

Depression in Adults – Stakeholder Scoping Workshop

Thursday 12 February 2015, 10am-1pm

Broadway House, Tothill Street, London SW1H 9NQ

Group 1

Facilitator: Steve Pilling

Scribe: Iona Symington

Scope issues and other key themes

Service delivery

Service delivery was highlighted as an important issue to address, particularly for older adults. The group agreed that service delivery is often a commissioning problem and there is an unmet need for more people to provide and deliver care.

The issue of stepped care was discussed and it was agreed by the group that there is a difficulty with the definition; it will be important to get this definition consistent in the guideline.

The flexibility of different models was raised as an important consideration, in particular how models can be adapted/ made flexible for different populations e.g. older adults. In addition, the setting in which these take place is also important e.g. residential homes.

Severity and complexity of the disorder

The group discussed the issue of ‘severity’ of depression and agreed it is hard to define. The group felt that often the ‘complexity’ of the problem is a more important consideration. There was a discussion surrounding how co-morbidity in depression is very common and reflects the reality of clinical practice. There was concern that the guideline may not be relevant to this large group of people if it does not consider these co-morbidities. Personality disorders were singled out as an important to consider.

There was a general consensus in the group that there is a need for implementation to be based on the complexity of the problem, rather than the severity of the problem and the importance of varying interventions for the complexity of the problem

Chronicity of the disorder

The group agree that there is a group of people for whom depression is a chronic problem and who currently have very poor care packages and often end up stuck in CMHTs and who’s complexity and chronicity is on a par with people who have schizophrenia. The group felt it will be important to consider this group of people, especially when it comes to commissioning.

Comparators

There was a discussion about how comparators are crucial and often unequal for different interventions. The importance of considering whether the comparator is placebo or another active intervention was raised, especially if a network meta-analysis is to be used. The importance of considering the populations in different studies was also raised.

Components of interventions

Some members of the group felt that it would be useful to have guidance on a) when to use treatments for certain conditions, and b) what the important components of those treatments are, for example, when a particular therapy worked well, what are the key components of that intervention?

Taking the example of CBT, there was discussion about how interventions vary according to the practitioner delivering it. The group discussed that it may not necessarily be the type of intervention that is important, but whether the intervention is properly implemented. It was agreed that tailoring the shape of the care package depending on the profile of the individual patient is important

Topics Listed in the scope

Alternative therapies were highlighted as important

Under Physical therapy the group highlighted the following as important to also include:

- Acupuncture
- Tai chi
- yoga

Social interventions were highlighted as crucial. In particular, social care social inclusion (particularly for older adults) and befriending were raised as important to include

The group thought it was important to highlight to commissioners the range of different therapies

It was discussed whether VNS/TMS should be dropped from the scope, with a general agreement that the guideline should focus on key areas rather than try to cover everything

Equalities

There was an agreement that all men should be included as a special consideration, with awareness on certain symptom manifestations e.g. anger/irritability

Home-bound people (including older adults) were mentioned, however it was agreed that this may cross over to people with physical health co-morbidities which is outside the scope

GDG constituency

There was an agreement that there may have to be GDG members representing multiple professional groups

The group thought that in addition to the existing list of GDG members it would be useful to have:

- A commissioner
- A third sector provider

Group 2

Facilitator: Odette Megnin-Viggars

Scribe: Julie Kane

General comments

- Mindfulness based Cognitive Behavioural Therapy should be added.
 - Specifically because it is cost effective as it is effective in a group setting of 10 – 12 people for acute depression.
- CBASP should be added as an option for treatment resistant depression. Research is currently being done in Aberdeen on the topic.
- Many trusts cannot adhere to the treatment timelines in the guidelines.
 - It would be good to add an implementation timeframe into the guideline
 - Possible where there are relevant cases.
- Group physiotherapy as a possible intervention.
- Acupuncture as a possible physical intervention.
- TMS and VNX are not widespread. They are used in trials and private practice, but as a last resort.
 - TMS Could be becoming more prevalent.

Groups that will be covered

- Specific considerations:
 - Coexisting conditions, presentation of symptoms differs across many of the consideration groups.
 - This is a big challenge, but necessary to address.
 - Will physical health symptoms be addressed in co-morbidity? I.e. Chronic pain

Activities, services or aspects of care

- In-patient / placement to be split between low and high intensity interventions.
 - Specify the importance of in-patient care in certain situations.
- Use of ketamine as a pharmacological intervention.

Main outcomes

- Recovery: Clinical vs Functional – this is an important distinction to make.
 - Treat to where the patient can return to full capacity before labelled ‘in remission’
 - Employment / global functioning – potential to add to the economic analysis
- Side effects from non-pharmacological interventions – important and complex.
 - Quality of life
 - Possible problems in the reporting of adverse side effects – these may be low and/or non-existent for non-pharmacological interventions.
- Areas with little / no RCT data will be looked at through other data analysis methods, i.e. consensus (based on GDG experience)
 - The group is happy to see older people as one of the special consideration groups.
 - Will this include late onset depression?

- The treatment pathway seems vague in the guidelines.
 - Pathways different based on treatment lines
 - Defined stages of treatment resistant depression analysis.
- Why is the guide excluding primary prevention?
 - This falls under public health
- It would be helpful to include specialist depression services.

GDG constituency

- Multiple members of some of the groups to prevent bias?
 - Some GDG members will have to act as a few different categories?

Group 3

Facilitator: Nav Kapur

Scribe: Maryla Moulin

Scope issues and other key themes

Title: the word 'management' implies prevention too; what about the inclusion of co-morbidities; how is depression going to be defined?

The group would like to see more on social care in the scope and it should also include the role of carers

Awareness of stigma notably in the work place

The impact of standardisation of treatment due to commercial availability of certain interventions

Consider individual person scenario (holistic treatment management, employment and risk triggers)

Settings: Home occupation, care home, occupation

Topics Listed in the scope

The following should be considered for inclusion:

- The impact of personal budgets and the choice of treatment; precision medication
- Role of complimentary therapies; acupuncture
- TMS (there's a growing evidence base)
- Prescription of medication; the role of antipsychotic augmentation
- Oxytocin
- RTMS (beginning to take off)
- Ketamine
- physical/ chemical testing undertaken by the GP to assess chemical imbalances
- DNA tools to assess ones reaction to serotonin
- Diet and exercise (healthy sleep, omega 3)
- Cognitive tools to stop negative thought
- Social interaction/ isolation
- Secondary prevention
- Technical/ social interventions such as tele-help
- Cognitive impairment

- Supportive decision making
- The role of training
- Continuous development
- Liaison networks with health and social care and the person's work

Equalities

To add: LGBT, military, abuse survivors

GDG constituency

Someone who understands bio-chemistry, neuro psychologist

Occupational physician with employment specialists

Religious minister

Group 4

Facilitator: Clifford Middleton

Scribe: Rebecca Pye

Target Audience

- People who educate the professionals
 - Educators and trainers
- Voluntary sector (not explicit from 2nd bullet)
- Also for consideration on GDG

Equality considerations / Groups covered

- Concern over exclusion of chronic health problems
 - Relevant studies which may change recs
 - Also acute (new evidence regarding treatments)
 - 'other way around' risk factors for other things
 - Rationale would help to be visible / signposting
 - Related guidance to be included APMH
 - Separate NICE pathways on web not enough to be in guidance
- Specific Considerations
 - Consider access issues / barriers / recognition for men
 - Existing (physical) conditions, pharmacological treatments that have impact (studies looking at this difference).
 - Add personality disorders to specified examples due to prominence
 - Agree with inclusion of black/ethnic groups
 - Pathway/ access issues to be considered.
 - Welsh/irish
 - Identifying vulnerable groups as well as creating access
- Issue around transition services – there is a big gap here

- Consideration for young adults (link to CYP guideline?)
- Service delivery
- Note: age cut-offs of important and big ongoing studies – depression intervention RCT
- Access, formulas, information services and recognition

Settings

- Interventions in the workplace as an area of special interest (including promotion, education, prevention)

Activities, Services or aspects of care

- Digital (psychosocial) interventions (approximately 1000 published studies)
- Group therapy = peer support – needs to be defined
- Facilitated self help
- Yoga (2000+ studies showing efficacy)
- Mindfulness (stand-alone but also linked to the above)
- Missing information from pharmacological
 - Atypical, anti-psychotics, mood stabilizers
- I.Ps
 - VNS is not widely used, cost issues
 - TBCS (being done at home) and TMS
 - It is felt that both are not necessary to look at but should be signposted.

Wrap up and other key points

- Recognition of key groups identified of depression
- Take up of computerized CBT is lower than expected.