NATIONAL INSTITUTE FOR HEALTH AND   
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Quality standards

Briefing paper: Depression in adults

**Quality Standards Advisory Committee meeting**: 21 September 2022

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1. Introduction

This briefing paper presents a structured overview of potential quality improvement areas for depression in adults. It provides the committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

Recommendations selected from the key development source are included to help the committee in considering potential statements and measures.

* 1. Development source

The key development source/sources referenced in this briefing paper are:

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

[Depression in adults with a chronic physical health problem: recognition and management. NICE guideline CG91](https://www.nice.org.uk/guidance/cg91/) (2009)

1. Overview
   1. Focus of quality standard

This quality standard covers the clinical assessment and management of depression in adults aged 18 and over.

It will update and replace the existing [NICE quality standard on depression in adults](https://www.nice.org.uk/guidance/qs8/) (QS8) which published in 2011.

* 1. Definition

Depression refers to a wide range of mental health problems characterised by a loss of interest and enjoyment in ordinary things, experiences, low mood and a range of associated emotional, cognitive, physical and behavioural symptoms.

Symptoms of depression listed in both the ICD-11 and DSM-5 manuals are:

* Reduced ability to concentrate or marked indecisiveness
* Feelings of low self-worth or excessive or inappropriate guilt
* Recurrent thoughts of death, suicidal ideation or attempted suicide
* Reduced energy or fatigue

Significant changes in appetite or weight.

Depression exists along a continuum and is composed of 3 elements:

* Symptoms (which may vary in frequency and intensity).
* Duration

Impact on personal and social functioning, which refers to a person's ability to effectively engage in normal activities of everyday living and react to experiences. Personal and social functioning encompasses the ability to interact with the people, develop relationships and to gain from and develop these interactions.

Severity of depression is a consequence of the contribution of all these elements.

Traditionally, depression severity has been grouped under 4 categories (subthreshold, mild, moderate and severe). NICE's updated guideline on depression in adults (NICE, 2022) however represents the severity of depression in a way that best represents the available evidence on the classification and will help the uptake of the recommendations in routine clinical practice. New episodes of depression are therefore defined as less severe or more severe depression. Less severe depression encompasses subthreshold and mild depression, and more severe depression encompasses moderate and severe depression.

Chronic depression (chronic depressive symptoms) refers to chronic depressive symptoms includes those who continually meet criteria for the diagnosis of a major depressive episode for at least 2 years, or have persistent subthreshold symptoms for at least 2 years, or who have persistent low mood with or without concurrent episodes of major depression for at least 2 years. People (adults) with depressive symptoms may also have a number of social and personal difficulties that contribute to the maintenance of their chronic depressive symptoms.

* 1. Incidence and prevalence

Depression is a common mental health problem, with 6% of adults in England experiencing an episode of depression each year. Over the course of their lifetime more than 15% of people experience an episode of depression. The average length of an episode is between 6 and 8 months. For many people the episode will be mild, but for more than 20%, the depression will be moderate or severe and have a significant impact on their daily lives. Recurrence rates are high: there is a 50% chance of recurrence after a first episode, rising to 70% and 90% after a second or third episode, respectively.

Symptoms can be disabling and the effects have a major detrimental impact on a person's personal, social and occupational functioning. Depression is a leading cause of disability worldwide and is a major contributor to the overall global burden of disease; see World Health Organisation’s [Depression: key facts](https://www.who.int/news-room/fact-sheets/detail/depression) (2021).

Women are between 1.5 and 2.5 times more likely to be diagnosed with depression than men. However, although men are less likely to be diagnosed with depression, they are more likely to die by suicide, have higher levels of substance misuse, and are less likely to seek help than women.

* 1. Current service delivery and management

Under-treatment of depression is widespread because many people are unwilling to seek help for depression and detection of depression by professionals is variable. For example, of the 130 people with depression per 1000 population, only 80 will consult their GP. Of these 80 people, 49 are not recognised as having depression. This is mainly because they have contacted their GP because of a somatic symptom and do not consider themselves as having a mental health problem (despite the presence of symptoms of depression).

Of those who are recognised as having depression, most are treated in primary care and about 1 in 4 or 1 in 5 are referred to secondary mental health services. There is considerable variation among individual GPs in their referral rates to mental health services, but people seen by specialist services are mainly people whose symptoms do not improve with antidepressants, people with more severe illnesses, single women and those aged under 35.

The most common method of treatment for depression in primary care is psychotropic medication. Treatment adherence and clinical evolution are often not sufficiently monitored. The Improving Access to Psychological Therapies (IAPT) programme is a large-scale initiative that aims to increase the availability of NICE-recommended psychological treatments for depression and aims to ensure that there is access to psychological therapies for all who would benefit from them. The programme began in 2008 and NHS Digital has published annual data since 2012.

In 2011/12 there were 887,452 referrals to IAPT. This increased to 1,676,985 in 2019/20. Although the number fell to 1,440,183 in 2020/21 this number represented a 62% increase from that of 2011/12. Between February and April 2020, the number of referrals more than halved following the onset of the Covid-19 pandemic. This may have been due to reductions in the number of patients presenting at GP practices during the lockdown; the number of referrals starting treatment fell by 34% over the same time period. Since then, both the number of referrals and the number starting treatment increased to levels that are slightly higher than before the pandemic (Nuffield Trust Quality Watch [Improving Access to Psychological Therapies 2022](https://www.nuffieldtrust.org.uk/resource/improving-access-to-psychological-therapies-iapt-programme) [online, accessed 1 August 2022]).

NHS Digital’s [annual report on the use of IAPT service in England](https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2020-21) 2020-21 highlights that over 1.4 million referrals were received, with around 1 million people entering treatment. Until 2020/21 IAPT met targets to expand access to psychological therapies (to 900,000 in 2015). However, IAPT fell short of the 2020/21 target to increase access, to 1.5 million. 474,790 more people would have needed to start treatment to attain it. The number of people starting IAPT treatment must increase considerably if the 2023/24 target (stated to be 1.88 million) is to be reached (Nuffield Foundation’s 2022 [Improving access to psychological therapies (IAPT) programme](https://www.nuffieldtrust.org.uk/resource/improving-access-to-psychological-therapies-iapt-programme) online [accessed 5 August 2022]). IAPT is currently delivering NICE-recommended treatments using a 'stepped-care' model. This is a system of delivering and monitoring treatments, so that the most effective, least intrusive and least resource intensive ones are delivered first. Stepped care has a built in 'self-correcting' mechanism so that people who do not benefit from initial treatments can be 'stepped up' to more intensive treatments as needed. NG222 refers to 'matched' care, which follows the principles of stepped care, but also takes into account other factors such as patient presentation, previous experience of treatment, patient choice and preferences (please see the matched care model visual summary from [NICE’s guideline on depression in adults](https://www.nice.org.uk/guidance/ng222/) in [Appendix 1](#_Appendix_3:_Preventing)).

* 1. Policy developments

The [Five Year Forward View for Mental Health](https://www.england.nhs.uk/publication/the-five-year-forward-view-for-mental-health/) (2016) recommended incentivising provision of integrated mental and physical healthcare and make adjustments to take account of inequalities. Reflecting that around 40% of people with depression and anxiety disorders also have a long-term physical health condition (LTC), new IAPT-LTC services were implemented from September 2016, and CCGs were asked to commission these services and recruit additional staff (National Collaborating Centre for Mental Health (2018) [The improving access to psychological pathways for people for long-term physical health conditions and medically unexplained symptoms](https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/iapt/nccmh-iapt-ltc-full-implementation-guidance.pdf?sfvrsn=de824ea4_4)). Local funding baselines including funding growth for sustaining and commissioning IAPT services for 1.9 million adults and older adults by 2023/24 including IAPT-LTC services from 2019/20 and salary support are established (Healthcare Financial Management Association 2019, [Summary of the NHS mental healthcare implementation plan 2019/20 to 2023/24](https://www.hfma.org.uk/online-learning/bitesize-courses/detail/summary-of-the-nhs-mental-health-implementation-plan-2019-20-2023-24#:~:text=The%20NHS%20mental%20health%20implementation%20plan%202019%2F20%20%E2%80%93,other%20sections%20of%20the%20NHS%20long%20term%20plan.) online [accessed 1 August 2022]).

In 2017, the minister for public health and primary care commissioned Public Health England (PHE) to identify the scale, distribution and causes of prescription drug dependence, and what might be done to address it. PHE published [dependence and withdrawal associated with some prescribed medicines](https://www.gov.uk/government/publications/prescribed-medicines-review-report) in 2019 which responded to the Government’s concerns that increasing numbers of people in England were taking antidepressants long term without a continuing indication, and that some people have problems stopping them.

See Appendices 2 to 6 for the associated care pathways from [NICE’s guideline on depression in adults.](https://www.nice.org.uk/guidance/ng222/)

* 1. Resource impact

Where the relevant NICE guideline has not been fully implemented additional resources may be needed. Clinical expert opinion suggests currently many people cannot access psychological therapy due to a shortage of suitably qualified therapists. Also, that there are variations in the choices of psychological treatments available across services, and more work is needed to ensure a meaningful choice of depression treatments for all. Both problems that are being targeted in the NHS Mental Health Implementation Plan 2019/20-2023/24. There are long waiting times to access psychological therapies and other treatments. Clinical experts also suggest that while significant resource has previously been used to improve primary care (IAPT) psychotherapy provision, this has not been the case for secondary care and will need to be addressed to effectively implement the guideline.

The NHS Mental Health Implementation Plan 2019/20 – 2023/24 states that access to IAPT services will be expanded to meet further demand for IAPT services. The plan commits baseline funding to clinical commissioning groups/integrated care systems of £310m and £442m in 2022/23 and 2023/24 respectively for IAPT services for adults with common mental illnesses.

There is also central/transformation funding distributed via Health Education England to improve access to evidence-based care, and to develop new models of integrated primary and community care for adults and older adults with severe mental illnesses. Therefore, in the NHS the updated recommendations may not necessarily result in more costs/resources beyond those covered by the implementation plan. However, any potential additional costs should be assessed at a local level.

1. Summary of suggestions
   1. Responses

In total 8 registered stakeholders responded to the 3-week engagement exercise.

* 7 stakeholders suggested areas
* 1 stakeholder had no comments

6 specialist committee members suggested areas

The responses have been summarised in table 1 for further consideration by the committee.

Full details of all the suggestions provided are given in [Appendix 7](#_Appendix_7:_Suggestions) for information.

* 1. Priorities for committee discussion

Table 1 Summary of information available for suggested areas for improvement

| Suggested area for improvement | Stakeholder | In scope | Guideline recs | Current practice evidence | Existing QS statement | Priority to discuss? |
| --- | --- | --- | --- | --- | --- | --- |
| **Assessment and diagnosis**   * Initial assessment * Identifying symptoms of other mental health conditions * Recognising and supporting communication needs | FPH-SIG, POMH, SCMs  RCGP    RCSLT | Yes  Yes  Yes | Yes  Yes  Yes | Yes  Limited  Limited | Yes  QS53  No | **Yes**  **Yes**  **Yes** |
| **Treatments**   * Choice * New episode of less severe depression * Severe, chronic and comorbid depression * Improving physical health | BACP, NHSE, RCGP, SCMs  SCMs  Mind, SCMs  FPH-SIG | Yes  Yes  Yes  Yes | Yes  Yes  Yes  Yes | Yes  Yes  Yes  Limited | No  Yes  Yes  Yes | **Yes**  **Yes**  **Yes**  **Yes** |
| **Monitoring, reassessment, relapse prevention and remission**   * Monitoring * Reassessment * Relapse prevention * Stopping antidepressants | RCSLT, SCMs  Mind, NHSE, POMH, SCMs  SCMs  Mind, SCMs  SCMs | Yes  Yes    Yes  Yes | Yes  Yes  Yes  Yes | Yes  Yes  Yes  Yes | No  Yes  Yes  No | **Yes**  **Yes**  **Yes**  **Yes** |
| **Service delivery**   * Access and quality of care * Multidisciplinary support and care * Reducing barriers to access and uptake | BACP, Mind, NHSE, RCGP, SCMs  RCSLT, SCMs  FPH-SIG, Mind, NHSE, SCMs | Yes  Yes  Yes | Yes  Yes  Yes | Yes  Yes  Yes | No  Yes  QS167 | **Yes**  **Yes**  **Yes** |
| **Additional areas**   * New guidance on trauma sensitive approaches to treatment * Practitioner competence and supervision * Regulation of the administration of ECT | FPH-SIG  SCMs  SCM | Yes  Yes  Yes | No  Yes  Yes | N/A  N/A  N/A | No  Yes  No | **No**  **No**  **No** |

Abbreviations:

* BACP, British Association for Counselling and Psychotherapy
* FPH-SIG, Faculty of Public Health - Public Mental Health - Special Interest Group
* Mind, MIND
* NHSE, NHS England
* RCGP, Royal College of General Practitioners
* RCN, Royal College of Nursing (no comment response)
* RCSLT, Royal College of Speech and Language Therapists
* SCM, Specialist Committee Member.

1. Suggested improvement areas

Section 4 presents a summary of the suggested improvement areas, with provisional recommendations that may support statement development and information on current UK practice.

* 1. Assessment and diagnosis

### Initial assessment

Stakeholders proposed initial assessment of an adult who may have depression as a quality improvement area, commenting on its importance for planning treatment.

Stakeholders highlighted the need to consider a range of factors and noted that adults should be asked about social determinants and context so that the information can be used to formulate the best treatment options and enable signposting to wider services and support alongside treatment. Stakeholders highlighted that an assessment which does not focus exclusively on counting symptoms can help to support long-term recovery.

Stakeholders also felt that using standardised rating scales for depression would enable symptoms and their severity to be communicated to other healthcare professionals.

Stakeholders also suggested that they felt that a holistic approach to assessment may improve take-up of treatment among adults from socially deprived backgrounds, including adults from a black, Asian and minority family background and older women.

#### Selected recommendations

[NICE's guideline on depression in adults (NG222):](https://www.nice.org.uk/guidance/ng222/)

1.2.4 Consider using a validated measure (for example, for symptoms, functions and/or disability) when assessing a person with suspected depression to inform and evaluate treatment.

1.2.6 Conduct a comprehensive assessment that does not rely simply on a symptom count when assessing a person who may have depression, but also takes into account severity of symptoms, previous history, duration and course of illness. Also, take into account both the degree of functional impairment and/or disability associated with the possible depression and the length of the episode.

1.2.7 Discuss with the person how the factors below may have affected the development, course and severity of their depression in addition to assessing symptoms and associated functional impairment:

* any history of depression and coexisting mental health or physical disorders
* any history of mood elevation (to determine if the depression may be part of bipolar disorder); see the NICE guideline on bipolar disorder
* 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 (also see the NICE guideline on post-traumatic stress disorder)

living conditions, drug (prescribed or illicit) and alcohol use, debt, employment situation, loneliness and social isolation.

1.16.1 (extract) Commissioners and providers of mental health services should consider using models such as stepped care or matched care for organising the delivery of care and treatment of people with depression.

Pathways should:

allow for prompt assessment of adults with depression, including assessment of severity and risk

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

* services delivered in culturally appropriate or culturally adapted language and formats

[NICE’s guideline on depression in adults with a chronic physical health problem (CG91):](https://www.nice.org.uk/guidance/cg91/)

1.1.3.1 When assessing a patient with a chronic physical health problem who may have depression, conduct a comprehensive assessment that does not rely simply on a symptom count. Take into account both the degree of functional impairment and/or disability associated with the possible depression and the duration of the episode.

1.1.3.2 In addition to assessing symptoms and associated functional impairment, consider how the following factors may have affected the development, course and severity of a patient's depression:

* any history of depression and comorbid mental health or physical disorders
* any past history of mood elevation (to determine if the depression may be part of bipolar disorder)
* any past experience of, and response to, treatments
* the quality of interpersonal relationships
* living conditions and social isolation.

1.1.3.3 Be respectful of, and sensitive to, diverse cultural, ethnic and religious backgrounds when working with patients with depression and a chronic physical health problem, and be aware of the possible variations in the presentation of depression. Ensure competence in:

* culturally sensitive assessment
* using different explanatory models of depression
* addressing cultural and ethnic differences when developing and implementing treatment plans

working with families from diverse ethnic and cultural backgrounds.

#### Existing quality statements

[NICE’s quality standard on depression in adults (QS8):](https://www.nice.org.uk/guidance/qs8/)

Statement 1. People who may have depression receive an assessment that identifies the severity of symptoms, the degree of associated functional impairment and the duration of the episode.

#### Current UK practice

Read et al’s (2020) online survey [depression, antidepressants and withdrawal: implementing the 2019 PHE report](https://doi.org/10.1177%2F2045125320950124) conducted in February and March 2020 was completed by 66 UK GPs. It investigated their experience, beliefs and knowledge in relation to a range of topics relating to antidepressants and depression. In response to the question 'What do you think are the relative contributions of bio-genetic causes (for example, chemical imbalance, genetic predisposition) versus social causes (such as stressful/traumatic events, loss etc.) for depression?’, 80% of GPs (53/66) felt that social causes contributed more than bio-genetic causes.

A limitation of this study is that it surveyed the views of a small sample of GPs.

An [audit initiated by the Prescribing Observatory for Mental Health (POMH)](https://journals.sagepub.com/doi/10.1177/2045125320930492) by Paton et al, 2020) used data from 2,082 patients who were under the care of a community psychiatric team for at least 1 year in 55 adult mental health services (out of 64 members of the POMH in the UK). Data were collected in May and June 2019. The patients had a diagnosis of moderate or severe unipolar depression. The report highlighted that:

Of 84% (956) of patients with moderate depression and documented clinical review addressing the symptoms and severity of their depression:

* The contribution of use of substances had been considered in 56% (644).

A formal rating scale was used in 11% (102) to rate the symptoms and severity of their depression.

Of 86% (807) of patients with severe depression and documented clinical review addressing the symptoms and severity of their depression:

* The contribution of use of substances had been considered in 55% (521).

A formal rating scale was used in 11% (85) to rate the symptoms and severity of their depression.

The National Clinical Audit of Anxiety and Depression (NCAAD)’s [report how are inpatient mental health services for people with anxiety and depression performing](https://www.hqip.org.uk/resource/national-clinical-audit-of-anxiety-and-depression-inpatient-mental-health-services/) (October 2019) presents findings of an audit based on the case notes of people aged 16 and over with a primary diagnosis of anxiety or depression at discharge who were admitted to an NHS-funded inpatient service for treatment for these conditions between 1 April and 30 September 2017. 100 case notes were randomly chosen by the Royal College of Psychiatrists from data submitted by all 54 mental health trusts in England from June to September 2018. There was a return rate of 85% ([technical report for the core audit 2017 to 2018](https://www.hqip.org.uk/resource/national-clinical-audit-of-anxiety-and-depression-inpatient-mental-health-services/#.YxzY-KTMI2y)) and a final set of notes from 3,795 service users was analysed. The report highlighted that:

* although 97% of assessments included information about difficulties relating to the person's social situation, concern was flagged about the reliability of this finding.

Information about difficulties relating to a financial situation was recorded in 71% of assessments (lower than for employment or employment and education, 84%, and for dependents, 89%).

### Identifying symptoms of other mental health conditions

Stakeholders felt that ensuring that assessments enable symptoms of other (comorbid) mental health conditions such as anxiety to be identified is a priority area. This is because a clear diagnosis of depression enables treatment to be sequenced, so that symptoms of one condition are improved before treatment is planned for the other.

#### Selected recommendations

[NICE’s guideline on depression in adults (NG222):](https://www.nice.org.uk/guidance/ng222/)

1.2.13 When depression is accompanied by symptoms of anxiety, which is particularly common in older people, the first priority should usually be to treat the depression. When the person has an anxiety disorder and comorbid depression or depressive symptoms, consult NICE guidance for the relevant anxiety disorder if available and consider treating the anxiety disorder first.

[NICE’s guideline on depression in adults with a chronic physical health problem (CG91):](https://www.nice.org.uk/guidance/cg91/)

1.4.1.1 When depression is accompanied by symptoms of anxiety, the first priority should usually be to treat the depression. When the patient has an anxiety disorder and comorbid depression or depressive symptoms, consult the NICE guideline for the relevant anxiety disorder (see the NICE webpage on depression) and consider treating the anxiety disorder first (since effective treatment of the anxiety disorder will often improve the depression or the depressive symptoms).

[NICE’s guideline on social anxiety disorder (CG159):](https://www.nice.org.uk/guidance/cg159)

1.2.11 If the person also has symptoms of depression, assess their nature and extent and determine their functional link with the social anxiety disorder by asking them which existed first.

* If the person has only experienced significant social anxiety since the start of a depressive episode, treat the depression in line with recommendations in the NICE guideline on depression in adults.
* If the social anxiety disorder preceded the onset of depression, ask: "if I gave you a treatment that ensured you were no longer anxious in social situations, would you still be depressed?"
* If the person answers 'no', treat the social anxiety (unless the severity of the depression prevents this, then offer initial treatment for the depression).
* If the person answers 'yes', consider treating both the social anxiety disorder and the depression, taking into account their preference when deciding which to treat first.

If the depression is treated first, treat the social anxiety disorder when improvement in the depression allows.

#### Existing quality standards

[NICE’s quality standard on anxiety (QS53):](https://www.nice.org.uk/guidance/qs53)

Statement 1: People with a suspected anxiety disorder receive an assessment that identifies whether they have a specific anxiety disorder, the severity of symptoms and associated functional impairment.

This quality standard covers a range of anxiety disorders, including generalised anxiety disorder, social anxiety disorder, post-traumatic stress disorder, panic disorder, obsessive-compulsive disorder and body dysmorphic disorder.

#### Current UK practice

An [audit initiated by the Prescribing Observatory for Mental Health (POMH)](https://journals.sagepub.com/doi/10.1177/2045125320930492) by Paton et al, 2020 highlighted that:

* Of 84% (956) of patients with moderate depression and a documented clinical review, the contribution of comorbid mental illness was considered in 78% (890).
* Of 86% (807) of patients with severe depression and a documented clinical review, the contribution of comorbid mental illness was considered in 75% (704).

### Recognising and supporting communication needs

Stakeholders highlighted that it was important to recognise and support all language, speech and communication needs as part of the initial assessment. Ensuring that they can participate enables them to, for example, express their health needs, and helps to establish an accurate diagnosis and effective treatment planning.

#### Selected recommendations

[NICE’s guideline on depression in adults (NG222):](https://www.nice.org.uk/guidance/ng222/)

1.2.5 If a person has language or communication difficulties (for example, sensory or cognitive impairments or autism), to help identify possible depression consider:

* asking the person 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 person's symptoms.

1.2.14 (extract) When assessing a person with suspected depression

* be aware of any acquired cognitive impairments

if needed, consult with a relevant specialist when developing treatment plans and strategies.

[NICE’s guideline on depression in adults with a chronic physical health problem (CG91):](https://www.nice.org.uk/guidance/cg91/)

1.1.3.4 When assessing a patient with a chronic physical health problem and suspected depression, be aware of any learning disabilities or acquired cognitive impairments, and if necessary consider consulting with a relevant specialist when developing treatment plans and strategies.

1.3.1.5 For patients with significant language or communication difficulties, for example patients with sensory impairments or a learning disability, consider using the Distress Thermometer and/or asking a family member or carer about the patient's symptoms to identify possible depression. If a significant level of distress is identified, investigate further.

#### Current UK practice

The NHS community mental health survey was first conducted in 2004 and forms part of the NHS Patient Survey Programme. The [NHS community mental health survey](https://www.cqc.org.uk/publications/surveys/community-mental-health-survey-2021) (2021) invited responses from adults (aged 18 and over) with at least 1 contact with community mental health services between 1 September and 30 November 2020, with another contact either before, during or after this period. Data from the survey shows that in the previous 12 months, NHS mental health services were reported to have supported people with physical needs. These needs might include an injury, disability or a long condition such as epilepsy:

* 32% reported that this was ‘definitely’ the case.
* 39% reported that they would have liked support.

A limitation of the survey's result is a low response rate (adjusted rate of 26%; (feedback was received from 17,322 adults). A very high proportion of respondents were of white ethnicity although the statistical release reports that no significant differences in experience by ethnicity or social deprivation were identified.

The NCAAD’s [psychological therapies spotlight report - how are secondary care psychological therapy services for adults with anxiety and depression performing?](https://www.hqip.org.uk/resource/national-clinical-audit-of-anxiety-and-depression-psychological-therapies-spotlight-report-2019/) (January 2020) presents findings of an audit of secondary care psychological therapy services, based on case notes of people aged 18 and over who ended psychological therapy between 1 September 2017 and 31 August 2018. Case notes from 30 service users were randomly chosen by the Royal College of Psychiatrists from data submitted by 50 trusts (around 232 services; some trusts registered more than 1 service) between October 2018 and January 2019. Adults who were eligible for the case note audit were also sent a user survey and all therapists at registered services were sent a separate questionnaire. Case notes from 4,462 service users, 662 user survey responses and 1,453 therapists’ questionnaire responses were analysed. The report highlights that:

* 45% of adults who used secondary care psychological therapy services reported that they were not given any choice of having therapy in another language or with an interpreter

13% felt that they were not enough choice in this matter.

The results of the survey of service users was published in a separate NCAAD report ([psychological therapies spotlight report - what are the experiences and perspectives of adults who are accessing secondary care psychological therapy for anxiety or depression?](https://www.hqip.org.uk/resource/national-clinical-audit-of-anxiety-and-depression-psychological-therapies-spotlight-report-2020/) (July 2020) - also referenced in this paper).

### Issues for consideration

**For discussion:**

* What is the priority for improvement within this area: the content of the initial assessment or identifying symptoms of other mental health conditions?
* If a statement on the initial assessment is progressed, how can the content or delivery of the assessment be adjusted to meet the needs of equality groups?
* Supporting adults with additional needs could be included in supporting information if a statement on the initial assessment is progressed.
* There are statements in other quality assessments for anxiety disorders (QS53). What could a statement based on the recommendation in NG222 add? Note that it is a ‘consider’ recommendation.
* Can we develop a specific, measurable statement for this area?

**For decision:**

* Should this area be prioritised for inclusion in the quality standard?
  1. Treatments

### Choice

Stakeholders felt that offering a choice of treatments is an area of quality improvement, highlighting new recommendations in NICE's guideline on depression in adults (NG222). They emphasised the importance of involving adults in decision making to support treatment planning, commenting that choice of the most appropriate treatment correlates with increased engagement. They also commented that offering a choice of treatments would avoid antidepressants being offered as the only option, in particular, for adults with a new episode of less severe depression. See the visual summaries from [NICE’s guideline on depression in adults](https://www.nice.org.uk/guidance/ng222/) in Appendices [2](#_Appendix_2:_Discussing) and [3](#_Appendix_43:_Discussing) for details of treatment for a new episode of less severe or more severe depression respectively.

Stakeholders identified building a trusting relationship with adults with depression, allowing enough time for consultations, involving family members (if agreed with the adult with depression) and providing continuity of care (seeing the same healthcare professional if possible) as key supporting mechanisms for enabling discussion and treatment planning.

Stakeholders commented that to support this area, the full recommended range of psychological therapies would need to be provided in primary care and IAPT settings.

Stakeholders also felt that documenting the rationale for treatments in both primary and secondary care should be improved, highlighting that the mode of psychological therapy is not always recorded. Limitations in coding for interventions were identified as a potential barrier.

#### Selected recommendations

[NICE’s guideline on depression in adults (NG222):](https://www.nice.org.uk/guidance/ng222/)

1.3.1 Discuss with people with depression:

* what, if anything, they think might be contributing to the development of their depression
* whether they have ideas or preferences about starting treatment, and what treatment options they have previously found helpful or might prefer
* their experience of any prior episodes of depression, or treatments for depression

what they hope to gain from treatment.

1.3.2 Allow adequate time for the initial discussion about treatment options, and involve family members, carers or other supporters if agreed by the person with depression.

1.3.3 Help build a trusting relationship with the person with depression and facilitate continuity of care by:

* build a trusting relationship and work in an open, engaging and non‑judgemental manner
* recording their views and preferences so that other practitioners are aware of these details. explore treatment choices (see the recommendations on choice of treatments) in an atmosphere of hope and optimism, explaining the different courses of depression and that recovery is possible

1.3.4 Discuss with people with depression their preferences for treatments (including declining an offer of treatment, or changing their mind once a treatment has started) by providing:

* information on what treatments are NICE-recommended, their potential benefits and harms, any waiting times for treatments, and the expected outcomes (see table 1 and table 2 on the recommended treatments for a new episode of less severe and more severe depression)
* a choice of:
  + the treatments recommended in this guideline
  + how they will be delivered (for example individual or group, in person or remotely) and
  + where they will be delivered
* the option to attend with a family member or friend when possible, for some or all of their treatment
* the option to express a preference for the gender of the healthcare professional, to see a professional they already have a good relationship with, or to change professional if the relationship is not working.

1.3.5 Make a shared decision with the person about their treatment. See the NICE guideline on shared decision making.

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

1.4.2 Match the choice of treatment to meet the needs and preferences of the person with depression. Use the least intrusive and most resource efficient treatment that is appropriate for their clinical needs, or one that has worked for them in the past.

[NICE’s guideline on depression in adults with a chronic physical health problem (CG91):](https://www.nice.org.uk/guidance/cg91/)

1.1.1.1 (extract) When working with patients with depression and a chronic physical health problem and their families or carers:

* build a trusting relationship and work in an open, engaging and non-judgemental manner
* explore treatment options for depression in an atmosphere of hope and optimism, explaining the different courses of depression and that recovery is possible
* explore treatment options for depression in an atmosphere of hope and optimism, explaining the different courses of depression and that recovery is possible.

1.1.1.4 Make all efforts necessary to ensure that a patient with depression and a chronic physical health problem can give meaningful and informed consent before treatment starts. This is especially important when a patient has severe depression or is subject to the Mental Health Act.

1.1.1.5 Ensure that consent to treatment is based on the provision of clear information (which should also be available in written form) about the intervention, covering:

* what it comprises
* what is expected of the patient while having it
* likely outcomes (including any side effects).

1.4.1.3 For patients who, in the judgement of the practitioner, may recover with no formal intervention, or patients with mild depression who do not want an intervention, or patients with subthreshold depressive symptoms who request an intervention:

* discuss the presenting problem(s) and any concerns that the patient may have about them
* provide information about the nature and course of depression
* arrange a further assessment, normally within 2 weeks

make contact if the patient does not attend follow-up appointments.

1.5.1.4 The choice of intervention should be influenced by the:

* duration of the episode of depression and the trajectory of symptoms.
* previous course of depression and response to treatment.
* likelihood of adherence to treatment and any potential adverse effects.
* course and treatment of the chronic physical health problem
* patient's treatment preference and priorities.

#### Existing quality statements

[NICE's quality standard on service user experience in adult mental health services (QS14):](https://www.nice.org.uk/guidance/qs14)

Statement 2: People using mental health services are supported in shared decision making

#### Current UK practice

Findings from the [NHS community mental health survey](https://www.cqc.org.uk/publications/surveys/community-mental-health-survey-2021) (2021) highlighted that:

* 52% (6,571/12,576) reported that they were 'definitely' involved as much as they would like in agreeing what care they will receive.
* 61% (5,056/8,313) felt that they 'definitely' made a decision together with the person they saw, in-person, via video call, and telephone (8% reported 'no').
* 43% (4,187/9,802) reported that they would have liked to receive any NHS talking therapies for mental health needs that did not involve medicines. The proportion has increased yearly since 2018 (37%), within an increase of 5 percentage points since 2020.

57% (5,615) reported that they received NHS talking therapies that did not involve medicines. This declined in 2021; between 2018 to 2020 the score ranged from 61% to 63%.

The survey also contains data on the extent to which people felt they had been involved in decisions about choosing which NHS psychological (talking) therapy would be suitable for them. 57% of respondents to the survey had participated in talking therapies in the previous 12 months (CBT and interpersonal therapy, as stated in the statistical release). The data shows:

* 65% (3,649/5,604) who had attended felt that NHS talking therapies were explained in a way that they could understand. 4% (247) reported that they could not understand the explanation.

50% (2,592/5,228) reported that they were 'definitely' involved as much as they wanted to be in deciding what talking therapies to use; 13% (692) reported 'no' but had wanted to be.

NHS Digital’s [annual report on the use of IAPT services (interactive dashboard - assessment and treatment questionnaires)](https://app.powerbi.com/view?r=eyJrIjoiNmViYTdjM2MtODk0Yi00NTAxLWE5MTUtMGJhZDVhMWM3OWI1IiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9) for 2020/21 shows that of 120,836 responses to a questionnaire about the assessment process:

* 13% reported that they did not receive any information for choosing a treatment appropriate 'to their problem' (86% answered 'yes').
* 72% reported that they had preferred any of the treatments among the available options (26%, 'no').

69% reported they had been offered their preference (8%, 'no').

Of 79,943 responses to the treatment questionnaire 83% reported that they felt involved in making choices about their treatment and care ‘at all times':

* 12% responded that this was the case 'most of the time'.

1% responded that this was 'never' the case.

Not stated, not known or invalid responses account for the remaining percentages.

The NCAAD’s [report on how are inpatient mental health services for people with anxiety and depression performing](https://www.hqip.org.uk/resource/national-clinical-audit-of-anxiety-and-depression-inpatient-mental-health-services/) (October 2019) highlights that of the 91% of service users had a care plan, 18% did not develop it jointly with the clinician.

The NCAAD’s [psychological therapies spotlight report](https://www.hqip.org.uk/resource/national-clinical-audit-of-anxiety-and-depression-psychological-therapies-spotlight-report-2019/) (January 2020) highlighted that, before their therapy began:

* 62% agreed they received enough information.
* 56% agreed they were given enough choice about the type of therapy.
* 24% reported they were not given any choice about the type of therapy.
* 76% discussed their agreed goals for therapy.

74% discussed their previous therapy and experiences with their therapist.

### New episode of less severe depression

Stakeholders suggested that offering a choice of recommended low-intensity psychological interventions as first-line treatment is a priority for this population. They highlighted the 'top 5' recommended first-line interventions (see the visual summary on discussing first-line treatments for less severe depression from [NICE’s guideline on depression in adults](https://www.nice.org.uk/guidance/ng222/) in [Appendix 2](#_Appendix_2:_Discussing)). They suggested that QS8 statement 4 could be updated to reflect that a broader range of psychological therapies should now be offered as first-line treatment.

Not offering antidepressants to adults with a new episode of less severe depression as a first-line treatment unless it is their preference as a first-line treatment, and following discussion of low intensity psychosocial interventions (in accordance with NICE guidance) was suggested as a specific quality improvement area. The area is covered by QS8 statement 3. Stakeholders noted that this statement would need to be updated to reflect updated recommendations in NG222 to emphasise the importance of discussing alternative treatments.

#### Selected recommendations

[NICE’s guideline on depression in adults (NG222):](https://www.nice.org.uk/guidance/ng222/)

1.5.2 Discuss treatment options with people with a new episode of less severe depression, and match their choice of treatment to their clinical needs and preferences:

* use table 1 and the visual summary (to guide and inform the conversation
* take into account that all treatments in table 1 can be used as first-line treatments, but consider the least intrusive and least resource intensive treatment first (guided self-help)
* reach a shared decision on a treatment choice appropriate to the person's clinical needs, taking into account their preferences (see also the recommendations on choice of treatments)

recognise that people have a right to decline treatment

1.5.3 Do not routinely offer antidepressant medication as first-line treatment for less severe depression, unless that is the person's preference.

[NICE’s guideline on depression in adults with a chronic physical health problem (CG91):](https://www.nice.org.uk/guidance/cg91/)

1.4.2.1 For patients with persistent subthreshold depressive symptoms or mild to moderate depression and a chronic physical health problem, and for patients with subthreshold depressive symptoms that complicate the care of the chronic physical health problem, consider offering one or more of the following interventions, guided by the patient's preference:

* a structured group physical activity programme
* a group-based peer support (self-help) programme
* individual guided self-help based on the principles of cognitive behavioural therapy (CBT)

computerised cognitive behavioural therapy (CCBT).

1.4.3.1 Do not use antidepressants routinely to treat subthreshold depressive symptoms or mild depression in patients with a chronic physical health problem (because the risk–benefit ratio is poor), but consider them for patients with:

* a past history of moderate or severe depression or
* mild depression that complicates the care of the physical health problem or
* initial presentation of subthreshold depressive symptoms that have been present for a long period (typically at least 2 years) or

subthreshold depressive symptoms or mild depression that persist(s) after other interventions.

#### Existing quality statements

[NICE’s guideline on depression in adults (QS8):](https://www.nice.org.uk/guidance/qs8)

Statement 4. People with persistent subthreshold depressive symptoms or mild to moderate depression receive appropriate low-intensity psychosocial interventions.

Statement 5: People with persistent subthreshold depressive symptoms or mild depression are prescribed antidepressants only when they meet specific clinical criteria in accordance with NICE guidance.

#### Current UK practice

An [online survey about depression, antidepressants and withdrawal: implementing the 2019 PHE report](https://doi.org/10.1177%2F2045125320950124) (Read et al, 2020) completed by 66 UK GPs highlighted that in terms of treatment approaches for 'minimal/mild' depression:

* 13% 'always' provided social prescribing (including self-help books); 3% 'never' did, and 46%, 'most of the time'.
* 8% 'always' referred people a counsellor, psychotherapist or psychologist; 6% 'never' did, and 22%, most of the time.
* 3% always referred to computerised CBT (such as 'Beating the Blues'); 25% 'never' did, and 14%, 'most of the time'.
* 5% 'always' provided a 'psychological intervention' themselves; 30% 'never', and 14%, most of the time.

The study also highlighted that 98% of the GPs who responded to the survey felt that talking therapies should be made equally accessible (available) as pharmacological treatments.

In terms of treatment approaches for ‘mild/moderate’ depression regarding antidepressants:

* 0% reported that they 'always' prescribe antidepressants, with 14% 'never' doing so, and 2% 'most of the time'.

In terms of perceived efficacy of antidepressants, in different circumstances, for moderate/severe depression:

* Only 5% felt that they were 'very effective'
* 28% felt that they were 'somewhat effective, and 31%, 'not at all'.
* 43% 'strongly agreed' and 40% 'agreed' that 'the current rate of antidepressant prescribing (1 in 6 adults in England)' was 'too high'. Only 2% 'disagreed'.

[PHE’s dependence and withdrawal associated with some prescribed medicines](https://www.gov.uk/government/publications/prescribed-medicines-review-report) (2019) report highlighted that 17% of adults in England had been dispensed 1 or more prescriptions for antidepressants during 2017 and 2018. Analysis highlighted:

* The rate of prescribing for antidepressants increased from 15.8% of the adult population to 16.6% between 2015 to 2016 and 2017 to 2018.

Large variations in the standardised rates of prescribing across CCGs.

Although antidepressant prescribing had a weaker association with deprivation, the proportion of patients who had at least a year of prescriptions increased with higher deprivation.

An [online survey about depression, antidepressants and withdrawal: implementing the 2019 PHE report](https://doi.org/10.1177%2F2045125320950124) (Read et al, 2020) highlighted that for ‘minimal/mild’ depression:

* 0% of UK GPs who responded to the survey 'always' prescribe antidepressants, with 14% 'never' doing so and 2% 'most of the time'.
* 71% reported that they did so 'sometimes'.
* 69% reported that they spent 10 to 20 minutes with a patient when they first prescribed antidepressants.
* 23% reported that they spent less than 10 minutes with a patient when they first prescribed antidepressants.

None took more than 31 to 45 minutes, or more than 45 minutes, when they first prescribed antidepressants.

In terms of perceived efficacy of antidepressants, in different circumstances, the study responses showed that:

* only 5% felt antidepressants were 'very effective' for 'minimal/mild' depression; 37% felt they were 'slightly effective', and 31%, 'not at all'.

29% felt that they were 'very effective' for 'short-term treatment of depression (less than a year)', 48% felt they were 'somewhat effective' and 8%, 'not at all'.

No published studies on current practice were highlighted for chronic depression; this area is based on stakeholder’s knowledge and experience.

### Severe, chronic, comorbid depression

Stakeholders suggested that offering recommended interventions for adults with a new episode of more severe depression. It was noted that this area would update QS8, statements 6 and 7.

They highlighted that the 'top 5' recommended interventions for a new episode of more severe depression are a combination of antidepressant with individual CBT, individual CBT, individual BA, antidepressant medication, using recommended methods (see the visual summary for discussing first-line treatment for more severe depression from [NICE’s guideline on depression in adults](https://www.nice.org.uk/guidance/ng222/) in [Appendix 3).](#_Appendix_3:_Discussing) They also commented that it was important to make a choice of recommended psychological therapies, not only CBT, available in secondary care and inpatient settings.

They also proposed that offering recommended interventions to adults with severe depression and a chronic physical health problem is a quality improvement area. They noted that this would update QS8 statement 8.

Stakeholders felt that a quality statement based on new recommendations in NG222 for chronic depressive symptoms should be developed to support their implementation. Offering cognitive behaviour therapy which focuses specifically on residual symptoms and covers relevant remaining processes such as rumination was a specific suggestion (see the visual summary for relapse prevention from [NICE’s guideline on depression in adults](https://www.nice.org.uk/guidance/ng222/) in [Appendix 5](#_Appendix_5:_Chronic) for the care pathway).

Stakeholders suggested that ensuring offering adults with depression and comorbid personality disorder a range of psychological therapies in secondary care is a quality improvement area (see the visual summary for chronic depression and depression with personality disorder from [NICE’s guideline on depression in adults](https://www.nice.org.uk/guidance/ng222/) in [Appendix 6](#_Appendix_6:_Chronic) for the care pathway).

Administration of ECT in accordance with NICE guidance, legislation and the need for awareness of potential overuse among older women was a further suggestion (see the visual summary for further-line treatments from [NICE’s guideline on depression in adults](https://www.nice.org.uk/guidance/ng222/) in [Appendix 4](#_Appendix_4:_Further-line_1)).

#### Selected recommendations

[NICE’s guideline on depression in adults (NG222):](https://www.nice.org.uk/guidance/ng222/)

1.6.1 Discuss treatment options with people who have a new episode of more severe depression, and match their choice of treatment to their clinical needs and preferences:

* use table 2 and the visual summary to guide and inform the conversation
* take into account that all treatments in table 2 can be used as first-line treatments
* reach a shared decision on a treatment choice appropriate to the person's clinical needs, taking into account their preferences (see also the recommendations on choice of treatments)

recognise that people have a right to decline treatment.

1.10.2 For people who present with chronic depressive symptoms that significantly impair personal and social functioning and who have not received previous treatment for depression, treatment options include:

* CBT or
* SSRIs (selective serotonin reuptake inhibitor) or
* SNRIs (serotonin–norepinephrine reuptake inhibitors) or
* TCAs (tricyclic antidepressant; be aware that TCAs are dangerous in overdose, although lofepramine has the best safety profile) or

combination therapy with CBT and either an SSRI or a TCA.

Discuss the options with the person and reach a shared decision on treatment choice, based on their clinical needs and preferences (see also the recommendations on choice of treatments).

1.10.3 For people with chronic depressive symptoms, offer cognitive behavioural treatment that:

* has a focus on chronic depressive symptoms
* covers related maintaining processes, including avoidance, rumination and interpersonal difficulties.

1.11.2 For people with depression and a diagnosis of personality disorder consider a combination of antidepressant medication and a psychological treatment (for example, BA, CBT, IPT or STPP). To help people choose between these psychological treatments, see the information on them provided in table 1 and table 2.

(BA is behavioural activation).

1.11.4 For people with depression and a diagnosis of personality disorder, consider referral to a specialist personality disorder treatment programme. See the NICE guideline on borderline personality disorder for recommendations on treatment for borderline personality disorder with coexisting depression.

1.13.1 Consider electroconvulsive therapy (ECT) for the treatment of severe depression if:

* the person chooses ECT in preference to other treatments based on their past experience of ECT and what has previously worked for them or
* a rapid response is needed (for example, if the depression is life‑threatening because the person is not eating or drinking) or
* other treatments have been unsuccessful (see the recommendations on further-line treatment).

1.13.2 (extract) Make sure people with depression who are going to have ECT are fully informed of the risks, and of the risks and benefits specific to them. Take into account:

* if the person is older, the possible increased risk associated with ECT treatment for this age group.

1.13.6 Clinics should only provide ECT if they:

* are Electroconvulsive Therapy Accreditation Service (ECTAS) accredited
* provide ECT services in accordance with ECTAS standards
* submit data, including outcomes, on each course of acute and maintenance ECT they deliver as needed for the ECTAS minimum dataset

Follow the ECT Accreditation Service Standards for Administering ECT.

1.13.7 Trusts which provide ECT services should ensure compliance with the ECTAS standards for administering ECT through board-level performance management.

[NICE’s guideline on depression in adults with a chronic physical health problem (CG91):](https://www.nice.org.uk/guidance/cg91/)

1.5.1.1 For patients with persistent subthreshold depressive symptoms or mild to moderate depression and a chronic physical health problem who have not benefited from a low-intensity psychosocial intervention, discuss the relative merits of different interventions with the patient and provide:

* an antidepressant (normally a selective serotonin reuptake inhibitor [SSRI]) or
* one of the following high-intensity psychological interventions:
* group-based CBT or
  + individual CBT for patients who decline group-based CBT or for whom it is not appropriate, or where a group is not available or
  + behavioural couples therapy for people who have a regular partner and where the relationship may contribute to the development or maintenance of depression, or where involving the partner is considered to be of potential therapeutic benefit.

1.5.1.2 For patients with initial presentation of moderate depression and a chronic physical health problem, offer the following choice of high-intensity psychological interventions:

* group-based CBT or
* individual CBT for patients who decline group-based CBT or for whom it is not appropriate, or where a group is not available or
* behavioural couples therapy for people who have a regular partner and where the relationship may contribute to the development or maintenance of depression, or where involving the partner is considered to be of potential therapeutic benefit.

1.5.1.3 For patients with initial presentation of severe depression and a chronic physical health problem, consider offering a combination of individual CBT and an antidepressant.

1.5.3.1 (extract) For all high-intensity psychological interventions, the duration of treatment should normally be within the limits indicated in this guideline. As the aim of treatment is to obtain significant improvement or remission the duration of treatment may be:

increased if progress is being made, and there is agreement between the practitioner and the patient with depression that further sessions would be beneficial (for example, if there is a comorbid personality disorder or psychosocial factors that impact on the patient's ability to benefit from treatment).

1.6.1.1 Practitioners providing treatment in specialist mental health services for patients with complex and severe depression and a chronic physical health problem should:

* refer to the NICE guideline on depression in adults
* be aware of the additional drug interactions associated with the treatment of patients with both depression and a chronic physical health problem (see recommendations 1.5.2.6 to 1.5.2.16)

work closely and collaboratively with the physical health service.

#### Existing quality statements

[NICE’s quality standard on in depression in adults (QS8):](https://www.nice.org.uk/guidance/qs8)

Statement 6: People with moderate or severe depression (and no existing chronic physical health problem) receive a combination of antidepressant medication and either high-intensity cognitive behavioural therapy or interpersonal therapy.

Statement 7: People with moderate depression and a chronic physical health problem receive an appropriate high-intensity psychological intervention.

Statement 8: People with severe depression and a chronic physical health problem receive a combination of antidepressant medication and individual cognitive behavioural therapy.

[NICE’s quality standard on personality disorders (QS88):](https://www.nice.org.uk/guidance/qs88)

Statement 3: People with borderline personality disorder are offered psychological therapies and are involved in choosing the type, duration and intensity of therapy.

#### Current UK practice

An [online survey about depression, antidepressants and withdrawal: implementing the 2019 PHE report](https://doi.org/10.1177%2F2045125320950124) (Read et al, 2020) highlighted that for moderate/severe depression’:

* 30% 'always' recommended self-referral to IAPT; 13% 'never' did and 30% did so 'most of the time'.
* 25% 'always' provided social prescribing (including self-help books, exercise, nutrition); 6% 'never' did, and 29%, 'most of the time'.
* 16% 'always' referred people a counsellor, psychotherapist or psychologist; 5% 'never' did, and 31%, most of the time.
* 6% always referred to computerised CBT (such as 'Beating the Blues'); 37% 'never' did , and 6%, 'most of the time'.

9% 'always' provided a 'psychological intervention' themselves; 37% 'never', an 13%, most of the time.

In terms of treatment approaches for 'moderate/severe' depression regarding antidepressants:

* 8% reported that they 'always' prescribe antidepressants, with 0% 'never' doing so, and 62% 'most of the time'.
* 9% reported that they did so 'sometimes'.

In terms of perceived efficacy of antidepressants, in different circumstances, for moderate/severe depression:

* 25% felt that they were 'very effective' for 'moderate' or 'severe' depression; 68% felt that they were 'somewhat effective, and 3%, 'not at all'.

43% 'strongly agreed' and 40% 'agreed' that 'the current rate of antidepressant prescribing (1 in 6 adults in England)' was 'too high'. Only 2% 'disagreed'.

The NCAAD’s [report on how are inpatient mental health services for people with anxiety and depression performing](https://www.hqip.org.uk/resource/national-clinical-audit-of-anxiety-and-depression-inpatient-mental-health-services/) (October 2019) highlight that:

* Only 39% service users were offered psychological therapies.
* 77% of these therapies were delivered in NHS secondary care and 13% in IAPT (7%, ‘other’).
* 47% who had started therapy were receiving a type of psychological therapy recommended by NICE for their diagnosis.

A recommendation of the report was that trusts should investigate the reasons for low referral rates.

Around 43% (of 3,795) of the service users in the audit had a comorbid diagnosis, among the 2 most common being personality disorder (11%, 416). The most common is mental and behavioural disorders due to psychoactive substance use (14%, 543).

No published studies on current practice were highlighted for chronic depression; this area is based on stakeholder’s knowledge and experience.

A 2019 independent audit by [Read et al (2021)](https://doi.org/10.1111/papt.12335) of responses to Freedom of Information requests from 37 trusts (out of 56 approached) in England highlighted:

* A 47-fold variation in rates of administration

In 20 of the 35 trusts which provided information on gender, 67% of people who received ECT were women, and in 20 trusts, twice as many women received ECT as men.

### Improving physical health

Stakeholders suggested that improving physical health of adults with 'moderate or severe' depression through early intervention is a priority. Supporting reduction of smoking, alcohol and drug use were highlighted as specific areas. Stakeholders also commented on the increased prevalence of these health behaviours in this population, highlighting their increased risk of poorer outcomes, such as premature mortality. They also commented that they felt poorer outcomes were linked to poorer levels of access to healthcare and healthcare improvement activities.

#### Selected recommendations

[NICE’s guideline on depression in adults (NG222):](https://www.nice.org.uk/guidance/ng222/)

1.4.42 Advise people that doing any form of physical activity on a regular basis (for example, walking, jogging, swimming, dance, gardening) could help enhance their sense of wellbeing. The benefits can be greater if this activity is outdoors.

1.4.43 Advise people that maintaining a healthy lifestyle (for example, eating a healthy diet, not over-using alcohol, getting enough sleep) may help improve their sense of wellbeing. See the also the NHS advice on mental wellbeing.

[NICE's guideline on depression in adults with a chronic physical health problem (CG91):](https://www.nice.org.uk/guidance/cg91/)

1.4.1.2 Offer patients with depression and a chronic physical health problem advice on sleep hygiene if needed, including:

* establishing regular sleep and wake times
* avoiding excess eating, smoking or drinking alcohol before sleep
* creating a proper environment for sleep

taking regular physical exercise where this is possible for the patient.

#### Existing quality statements

[NICE's quality standard on tobacco: treating dependence - draft quality standard (update of QS43 and QS92):](https://www.nice.org.uk/guidance/indevelopment/gid-qs10153)

Statement 1: People are asked at key points of contact with a healthcare professional if they smoke or use smokeless tobacco. [2013, updated 2022]

Statement 2: People who smoke or use smokeless tobacco receive advice on quitting. [2013, updated 2022]

[NICE's quality standard on coexisting severe mental illness and substance misuse (QS188):](https://www.nice.org.uk/guidance/qs188)

Statement 1: People aged 14 and over with suspected or confirmed severe mental illness are asked about their use of alcohol and drugs.

Note: severe episodes of depression with or without psychosis are covered by this statement.

[NICE's quality standard on alcohol use disorders - update in progress (QS11):](https://www.nice.org.uk/guidance/qs11)

Statement 2: Health and social care staff opportunistically carry out screening and brief interventions for hazardous (increasing risk) and harmful (high-risk) drinking as an integral part of practice.

#### Current UK practice

An [online survey about depression, antidepressants and withdrawal: implementing the 2019 PHE report](https://doi.org/10.1177%2F2045125320950124) (Read et al, 2020) highlighted that in relation to social prescribing (exercise, nutrition, social activity, self-help books etc) that for ‘minimal/moderate’ depression:

* 13% 'always' did so
* 46% did 'most of the time'
* 17% 'about half the time'
* 21% ‘sometimes’
* 3% never'.

For ‘moderate/severe’ depression’:

* 25% 'always' did so
* 29% did 'most of the time'
* 19% 'about half the time'
* 21% ‘sometimes’

6% ‘never'.

NHS Digital’s [Psychological Therapies, Annual report on the use of IAPT services, 2020-21: additional analyses of therapy based outcomes – executive summary](https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2020-21) shows that for more than half of courses of structured physical activity were given as a second or subsequent course of therapy.

The NCAAD's [report on how inpatient mental health services for people with anxiety and depression performing](https://www.hqip.org.uk/resource/national-clinical-audit-of-anxiety-and-depression-inpatient-mental-health-services/) (October 2019) highlights that as part of their assessment and treatment (with support, advice or onward referral offered where appropriate):

* BMI was documented in 70% of people, and 29% were offered an intervention.
* Smoking status was documented for 84% of people, and 47% were offered an intervention.
* Alcohol intake was documented for 83% of people, and 35% were offered an intervention.

Substance abuse was documented in 91% of people, and 34% were offered an intervention.

A limitation of this data is that it does not distinguish between advice given at an initial assessment or during treatment.

Issues for consideration

**For discussion:**

* What is the priority for quality improvement?
* A general statement on offering a choice of treatment options or one focusing on a particular population?
* No published current UK practice data identified for chronic depression.
* What should a statement on improving physical health through early intervention focus on? At what time point(s) is this typically delivered?
* What is the key action that will lead to improvement?
* Can we develop a specific, measurable statement?

**For decision:**

* Should this area be prioritised for inclusion in the quality standard?
  1. Monitoring, reassessment, relapse prevention and remission

### Monitoring

Stakeholders suggested that monitoring pharmacological treatment is a quality improvement area. Supporting safe prescribing practice for antidepressants and monitoring antipsychotics for side-effects were highlighted as specific areas.

#### Selected recommendations

[NICE’s guideline on depression in adults (NG222):](https://www.nice.org.uk/guidance/ng222/)

1.4.3 (extract) For all people with depression having treatment:

* review how well the treatment is working with the person between 2 and 4 weeks after starting treatment
* monitor for side effects and harms of treatment

1.4.11 (extract) When prescribing antidepressant medication, ensure people have information about:

* when their first review will be; this will usually be within 2 weeks to check their symptoms are improving and for side effects, or after 1 week if a new prescription is for a person aged 18 to 25 years or if there is a particular concern for risk of suicide (see recommendations on antidepressant medication for people at risk of suicide)
* why regular monitoring is needed, and how often they will need to attend for review
* that treatment might need to be taken for at least 6 months after the remission of symptoms, but should be reviewed regularly

how some side effects may persist throughout treatment

1.4.36 Carry out monitoring as indicated in the summary of product characteristics for individual medicines, for people who take an antipsychotic for the treatment of their depression. This may include:

* monitoring full blood count, urea and electrolytes, liver function tests and prolactin
* monitoring their weight weekly for the first 6 weeks, then at 12 weeks, 1 year and annually
* monitoring their fasting blood glucose or HbA1c and fasting lipids at 12 weeks, 1 year, and then annually
* ECG monitoring (at baseline and when final dose is reached) for people with established cardiovascular disease or a specific cardiovascular risk (such as diagnosis of high blood pressure) and for those taking other medicines known to prolong the cardiac QT interval (for example, citalopram or escitalopram)
* at each review, monitoring for adverse effects, including extrapyramidal effects (for example, tremor, parkinsonism) and prolactin-related side effects (for example, sexual or menstrual disturbances) and reducing the dose if necessary
* being aware of any possible drug interactions which may increase the levels of some antipsychotics, and monitoring and adjusting doses if necessary

if there is rapid or excessive weight gain, or abnormal lipid or blood glucose levels, investigating and managing as needed.

[NICE's guideline on depression in adults with a chronic physical health problem (CG91):](https://www.nice.org.uk/guidance/cg91/)

1.5.2.19 For patients started on antidepressants who are not considered to be at increased risk of suicide, normally see them after 2 weeks. See them regularly thereafter, for example at intervals of 2 to 4 weeks in the first 3 months, and then at longer intervals if response is good.

1.5.2.21 If a patient with depression and a chronic physical health problem develops side effects early in antidepressant treatment, provide appropriate information and consider one of the following strategies:

* monitor symptoms closely where side effects are mild and acceptable to the patient or
* stop the antidepressant or change to a different antidepressant if the patient prefers or
* in discussion with the patient, consider short-term concomitant treatment with a benzodiazepine if anxiety, agitation and/or insomnia are problematic, but:
* do not offer benzodiazepines to patients with chronic symptoms of anxiety
* use benzodiazepines with caution in patients at risk of falls

in order to prevent the development of dependence, do not use benzodiazepines for longer than 2 weeks.

[NICE's guideline on medicines associated with dependence or withdrawal symptoms (NG215)](https://www.nice.org.uk/guidance/ng215)

1.4.1 Offer regular reviews (by phone, video or face to face) to people taking an opioid, benzodiazepine, gabapentinoid, Z-drug or antidepressant. Base the frequency of reviews on:

* the person's preferences and circumstances
* the type of medicine they are taking and the dose
* factors that might indicate a need for frequent reviews, for example if:
* the person has additional care needs (such as people with a learning disability or cognitive impairment)
* the person is taking the medicine for the first time
* there are potential adverse effects or problems associated with dependence
* the medicine is being used outside its licensed indications

there is potential for misuse of the medicine.

1.4.2 Consider increasing the frequency of reviews during dose adjustment. Take into account the person's clinical and support needs when agreeing review frequency.

1.4.3 Offer extra, unscheduled reviews when needed, for example if the person:

* reports adverse effects from the medicine
* becomes pregnant or is planning pregnancy
* has a change in their physical or mental health condition, or social circumstances
* starts taking medicines from a different prescriber

requests a change in dose.

[NICE's guideline on medicines optimisation (NG5)](https://www.nice.org.uk/guidance/ng5):

1.4.3 During a structured medication review, take into account:

* the person's, and their family members or carers where appropriate, views and understanding about their medicines
* the person's, and their family members' or carers' where appropriate, concerns, questions or problems with the medicines
* all prescribed, over-the-counter and complementary medicines that the person is taking or using, and what these are for
* how safe the medicines are, how well they work for the person, how appropriate they are, and whether their use is in line with national guidance
* whether the person has had or has any risk factors for developing adverse drug reactions (report adverse drug reactions in line with the yellow card scheme)

any monitoring that is needed.

#### Existing quality standards

[NICE's quality standard on depression in adults (QS8):](https://www.nice.org.uk/guidance/qs8)

Statement 11: People with depression whose treatment consists solely of antidepressants are regularly reassessed at intervals of at least 2 to 4 weeks for at least the first 3 months of treatment.

Quality and Outcomes Framework:

[DEP003](https://qof.digital.nhs.uk/): The percentage of patients with a new diagnosis of depression in the preceding 1 April to 31 March who have been reviewed within 10-35 days of the date of diagnosis

#### Current UK practice

NHS Digital’s [QOF data](https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data) (2019-20) for DEP003 highlights that 64.48% of patients aged 18 or over with a new diagnosis of depression were reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis. Counting personalised care adjustments, the achievement rate for England was 82.04%.

Data from the [NHS community mental health survey](https://www.cqc.org.uk/publications/surveys/community-mental-health-survey-2021) (2021) show:

* 63% (8,362/13,374) reported that the purpose of their medicines had been discussed with them; 6% replied that they had not. This has improved since 2019 and 2020 (57% and 59% respectively).
* a small increase in 2021 and 2020 (43%; in 2021 5,674/13,123) compared to 2019 (41%) in the proportion of people who reported they had the possible side effects of their medicines explained. 24% (3,203) did not in 2021 (compared to 24% in 2020 and 26% in 2019).
* almost a quarter (24%) who had received their medicines for 12 months or longer had not had their medicines reviewed in the last 12 months, which is a greater proportion than in 2020 (21%) and 2019 (22%).

although 76% (8,133/10,716) reported they had their medicines reviewed in the last 12 months, this is the lowest proportion since 2014 (78%, and lower than in 2020, 79%, and 2019, 78%).

The NCAAD's [how are inpatient mental health services for people with anxiety and depression performing](https://www.hqip.org.uk/resource/national-clinical-audit-of-anxiety-and-depression-inpatient-mental-health-services/" \l ".YxOhdMjMI2w) (October, 2019) highlighted that 87% people had their psychotropic medication reviewed prior to discharge, of whom:

* 38% were not advised of the side effects of their medication.

20% did not have their response to medication reviewed.

### Reassessment

Stakeholders felt that reassessment is an area for quality improvement. This enables the treatment plan to be reviewed and a discussion of adding or switching interventions if response to treatment has been poor. Augmenting pharmacological treatment with lithium was a specific suggestion.

They also highlighted the importance of documenting a treatment history to inform evidence-based treatment. They also commented on the importance of using health outcome data to guide and adjust treatment planning.

Stakeholders commented that statement 12 in QS8 could be retained, but that the timeframe would need adjusting to align with the updated NICE guideline on depression NG222 (to 4 to 6 weeks, from 6 to 8 weeks).

#### Selected recommendations

[NICE’s guideline on depression in adults (NG222):](https://www.nice.org.uk/guidance/ng222/)

1.9.1 If a person's depression has not responded at all after 4 weeks of antidepressant medication at a recognised therapeutic dose, or after 4 to 6 weeks for psychological therapy or combined medication and psychological therapy, discuss with them:

* whether there are any personal, social or environmental factors or physical or other mental health conditions that might explain why the treatment is not working
* whether they have had problems adhering to the treatment plan (for example, stopping or reducing medication because of side effects, or missing sessions with their therapist).

If any of these are the case, make a shared decision with the person about the best way to try and address any problems raised, including how other agencies may be able to help with these factors. See the visual summary on further-line treatment.

1.9.4 If a person's depression has had no or a limited response to treatment with psychological therapy alone, and no obvious cause can be found and resolved, discuss further treatment options with the person (including what other treatments they have found helpful in the past) and make a shared decision on how to proceed based on their clinical need and preferences. Options include:

* switching to an alternative psychological treatment
* adding an SSRI to the psychological therapy

switching to an SSRI alone.

1.9.5 If a person's depression has had no or a limited response to treatment with antidepressant medication alone, and no obvious cause can be found and resolved, discuss further treatment options with the person and make a shared decision on how to proceed based on their clinical need and preferences. Options include:

* adding a group exercise intervention
* switching to a psychological therapy (see the suggested treatment options for more severe depression)
* continuing antidepressant therapy by either increasing the dose or changing the drug. For example, by:
  + increasing the dose of the current medication (within the licensed dose range) if the medication is well tolerated; be aware that higher doses of antidepressants may not be more effective and can increase the frequency and severity of side effects; ensure follow-up and frequent monitoring of symptoms and side effects after dose increases.
  + switching to another medication in the same class (for example, another SSRI)
  + switching to a medication of a different class (for example, an SSRI, SNRI) or in secondary care a TCA or MAOI (monoamine oxidase inhibitor); take into account that:
    - switching medication may mean cross-tapering is needed; see the NICE clinical knowledge summary on switching antidepressants
    - switching to or from an MAOI, or from one MAOI to another, will need to take place in, or with advice from, secondary care
    - TCAs are dangerous in overdose, although lofepramine has the best safety profile

changing to a combination of psychological therapy (for example, CBT, interpersonal psychotherapy [IPT] or short-term psychodynamic psychotherapy [STPP] and medication.

Consider whether some of these decisions and treatments need other services to be involved (for example, specialist mental health services for advice on switching antidepressants).

1.9.6 If a person's depression has had no or a limited response to treatment with a combination of antidepressant medication and psychological therapy, discuss further treatment options with the person and make a shared decision on how to proceed based on their clinical need and preferences. Options include:

* switching to another psychological therapy
* increasing the dose or switching to another antidepressant (see recommendation 1.9.5)

adding in another medication (see recommendation 1.9.9).

1.9.9 If a person with depression wants to try a combination treatment and is willing to accept the possibility of an increased side-effect burden (see recommendation 1.9.8), consider referral to a specialist mental health setting or consulting a specialist. Treatment options include:

* adding an additional antidepressant medication from a different class (for example, adding mirtazapine or trazodone to an SSRI)
* combining an antidepressant medication with a second-generation antipsychotic (for example, aripiprazole, olanzapine, quetiapine or risperidone) or lithium
* augmenting antidepressants with electroconvulsive therapy (see the recommendations on electroconvulsive therapy for depression), lamotrigine, or triiodothyronine (liothyronine).
* Be aware that some combinations of classes of antidepressants are potentially dangerous and should be avoided (for example, a SSRI, SNRI or TCA with a MAOI), and that when using an antipsychotic the effects of this on depression, including loss of interest and motivation, should be carefully reviewed.

In June 2022, this was an off-label use for some antipsychotics, lamotrigine, and triiodothyronine (liothyronine). See NICE's information on prescribing medicines.

[NICE's guideline on depression in adults with a chronic physical health problem (CG91):](https://www.nice.org.uk/guidance/cg91/)

1.1.4.1 (extract) All interventions for depression should be delivered by competent practitioners. Psychological and psychosocial interventions should be based on the relevant treatment manual(s), which should guide the structure and duration of the intervention. Practitioners should consider using competence frameworks developed from the relevant treatment manual(s) and for all interventions should:

* use routine outcome measures and ensure that the patient with depression is involved in reviewing the efficacy of the treatment

1.5.2.24 If the patient's depression shows no improvement after 2 to 4 weeks with the first antidepressant, check that the drug has been taken regularly and in the prescribed dose.

1.5.2.25 If response is absent or minimal after 3 to 4 weeks of treatment with a therapeutic dose of an antidepressant, increase the level of support (for example, by weekly face-to-face or telephone contact) and consider:

* increasing the dose in line with the summary of product characteristics if there are no significant side effects or

switching to another antidepressant as described in section 1.8 of the NICE guideline on depression in adults if there are side effects or if the patient prefers.

1.5.2.26 If response is absent or minimal after 3 to 4 weeks of treatment with a therapeutic dose of an antidepressant, increase the level of support (for example, by weekly face-to-face or telephone contact) and consider:

* increasing the dose in line with the summary of product characteristics if there are no significant side effects or

switching to another antidepressant as described in section 1.8 of the NICE guideline on depression in adults if there are side effects or if the patient prefers.

1.5.2.27 When switching from 1 antidepressant to another, be aware of:

* the need for gradual and modest incremental increases in dose
* interactions between antidepressants

the risk of serotonin syndrome (features include confusion, delirium, shivering, sweating, changes in blood pressure and myoclonus) when combinations of serotonergic antidepressants are prescribed.

1.5.2.28 If an antidepressant has not been effective or is poorly tolerated:

* consider offering other treatment options, including high-intensity psychological treatments

prescribe another single antidepressant (which can be from the same class) if the decision is made to offer a further course of antidepressants.

#### [Existing quality statements](https://www.nice.org.uk/guidance/qs8)

[NICE's quality standard on depression in adults (QS8):](https://www.nice.org.uk/guidance/qs8)

Statement 3: Practitioners delivering pharmacological, psychological or psychosocial interventions for people with depression record health outcomes at each appointment and use the findings to adjust delivery of interventions.

Statement 12: People with depression that has not responded adequately to initial treatment within 6 to 8 weeks have their treatment plan reviewed.

#### Current UK practice

An [audit initiated by the Prescribing Observatory for Mental Health (POMH)](https://journals.sagepub.com/doi/10.1177/2045125320930492) by Paton et al, 2020 highlighted that comprehensive treatment histories were available for 50% of patients with moderate (504) and severe depression (411).The study also highlighted that:

* Those with severe depression were more likely than those with moderate depression to have been prescribed antidepressant medication often in combination with an antipsychotic medication (78% compared to 47%).

Only 1 in 5 of adults with a comprehensive treatment history documented had received a trial of lithium augmentation.

The IAPT service routinely collects activity and outcome data. Adoption of the session-by-session outcome monitoring has enabled services to obtain outcome data on 98.5% of all patients who have a course of treatment (National Collaborating Centre for Mental Health (2018) [Improving Access to Psychological Therapies manual](https://www.england.nhs.uk/publication/the-improving-access-to-psychological-therapies-manual/)). NHS Digital’s [annual report on the use of IAPT services (interactive dashboard - treatment questionnaires)](https://app.powerbi.com/view?r=eyJrIjoiNmViYTdjM2MtODk0Yi00NTAxLWE5MTUtMGJhZDVhMWM3OWI1IiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9) for 2020-21 shows that:

* 1% reported that they never felt involved in making choices about their treatment and care.

83% reported that they felt involved ‘at all times’ and 12%, ‘most of the time’.

Whether views vary between sessions is not stated.

The NCAAD’s [psychological therapies spotlight report](https://www.hqip.org.uk/resource/national-clinical-audit-of-anxiety-and-depression-psychological-therapies-spotlight-report-2019/) (January 2020) highlighted that, before their therapy began:

* In 50% of cases there was evidence of an outcome being used at least once.
* There was evidence of an outcome being used on 2 or more occasions in only 34% of cases.
* 26% percent of adults reported that they did not discuss their progress with their therapist.
* A range of validated measures were used. 15% (the greatest proportion) of completed initial measures used the Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM). The Patient Health Questionnaire-9 (PHQ-9), mentioned as an example in NICE's updated guideline on depression and used in IAPT services, accounted for 10%.

### Relapse prevention

Stakeholders suggested that adults coming to the end of psychological treatment are an important group to focus on. They also proposed offering high quality psychological therapies that include relapse prevention work before an adult is discharged from psychological therapy, to reduce current variation in treatment options is a priority.

Stakeholders suggested that statement 10 in QS8 could be retained to address this quality improvement area. A further suggestion was that statements 10 and 13 should be updated to reflect the updated NICE guideline on depression in adults.

#### Selected recommendations

[NICE’s guideline on depression in adults (NG222):](https://www.nice.org.uk/guidance/ng222/)

1.4.9 When people are nearing the end of a course of psychological treatment, discuss ways in which they can maintain the benefits of treatment and ensure their ongoing wellness.

1.8.1 Discuss with people that continuation of treatment (antidepressants or psychological therapies) after full or partial remission may reduce their risk of relapse and may 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. See the visual summary on preventing relapse.

1.8.3 Discuss with people the potential risks of continuing with antidepressants long term, and how these balance against the risks of depression relapse. These include:

* possible side effects, such as an increased bleeding risk or long-term effects on sexual function
* difficulty stopping antidepressants.

1.8.4 If a person chooses not to continue antidepressant medication for relapse prevention, advise them:

* how to stop their antidepressant medication (see the recommendations on stopping antidepressant medication) and

to seek help as soon as possible if the symptoms of depression return or residual symptoms worsen.

1.8.5 For people who have remitted from depression when treated with antidepressant medication alone, but who have been assessed as being at higher risk of relapse, consider:

* 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 (group CBT or mindfulness-based cognitive therapy [MBCT]) for people who do not wish to continue on antidepressants (follow the recommendations on stopping antidepressants) or

continuing with their antidepressant medication and a course of psychological therapy (group CBT or MBCT).

1.8.6 For people starting group CBT or MBCT for relapse prevention, offer a course of therapy with an explicit focus on the development of relapse prevention skills and what is needed to stay well. This usually consists of 8 sessions over 2 to 3 months with the option of additional sessions in the next 12 months.

1.8.7 Relapse prevention components of psychological interventions 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.

1.8.8 Discuss with people who have remitted from depression when treated with a psychological therapy alone, but who have been assessed as being at higher risk of relapse, whether they wish to continue with their psychological therapy for relapse prevention. Reach a shared decision on further treatment.

1.8.9 Discuss with people who have remitted from depression when treated with a combination of an antidepressant medication and psychological therapy, but who have been assessed as being at higher risk of relapse, whether they wish to continue 1 or both treatments. Reach a shared decision on further treatment.

1.8.10 Continue the same therapy for people who wish to stay on a psychological therapy for relapse prevention (either alone or in combination with an antidepressant), adapted by the therapist for relapse prevention. This should include at least 4 more sessions of the same treatment with a focus on a relapse prevention component (see recommendation 1.8.7) and what is needed to stay well.

1.8.11 Review treatment for people continuing with antidepressant medication to prevent relapse at least every 6 months. At each review:

* monitor their mood using a validated rating scale (see the [recommendations on delivery of treatments](https://www.nice.org.uk/guidance/ng222/chapter/recommendations#delivery-of-treatments))
* review any side effects
* review any medical, personal, social or environmental factors that may affect their risk of relapse, and encourage them to access help from other agencies

discuss with them if they wish to continue treatment; if they wish to stop antidepressant treatment, see the [recommendations on stopping antidepressant medication](https://www.nice.org.uk/guidance/ng222/chapter/recommendations#stopping-antidepressant-medication).

1.8.12 Reassess the risk of relapse for people who continue with psychological therapy to prevent relapse, when they are finishing the relapse prevention treatment, and assess the need for any further follow up.

[NICE’s guideline on depression in adults with a chronic physical health problem (CG91):](https://www.nice.org.uk/guidance/cg91/)

1.5.2.22 Support and encourage a patient with a chronic physical health problem who has benefited from taking an antidepressant to continue medication for at least 6 months after remission of an episode of depression. Discuss with the patient that:

* this greatly reduces the risk of relapse

antidepressants are not associated with addiction.

1.5.2.23 Review with the patient with depression and a chronic physical health problem the need for continued antidepressant treatment beyond 6 months after remission, taking into account:

* the number of previous episodes of depression
* the presence of residual symptoms

concurrent physical health problems and psychosocial difficulties.

1.5.3.1 For all high-intensity psychological interventions, the duration of treatment should normally be within the limits indicated in this guideline. As the aim of treatment is to obtain significant improvement or remission the duration of treatment may be:

* reduced if remission has been achieved
* increased if progress is being made, and there is agreement between the practitioner and the patient with depression that further sessions would be beneficial (for example, if there is a comorbid personality disorder or psychosocial factors that impact on the patient's ability to benefit from treatment).

1.5.3.3 (extract) Individual CBT for patients with moderate depression and a chronic physical health problem should be:

followed up by 2 further sessions in the 6 months after the end of treatment, especially if treatment was extended.

1.5.3.4 (extract) Individual CBT for patients with severe depression and a chronic physical health problem should be:

* followed up by 2 or 3 further sessions in the 12 months after the end of treatment.

#### Existing quality statements

[NICE’s quality standard on depression in adults (QS8):](https://www.nice.org.uk/guidance/qs8)

Statement 10: People with depression who benefit from treatment with antidepressants are advised to continue with treatment for at least 6 months after remission, extending to at least 2 years for people at risk of relapse.

Statement 13: People who have been treated for depression who have residual symptoms or are considered to be at significant risk of relapse receive appropriate psychological interventions.

#### Current UK practice

[A mixed-methods qualitative study (68 interviews across 40 UK NHS sites and 10 case studies)](http://dx.doi.org/10.1136/bmjopen-2018-026244) by Rycroft-Malone et al (2019) investigated the accessibility and implementation of mindfulness CBT (MBCT) to support people at risk of relapse in their long-term recovery. The settings were primary and secondary care mental health services. Stakeholders from 40 service providers (including users) were interviewed about current provision of MBCT and 10 were sampled to provide case studies to enable a more detailed understanding of implementation of MBCT. The study highlighted that:

* Access and the format of delivery of this evidence-based intervention is variable across the NHS.
* Only a small minority of examples were of ‘top–down’ facilitation, where service commissioners or managers instigated and drove implementation, although there were a few notable exceptions.
* Integration into care pathways was variable, even within a single area.
* The majority of people who accessed MCBT were known to the service and were referred on.
* Increasingly, sites were accepting self-referrals.
* Some reports suggested that GPs were less likely to refer straight to an MCBT service.
* 34 out of the 40 NHS sites offered services that did not fully match NICE recommendations of the time.

Limitations of the study are that services which were most invested in MBCT implementation were overrepresented and the research team has an interest and affiliation to both the MBCT intervention and the conceptual framework (Promoting Action on Research Implementation in Health Services (PARIHS) framework) which underpinned the study. The latter was mitigated by obtaining views from sceptics, and public patient involvement and study advisory groups and transparency of the research methods. Note: the data were collected between 2013 to 2015.

NHS Digital’s [annual report on the use of IAPT services (interactive dashboard –– post-treatment follow-up rates](https://app.powerbi.com/view?r=eyJrIjoiNmViYTdjM2MtODk0Yi00NTAxLWE5MTUtMGJhZDVhMWM3OWI1IiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9) (2020 to 2021) shows that a very small percentage of 327,081 referrals where treatment was finished in the first 6 months, 0.6% (1,906) had follow up. The percentages were extremely low across commissioning regions, the greatest being in the south east (2%) and east of England (1%).

Data from the [NHS community mental health survey](https://www.cqc.org.uk/publications/surveys/community-mental-health-survey-2021) (2021) shows that 85% (11,480/13,492) reported that they had been receiving medicines (unspecified) for their mental health needs for 12 months or longer. This has not improved since 2018. In 2014 to 2017 it was only slightly higher, at 86% to 87%.

A limitation of this data is that it covers all prescriptions of 12 months or longer, including those who may need to take antidepressants on a longer basis for relapse prevention and the duration is patient-reported.

The NCAAD’s [psychological therapies spotlight report - what are the experiences and perspectives of adults who are accessing secondary care psychological therapy for anxiety or depression?](https://www.hqip.org.uk/resource/national-clinical-audit-of-anxiety-and-depression-psychological-therapies-spotlight-report-2020/) (July 2020) highlighted that, in relation to recovery, service users felt that:

* well-managed endings to therapy were characterised by discussion before the end of therapy and being signposted to other forms of support.
* the importance of a formal assessment of further needs before therapy is completed.
* the process takes time, is not predictable, and varies according to the individual.
* Poor communication was most commonly at the end of treatment, and instances of users not being told whether they were discharged or what would happen after the end of therapy were highlighted.

Public Health England’s [dependence and withdrawal associated with some prescribed medicines](https://www.gov.uk/government/publications/prescribed-medicines-review-report) highlighted that:

* 82% who started a prescription of antidepressants in June 2015 were estimated to have received it for 3 months or fewer.
* 930,000 people received a prescription for antidepressants continuously between 2015 and 2018 (and possibly prior to 2018).

A limitation of this report and is that it does not discuss those who have prescriptions specifically for relapse prevention.

An [online survey about depression, antidepressants and withdrawal: implementing the 2019 PHE report](https://doi.org/10.1177%2F2045125320950124) (Read et al, 2020) highlighted that only 15% (n=65) of GPs felt that antidepressants were ‘very effective’ as long-term treatment of depression (1 year or more); 62% felt that they were ‘slightly effective’ and 6%, ‘not at all effective’.

### Stopping antidepressants

Stakeholders proposed that tapering over months, and not stopping them suddenly when stopping antidepressants, to reduce the risk of withdrawal symptoms, is a quality improvement area.

#### Selected recommendations

[NICE's guideline on depression in adults (NG222](https://www.nice.org.uk/guidance/ng222)):

1.8.4 If a person chooses not to continue antidepressant medication for relapse prevention, advise them:

* how to stop their antidepressant medication (see the recommendations on stopping antidepressant medication) and
* to seek help as soon as possible if the symptoms of depression return or residual symptoms worsen.

1.4.13 Advise people taking antidepressant medication to talk with the person who prescribed their medication (for example, their primary healthcare or mental health professional) if they want to stop taking it. Explain that it is usually necessary to reduce the dose in stages over time (called 'tapering') but that most people stop antidepressants successfully.

1.4.15 Explain to people taking antidepressant medication that:

* withdrawal symptoms can be mild, may appear within a few days of reducing or stopping antidepressant medication, and usually go away within 1 to 2 weeks
* withdrawal can sometimes be more difficult, with symptoms lasting longer (in some cases several weeks, and occasionally several months)

withdrawal symptoms can sometimes be severe, particularly if the antidepressant medication is stopped suddenly

1.4.16 Recognise that people may have fears and concerns about stopping their antidepressant medication (for example, the withdrawal effects they may experience, or that their depression will return) and may need support to withdraw successfully, particularly if previous attempts have led to withdrawal symptoms or have not been successful. This could include:

* details of online or written resources that may be helpful

increased support from a clinician or therapist (for example, regular check-in phone calls, seeing them more frequently, providing advice about sleep hygiene).

1.4.17 When stopping a person's antidepressant medication:

* take into account the pharmacokinetic profile (for example, the half-life of the medication as antidepressants with a short half-life will need to be tapered more slowly) and the duration of treatment
* slowly reduce the dose to zero in a step-wise fashion, at each step prescribing a proportion of the previous dose (for example, 50% of previous dose)
* consider using smaller reductions (for example, 25%) as the dose becomes lower
* if, once very small doses have been reached, slow tapering cannot be achieved using tablets or capsules, consider using liquid preparations if available
* ensure the speed and duration of withdrawal is led by and agreed with the person taking the prescribed medication, ensuring that any withdrawal symptoms have resolved or are tolerable before making the next dose reduction
* take into account the broader clinical context such as the potential benefit of more rapid withdrawal if there are serious or intolerable side effects (for example, hyponatraemia or upper gastrointestinal tract bleeding)
* take into account that more rapid withdrawal may be appropriate when switching antidepressants
* recognise that withdrawal may take weeks or months to complete successfully.

1.4.18 Monitor and review people taking antidepressant medication while their dose is being reduced, both for withdrawal symptoms and the return of symptoms of depression. Base the frequency of monitoring on the person's clinical and support needs.

[NICE's guideline on depression in adults with a chronic physical health problem (CG91):](https://www.nice.org.uk/guidance/cg91/)

1.5.2.29 Advise patients with depression and a chronic physical health problem who are taking antidepressants that discontinuation symptoms may occur on stopping, missing doses or, occasionally, on reducing the dose of the drug. These include increased mood change, restlessness, difficulty sleeping, unsteadiness, sweating, abdominal symptoms and altered sensations. Explain that symptoms are usually mild and self-limiting over about 1 week, but can be severe, particularly if the drug is stopped abruptly.

1.5.2.30 When stopping an antidepressant, gradually reduce the dose, normally over a 4-week period, although some patients may require longer periods, particularly with drugs with a shorter half-life (such as paroxetine and venlafaxine). This is not required with fluoxetine because of its long half-life.

1.5.2.31 Inform the patient that they should seek advice from their practitioner if they experience significant discontinuation symptoms. If discontinuation symptoms occur:

* monitor symptoms and reassure the patient if symptoms are mild

consider reintroducing the original antidepressant at the dose that was effective (or another antidepressant with a longer half-life from the same class) if symptoms are severe, and reduce the dose gradually while monitoring symptoms.

[NICE’s guideline on medicines associated with dependence or withdrawal symptoms (NG215):](https://www.nice.org.uk/guidance/ng215)

1.5.7 When planning withdrawal from an opioid, benzodiazepine, gabapentinoid, Z‑drug or antidepressant, take into account:

* the urgency of the withdrawal, for example gradual withdrawal of a medicine that is no longer effective or necessary, or more rapid withdrawal of a medicine that is causing significant harm (the speed of rapid withdrawal depends on the type of medicine and the person's circumstances, see recommendation 1.5.6)
* whether the initial goal should be complete withdrawal or, for people who find complete withdrawal too difficult, whether dose reduction with ongoing review is a more realistic initial aim
* which medicine to reduce first, if the person will be withdrawing from more than 1 medicine
* factors that might increase the person's risk of problems during withdrawal, including:
  + long duration of medicine use
  + high dose of medicine
  + history of withdrawal symptoms
  + history of problems associated with dependence
  + taking an antidepressant with a short half-life
* any concurrent medicines and how these might affect the person's response to withdrawal

factors that might influence the timing of the start of the dose reduction, such as the person's circumstances and available support.

#### UK current practice

[Data from the](https://repository.uel.ac.uk/item/84718) [[NHS community mental health survey](https://repository.uel.ac.uk/item/84718)](https://www.cqc.org.uk/publications/surveys/community-mental-health-survey-2021) [(2021) shows that 63% (8,362/13,374) reported that the purpose of their medicines had been discussed with them; 6% (861) replied that they had not. This has improved since 2019 and 2020 (57% and 59% respectively).](https://repository.uel.ac.uk/item/84718)

[A survey of 752 adults in the UK who had taken antidepressants, but no other psychiatric drugs, in the last 2 years](https://repository.uel.ac.uk/item/84718) (Read et al, 2018) reports responses of a convenience sample of adult users of psychiatric medicines who had taken antidepressants but no psychiatric drugs in relation to the process of trying to withdraw from antidepressants and had completed the Medications for Mental Health Survey (designed by Mind) online in the UK.

* 34% of participants had come off antidepressants
* 36% had tried and failed
* Of those still taking them, 76% had been taking antidepressants for at least a year, and 36% for 5 or more years.
* 26% of people expected to be taking antidepressants forever.
* 65% had never had a discussion about coming off. The study also notes that 48% did not have their drugs reviewed at least every 3 months.
* 45% had stopped taking antidepressants without first consulting their doctor (GP or psychiatrist).

The study also highlighted that:

* 68% took less than 3 months to come off, 20.6% took between 3 and 6 months, 6.1% took between 6 and 12 months and 5.3% took longer than a year.
* 29.4% reported that they found it 'not very easy at all' to come off, and 20.0% reported they found it 'very easy'.

The most common reasons for not respondents not discussing coming off antidepressants was that they felt they could do so without their doctor's help (52.6%). 29.8% felt that their doctor would not support them and 27.2% felt that their doctor does not listen. Further, the 35% who discussed coming off antidepressants did not describe their doctor to have been supportive of it.

An [online survey about depression, antidepressants and withdrawal: implementing the 2019 PHE report](https://doi.org/10.1177%2F2045125320950124) (Read et al, 2020) highlighted that:

* 36% initiated discussion around coming off antidepressants every 3 or 6 months (both). 3% replied that they 'never' did, 11% once a month and 17%, annually.
* Regardless of whether adults had been on antidepressants for either 3 months, more than 1 year, or more than 3 years, about 1 in 4 (n=63 responses) reported that they believed that withdrawal effects are experienced by no more than 10% after 3 months (27%), after 1 year (24%), or after 3 years (24%).
* Most (83%) felt that the prescribing rate of antidepressants was too high.

Issues for consideration

**For discussion:**

* What is the priority for quality improvement: monitoring, reassessment, relapse prevention or stopping antidepressants?
* If prioritised, should a statement on monitoring focus on antidepressants or antipsychotics?
* If prioritised, a statement on reassessment can refer to recording treatment outcomes in the measures (existing statement 3). Note that we would not progress recording treatment outcomes as a separate statement, as our approach has changed since QS8 published.
* Should statement 10 (continuing antidepressants) be refocused to highlight the need for review? The timescale of extending use to 2 years is not mentioned in NICE’s guideline on depression in adults.
* Can a statement on relapse prevention cover both populations covered by NICE’s guidelines on depression in adults and depression in adults with a chronic physical health problem?
* What is the key action that will lead to improvement?
* Can we develop a specific, measurable statement?

**For decision:**

* Should this area be prioritised for inclusion in the quality standard?
  1. Service delivery

### Access and quality of care

Stakeholders proposed the following to support timely access to assessment and psychological treatments, commenting that delays are associated with poorer outcomes:

* pathways that enable seamless navigation, including through different geographical areas to ensure timely access to treatment.
* assessment should be measured against a standard of ‘within 4 weeks of referral’ for a psychological intervention.
* all treatments should be started within 6 weeks

no more than a certain percentage (to be determined by the committee) of appointments should be delivered within 90 days (approximately 12 weeks).

Stakeholders felt that reducing 'did not attend' rates need to be reduced, commenting that there is a link between poorer outcomes and missed appointments. It was suggested that text messaging could be used to help reduce the proportion of missed appointments.

It was proposed that supporting people on waiting lists to start psychological therapy is a priority.

Stakeholders also highlighted the importance of delivering evidence-based treatments, raising a concern that the number of sessions recommended by NICE for psychological therapies were not always delivered, including when recovery had not already been achieved and relapse-prevention interventions delivered.

#### Selected recommendations

[NICE’s guideline on depression in adults (NG222):](https://www.nice.org.uk/guidance/ng222/)

1.4.4 Inform people if there are waiting lists for a course of treatment and how long the wait is likely to be (for example, the NHS constitution advises that treatment should be started within 18 weeks). Keep in touch with people at regular intervals, ensure they are aware of how to access help if their condition worsens, ensure they are made aware of who they can contact about their progress on the waiting list. Consider providing self-help materials and addressing social support issues in the interim.

1.4.5 Use psychological and psychosocial treatment manuals to guide the form, duration and ending of interventions.

1.16.1 Commissioners and providers of mental health services should consider using models such as stepped care or matched care for organising the delivery of care and treatment of people with depression.

Pathways should:

* promote easy access to, and uptake of, the treatments covered
* allow for prompt assessment of adults with depression, including assessment of severity and risk
* ensure coordination and continuity of care, with agreed protocols for sharing information support the integrated delivery of services across primary and secondary care, to ensure individuals do not fall into gaps in service provision
* have clear criteria for entry to all levels of a stepped care service

have routine collection of data on access to, uptake of and outcomes of the specific treatments in the pathway.

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

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 people who wish to access and are able to access services in this way).

#### Current UK practice

NHS Digital’s annual report on the use of IAPT services ([annual interactive dashboard – key activity – England (referrals received) and waiting times for referrals entering treatment and waiting times for finishing treatment](https://app.powerbi.com/view?r=eyJrIjoiNmViYTdjM2MtODk0Yi00NTAxLWE5MTUtMGJhZDVhMWM3OWI1IiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9)) for 2020/21 shows waiting times for referrals to IAPT services that enter and finish treatment. Referrals which enter, rather than finish treatment, consist of an assessment, advice and signposting. Referrals which finish treatment are referrals for which 2 or more sessions are delivered.

National waiting time targets are:

* 95% of referrals entering treatment within 18 weeks, which is the standard in the Department of Health and Social Care’s (2012, updated 2021) [NHS Constitution](https://www.gov.uk/government/publications/the-nhs-constitution-for-england).
* 75% enter treatment within 6 weeks (Department of Health, 2015, [The mandate from the Government to NHS England, April 2015 to March 2016](https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-report-on-the-use-of-iapt-services/april-2021-final-including-reports-on-the-iapt-pilots/waiting-times)).

The [NHS long term plan](https://www.longtermplan.nhs.uk/) states that a target of a 4-week wait will be tested in community mental health teams.

| **Referrals** | **Total** | **Average wait time (days)** | **<= 28 days** | **>90 days** | **<18 weeks** | **% wait time within 6 weeks** | **% wait time within 18 weeks** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Entering treatment – waiting time to first treatment | 1,024,014 | 17.9 | 869,697 | 21,532 | 1,010,718 | Reported locally | Reported locally |
| Entering treatment – waiting time between first to second treatments | 1,024,014 | 33.2 | 336,729 | 38,246 | 532,014 | Reported locally | Reported locally |
| Finishing treatment – waiting time to first treatment | 634,649 | 21.1 | 513,499 | 19,973 | 622,012 | 90% (571,035) | See below (for April 2021) |
| Finishing treatment – waiting time between first and second treatments | 634,649 | 53.2 | 318,638 | 112,087 | 565,541 | 62.6% (396,992) | See below (for April 2021) |

[The Psychological Therapies: reports on the use of IAPT services, England April 2021 Final including reports on the IAPT pilots](https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-report-on-the-use-of-iapt-services/april-2021-final-including-reports-on-the-iapt-pilots/waiting-times) (April 2021) reports that both targets were consistently exceeded each month April 2020 to April 2021 inclusive, particularly the 6-week target. For April 2021:

* 98.9% (of referrals which completed treatment) entered treatment within 18 weeks.
* 92.8% (of referrals which completed treatment) entered treatment within 6 weeks.

This data is largely representative of that for the other months, although the percentage of referrals that entered treatment within 6 weeks was below 90% April to August 2020 (ranged from 86.2% to 89.1%). The percentage of referrals that entered treatment within 18 weeks was slightly lower, April to October 2020 (ranging from 97.4% to 97.9%).

NHS Digital’s annual report on the use of IAPT services ([annual interactive dashboard – other activity in the year](https://app.powerbi.com/view?r=eyJrIjoiNmViYTdjM2MtODk0Yi00NTAxLWE5MTUtMGJhZDVhMWM3OWI1IiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9)) for 2020/21 shows that:

* 412,449 out of 1,439,603 referrals that had ended did so before treatment.
* Only 2 commissioning regions had fewer than 50,000 of referrals which ended before treatment (the south west and east of England); the north west had more than 90,500.

Data from the [NHS community mental health survey](https://www.cqc.org.uk/publications/surveys/community-mental-health-survey-2021) (2021) shows that:

* 42% (2,843/4,999) felt the waiting time before receiving NHS talking therapies was 'too long'.
* 41% (6,818/16,479) felt that they had 'definitely' seen services enough for their needs.

27% (4,509/16,479) reported that they had not seen services when they needed them in the last 12 months.

The NCAAD’s [psychological therapies spotlight report - what are the experiences and perspectives of adults who are accessing secondary care psychological therapy for anxiety or depression?](https://www.hqip.org.uk/resource/national-clinical-audit-of-anxiety-and-depression-psychological-therapies-spotlight-report-2020/) (July 2020) highlighted that users felt that they waited too long to begin therapy, and that the time they spent on waiting lists could be extremely stressful.

National Collaborating Centre for Mental Health (2018), [Improving Access to Psychological Therapies manual](https://www.england.nhs.uk/publication/the-improving-access-to-psychological-therapies-manual/) notes that services vary considerably in the percentage of clinical appointments that people miss without notifying the service in advance and that services with higher rates of missed appointments have worse overall outcomes.

NHS Digital’s [annual report on the use of IAPT services in England](https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2020-21) (2020-2021) highlights that the average number of sessions delivered was 7.5 (an increase from 6.9 in 2019-20). The [additional analyses of therapy based outcomes – executive summary](https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2020-21) presents data on the average number of appointments by therapy type (referrals finishing a course of treatment). It highlights that 8.1 sessions were given on average for ‘cognitive behaviour therapy’ (8 is recommended) but that the average number of sessions for some interventions was below the recommended number, including for guided self-help (4.3 - computer, 4.6 - book) and behavioural activation (4.0 – low intensity, 3.9 – high-intensity) treatments. The recommended number is 6 to 8 (for guided self-help), 8 (for group behavioural activation) and 12 (for individual behavioural activation).

The NCAAD’s [psychological therapies spotlight report - what are the experiences and perspectives of adults who are accessing secondary care psychological therapy for anxiety or depression?](https://www.hqip.org.uk/resource/national-clinical-audit-of-anxiety-and-depression-psychological-therapies-spotlight-report-2020/) (July 2020) highlighted a lack of communication before starting therapy, including when it would begin.

The NCAAD’s [psychological therapies spotlight report](https://www.hqip.org.uk/resource/national-clinical-audit-of-anxiety-and-depression-psychological-therapies-spotlight-report-2019/#.YxM7FsjMI2w) (January 2020) highlighted that:

* An average of 13 sessions was received.
* Of those who received NICE-recommended therapy because they completed treatment, 63% ended therapy because they had completed it.

20% dropped out of treatment, 6% were referred to another service/therapy and 5% declined treatment.

No published studies on current UK practice were highlighted for supporting adults waiting to start psychological treatments; this area is based on stakeholder’s knowledge and experience.

### Multidisciplinary support and care

Stakeholders felt that delivery of multidisciplinary care is a quality improvement area, to support communication needs of adults with complex needs, including complex brain injury, to support their communication needs. This reflects that talking therapies are delivered through language and interactions and adults with additional communication or language need specialist support.

There was some support for retaining statement 9, on collaborative care, in QS8, although some stakeholders commented that measurement of achievement may be challenging.

#### Selected recommendations

[NICE's guideline on depression in adults (NG222):](https://www.nice.org.uk/guidance/ng222/)

1.16.2 (extract) Commissioners and providers of mental health services for people with depression should ensure the effective delivery of treatments. This should build on the key functions of a catchment area-based community mental health service and be provided in the context of a coordinated primary and secondary care mental health service, as well as community services (for example social care, education, housing, statutory services and the voluntary and social enterprise sector). This should include:

* collaboration between professionals

delivery of interventions for personal, social and environmental factors (for example, housing problems, isolation and unemployment).

1.16.3 (extract) Commissioners and providers of primary and secondary care mental health services should ensure support is in place so integrated services can be delivered by:

* individual practitioners (including primary care healthcare professionals), providing treatments, support or supervision
* mental health staff, for team-based treatments in primary care for the majority of people with depression
* mental health specialists, providing advice, consultation and support for primary care mental health staff

specialist-based mental health teams, for people with severe and complex needs.

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

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 people).

1.16.6 (extract) When promoting access and uptake of services, identify and address the needs of groups who may have difficulty in accessing, or face stigma or discrimination when using some or all mental health services. This may include:

* people with learning disabilities or acquired cognitive impairments (see the NICE guideline on mental health problems in people with learning disabilities)
* people with physical or sensory disabilities, who may need reasonable adjustments to services as defined by legislation to enable this access; see the Equality Act 2010
* people who have conditions which compromise their ability to communicate.

1.16.7 Consider collaborative care for people with depression, particularly older people, those with significant physical health problems or social isolation, or those with more chronic depression not responding to usual specialist care.

1.16.8 Collaborative care for people with depression should comprise:

* patient-centred assessment and engagement
* symptom measurement and monitoring
* medication management (a plan for starting, reviewing and discontinuing medication)
* active care planning and follow up by a designated case manager
* delivery of psychological and psychosocial treatments within a structured protocol
* integrated care of both physical health and mental health
* joint working with primary and secondary care colleagues
* involvement of other agencies that provide support

supervision of practitioners by an experienced mental health professional.

1.16.9 Refer people with more severe depression or chronic depressive symptoms, to specialist mental health services for coordinated multidisciplinary care if:

* their depression significantly impairs personal and social functioning and
* they have not benefitted from previous treatments, and either
* have multiple complicating problems, for example unemployment, poor housing or financial problems or
* have significant coexisting mental and physical health conditions.

1.16.10 Deliver multidisciplinary care plans for people with more severe depression or chronic depressive symptoms (either of which significantly impairs personal and social functioning) and multiple complicating problems, or significant coexisting conditions that:

* are developed together with the person, their GP and other relevant people involved in their care (with the person's agreement), and that a copy in an appropriate format is offered to the person
* set out the roles and responsibilities of all health and social care professionals involved in delivering the care
* include information about 24-hour support services, and how to contact them
* include a crisis plan that identifies potential crisis triggers, and strategies to manage those triggers and their consequences
* are updated if there are any significant changes in the person's needs or condition
* are reviewed at agreed regular intervals

include medication management (a plan for starting, reviewing and discontinuing medication).

[NICE's guideline on depression in adults with a chronic physical health problem (CG91):](https://www.nice.org.uk/guidance/cg91/)

1.1.4.3 Where a patient's management is shared between primary and secondary care, there should be clear agreement between practitioners (especially the patient's GP) on the responsibility for the monitoring and treatment of that patient. The treatment plan should be shared with the patient and, where appropriate, with their family or carer.

1.1.4.4 If a patient's chronic physical health problem restricts their ability to engage with a preferred psychosocial or psychological treatment for depression (see sections 1.4.2, 1.5.1 and 1.5.3), consider alternatives in discussion with the patient, such as antidepressants (see section 1.5.2) or delivery of psychosocial or psychological interventions by telephone if mobility or other difficulties prevent face-to face contact.

1.4.2.4 (extract) Individual guided self-help programmes based on the principles of CBT (and including behavioural activation and problem-solving techniques) for patients with persistent subthreshold depressive symptoms or mild to moderate depression and a chronic physical health problem, and for patients with subthreshold depressive symptoms that complicate the care of the chronic physical health problem, should:

include the provision of written materials of an appropriate reading age (or alternative media to support access)

1.5.4.1 Consider collaborative care for patients with moderate to severe depression and a chronic physical health problem with associated functional impairment whose depression has not responded to initial high-intensity psychological interventions, pharmacological treatment or a combination of psychological and pharmacological interventions.

1.5.4.2 Collaborative care for patients with depression and a chronic physical health problem should normally include:

* case management which is supervised and has support from a senior mental health professional
* close collaboration between primary and secondary physical health services and specialist mental health services
* a range of interventions consistent with those recommended in this guideline, including patient education, psychological and pharmacological interventions, and medication management

long-term coordination of care and follow-up.

#### Existing quality statements

[NICE's quality standard on depression (QS8)](https://www.nice.org.uk/guidance/qs8/):

Statement 9: People with moderate to severe depression and a chronic physical health problem with associated functional impairment, whose symptoms are not responding to initial interventions, receive collaborative care.

#### Current UK practice

23 speech and language therapists (SLTs) working in a range of SLT settings participated in 6 focus groups, 1 per NHS trust site, in a study by [Northcott et al, 2017](https://openaccess.city.ac.uk/id/eprint/17216/). The timeframe for data collection was not provided. The survey investigated their perceptions of barriers and facilitators to working with mental health professionals. Key findings include:

* There was wide variation in the extent to which mental health professionals

(MHPs) were perceived to provide an aphasia-accessible service.

* The need for collaborative working between SLTs and mental health professionals.
* Services requiring telephone self-referral (for example, community-based well-being services) excluded many people with aphasia.
* Provision of talking therapy was perceived to be rare.

When the person with aphasia was reliant on mainstream community services were rarely accessible for people with aphasia and that good mobility may be required to access them.

NHS Digital’s [Psychological Therapies, Annual report on the use of IAPT services, 2020-21: annual interactive dashboard (key activity by variable)](https://app.powerbi.com/view?r=eyJrIjoiNmViYTdjM2MtODk0Yi00NTAxLWE5MTUtMGJhZDVhMWM3OWI1IiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9) dashboard shows that:

* 37.3% of referrals which no disability was recorded as finishing treatment, but rates were much lower for people with a recorded disability. People with a speech-related disability had the lowest rate (0.1%).
* A disability code was not recorded for 47.8% of completed treatments (and 3.1% or less for 'not stated' person declined to answer, 'other' or 'invalid code').

Data from the [NHS community mental health survey](https://www.cqc.org.uk/publications/surveys/community-mental-health-survey-2021) (2021) shows that:

* 72% (9,997/13,849) reported that they had been told who would organise their care and services (examples given were care coordinator or lead professional). The proportion has declined yearly since 2015 and 2016 (76%), and has not changed since 2019.
* 21% (2,111/10,031) reported that GP was responsible for organising their care and services but the majority (76%, 7,626) it was an NHS healthcare professional or social worker.
* 6% replied they didn’t know or weren’t sure (632).

The data also shows that:

* Only 58% (4,501/7,807) thought that they did this ‘very well’.
* 3% (232) reported that it was done ‘not at all well’.

The data also shows that in terms of other forms of support:

* Only 27% reported that they had ‘definitely’ received help or advice to find financial advice or benefits (2,367/8,808), the lowest proportion since 2014 (32%).
* 96% (7,433/7,746) reported they knew how to contact this person if they had a concern about their care.
* 25% (1,153/4,666) reported that they ‘definitely been given help or advice with finding support for finding work (paid or voluntary). This question has been included in the survey since 2020.

NHS Digital’s [Psychological Therapies, Annual report on the use of IAPT services, 2020-21: additional analyses of therapy based outcomes – executive summary](https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2020-21) shows that:

* An average of 3.3 sessions was delivered for collaborative care.
* Over 90% of courses of collaborative care were given as a first course of therapy.

IAPT data includes data on the number of referrals with an integrated care contact and the percentage which moved to recovery. NHS Digital’s [Psychological Therapies: reports on the use of IAPT services, England Final including a report on the IAPT Employment Advisers pilot - Interactive dashboard](https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-report-on-the-use-of-iapt-services/june-2022-final-including-a-report-on-the-iapt-employment-advisers-pilot) (June 2022) shows that:

* 14,980 referrals had an integrated care contact

47.8% removed to recovery, compared to 49.5% of all referrals.

The national recovery rate standard is that a minimum of 50% of eligible referrals should move to recovery; Collaborating Centre for Mental Health’s (2018) [Improving Access to Psychological Therapies manual](https://www.england.nhs.uk/publication/the-improving-access-to-psychological-therapies-manual/).

### Reducing barriers to access and uptake

Stakeholders also highlighted that variation in pathway entry thresholds may result in some people not accessing treatment.

Stakeholders highlighted people from a Black, Asian and minority ethnic family backgrounds and women are important groups to focus on, commenting that access to care and their experiences need to be improved given their greater risk of developing depression.

Providing culturally appropriate models of treatment and services was suggested an area for quality improvement for groups who are at a higher risk of depression, which may restrict their choice of treatment:

* older people

Adults from Black, Asian and minority ethnic family backgrounds, who are at greater risk of poorer treatment outcomes than their white peers.

#### Selected recommendations

[NICE's guideline on depression in adults (NG222):](https://www.nice.org.uk/guidance/ng222/)

1.1.1 (extract) When working with people with depression and their families or carers:

* be aware that stigma and discrimination can be associated with a diagnosis of depression
* be aware that the symptoms of depression itself, and the impact of stigma and discrimination, can make it difficult for people to access mental health services or take up offers of treatment

ensure steps are taken to reduce stigma, discrimination and barriers for individuals seeking help for depression (for example, reducing judgemental attitudes, showing compassion, parity of esteem between mental illness and physical illness, treating people as individuals).

1.1.3 Provide people with depression with up-to-date and evidence-based verbal and written information about depression and its treatment, appropriate to their language, cultural and communication needs. Follow the sections on communication and information in the NICE guideline on patient experience in adult NHS services.

1.2.15 (extract) When providing interventions for people with an acquired cognitive impairment who have a diagnosis of depression:

* if possible, provide the same interventions as for other people with depression

if needed, adjust the method of delivery or length of the intervention to take account of the person's ability to communicate, disability or impairment.

1.4.1 (extract) When considering treatments for people with depression:

* address any barriers to the delivery of treatments due because of any disabilities, language or communication difficulties.

ensure regular liaison between healthcare professionals in specialist and non-specialist settings, if the person is receiving specialist support or treatment.

1.16.4 Commissioners and providers of mental health services should ensure that accessible, inclusive and culturally adapted information about the pathways into treatment and different explanatory models of depression is available, for example in different languages and formats and in line with NHS England's Accessible Information Standard.

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

* services delivered in culturally appropriate or culturally adapted language and formats
* 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 people)

bilingual therapists or independent translators.

1.16.6 (extract) When promoting access and uptake of services, identify and address the needs of groups who may have difficulty in accessing, or face stigma or discrimination when using some or all mental health services. This may include:

* older people
* people from black, Asian and minority ethnic communities

[NICE's guideline on depression in adults with a chronic physical health problem (CG91):](https://www.nice.org.uk/guidance/cg91/)

1.1.1.2 When working with patients with depression and a chronic physical health problem and their families or carers:

* provide information appropriate to their level of understanding about the nature of depression and the range of treatments available
* avoid clinical language without adequate explanation
* ensure that comprehensive written information is available in the appropriate language and in audio format if possible

provide and work proficiently with independent interpreters (that is, someone who is not known to the patient) if needed.

1.1.3.3 (extract) Be respectful of, and sensitive to, diverse cultural, ethnic and religious backgrounds when working with patients with depression and a chronic physical health problem, and be aware of the possible variations in the presentation of depression. Ensure competence in:

* addressing cultural and ethnic differences when developing and implementing treatment plans

working with families from diverse ethnic and cultural backgrounds.

#### Existing quality statements

[NICE's quality standard on Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups (QS167):](https://www.nice.org.uk/guidance/qs167)

Statement 5: People from black, Asian and other minority ethnic groups can access mental health services in a variety of community-based settings.

#### Current UK practice

NHS Digital’s [Psychological Therapies, Annual report on the use of IAPT services, 2020-21: annual interactive dashboard (key activity in the year by variable for % finished course treatment - England and CCG)](https://app.powerbi.com/view?r=eyJrIjoiNmViYTdjM2MtODk0Yi00NTAxLWE5MTUtMGJhZDVhMWM3OWI1IiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9) shows that most people from Black, Asian and minority (BAME) family backgrounds, compared to their white peers, having been referred and entered treatment, are far less likely to have finished a course of treatment:

| Ethnic group | Completed treatment rate (“finished course treatment”) |
| --- | --- |
| White | 79.9% |
| Asian or British Asian | 5.8% |
| Black or Black British | 3.3% |
| Mixed | 2.8% |
| Other ethnic groups | 1.9% |
| Unknown | 6.2% |

[Research based on 3 surveys conducted using a nationally representative sample of adults in Great Britain in January of each year from 2018 to 2022](https://www.natcen.ac.uk/our-research/research/society-watch-2022-anxious-britain-how-worried-are-we-in-2022/) by NatCen (2022) highlighted that a ‘worry gap’ had emerged, mostly in January 2022:

* 1 in 5 women reported being extremely worried about most of the areas they were asked about, compared to only 1 in 10 men.
* Women were also more likely than men to be caught between worrying about both generations. 4 out of 10 women reported being extremely worried about both their parents’ and their children’s health and wellbeing. Half as many men (2 out of 10) reported being extremely worried about both.
* Similar differences were seen in people’s worries about their children’s health and wellbeing in January 2022, but a gap had already opened up in this area in January 2019.

The NCCAD’s [psychological therapies spotlight report](https://www.hqip.org.uk/resource/national-clinical-audit-of-anxiety-and-depression-psychological-therapies-spotlight-report-2019/) (January 2020) highlighted that demographic data on ethnicity was not recorded for 5% of adults. A lack of this data affects monitoring equity of access.

### Issues for consideration

**For discussion:**

* Note that there is only a ‘consider’ recommendation for collaborative care which means we could not develop a statement in this area.
* Further, collaborative care models for older adults and adults with long-term conditions have been commissioned since 2018/19.
* NG222 only refers to the 18-week waiting time target which is covered by the NHS Constitution.
* What specific action could help increase access to mental health services? There is an existing statement on increasing access to community mental health in QS167 promoting health and preventing premature mortality in black, Asian and other minority ethnic groups.
* Can a specific, measurable statement be developed?

**For decision:**

* Should this area be prioritised for inclusion in the quality standard?
  1. Additional areas

### Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However, they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or need further discussion by the committee to establish potential for statement development.

There will be an opportunity for the committee to discuss these areas at the end of the Advisory Committee meeting.

Table 2 Summary of information available for additional areas

| Suggested area for improvement | Within remit of NICE QS | In scope | Guideline recs | Relevant  existing QS |
| --- | --- | --- | --- | --- |
| New guidance on trauma sensitive approaches to treatment | Yes | Yes | No | No |
| Practitioner competence and supervision | No | Yes | Yes | Yes |
| Regulation of the administration of ECT | No | No | No | No |

### New guidance on trauma sensitive approaches to treatment

Greater recognition of trauma sensitive approaches was highlighted in treatments as a quality improvement area, not only for the current quality standard, but also for other quality standards relating to mental health. The stakeholder also suggested that many mental health problems begin in childhood, and commented on the impact of the COVID-19 pandemic on mental health in the general population.

The guideline group which developed the update to NICE's guideline on depression NG222 did not review evidence relating specifically to trauma sensitive interventions for depression.

### Practitioner competence and supervision

Stakeholders felt that practitioner competence is a quality improvement area. They raised consultant medical practitioners do not routinely receive supervision is a specific area of concern. They also felt that competence was not facilitated exclusively by supervision, but that supervision should take place alongside developing it. This suggestion has not been progressed. Although there is a statement (2) on practitioner competence being supported by supervision in the current version of NICE’s quality standard on depression QS8, the approach to this aspect of care has changed since publication of the standard. Quality statements focus on actions that demonstrate high quality care or support, not the supervision that enables the actions to take place. The committee should consider which parts of care and support would be improved by increased supervision and competence. Supervision and competence may be referred to in the audience descriptors.

### Regulation of the administration of ECT

NICE does not have a regulatory role in the health and social care system.

Oversight of ECT in England is the responsibility of the Royal College of Psychiatrists’ voluntary network, the Electroconvulsive Therapy Accreditation Service (ECTAS). They use a system of peer review to improve the quality of services, using standards agreed by the network.

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# Appendix 1: Matched care model – NICE’s guideline on adults in depression (NG222), visual summaryAppendix 1: Matched care model – NICE’s guideline on adults in depression (NG222), visual summary

# Appendix 2: Discussing first-line treatments for less severe depression – visual summary

Appendix 2: Discussing first-line treatments for less severe depression – visual summary 

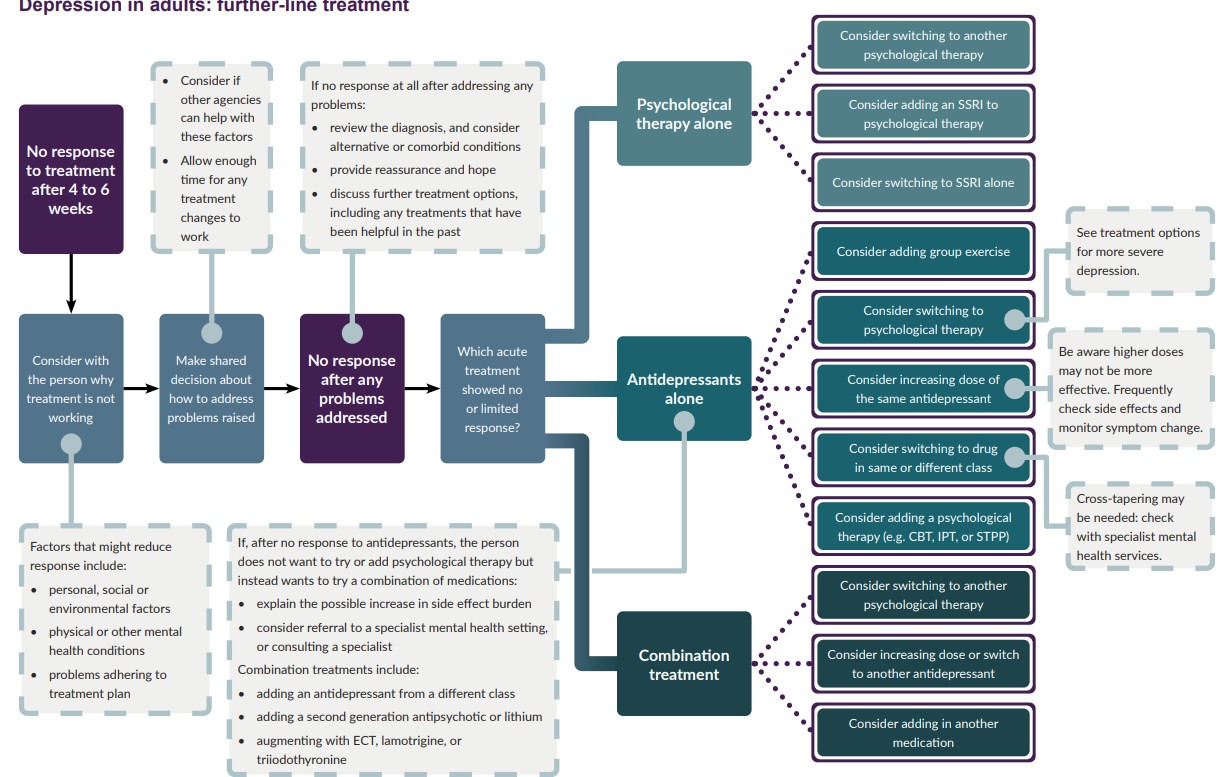

# Appendix 3: Discussing first-line treatments for more severe depression – visual summary

Appendix 3: Discussing first-line treatments for more severe depression – visual summary 

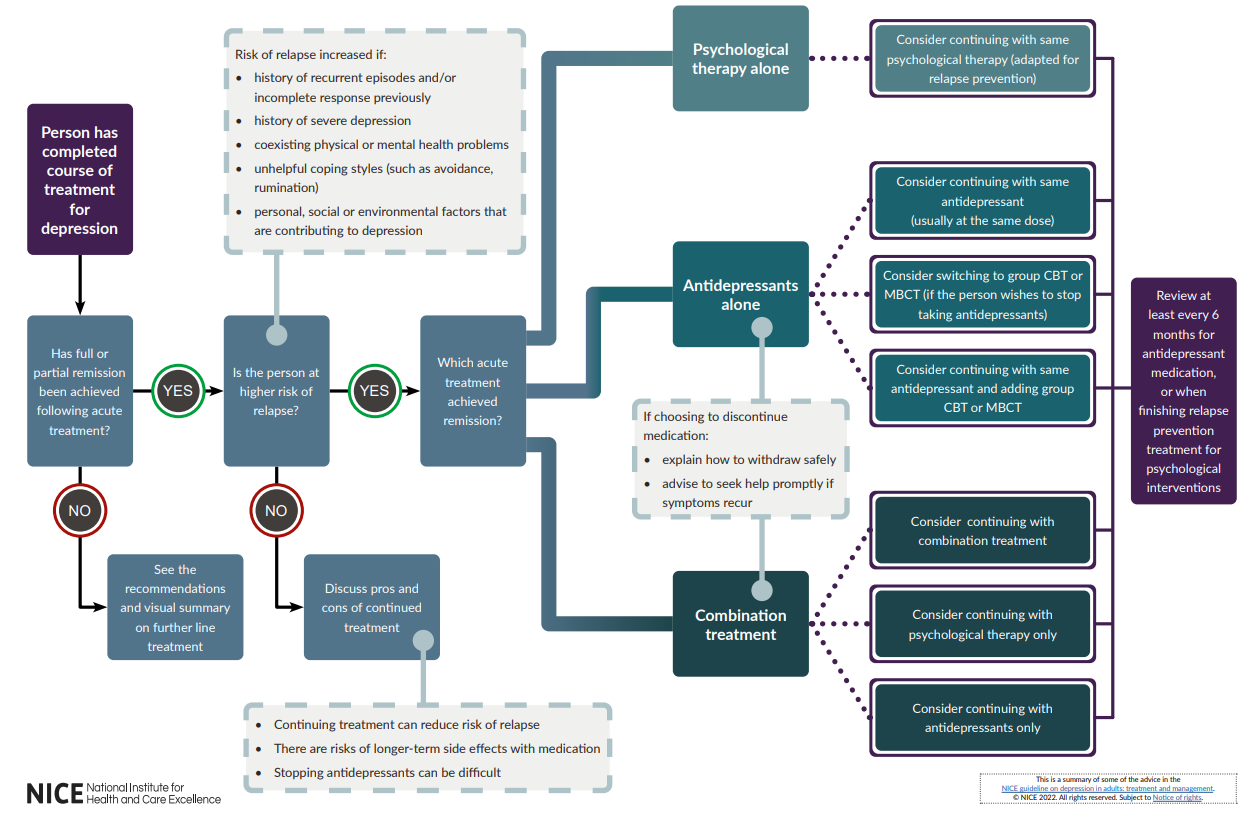
Diagram



# Appendix 4: Further-line treatment – visual summary



# Appendix 5: Relapse prevention – visual summary



# Appendix 6: Chronic depression & depression with personality disorder – visual summary

# Appendix 6: Chronic depression & depression with personality disorder – visual summary

# Appendix 7: Suggestions from registered stakeholders

| ID | Stakeholder | Suggested key area for quality improvement | Why is this a key area for quality improvement? | Supporting information |
| --- | --- | --- | --- | --- |
| 01 | Faculty of Public Health – Public Mental Health Special Interest Group | Assessment and diagnosis:  Integration of treatment with wider support | Relating to Assessment (QS1)– this should include identification of social risk factors and conditions, e.g. debt, gambling, addiction, domestic violence, unemployment, poor housing, or bereavement. Clinicians need to be able to signpost to wider services and support alongside clinical treatment (e.g. via social prescribing) to help address underlying causes and support recovery over the longer term. | PHE Briefing (2015). [A guide to community-centred approaches for health and wellbeing](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/402889/A_guide_to_community-centred_approaches_for_health_and_wellbeing__briefi___.pdf)  The voluntary and community sector has a crucial role to play in protecting and improving mental health and wellbeing in communities. This has been demonstrated through a number of programmes and projects implemented via the [OHID Prevention & Promotion Fund for Better Mental Health.](https://www.centreformentalhealth.org.uk/evaluation-ohids-better-mental-health-fund) |
| 02 | Prescribing Observatory for Mental Health | Assessment and diagnosis  Not submitted | Standardised rating scales for depression should be used to assess response to treatment and to facilitate the communication of the symptoms and severity of the illness to other mental health professionals. This relates to recommendation 1.2.4 in the NICE depression guidelines (NG 222). | In this large-scale clinical audit, only a small proportion of patients with depression, under the care of mental health services, had the symptoms and severity of their depressive illness quantified using a formal rating scale.  See:  <https://journals.sagepub.com/doi/pdf/10.1177/2045125320930492> |
| 03 | Royal College of General Practitioners | Assessment and diagnosis:  An assessment of the element of depression, anxiety and other mental health issues should be clear in any specialist assessment in the diagnosis area | People with low mood often have a complex background with elements of anxiety and other traits. A clear diagnosis helps in planning management – and helping to advise patients. | Not submitted |
| 04 | Royal College of Speech & Language Therapists | Assessment and diagnosis  Assessment, care planning and treatment decision: Recognising and supporting people’s speech, language and communication needs. | The RCSLT recommend that supporting people’s speech, language and communication needs must be a core part of the initial assessment, care planning and decision-making processes.  Language and communication breakdown has been recognised as an important part of mental health, both in terms of diagnosis and pathology (Walsh, 2004).  Even if someone has no existing speech, language and communication difficulties, a chronic or acute mental health episode can impair someone’s communication.  Approximately 60% of people accessing mental health services have communication difficulties (Walsh, 2007).  Access to support is variable. Unsupported communication needs can be a barrier to a person expressing health needs during assessment, treatment and care planning (Emerson E, et al, 2010).  People’s communication neds must be supported to enable them to express their needs, to participate in decisions about their care and treatment and for accurate capacity and consent decisions.  The draft Mental Health Bill places the person’s wishes, feelings, beliefs and values at the heart of care planning. People accessing services need choice and control over the services and treatment they receive.  Unsupported communication is a barrier to a person expressing their health needs during the initial assessment, diagnosis, treatment and care planning,  This results in in inaccurate risk assessments, inappropriate care and treatment planning and the person not having a voice in decisions about themselves. | Walsh I. Language and Communication in Schizophrenia. 2004. Jenny France (ed) Communication and Mental Illness. (pp 351-pp 400) Jessica Kingsley Publishers.  Walsh, I. et al. (2007). A needs analysis for the provision of a speech and language therapy service to adults with mental health disorders. Ir J Psych Med 24(3): 89-93  The NICE guideline on “Rehabilitation for adults with complex psychosis and related severe mental health conditions” (NG181) recognises that communication difficulties create a barrier for people with complex mental health, and support and resources are required to ensure effective engagement.  The NICE guideline on Depression in adults: treatment and management (NG222) highlights the importance of providing people with accessible information, different ways of engagement and addressing barriers to engagement.  [Draft Mental Health Bill 2022](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1093555/draft-mental-health-bill-web-accessible.pdf) |
| 05 | SCM3 | Assessment and diagnosis | High quality initial assessment | NG222 section 1.2, specifically rec 1.2.6 |
| 06 | SCM4 | Assessment and diagnosis:  Assessment:  Quality statement 1: Assessment (a) Diagnosis | Assessment in the field of mental health is most commonly diagnostic, medicalised and neglects social context.  Diagnostic or medicalised approaches dominate mental health, despite the supposed ‘biopsychosocial’ nature of the field, the multidisciplinary nature of care, and the well-known debates about fundamental issues.  Assessment practices should reflect this welcome diversity of perspective. | See: <https://ebmh.bmj.com/content/16/1/2.short> |
| 07 | SCM4 | Assessment and diagnosis:  Quality statement 1: Assessment (b) social determinants | Current assessment practices appear to neglect (or at least fail to record) social determinants of mental health issues.  The current proposed wording is: “People who may have depression receive an assessment that identifies the severity of symptoms, the degree of associated functional impairment and the duration of the episode”.  To reflect the issues outlined above, a more appropriate form of words may be: “People who may have experienced depression receive an assessment that identifies the severity of their problems, the degree to which they impact on activities of everyday life, the duration of the problems, and any possible events or circumstances that may have led to or maintained the problems”. | Please see: https://www.tandfonline.com/doi/full/10.1080/09638237.2021.1952944  and: https://link.springer.com/article/10.1007/s10597-021-00916-4 |
| 08 | SCM4 | Assessment and diagnosis:  Quality statement 1: Assessment (c) Formulation | Formulation is the cornerstone of mental health care. Assessment – a quality standard for assessment – cannot simply be the identification of the presence, severity and duration of depression, but should also include at least a minimal formulation. Such a formulation must be collaborative and consensual.  A suitable form of words might be: “Care providers work openly and collaboratively with people who have experienced depression to develop a shared formulation of the nature, severity, impact and duration of their problems, including working hypotheses as to how events or circumstances that may have led to or maintained the problems, and what might help recovery”. | Please see:  https://www.sisdca.it/public/pdf/DCP-Guidelines-for-Formulation-2011.pdf  and:  https://www.yumpu.com/en/document/view/56758061/using-formulation-in-general-psychiatric-care-good-practice |
| 09 | SCM4 | Assessment and diagnosis: Quality statement 1:  Assessment (d) Equality and diversity considerations | Although formulation-led psychosocial interventions are ‘gold-standard’ recommendations, people from socially deprived backgrounds (people from minority groups and older women, in particular) tend to be relatively excluded from provision. The three recommendations above – a) a shift from a purely medicalised or diagnostic approach, b) the assessment of social determinants and c) the use for formulation – may help address this lack of equality | Not submitted |
| 10 | SCM6 | Assessment and diagnosis | People who may have depression receive an assessment that identifies the severity of symptoms, the degree of associated functional impairment and the duration of the episode. | Existing standard that should be retained. |
| 11 | British Association for Counselling & Psychotherapy | Treatments:  All service users are given an informed choice of a full range of psychological therapies | Evidence shows that giving clients choice about treatment options improves outcomes, the quality of the therapeutic alliance, engagement in treatment as well as reducing drop-out rates from treatment. | Lindhiem, O., Bennett, C. B., Trentacosta, C. J., & McLear, C. (2014). Client preferences affect treatment satisfaction, completion, and clinical outcome: a meta-analysis. Clinical psychology review, 34(6), 506-517.  Swift, J. K., Callahan, J. L., Cooper, M., & Parkin, S. R. (2018). The impact of accommodating client preference in psychotherapy: A meta-analysis. Journal of Clinical Psychology, 74(11), 1924- 1937.  4 of 6 Williams, R., Farquharson, L., Palmer, L., Bassett, P., Clarke, J., Clark, D. M., & Crawford, M. J. (2016). Patient preference in psychological treatment and associations with self-reported outcome: national cross-sectional survey in England and Wales. BMC psychiatry, 16(1), 1-8  Windle, E., Tee, H., Sabitova, A., Jovanovic, N., Priebe, S., & Carr, C. (2020). Association of patient treatment preference with dropout and clinical outcomes in adult psychosocial mental health interventions: a systematic review and meta-analysis. JAMA psychiatry, 77(3), 294-302 |
| 12 | Faculty of Public Health – Public Mental Health Special Interest Group | Treatments:  Physical health of people with moderate or severe depression – improving accessibility to health improvement/preventative interventions and identification/management of physical health conditions | It is well known that people with severe and enduring mental health conditions die 20 years earlier on average than the general population. This is due in part to increased prevalence of health harming behaviours in this group, including smoking, alcohol and drug use, but is also linked to poorer access to healthcare and health improvement activity. | The Equally Well UK Charter is a commitment to prioritising the physical health of people with mental health problems, and to ensuring that they have an equal right to good health. This includes equipping them with information and support to empower them to look after their wellbeing; working with primary care to ensure equitable access to high-quality, evidence-based care; supporting outreach activity by primary care and public health to enable earlier intervention and additional support where needed; training health and care staff to understand and support the physical health needs of people with mental health problems; and for service providers and commissioners to collect and publish routine data to monitor and support. |
| 13 | Mind | Treatments:  Choice of treatment and involvement in decision making– to include points 1.3, 1.5.2 and 1.6.1 of the guidance. | Patient choice is a challenge as part of access to psychological therapies. <https://www.england.nhs.uk/blog/iapt-at-10-achievements-and-challenges/> not enough data is know about the choices available.  People accessing community mental health services are least likely to report feeling as involved in decisions about their care as they wanted to be. The number of people accessing community mental health services saying they were as involved in choices about their care hovers around 50% but has been decreasing in recent years. <https://www.nuffieldtrust.org.uk/resource/do-patients-feel-involved-in-decisions-about-their-care#background>  Accessing care  Two in five people (42%) thought the waiting time for their NHS talking therapies was too long.  Only 41% of people have ‘definitely’ seen services enough for their needs.  Almost 1 in 5 (17%) reported care and services were not available when they needed them in the last 12 months.  Two in five people (44%) were not given enough time discuss their needs.  Involvement  Only half (52%) of people were involved as much as they wanted to be in planning their care.  Only 41% of people said they ‘definitely’ agreed what care they would receive with someone from NHS community mental health services.  Only half of people (50%) were involved as much as they wanted to be in deciding which therapies to use.  [https://www.cqc.org.uk/publications/srveys/community-mental-health-survey-2021](https://www.cqc.org.uk/publications/surveys/community-mental-health-survey-2021) | Not submitted |
| 14 | Mind | Treatments:  Psychological therapies for people with severe depression, in secondary care, with PD diagnosis as well | The is a lack of data in this area but it is a known issue. | Not submitted |
| 15 | NHS England | Treatments:  Choice of treatments for those with depression to avoid antidepressant being only option | Patients should be offered a choice of treatment when NICE recommends several interventions at a similar level of confidence | Not submitted |
| 16 | Royal College of General Practitioners | Treatments:  A clear diagnosis of depression is made – and a rationale documented for the intervention proposed (across health care boundaries) | It would be useful to establish that a timely diagnosis is made in primary care and more specialist care. We feel that a commentary on the relevant treatment choice should be documented in primary and specialist care. (It should be easy to clarify that a diagnosis has been made… the coding in sectors for choice of intervention is more challenging) | This is based primarily on the experience of many colleagues that the diagnosis may be made in primary care and coded – but the choice is not explicit. In more specialist care it appears that many colleagues describe the fact that the patient has had an intervention without clarity on the mode (if not medication) of talking therapy – nor indeed confirmation of the diagnosis. |
| 17 | SCM1 | Treatments:  Patient Choice:  All treatments specified in NICE Depression in Adults: Treatment and Management Guideline Update published 29 June 2022 for less severe and more severe depression respectively can be used as first line treatments. However it is recommended that for less severe depression, practitioners ask patients to consider less intensive treatment first, and for more severe depression, that interventions with more therapist contact be tried first.  Treatment options must be discussed with people with a new episode of depression, to match the choice of treatment to their needs and preferences  Adequate time should be allowed for the initial discussion about treatment options, involving family members, carers, or other supporters if agreed by the person with depression  A trusting relationship should be built with the person with depression and continuity of care facilitated 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. | The NICE Depression in Adults: Treatment and Management Guideline update published 29 June 2022 [ [Recommendations | Depression in adults: treatment and management | Guidance | NICE](https://www.nice.org.uk/guidance/ng222/chapter/Recommendations) ] provides for greater patient choice than the previous version of the guideline and therefore care in these aspects requires improvement. | Section 1.3 (Choice of Treatments) in the NICE Depression in Adults: Treatment and Management Guideline update published 29 June 2022. [Recommendations | Depression in adults: treatment and management | Guidance | NICE](https://www.nice.org.uk/guidance/ng222/chapter/Recommendations) |
| 18 | SCM1 | Treatments:  Antidepressants not routinely offered as first line treatment for less severe depression:  Antidepressant medication should not be offered as first line treatment for less severe depression unless that is the person’s preference. | The 2009 guideline advised against the routine use of antidepressants for sub-threshold or mild depression, as the risk or benefit ratio is poor, but antidepressants continued to be prescribed for 70% of people with depression [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:-7.], so a new recommendation emphasises that psychological treatments should be offered first. | Section 1.5.3 (Treatment Options) in the NICE Depression in Adults: Treatment and Management Guideline update published 29 June 2022. [Recommendations | Depression in adults: treatment and management | Guidance | NICE](https://www.nice.org.uk/guidance/ng222/chapter/Recommendations) |
| 19 | SCM2 | Treatments:  Range of treatment options and appropriate delivery of interventions for people with a new episode of less severe depression | The NICE recommendations reflect current practice, but there are variations in practice across the NHS. Commissioners and services will need to ensure that a meaningful choice of all NICE-recommended therapies is available, and Quality Standards may help to reduce variability.  The NICE Guideline committee reviewed audits which suggested that reduced numbers of sessions for psychological interventions are used in practice compared with what is recommended, and that commissioners may not be clear how many sessions of a particular therapy are required. It was also important for people with depression to be aware of what was involved in the different types of therapy before making a decision. The committee therefore agreed it was important to specify the focus and structure of the psychological interventions being recommended to ensure consistency, and to highlight any particular advantages or drawbacks so that people could make an informed choice.  This may require an update to QS4 from 2011: “People with persistent subthreshold depressive symptoms or mild to moderate depression receive appropriate low-intensity psychosocial interventions.” | NICE Guideline for Adult Depression 2022 made new recommendations requiring updates in service delivery and Quality standards from 2011:  Key changes (new since 2009 Guideline) include:  A. Greater emphasis on patient choice -see Section 1.3 Choice of treatments;  e.g., Recommendation 1.3.6. Commissioners and service managers should ensure that people can express a preference for NICE-recommended treatments, that those treatments are available in a timely manner, particularly in severe depression, and that they are monitored to ensure equality of access, provision, outcomes and experience. [2022]  1.4.2 Match the choice of treatment to meet the needs and preferences of the person with depression. Use the least intrusive and most resource efficient treatment that is appropriate for their clinical needs, or one that has worked for them in the past. [2022]  B. Reoperationalizing severity of depression into less versus more severe depression  C. revised recommendations for treatments – see Section 1.5 Treatment for a new episode of less severe depression  e.g., 1.5.2 Discuss treatment options with people with a new episode of less severe depression, and match their choice of treatment to their clinical needs and preferences  use table 1 and the visual summary to guide and inform the conversation  take into account that all treatments in table 1 can be used as first-line treatments, but consider the least intrusive and least resource intensive treatment first (guided self-help)  reach a shared decision on a treatment choice appropriate to the person's clinical needs, taking into account their preferences (see also the recommendations on choice of treatments)  recognise that people have a right to decline treatment. [2022]  The top 5 recommended interventions are guided self-help, group CBT, group BA, individual CBT, individual BA, each with specified delivery in Table 1. |
| 20 | SCM2 | Treatments:  Range of treatment options and appropriate delivery of interventions for people with a new episode of more severe depression | The NICE recommendations reflect current practice, but there are variations in practice across the NHS. Commissioners and services will need to ensure that a meaningful choice of all NICE-recommended therapies is available, and Quality Standards may help to reduce variability.  The NICE Guideline committee reviewed audits which suggested that reduced numbers of sessions for psychological interventions are used in practice compared with what is recommended, and that commissioners may not be clear how many sessions of a particular therapy are required. It was also important for people with depression to be aware of what was involved in the different types of therapy before making a decision. The committee therefore agreed it was important to specify the focus and structure of the psychological interventions being recommended to ensure consistency, and to highlight any particular advantages or drawbacks so that people could make an informed choice. Quality standards may help to reduce variability.  This may require an update to QS6 from 2011. | NICE Guideline for Adult Depression 2022 made new recommendations requiring updates in service delivery and Quality standards from 2011:  Key changes (new since 2009 Guideline) include:  A. Greater emphasis on patient choice -see Section 1.3 Choice of treatments;  e.g., Recommendation 1.3.6. Commissioners and service managers should ensure that people can express a preference for NICE-recommended treatments, that those treatments are available in a timely manner, particularly in severe depression, and that they are monitored to ensure equality of access, provision, outcomes and experience. [2022]  1.4.2 Match the choice of treatment to meet the needs and preferences of the person with depression. Use the least intrusive and most resource efficient treatment that is appropriate for their clinical needs, or one that has worked for them in the past. [2022]  B. Reoperationalizing severity of depression into less versus more severe depression  C. revised recommendations for treatments – see Section 1.6 Treatment for a new episode of more severe depression  e.g. recommendation 1.6.1 Discuss treatment options with people who have a new episode of more severe depression, and match their choice of treatment to their clinical needs and preferences:  use table 2 and the visual summary to guide and inform the conversation  take into account that all treatments in table 2 can be used as first-line treatments  reach a shared decision on a treatment choice appropriate to the person's clinical needs, taking into account their preferences (see also the recommendations on choice of treatments)  recognise that people have a right to decline treatment. [2022]  Top ranked interventions by committee: combination of antidepressant with individual CBT, individual CBT, individual BA, antidepressant medication |
| 21 | SCM2 | Treatments:  Use of antidepressant medication for people with less severe depression | Evidence reviewed by NICE Guideline for Adult Depression committee suggested that some psychological therapies were more effective than antidepressants and due to the potential for side effects, medication should not be the default treatment for people with less severe depression, unless it was the person's preference to take antidepressants rather than engage in a psychological intervention. There is evidence that the prescription of antidepressant medication in NHS has significantly increased, and there is variability in how appropriately antidepressant medications are prescribed. This may require an update to QS5 from 2011 “People with persistent subthreshold depressive symptoms or mild depression are prescribed antidepressants only when they meet specific clinical criteria in accordance with NICE guidance.” | NICE Guideline for Adult Depression 2022 made a new recommendation requiring an update in service delivery and Quality standards from 2011:  1.5.3 Do not routinely offer antidepressant medication as first-line treatment for less severe depression, unless that is the person's preference. [2022] |
| 22 | SCM2 | Treatments:  Chronic Depression | Based on review of evidence, NICE Guidelines for Depression committee made new recommendations concerning treatment of chronic depression – and as such there may need to be Quality Standards to enhance their implementation. It is noteworthy that the committee recognised the overlap between severe depression, further-line treatment (e.g., of residual symptoms) and chronic depression, and made use of evidence for all these areas in recommending effective interventions – and recommendations for further-line treatment and chronic depression cross-over with each other. | NICE Guideline for Adult Depression 2022 made new recommendations requiring updates in service delivery and Quality standards from 2011:  See Section 1.10 Chronic depressive symptoms  e.g., Recommendation 1.10.3 For people with chronic depressive symptoms, offer cognitive behavioural treatment that:  has a focus on chronic depressive symptoms;  covers related maintaining processes, including avoidance, rumination and interpersonal difficulties. [2022] |
| 23 | SCM3 | Treatments:  Not submitted | For less severe depression prompt access to choice of psychological treatment, do not routinely prescribe antidepressants | NG222 1.5.2 and 1.5.3,  choice and matched care = 1.3.6 and 1.4.2 |
| 24 | SCM3 | Treatments: | For more severe depression – choice of combination treatments/ psychological interventions, pharmacological interventions | NG222 Section 1.6 |
| 25 | SCM4 | Treatments:  Quality statement 4: Low-intensity interventions for persistent subthreshold depressive symptoms or mild to moderate depression | This quality statement: “People with persistent subthreshold depressive symptoms or mild to moderate depression receive appropriate low-intensity psychosocial interventions.” And its practical implementation: “... evidence of local arrangements...” is welcome. I do, however, feel that the diagnostic definition is unfortunate. If “persistent subthreshold depressive symptoms” is synonymous with “mild to moderate depression”, it’s tautological and unnecessary... as well as being highly medicalised and possibly pejorative. It also lacks a referent – ‘subthreshold’ in relation to what threshold – and, if in that context, diagnostic, then that opens up a large can of worms. Better to stick to: “People experiencing mild to moderate depression receive appropriate low-intensity psychosocial interventions.” | Not submitted |
| 26 | SCM4 | Treatments:  Quality statement 5: Antidepressants for persistent subthreshold depressive symptoms or mild depression | This quality statement: “People with persistent subthreshold depressive symptoms or mild depression are prescribed antidepressants only when they meet specific clinical criteria in accordance with NICE guidance” is very welcome. We know that antidepressant medication – when the most favourable possible outcome measures and timings are chosen, and when publication bias by pharmaceutical companies is ignored – is little better than placebo (±15% of patients benefitting). We know, also, that this already inadequate clinical response is further undermined when adverse effects are considered. We know that many people are now reporting significant problems with withdrawal effects. Therefore, any quality standard that ensures that antidepressants are “only” prescribed when appropriate is welcome.  I therefore also welcome the associated quality measure: “Evidence of local arrangements to support the correct prescribing of antidepressants to people with persistent subthreshold depressive symptoms or mild depression in accordance with the NICE guidance”.  However, it is clear that – at present – many people are indeed prescribed antidepressants inappropriately. Therefore, I recommend additional necessary steps:  “Evidence of local or national arrangements to monitor the rates of antidepressant prescribing, and to take action to address inappropriate practices.”  And: “Evidence of local or national systems to support people withdrawing from, or wishing to withdraw safely from, prescribed antidepressant medication”. | See: <https://www.bmj.com/content/378/bmj-2021-067606> |
| 27 | SCM5 | Treatments:  To ensure that meaningful choice is offered to patients, in primary care and IAPT settings, covering the full range of recommended psychological therapies. | The new guidelines contain a shift in emphasis, so that the importance of patient choice is stressed. We need to ensure that the full range of psychological therapies contained within the guideline are available consistently across the country and that patients are offered meaningful choice and the ability to exercise that choice. | Some of this work is underway, with the IAPT Manual making recommendations for proportions of modalities other than CBT which services should provide. This needs to be monitored but also compared with monitoring of patient demand and preference as these recommended proportions may not reflect actual demand. |
| 28 | SCM5 | Treatments:  To ensure that meaningful choice is offered to patients, in secondary care mental health settings, covering the full range of recommended psychological therapies. | The new guidelines contain a shift in emphasis, so that the importance of patient choice is stressed. It also states that psychological therapies other than CBT can be seen as first line treatments for more severe depression. We need to ensure that the full range of psychological therapies contained within the guideline are consistently available across the country and that patients are offered meaningful choice and the ability to exercise that choice. | The IAPT SMI programme is geared towards implementing the previous version of the guideline and we need to ensure this programme takes account of the new guidance. |
| 29 | SCM6 | Treatments:  Not submitted | People with less severe depression receive appropriate low-intensity psychosocial interventions. | Existing standard but terminology has changed from sub-threshold/mild to moderate depression, to less severe depression. |
| 30 | SCM6 | Treatments:  Not submitted | People with less severe depression are prescribed antidepressants only when that is their expressed preference and after discussion of low intensity psychosocial interventions, in accordance with NICE guidance. | Existing standard but terminology has changed from sub-threshold/mild to moderate depression, to less severe depression, and recommendation on use of antidepressants in less severe depression has also changed. |
| 31 | SCM6 | Treatments:  Not submitted | Practitioners should discuss the full range of possible treatments for less severe, or more severe depression, with people with depression and achieve a shared decision on treatment. | New recommendation in updated NICE guidance |
| 32 | SCM6 | Treatments:  Not submitted | People with more severe depression (and no existing chronic physical health problem) receive either a combination of antidepressant medication and cognitive behavioural therapy, or high-intensity cognitive behavioural therapy alone, or behavioural activation alone. | Existing standard but terminology has changed from moderate or severe depression, to more severe depression, and recommendations on preferred treatments for more severe depression have also changed. |
| 33 | SCM6 | Treatments:  Not submitted | People with moderate depression and a chronic physical health problem receive either high-intensity cognitive behavioural therapy alone, or behavioural activation alone. | Existing standard but recommendations on preferred treatments for more severe depression have changed. |
| 34 | SCM6 | Treatments:  Not submitted | People with severe depression and a chronic physical health problem receive a combination of antidepressant medication and individual cognitive behavioural therapy. | Existing standard which should be retained. |
| 35 | Mind | Monitoring, reassessment, relapse prevention and remission:  Starting and stopping antidepressant medication to include points 1.4.11 & 1.4.12 of guidance | From CMHS 2021, link above  Most respondents (81%) said they received medication in the previous 12 months. When respondents were asked if the purpose of their medicines had ever been discussed with them, almost two thirds (63%) of people responded ‘yes, definitely’. This is a significant increase of four percentage points when compared with the results in 2020, and six percentage points when compared with 2019, indicating overall improvement over the last three years.  Similarly, when asked if the possible side effects of their medicines had ever been discussed with them, 43% of people responded ‘yes, definitely’. This is a statistically significant increase of two percentage points when compared with 2019, once again demonstrating overall improvement. However, almost a quarter of respondents (24%) had not had the possible side effects of their medicines discussed with them.  Respondents who had been receiving medicines for 12 months or longer were asked if an NHS mental health worker had checked with them about how they were getting on with their medicines during this period. Almost a quarter of people (24%) had not had their medicines reviewed in the last 12 months. Three quarters (76%) had received a review, but this proportion has dropped to its lowest point since 2014. |  |
| 36 | Mind | Monitoring, reassessment, relapse prevention and remission  People who are waiting for treatment (1.4.4) and people who are coming to the end of psychological treatment (1.4.9). | Not submitted |  |
| 37 | NHS England | Monitoring, reassessment, relapse prevention and remission  The top priority must be ensuring that courses of psychological therapy include relapse prevention work before a patient is discharged. | Someone should not be immediately discharged after recovery if relapse prevent work has not occurred. | Not submitted |
| 38 | Prescribing Observatory for Mental Health | Monitoring, reassessment, relapse prevention and remission  Not submitted | A comprehensive treatment history should be documented in the clinical records. This is essential for an evidence-based treatment strategy, as recommended in sections 1.9 and 1.10 of the NICE depression guidelines (NG 222). | In a large audit sample of patients with depression under the long-term care of mental health services, half did not have a comprehensive treatment history documented in their clinical records.  <https://journals.sagepub.com/doi/pdf/10.1177/2045125320930492> |
| 39 | Prescribing Observatory for Mental Health | Monitoring, reassessment, relapse prevention and remission  Not submitted | Lithium augmentation should be considered where depression has proved refractory to an adequate trial of an antidepressant alone. This relates to recommendation 1.9.9 in the NICE depression guidelines (NG 222). | In a large audit sample of patients with depression under the long-term care of mental health services, only one in five of those with a comprehensive treatment history documented in their clinical records had ever received a trial of lithium augmentation.  See:  <https://journals.sagepub.com/doi/pdf/10.1177/2045125320930492> |
| 40 | Royal College of Speech & Language Therapists | Monitoring, reassessment, relapse prevention and remission  Monitoring for side effects from anti-psychotic medication | Some anti-psychotic medication has side effects, including dysphagia (eating, drinking and swallowing difficulties). This can result in choking, pneumonia, chest infections, dehydration, malnutrition and weight loss. They can also make taking medication more difficult.  There is a greater prevalence of dysphagia in acute and community mental health settings compared to the general population. Over 30% of people in a mental health population showed signs of dysphagia (Regan, 2006), which is significantly higher than the general population (Bhattacharyya, 2014).  People with a diagnosis of schizophrenia, are 30 times more likely to die from choking than the general population (Rushena et al, 2003).  The prevalence of people with swallowing problems taking antipsychotic medication ranges from 21.9% to 69.5% (Font M. and Salsench R., 2017). | For more on dysphagia see the RCSLT factsheet  www.rcslt.org/wp-content/uploads/ media/Project/RCSLT/rcslt-dysphagia-factsheet.pdf  Regan, J., Sowman, R. and Walsh, I., 2006. Prevalence of dysphagia in acute and community mental health settings. Dysphagia, 21(2), pp.95-101  Bhattacharyya, N., 2014. The prevalence of dysphagia among adults. Otolaryngol Head Neck Surg. 2014 Nov;151(5):765-9  D. Ruschena, P. E. Mullen, s. Palmer, P. Burgess, S. M. Cordner, O. H. Drummer, C. Wallace and J. Barry-Walsh, 2003. Choking deaths: the role of antipsychotic Medication, British Journal of Psychiatry  Antipsychotic medication and oropharyngeal dysphagia: systematic review, 2017, [Marta Miarons Font](https://pubmed.ncbi.nlm.nih.gov/?term=Miarons+Font+M&cauthor_id=29023321), [Laia Rofes Salsench](https://pubmed.ncbi.nlm.nih.gov/?term=Rofes+Salsench+L&cauthor_id=29023321) |
| 41 | SCM1 | Monitoring, reassessment, relapse prevention and remission  Stopping antidepressants – slow tapering:  • 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. | 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 ].[ Taylor S, Ann and 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)]  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] [13 Horowitz MA, Taylor D. Tapering of SSRI treatment to mitigate withdrawal symptoms. Lancet Psychiatry 2019;6:-46.] | Sections 1.4.13-1.4.23 (Stopping Antidepressant Medication) in the NICE Depression in Adults: Treatment and Management Guideline update published 29 June 2022. [Recommendations | Depression in adults: treatment and management | Guidance | NICE](https://www.nice.org.uk/guidance/ng222/chapter/Recommendations) |
| 42 | SCM2 | Monitoring, reassessment, relapse prevention and remission:  Relapse Prevention | Based on review of evidence, NICE Guidelines for Depression committee made new recommendations concerning relapse prevention – and as such there may need to be Quality Standards to enhance their implementation. The committee recognised that there was variability in the treatment options provided for relapse prevention and the quality of interventions provided – and recommendations were made to reduce variability of both provision and quality of delivery.  These recommendations may require updates to QS10 and QS13 from 2011 dealing respectively with continuation of antidepressant medication and use of psychological interventions. | NICE Guideline for Adult Depression 2022 made new recommendations requiring updates in service delivery and Quality standards from 2011:  See Section 1.8 Preventing Relapse  e.g.,  1.8.1 Discuss with people that continuation of treatment (antidepressants or psychological therapies) after full or partial remission may reduce their risk of relapse and may 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. See the visual summary on preventing relapse. [2022]  1.8.2 Discuss with people that the likelihood of having a relapse may be increased if they have:  a 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  unhelpful coping styles (for example, avoidance and rumination)  a history of severe depression (including people with severe functional impairment)  other chronic physical health or mental health problems  personal, social and environmental factors that contributed to their depression (see recommendation 1.2.7) and that are still present (for example, relationship problems, ongoing stress, poverty, isolation, unemployment). [2022]  1.8.5 For people who have remitted from depression when treated with antidepressant medication alone, but who have been assessed as being at higher risk of relapse, consider:  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 (group CBT or mindfulness-based cognitive therapy [MBCT]) for people who do not wish to continue on antidepressants (follow the recommendations on stopping antidepressants) or  continuing with their antidepressant medication and a course of psychological therapy (group CBT or MBCT). [2022]  1.8.6 For people starting group CBT or MBCT for relapse prevention, offer a course of therapy with an explicit focus on the development of relapse prevention skills and what is needed to stay well. This usually consists of 8 sessions over 2 to 3 months with the option of additional sessions in the next 12 months. [2022]  1.8.7 Relapse prevention components of psychological interventions 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. [2022]  1.8.8 Discuss with people who have remitted from depression when treated with a psychological therapy alone, but who have been assessed as being at higher risk of relapse, whether they wish to continue with their psychological therapy for relapse prevention. Reach a shared decision on further treatment. [2022]  1.8.9 Discuss with people who have remitted from depression when treated with a combination of an antidepressant medication and psychological therapy, but who have been assessed as being at higher risk of relapse, whether they wish to continue 1 or both treatments. Reach a shared decision on further treatment. [2022]  1.8.10 Continue the same therapy for people who wish to stay on a psychological therapy for relapse prevention (either alone or in combination with an antidepressant), adapted by the therapist for relapse prevention. This should include at least 4 more sessions of the same treatment with a focus on a relapse prevention component (see recommendation 1.8.7) and what is needed to stay well. [2022]  1.8.11 Review treatment for people continuing with antidepressant medication to prevent relapse at least every 6 months. At each review:  monitor their mood using a validated rating scale (see the recommendations on delivery of treatments)  review any side effects  review any medical, personal, social or environmental factors that may affect their risk of relapse, and encourage them to access help from other agencies  discuss with them if they wish to continue treatment; if they wish to stop antidepressant treatment, see the recommendations on stopping antidepressant medication. [2022]  1.8.12 Reassess the risk of relapse for people who continue with psychological therapy to prevent relapse, when they are finishing the relapse prevention treatment, and assess the need for any further follow up. [2022] |
| 43 | SCM3 | Monitoring, reassessment, relapse prevention and remission  Not submitted | When interventions don’t work, assessing, switching, adding treatments | NG222 Section 1.9 specifically recc 1.9.1 1.9.4 1.9.5 |
| 44 | SCM3 | Monitoring, reassessment, relapse prevention and remission  Not submitted | When reducing antidepressants they should be tapered rather than being stopped suddenly | NG222 1.4.13 onwards |
| 45 | SCM4 | Monitoring, reassessment, relapse prevention and remission:  Quality statement 10: Continuing antidepressants (a) | This statement follows from NICE clinical guidelines, but is internally inconsistent.  Given the very poor evidence for long-term, real-world, effectiveness of antidepressants, it may be reasonable to advice people to continue to use an approach that helps them, but it is equally important to keep this under review. As it currently reads, the ‘statement’ implies that people should simply remain taking antidepressants (“People with depression who benefit from treatment with antidepressants are advised to continue with treatment for at least 6 months after remission, extending to at least 2 years for people at risk of relapse”), but the ‘measure’ assesses whether people have a review of the appropriateness of treatment (“Evidence of local arrangements for monitoring and reviewing people prescribed antidepressants”). Logically, since we know that many people are inappropriately taking medication, the emphasis on “monitoring and review’ should be highlighted. I recommend: “People experiencing depression who benefit from treatment with antidepressants should have their care regularly monitored and reviewed. If appropriate, people in such circumstances are advised to continue with treatment for at least 6 months after remission, extending to at least 2 years for people at risk of relapse”. | Not submitted |
| 46 | SCM4 | Monitoring, reassessment, relapse prevention and remission  Quality statement 10: Continuing antidepressants (b) Withdrawal and tapering | We know that withdrawal from antidepressants can be a painful and difficult process. We also know that many people are given inappropriate advice – that is, are not advised as to hyperbolic tapering. That should be addressed in this document, as it speaks to the standard of care received. | See: <https://www.gov.uk/government/publications/prescribed-medicines-review-report> |
| 47 | SCM4 | Monitoring, reassessment, relapse prevention and remission  Quality statement 11: Reassessing people prescribed antidepressants | This quality statement – “...regularly reassessed at intervals of at least 2 to 4 weeks for at least the first 3 months of treatment” – is excellent... except that the terminology reifies the experience of depression to reflect a particular, medicalised, perspective on the issue. Better would be: “People experiencing depression whose treatment consists solely of antidepressants are regularly reassessed at intervals of at least 2 to 4 weeks for at least the first 3 months of treatment.” | Not submitted |
| 48 | SCM4 | Monitoring, reassessment, relapse prevention and remission  Quality statement 12: Lack of response to initial treatment within 6 to 8 weeks | As above, this quality statement – “...review treatment plans” – is excellent... except that the terminology reifies the experience of depression to reflect a particular, medicalised, perspective on the issue. Better would be: “People experiencing depression, and who have not benefited adequately within 6 to 8 weeks from initial treatment have their treatment plan reviewed.” | Not submitted. |
| 49 | SCM4 | Monitoring, reassessment, relapse prevention and remission  Quality statement 13: Residual symptoms or risk of relapse | As above, this is a positive statement, but rather than the current focus on ‘symptoms’ and ‘relapse’ (which are particular and disputed ways of causally describing our experiences), this might better be phrased as: “People who have received treatment for depression but who continue to experience depression, or who are considered to be at significant risk of a return of depression, receive appropriate psychological interventions.” | Not submitted. |
| 50 | SCM4 | Monitoring, reassessment, relapse prevention and remission:  Quality statement 3: Recording health outcomes | This quality statement is welcome, but is slightly at variance with quality statement 1 – even in its unamended form – in that quality statement 1 refers to the functional impact of an individual’s experience, but this is not reflected in quality statement 3. Moreover, as I have indicated above, there is a need for assessment to be somewhat broader, which again should be reflected in quality statement 3. A possible form of words might be: “Practitioners delivering pharmacological, psychological or psychosocial interventions for people experiencing depression record health outcomes, including the nature, severity, impact and duration of the problems, at each appointment and use the findings to adjust delivery of interventions and to refine and develop the shared formulation of the problems, and what might help recovery”. | Not submitted |
| 51 | SCM6 | Service delivery:  Not submitted | Practitioners delivering pharmacological, psychological or psychosocial interventions for people with depression record health outcomes at each appointment and use the findings to adjust delivery of interventions. | Existing standard that should be retained. |
| 52 | SCM6 | Monitoring, reassessment, relapse prevention and remission  Not submitted | People with depression who benefit from treatment with antidepressants are advised to continue with treatment for at least 6 months after remission, extending to at least 2 years for people at risk of relapse. | Existing standard that should be retained. |
| 53 | SCM6 | Monitoring, reassessment, relapse prevention and remission  Not submitted | People with depression whose treatment consists solely of antidepressants are regularly reassessed at intervals of at least 2 to 4 weeks for at least the first 3 months of treatment. | Existing standard that should be retained. |
| 54 | SCM6 | Monitoring, reassessment, relapse prevention and remission  Not submitted | People with depression that has not responded adequately to initial treatment within 4 to 6 have their treatment plan reviewed. | Existing standard but recommendations in updated guidance are 4 to 6 weeks instead of 6 to 8 weeks. |
| 55 | SCM6 | Monitoring, reassessment, relapse prevention and remission  Not submitted | People who have been treated for depression who have residual symptoms or are considered to be at significant risk of relapse receive appropriate psychological interventions. | Existing standard which should be retained. |
| 56 | SCM6 | Monitoring, reassessment, relapse prevention and remission  Not submitted | When stopping antidepressants for people with depression, practitioners should slowly reduce the dose to zero, at each step prescribing a proportion of the previous dose (for example, 50%). | New recommendation in updated NICE guidance, to use proportionate (exponential or hyperbolic) instead of linear reduction. |
| 57 | SCM6 | Monitoring, reassessment, relapse prevention and remission  Additional developmental areas of emergent practice | 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. | 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>) |
| 58 | SCM6 | Monitoring, reassessment, relapse prevention and remission  Additional evidence sources for consideration | Tapering antidepressants over months rather than weeks reduces the risk of withdrawal symptoms. Proportionate (exponential or hyperbolic) tapering down to doses much lower than minimum therapeutic doses may help people with particular problems coming off treatment. | Horowitz MA, Taylor D. Tapering of SSRI treatment to mitigate withdrawal symptoms. Lancet Psychiatry 2019;6:-46. |
| 59 | British Association for Counselling & Psychotherapy | **Service delivery**  All service users can access psychological therapy services in a quick and timely manner | Service users being able to quickly access services would have a positive impact on both outcomes but would also help prevent people’s conditions potentially worsening whilst they’re on a lengthy wait list. | Not submitted |
| 60 | British Association for Counselling & Psychotherapy | Service delivery:  Service users can easily navigate between different care options to meet their needs, including between different interventions within a service or by moving between different services in their locality. | The mental health system structures in England at present have a number of gaps between services where service users are unable to access the care they need – this is sometimes through geographical variation in provision or different clinical thresholds for entering or existing services. Seamless navigation of care pathways for service users is important to ensure that people receive the care they need in a quick and efficient manner, as well as helping with reducing drop out waits | Not submitted |
| 61 | Faculty of Public Health – Public Mental Health Special Interest Group | Service delivery:  Addressing systemic inequalities in access to and experiences of care | Addressing mental health inequalities means addressing inequalities in access and experiences of services as well as wider society – including tackling systemic racism. It is well documented that people from ethnic minority backgrounds are disproportionately less likely to access early help and intervention, but disproportionately more likely to be detained under the Mental Health Act.  Gender is a key global factor in the prevalence of depression, and poor maternal mental health has impacts across generations.  The NatCen report cited above also highlights the disproportionate impacts of the COVID-19 pandemic on the mental wellbeing of women due to work-life balance and intergenerational responsibilities.  Recognising the impacts of systemic inequalities is key to being able to identify appropriate support for individuals, and to improving both access to and experiences of treatment. | The National Collaborating Centre for Mental Health developed a resource for tackling mental health inequalities across the system, and includes evidence for the case for change:  <https://www.rcpsych.ac.uk/improving-care/nccmh/service-design-and-development/advancing-mental-health-equality>  Tackling Inequalities in Mental Health through Personalised Care Development Support programme is a partnership between Association of Mental Health Providers and the Race Equality Foundation, sponsored by NHS England and NHS Improvement’s Personalised Care group. This focuses on a set of tangible actions that local health and care systems can take to help facilitate continuous system-wide improvement, illustrating the transformative potential of personalised care in tackling inequalities in mental health.  <https://www.england.nhs.uk/blog/the-importance-of-personalised-care-and-personal-health-budgets-in-addressing-health-inequalities-for-people-within-minority-groups/#utm_source=The%20King%27s%20Fund%20newsletters%20%28main%20account%29&utm_medium=email&utm_campaign=13161800_NEWSK_HWB-2022-05-03&dm_i=21A8,7U3PK,3XH98D,VZLFW,1> |
| 62 | Faculty of Public Health – Public Mental Health Special Interest Group | Effective models of treatment to meet the needs of groups who are at higher risk of depression and less likely to be offered treatment choice | This should include culturally appropriate treatment, as well as suitable options for older adults; Older adults may face more difficulties due to the myth that depression is a normal part of aging (NHS England 5YFVMH, 2015). | See 2 above  (see additional areas) |
| 63 | Mind | Service delivery:  Culturally appropriate/adapted services | People must be able to access culturally competent and relevant community services at an earlier point, to enable more people to be helped before they reach crisis point. This will require investment in initiatives to address the cultural barriers to certain groups seeking support. Accessing psychological therapies is still not the reality for many people from BAME communities. For those who do receive support through the IAPT programme, the recovery rate on average for people from BAME communities is consistently lower.  Compared to their White peers, people from most BAME communities are:  Less likely to complete treatment having been referred to IAPT (35 per cent compared to 40 per cent of White people)  More likely to see a deterioration of their mental health after a course of IAPT (7.3 per cent compared to 5.6 per cent of White people)  Less likely to see an improvement of their mental health after a course of IAPT (65 per cent compared to 68 per cent of White people)  Less likely to achieve full recovery (42 per cent compared to 47 per cent of White people)  NHS Digital (July 2020). ‘Psychological Therapies, Annual report on the use of IAPT services 2019-20’ | <https://www.cqc.org.uk/guidance-providers/adult-social-care/culturally-appropriate-care> |
| 64 | NHS England | Service delivery:  The second priority is that patients should be offered up to at least the NICE recommended number of sessions if they have not already recovered and had relapse prevention work. | Not submitted | Not submitted |
| 65 | NHS England | Service delivery:  Waits between clinical appointments being no longer than 90 days  Services should aim to treat to revery as we know that one of the best predictors of relapse in depression is the presence of residual symptoms at the point of discharge | Ensure that patients start treatment with a minimal delay after their initial assessment as we know that delays are associated with poorer outcomes (Clark et al paper again). I think we would say delay should ideally be no more that 6 weeks and that IAPT expects service to have no more that X% (you fill in) patients waiting more than 90% | Not submitted |
| 66 | NHS England | Service delivery:  Addressing equalities | We believe ethnic minorities generally attend less sessions compared to White British, but we would need to explore the national data in more depth if we were to take this idea forwards. | Services should carefully monitor and compare outcomes between ethnic groups and individuals with protected characteristics, ensure that they have at least a many sessions of treatment as non-minority groups and work to identify ways of enhancing outcomes in minority groups with lower outcomes (this might, for example, mean a higher dose of treatment, hence the bold on “at least”). |
| 67 | NHS England | Service delivery:  The number of sessions in a course of treatment being in line with what is recommended within the NICE guidance with a view to encouraging services not to cap no. of sessions. | Not submitted | Not submitted |
| 68 | NHS England | Service delivery:  Reduction in the number of DNAs to bring national average more in line with up to 5% recommendation in research | Reduce DNA rates with SMS text reminders and other innovations as high DNA rates are associated with poorer outcomes (Clark et al, 2018, Lancet paper) | Not submitted |
| 69 | Royal College of General Practitioners | Service delivery:  Key area for quality improvement 1  People referred for psychological therapies / talking therapies are assessed within four weeks of referral | Many people with depression take a while to present medically – and though easy to prescribe this is very often not appropriate. Patients wait months for psychological therapies will often in our experience run into further problems (employment, relationships, social aspects of their life) during waiting periods. Though the national criteria are 18 weeks for this group of people we would suggest that services are available rapidly like they | We are not aware of hard evidence for the further impact of depression on these people’s lives by delaying effective interventions – but we assume there are figures kept of time from referral (including self referral) to intervention in most services. |
| 70 | Royal College of Speech & Language Therapists | Service delivery:  All interventions are person centred and appropriate for the individual’s needs. | Almost all mental health services and therapies are verbally mediated, that is conducted through language and interactions, for example, cognitive behavioural therapy or ‘talking therapies’.  The evidence shows that such verbally mediated interventions and programmes are inaccessible to people with communication needs (Bryan, 2004) (Bryan, Freer, Furlong, 2007).  People with mental health conditions are more likely to present with communication needs (Walsh, 2007). Such difficulties are a barrier to accessing and engaging in rehabilitation and psychological programmes, which are often delivered verbally and are thus reliant on people’s language skills.  Talking therapies put a significant demand on language processes, both expressive and receptive, and can be difficult for individuals with communication needs to access and benefit from. Offering talking therapies, without consideration of the adjustments required to support engagement, results in offering inappropriate interventions where the person has insufficient language skills to engage and increases their change of failure.  Unmet needs impact on recovery and length of stay in mental health settings (Bryan, 2014).  It is crucial that verbally mediated interventions are tailored to make them accessible as a matter for priority. It is possible for assessments and interventions to be modified and adapted for use with people with communication needs (Bryan, Gregory, 2013) (Gregory and Bryan 2011).  Support from a speech and language therapist, to undertake a language assessment, will inform planning decisions tailored to the needs of the individual based on their language ability. | Reference: 5 Bryan K. Psychiatric disorders and Communication. 2014. Louise Cummings (ed) Handbook of Communication Disorders. (pp. 300-318) Cambridge: Cambridge University Press  Reference: Talking about mental health: Speech, language, communication and swallowing, RCSLT, 2020, <https://www.rcslt.org/wp-content/uploads/media/docs/Talking-about-mental-health_-communication-and-swallowing-needs---FINAL---May-2020.pdf>  NICE has recognised that certain interventions and therapies may be unsuitable for children or adults with communication needs and these barriers needs to be addressed (NICE: Depression in adults, 2022; NICE: depression in children 2019). |
| 71 | Royal College of Speech & Language Therapists | Service delivery:  Services are provided by the full MDT. | Supporting communication and swallowing needs is critical.  Speech and language therapists should be embedded as a core part of the multi-disciplinary team in all relevant child, adolescent and adult mental health services. They have a vital role in protecting and promoting the wellbeing and resilience of people with communication and swallowing needs.  Mental health teams are seeing more people with a range of complex needs, including learning disability, autism, acquired brain injury, or neurological conditions. It is critical that staff have the breadth of skills to work with these people. Speech and language therapists are uniquely placed to bring an extensive set of skills and knowledge to the role.  The role of speech and language therapists is increasingly becoming recognised in supporting people with mental health conditions. In its submission to the Migration Advisory Committee’s Full Review of the Shortage Occupation List, the Department of Health and Social Care argued that speech and language therapists should be added to the Shortage Occupation List because the profession is facing a range of pressures including increasing demand, in mental health in particular. | Rees H, Forrest C, Rees G (2018) Assessing and managing communication needs in people with serious mental illness  Migration Advisory Committee, May 2019, <https://bit.ly/36cX5KB> |
| 72 | SCM1 | Service delivery:  Availability of preferred treatment in a timely manner:  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 the service be monitored to ensure equality of access, provision, outcomes and experience. | Based on the experience and opinion of the Guideline Committee, care in these aspects is poor or variable and requires improvement. | Section 1.3.6 in the NICE Depression in Adults: Treatment and Management Guideline update published 29 June 2022. [Recommendations | Depression in adults: treatment and management | Guidance | NICE](https://www.nice.org.uk/guidance/ng222/chapter/Recommendations) |
| 73 | SCM4 | Service delivery:  Quality statement 9: Collaborative care | In my opinion, the term ‘collaborative care’ is close to meaningless. Later in the document, this is further specified as: “... which means that a dedicated team of healthcare professionals work together to treat the depression and the physical health problem”, but this, too, seems vague. | Not submitted |
| 74 | SCM6 | Service delivery  Not submitted | People with more severe depression and a chronic physical health problem with associated functional impairment, whose symptoms are not responding to initial interventions, receive collaborative care. | Existing standard which should be retained. |
| 75 | Faculty of Public Health – Public Mental Health Special Interest Group | Additional areas:  Trauma informed/trauma sensitive care | Relating to treatment (crosses a number of quality standards) – there needs to be greater recognition of trauma sensitive approaches in treatments, as well as addressing social factors alongside other treatment options as part of a person-centred approach to care. | Many mental health problems begin in childhood, with trauma, bullying and neglect having lifelong impacts. Children who are looked after by local authorities are at particular risk of poor mental health, both due to trauma experienced and the instability they face in navigating the care system.  The COVID-19 pandemic has brought new challenges in public mental health through both direct impacts of the pandemic and indirect effects of control measures, and exacerbating existing inequalities in mental health – this is likely to be deepened by the cost of living crisis.  National Centre for Social Research, July 2022. They Think It’s All Over: The Social Legacy of the COVID-19 Pandemic. (Report available from <https://natcen.ac.uk/our-research/research/society-watch-2022/?utm_campaign=Report%20and%20Event%20follow-up%3A%20Society%20Watch%202022&utm_source=emailCampaign&utm_content=&utm_medium=email>) |
| 76 | SCM4 | Additional areas:  Quality statement 2: Practitioner competence | At present, the quality statement reads: “Practitioners delivering pharmacological, psychological or psychosocial interventions for people with depression receive regular supervision that ensures they are competent in delivering interventions of appropriate content and duration in accordance with NICE guidance.”  This is welcome – supervision is important. However, there are several important details here.  a) Supervision is by no means ubiquitous in healthcare. Notoriously, consultant medical practitioners do not routinely receive supervision for their practice. If this quality statement is to be meaningful, this must be addressed.  b) Supervision is welcome, but is certainly not the only issue. It would make more sense if the statement were to reflect competence – not just supervision – and perhaps could read: “Practitioners delivering pharmacological, psychological or psychosocial interventions for people with depression are competent in delivering interventions of appropriate content and duration in accordance with NICE guidance, and receive regular supervision of their practice.”  c) These standards apply to individual practitioners, but similar quality standards should apply to clinics / Trusts / providers. For instance, recent investigations have revealed not only that no body has responsibility for the regulation of ECT clinics, but even that clinics that fail the basic (and voluntary) standards of the ECTAS – therefore, specifically, putting the public at risk – continue to practice. This is important, in the light of NICE recommendations, because ECT is given very frequently in breach of NICE guidelines (that is, not limited as recommended only to people with severe depression that has failed to respond to other modalities of care) and with a 47-fold disparity in frequency. Services, as well as individuals, need to be competent, need to follow NICE guidelines, and need to be supervised.  This, in particular, speaks to equality and diversity considerations, as older women are disproportionately at risk of receiving ECT. | Please see (re point c): <https://bpspsychub.onlinelibrary.wiley.com/doi/full/10.1111/papt.12335> |
| 77 | SCM6 | Additional areas:  Not submitted | Practitioners delivering pharmacological, psychological or psychosocial interventions for people with depression receive regular supervision that ensures they are competent in delivering interventions of appropriate content and duration in accordance with NICE guidance. | Existing standard that should be retained. |
| 78 | Royal College of Nursing | No comments | N/A | N/A |