NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Guideline scope

Depression in adults: treatment and management

Short title

Depression in adults

Topic

This guideline will update the NICE guideline on depression in adults (CG 90) as set out in the update decision.

Who the guideline is for

Who should take action:

- professionals who share in the treatment and care of people with depression in primary care, secondary care and specialist mental health care
- professionals in other health, social care and non-health sectors who may have direct contact with or are involved in the provision of health and other public services for those with depression. These may include professionals who work in the criminal justice sector
- those with responsibility for planning services for people with depression and their carers, including directors of public health, NHS trust managers and managers in clinical commissioning groups.

It will also be relevant for:

- people with depression (depressive disorder and persistent subthreshold depressive symptoms) and their families/carers
- the public.

NICE guidelines cover health and care in England. Decisions on how they apply in other UK countries are made by ministers in the Welsh Government, Scottish Government, and Northern Ireland Executive.

Equality considerations

NICE has carried out an equality impact assessment [link in final version] during scoping. The assessment:

- lists equality issues identified, and how they have been addressed
- explains why any groups are excluded from the scope, if this was done.

1 What the guideline is about

1.1 Who is the focus?

Groups that will be covered

- Adults (aged 18 years and older) with mild, moderate or severe depression, including people with complex and chronic depression. People with persistent subthreshold symptoms will also be included.
- Specific consideration will be given to:
  - men
  - older people
  - people from black and minority ethnic groups.

1.2 Settings

Settings that will be covered

- The guideline will cover the care and shared care provided or commissioned by health (primary, secondary and tertiary) and social care services.
- This guideline will also be relevant to other community and social care settings (including criminal justice settings) although they are not explicitly covered.

1.3 Activities, services or aspects of care

Key areas that will be covered

In the sections below, examples are given for each key area to provide context, but these are not exhaustive. They do not include details of the mode or format of delivery of interventions that will be covered (including face-to-face, telephone-based, digital, individual and group).

Areas from the published guideline that will be updated

1 Service delivery:

- Models of care for the coordination and delivery of services to people with depression (including collaborative care, stepped care, case management, stratified (matched) care and primary care liaison).
- Settings for the delivery of care (including inpatient settings, day hospital care, specialist tertiary affective disorders settings, crisis resolution and home treatment and residential services).

2 Treatment of depressive episodes of differing severity (including subthreshold symptoms):

- Low-intensity psychological interventions (including self-help and facilitated self-help).
- High-intensity psychological interventions (including cognitive behavioural therapy [CBT], behavioural activation, problem solving, family interventions/couples therapy, interpersonal therapy [IPT], mindfulness-based cognitive therapy, counselling and psychodynamic psychotherapy).
- Psychosocial interventions (including befriending, mentoring, peer support and community navigators).
- Pharmacological interventions (including tricyclic antidepressants [TCAs], Serotonin-norepinephrine reuptake inhibitors [SNRIs], selective serotonin reuptake inhibitors [SSRIs] and other substances (for example, fatty acids)). Note that guideline recommendations will normally fall within licensed indications; exceptionally, and only if clearly supported by evidence, use outside a licensed indication may be recommended. The guideline will assume that prescribers will use

a drug's summary of product characteristics to inform decisions made with individual patients.

- Physical interventions (including acupuncture, electroconvulsive therapy [ECT], exercise, yoga and light therapy).
- Combined psychological or psychosocial and pharmacological interventions.

Areas from the published guideline that will not be updated

1 Experience of care.

2 Recognition, assessment and initial management of depression.

3 Variations to accessing and delivering treatment for people with learning disabilities.

Areas not covered by the published guideline or the update

1 Primary prevention of depression.

Recommendations in areas that are not being updated may be edited to ensure that they meet current editorial standards, and reflect the current policy and practice context.

1.4 Economic aspects

Economic aspects will be taken into account when making recommendations. An economic plan will be developed that states for each review question (or key area in the scope) whether economic considerations are relevant, and if so whether this is an area that should be prioritised for economic modelling and analysis. The economic evidence will be reviewed and economic analyses carried out, using a NHS and PSS perspective, as appropriate.

1.5 Draft review questions

While writing this scope, we have drafted the following potential review questions and sub-questions that address the key issues identified:

1 For adults with depression, what are the relative benefits and harms associated with different models for the coordination and delivery of services?

- Are different service delivery models appropriate to the care of people with different types of depression, such as complex and chronic depression?

2 For adults with depression, what are the relative benefits and harms associated with different settings for the delivery of care?

3 For adults with mild to moderate depression, what are the relative benefits and harms of psychological, pharmacological and physical interventions alone or in combination?

- Does mode of delivery of psychological interventions (group-based or individual) impact on outcomes?
- Does format of delivery of psychological interventions (face-to-face, telephone-based or digital) impact on outcomes?
- Following poor response to treatment of depression, which psychological, pharmacological or physical interventions are appropriate?
- In people whose depression has responded to treatment, what strategies are effective in preventing relapse (including maintenance treatment)?

4 For adults with moderate to severe depression, what are the relative benefits and harms of psychological, pharmacological and physical interventions alone or in combination?

- Does mode of delivery of psychological interventions (group-based or individual) impact on outcomes?
- Does format of delivery of psychological interventions (face-to-face, telephone-based or digital) impact on outcomes?
- Following poor response to treatment of depression, which psychological, pharmacological or physical interventions are appropriate?
- In people whose depression has responded to treatment, what strategies are effective in preventing relapse (including maintenance treatment)?

5 For adults with complex and chronic depression, what are the relative benefits and harms of psychological, pharmacological and physical interventions alone or in combination?

6 For adults with mild to moderate depression, what are the relative benefits and harms of psychosocial interventions alone or in combination?

7 For adults with moderate to severe depression, what are the relative benefits and harms of psychosocial interventions alone or in combination?

8 For adults with complex and chronic depression, what are the relative benefits and harms of psychosocial interventions alone or in combination?

1.6 Main outcomes

The main outcomes that will be considered when searching for and assessing the evidence are:

1 Depression symptomatology.

2 Recovery and relapse.

3 Adaptive functioning (for example, employment, social functioning, ability to carry out activities of daily living and quality of life).

4 Rates of self-injury.

5 Drop-out (including all cause and drop-out because of side effects).

6 Side effects.

7 Carer wellbeing.

8 Cost effectiveness.

9 Resource use.

2 Links with other NICE guidance

NICE guidance about the experience of people using NHS services

- Patient experience in adult NHS services (2012) NICE guideline CG138

- Service user experience in adult mental health (2011) NICE guideline CG136
- Medicines adherence (2009) NICE guideline CG76

NICE guidance in development that is closely related to this guideline

NICE is currently developing the following guidance that is closely related to this guideline:

- Depression in children and young people (update) NICE guideline. Publication expected March 2015.
- Major depressive disorder – vortioxetine. NICE technology appraisal. Publication expected September 2015.
- Transcutaneous cranial electrical stimulation for insomnia, depression or anxiety. NICE interventional procedure guidance. Publication date to be confirmed.

2.1 NICE Pathways

When this guideline is published, the recommendations will update the adults section of the current NICE pathway on depression. NICE Pathways bring together all related NICE guidance and associated products on a topic in an interactive topic-based flow chart.

Other relevant NICE guidance included in the NICE Pathway:

- Depression in adults with a chronic physical health problem (2009) NICE guideline CG91
- Depression in children and young people (2005) NICE guideline CG28
- Agomelatine for the treatment of major depressive episodes (terminated appraisal) (2011) NICE technology appraisal 231
- Vagus nerve stimulation for treatment-resistant depression (2009) NICE interventional procedure guidance 330
- Transcranial magnetic stimulation for severe depression (2007) NICE interventional procedure guidance 242.

3 Context

3.1 Key facts and figures

Each year 6% of adults will experience an episode of depression, and over the course of their lifetime more than 15% of the population will experience an episode of depression. The average length of an episode of depression is between 6 and 8 months. For many people the episode will be mild, but for more than 30%, 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.

Women are 1.5 to 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 commit suicide, to have higher levels of substance misuse, and are less likely to seek help than women.

The symptoms of depression can be disabling and the effects of the illness pervasive. Depression can have a major detrimental effect on a person's personal, social and occupational functioning, placing a heavy burden on the person and their carers and dependents, as well as placing considerable demands on the healthcare system. Depression is expected to become the second most common cause (after ischaemic heart disease) of loss of disability-adjusted life years in the world by 2020.

Depression is the leading cause of suicide, accounting for two-thirds of all deaths by suicide.

3.2 Current practice

Treatment for depressive illnesses in the NHS is hampered by the unwillingness of many people to seek help for depression and the variable detection of depression by professionals, and this inevitably results in under-treatment. For example, of the 130 depressed people per 1000 population, only 80 will consult their GP. Of these 80 people, 49 are not recognised as depressed, mainly because these patients are consulting for 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 depressed, most are treated in primary care and about 1 in 4 or 5 are referred to secondary mental health services. There is considerable variation among individual GPs in their referral rates to mental health services, but those seen by specialist services are a highly selected group – they are skewed towards those who do not respond to antidepressants, people with more severe illnesses, single women and those under 35 years.

The previous guideline recommends a stepped-care approach for the management of depression, with the least intrusive, most effective intervention provided first (low-intensity psychosocial intervention for people with persistent subthreshold depressive symptoms or mild to moderate depression, and a combination of antidepressant medication and high-intensity psychological intervention (CBT or IPT) for people with moderate or severe depression). If a person does not benefit from the intervention initially offered (or declines an intervention) they should be offered an appropriate intervention from the next step.

The most common method of treatment for depression in primary care is psychotropic medication, and 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 to ensure that there is access to psychological therapies for all who would benefit from them.

3.3 Policy, legislation, regulation and commissioning

Policy

- The Sainsbury's Centre for Mental Health (2007) Delivering the Government's Mental Health Policies.

Legislation, regulation and guidance

- Health and Social Care Act 2012
- The Mental Health Act, 1983
- The Mental Capacity Act, 2005
- The Human Rights Act, 1998.

Commissioning

- NICE (2011) Commissioning stepped care for people with common mental health disorders.

4 Further information

This is the draft scope for consultation with registered stakeholders. The consultation dates are 2 March to 30 March 2015.

The guideline is expected to be published in 10 May 2017.

You can follow progress of the guideline.

Our website has information about how NICE guidelines are developed.