NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Depression in adults

NICE quality standard

Draft for consultation

29 March 2011

17 January 2023

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| **This quality standard covers** the clinical assessment and management of depression in adults aged 18 and over. It describes high-quality care in priority areas for improvement.  This quality standard will update and replace the existing quality standard on [depression in adults](https://www.nice.org.uk/guidance/qs8) (published March 2011). The topic was identified for update following a review of quality standards. The review identified:   * updated guidance on depression in adults.   For more information see [update information](http://www.nice.org.uk/guidance/qsXXX/chapter/Update-information).  This is the draft quality standard for consultation (from 17 January to 14 February 2023). The final quality standard is expected to publish in June 2023. |

# Quality statements

[Statement 1](#_Quality_statement_1:) Adults who may have depression have a comprehensive assessment. **[2011, updated 2023]**

[Statement 2](#_Quality_statement_2:) Adults with a new episode of depression discuss the full range of treatment options with their healthcare professional. **[new 2023]**

[Statement 3](#_Quality_statement_3:) Adults with depression who are at a higher risk of relapse are offered relapse prevention interventions. **[2011, updated 2023]**

[Statement 4](#_Quality_statement_4:) Adults with depression who are stopping antidepressant medication have the dose reduced in stages. **[new 2023]**

[Statement 5](#_Quality_statement_5:) Adults with depression from minority ethnic family backgrounds are supported to access mental health services. **[new 2023]**

In 2023 this quality standard was updated and statements prioritised in 2023 were updated (2011, updated 2023) or replaced (new 2023). For more information, see [update information](#_Update_information_3).

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| Questions for consultationQuestions about the quality standard **Question 1** Does this draft quality standard accurately reflect the key areas for quality improvement?  **Question 2** Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?  **Question 3** Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment. Questions about individual quality statements **Question 4** For draft quality statement 3: Can the population for the statement’s denominator – adults with depression who are at a higher risk of relapse (see definitions section) - be identified in practice? Please give reasons for your answer. Local practice case studies **Question 5** Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please provide details on the comments form. |

# Quality statement 1: Assessment

## Quality statement

Adults who may have depression have a comprehensive assessment. **[2011, updated 2023]**

## Rationale

A comprehensive assessment includes discussion of factors affecting the development, course and severity of an adult’s depression and does not rely on symptom count alone. The assessment enables an accurate diagnosis of depression or other mental health conditions, such as bipolar disorder and post-traumatic stress disorder. It also supports discussion of ideas and preferences for treatment options.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Process

Proportion of adults with a new diagnosis of depression who had a comprehensive assessment which included discussion of factors affecting the development, course and severity of their depression.

Numerator – the number in the denominator who had a comprehensive assessment which included discussion of factors affecting the development, course and severity of their depression.

Denominator – the number of adults with a new diagnosis of depression.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

## What the quality statement means for different audiences

**Service providers** (such as GP practices, Improving Access to Psychological Therapies [IAPT] services and NHS acute and mental health trusts) ensure that assessment protocols are in place for adults who may have depression to have a comprehensive assessment which includes discussion of factors that may have influenced the development of their depression. They ensure that there is capacity to enable adults who may have depression to be assessed by a healthcare professional who is competent to carry out a mental health assessment and for them to allow enough time to carry out the assessment during more than 1 appointment if needed.

**Healthcare professionals** (such as GPs, specialist nurses and mental health professionals) carry out a comprehensive assessment which includes discussion of factors that may have influenced the development of adults’ depression and does not rely on symptom count alone. If necessary, they carry out the assessment during more than 1 appointment. If they do not have the competence to carry out a mental health assessment, they refer an adult who may have depression to a healthcare professional who does.

**Commissioners** (NHS England and integrated care systems) ensure that they commission services in which adults who may have depression have a comprehensive assessment which includes discussion of factors that may have influenced the development of their depression. They ensure that services have local referral pathways in place so that if an adult who may have depression presents to a healthcare professional who is not competent to carry out a mental health assessment, they are referred to a healthcare professional who does.

**Adults who may have depression** have a holistic assessment during which they discuss factors that may have influenced the development of their depression with a healthcare professional who is competent to carry out the assessment. The aim of the assessment is to establish an accurate diagnosis and support discussion of ideas and preferences for treatment options.

## Source guidance

* [Depression in adults: treatment and management. NICE guideline NG222](https://www.nice.org.uk/guidance/ng222/) (2022), recommendations 1.2.6 and 1.2.7
* [Depression in adults with a chronic physical health problem: recognition and management. NICE guideline CG91](https://www.nice.org.uk/Guidance/CG91) (2009), recommendations 1.1.3.1 and 1.1.3.2.

## Definitions of terms used in this quality statement

### May have depression

Adults who have answered 'yes’ to either of the 2 questions used to initially identify depression.

The initial identification questions are:

* During the last month, have you been bothered by feeling down, depressed or hopeless?
* During the last month, have you often been bothered by having little interest or pleasure in doing things?

[Adapted from [NICE’s guideline on depression in adults](https://www.nice.org.uk/guidance/ng222), recommendation 1.2.1 and [NICE’s guideline on depression in adults with a chronic physical health problem,](https://www.nice.org.uk/guidance/cg91) recommendation 1.3.1.1]

### Comprehensive assessment

If an adult answers 'yes' to either of the depression identification questions (and the healthcare professional is competent to perform a mental health assessment), review the person's mental state and associated functional, interpersonal and social difficulties.

A comprehensive assessment should include:

* severity of symptoms
* previous history, duration
* course of illness.
* degree of functional impairment or disability, or both.

The assessment should include discussion of how the following factors may have affected the development, course and severity of their depression:

* any history of depression and coexisting mental health or physical disorders
* any history of mood elevation (to determine if depression may be part of bipolar disorder) (see the [NICE guideline on bipolar disorder](https://www.nice.org.uk/guidance/cg185))
* any past experience of, and response to, previous treatments
* personal strengths and resources, including supportive relationships
* difficulties with previous and current interpersonal relationships
* current lifestyle (for example, diet, physical activity, sleep)
* any recent or past experience of stressful or traumatic life events, such as redundancy, divorce, bereavement, trauma (see the [NICE guideline on post-traumatic stress disorder](https://www.nice.org.uk/guidance/ng116))
* living conditions, drug (prescribed or illicit) and alcohol use, debt, employment situation, loneliness and social isolation.

The assessment may be carried out during the course of more than 1 appointment.

The assessment is carried out by a healthcare professional who is competent to carry out a mental health assessment. If this professional is not the person's GP, inform the person's GP about the referral.

To improve the accuracy of the assessment of depression for adults with a physical health problem who may have depression, a healthcare professional who is competent for mental health assessment should additionally:

* consider the role of both the chronic physical health problem and any prescribed medication in development or maintenance of the depression
* ensure that the optimal treatment of the physical health problem is being adhered to, seeking specialist advice if necessary.

[Adapted from [NICE’s guideline on depression in adults](https://www.nice.org.uk/guidance/ng222), recommendations 1.2.2, 1.2.3, 1.2.6 and 1.2.7 and [NICE’s guideline on depression in adults with a chronic physical health problem](https://www.nice.org.uk/guidance/cg91), recommendations 1.1.3.2 and 1.3.1.3, and expert opinion]

## Equality and diversity considerations

The following should be considered when assessing adults who have additional needs relating to language or communication (for example, sensory or cognitive disabilities, or autism):

* asking the adult about their symptoms directly, using an appropriate method of communication depending on the person's needs (for example, using a British Sign Language interpreter, English interpreter, or augmentative and alternative communication)
* asking a family member or carer about the adult’s symptoms.

Healthcare professionals should be aware of acquired cognitive impairments that affect cognitive abilities, including communication. Examples are medical conditions such as dementia, Parkinson's disease or traumatic brain injury. When assessing adults with suspected depression and an acquired cognitive impairment, consideration should be given to consulting the relevant specialist.

For adults with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in [NHS England's Accessible Information Standard](https://www.england.nhs.uk/ourwork/accessibleinfo/), or the equivalent standards for the devolved nations.

To promote access and uptake of services, the needs of the following groups should be identified and addressed:

* adults who are from minority ethnic family backgrounds
* older adults
* women
* adults who are experiencing homelessness, refugees and asylum seekers.

Information on depression needs to be presented in a way that is age appropriate and culturally appropriate. Examples of adapting assessments to deliver them in a culturally sensitive way include:

* using interpreters from the same cultural background
* using language which takes into account the person’s family and wider context.

Service providers and commissioners should ensure that pathways promote access to mental health services through provision of independent translators.

[Adapted from [NICE’s guideline on depression in adults with a chronic physical health problem](https://www.nice.org.uk/guidance/cg91/), recommendation 1.1.3.3 and [NICE’s guideline on depression in adults](https://www.nice.org.uk/guidance/ng222/), recommendations 1.1.3, 1.2.5, 1.2.14, 1.16.5 and 1.16.6 and expert opinion]

# Quality statement 2: Discussing treatment options

## Quality statement

Adults with a new episode of depression discuss the full range of treatment options with their healthcare professional. **[new 2023]**

## Rationale

Discussing the full range of treatment options with adults who have a new episode of depression helps support the person to make an informed decision about their treatment preferences. It also enables the choice of treatment to be matched to their clinical needs and preferences. The discussion includes the number of sessions to be delivered for psychological therapies and choices around aspects of delivery. Providing information about choices is likely to lead to improved adherence to therapy and better outcomes, offsetting any costs associated with longer consultations. Having information and discussion also help to ensure that antidepressants are not routinely offered as first-line treatment for a new episode of less severe depression unless that is the adult’s preferred option.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Process

Proportion of adults with a new episode of depression who have a discussion with their healthcare professional about the full range of treatment options.

Numerator – the number in the denominator who have a discussion about the full range of treatment options with their healthcare professional.

Denominator – the number of adults with a new episode of depression.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

### Outcome

a) Proportion of adults with a new episode of depression who felt fully involved in decision-making about their care.

Numerator – the number in the denominator who felt fully involved in decision-making about their care.

Denominator – the number of adults with a new episode of depression.

**Data source:**Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records. [The Care Quality Commission’s NHS community mental health survey](https://www.cqc.org.uk/publications/surveys/community-mental-health-survey-2021) collects data on 3 questions for adults with depression: the extent of adults’ involvement in agreeing their care, the extent they felt involved in making a decision about their care together with the person they saw and whether they felt involved as much as they wanted to be in deciding what NHS talking therapies to use. [NHS Digital’s Improving Access to Psychological Therapies (IAPT)](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/improving-access-to-psychological-therapies-data-set/improving-access-to-psychological-therapies-data-set-reports) patient experience (treatment) questionnaire includes the question ‘Did you feel involved in decision making about your treatment and care?’ Annual results are presented at national and different commissioning and provider levels.

b) Proportion of adults with a new episode of depression who expressed a preference for treatment and were offered their preferred treatment.

Numerator – the number in the denominator who were offered their preferred treatment.

Denominator – the number of adults with a new episode depression who expressed a preference for their treatment.

**Data source:** [NHS Digital’s Improving Access to Psychological Therapies (IAPT)](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/improving-access-to-psychological-therapies-data-set/improving-access-to-psychological-therapies-data-set-reports) patient experience (treatment) questionnaire includes the questions ‘Do you prefer any of the treatments among the options available’ and ‘Have you been offered your preference?' Annual results are presented at national and different commissioning and provider levels.

## What the quality statement means for different audiences

**Service providers** (such as GP practices, IAPT services and NHS acute and mental health trusts) ensure that pathways, service protocols and capacity are in place so that adults with a new episode of depression can express a preference for treatments, and that these are available in a timely manner (particularly for adults with severe depression). They monitor uptake of treatments to ensure equity of access, provision, outcomes and experience.

**Healthcare professionals** (such as GPs, specialist nurses and mental health professionals) discuss the full range of treatment options and choices around aspects of delivery. They provide supporting information such as the potential benefits and harms, waiting times, expected outcomes and the number of sessions for psychological therapies. They support adults with a new episode of depression in making an informed decision, including allowing enough time for discussion.

**Commissioners** (such as integrated care systems and NHS England) ensure that they commission services with the capacity to ensure that adults can express a preference for treatments, and that these are available in a timely manner (particularly for adults with severe depression). They monitor service providers providing treatment to ensure equity of access, provision, outcomes and experience.

**Adults with a new episode of depression** talk to their healthcare professional about all their options for treatment. They are given information about the full range of treatments, including the number of sessions for psychological therapies, and discuss their preferences for how they are delivered. In this way, they are actively involved choosing a treatment that reflects their preferences, symptoms, and other circumstances.

## Source guidance

* [Depression in adults: treatment and management. NICE guideline NG222](https://www.nice.org.uk/guidance/ng222/) (2022), recommendations 1.3.4, 1.3.6 and 1.5.3
* [Depression in adults with a chronic physical health problem: recognition and management. NICE guideline CG91](https://www.nice.org.uk/Guidance/CG91) (2009), recommendations 1.4.2.1, 1.4.3.1, 1.5.1.2 and 1.5.1.3

## Definitions of terms used in this quality statement

### Treatment options

For information about treatment options please refer to [NICE’s guideline on depression in adults](https://www.nice.org.uk/guidance/ng222/), [table 1](https://www.nice.org.uk/guidance/ng222/chapter/recommendations#treatment-for-a-new-episode-of-less-severe-depression) (for less severe depression) and [table 2](https://www.nice.org.uk/guidance/ng222/chapter/recommendations#treatment-for-a-new-episode-of-more-severe-depression) (for more severe depression).

[Adapted from [NICE’s guideline on depression in adults](https://www.nice.org.uk/guidance/ng222), recommendations, 1.3.4, 1.5.2 and 1.6.1]

### New episode of depression

A first or subsequent episode of less or more severe depression.

Less severe depression includes the traditional categories of subthreshold and mild depression, and in the NICE guideline was defined as depression scoring less than 16 on the [Patient Health Questionnaire (PHQ-9)](https://patient.info/doctor/patient-health-questionnaire-phq-9) scale.

More severe depression includes the traditional categories of moderate and severe depression, and in this guideline was defined as depression scoring 16 or more on the PHQ-9 scale.

[[NICE’s guideline on depression in adults](https://www.nice.org.uk/guidance/NG222), terms used in this guideline and expert opinion]

## Equality and diversity considerations

Adults with a new episode of depression should be provided with information about treatments that they can easily read and understand themselves, or with support, so they can discuss treatment options and express their preferences. The information should be in a format that suits their needs (including being appropriate to their level of understanding about the range of treatments) and preferences. It should be accessible to adults who do not speak or read English and it should be culturally appropriate and age appropriate. Adults should have access to an interpreter or advocate if needed.

For adults with additional needs related to a disability, impairment or sensory loss, or whose ability to communicate is affected, information should be provided as set out in [NHS England's Accessible Information Standard](https://www.england.nhs.uk/ourwork/accessibleinfo/), or the equivalent standards for the devolved nations.

To support informed decision making when discussing treatment options and preferences, healthcare professionals should recognise any barriers to the delivery of treatments arising from disabilities (including learning disabilities) and acquired cognitive impairments (such as dementia), language or communication needs, as recommended in [NICE’s guidelines on depression in adults](https://www.nice.org.uk/guidance/ng222/) and [depression in adults with a chronic physical health problem](https://www.nice.org.uk/guidance/cg91/). Adjustments to the delivery of all treatments may include:

* consulting with a relevant specialist when developing treatment plans and strategies if the adult is receiving specialist support or treatment
* adjusting the method of delivery
* adjusting the length of the intervention
* offering a therapist of the gender preferred by the adult.

Healthcare professionals should also recognise and address cultural and ethnic differences when developing and implementing treatment plans. This includes a faith-sensitive approach and explaining depression in a way that is meaningful to specific cultures, for example, to reduce stigma that can be associated with symptoms and diagnosis.

[Adapted from [NICE’s guideline on depression in adults](https://www.nice.org.uk/guidance/NG222), recommendations 1.1.1, 1.2.15, 1.4.1, 1.16.4, 1.16.6, tables 1 and 2 and [NICE’s guideline on depression in adults with a chronic physical health problem](https://www.nice.org.uk/guidance/cg91), recommendations 1.1.1,1, 1.1.1.2, 1.1.3.3, 1.1.3.4 and 1.1.3.5]

# Quality statement 3: Preventing relapse

## Quality statement

Adults with depression who are at a higher risk of relapse are offered relapse prevention interventions. **[2011, updated 2023]**

## Rationale

All adults who achieve full or partial remission from depression should discuss with their healthcare professional whether they need to continue treatment. Adults who are at a higher risk of relapse should, after discussion, be offered interventions which focus on relapse prevention. This will help reduce the likelihood of further episodes of depression.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Process

The proportion of adults with depression who are at a higher risk of relapse who received relapse prevention interventions.

Numerator – the number in the denominator who received relapse prevention interventions.

Denominator – the number of adults with depression who are at a higher risk of relapse.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

### Outcome

Rates of relapse within 2 years of treatment among adults who have been treated for depression.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.[NHS Digital’s Improving Access to Psychological Therapies (IAPT) data](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/improving-access-to-psychological-therapies-data-set/improving-access-to-psychological-therapies-data-set-reports) includes therapy-based outcomes for courses of therapy using mean Patient Health Questionnaire (PHQ-9) scores at the start and end of therapy. Annual results are presented at national and different commissioning and provider levels.

## What the quality statement means for different audiences

**Service providers** (GP practices, mental health services including IAPT services and voluntary, community and social enterprise organisations commissioned to provide services) ensure that systems and protocols are in place for adults with depression who are at a higher risk of relapse to be offered relapse prevention interventions based on their clinical needs and preferences.

**Healthcare professionals** (such as GPs, specialist nurses and mental health professionals)discuss treatment options with adults with depression who are at a higher risk of relapse. They offer relapse prevention interventions, based on the adults’ clinical needs and preferences after reaching a joint decision about the treatment.

**Commissioners** (NHS England or integrated care systems) ensure that they commission services that offer relapse prevention interventions to adults with depression who are at a higher risk of relapse. The choice of intervention is based on a joint decision with the person and takes into account their clinical needs and preferences.They commission psychological therapy services that offer psychological therapies which have a relapse prevention component.

**Adults with depression whose symptoms are likely to return** are offered interventions to prevent relapse, following discussion with their healthcare professional. The treatment is based on their clinical needs and preferences and joint decision making.

## Source guidance

[Depression in adults: treatment and management. NICE guideline NG222](https://www.nice.org.uk/guidance/ng222/) (2022), recommendations 1.8.1 and 1.8.7

## Definitions of terms used in this quality statement

### Adults with depression at a higher risk of relapse

* Adults who have received acute treatment for a first or new episode of less severe or more severe depression:
  + a complete course of psychological therapy, as defined in [table 1](https://www.nice.org.uk/guidance/ng222/chapter/recommendations#treatment-for-a-new-episode-of-less-severe-depression) and [table 2](https://www.nice.org.uk/guidance/ng222/chapter/recommendations#treatment-for-a-new-episode-of-more-severe-depression)
  + a course of antidepressant medication.

Adults who have achieved full or partial response following acute treatment (using criteria such as the Diagnostic and Statistical Manual of Mental Disorders and International Classification of Diseases) are at a higher risk of relapse if they have:

* history of recurrent episodes of depression, particularly if these have occurred frequently or within the last 2 years
* a history of incomplete response to previous treatment, including residual symptoms (such as fatigue, poor sleep, poor concentration, impaired motivation)
* history of severe depression (including people with severe functional impairment)
* coexisting physical or mental health problems
* unhelpful coping styles (such as [avoidance](https://www.nice.org.uk/guidance/ng222/chapter/recommendations#avoidance), [rumination](https://www.nice.org.uk/guidance/ng222/chapter/recommendations#rumination))
* personal, social or environmental factors contributed to depression and that are still present (for example, relationship problems, ongoing stress, poverty, isolation, unemployment).

[Adapted from [NICE’s guideline on depression in adults](https://www.nice.org.uk/guidance/NG222), recommendation 1.8.2 and visual summary on preventing relapse ]

### Relapse prevention interventions

### These include:

* continuing with their antidepressant medication to prevent relapse, maintaining the dose that led to full or partial remission, unless there is good reason to reduce it (such as side effects) or
* a course of psychological therapy for relapse prevention (group cognitive behavioural therapy [CBT] or mindfulness-based cognitive therapy [MBCT]) for adults who do not wish to continue on antidepressants (follow the [recommendations on stopping antidepressants](https://www.nice.org.uk/guidance/ng222/chapter/recommendations#stopping-antidepressant-medication)) or
* continuing with their antidepressant medication and a course of psychological therapy for relapse prevention (group CBT or MBCT).

Relapse prevention components of psychological interventions focus on the development of relapse prevention skills and what is needed to stay well. These may include:

* reviewing what lessons and insights were learnt in therapy and what was helpful in therapy
* making concrete plans to maintain progress beyond the end of therapy, including plans to consolidate any changes made to stay well and to continue to practice useful strategies
* identifying stressful circumstances, triggering events, warning signs (such as anxiety or poor sleep), or unhelpful behaviours (such as avoidance or rumination) that have preceded worsening of symptoms and personal or social functioning, and making detailed contingency plans of what to do if each of these re-occur
* making plans for any anticipated challenging events over the next 12 months, including life changes and anniversaries of difficult events.

[Adapted from [NICE’s guideline on depression in adults](https://www.nice.org.uk/guidance/ng222), recommendations 1.8.5 to 1.8.7, and 1.8.10]

# Quality statement 4: Stopping antidepressants

## Quality statement

Adults withdepression who are stopping antidepressant medication have the dose reduced in stages. **[new 2023]**

## Rationale

Reducing the dose of antidepressant medication in stages over time (known as ‘tapering’) helps to reduce withdrawal effects and long-term dependence on antidepressants where their continued use is not indicated. The decision to stop antidepressant medication, including speed and duration of withdrawal, should be taken after discussion and agreement between the adult and their healthcare professional. Any withdrawal symptoms need to have been resolved or be tolerable before making the next dose reduction.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Process

The proportion of adults with depression who stopped taking antidepressant medication who had their dose reduced in stages.

Numerator – the number in the denominator who had their dose reduced in stages.

Denominator – the number of adults with depression who stopped taking antidepressant medication.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

## What the quality statement means for different audiences

**Service providers** (such as GP practices and mental health services) ensure that procedures and protocols are in place to ensure that adults with a diagnosis of depression who are stopping antidepressant medication have the dose reduced in stages, following discussion and agreement with their healthcare professional. They monitor prescribing patterns during withdrawal.

**Healthcare professionals** (such as GPs, specialist nurses and mental health professionals) reduce the adult’s dose of antidepressant medication in stages to optimise withdrawal. This follows a discussion and agreement with the adult with depression to stop taking antidepressant medication, including the speed and duration of withdrawal. The speed and duration of withdrawal is led by and agreed with the adult taking the prescribed medication, ensuring that any withdrawal symptoms have resolved or are tolerable before making the next dose reduction.

**Commissioners** (NHS England and integrated care systems) ensure that they monitor prescribing patterns for antidepressant medication for adults with depression. They commission services from providers who demonstrate that, following discussion and agreement to stop antidepressant medication, the dose is reduced in stages.

**Adults with depression who are stopping antidepressant medication** have the dose of their medication reduced in stages. The aim is to reduce the likelihood and severity of withdrawal symptoms, and to help them come off the medication permanently.

## Source guidance

* [Depression in adults: treatment and management. NICE guideline NG222](https://www.nice.org.uk/guidance/ng222/) (2022), recommendations 1.4.13 and 1.4.17
* [Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults. NICE guideline NG215](https://www.nice.org.uk/guidance/ng215) (2022), recommendation 1.5.7
* [Depression in adults with a chronic physical health problem: recognition and management. NICE guideline CG91](https://www.nice.org.uk/Guidance/CG91) (2009), recommendations 1.5.2.29 and 1.5.2.30

# Quality statement 5: Access to services for adults from minority ethnic family backgrounds

## Quality statement

Adults with depression from minority ethnic family backgrounds are supported to access mental health services. **[new 2023]**

## Rationale

Adults from minority ethnic family backgrounds are disproportionately less likely to access mental health services than the general population. Adults in this group are among those who may face stigma and difficulty in accessing some or all mental health services. By monitoring and comparing rates of access to mental health services among adults with depression by ethnicity, approaches to promoting and improving access to mental health services can be identified. Examples of strategies to address variation in access to mental health services among adults from minority ethnic family backgrounds who have depression include pathways for delivering culturally appropriate and culturally adapted treatments.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

**Structure**

Evidence of action plans that identify strategies and measures to support adults from underrepresented groups to access treatment for depression where a need to improve and promote access has been identified from monitoring local data.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by provider organisations and healthcare professionals, for example, local plans.

### Outcome

a) Rate per 100,000 of adults with depression who accessed mental health services by ethnicity.

Numerator – the number in the denominator with depression who accessed mental health services by ethnicity.

Denominator – total numbers of adults by ethnicity using Office for National Statistics population data.

**Data source:** [NHS Digital’s Improving Access to Psychological Therapies (IAPT) data set](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/improving-access-to-psychological-therapies-data-set/improving-access-to-psychological-therapies-data-set-reports) records numbers of referrals received and referrals accessing services by ethnicity. [NHS Digital’s Mental Health Services Data Set](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set) records numbers of referrals, care contacts (including a group session or drop-in contact).

b) Proportion of adults who completed treatment for depression in mental health services by ethnicity.

Numerator – the number in the denominator who completed treatment by ethnicity.

Denominator – the number of adults with depression in mental health services.

**Data source:** Data on the number of referrals that finished a course of treatment is collected for [NHS Digital’s IAPT data set reports](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/improving-access-to-psychological-therapies-data-set/improving-access-to-psychological-therapies-data-set-reports). Data on current prescriptions for antidepressants for adults with depression by ethnicity is available from the [NHS Business Services Authority’s Prescription data](https://www.nhsbsa.nhs.uk/prescription-data/).

## What the quality statement means for different audiences

**Service providers** (such as GP practices, community health services, mental health services, voluntary organisations and independent providers) work with commissioners to develop local care pathways which promote access to mental health services tailored to the needs of the local population. They ensure that services are accessible and culturally appropriate to adults from minority ethnic family backgrounds with depression. They also ensure that culturally adapted information, which is also available in different languages and formats, is provided about pathways into treatment. Services routinely collect ethnicity data to monitor, assess and support equity of access.

**Healthcare professionals** (such as GPs, specialist nurses and mental health professionals) give adults from minority ethnic family backgrounds with depression information on how to access mental health services. They are aware of local pathways and relevant culturally adapted information available in different languages. They offer different options for accessing services, ensuring that adults with depression from minority ethnic family backgrounds can choose culturally appropriate services.

**Commissioners** (integrated care systems and NHS England) work with providers to promote access to mental health services among adults from minority ethnic family backgrounds with depression. Commissioners identify the needs of the local population and work with providers to develop local care pathways tailored to their needs. They also provide culturally adapted information about these pathways in different languages. They ensure that mental health services are provided in a variety of settings and that a range of support is available. They match access rates to local population and demographic services (collected, for example, by IAPT services) and monitor the extent to which providers reduce barriers to access in these groups.

**Adults from minority ethnic family backgrounds with depression** are given a choice of methods to access mental health services that are culturally appropriate to them. They can access culturally adapted information about routes to treatment in a language that they can understand.

## Source guidance

* [Depression in adults: treatment and management. NICE guideline NG222](https://www.nice.org.uk/guidance/ng222/) (2022), recommendations 1.16.4, 1.16.5 and 1.16.6
* [Depression in adults with a chronic physical health problem: recognition and management. NICE guideline CG91](https://www.nice.org.uk/Guidance/CG91) (2009), recommendation 1.1.3.3

## Definitions of terms used in this quality statement

### Supported to access mental health services

Commissioners and providers of mental health services should ensure pathways have the following in place for adults with depression to promote access, and increased uptake and retention:

* services delivered in culturally appropriate or culturally adapted language and formats
* services available outside normal working hours
* a range of different methods to engage with and deliver treatments in addition to in-person meetings, such as text messages, email, telephone and online or remote consultations (where clinically appropriate, and for adults who wish to access and are able to access services in this way)
* services provided in community-based settings, for example in a person's home, community centres, leisure centres, care homes, social centres and integrated clinics within primary care (particularly for older adults)
* services delivered jointly with charities or the voluntary sector
* bilingual therapists or independent translators
* procedures to support active involvement of families, partners and carers, if agreed by the person with depression.

Commissioners and providers of mental health services should also ensure that culturally adapted information about pathways to treatment is available. Examples include adaptations to reflect religion and spirituality, beliefs about mental illness, experience of stigma, use of metaphor, stories and examples that are meaningful to the respective culture. The information should also be made available in different languages.

[[NICE’s guideline on depression in adults](https://www.nice.org.uk/guidance/ng222/), recommendations 1.16.4 and 1.16.5]

## Equality and diversity considerations

For adults with additional needs related to a disability, impairment or sensory loss, or whose ability to communicate is affected, information should be provided as set out in [NHS England's Accessible Information Standard](https://www.england.nhs.uk/ourwork/accessibleinfo/) or the equivalent standards for the devolved nations, to enable these groups to access information about pathways to treatment.

# Update information

**January 2023:** This quality standard was updated and statements prioritised in 2011 were replaced. The topic was identified for update following a review of quality standards. The review identified:

* updated guidance on depression in adults.

Statements are marked as:

* **[new 2023]** if the statement covers a new area for quality improvement
* **[2011, updated 2023]** if the statement covers an area for quality improvement included in the 2011 quality standard and has been updated.

# About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about [how NICE quality standards are developed](https://www.nice.org.uk/standards-and-indicators/timeline-developing-quality-standards) is available from the NICE website.

See our [webpage on quality standards advisory committees](http://www.nice.org.uk/Get-Involved/Meetings-in-public/Quality-Standards-Advisory-Committee) for details about our standing committees. Information about the topic experts invited to join the standing members is available from the [webpage for this quality standard](https://www.nice.org.uk/guidance/indevelopment/gid-qs10165/documents).

NICE has produced a [quality standard service improvement template](https://www.nice.org.uk/about/what-we-do/into-practice/measuring-the-uptake-of-nice-guidance) to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

## Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the [resource impact summary report](https://www.nice.org.uk/guidance/ng222/resources) for the NICE guideline on depression in adults to help estimate local costs.

## Diversity, equality and language

Equality issues were considered during development and [equality assessments for this quality standard](https://www.nice.org.uk/guidance/indevelopment/gid-qs10165/documents) are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

ISBN:

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