

# Summary of recommendations

## Screening and suicide risk factors in the major depression of adults

✓	Screening of depression is not generally recommended, given that there are reasonable doubts about its effectiveness for modifying the course of the illness if it is not accompanied by follow-up measures.
✓	The possibility of a depressive pathology in persons with risk factors must be taken into account.
B	The questionnaires to be used should include at least two questions referring to the person's mood and ability to enjoy.
✓	In any patient with a major depressive disorder, it is advisable to explore ideas of death and intent to inflict self-harm.
✓	The clinical history of a patient with major depression must always include previous attempts to inflict self-harm.
✓	In patients with a high risk of suicide, it is advisable to seek frequent, additional support and to assess sending them urgently to a mental health specialist.
✓	Hospitalisation should be considered for patients with a high risk of suicide.

## Pharmacological treatment of depression

A	Antidepressant drugs represent a first line of treatment for moderate or severe depression.
✓	For mild depression, other therapeutic strategies can be considered before antidepressant drugs.
D	The use of drugs is recommended for those patients with mild depression and a history of moderate or severe episodes of depression.
D	The use of drugs is recommended for mild depression when other medical illnesses or associated comorbidity may be present.
✓	It is advisable to set up an appointment within 15 days for any patient with depression who does not receive pharmacological treatment.
A	SSRIs are recommended as drugs of first choice in the treatment of major depression.
B	In the event that an SSRI drug is not well-tolerated due to the appearance of adverse effects, it should be switched to another drug of the same group.
A	An SSRI should be prescribed for patients who may receive treatment with any tricyclic antidepressant and who do not tolerate it.
✓	TCAs are an alternative to SSRIs if a patient has not tolerated at least two drugs from this group or is allergic to them.
✓	New drugs could be used in the event of intolerance to SSRIs, thereby using the profile of their adverse effects as a guideline.

B	Specific patient profiles could warrant different drugs, thereby using the adverse effects rather than their efficacy as a guideline.
A	Venlafaxine should be considered as a second line of treatment in patients with major depression.
✓	Before starting antidepressant treatment, a healthcare professional should adequately inform the patient about the expected benefits; the frequent, infrequent and patient-specific side effects that could arise, in both the short and the long-term; and especially about the duration of the treatment.
✓	It is especially advisable to inform about a possible delay in the therapeutic effect of antidepressants.
✓	Patients receiving antidepressant drug treatment must be closely monitored, at least during the first 4 weeks.
✓	All patients who show moderate major depression and who are treated with antidepressant drugs must be assessed again before 15 days after initiating treatment.
✓	All patients who show severe major depression and who receive outpatient treatment with antidepressant drugs must be assessed again before 8 days after initiating treatment.
A	Pharmacological treatment must be maintained in all patients for at least 6 months after remission.
B	In patients with any previous episode or the presence of residual symptoms, the treatment must be maintained for at least 12 months after remission.
✓	In patients with more than 2 previous episodes, the treatment must be maintained for at least 24 months after remission.
B	The dose of the drug used during the maintenance phase must be similar to the dose used to achieve remission.
✓	In patients with a partial response at the third or fourth week of treatment, it is advisable: - To wait for the clinical evolution until week eight. - To increase the dose of the drug up to the maximum therapeutic dose.
✓	For a patient who does not improve with the initial drug treatment for depression, it is advisable: - To revise the diagnosis of depressive disorder. - To verify that the treatment is being followed. - To confirm that the antidepressant is being taken at the right time and dose.
B	If the patient does not improve at the third or fourth week, any of the following strategies could be followed: - Switching from an antidepressant to any family, including another serotonergic. - Combining antidepressants. - Augmenting the initiated treatment with lithium or triiodothyronine.
B	It is not advisable to increase the SSRI dose if there is no response after 3 weeks of treatment.

C	The association of SSRI with mirtazapine or mianserin could also be a recommendable option, but thereby taking into account the possibility of greater adverse effects.
B	There is insufficient information available to recommend an increase in the dose of tricyclic antidepressants in non-responders.
✓	In the event of resistance to various treatments according to the aforementioned guidelines, assess the use of MAOIs.
✓	There is insufficient data for recommending augmentation with valproate, carbamazepine, lamotrigine, gabapentin or topiramate, pindolol, benzodiazepines, buspirone, methylphenidate or atypical antipsychotics.

## Psychotherapy

✓	Psychological interventions should be provided by professionals who have experience at managing depression and who are experts in the applied therapy. This is especially important in the most severe cases.
B	In mild and moderate depression, specific and brief psychological treatment (such as problem-solving therapy, cognitive behavioural therapy or counselling) in 6 to 8 sessions during 10-12 weeks should be considered.
B	The preferred psychological treatment for moderate, severe or resistant depression is cognitive behavioural therapy. Interpersonal therapy can be considered as a reasonable alternative.
B	For moderate and severe depression, suitable psychological treatment should include 16 to 20 sessions during at least five months.
B	For moderate depression, either antidepressant drug treatment or suitable psychological intervention can be recommended.
B	Cognitive behavioural therapy should be offered to patients with moderate or severe depression who reject drug treatment or for whom avoiding the secondary effects of antidepressants is a clinical priority or who express that personal preference.
B	Couples therapy should be considered, if applicable, in the event that a suitable response is not obtained with previous individual intervention.
B	Cognitive behavioural therapy should be considered for patients who have not had a suitable response to other interventions or who may have a prior history of relapses or residual symptoms, despite treatment.
B	Cognitive behavioural therapy should be considered for patients who have recurrent depression and who have relapsed despite antidepressant treatment or who express a preference for psychological treatment.

A	For patients whose depression is resistant to pharmacological treatment and/or who have multiple episodes of recurrence, a combination of antidepressants and cognitive behavioural therapy should be offered.
A	A combination of cognitive behavioural therapy and antidepressant medication should be offered to patients with chronic depression.
C	Whenever cognitive behavioural therapy is applied to more severe patients, the techniques based on behavioural activation should be given priority.
C	Psychological interventions other than the aforementioned could be useful for dealing with comorbidity or the complexity of the family relationships frequently associated with the depressive disorder.

## Other treatments

A	Electroconvulsive therapy should be considered as a therapeutic alternative in adults with severe major depression.
✓	ECT is especially indicated for patients with severe major depression (with a high risk of suicide or severe physical impairment) in resistant depression and by informed choice of the patient.
✓	In general, guided self-help is not recommended for patients with severe major depression.
B	However, for patients with mild or moderate depression, professionals could consider recommending guided self-help programmes based on cognitive behavioural therapy.
✓	Participation in support groups is not considered an effective treatment measure in patients with the major depression disorder, either alone or combined with other therapeutic measures.
C	Programmes of structured and supervised exercise of moderate intensity, with a frequency of 2-3 times per week, with a duration of 40-45 minutes and for a period of 10 to 12 weeks should be recommended to patients with mild-moderate depression.
✓	The existing scientific evidence does not allow recommending the use of acupuncture as a treatment for major depression.
B	The use of St John's Wort is not recommended as a treatment option for patients with major depression.
✓	Health professionals should inform patients who consume it about the possible risks and benefits.

## Quality indicators

### Quality indicators:

- Underdiagnosis of major depression.
- Follow-up on treatment with antidepressants.
- ✓ - Maintenance of treatment with antidepressants.
- Efficient use of antidepressant drugs.
- Psychotherapeutic treatment in severe major depression.
- Psychotherapeutic treatment in mild major depression.