG</sup>:** If withdrawal symptoms occur, a diagnostic confirmation should be performed and, if the symptoms are significant, reintroducing the original antidepressant at effective doses should be considered (or the use of another antidepressant in the same class with a long half-life) and the dose gradually reduced.

**Q:** When drug treatment is prescribed, the patient's perception should be explored and a positive attitude will be favoured. In addition, adequate monitoring for side effects, as well as evolution of the symptoms and functional capacity, should be performed. Moreover, after obtaining patient authorisation, any doubts the family has about the treatment must be clarified to gain their support.

### **Strategies for Resistant Depression**

#### **Psychotherapeutic Strategies in Resistant Depression**

*What is the role of psychotherapy as an enhancement or alternative in patients with resistant depression?*

**B:** A combined therapy of cognitive behavioural therapy and antidepressant pharmacotherapy is recommended for patients with resistant depression.

#### **Pharmacological Strategies in Resistant Depression**

*What pharmacological strategies are most effective in patients with treatment-resistant depression?*

✓: The following is recommended for patients who do not improve with initial antidepressant treatment for depression:

- Review of diagnosis
- Verify compliance with taking the appropriate dosage and treatment time
- Assess the existence of disease awareness, motivation to change and possible comorbidity

✓: The following is recommended for patients with a partial response after the 3rd or 4th week:

- Wait for clinical evolution until the 8th week
- Increase the drug dose to the maximum therapeutic dose

**B:** If the patient does not respond by the 3rd or 4th week of treatment, any of the following strategies could be attempted:

- Change of antidepressant to another in the same or a different family
- Combination of antidepressants
- Enhancement with lithium or antipsychotics

**C:** When the strategy is changing the antidepressant, a different SSRI or another second-generation antidepressant should initially be evaluated. If there is no response, an antidepressant with greater side effects, such as a tricyclic or monoamine oxidase inhibitor (MAOI), could be assessed.

**C:** The combination of SSRI and mianserin or mirtazapine may be a recommendable option, bearing in mind the possibility of adverse effects.

**C:** Enhancement with lithium or antipsychotics, such as olanzapine, quetiapine, aripiprazole or risperidone may also be a strategy to consider, bearing in mind the possibility of greater adverse effects.

**DCPG:** When enhancement or a drug combination is used:

- Be aware that these strategies usually increase adverse effects
- Select those drugs for which there is information on safety in combined use
- Document the rationale for the strategy
- Monitor carefully for adverse effects

✓: There are insufficient data to recommend enhancement with carbamazepine, lamotrigine, topiramate, valproate, pindolol, thyroid hormones, zinc or benzodiazepines.

### **Electroconvulsive Therapy**

*What is the safety and efficacy of electroconvulsive therapy as a treatment for depression?*

**A:** Electroconvulsive therapy should be considered a therapeutic option in patients with severe depression; mainly if there is a need for a rapid response due to high suicidal intent, severe physical damage or when other treatments have failed.

✓: ECT should always be given by experienced professionals, following a physical and psychiatric assessment and in a hospital setting; and informed consent is essential.

**Q:** The decision to use ECT should be made jointly with the patient and/or family, by taking into account factors such as diagnosis, type and severity of symptoms, medical history, risk/benefit ratio, alternative therapies and patient preference.

**Q:** Should ECT be required, it is recommended to place special emphasis on providing all the necessary information, focusing on the purpose of the procedure, the side effects and a treatment plan.

### **Vagus Nerve Stimulation as Adjunctive Treatment for Resistant Depression**

*What is the safety and efficacy of vagus nerve stimulation as adjunctive treatment for resistant depression?*

✓: The use of vagus nerve stimulation outside the scope of research is discouraged due to the invasive nature of the procedure, uncertainty about its efficacy and adverse effects.

### **Transcranial Magnetic Stimulation as Adjunctive Treatment for Resistant Depression**

*What is the safety and efficacy of transcranial magnetic stimulation as adjunctive treatment for resistant depression?*

**B:** Transcranial magnetic stimulation is not currently recommended as a treatment for depression, due to uncertainty about its clinical efficacy.

### **Other Treatments**

#### **Exercise**

*Is physical exercise effective in patients with depression?*

**B:** Patients with depression are strongly encouraged to perform physical exercise as a healthy living habit. It is imperative that the patient is motivated and willing to do exercise, according to their physical condition and tailored to their individual preferences.

**B:** Physical activity should be considered an adjunct to antidepressants and/or psychotherapy in severe and moderate depression.

#### **St. John's Wort**

*What is the safety and efficacy of St. John's wort in the treatment of adult depression?*

**B:** Although there is evidence of the efficacy of St. John's wort in the treatment of mild to moderate depression, its use is not recommended for the following reasons:

- Ignorance of the active ingredients, mechanisms of action and persistence of the antidepressant effect
- A lack of standardisation of the dose
- The variability of different commercial preparations, which may have different amounts and proportions of its components and may not be therapeutically equivalent

**B:** Healthcare professionals should inform patients taking St. John's wort of its serious potential interactions with some drugs, some of which are commonly used, such as oral contraceptives.

### **Definitions**

#### **Scottish Intercollegiate Guidelines Network (SIGN) Levels of Evidence**

<b>1++</b>	High quality meta-analyses, systematic reviews of clinical trials or high-quality clinical trials with very low risk of bias
<b>1+</b>	Well-conducted meta-analyses, systematic reviews of clinical trials, or well-conducted clinical trials with little risk of bias
<b>1-</b>	Meta-analyses, systematic reviews of clinical trials or clinical trials with high risk of bias
<b>2++</b>	High quality systematic reviews of case control or cohort studies. High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal
<b>2+</b>	Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal
<b>2-</b>	Cohort or case-control studies with a high risk of bias and a significant risk that the relationship is not causal
<b>3</b>	Non-analytical studies such as case reports and case series
<b>4</b>	Expert opinion

**Note:** Studies classified as 1- and 2- must not be used in the preparation of recommendations due to their high potential for bias.

Source: Scottish Intercollegiate Guidelines Network. Forming guideline recommendations. In: SIGN 50: A guideline developers' handbook: Edinburgh: SIGN; 2008.

## SIGN Grades of Recommendation

<b>A</b>	At least one meta-analysis, systematic review or clinical trial rated as 1++ and directly applicable to the target population; or a body of evidence consisting of studies rated as 1+ and showing overall consistency of results
<b>B</b>	A body of evidence consisting of studies rated as 2++, directly applicable to the target population of the guideline and showing overall consistency of results; or evidence extrapolated from studies rated as 1++ or 1+
<b>C</b>	A body of evidence consisting of studies rated as 2+, directly applicable to the target population of the guideline and showing overall consistency of results; or evidence extrapolated from studies rated as 2++
<b>D</b>	Evidence level 3 or 4; or evidence extrapolated from studies rated as 2+
<b>Q</b>	Evidence taken from relevant qualitative studies of appropriate quality. This category is not considered by SIGN.
√ <sup>1</sup>	Recommended practice based on clinical experience and consensus of the editorial team

<sup>1</sup>Sometimes the development group wishes to highlight an important practical aspect for which there is probably no supporting evidence. In general, these cases are related to an aspect of treatment generally accepted to be good clinical practice, and is evaluated as a point of good clinical practice. These messages are not an alternative to the recommendations based on evidence, but should be considered only when there is no other way of highlighting that aspect.

The recommendations adapted from a CPG are indicated with the superscript<sup>CPG</sup>.

Source: Scottish Intercollegiate Guidelines Network. Forming guideline recommendations. In: SIGN 50: A guideline developers' handbook: Edinburgh: SIGN; 2008.

## Clinical Algorithm(s)

An algorithm titled "Diagnostic and Therapeutic Strategies" is provided in the original guideline document.

## Evidence Supporting the Recommendations

### Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

## Benefits/Harms of Implementing the Guideline Recommendations

### Potential Benefits

Effective management of depression in adults

### Potential Harms

- There are negative aspects associated with drug therapy (dependency, side effects, sedation, among others). See specific side effects of each medication option in the "Evidence Summary" sections and in Table 13 in the original guideline document.
- Electroconvulsive therapy (ECT) has no absolute contraindications, although there are relative risk situations: presence of space-occupying lesions (tumours or haemorrhages) or any other situation in which the intracranial pressure is increased, recent serious cardiovascular disease, treatment with monoamine oxidase inhibitors (MAOIs) or lithium and the risks from general anaesthesia itself. Side effects can be immediate (confusion, amnesia and headaches) or long-term (mainly cognitive impairment) and depend on the preconditions of patients, their personal susceptibility, the technique used (bilateral or unilateral), the number of sessions employed and administration frequency.

## Contraindications

### Contraindications

See Table 13 in the original guideline document for contraindications and drug combinations to avoid.

## Qualifying Statements

### Qualifying Statements

This clinical practice guideline (CPG) is an aid to decision-making in health care. It is not mandatory to comply with it, nor does it replace the clinical judgment of medical staff.

## Implementation of the Guideline

### Description of Implementation Strategy

#### Diffusion and Dissemination

There are 2 versions of this clinical practice guideline (CPG): the full and summary versions, as well as a document with information for patients and relatives and a document with methodological material. The full version, the information for patients and the methodological document can be accessed through the websites of the Galicia Health Technology Assessment Agency, avalia-t (<http://avalia-t.sergas.es>) and GuíaSalud (<http://portal.guiasalud.es>).

The strategies outlined for the diffusion and dissemination of this CPG are:

- Official individual delivery of the guideline to potential professional users by the health authorities
- Diffusion in electronic format on health service websites and those of companies and associations involved in the management of depression
- Incorporation of the guideline to CPG compilation databases, both nationally and internationally
- Distribution of information to patients and relatives by working with different patient groups
- Presentation in primary and specialty care through interactive lectures and workshops with patients, family members and stakeholders
- Presentation of the guideline in scientific activities (conferences, congresses and meetings)
- Online and/or workplace training on the evaluation and management of patients with depression
- Publication of the guideline or studies derived from it in scientific journals
- Establishing clinical decision support systems to integrate the guideline and selected indicators in the software used in primary care, emergency services and specialist care

- Translation of the full version into English

See Chapter 12 in the original guideline document for further information on how to implement and integrate the guideline recommendations.

## Implementation Tools

Audit Criteria/Indicators

Chart Documentation/Checklists/Forms

Clinical Algorithm

Foreign Language Translations

Mobile Device Resources

Patient Resources

Quick Reference Guides/Physician Guides

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

## Institute of Medicine (IOM) National Healthcare Quality Report Categories

### IOM Care Need

Getting Better

Living with Illness

### IOM Domain

Effectiveness

Patient-centeredness

## Identifying Information and Availability

### Bibliographic Source(s)

Working Group of the Clinical Practice Guideline on the Management of Depression in Adults. Clinical practice guideline on the management of depression in adults. Madrid: Ministry of Health, Social Services and Equality, Galician Health Technology Assessment Agency (HTA) (avalía-t); 2014. 232 p. [408 references]

### Adaptation

Not applicable: The guideline was not adapted from another source.

### Date Released

2008 (revised 2014)

### Guideline Developer(s)

Galician Health Technology Assessment Agency - State/Local Government Agency [Non-U.S.]

GuiaSalud - National Government Agency [Non-U.S.]

Ministry of Health (Spain) - National Government Agency [Non-U.S.]

### Source(s) of Funding

This clinical practice guideline (CPG) has been financed through the collaboration agreement signed by the Carlos III Health Institute, an autonomous body of the Ministry of Economy and Competitiveness, and the Profesor Novoa Santos Foundation, within the activities of the Spanish Network of Technology and Services Evaluation Agencies for the Spanish National Health System (SNS), financed by the Ministry of Health, Social Services and Equality.

### Guideline Committee

Working Group of the Clinical Practice Guideline (CPG) on the Management of Depression in Adults

### Composition of Group That Authored the Guideline

#### **Working Group of the Clinical Practice Guideline (CPG) on the Management of Depression in Adults**

*Working Group Members:* María Álvarez Ariza, Doctor of Medicine, Psychiatry Specialist, Vigo University Hospital, Pontevedra; Gerardo Atienza Merino, Doctor of Medicine, Technical Consultant, Galicia Health Technology Assessment Agency, Department of Health, Government of Galicia; María José González Ávila, Degree in Medicine, Psychiatry Specialist, La Coruña University Hospital; Amparo González García, Mental Health Specialist Nurse, Ourense University Hospital; Delia Guitián Rodríguez, Degree in Psychology, Clinical Psychology Specialist, Lucus Augusti University Hospital, Lugo; Elena de las Heras Liñero, Doctor of Medicine, Psychiatry Specialist, Vigo University Hospital, Pontevedra; Arturo Louro González, Degree in Medicine, Family and Community Medicine Specialist, Cambre Primary Health Centre, La Coruña; Jose Luis Rodríguez-Arias Palomo, Doctor of Psychology, Clinical Psychology Specialist, La Coruña University Hospital; Yolanda Triñanes Pego, Degree in Psychology, Technical Consultant, Galicia Health Technology Assessment Agency, Department of Health, Government of Galicia

*Clinical Coordination:* Elena de las Heras Liñero, Doctor of Medicine, Psychiatry Specialist, Vigo University Hospital, Pontevedra

*Methodical Coordination:* Gerardo Atienza Merino, Doctor of Medicine, Technical Consultant, Galicia Health Technology Assessment Agency, Department of Health, Government of Galicia

*Collaboration:* Beatriz Casal Acción, Documentalist, Galicia Health Technology Assessment Agency, Department of Health, Government of Galicia

*Expert Collaboration:* Manuel Castro Bouzas, Clinical Psychology Specialist, Ferrol Health District, La Coruña; Marlén Fernández Silva, Primary Care Pharmacist, O Ventorrillo Primary Health Centre, La Coruña; Ernesto Ferrer Gómez del Valle, Psychiatry specialist, Ourense University Hospital; Diego Palao Vidal, Psychiatry specialist, Mental Health Executive Director, Taulí Park Health Corporation, Sabadell; Antonio Rial Boubeta, Professor at the Behavioural Sciences Methodology Department, Santiago de Compostela University

*External Review:* Enric Aragonés Benaiges, Specialist in Family and Community Medicine, Constantí Primary Care Centre, Tarragona, Catalonia Health Institute; José Angel Arbesu Prieto, Specialist in Family and Community Medicine, Mental Health Working Group Coordinator, representing SEMERGEN; Germán E. Berrios, Professor of Epistemology of Psychiatry (Emeritus), Life Fellow at Robinson College, Psychiatry Department, Cambridge University, United Kingdom; Rosendo Bugarín González, Specialist in Family and Community Medicine, Director of Outpatients and Emergency Department, Lugo, Cervo and Monforte de Lemos Health District, representing SEMERGEN; Carlos Calderón Gómez, Specialist in Family and Community Medicine, Alza Primary Health Centre, Osakidetza-Basque Health Service, REDICS-Investén, Carlos III Health Institute; M<sup>a</sup> Consuelo Carballeda Balsa, Mental Health Specialist Nurse, Naval Hospital, Ferrol, La Coruña, Vice President of ANESM; Francisco José Estupiñá Puig, Associate Professor, Faculty of Psychology, Complutense University, Madrid, representing SEPCyS; Juan L. Fernández Hierro, Psychiatry Specialist, Vigo University Hospital, Pontevedra representing SEPL;

Aurora Gavino Lázaro, Associate Professor, Faculty of Psychology, Málaga University, representing SEPCyS; Marta González Pescador, Clinical Psychologist and President of the Spanish Association for Research and Development in Family Therapy; Guillermo Lahera Forteza, Assistant Professor, Faculty of Medicine, Alcalá University, Madrid, representing AEN; Raquel León Lamela, Degree in Psychology, Information and socio-family care, FEAFES-GALICIA; Germán López Cortacáns, Mental Health Specialist Nurse, Salou Primary Health Centre, Tarragona, representing FAECAP; Cristina Losada Pérez, Psychiatry Specialist, South London and Maudsley NHS Foundation Trust, London, United Kingdom; Antonio Madueño Caro, Specialist in Family and Community Medicine, La Laguna Primary Health Centre, Tenerife, representing SEMFYC; José Manuel Olivares Díez, Psychiatry Specialist, Vigo University Hospital, Pontevedra, representing SEP; Antonio Olives Alonso, Degree in Psychology, President of the Galicia Association for Family Therapy and Mediation; Manuel Portela Romero, Specialist in Family and Community Medicine, Padrón Primary Health Centre, La Coruña, representing SEMERGEN; Javier Sardiña Agra, Clinical Psychology Specialist, Oza Hospital, La Coruña; Carmen Senra Rivera, Professor, Department of Clinical Psychology and Psychobiology, Santiago de Compostela University, La Coruña; Manuel Serrano Vázquez, Psychiatry Specialist, Head of Psychiatry, La Coruña University Hospital, representing SEP; Mercé Teixido Casas, Psychiatry Specialist, Les Corts Mental Health Centre, Barcelona, representing AEN; Mikel Urretavizcaya Sarachaga, Psychiatry Specialist, Bellvitge University Hospital, Barcelona, representing SEPB; Fernando Lino Vázquez González, Professor, Department of Clinical Psychology and Psychobiology, Santiago de Compostela University, La Coruña

### Financial Disclosures/Conflicts of Interest

Declaration of interest: All members of the Working Group, as well as those who have participated in the expert collaboration and external review, have made a declaration of interest which is presented in Annex 7 in the original guideline document.

### Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Working Group on the Management of Major Depression in Adults. Clinical practice guideline on the management of major depression in adults. Madrid: Ministry of Health and Consumer Affairs, Galician Health Technology Assessment Agency (HTA) (avalía-t); 2008. 120 p.

This guideline meets NGC's 2013 (revised) inclusion criteria.

### Guideline Availability

Available in [English](#) and [Spanish](#) from the [GuíaSalud Web site](#).

### Availability of Companion Documents

The following are available:

- Quick reference guides and summary versions are available from the [GuíaSalud Web site](#).
- The Spanish version of the guideline is also available via a mobile application from the [GuíaSalud Web site](#).
- Working Group for CPG Updates. Updating clinical practice guidelines in the National Health System: methodology handbook. Madrid (Spain): National Health System Quality Plan of the Spanish Ministry of Health and Social Policy; Aragon Institute for Health Sciences (IACS); 2009. 67 p. (Clinical Practice Guidelines in the National Health System: IACS; no. 2007/02-01). Available from the [GuíaSalud Web site](#).

Proposed quality indicators are listed and described in Section 8 of the original guideline document. Outcome measures and instruments for assessing depression are provided in the annexes of the original guideline document.

### Patient Resources

Patient information can be found in Annex 4 of [the original guideline document](#). A Spanish version is also available from the [GuíaSalud Web site](#).

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

### NGC Status

This NGC summary was completed by ECRI Institute on January 20, 2011. The information was verified by the developer on January 27, 2011. This summary was updated by ECRI Institute on September 2, 2015. The updated information was verified by the guideline developer on October 6, 2015.

### Copyright Statement

This NGC summary is based on the original guideline, which is copyrighted by the Galician Health Technology Assessment Agency.

All rights reserved, reproduction and dissemination of the document(s) for education or other non-commercial purposes are authorized without any prior written permission provided the source is fully acknowledged.

Reproduction of dissemination of the document(s) for resale, advertising or other commercial purposes is prohibited without written permission of the copyright.

## Disclaimer

### NGC Disclaimer

The National Guideline Clearinghouse™ (NGC) does not develop, produce, approve, or endorse the guidelines represented on this site.

All guidelines summarized by NGC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public or private organizations, other government agencies, health care organizations or plans, and similar entities.

Guidelines represented on the NGC Web site are submitted by guideline developers, and are screened solely to determine that they meet the NGC Inclusion Criteria which may be found at <http://www.guideline.gov/about/inclusion-criteria.aspx>.

NGC, AHRQ, and its contractor ECRI Institute make no warranties concerning the content or clinical efficacy or effectiveness of the clinical practice guidelines and related materials represented on this site. Moreover, the views and opinions of developers or authors of guidelines represented on this site do not necessarily state or reflect those of NGC, AHRQ, or its contractor ECRI Institute, and inclusion or hosting of guidelines in NGC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding guideline content are directed to contact the guideline developer.