

Depression in adults

Quality standard

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This standard is based on CG91, NG222 and NG215.

This standard should be read in conjunction with QS14, QS15, QS34, QS48, QS50, QS53, QS87, QS88, QS108, QS99, QS80, QS9, QS115, QS134, QS143, QS164, QS175, QS189, QS196 and QS200.

Quality statements

Statement 1 Adults with suspected depression have a comprehensive assessment. **[2011, updated 2023]**

Statement 2 Adults with a new episode of depression have a discussion with their healthcare professional about the full range of treatment options. **[new 2023]**

Statement 3 Adults with depression who are at a higher risk of relapse have relapse prevention interventions. **[2011, updated 2023]**

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

Statement 5 Adults from minority ethnic backgrounds with depression are supported to access mental health services. **[new 2023]**

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

The [previous version of the quality standard for depression in adults](#) is available as a pdf.

Quality statement 1: Assessment

Quality statement

Adults with suspected depression have a comprehensive assessment. [2011, updated 2023]

Rationale

Recognition of suspected depression is based on clinical suspicion or responses to questions used to initially identify depression. A comprehensive assessment includes discussion of factors affecting the development, course and severity of depression and enables confirmation of a diagnosis of depression. The assessment may also identify other mental health conditions that share similar symptoms, such as bipolar disorder and post-traumatic stress disorder. If the adult has additional needs affecting language and communication, these should be identified and the assessment adjusted to enable participation. Establishing a diagnosis of depression is an essential first step in the care of adults with depression, leading to appropriate treatment at the earliest opportunity.

Quality measures

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

This is a retrospective measure because the statement's denominator population (adults with suspected depression) cannot be routinely identified using data in the electronic medical record.

Process

Proportion of adults with a new episode of depression who had a comprehensive assessment before receiving a diagnosis.

Numerator – the number in the denominator who had a comprehensive assessment before

receiving a diagnosis.

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

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

Outcome

The proportion of adults diagnosed with depression who reported satisfaction with their assessment.

Numerator – the number in the denominator who reported satisfaction with their assessment.

Denominator – the number of adults diagnosed with depression who had an assessment.

Data source: [NHS England's Improving Access to Psychological Therapies \(IAPT\)](#) collects data on satisfaction with assessments delivered in IAPT services. Annual results are presented at national, commissioning and provider levels. The [Care Quality Commission's NHS community mental health survey](#) contains the question: 'did the person or people you saw understand how your mental health needs affect other areas of your life?'

What the quality statement means for different audiences

Service providers (such as GP practices, NHS talking therapy services and NHS acute and mental health trusts) ensure that protocols are in place for adults with suspected depression to have a comprehensive assessment, which includes discussion of factors that may have influenced the development of their depression.

Healthcare professionals (such as GPs, nurse practitioners, specialist nurses, therapists in NHS talking therapy services and mental health professionals) carry out a comprehensive assessment if they suspect depression (based on clinical suspicion or responses to questions used to initially identify depression). This assessment includes discussion of factors that may have influenced the development of the adult's depression. If they think

they do not have the competence to carry out a mental health assessment, they refer adults with a new episode of depression to a healthcare professional who does.

Commissioners ensure that they commission services in which adults with suspected depression based on clinical suspicion have a comprehensive assessment, which includes discussion of factors that may have influenced the development of their depression.

Adults with suspected depression have an assessment during which they discuss factors that may have contributed to their depression with a healthcare professional. The aim of the assessment is to confirm a diagnosis of depression.

Source guidance

- [Depression in adults: treatment and management. NICE guideline NG222 \(2022\)](#), recommendations 1.2.6 and 1.2.7
- [Depression in adults with a chronic physical health problem: recognition and management. NICE guideline CG91 \(2009\)](#), recommendations 1.1.3.1 and 1.1.3.2

Definitions of terms used in this quality statement

Suspected depression

A healthcare professional suspects that an adult has depression based on clinical judgement or if the adult answers 'yes' to either of the following questions used to initially identify depression:

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

[Adapted from [NICE's guideline on depression in adults](#), recommendations 1.2.1 to 1.2.3 and terms used in this guideline; [NICE's guideline on depression in adults with a chronic physical health problem](#), recommendation 1.3.1.1; and expert opinion]

New episode of depression

A first or subsequent episode of depression. [[NICE's guideline on depression in adults, definitions of depression and severity](#)]

Comprehensive assessment

A comprehensive assessment should include:

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

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

- any history of depression and coexisting mental health or physical disorders
- any history of mood elevation (to determine if depression may be part of bipolar disorder; see the [NICE guideline on bipolar disorder](#))
- 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 and sleep)
- any ongoing, recent or past experience of stressful or traumatic life events, such as early adversity (including physical abuse, sexual abuse or bullying), redundancy, divorce, bereavement, or trauma (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.

To improve the accuracy of the assessment for adults with a physical health problem with a new episode of depression, a healthcare professional should also:

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

Healthcare professionals should be aware that symptoms of depression may overlap with symptoms of, for example, learning disabilities, other existing or new mental health conditions, physical health conditions, or menopause. [Adapted from [NICE's guideline on depression in adults](#), recommendations 1.2.2, 1.2.3, 1.2.6 and 1.2.7; [NICE's guideline on depression in adults with a chronic physical health problem](#), recommendations 1.1.3.2 and 1.3.1.3; and expert opinion]

Equality and diversity considerations

Some adults may need additional support during assessments of depression, including:

- adults with language or communication difficulties (for example, sensory or cognitive disabilities, or autism)
- adults with acquired cognitive impairments that affect communication (for example, dementia, Parkinson's disease or traumatic brain injury)
- adults who do not speak English.

Examples of adapting assessments include:

- using a method of communication appropriate for their needs (for example, using a British Sign Language interpreter, or augmentative and alternative communication)
- using interpreters from the same cultural background
- using language that takes into account family background and wider context.

Commissioners and providers should consider their local population and any unwarranted variation in prevalence of depression between adults in groups such as:

- adults from minority ethnic backgrounds
- lesbian, gay, bisexual and trans adults

- adults experiencing homelessness, refugees and asylum seekers.

[Adapted from [NICE's guideline on depression in adults](#), recommendations 1.2.5, 1.2.14, 1.16.5 and 1.16.6 and information for the public, and [NICE's guideline on depression in adults with a chronic physical health problem](#), recommendation 1.1.3.3]

Quality statement 2: Discussing treatment options

Quality statement

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

Rationale

Discussing the full range of treatment options with adults who have a new episode of depression helps support them to make an informed decision about their treatment preferences. Using shared decision making, the discussion should lead to the development of a treatment plan, with choices based on the person's clinical needs and preferences. The discussion includes the risks and benefits of each option, the expected outcomes, the number of sessions to be delivered for psychological therapies and choices around aspects of delivery. Providing information about treatment options is likely to lead to improved adherence to therapy and better outcomes. It can also help to ensure that antidepressants are not routinely offered as first-line treatment for a new episode of less severe depression unless that is the adult's preferred option.

Quality measures

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

Process

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

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

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

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

Outcome

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

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

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

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from a patient survey.

The [Care Quality Commission's NHS community mental health survey](#) collects data on 3 questions for adults with depression: the extent of adults' involvement in agreeing their care, the extent to which they felt involved in making a decision about their care together with the person they saw, and whether they felt involved as much as they wanted to be in deciding what NHS talking therapies to use. [NHS England's Improving Access to Psychological Therapies \(IAPT\) patient experience \(treatment\) questionnaire](#) includes the question: 'did you feel involved in making choices about your treatment and care?' Annual results are presented at national, commissioning and provider levels.

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

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

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

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from a patient survey.

NHS England's Improving Access to Psychological Therapies (IAPT) patient experience (assessment) questionnaire includes the questions: 'do you prefer any of the treatments among the options available?' and 'have you been offered your preference?' Annual results are presented at national, commissioning and provider levels.

What the quality statement means for different audiences

Service providers (such as GP practices, NHS talking therapy services and NHS acute and mental health trusts) ensure that pathways (including referral pathways), service protocols and capacity are in place so that adults with a new episode of depression can express a preference for treatments. They ensure that there is capacity to enable this discussion to take place, including when adults are referred across primary and secondary care.

Healthcare professionals (such as GPs, specialist nurses and mental health professionals) discuss with adults with a new episode of depression the full range of treatment options, including choices about delivery and tailoring treatments to individual needs. They provide supporting information such as the potential benefits and harms, waiting times, expected outcomes and the number of sessions for psychological therapies. Healthcare professionals support adults with a new episode of depression in shared decision making about their treatment and recognise that the discussion may take place following referral from primary to secondary care services.

Commissioners ensure that they commission services with the capacity to ensure that adults can express a preference for treatments, and that these are available in a timely manner (particularly for adults with severe depression) so that adults have a choice of treatments. They ensure that services have local referral pathways in place so that the discussion can happen, when necessary, across primary and secondary care services. They monitor services providing treatment to ensure equity of access, provision, outcomes and experience.

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

Source guidance

- [Depression in adults: treatment and management. NICE guideline NG222 \(2022\)](#), recommendations 1.3.1, 1.3.4 to 1.3.6 and 1.5.3
- [Depression in adults with a chronic physical health problem: recognition and management. NICE guideline CG91 \(2009\)](#), recommendations 1.4.2.1, 1.4.3.1, 1.5.1.2 and 1.5.1.3

Definitions of terms used in this quality statement

Treatment options

For information about treatment options for adults with depression, see [table 1 in NICE's guideline on depression in adults](#) for less severe depression, and [table 2](#) for more severe depression. [Adapted from [NICE's guideline on depression in adults](#), recommendations 1.3.4, 1.5.2 and 1.6.1]

New episode of depression

A first or subsequent episode of depression. [[NICE's guideline on depression in adults](#), definitions of depression and severity]

Equality and diversity considerations

There are risks associated with taking antidepressants in pregnancy and during breastfeeding. Therefore, when planning pregnancy, during pregnancy, postnatally or when considering breastfeeding, healthcare professionals should consult [NICE's guidelines on antenatal and postnatal mental health](#) and [medicines associated with dependence or withdrawal symptoms](#).

Some adults may need additional support during discussions about treatment options:

- adults with language or communication difficulties (for example, sensory or cognitive disabilities, or autism)

- adults with acquired cognitive impairments that affect communication (for example, dementia, Parkinson's disease or traumatic brain injury)
- adults who do not speak English.

Examples of additional support include:

- using a method of communication appropriate for their needs (for example, using a British Sign Language interpreter, or augmentative and alternative communication)
- using interpreters from the same cultural background
- using language that takes into account family background and wider context.

Commissioners and providers should consider their local population and any unwarranted variation in provision of treatment between adults with depression in groups such as:

- adults from minority ethnic backgrounds
- lesbian, gay, bisexual and trans adults
- adults experiencing homelessness, refugees and asylum seekers.

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

Adults should also be given the option to express a preference for the gender of the healthcare professional. [Adapted from [NICE's guideline on depression in adults](#), recommendations 1.1.1, 1.2.15, 1.4.1, 1.16.5, 1.16.6, and tables 1 and 2; [NICE's guideline on depression in adults with a chronic physical health problem](#), recommendations 1.1.3.3 to 1.1.3.5; and expert opinion]

Quality statement 3: Preventing relapse

Quality statement

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

Rationale

All adults who achieve full or partial remission and have 1 or more risk factor for relapse should discuss with their healthcare professional whether they need to continue treatment. They should, after discussion, be offered interventions that focus on relapse prevention, which will help reduce the likelihood of further episodes of depression.

Quality measures

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

Process

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

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

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

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

Outcome

a) Rates of relapse within 2 years of their last session among adults who have been treated for depression with psychological therapy.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

NHS England's Improving Access to Psychological Therapies (IAPT) data set includes therapy-based outcomes for courses of therapy using mean Patient Health Questionnaire (PHQ-9) scores at the start and end of a course of therapy.

b) Rates of relapse within 2 years of a review at 9 to 12 months after starting antidepressants among adults who have been treated for a first episode of depression.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

c) Rates of relapse within 2 years of a review 2 years after starting antidepressants among adults who have been treated for a second or subsequent episode of depression.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

What the quality statement means for different audiences

Service providers (GP practices and mental health services, including NHS talking therapy services) ensure that systems and protocols are in place for adults with depression who are at a higher risk of relapse to be offered relapse prevention interventions based on their clinical needs and preferences.

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

Commissioners ensure that they commission services that offer relapse prevention interventions to adults with depression who are at a higher risk of relapse. They commission psychological therapy services that offer psychological therapies with a relapse prevention component.

Adults with depression whose symptoms are likely to return talk to their healthcare professional about treatment options to prevent new episodes of depression. These may include continuing with their existing treatment (psychological therapy, adapted for relapse prevention or antidepressants, or both), or switching to or adding psychological therapy if they are on antidepressants alone. They make decisions with their healthcare professional and are offered treatment based on their needs and preferences.

Source guidance

Depression in adults: treatment and management. NICE guideline NG222 (2022), recommendations 1.8.1 and 1.8.2

Definitions of terms used in this quality statement

Adults with depression at a higher risk of relapse

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

- 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 (such as fatigue, poor sleep, poor concentration and impaired motivation)
- a history of severe depression (including adults with severe functional impairment)
- coexisting physical or mental health problems
- unhelpful coping styles (such as avoidance or rumination)

- personal, social or environmental factors that contributed to depression and that are still present (for example, relationship problems, ongoing stress, poverty, isolation and unemployment).

[Adapted from [NICE's guideline on depression in adults](#), recommendation 1.8.2 and the [visual summary on preventing relapse](#) after completing a course of treatment for depression]

Relapse prevention interventions

Options for relapse prevention include:

- continuing with the same psychological therapy, adapted by the therapist for relapse prevention, or
- continuing with antidepressant medication to prevent relapse, maintaining the dose that led to full or partial remission, unless there is good reason to reduce it (such as side effects), or
- a course of psychological therapy for relapse prevention (group cognitive behavioural therapy [CBT] or mindfulness-based cognitive therapy [MBCT]) for adults who do not wish to continue on antidepressants, or
- continuing with antidepressant medication and a course of psychological therapy for relapse prevention (group CBT or MBCT).

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

- reviewing lessons and insights 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 any of these reoccur

- making plans for any anticipated challenging events over the next 12 months, including life changes and anniversaries of difficult events.

[Adapted from [NICE's guideline on depression in adults](#), recommendations 1.8.5 to 1.8.10, and expert opinion]

Equality and diversity considerations

Commissioners and providers should consider their local population and any unwarranted variation in provision of treatment between adults with depression in groups such as:

- adults from minority ethnic backgrounds
- lesbian, gay, bisexual and trans adults
- adults experiencing homelessness, refugees and asylum seekers.

[Adapted from [NICE's guideline on depression in adults](#), recommendation 1.16.6, and [NICE's guideline on depression in adults with a chronic physical health problem](#), recommendation 1.1.3.3]

Quality statement 4: Stopping antidepressants

Quality statement

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

Rationale

Reducing the dose of antidepressant medication in stages over time (known as 'tapering') helps to reduce withdrawal effects and supports withdrawing from the medication when their long-term use is not indicated. The decision to stop antidepressant medication, including speed and duration of withdrawal, should be taken after discussion and agreement between the adult and their healthcare professional. It is important that adults are monitored and reviewed while their dose is being reduced, both for withdrawal symptoms and the return of symptoms of depression. The frequency of monitoring is based on the person's clinical and support needs. Any withdrawal symptoms need to have been resolved or be tolerable before making the next dose reduction.

Quality measures

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

Process

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

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

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

medication.

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

What the quality statement means for different audiences

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

Healthcare professionals (such as GPs, specialist nurses and mental health professionals) reduce the adult's dose of antidepressant medication in stages to optimise withdrawal. This follows a discussion and agreement with the adult with depression to stop taking antidepressant medication, including the speed and duration of withdrawal. Healthcare professionals offer follow-up appointments (which could be by telephone) to monitor and review adults while their dose is being reduced, both for withdrawal symptoms and the return of symptoms of depression. Healthcare professionals should base the frequency of monitoring on the adult's clinical and support needs, ensuring that any withdrawal symptoms have resolved or are tolerable before making the next dose reduction.

Commissioners ensure that services monitor prescribing patterns for antidepressant medication for adults with depression. They commission services from providers who demonstrate that, following discussion and agreement to stop antidepressant medication, the dose is reduced in stages.

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

Source guidance

- [Depression in adults: treatment and management. NICE guideline NG222 \(2022\)](#), recommendations 1.4.13 and 1.4.17
- [Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults. NICE guideline NG215 \(2022\)](#), recommendation 1.5.7
- [Depression in adults with a chronic physical health problem: recognition and management. NICE guideline CG91 \(2009\)](#), recommendations 1.5.2.29 and 1.5.2.30

Definitions of terms used in this quality statement

Dose reduced in stages

See [NICE's guideline on depression in adults](#), recommendation 1.4.17, for details.

Equality and diversity considerations

There are risks associated with taking and stopping antidepressants for depression in pregnancy or during breastfeeding. Therefore, when planning pregnancy, during pregnancy, postnatally or when considering breastfeeding, healthcare professionals should consult [NICE's guidelines on antenatal and postnatal mental health](#) and [medicines associated with dependence or withdrawal symptoms](#).

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

Quality statement

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

Rationale

Adults from minority ethnic backgrounds may experience difficulty and stigma accessing mental health services. Strategies to address variation in access to mental health services may include offering culturally appropriate access and pathways to care that deliver culturally appropriate and adapted treatments. By monitoring and comparing rates of access to mental health services among adults with depression by ethnicity, approaches to promoting and improving access to mental health services can be identified.

Quality measures

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

Structure

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

Data source: Evidence can be collected from information recorded locally by provider organisations and healthcare professionals, for example from local plans.

Outcome

a) Rates of access to mental health services among adults with depression, by ethnicity.

Data source: [NHS England's Improving Access to Psychological Therapies \(IAPT\) data set](#) records numbers of referrals received and referrals accessing services by ethnicity. [NHS England's Mental Health Services Data Set](#) records numbers of referrals and care contacts (including a group session or drop-in contact).

b) Treatment completion rates for adults with depression, by ethnicity.

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

Data on the number of referrals that finished a course of treatment is collected for [NHS England's IAPT data set reports](#).

c) Time from first presentation with symptoms of depression to starting treatment for depression, by ethnicity.

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

[NHS England's IAPT data set](#) records data on referrals accessing services by ethnicity. [NHS England's Mental Health Services Data Set](#) records care contacts and collects data on diagnosis and ethnicity.

What the quality statement means for different audiences

Service providers (such as GP practices, community health services, mental health services including NHS talking therapy services, charities and third-sector organisations) work with commissioners to develop local care pathways that promote access to mental health services tailored to the needs of the local population. They ensure that services are

accessible and culturally appropriate to adults from minority ethnic backgrounds with depression. They also provide culturally adapted information about pathways into treatment, which is also available in different languages and formats. Services routinely collect ethnicity data to monitor, assess and support equity of access.

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

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

Adults from minority ethnic backgrounds with depression are given a choice of ways to access mental health services that are culturally appropriate to them. They can access information about routes to treatment that has been adapted to their culture and beliefs, and written in a language that they can understand.

Source guidance

- [Depression in adults: treatment and management. NICE guideline NG222 \(2022\)](#), recommendations 1.16.4 to 1.16.6
- [Depression in adults with a chronic physical health problem: recognition and management. NICE guideline CG91 \(2009\)](#), recommendation 1.1.3.3

Definitions of terms used in this quality statement

Supported to access mental health services

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

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

Commissioners and providers of mental health services should also ensure that culturally adapted information about pathways to treatment is available. Examples include adaptations to reflect religion and spirituality, beliefs about mental illness, experience of stigma, and use of metaphor, stories and examples that are meaningful to the respective culture. The information should also be made available in different languages. [[NICE's guideline on depression in adults](#), recommendations 1.16.4 and 1.16.5, and expert opinion]

Equality and diversity considerations

The [NICE guideline on depression in adults](#) recognises that other groups also experience barriers to accessing mental health services and may benefit from interventions designed

to improve access. Commissioners and providers should consider their local population and any unwarranted variation in access between adults with depression in groups such as:

- lesbian, gay, bisexual and trans adults
- adults experiencing homelessness, refugees and asylum seekers.

[Adapted from NICE's guideline on depression in adults, recommendation 1.16.6, and NICE's guideline on depression in adults with a chronic physical health problem, recommendation 1.1.3.3]

Update information

June 2023: This quality standard was updated and statements prioritised in 2011 were replaced. The topic was identified for update following a review of quality standards. The review identified updated guidance on depression in adults.

Statements are marked as:

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

The [previous version of the quality standard for depression in adults](#) is available as a pdf.

About this quality standard

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

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

Information about [how NICE quality standards are developed](#) is available from the NICE website.

See our [webpage on quality standards advisory committees](#) for details about our standing committees. Information about the topic experts invited to join the standing members is available from the [webpage for this quality standard](#).

NICE has produced a [quality standard service improvement template](#) to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

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

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource

impact work for the source guidance. Organisations are encouraged to use the [resource impact summary report for the NICE guideline on depression in adults](#) to help estimate local costs.

Diversity, equality and language

Equality issues were considered during development and [equality assessments for this quality standard](#) are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

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

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)