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Guidelines

Management of depression in adults: summary of [updated?] updated NICE guidance

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Box start

What you need to know

- Discuss treatment options to match the needs and preferences of a person with a new episode of depression
- Consider the least intrusive and least resource-intensive available treatment (eg, guided self-help) first for less severe depression
- Do not offer antidepressant medication routinely as first line treatment for less severe depression unless that is the person's preference
- When stopping antidepressants, advise a relatively long tapering using a proportional (hyperbolic) reduction schedule

Box end

Since the National Institute for Health and Care Excellence (NICE) published its last guideline on depression in 2009,[1] the prevalence of depression has increased,[2] particularly among vulnerable adults during the covid-19 pandemic.[3] Yet fewer than half of people affected receive treatment,[2] despite increased provision of psychological therapies[5] and antidepressants.[4] Most people who are treated still receive antidepressants[6] despite previous guideline recommendations to offer psychological therapies first,[1] and Public Health England is concerned that long term antidepressant prescribing is increasing, with many people experiencing withdrawal symptoms and having difficulty stopping them when appropriate[7][rephrase? being more specific would help too eg many people experience withdrawal effects when trying to stop taking antidepressants.]. Psychological treatments that have shown promise in recent years, eg, behavioural activation[8] and mindfulness based therapies,[9] [CBT? (the guideline seems to give a lot of space to increasing the options for psychological therapies)] could offer more alternatives to antidepressants in the future, besides Cognitive Behavioural Therapy (CBT) as previously recommended [1]. [Could you explain how the broader range of treatment options (in table 1) came about

This article summarises new recommendations on management of depression most relevant to primary care and services providing psychological therapies, from the NICE guideline published in June 2022,[10] updating and replacing the 2009 guideline.[1]

NICE recommendations are based on systematic reviews of best available evidence and explicit consideration of cost effectiveness. When minimal evidence is available, recommendations are based on the Guideline Committee (GC)'s experience and opinion of what constitutes good practice. Evidence levels for the recommendations are given in italics in square brackets. Definitions of evidence certainty (GRADE) are given in box 1.

Box start

Box 1 GRADE Working Group grades of evidence

High certainty—we are very confident that the true effect lies close to that of the estimate of the effect

Moderate certainty—we are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different

Low certainty—our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect

Very low certainty—we have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect

Box end

Recommendations

New classification into less severe and more severe depression

In the new guideline, depression is classified as "less severe" and "more severe," because the NICE 2009 recommendations, split into "mild to moderate" and "moderate to severe," left ambiguity for moderate depression.[1] More severe includes moderate and severe, and less severe includes mild and sub-threshold depression. Sub-threshold was defined as just below the cut-off on a validated depression scale for the evidence reviews. Clinically, sub-threshold is depression with fewer than five symptoms which nevertheless causes functional impairment.[11 12] All cut-offs are arbitrary to an extent, along a continuum of severity.

Tables 1 and 2 are modified from the guideline, and list recommended treatments for less severe and more severe depression, respectively, based on clinical and cost-effectiveness evidence, informed by network meta-analysis of candidate treatments, and consideration by the Guideline Committee of factors related to implementation.

Table 1 Treatment options for new episodes of less severe depression

Treatment	How is this delivered?
Guided self-help (supportive self-management)	Printed or digital materials that follow the principles of guided self-help, including cognitive behavioural therapy (CBT), behavioural activation, problem solving, or psychoeducation materials. These can be delivered in-person, by telephone, or online. Support from a trained practitioner who facilitates the self-help intervention, encourages completion, and reviews progress and outcome. Usually six to eight sessions
Group CBT	A group intervention delivered by two practitioners, at least one of whom has therapy-specific training and competence. Usually consists of eight sessions. Usually eight participants per group
Group behavioural activation	A group intervention delivered by two practitioners, at least one of whom has therapy-specific training and competence. Usually consists of eight sessions with eight participants per group
Individual CBT	Individual intervention delivered by a practitioner with therapy-specific training and competence. Usually consists of eight sessions, although additional sessions may be needed for people with comorbid mental or physical health problems or complex social needs, or to address residual symptoms

Treatment	How is this delivered?
Individual behavioural activation	Individual intervention delivered by a practitioner with therapy-specific training and competence. Usually consists of eight sessions, although additional sessions may be needed for people with comorbid mental or physical health problems or complex social needs, or to address residual symptoms
Group exercise	A group physical activity intervention provided by a trained practitioner. Uses a physical activity programme specifically designed for people with depression. Usually consists of more than one session per week for 10 weeks. Usually eight participants per group
Group mindfulness and meditation	A group intervention provided preferably by two practitioners, at least one of whom has therapy-specific training and competence. Uses a programme such as mindfulness based cognitive therapy (MBCT) specifically designed for people with depression. Usually consists of eight sessions. Usually eight to 15 participants per group
Interpersonal psychotherapy	Individual intervention delivered by a practitioner with therapy-specific training and competence. Usually consists of eight to 16 sessions, although additional sessions may be needed for people with comorbid mental or physical health problems or complex social needs, or to address residual symptoms
Selective serotonin reuptake inhibitors (SSRIs)	A course of antidepressant medication. Usually taken for at least six months (including after symptoms remit). See the guideline recommendations on starting, monitoring, and stopping antidepressant medication
Counselling	Individual intervention delivered by a practitioner with therapy-specific training and competence. Usually eight sessions, although additional sessions may be needed for people with comorbid mental or physical health problems or complex social needs, or to address residual symptoms. Uses an empirically validated protocol developed specifically for depression
Short term psychodynamic psychotherapy (STPP)	Individual sessions delivered by a practitioner with therapy-specific training and competence. Usually eight to 16 sessions, although additional sessions may be needed for people with comorbid mental or physical health problems or complex social needs, or to address residual symptoms. Uses an empirically validated protocol developed specifically for depression

[*Based on low quality evidence and the experience and opinion of the GC]*

Table 2 Treatment options for new episodes of more severe depression

Treatment	How is this delivered?
Combination of individual CBT and a course of an antidepressant	A combination of a course of antidepressant medication and individual CBT delivered by a practitioner with therapy-specific training and competence. Usually consists of 16 sessions, although additional sessions may be needed for people with comorbid mental or physical health problems or complex social needs, or to address residual symptoms
Individual CBT	Individual intervention delivered by a practitioner with therapy-specific training and competence. Usually consists of 16 sessions, although additional sessions may be needed for people with comorbid mental or physical health problems or complex social needs, or to address residual symptoms
Individual BA	Individual intervention delivered by a practitioner with therapy-specific training and competence. Usually 12-16 sessions, although additional sessions may be needed for people with comorbid mental or physical health problems or complex social needs, or to address residual symptoms
Antidepressant medication	A course of antidepressant medication. Usually taken for at least six months (including after symptoms remit). Can be a SSRI, serotonin and noradrenaline reuptake inhibitor, or other antidepressant if indicated based on clinical and treatment history. See the guideline recommendations on starting, monitoring, and stopping antidepressant medication for more details
Individual problem-solving	Individual sessions delivered by a practitioner with therapy-specific training and competence. Usually six to 12 sessions

Treatment	How is this delivered?
Counselling	Individual intervention delivered by a practitioner with therapy-specific training and competence. Usually consists of 12-16 sessions, although additional sessions may be needed for people with comorbid mental or physical health problems or complex social needs, or to address residual symptoms. Uses an empirically validated protocol developed specifically for depression
STPP	Individual sessions delivered by a practitioner with therapy-specific training and competence. Usually 16 sessions, although additional sessions may be needed for people with comorbid mental or physical health problems or complex social needs, or to address residual symptoms. Uses an empirically validated protocol developed specifically for depression
Interpersonal Therapy (IPT) [spell out on first ref]	Individual intervention delivered by a practitioner with therapy-specific training and competence. Usually consists of 16 sessions, although additional sessions may be needed for people with comorbid mental or physical health problems or complex social needs, or to address residual symptoms
Guided self-help (supportive self-management)	Printed or digital materials that follow the principles of guided self-help including CBT, behavioural activation, problem solving, or psychoeducation materials. These can be delivered in-person, by telephone, or online. Support from a trained practitioner who facilitates the self-help intervention, encourages completion, and reviews progress and outcome. Usually six to eight sessions. In more severe depression, the potential advantages of providing other treatment choices with more therapist contact should be carefully considered first
Group exercise	A group physical activity intervention provided by a trained practitioner. Uses a physical activity programme specifically designed for people with depression. Usually consists of more than one session per week for 10 weeks. Usually eight participants per group. In more severe depression, the potential advantages of providing other treatment choices with more therapist contact should be carefully considered first

[*Based on low to moderate quality evidence and the experience and opinion of the GC*]

Stepped care or matched care

The principle of stepped care is that the least intrusive and least resource intensive effective treatments should be offered first (fig 1) and "stepped up" to more intensive treatments as needed. Matched care may mean offering a higher step straight away, taking into account patient presentation, previous experience of treatment, and patient preferences.

All treatments in tables 1 and 2 can be used as first line treatments, but the 2022 guideline recommends that for less severe depression, practitioners ask patients to consider less intensive treatment first (eg, guided self-help), and for more severe depression, that interventions with more therapist contact be tried first.

- Discuss treatment options with people with a new episode of depression, to match the choice of treatment to their needs and preferences
- Allow adequate time for the initial discussion about treatment options, involving family members, carers, or other supporters if agreed by the person with depression
- Help build a trusting relationship with the person with depression and facilitate continuity of care by ensuring they can see the same healthcare professional wherever possible, and by recording their views and preferences so that other practitioners are aware of these. *[Updated guidance]*

[*Based on moderate quality evidence and the experience and opinion of the GC*]

Fig 1 Stepped or matched care model of treatments

Antidepressants in less severe depression

[this heading seems too broad for the point that follows, which is just a statement about not offering antidepressants. consider another title eg Antidepressants in less severe depression / the role of antidepressants in less severe depression. or maybe it could be tagged into another section?]

The 2009 guideline advised against the routine use of antidepressants for sub-threshold or mild depression, as the risk or benefit ratio is poor,[1] but antidepressants continued to be prescribed for 70% of people with depression,[6] so a new recommendation emphasises that psychological treatments should be offered first.

- Do not routinely offer antidepressant medication as first line treatment for less severe depression unless that is the person's preference. *[Updated guidance]*
  [*Based on low quality evidence and the experience and opinion of the GC*]

Further line treatment

If a person's depression has not responded to initial treatment, discuss any personal and social perpetuating factors, and difficulties following the treatment plan, and review the diagnosis. Choice of further line treatment should be guided by patient preference and what has been tried already. Consider stepping up to an alternative psychological therapy after 4-6 weeks of therapy if necessary [does this mean 4-6 weeks after treatment has ended, or during therapy? GPs are usually told the patient has to have a period of no therapy before a new one can begin, but i'm not sure there's any evidence base to this? would be useful to know if the guideline supports GPs advocating for further therapy sooner]. Consider switching to a different antidepressant if there is no, or limited, response to four weeks of a therapeutic dose, or consider combining pharmacological with psychological therapy.

If the response to four weeks of a second antidepressant is limited, consider seeking specialist advice on combining two antidepressants of different classes, if the person with depression is willing to accept the possibility of an increased burden of side effects.

Preventing relapse

Advise patients to continue antidepressants for six months after remission, to reduce the risk of relapse.[1] Consider continuing antidepressants for up to two years, or referral for psychological treatments to prevent relapse (group CBT or MBCT), if a person has had recurrent depression, particularly within two years, incomplete response to treatment, severe functional impairment, and/or ongoing health or social problems that contributed to their depression.

- Discuss with people that continuation of antidepressants or psychological therapies after full or partial remission may reduce their risk of relapse and help them stay well. Reach a shared decision on whether or not to continue a treatment for depression based on their clinical needs and preferences. *[Updated guidance]*
- Discuss with people the potential risks of continuing with antidepressants long term, and how these balance against the risks of depression relapse. These may include:
  - possible side effects, such as an increased bleeding risk or long term effects on sexual function
  - difficulty stopping antidepressants. *[Updated guidance]*

  [*Based on very low to low quality evidence and the experience and opinion of the GC*]

Stopping antidepressants

[from whom?] Public Health England is concerned that more and more people in England are taking antidepressants long term without a continuing indication, and some have problems stopping them.[7] Tapering antidepressants over months rather than weeks reduces the risk of withdrawal symptoms.[13] Proportionate (exponential or hyperbolic) tapering down to doses much lower than minimum therapeutic doses may help people with particular problems coming off treatment.[13]

- When stopping a person's antidepressant:
  - take into account the pharmacokinetic profile (antidepressants with a short half-life need to be tapered more slowly) and duration of treatment
  - slowly reduce the dose to zero, at each step prescribing a proportion of the previous dose (for example, 50%)
  - consider using smaller reductions (for example, 25%) as the dose becomes lower
  - if slow tapering cannot be achieved using tablets or capsules, consider using liquid preparations. *[Updated guidance]*

  [*Based on the experience and opinion of the GC*]

Visual summaries

The visual summaries in figures 2 and 3 can be used to guide and inform the conversation with patients and reach a shared decision on treatment choices for a new episode of less severe and more severe depression, respectively. These are guides rather than algorithms or decision aids to be followed rigidly. The important overarching principles are eliciting patient preference and collaborative decision making.

Fig 2 Visual summary of treatments for less severe depression

Fig 3 Visual summary of treatments for more severe depression

Implementation

- Commissioners and service managers should ensure that people can express a preference for treatments recommended by NICE, that those treatments are available in a timely manner, particularly in severe depression, and that services be monitored to ensure equality of access, provision, outcomes, and experience.

[Based on the experience and opinion of the GC]

To implement the guideline fully, the whole range of psychological treatments listed in tables 1 and 2 would need to be provided between the Improving Access to Psychological Therapies (IAPT) programme and community and hospital mental health teams. Increased investment in IAPT is in the NHS Long Term Plan.[14] Longer initial GP appointments may be needed to allow for shared decision making about initial choice of treatment, but if more people taper off unnecessary long term antidepressant medication then there will be fewer follow-up appointments for medication management. NICE will produce a resource impact summary report for commissioners and providers.

Implementation tools

The NICE depression clinical knowledge summary provides practitioners with a readily accessible summary of the current evidence base and practical guidance on best practice at https://cks.nice.org.uk/topics/depression/.

Box start

When to offer referral to specialist mental health services

- If a person with depression presents considerable immediate risk to themselves or others, refer them urgently
- If a patient's depression shows no, or limited response to treatment for more severe or chronic depressive symptoms that significantly impair personal and social functioning, and has not responded to the psychological and pharmacological treatments recommended, treatment options include:
  - adding an additional antidepressant medication from a different class
  - combining an antidepressant medication with a second-generation antipsychotic or lithium, electroconvulsive therapy, lamotrigine, or triiodothyronine.
- If a person with depression has psychotic symptoms, specialist treatment should include:
  - an assessment of needs and risk
  - a programme of coordinated multidisciplinary care
  - access to psychological treatments, after improvement of acute psychotic symptoms.

[*Based on very low to low quality evidence and the experience and opinion of the GC*]

Box end

Box start

Key recommendations for research

Stopping antidepressants

What is the incidence and severity of withdrawal symptoms for antidepressant medication?

Relapse prevention

What is the effectiveness and cost effectiveness of brief courses of psychological treatment in preventing relapse for people who have had a successful course of treatment with antidepressants or psychological therapies but remain at high risk of relapse?

Further line treatment

What are the relative benefits and harms of further line psychological, psychosocial, pharmacological, and physical treatments (alone or in combination), for adults with

depression showing a limited response to an initial psychological treatment for the current episode?

Chronic depression

Are psychological, pharmacological, or a combination of these treatments effective and cost effective for the treatment of older adults with chronic depressive symptoms?

Access

What are the most effective and cost-effective methods to promote increased access to, and uptake of, treatments for people with depression who are under-served and under-represented in current services?

Box end

Box start

Further information on the guidance

This guidance was developed by the National Guideline Alliance (NGA) in accordance with NICE guideline methodology (www.nice.org.uk/media/default/about/what-we-do/our-programmes/developing-nice-guidelines-the-manual.pdf). A guideline committee (GC) was established by the National Guideline Alliance, which incorporated healthcare and allied healthcare professionals and three lay members.

The guideline is available at https://www.nice.org.uk/guidance/ng222[please add]

The GC identified relevant review questions and collected and appraised clinical and cost effectiveness evidence. Quality ratings of the evidence were based on GRADE methodology (www.gradeworkinggroup.org). These relate to the quality of the available evidence for assessed outcomes or themes rather than the quality of the study. The GC agreed recommendations for clinical practice based on the available evidence or, when evidence was not found, based on their experience and opinion using informal consensus methods.

The scope and the draft of the guideline went through a rigorous reviewing process, in which stakeholder organisations were invited to comment; the GC took all comments into consideration when producing the final version of the guideline. NICE will conduct regular reviews after publication of the guidance, to determine whether the evidence base has progressed significantly enough to alter the current guideline recommendations and require an update.

Box end

Box start

Guidelines into practice

- How would you discuss the full range of possible treatments for less severe, or more severe depression with a person with depression and achieve a shared decision on treatment?
- How would you audit the use of long term antidepressants in your practice and identify people who have recovered from depression, are not at high risk of relapse, and might be advised to try slow tapering off with monitoring?

Box end

Box start

How patients were involved in the creation of this article

Catherine Ruane was a lay carer member of the Guideline Committee. The other lay patient/carer members of the committee also contributed to the formulation of the recommendations summarised here.

Box end

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Disclaimer: The views expressed in this publication are those of the authors and not necessarily those of NGA or NICE.

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1. National Institute for Health and Care Excellence. Depression in adults: recognition and management (clinical guideline CG90). 2009. https://www.nice.org.uk/guidance/cg90

2. McManus S, Bebbington P, Jenkins R, Brugha T. (eds.) Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds, NHS Digital. 2016. https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014.

3. Patel K, Robertson E, Kwong ASF, et al. Psychological distress before and during the covid-19 pandemic among adults in the United Kingdom based on coordinated analyses of 11 longitudinal studies. *JAMA Netw Open* 2022;5:e227629.

4. NHS Business Services Authority. Medicines Used in Mental Health – England – Quarterly Summary Statistics April to June 2021.

5. NHS Digital. Psychological Therapies, Annual report on the use of IAPT services, 2020-21. Leeds: NHS Digital. https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2020-21.

6. Kendrick T, Stuart B, Newell C, Geraghty AWA, Moore M. Did NICE guidelines and the Quality Outcomes Framework change GP antidepressant prescribing in England? Observational study with time trend analyses 2003-2013. *J Affect Disord* 2015;186:171-7.

7. Taylor S, Annand F, Burkinshaw P, Dependence and withdrawal associated with some prescribed medicines: an evidence review. Public Health England, London. 2019. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/940255/PHE_PMR_report_Dec2020.pdf)

8. Ekers D, Webster L, Van Straten A, Cuijpers P, Richards D, Gilbody S. Behavioural activation for depression; an update of meta-analysis of effectiveness and sub group analysis. *PLOS One* 2014;9:e100100.

9. Kuyken W, Warren FC, Taylor RS, et al. Efficacy of mindfulness-based cognitive therapy in prevention of depressive relapse: an individual patient data meta-analysis from randomized trials. *JAMA Psychiatry* 2016;73:565-74.

10. National Institute for Health and Care Excellence. Depression in adults: treatment and management (update). Published: 29 June 2022. https://www.nice.org.uk/guidance/ng222

11. World Health Organization. International classification of diseases for mortality and morbidity statistics, 11th Revision (ICD-11). World Health Organization, 2018. https://www.who.int/standards/classifications/classification-of-diseases

12. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Arlington: American Psychiatric Publishing. 2013. https://www.psychiatry.org/psychiatrists/practice/dsm

13. Horowitz MA, Taylor D. Tapering of SSRI treatment to mitigate withdrawal symptoms. *Lancet Psychiatry*. 2019 Jun;6:538-46.

14. NHS England Chief Executive. NHS Long Term Plan. NHS Mental Health Implementation Plan 2019/20-2023/24. 2019.