National Institute for Health and Care Excellence

Version 1.0

# Depression in adults: treatment and management

## Appendices A to G

*NICE Guideline*

*Appendices*

*18 July 2017*

*Draft for Consultation*

*Developed by the National Guideline Alliance, hosted by the Royal College of Obstetricians and Gynaecologists*

**Disclaimer**
Healthcare professionals are expected to take NICE clinical guidelines fully into account when exercising their clinical judgement. However, the guidance does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of each patient, in consultation with the patient and/or their guardian or carer.

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# Appendices

# Appendix A: Scope for the development of the clinical guideline

## A.1 Guideline scope 2017: Depression in adults: treatment and management

### A.1.1 Topic

This guideline will update the NICE guideline on depression in adults (CG90) as set out in the update decision.

### A.1.2 Who the guideline is for

Who should take action:

- professionals involved 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. This 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.

### A.1.3 Equality considerations

NICE has carried out an equality impact assessment 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.

### A.1.4 What the guideline is about

#### A.1.4.1 Who is the focus?

**Groups that will be covered**

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

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- men
- older people
- people from black and minority ethnic groups
- people with coexisting mental health conditions.

**A.1.4.2 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.

**A.1.4.3 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), or service-user preference for these interventions, or the sequencing of these interventions.

***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, 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], antipsychotics, lithium 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 interventions, including psychological or psychosocial and pharmacological interventions.

***Areas from the published guideline that will not be updated***

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1. Experience of care.
2. Recognition, assessment and initial management of depression.
3. Variations to accessing and delivering treatment for people with learning disabilities.

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.

***Areas not covered by the published guideline or the update***

1. Primary prevention of depression.

### A.1.4.4 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.

### A.1.4.5 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 adults 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) affect outcomes?
   - Does format of delivery of psychological interventions (face-to-face, telephone-based or digital) affect outcomes?
   - Following poor response to treatment of depression, which psychological, pharmacological or physical interventions are appropriate?
   - In adults 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) affect outcomes?
   - Does format of delivery of psychological interventions (face-to-face, telephone-based or digital) affect outcomes?
   - Following poor response to treatment of depression, which psychological, pharmacological or physical interventions are appropriate?
   - In adults 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?

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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?

### A.1.4.6 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. Cognitive function.
5. Rates of self-injury.
6. Mortality (including all-cause and suicide).
7. Drop-out (including all-cause and drop-out because of side effects).
8. Side effects and withdrawal effects.
9. Carer wellbeing.
10. Service utilisation.
11. Cost effectiveness.
12. Resource use.

## A.1.5 Links with other NICE guidance

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**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:

- 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.

### A.1.5.1 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 (2015) NICE guideline CG28
- Agomelatine for the treatment of major depressive episodes (terminated appraisal) (2011) NICE technology appraisal 231

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- 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.

Other relevant NICE guidance related to the NICE Pathway:

- Common mental health disorders: Identification and pathways to care (2011) NICE guideline CG123

## A.1.6 Context

### A.1.6.1 Key facts and figures

Each year 6% of adults in England will experience an episode of depression, and over the course of their lifetime more than 15% of people will 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 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 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.

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.

### A.1.6.2 Current practice

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 2009 NICE guideline on depression in adults 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

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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 aims to ensure that there is access to psychological therapies for all who would benefit from them.

#### A.1.6.3 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.

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### A.1.7 Further information

This is the final scope incorporating comments from registered stakeholders during consultation.

The guideline is expected to be published in May 2017.

You can follow progress of the guideline.

Our website has information about how NICE guidelines are developed.

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# A.2 Guideline scope 2009: Depression: the treatment and management of depression in adults (update)

## A.2.1 Guideline title

Depression: the treatment and management of depression in adults (update)

### A.2.1.1 Short title

Depression in adults (update)

## A.2.2 Background

The National Institute for Health and Clinical Excellence ('NICE' or 'the Institute') has commissioned the National Collaborating Centre for Mental Health to review recent evidence on the treatment and management of depression and to update the existing guideline 'Depression: management of depression in primary and secondary care' (amended) (NICE clinical guideline 23, 2007). The guideline update will provide recommendations for good practice that are based on the best available evidence of clinical and cost effectiveness.

The Institute's clinical guidelines support the implementation of National Service Frameworks (NSFs) in those aspects of care for which a Framework has been published. The statements in each NSF reflect the evidence that was used at the time the Framework was prepared. The clinical guidelines and technology appraisals published by NICE after an NSF has been issued have the effect of updating the Framework.

NICE clinical guidelines support the role of healthcare professionals in providing care in partnership with service users, taking account of their individual needs and preferences, and ensuring that service users (and their carers and families, if appropriate) can make informed decisions about their care and treatment.

## A.2.3 Clinical need for the guideline

Depression refers to a range of mental health disorders characterised by the absence of a positive affect (a loss of interest and enjoyment in ordinary things and experiences), low mood and a range of associated emotional, cognitive, physical and behavioural symptoms. It is often accompanied by anxiety, and can be chronic even in milder presentations. People with more severe depression may also develop psychotic symptoms (hallucinations and/or delusions).

The symptoms of depression can be disabling and the effects of the illness pervasive. Depression can have a major detrimental effect on people's personal, social and occupational functioning, placing a heavy burden on individuals and their carers and dependents, as well as placing considerable demands on the healthcare system. Among all diseases, depression is currently the fourth leading cause of burden to society. World Health Organisation projections indicate that it will be the highest ranking cause of disease burden in developed countries by the year 2020.

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. 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 with 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.

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Estimated prevalence rates for men do not vary greatly among ethnic groups but those for women differ remarkably. In the UK significantly higher rates of depression are reported in women of Asian and Oriental family origin or background compared with other groups, with the next highest rates being in white women and the lowest rates in women of West Indian or African family origin or background. However, these estimates are based on relatively small samples.

Depression is the leading cause of suicide, which accounts for less than 1% of all deaths. Nearly two-thirds of deaths by suicide occur in people with depression (that is, about 2,600 suicides per year in England alone).

Data from the Prescription Cost Analysis (PCA) system show that in the 12 months to March 2006, antidepressant drugs accounted for 4.1% of all items dispensed in the community in England, at a net ingredient cost of £31 million.

The NICE clinical guideline 'Depression: management of depression in primary and secondary care' (clinical guideline 23) was published in December 2004, and was amended in 2007 to take into account new prescribing advice for venlafaxine. New evidence regarding the care of people with depression involving psychosocial, pharmacological and other physical interventions means that NICE's original guideline on depression needs to be updated.

### A.2.4 The guideline

The guideline development process is described in detail in two publications that are available from the NICE website (see 'Further information'). 'The guideline development process: an overview for stakeholders, the public and the NHS' describes how organisations can become involved in the development of a guideline. The guidelines manual' provides advice on the technical aspects of guideline development.

This document is the scope. It defines exactly what this guideline will (and will not) examine, and what the guideline developers will consider. The areas that will be addressed by the guideline are described in the following sections.

### A.2.5 Population

#### A.2.5.1 Groups that will be covered

- Adults (aged 18 years and older) who have a clinical diagnosis of depression established by a recognised diagnostic system such as DSM–IV or ICD–10. The guideline will be relevant to people with mild, moderate and severe major depressive disorders.
- People in the above group who also have learning difficulties, acquired cognitive impairments, or language difficulties.

#### A.2.5.2 Groups that will not be covered

- People with chronic physical disorders. A separate guideline on the treatment of depression in people with chronic physical health problems has been commissioned and will be developed in conjunction with this guideline.
- People with other primary psychiatric disorders, such as schizophrenia or substance misuse.

### A.2.6 Healthcare setting

Primary, secondary and tertiary care. The guidance will be relevant to all healthcare professionals who provide care for people with depression, irrespective of setting.

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### A.2.7 Clinical management

a) Recognition, assessment and classification of depression, including variations to the assessment to take account of the needs of people with learning difficulties, acquired cognitive impairments or language difficulties.
b) Treatment of depressive episodes of differing severity, including the appropriate use of psychosocial interventions (such as guided self-help, formal psychological interventions, support groups and programmes aimed at facilitating employment), pharmacological interventions (including antidepressants and other medication), and physical interventions (such as exercise and electroconvulsive therapy).
c) Variations to the systems for accessing and delivering treatment required to take account of the needs of people with learning difficulties, acquired cognitive impairments or language difficulties.
d) Interventions to reduce the risk of relapse after an acute depressive episode.
e) Assessment and management of the known side effects and other drawbacks of psychotropic medication, physical interventions, and psychosocial interventions, including long-term side effects and risks of suicide.
f) Combined psychosocial and pharmacological treatments, the use of combined pharmacological treatments and the sequencing of both pharmacological and psychosocial interventions.
g) The safe withdrawal/discontinuation of psychotropic medication.
h) Interactions between psychotropic medication and common prescription and over-the-counter drugs.
i) The varying approaches of different races and cultures, and issues of internal and external social exclusion.
j) The role of the families and carers in the treatment and support of people with depression.
k) The ways in which services are delivered, including models of care such as case management and collaborative care, and the structured delivery of care in primary and secondary care services.

Note that guideline recommendations for pharmacological interventions 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 their decisions for individual service users.

The Guideline Development Group will take reasonable steps to identify ineffective interventions and approaches to care. If robust and credible recommendations for re-positioning an intervention for optimal use or changing an approach to care to make more efficient use of resources can be made, they will be clearly stated. If the resources released are substantial, consideration will be given to listing such recommendations in the 'Key priorities for implementation' section of the guideline.

### A.2.8 Areas that will not be covered by the guideline

The guideline will not cover:

- diagnosis of depression
- primary prevention of depression.

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## A.2.9 Status

### A.2.9.1 Scope

This is the final scope.

The guideline will be developed in conjunction with 'Depression: the treatment and management of depression in adults with a chronic physical health problem'; together they will update 'Depression: management of depression in primary and secondary care (amended)' (NICE clinical guideline 23 [amended] [2007]).

They will also update and replace the following NICE guidance:

- Computerised cognitive behaviour therapy for depression and anxiety. NICE technology appraisal guidance 97 (2006).
- Guidance on the use of electroconvulsive therapy. NICE technology appraisal guidance 59 (2003).

## A.2.10 Guideline

The development of the guideline recommendations will begin in November 2007.

## A.2.11 Further information

Information on the guideline development process is provided in:

- 'The guideline development process: an overview for stakeholders, the public and the NHS'
- 'The guidelines manual'.

These are available as Portable Document Files (PDFs) from the NICE website (www.nice.org.uk/guidelinesmanual). Information on the progress of the guideline will also be available from the website.

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# Appendix B: Declarations of interests by Guideline Committee members

With a range of practical experience relevant to depression in the GC, members were appointed because of their understanding and expertise in healthcare for people with depression and support for their families/carers, including: scientific issues; health research; the delivery and receipt of healthcare, along with the work of the healthcare industry; and the role of professional organisations and organisations for people depression and their families/carers.

To minimise and manage any potential conflicts of interest, and to avoid any public concern that commercial or other financial interests have affected the work of the GC and influenced guidance, members of the GC must declare as a matter of public record any interests held by themselves or their families which fall under specified categories (see below). These categories include any relationships they have with the healthcare industries, professional organisations and organisations for people with depression and their families/carers.

Individuals invited to join the GC were asked to declare their interests before being appointed. To allow the management of any potential conflicts of interest that might arise during the development of the guideline, GC members were also asked to declare their interests at each GC meeting throughout the guideline development process. The interests of all the members of the GC are listed below, including interests declared prior to appointment and during the guideline development process.

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## B.1 Categories of interest

- Paid employment
- Personal pecuniary interest: financial payments or other benefits from either the manufacturer or the owner of the product or service under consideration in this guideline, or the industry or sector from which the product or service comes. This includes holding a directorship or other paid position; carrying out consultancy or fee paid work; having shareholdings or other beneficial interests; receiving expenses and hospitality over and above what would be reasonably expected to attend meetings and conferences. This also includes personal family interest in 2017 declarations: financial payments or other benefits from the healthcare industry that were received by a member of the close family. These are listed separately in 2009 declarations of interest.
- Non-personal pecuniary interest: financial payments or other benefits received by the GC member's organisation or department, but where the GC member has not personally received payment, including fellowships and other support provided by the healthcare industry. This includes a grant or fellowship or other payment to sponsor a post, or contribute to the running costs of the department; commissioning of research or other work; contracts with, or grants from, NICE.
- Personal non-pecuniary interest: these include, but are not limited to, clear opinions or public statements you have made about individuals with depression, holding office in a professional organisation or advocacy group with a direct interest in depression, other reputational risks relevant to depression.

## B.2 Declarations of interests by Guideline Committee members and NGA/NCCMH staff 2017

| Guideline Committee declarations of interest and date declared |
| --- |
| **Professor Navneet Kapur (Committee Chair)** |

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| Guideline Committee declarations of interest and date declared | |
|---|---|
| Employment | Professor of Psychiatry and Population Health, University of Manchester and Honorary Consultant in Psychiatry, Greater Manchester Mental Health and Social Care Trust<br>Head of Research, Centre for Suicide Prevention & National Confidential Inquiry into Suicide and Homicide<br>Member, National Suicide Prevention Strategy Advisory Group, Department of Health (England) |
| Personal pecuniary interest | None |
| Non-personal pecuniary interest | 9.6.2015 Academic psychiatrist in a University post undertaking non-industry funded research in the field of suicidal behaviour. Programmes of research funded by the National Institute of Health Research, the Healthcare Quality Improvement Partnership, and the Department of Health. |
| Personal non-pecuniary interest | 25.5.2016 Co-author paper: Mental health service changes, organisational factors, and patient suicide in England in 1997–2012: a before-and-after study, Lancet Psychiatry 2016 (mentions NICE depression guidelines specifically).<br>21.3.2017 Co-author of many academic papers on the treatment and prevention of suicidal behaviour.<br>20.3.2017 Topic Expert Member NICE Public Health Advisory Committee: Preventing suicide in community and custodial setting. |
| Non-personal non-pecuniary interest | None |
| Decision taken | No action needed |
| **Dr June Brown** | |
| Employment | Senior Lecturer in Clinical Psychology, Institute of Psychiatry (IoP), Kings College London |
| Personal pecuniary interest | None |
| Non-personal pecuniary interest | 26.2.2016 Paper submitted to the British Journal of Psychiatry. Not accepted. |
| Personal non-pecuniary interest | None |
| Decision taken | No action needed |
| **Professor Carolyn Chew-Graham** | |
| Employment | Professor of General Practice Research, Keele University<br>Honorary Professor of Primary Care, University of Manchester<br>Honorary Professor of Primary Care Mental Health, South Staffs & Shropshire Foundation Trust (SSSFT)<br>Principal in General Practice, NHS Manchester<br>Honorary Consultant in Primary Care, NHS Manchester |
| Personal pecuniary interest | 5.12.2016 Paid by Lundbeck UK as reviewer of educational materials for clinicians on the management of treatment resistant depression. These materials are non-promotional (do not suggest specific drugs).<br>6.2.2017 Commissioned by MIMS, to write a clinical review on management of depression: deferred until guideline is published. |
| Non-personal pecuniary interest | 9.6.2015 Grant-holder on a number of research studies, some of which involve the evaluation of primary care interventions for people with depression.<br>25.5.2016 Co-investigator in study funded by PHR 14/186/11 Community Pharmacy Mood Intervention Study, |

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| Guideline Committee declarations of interest and date declared | |
|---|---|
| | leading the qualitative study.<br>5.12.2016 Delivered training to GP trainees on Management of MH problems in general practice, for RCGP NW Faculty, 30th Nov 2016. Payment to university.<br>5.12.2016 Organised a seminar on physical health of people with severe mental illness at South Staffs and Shropshire Foundation Trust, which was sponsored by Lundbeck UK (provided refreshments).<br>5.12.2016 Organising a regional Integrated Clinical Academic Training Conference in April 2017. Lundbeck UK have offered to support this by paying for refreshments. |
| Personal non-pecuniary interest | 9.6.2015 RCGP Curriculum Advisor, Mental Health.<br>9.6.2015 Delivered training to GPs in Slovenia on identification and management of depression in patients with diabetes; travel expenses were reimbursed by DDD (Dialogue on Diabetes and Depression).<br>1.9.2016 Invited to write a BMJ online learning module on the management of depression. |
| Decision taken | 5.12.2016 Declare an interest and withdraw from discussions on treatment resistant depression at GC meetings. |
| **Dr Jeremy Clarke** | |
| Employment | Psychological therapist, Newham Psychological Therapies, ELFT<br>Senior Accredited DIT Supervisor, Southwark IAPT, Wandsworth IAPT, Sutton and Merton IAPT<br>Consultant Mental Health Advisor, Greater Manchester Combined Authority)<br>Research Associate, Centre for Humanities Engaging Science and Society, University of Durham |
| Personal pecuniary interest | 9.6.2015 Paid consultant to the Greater Manchester Combined Authorities for mental health. |
| Non-personal pecuniary interest | 23.10.2015 Awarded an EU funded grant. |
| Personal non-pecuniary interest | 9.6.2015 Research Associate at CHESS, Durham University conducting research into evaluation methodologies for psychological therapies. Unpaid<br>9.6.2015 Research lead for the Association for Psychoanalytic Psychotherapy in the NHS, which submitted comments to the scope consultation. Unpaid.<br>9.6.2015 Unpaid member of a number of lead bodies for psychological therapies and mental health policy: viz. the Ministerial Advisory Group for mental health; DWP's mental health advisory group; the Accreditation Committee for Psychological Therapy services; the IAPT Payment by Results Board; the We Need to Talk coalition; Action for Choice in Therapy and the Action for Choice in Therapy Task Force, IAPT. Also runs the annual Psychological Therapies in the NHS conference.<br>25.5.2016 Joining a Clinical Advisory Group for Ingeus advising on clinical governance and quality for health and wellbeing services related to welfare benefits |
| Decision taken | No action needed |
| **Sinead Dervin** | |
| Employment | Commissioning Manager, Mental Health, NHS England |
| Personal pecuniary interest | None |

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| Guideline Committee declarations of interest and date declared | |
|---|---|
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| Decision taken | No action needed |
| **Dr David Ekers** | |
| Employment | Nurse Consultant/Senior Visiting Research Fellow,, Tees Esk and Wear Valleys NHS Trust/University of York (Mental Health and Addictions Research Group) |
| Personal pecuniary interest | None |
| Non-personal pecuniary interest | 9.6.2015 Conducts research into psychological interventions for depression including CASPER and COBRA trials.<br>25.5.2016 Research grant Community Pharmacy Mood Intervention Study NIHR PHR funded. |
| Personal non-pecuniary interest | 22.7.2016 COBRA paper published in Lancet. |
| Decision taken | No action needed |
| **Professor Simon Gilbody** | |
| Employment | Professor of Psychological Medicine and Health Services Research; University of York |
| Personal pecuniary interest | None |
| Non-personal pecuniary interest | 9.6.2015 Conducts research into psychological interventions for depression including the CADET trial.<br>23.10.2015 Co-applicant on a HTA funded grant.<br>25.5.2016 Co-applicant and grant holder on NIGHR programme on antidepressant prescribing REDUCE. |
| Personal non-pecuniary interest | 23.10.2015 Publishing a large scale cCBT RCT in the BMJ. |
| Decision taken | No action needed |
| **Dr David Hewison** | |
| Employment | Head of Research; Consultant to 'Couple Therapy for Depression' Training, Tavistock Relationships<br>Programme Leader & Supervisor, Professional Doctorate in Couple Psychotherapy, TCCR/UEL |
| Personal pecuniary interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | 9.6.2015 Developed the model of couple therapy used in IAPT Services and employer is a provider of training programmes in the 'Couple Therapy for Depression' model. In-house consultant to the training providers. Co-authored the book Couple Therapy for Depression. A Clinicians Guide to Integrative Practice, which is the manual for the training and the intervention (personally receives no royalties).<br>18.10.2016 Paper accepted for publication in Psychotherapy on the current state of the evidence base for couple therapy both RCT and naturalistic. (Published in Psychotherapy December 2016.) |
| Decision taken | No action needed |
| **Professor Anthony Kendrick** | |
| Employment | Professor of Primary Care, University of Southampton |
| Personal pecuniary interest | 26.8.2015 Has not received funding from pharmaceutical companies for more than five years; prior to that did receive some as fees for speaking, and had unrestricted educational grants from Lundbeck, Lilly, Wyeth and Servier |

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| Guideline Committee declarations of interest and date declared | |
|---|---|
| | totalling £70,000 in 2007-8, which co-funded research on the impact of symptom questionnaires for depression incentivised in the GP contract quality and outcomes framework (QOF) pay for performance scheme. |
| Non-personal pecuniary interest | 26.8.2015 NIHR funding for PROMDEP study of the value of patient-reported outcome measures (PROMs) in the monitoring of depression.<br>26.8.2015 Shortlisted NIHR programme grant application on an intervention to reduce long-term antidepressant taking. "I believe we are prescribing too many long-term antidepressants in general practice."<br>23.10.2015 Co-applicant on a HTA funded grant. |
| Personal non-pecuniary interest | 25.5.2016 Conducting research on measuring severity of depression, and reducing inappropriate long-term antidepressant treatment.<br>9.6.2015 Research at the University of Southampton focuses on the GP assessment and management of depression and how they can be improved.<br>23.11.2015 Part of a collaboration (PANDA), looking into how drug treatment can benefit people based on the number of symptoms of depression and other factors (equity of access issue).<br>14.1.2016 Part of the ANTLER placebo-controlled trial of withdrawing maintenance antidepressants.<br>14.1.2016 Published editorial on the need to reduce long-term antidepressant prescribing in The Prescriber.<br>25.5.2016 Member of NICE National Indicators Advisory Committee.<br>22.7.2016 Conducting research on routine measurement of outcomes in depression: Cochrane review published 13.7.2016 showing evidence base is weak.<br>22.7.2016 Conducting research on reducing inappropriate long-term antidepressant prescribing.<br>14.2.2017 Spoke on Radio 5 Live on 12.2.2017 to say that he believes that antidepressants are being prescribed for too long, and unnecessarily, and are not being reviewed or tapered appropriately, due to pressure on GPs resulting in a lack of available appointments for drug review.<br>16.3.2017 Paper accepted as lead author by BMJ Open showing some benefit from monitoring primary care patients with depression using patient reported outcome measures (PROMDEP feasibility randomised controlled trial).<br>13.6.2017 Chair of the Trial Steering Committee for the Barkham and colleagues' RCT study of counselling versus CBT for depression. |
| Decision taken | No action needed |
| **Dr Neil Nixon** | |
| Employment | Consultant Psychiatrist and Director of Medical Education, Nottinghamshire Healthcare NHS Trust<br>Honorary Associate Professor, University of Nottingham |
| Personal pecuniary interest | 9.6.2015 Has received financial assistance to attend academic meetings from Janssen-Cilag, AstraZeneca and Servier. Dr. Nixon has also taken part in advisory panels for Janssen-Cilag and Servier. There has been no such financial assistance within the last 5 years and there is no current financial assistance to declare. |

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| Guideline Committee declarations of interest and date declared | |
|---|---|
| Non-personal pecuniary interest | 17.9.2015 Lead applicant on a grant currently being considered by NIHR for MBCT in adolescents with depression. Application not successful.<br>17.9.2015 Writing up research on a pragmatic trial (CLAHRC) using a form of collaborative care for treatment of persistent depression.<br>13.6.2017 NIHR Grant – rTMS versus theta-burst stimulation in secondary care depression |
| Personal non-pecuniary interest | 22.7.2016 Co-author on a paper accepted for publication by Lancet Psychiatry: CLAHRC randomised controlled trial of clinical and cost effectiveness of a specialist depression service versus usual specialist mental health care for managing persistent depression: 18 month results.<br>16.3.2017 Collaborator on REBOOT, a study set up to see whether an online peer support website 'Big White Wall' is more or less effective in helping people when they are experiencing symptoms of depression and anxiety, compared to freely available online information from the NHS (Moodzone).<br>13.6.2017 Co-author of a paper on PHQ-9 factor structure in severe depression. Journal of Affective Disorders 2017 |
| Decision taken | No action needed |
| **Louise O'Connor** | |
| Employment | Lay Member |
| Personal pecuniary interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| Decision taken | No action needed |
| **Catherine Ruane** | |
| Employment | Lay Member |
| Personal pecuniary interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| Decision taken | No action needed |
| **Prishah Shah** | |
| Employment | Lay Member |
| Personal pecuniary interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | 9.6.2015 Service User member of ToSCA trial for generalised anxiety disorder, UCL.<br>9.6.2015 Service User member of accreditation of psychological services programme run by Royal College of Psychiatrists/British Psychological Society.<br>25.5.2016 Service User member of Community Navigator study, UCL. |
| Decision taken | No action needed |
| **Jennifer Speller** | |
| Employment | Senior Mental Health Joint Commissioning Manager, Islington Clinical Commissioning Group/London Borough of Islington (to April 2016)<br>Head of Service Transformation (acting), Islington Clinical Commissioning Group (from April 2016) |

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| Guideline Committee declarations of interest and date declared | |
|---|---|
| Personal pecuniary interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| Decision taken | No action needed |
| **Professor David Taylor** | |
| Employment | Director of Pharmacy and Pathology, South London and Maudsley NHS Foundation Trust<br>Professor of Pharmacology, King's College London |
| Personal pecuniary interest | 9.6.2015 Lundbeck: advisory board member, paid lectures and research funding.<br>9.6.2015 Advisory board member Sunovion, paid lectures Janssen and Otsuka, research funding BMS and Janssen. |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | 22.7.2016 Publication: Taylor et al. (2014), Agomelatine – a meta-analysis of published and unpublished trials.<br>22.7.2016 Publication: Catchart-Harris (2016), Psilocybin in depression. Lancet Psychiatry. |
| Decision taken | No action needed |
| **Professor Ed Watkins** | |
| Employment | Professor of Experimental and Applied Clinical Psychology, University of Exeter<br>Chartered Clinical Psychologist,<br>Director of Sir Henry Wellcome Building for Mood Disorders Research<br>Director of Research for DClinPsy Programme<br>Director of SMART Lab |
| Personal pecuniary interest | 9.6.2015 Personal shareholdings of companies within the pharmaceutical industry (e.g., GlaxoSmithKline).<br>25.5.2016 On the scientific expert advisory board of SME: Ogenblik, which seeks to develop handheld devices to support mental health (expenses only).<br>25.5.2016 On the scientific expert advisory board of SME IESO which provides CBT treatments online (expenses and one-day honorarium payment as expert advisor to board).<br>22.7.2016 Submitted ESRC Mental Health Leadership Fellow application focused on investigating underlying mechanisms of psychological treatment and promoting a social framework approach to mental health. This application was not successful. |
| Non-personal pecuniary interest | 9.6.2015 The Mood Disorders Centre holds research grants from Help for Heroes charity and from Cornwall NHS Partnership Trust in order to conduct research respectively into improving low-intensity treatments for common mental health problems in armed forces veterans and in improving computerised internet-delivered treatments for depression in a low-intensity IAPT services.<br>25.5.2016 Research trials include Concreteness training, PREVENT, COBRA, IMPROVE1, IMPROVE 2, MooDFOOD, funded by the NIHR, MRC, and EC. Developer and lead of rumination-focused cognitive behavioural therapy for severe depression.<br>22.7.2016 Through to second stage for NIHR Public Health Research grant called PREVAIL for using digital e-health to promote resilience in young people, focused on using |

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| Guideline Committee declarations of interest and date declared | |
|---|---|
| | cognitive-behavioural approaches (£2M). |
| Personal non-pecuniary interest | 9.6.2015 Involved in research trials that have published opinions about the efficacy of cognitive-behavioural therapy and behavioural activation approaches for depression, including rumination-focused cognitive-behavioural therapy and mindfulness-based cognitive therapy. Papers arising from these completed research projects may be submitted as evidence to the NICE committee.<br>9.6.2015 On the expert review board for the MQ charity PSYIMPACT scheme, which focuses on funding the development and evaluation of psychological treatments for mental health problems.<br>18.9.2015 Involved in two trials included in the service delivery evidence review (Segal, Williams & Teasdale).<br>22.7.2016 Cost and Outcome of BehaviouRal Activation versus Cognitive Behaviour Therapy for Depression (COBRA): results of a non-inferiority randomised controlled trial. Richards et al., published in Lancet July 2016.<br>22.7.2016 Co-author of paper Rumination-focused Cognitive Behavior Therapy versus Cognitive Behavior Therapy for Major Depression: Results from a randomized controlled trial, in review. |
| Decision taken | No action needed |
| **Dr Philip Wilkinson** | |
| Employment | Consultant in Psychiatry of Old Age, Oxford Health NHS Foundation Trust and Honorary Senior Clinical Lecturer, University of Oxford |
| Personal pecuniary interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | 9.6.2015 Member of the board of trustees (unremunerated) of the Oxford Mindfulness Foundation. This is the charity that supports the Oxford Mindfulness Centre (part of the Department of Psychiatry, University of Oxford) in its work researching mindfulness based interventions and disseminating evidence-based mindfulness interventions.<br>01.09.2016 Amendment: Stood down from the board of trustees of the Oxford Mindfulness Foundation on 20.07.2016.<br>9.6.2015 Review author for the Cochrane review of maintenance treatments in late life depression.<br>01.09.2016 Author of the update Cochrane review Continuation and maintenance treatments for depression in older people, published on 9.9.2016.<br>5.12.2016 Named on a new HTA grant that will be recruiting participants with major depression. HTA Project: 15/161/05 - A feasibility study of Acceptance and Commitment Therapy for older people with treatment-resistant generalised anxiety disorder (FACTOID). |
| Decision taken | No action needed |

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| NGA/NCCMH staff declarations of interest | |
|---|---|
| **Lauren Becker** | |
| Employment | Assistant Systematic Reviewer, NCCMH (to March 2016) |
| Personal pecuniary interest | None |

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| NGA/NCCMH staff declarations of interest | |
|---|---|
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| Decision taken | No action needed |
| **Angela Bennett** | |
| Employment | Guideline Lead, NGA (from August 2016) |
| Personal pecuniary interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| Decision taken | No action needed |
| **Bishal Bhandari** | |
| Employment | Assistant Systematic Reviewer, NGA (September 2016 to January 2017) |
| Personal pecuniary interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| Decision taken | No action needed |
| **Gemma Halliday** | |
| Employment | Research Assistant, NCCMH (to March 2016) |
| Personal pecuniary interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| Decision taken | No action needed |
| **Dr Sally Humphreys** | |
| Employment | Project Manager, NGA (from April 2016) |
| Personal pecuniary interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| Decision taken | No action needed |
| **Dr Ifigeneia Mavranezouli** | |
| Employment | Senior Health Economist |
| Personal pecuniary interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| Decision taken | No action needed |
| **Dr Odette Megnin-Viggars** | |
| Employment | Senior Systematic Reviewer, |
| Personal pecuniary interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| Decision taken | No action needed |
| **Maryla Moulin** | |
| Employment | Senior Project Manager, NCCMH (to March 2016) |
| Personal pecuniary interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| Decision taken | No action needed |

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| NGA/NCCMH staff declarations of interest | |
|---|---|
| **Professor Steve Pilling** | |
| Employment | Clinical Adviser, NGA<br>Director, Centre for Outcomes Research and Effectiveness, University College London |
| Personal pecuniary interest | None |
| Non-personal pecuniary interest | 9.6.2015 Medical Research Council funding looking at psilocybin<br>9.6.2015 Grant from National Alliance for Research on Schizophrenia and Depression to look at transcranial direct-current stimulation in treatment of depression<br>9.6.2015 Involved in CADET, IAPT and PRMOS study programmes<br>14.7.2015 I Study investigating a new model of acute services in A&E<br>25.5.2016 Funding from DHSE on the development of Evidence-Based Treatment Pathways and Safer Staffing Mental Health<br>1.9.2016 Chief Investigator, Programme Grant of £2.3M from NIHR (2017-2022), Open Dialogue: Evaluating Service System for Severe Mental Illness (ODESSI) |
| Personal non-pecuniary interest | None |
| Decision taken | No action needed |
| **Christine Sealey** | |
| Employment | Centre Manager, NCCMH (to July 2016) |
| Personal pecuniary interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| Decision taken | No action needed |
| **Emma Seymour** | |
| Employment | Systematic Reviewer, NGA (from September 2016) |
| Personal pecuniary interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| Decision taken | No action needed |
| **Sarah Stockton** | |
| Employment | Senior Information Scientist |
| Personal pecuniary interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| Decision taken | No action needed |
| **Iona Symington** | |
| Employment | Assistant Systematic Reviewer (to July 2016) |
| Personal pecuniary interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| Decision taken | No action needed |

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# B.3 Declarations of interests by Guideline Development Group 2009

| Guideline Development Group declarations of interest | |
|---|---|
| **Professor Ian Anderson (Chair, Guideline Development Group)** | |
| Employment | Professor of Psychiatry, University of Manchester |
| Personal pecuniary interest | Consultant for Wyeth Ltd Global Depression and Anxiety Strategy Consultant Board (specific), ended August 2007<br>Consultant for Bristol-Myers Squibb Pharmaceuticals Ltd/Otsuka Pharmaceuticals UK Ltd Bipolar Disorder Advisory Board (non-specific), ended August 2007<br>Consultant for Servier Ltd Agomelatine Advisory Board, ended August 2007<br>Honoraria for speaking at non-promotional meetings from the following companies: AstraZeneca, Wyeth, Janssen Cilag, Lundbeck, 2007–2008 |
| Personal Family interest | None |
| Non-personal pecuniary interest | AstraZeneca investigator – initiated grant (specific)<br>Honorarium paid into university research fund by Wyeth Ltd for speaking at non-promotional meeting<br>Talk on Managing Depression (independent content) at meeting supported by Lilly<br>P1vital commercial study sponsored by Servier |
| Personal non-pecuniary interest | Member of MHRA Psychiatry Expert Advisory Group<br>Member of Royal College of Psychiatrists Special Committee on ECT |
| **Alison Barnes** | |
| Employment | Social Worker |
| Personal pecuniary interest | None |
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| **Dr Carolyn Chew-Graham** | |
| Employment | General Practitioner and Senior Lecturer in Primary Care, University of Manchester |
| Personal pecuniary interest | Mental health clinical adviser for Manchester Joint Commissioning Team (Manchester Primary Care Trust, Central PBC Hub) |
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| **Jeremy Clarke** | |
| Employment | Psychological Therapist, Lambeth Primary Care Trust |
| Personal pecuniary interest | None |
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | Research and development lead for the Association of Psychoanalytic Psychotherapy in the NHS<br>Member of Expert Reference Group for Improving Access to Psychological Therapies (IAPT) |
| **Catherine Harris** | |

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| Guideline Development Group declarations of interest | |
|---|---|
| Employment | Labour Councillor for Haringey |
| Personal pecuniary interest | Mental Health Act Commissioner from April 2008 |
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | Role as councillor does not entail a portfolio for health issues although the Labour Party campaigns on health issues<br>Member of Mental Health Carers Support Association |
| **Dr Mark Kenwright** | |
| Employment | Consultant Cognitive Behavioural Psychotherapist, Ealing Cognitive Behavioural Therapy Service |
| Personal pecuniary interest | None |
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | Coordinator of two pilot studies and an RCT on computerised cognitive behavioural therapy (CCBT), guided self-help for panic disorder and phobias formed focus of doctoral thesis and three publications in British Journal of Psychiatry (1999 to 2002)<br>Manager of Stress Self-Help Clinic research project in first CCBT clinic in primary care which offered CCBT for panic/phobia (Fearfighter), obsessive-compulsive disorder (BT Steps) and depression (COPE). Published in Psychological Medicine (2001 to 2003)<br>Project lead for Improving Access to Psychological Therapies (IAPT) Pathfinder Site for London and South East (Ealing CBT Service). The service received £200,000 from IAPT for the period October 2007 to 2008 |
| **Professor Willem Kuyken** | |
| Employment | Professor of Clinical Psychology and Co-Director, Mood Disorders Centre, School of Psychology, University of Exeter |
| Personal pecuniary interest | None |
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | Co-director of Mood Disorders Centre, funded by Devon Partnership NHS Trust and Devon Primary Care Trust<br>Co-principal investigator, NHS HTA (£1.2 million, 1.7 million with NHS costs). Cognitive behavioural therapy as an adjunct to pharmacotherapy for treatment resistant depression in primary care: a randomised control trial. 2008 to 2011. (Principal Investigator: Dr Nicola Wiles, University of Bristol)<br>Principal Investigator, Medical Research Council (£233,000). Trial platform: Preventing depression relapse in NHS practice using mindfulness-based cognitive therapy (MBCT) 2005 to 2007 |
| **Professor Glyn Lewis** | |
| Employment | Professor of Psychiatric Epidemiology, University of Bristol |
| Personal pecuniary interest | Occasional payment from pharmaceutical companies for non-promotional talks, for example, to other departments of psychiatry or at conferences |
| Personal Family interest | None |
| Non-personal pecuniary interest | Colleagues in department at Bristol University received funds |

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| Guideline Development Group declarations of interest | |
|---|---|
| | from pharmaceutical industry to carry out research which I am not involved in |
| Personal non-pecuniary interest | None |
| **Brendan Masterson** | |
| Employment | Clinical Nurse Leader, Affective Disorders Unit, Bethlem Royal Hospital |
| Personal pecuniary interest | Presented a session on NICE guidelines for bipolar disorder at a study day sponsored by Janssen Cilag (February 2007) |
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| **Alan Meudell** | |
| Employment | Service User Member, Healthy Minds at Work |
| Personal pecuniary interest | None |
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | Member of Mind Expert Policy Group on Psychiatric Medicine and other Therapies<br>Member of Pwyllgor Cymru (Governance body of Mind Cymru, Mind Wales)<br>Member of Caerphilly Borough Council Mental Health Strategy Group<br>Member of Adult Mental Health NSF Implementation Advisory Group (WAG) |
| **Dr Alex Mitchell** | |
| Employment | Consultant Psychiatrist and Honorary Lecturer in Liaison Psychiatry, University of Leicester |
| Personal pecuniary interest | None |
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| **Dr Richard Moore** | |
| Employment | Clinical Psychologist, Cambridge and Peterborough NHS Foundation Trust |
| Personal pecuniary interest | None |
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | Interest in effectiveness of treatments for depression including taking part in related RCTs and the production of a treatment manual for treatment of chronic depression |
| **Carol Paton** | |
| Employment | Chief Pharmacist, Oxleas NHS Foundation Trust |
| Personal pecuniary interest | Eli Lilly Advisory Board and consultancy for duloxetine. Involvement has been since phase three trials and is not ongoing (2003–2007)<br>Attendance at European Congress of Neuropsychopharmacology (ECNP) 2007, sponsored by Janssen Cilag, without personal financial gain<br>Eli Lilly Advisory Board for other products currently subject to clinical trials: depot IM olanzapine and novel drugs in phase |

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| Guideline Development Group declarations of interest | |
|---|---|
| | two studies. None of these drugs was currently licensed and none was intended to treat depression (February 2008) |
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | Co-author of paper describing clinical use of depot antipsychotics in the United Kingdom, to be published in British Medical Journal supplement. The supplement is funded by Eli Lilly who have no influence over the content. No personal payment has been or will be received for this (April 2008) |
| **Dr Thomas Shackleton** | |
| Employment | General Practitioner, Suffolk |
| Personal pecuniary interest | None |
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| **Jane Wood** | |
| Employment | Nurse, Strategic Development Manager, Mental Health, Leeds Primary Care Trust |
| Personal pecuniary interest | None |
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |

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| NCCMH staff declarations of interest | |
|---|---|
| **Professor Stephen Pilling – Facilitator, Guideline Development Group** | |
| Employment | Director, NCCMH<br>Director, Centre for Outcomes Research and Effectiveness, University College London |
| Personal pecuniary interest | In receipt of funding from NICE to develop clinical guidelines |
| Personal Family interest | None |
| Non-personal pecuniary interest | RCT to evaluate multi-systemic therapy. Chief Investigator is Professor Peter Fonagy. Department of Health funding of £1,000,000 (2008 to 2012) |
| Personal non-pecuniary interest | None |
| **Victoria Bird** | |
| Employment | Research Assistant, NCCMH |
| Personal pecuniary interest | None |
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| **Rachel Burbeck** | |
| Employment | Systematic Reviewer, NCCMH |
| Personal pecuniary interest | None |
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |

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| NCCMH staff declarations of interest | |
|---|---|
| **Matthew Dyer** (from 2008) | |
| Employment | Health Economist, NCCMH |
| Personal pecuniary interest | None |
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| **Personal non-pecuniary interest** | None |
| **Sarah Hopkins** (2007 to 2008) | |
| Employment | Project Manager, NCCMH |
| Personal pecuniary interest | None |
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| **Angela Lewis** | |
| Employment | Research Assistant, NCCMH |
| Personal pecuniary interest | None |
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| **Ryan Li** (2008) | |
| Employment | Project Manager, NCCMH |
| Personal pecuniary interest | None |
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| **Nick Meader** | |
| Employment | Systematic Reviewer, NCCMH |
| Personal pecuniary interest | None |
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| **Dr Suffiya Omarjee** (from 2008) | |
| Employment | Health Economist, NCCMH |
| Personal pecuniary interest | None |
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| **Peny Retsa** (until 2008) | |
| Employment | Health Economist, NCCMH |
| Personal pecuniary interest | None |
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| **Maria Rizzo** | |
| Employment | Research Assistant, NCCMH |
| Personal pecuniary interest | None |

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| **NCCMH staff declarations of interest** | |
|---|---|
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| **Jennie Robertson** | |
| Employment | Research Assistant, NCCMH |
| Personal pecuniary interest | None |
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| **Rob Saunders** | |
| Employment | Research Assistant, NCCMH |
| Personal pecuniary interest | None |
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| **Christine Sealey** (from 2008) | |
| Employment | Centre Manager, NCCMH |
| Personal pecuniary interest | On secondment from NICE |
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| **Beth Shackleton** (until 2008) | |
| Employment | Project Manager, NCCMH |
| Personal pecuniary interest | None |
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| **Sarah Stockton** | |
| Employment | Information Scientist, NCCMH |
| Personal pecuniary interest | None |
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |
| **Dr Clare Taylor** | |
| Employment | Editor, NCCMH |
| Personal pecuniary interest | None |
| Personal Family interest | None |
| Non-personal pecuniary interest | None |
| Personal non-pecuniary interest | None |

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# Appendix C: Special advisors to the Guideline Committee

## C.1 Special advisors to the guideline 2017

Update 2017

Dr James Coulson

## C.2 Special advisors to the guideline 2009

Dr John Eagles

Professor Steven Hollon

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# Appendix D: Stakeholders

## D.1 Stakeholders 2017

2gether NHS Foundation Trust

5 Boroughs Partnership NHS Foundation Trust

Aberdeen Chiropractic Clinic

Absolute Therapy

Action for Sick Children

Action on Hearing Loss

Action on Smoking & Health

activematters

Acupuncture Association of Chartered Physiotherapists

Addaction

Addiction Today

Addison's Disease Self-Help Group

Adverse Psychiatric Reactions Information Link

Advisory Committee for Community Dentistry

Africa Advocacy Foundation

Age UK

Age UK Northumberland

ALD Life

Alder Hey Children's NHS Foundation Trust

Alexin Healthcare CIC

Allergan Ltd UK

Alliance for Natural Health

Allocate Software PLC

Alpha Medical

Amaven Ltd

Amberley Lodge Care Home with Nursing

Amdipharm Mercury Company Ltd

Anna Freud Centre

Update 2017

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1 Anxiety UK
2 ASSIST Trauma Care
3 Association of NHS Occupational Physicians
4 Association for Cognitive Analytic Therapy
5 Association for Dance Movement Psychotherapy UK
6 Association for Family Therapy and Systemic Practice in the UK
7 Association for Improvements in the Maternity Services
8 Association for Psychoanalytic Psychotherapy in the NHS
9 Association of Anaesthetists of Great Britain and Ireland
10 Association of British Neurologists
11 Association of Child Psychotherapists
12 Association of Directors of Children's Services
13 Association of Paediatric Emergency Medicine
14 Association of Pakistani Physicians and Surgeons of the United Kingdom
15 Association of Professional Music Therapists
16 Association of Psychoanalytic Psychotherapy in the NHS
17 Association of School and College Leaders
18 Association of Teachers and Lecturers
19 Association of Young People with ME
20 Autistic People Against Neuroleptic Abuse
21 Autistica
22 Avon, Gloucestershire and Wiltshire Strategic Health Authority
23 Barefoot Birth Pools Ltd
24 Barking and Dagenham, Havering & Redbridge Clinical Commissioning Groups
25 Barnardo's
26 Barnet Enfield and Haringey Mental Health Trust
27 Barnsley Hospice
28 Barnsley Hospital NHS Foundation Trust
29 Barnsley Youth Offending Team
30 Barts Health NHS Trust
31 Bath Psychological Therapies
32 Beds and Luton Fair Play
33 Behind The Mask Foundation



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1 Belfast Health and Social Care Trust
2 Benslow Management Co Ltd
3 Berkshire Local Pharmaceutical Committees
4 Bespoke Supported Living
5 BeTr Foundation
6 Big White Wall
7 Bipolar UK
8 Birmingham and Solihull Mental Health NHS Foundation Trust
9 Birmingham City Council
10 Birmingham Counselling & Psychotherapy Centre
11 Birmingham Women's NHS Foundation Trust
12 Birmingham, Sandwell and Solihull Cardiac and Stroke Network
13 Black and Ethnic Minority Diabetes Association
14 Black Country Partnership Foundation Trust
15 Boehringer Ingelheim
16 Bolton Council
17 Borderland Voices, Arts for Health & Mental Wellbeing
18 Bournemouth University
19 Brain and Spinal Injury Charity
20 Brighton and Hove Integrated Care Service
21 Bristol-Myers Squibb Pharmaceuticals Ltd
22 British Acupuncture Council
23 British Association for Adoption and Fostering
24 British Association for Applied Nutrition and Nutritional Therapy
25 British Association for Community Child Health
26 British Association for Counselling and Psychotherapy
27 British Association for Music Therapy
28 British Association for Performing Arts Medicine
29 British Association for Psychopharmacology
30 British Association of Art Therapists
31 British Association of Dermatologists
32 British Association of Dramatherapists
33 British Association of Play Therapists



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1 British Association of Psychodrama and Sociodrama
2 British Association of Skin Camouflage
3 British Association of Social Workers
4 British Association of Stroke Physicians
5 British Autogenic Society
6 British Dietetic Association
7 British Geriatrics Society
8 British Heart Foundation
9 British Liver Trust
10 British Medical Association
11 British Medical Journal
12 British National Formulary
13 British Nuclear Cardiology Society
14 British Paediatric Mental Health Group
15 British Pain Society
16 British Polio Fellowship
17 British Psychoanalytic Council
18 British Psychodrama Association
19 British Psychological Society
20 British Red Cross
21 British Society for Paediatric Dermatology
22 British Society of Gastroenterology
23 British Society of Paediatric Gastroenterology Hepatology and Nutrition
24 British Thoracic Society
25 British Thyroid Foundation
26 Brookdale care
27 Buckinghamshire Healthcare NHS Trust
28 Business Boosters Network CIC
29 Busybees Care Ltd
30 Calderdale and Huddersfield NHS Trust
31 Cambian
32 Cambridge University Hospitals NHS Foundation Trust
33 Camden Link



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1 Cancer Black Care
2 CancerCare
3 Caplond Services
4 Capsulation PPS
5 Capsulation PPS
6 Cardiff Council
7 Cardiff Univesity Psychiatric Services
8 Care Council for Wales
9 Care Quality Commission
10 Care Right Now
11 Carers UK
12 CareTech Community Services
13 CCBT Ltd
14 Central & North West London NHS Foundation Trust
15 Central and North West London Mental Health NHS Trust
16 Central London Community Health Care NHS Trust
17 Centre for Mental Health
18 Centre for Mental Health Research
19 Centre for Psychological Services Research
20 Centro de Terapia Familiar
21 Champs Public Health Collaborative
22 Changed to British Paediatric Mental Health Group. British Paediatric Psychology &
23 Psychiatry Group
24 Changing Faces
25 Chartered Physiotherapists in Mental Health
26 Chartered Physiotherapists Promoting Continence
27 Chartered Society of Physiotherapy
28 Cheshire East Council
29 Cheswold Park Hospital
30 Child and Adolescent Mental Health
31 Childhood Bereavement Network
32 Children and Young Peoples Mental Health Coalition
33 Children England



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1 Children's HIV Association
2 Cholwell House Nursing Home Ltd
3 Chroma
4 Chronic Pain Policy Coalition
5 CIS' ters
6 Citizens Commission on Human Rights
7 Clarity Informatics Ltd
8 CLEAR Cannabis Law Reform
9 CLIC Sargent
10 Cochrane Common Mental Disorders Group
11 Cochrane Depression Anxiety and Neurosis Group
12 Cochrane UK
13 College of Mental Health Pharmacy
14 College of Occupational Therapists
15 College of Optometrists
16 College of Paramedics
17 Community Health Action Trust
18 Community Links
19 Community Links Trust Ltd.
20 Community Practitioners' & Health Visitors Association
21 Company Chemists Association Ltd
22 Compass wellbeing
23 Complementary Health Professionals
24 Compton Hospice
25 Consortium of Adoption Support Agencies
26 Coram
27 Core Health Consultancy
28 CORE Information Management Systems Ltd
29 Council for Evidence-based Psychiatry
30 Council for Involuntary Tranquilliser Addiction
31 Counselling Haverhill
32 Counsellors Southwest CIC
33 Coventry and Warwickshire Cardiac Network



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1 Coventry City Council
2 Coventry University
3 Cregagh Nursing Home
4 Crest House Care Home
5 Critical Psychiatry Network
6 Croydon Clinical Commissioning Group
7 Croydon Council
8 Croydon Health Services NHS Trust
9 Croydon University Hospital
10 Cruse Bereavement Care
11 Cumbria Partnership NHS Foundation Trust
12 Cure Parkinson's Trust, The
13 CWHHE Collaborative Clinical Commissioning Groups
14 Cygnet Health Care
15 Darnall Well Being
16 Dementia Care Matters
17 Dental Practitioners Association
18 Department for Education
19 Department of Health
20 Department of Health, Social Services and Public Safety - Northern Ireland
21 Depression UK
22 Derbyshire County Council
23 Devon Partnership NHS Trust
24 Diabetes UK
25 Division of Education and Child Psychology
26 Doncaster and South Humber Healthcare NHS Trust
27 Dorset Action on Abuse
28 Dorset County Council
29 Drinksense
30 Dudley and Walsall Mental Health Trust
31 DUPLICATE - Cumbria Partnership NHS Trust
32 East and North Hertfordshire NHS Trust
33 East Kent Hospitals University NHS Foundation Trust



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1 East London NHS Foundation Trust
2 East Midlands Patient & Public Involvement Senate
3 East of England Ambulance Service NHS Trust
4 East Riding of Yorkshire Council
5 East Sussex County Council
6 Eastbourne District General Hospital
7 Eating Disorder Association (NI)
8 Economic and Social Research Council
9 Eli Lilly and Company
10 Elm Healthcare
11 Empowerment Matters
12 Enhanced Care
13 Equalities National Council
14 Equality and Human Rights Commission
15 Esoteric Practitioners Association UK/EU
16 Essex County Council
17 Ethical Medicines Industry Group
18 Europa Healthcare Solutions
19 Experts by experience
20 Faculty of Dental Surgery
21 Faculty of Forensic and Legal Medicine
22 Faculty of Occupational Medicine
23 Faculty of OH Nursing
24 Faculty of Public Health
25 Faculty of Sport and Exercise Medicine
26 Family Action
27 Fatherhood Institute
28 Ferndale Care Home
29 Fetal Anti Convulsant Syndrome Association
30 First Person Plural
31 Five Boroughs Partnership NHS Trust
32 Food for the Brain Foundation
33 Foundation for People with Learning Disabilities



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1 Freshwinds
2 Gateshead Council
3 Gender Identity Research and Education Society
4 General Hypnotherapy Register
5 General Hypnotherapy Register
6 GlaxoSmithKline
7 Global Organization for EPA & DHA Omega-3s
8 Gloucestershire County Council
9 Gloucestershire Hospitals NHS Foundation Trust
10 Gorlin Syndrome Group
11 Greater London Prevention Center
12 Greater Manchester Health and Social Care Partnership
13 Greater Manchester West Mental Health NHS Foundation Trust
14 Green House Surgery
15 Guy's and St Thomas' NHS Foundation Trust
16 Hafal - Wales
17 Hafan Cymru
18 Halton Fibromyalgia Support Group
19 Harmless
20 Harrow Council
21 Health and Care Professions Council
22 Health Sciences Research Institute
23 Healthcare Improvement Scotland
24 Healthcare Quality Improvement Partnership
25 Healthwatch Barnet
26 Healthwatch Bristol
27 Healthwatch Cumbria
28 Healthwatch Darlington
29 Healthwatch East Sussex
30 Healthwatch Knowsley
31 Healthwatch North Tyneside
32 Healthwatch Portsmouth
33 Healthwatch Salford



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1 Heart To Heart Psychotherapy Outreach Clinic
2 Helen and Douglas House
3 Help Adolescents With Cancer
4 HelpAge International
5 Heritage Manor Ltd
6 Herpes Viruses Association
7 Hertfordshire Partnership NHS Trust
8 Hertfordshire Partnership University NHS Foundation Trust
9 HICA Group
10 Hiraeth Services Ltd
11 HM Treasury
12 Hockley Medical Practice
13 Holistic Stress Management
14 Home of Comfort
15 Home Office
16 HQT Diagnostics
17 Hull City Council
18 Human Givens Institute
19 Huntingtons Disease Association
20 Hyperparathyroid UK Action 4 Change
21 Hywel Dda University Health Board
22 Independent Children's Homes Association
23 InferMed
24 Innersights
25 Institute for Food, Brain and Behaviour
26 Institute of group analysis
27 Institute of Health Visiting
28 Institute of Neurology
29 Institute of Psychiatry
30 Intapsych Ltd
31 Integrity Care Services Ltd.
32 International Federation of Professional Aromatherapists
33 International Longevity Centre UK



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1 Isle of Wight Council
2 Janssen
3 Jigsaw4u
4 Journey Method Therapy
5 JT Healing
6 Keele University
7 Kent and Medway NHS and Social Care Partnership Trust
8 King's College Hospital - Weston Education Centre
9 King's College London
10 Kirklees Council
11 Lactation Consultants of Great Britain
12 Lancashire Care NHS Foundation Trust
13 Lancashire Wildlife Trust
14 Lanes Health
15 Laughter Ball Yoga
16 Leeds and York Partnership Foundation Trust
17 Leeds Irish Health and Homes
18 Leeds North Clinical Commissioning Group
19 Leeds South and East Clinical Commissioning Group
20 Leicestershire County Council
21 Leicestershire Partnership NHS Trust
22 Leicestershire South Asian Diabetes Support Group
23 LGBT Foundation
24 Lilly UK
25 Lincolnshire County Council
26 Liverpool adult ADHD - Ladders of Life
27 Liverpool Community Health
28 Liverpool John Moores University
29 Liverpool Women's NHS Foundation Trust
30 Local-Medic.co.uk Ltd
31 London Ambulance Service NHS Trust
32 London Borough of Islington
33 London cancer alliance



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1 London North West Healthcare NHS Trust
2 London South Bank University
3 Lundbeck UK
4 Luton and Dunstable Hospital NHS Trust
5 Making a difference
6 Making Waves
7 Manchester Mental Health & Social Care Trust
8 Manchester Metropolitan University
9 Mansfield District Council
10 Marie Curie
11 Market Access & Reimbursement Solutions Ltd
12 Mary Clifton consulting Ltd
13 Mastercall Healthcare
14 Maternal Mental Health Alliance
15 Maternity and Health Links
16 Max Appeal
17 MBB Connections Healthcare
18 Medical Directorate Services
19 Medicines and Healthcare Products Regulatory Agency
20 Medtronic
21 Medway NHS Foundation Trust
22 Men and Boys Initiative
23 Menarini Diagnostics UK
24 Mental Health and Substance Use: dual diagnosis
25 Mental Health Foundation
26 Mental Health Group - British Dietetic Association
27 Mental Health Matters
28 Mental Health Nurses Association
29 Mental Health Providers Forum
30 Mermaids
31 Mersey Care NHS Trust
32 Merseyside Police Federation
33 METRO Charity



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1 Middlesex University
2 Midlands Centre for Spinal Injuries
3 Mind
4 Mind Wise New Vision
5 Ministry of Defence
6 MK ADHD
7 MPGN/DDD Support Group
8 MQ Transforming Mental Health
9 Msb consultancy
10 Musiclusive
11 Muslim Doctors and Dentists Association
12 Napp Pharmaceuticals Ltd
13 National AIDS trust
14 National Association for People Abused in Childhood
15 National Association of Primary Care
16 National Association of Psychiatric Intensive Care and Low Secure Units
17 National Autistic Society
18 National Bereavement Alliance
19 National Childbirth Trust
20 National Community Hearing Association
21 National Counselling Society
22 National Deaf Child and Adolescent Mental Health Service
23 National Deaf Children's Society
24 National Development Team for Inclusion
25 National Guideline Alliance
26 National Guideline Centre
27 National Institute for Health Research
28 National Nurse Consultants in CAMHS forum
29 National Patient Safety Agency
30 National Pharmacy Association
31 National Public Health Service for Wales
32 National Rheumatoid Arthritis Society
33 National Society for the Prevention of Cruelty to Children



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1 NAViGO
2 NCRI - Breast CSG Working Group on Symptom Management
3 Neonatal & Paediatric Pharmacists Group
4 Network Rail
5 Neurocentrx pharma Ltd
6 Neurolink
7 Newcare
8 NHS Barnsley Clinical Commissioning Group
9 NHS Choices
10 NHS Chorley and South Ribble Clinical Commissioning Group
11 NHS Confederation
12 NHS Cumbria Clinical Commissioning Group
13 NHS Digital
14 NHS Eastbourne, Hailsham and Seaford Clinical Commissioning Group
15 NHS Employers
16 NHS England
17 NHS Halton Clinical Commissioning Group
18 NHS Hardwick Clinical Commissioning Group
19 NHS Havering Clinical Commissioning Group
20 NHS Health at Work
21 NHS Lambeth Clinical Commissioning Group
22 NHS Lothian
23 NHS Luton Clinical Commissioning Group
24 NHS Medway Clinical Commissioning Group
25 NHS Mid Essex Clinical Commissioning Group
26 NHS Milton Keynes
27 NHS Nene Clinical Commissioning Group
28 NHS NEW Devon Clinical Commissioning Group
29 NHS North East Lincolnshire Clinical Commissioning Group
30 NHS Oxfordshire Clinical Commissioning Group
31 NHS Plus
32 NHS Portsmouth Clinical Commissioning Group
33 NHS Richmond



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1 NHS Sheffield
2 NHS Sheffield Clinical Commissioning Group
3 NHS Somerset Clinical Commissioning Group
4 NHS South Cheshire Clinical Commissioning Group
5 NHS Southern Derbyshire Clinical Commissioning Group
6 NHS Tayside
7 NHS Telford & Wrekin Clinical Commissioning Group
8 NHS Wakefield Clinical Commissioning Group
9 NHS West Cheshire Clinical Commissioning Group
10 NHS West Lancashire Clinical Commissioning Group
11 NHSCC
12 NICE - Clinical Guidelines Surveillance
13 NICE - CPHE
14 NICE - DAP
15 NICE - Implementation
16 NICE - Internal Clinical Guidelines Programme
17 NICE - Interventional Procedures
18 NICE - Medicines and Prescribing Centre
19 NICE - MTEP
20 NICE - PIP
21 NICE - Quality Programme
22 NICE - Scientific Advice
23 NICE - Social Care
24 NICE - Technology Appraisals & HST
25 NICE - Topic selection
26 Niger Delta University
27 Norfolk and Suffolk NHS Foundation Trust
28 Norfolk Community Health and Care NHS Trust
29 North East & Cumbria Critical Care Network
30 North East Autism Society
31 North East Essex Clinical Commissioning Group
32 North East London Foundation Trust
33 North East London Mental Health Trust



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1 North Essex Mental Health Partnership Trust
2 North Essex Partnership Foundation Trust
3 North of England Commissioning Support
4 North Staffordshire Combined Healthcare NHS Trust
5 North Staffs Mind
6 North Wales Health Education Support Charity
7 North Wales Psychology Services
8 North West Ambulance Service NHS Trust
9 North West London Perinatal Network
10 Northamptonshire County Council
11 Northern Health and Social Care Trust
12 Northern School of Child and Adolescent Psychotherapy
13 Northern School of Child and Adolescent Psychotherapy
14 Northumberland County Council
15 Northumberland, Tyne & Wear NHS Trust
16 Northumbria Healthcare NHS Foundation Trust
17 Nottingham Children's Hospital
18 Nottingham Support Group for Carers of Children with Eczema
19 Nottingham University Hospitals NHS Trust
20 Nottinghamshire Acute Trust
21 Nottinghamshire Healthcare NHS Foundation Trust
22 Nursing and Midwifery Council
23 Nurtured Journey
24 Octavia
25 Oklahoma State University
26 Openspace Research Centre
27 Otsuka Pharmaceuticals
28 Oxford Health NHS Foundation Trust
29 Oxford Neurological Society
30 Oxford Parent Infant Project
31 Oxfordshire Clinical Commissioning Group
32 Oxleas NHS Foundation Trust
33 PANDAS Foundation



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1 PAPYRUS
2 Parenteral and Enteral Nutrition Group
3 Parents for the Early intervention of Autism
4 Parkinson's UK
5 Partnerships for Children, Families, Women and Maternity
6 Partnerships in Care
7 Patient Assembly
8 Patient information Forum
9 PCS Awareness Trust
10 Pelvic Pain Support Network
11 People First
12 Perfect Portion Control Ltd
13 Perfect Response Care Solutions UK Ltd
14 PERIGON Healthcare Ltd
15 Pernicious Anaemia Society
16 Pharmicus - Gateshead CBC
17 Play Therapy UK
18 PNI ORG UK
19 POhWER
20 Polycystic Kidney Disease Charity
21 Pontefract Family Centre
22 Positively UK
23 Powys Local Health Board
24 PrescQIPP NHS Programme
25 Preston Royal Hospital
26 Primary Care Child Safeguarding Forum
27 Primary Care Mental Health Collaborative
28 Primary Care Neurology Society
29 Primary Care Pharmacists Association
30 Primary Care Respiratory Society UK
31 Primrose Bank Medical Centre
32 Priory Group
33 Professional Network for Physiotherapists in Respiratory Care



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1 Prospect PBS Training Ltd
2 Psychology Associates
3 Public Health Agency
4 Public Health England
5 Public Health England - Improving Health and Lives Learning Disabilities Observatory
6 Public Health Wales
7 Public Health Wandsworth
8 Pulmonary Fibrosis Trust
9 Qualitative Training Services Ltd
10 Queens Nursing Institute
11 Real DPO Ltd
12 Redbridge Clinical Commissioning Groups
13 Redbridge Concern for Mental Health
14 Regard
15 Regenda Homes
16 Relate
17 Research Autism
18 Re-Solv
19 Respond
20 Rethink Mental Illness
21 Ribble Care Ltd
22 Roche Products
23 Rocklee Residential Home Ltd
24 Rotherham Council
25 Rotherham Doncaster and South Humber NHS Foundation Trust
26 Roundhouse Care Ltd
27 Royal College of Anaesthetists
28 Royal College of General Practitioners
29 Royal College of General Practitioners in Wales
30 Royal College of Midwives
31 Royal College of Nursing
32 Royal College of Obstetricians and Gynaecologists
33 Royal College of Paediatrics and Child Health



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1 Royal College of Pathologists
2 Royal College of Physicians
3 Royal College of Psychiatrists
4 Royal College of Radiologists
5 Royal College of Speech and Language Therapists
6 Royal Mencap Society
7 Royal National Institute of Blind People
8 Royal Pharmaceutical Society
9 Royal Society of Medicine
10 SafeHaven Trauma Centre
11 Safeline
12 Sainsbury Centre for Mental Health
13 Salford City Council
14 Salisbury NHS Foundation Trust
15 Sandoz Ltd
16 Sandwell and West Birmingham Hospitals NHS Trust
17 SANE
18 Scottish Directors of Public Health
19 Scottish Health Promotion Managers
20 Scottish Intercollegiate Guidelines Network
21 Self Management UK
22 Sensory Integration Network
23 Servier Laboratories Ltd
24 Shared Lives Plus
25 Sheffield Health and Social Care NHS Foundation Trust
26 Sheffield Teaching Hospitals NHS Foundation Trust
27 SignHealth
28 SJ Helpline Services CIC
29 Skills for Care
30 Social Care Institute for Excellence
31 Social Support Systems CIC
32 Society for Academic Primary Care
33 Society for Research in Rehabilitation



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1 Society of British Neurological Surgeons
2 Society of Homeopaths
3 Solent NHS Trust
4 Somerset Local Medical Committee
5 Sophia Forum
6 South Asian Health Foundation
7 South Belfast Partnership Board
8 South Eastern Health and Social Care Trust
9 South Essex Partnership NHS Foundation Trust
10 South Essex Rape and Crisis Centre
11 South London & Maudsley NHSFT
12 South West London and St George's Mental Health NHS Trust
13 South West Yorkshire Partnership NHS Foundation Trust
14 South Weston Children's Centre
15 South Yorkshire Criminal Justice Board
16 Southampton City Council
17 Southend-on-Sea Borough Council
18 Southern Health & Social Care Trust
19 Southport and Ormskirk Hospital NHS Trust
20 Spirit Healthcare
21 SSG Locums Ltd
22 St Andrews Healthcare
23 St Mary's Hospital
24 St Michaels Hospice
25 ST Solutions Ltd
26 Stable Family Home Trust
27 Staffordshire and Stoke on Trent Partnership NHS Trust
28 Staffordshire County Council
29 State Hospitals Board For Scotland, The
30 States of Jersey
31 STEM4
32 Stockport Clinical Commissioning Group
33 Stockport Homes



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1 Suffolk County Council
2 Surrey and Borders Partnership NHS Foundation Trust
3 Surrey Downs Clinical Commissioning Group
4 Sussex Partnership NHS Foundation Trust
5 Sustrans
6 Swansea University
7 Taif university
8 Talking Couch
9 Tavistock & Portman NHS Foundation Trust
10 Tavistock Centre for Couple Relationships
11 Team Prevent UK Ltd
12 Tees, Esk and Wear Valleys NHS Trust
13 Terrence Higgins Trust
14 Terrence Higgins Trust Scotland
15 Teva UK
16 The Acupuncture Now Foundation
17 The African Eye Trust
18 The Alliance for Counselling and Psychotherapy
19 The Autistic Women's Empowerment Project
20 The British False Memory Society
21 The British Homeopathic Association & Faculty of Homeopathy
22 The Cerebra Centre for Neurodevelopmental Disorders
23 The For All Healthy Living Centre
24 The Fragile X Society
25 The Independent Fetal Anti-Convulsant Trust
26 The ME Association
27 The Medicines Management Partnership
28 The Minded Institute
29 The National Association for Children of Alcoholics
30 The National Association of Care Catering
31 The National Institute of Medical Herbalists
32 The National LGB&T Partnership
33 The Old Vicarage



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1 The Pelvic Partnership
2 The Princess Alexandra Hospital NHS Trust
3 The Project Surgery
4 The Rees Centre for Research in Fostering and Education
5 The Reiki Guild
6 The Relatives and Residents Association
7 The Retreat York
8 The Royal British Legion
9 The Seasonal Affective Disorder Association
10 The Stroke Association
11 The Survivors Trust
12 The University of South Wales
13 Therapies4Forces
14 Tizard Centre
15 Together for Mental Wellbeing
16 Tracscare
17 Trafford Healthcare NHS Trust
18 Transverse Myelitis Society
19 Triangle
20 Tuke Centre, The
21 Turning Point
22 UK Multiple Sclerosis Specialist Nurse Association
23 UK National Screening Committee
24 UK Pain Society
25 UK Reiki Federation
26 UK Thalassaemia Society
27 Ulster University
28 uMotif Digital Health
29 Unite - the Union
30 United Kingdom Council for Psychotherapy
31 United Kingdom Homecare Association Ltd
32 University College London Hospital NHS Foundation Trust
33 University Hospital Birmingham NHS Foundation Trust



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1 University Hospital Of South Manchester NHS Foundation Trust
2 University Hospitals of Leicester NHS Trust
3 University of Birmingham
4 University of Edinburgh
5 University of Essex
6 University of Greenwich
7 University of Nottingham
8 University of Oxford
9 University of Reading/ Royal Berkshire Hospital
10 University of York
11 Unum
12 Veksten
13 Victim Support
14 Voiceability
15 Volition
16 Warm Wales CIC / Integrated Energy Services Ltd
17 Warrington Health Plus
18 Waterloo Care
19 WAVE Trust
20 Way Ahead Care
21 Welsh Government
22 Welsh Scientific Advisory Committee
23 West London Collaborative
24 West London Mental Health NHS Trust
25 West London Mental Health Trust
26 Westelm Homes Ltd
27 Western Health and Social Care Trust
28 Western Health and Social Care Trust
29 Whipps Cross University Hospital NHS Trust
30 White Ribbon Association
31 Wigan Borough Clinical Commissioning Group
32 Wirral University Teaching Hospital NHS Foundation Trust
33 WISH - A voice for women's mental health



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Women's Support Network

Women's Health Alliance

Woodbine Manor Care Home

Worcestershire Health and Care NHS Trust

Wren Hall Nursing Home

XCD Consulting Services T/A BrainTrainUK

Yogaforbacks

York Mental Health and Addictions Research Group

Young People's Unit

Young Person's Advisory Service

YoungMinds

Your Care & Support

Youth Access

YPI Counselling

## D.2 Stakeholders and experts who submitted comments in response to the consultation draft of the guideline in 2009

**Stakeholders**

Association for Family Therapy

Association for Psychoanalytic Psychotherapy in the NHS

Association of Counsellors and Psychotherapists in Primary Care (CPC)

AstraZeneca UK Ltd

British Association for Behavioural and Cognitive Psychotherapies (BABCP)

British Association for Counselling and Psychotherapy

British Association for Psychopharmacology

British Association of Art Therapists

British Psychoanalytic Council

British Psychological Society

Central and North West London NHS Foundation Trust

Centre for Clinical Practice Health Economists, NICE

Centre for Clinical Practice Technical Adviser

Centre for Psychological Services Research

Counselling Haverhill

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1 Critical Psychiatry Network
2 Department of Health
3 Depression Alliance
4 Diabetes UK
5 Eli Lilly and Company Limited and Boehringer Ingelheim
6 GlaxoSmithKline UK Limited
7 Headway – The Brain Injury Association
8 Institute of Group Analysis
9 Institute of Psychiatry
10 Intapsych Ltd
11 Leeds Partnerships NHS Foundation Trust
12 Lundbeck Ltd
13 Medicines and Healthcare products Regulatory Agency
14 Mental Health Providers Forum
15 Mind
16 NHS Direct
17 Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust
18 Royal College of General Practitioners
19 Royal College of Midwives
20 Royal College of Nursing
21 Royal College of Pathologists
22 Royal College of Psychiatrists
23 Royal Pharmaceutical Society of Great Britain (RPSGB)
24 Servier Laboratories Ltd
25 Sheffield Health and Social Care Foundation Trust
26 South London and Maudsley NHS Foundation Trust
27 St Mungo's
28 Tavistock and Portman NHS Foundation Trust
29 Tees Esk and Wear Valleys NHS Foundation Trust
30 Tuke Centre
31 UK Psychiatric Pharmacy Group (UKPPG)
32 Ultrasis UK Limited
33 United Kingdom Council for Psychotherapy (UKCP)

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Young Minds

Youth Access

**Experts**

Professor Aaron Beck

Professor John Cape

Professor Mick Cooper

Professor Steven Hollon

Professor Wayne Katon

Professor Tony Kendrick

Dr Roslyn Law

Professor Helen Lester

Dr John Markowitz

Professor Keith Matthews

Professor Declan McLoughlin

Professor Robert Peveler

Professor David Richards

Professor Myrna Weissman

## D.3 Stakeholders and experts who submitted comments in response to the pre-publication check in 2009

**Stakeholders**

Association of British Neurologists

Cambridgeshire and Peterborough NHS Foundation Trust

CPC Association of Counsellors in Primary Care

Department of Health

Eli Lilly and Company Ltd and Boehringer Ingelheim Ltd

GlaxoSmithKline UK Ltd

Lundbeck Ltd

National Hospital for Neurology and Neurosurgery (NHNN)

Ultrasis UK Limited

**Experts**

Dr David Healy

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# Appendix E: Researchers contacted to request information about unpublished or soon-to-be published studies

## E.1 Researchers contacted to request information about unpublished or soon-to-be published studies in 2017

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Dr Dee Mangin

Professor Richard Morris

## E.2 Researchers contacted to request information about unpublished or soon-to-be published studies in 2009

Dr Allan Abbass

Professor Anthony Bateman

Professor Paul Crits-Christoph

Dr John Eagles

Dr Robert Golden

Professor Hayes

Dr Mark Hilsenroth

Professor Peter Fonagy

Professor Charles Kellner

Professor Falk Leichsenring

Dr Chris Martell

Professor Glenys Parry

Professor Carolyn Webster-Stratton

Professor Kenneth Wilson

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# Appendix F: Review questions and review protocols

## F.1 Review questions (RQs) 2017

| RQ | Review questions |
|---|---|
| 1.1 | For adults with depression, what are the relative benefits and harms associated with different models for the coordination and delivery of services? |
| 1.2 | For adults with depression, what are the relative benefits and harms associated with different settings for the delivery of care? |
| 2.1 | For adults with a new episode of less severe depression, what are the relative benefits and harms of psychological, psychosocial, pharmacological and physical interventions alone or in combination? |
| 2.2 | For adults with a new episode of more severe depression, what are the relative benefits and harms of psychological, psychosocial, pharmacological and physical interventions alone or in combination? |
| 2.3 | For adults whose depression has responded to treatment, what are the relative benefits and harms of psychological, psychosocial, pharmacological and physical interventions for preventing relapse (including maintenance treatment)? |
| 2.4 | For adults with depression following no or limited response to previous treatment (of the current episode), or those not tolerating previous treatment (of the current episode), what are the relative benefits and harms of psychological, psychosocial, pharmacological and physical interventions alone or in combination? |
| 2.5 | For adults with treatment-resistant depression, what are the relative benefits and harms of psychological, psychosocial, pharmacological and physical interventions alone or in combination? |
| 2.6 | For adults with chronic depression what are the relative benefits and harms of psychological, psychosocial, pharmacological and physical interventions alone or in combination? |
| 2.7 | For adults with complex depression (defined as depression with coexisting personality disorder) what are the relative benefits and harms of psychological, psychosocial, pharmacological and physical interventions alone or in combination? |
| 2.8 | For adults with psychotic depression what are the relative benefits and harms of psychological, psychosocial, pharmacological and physical interventions alone or in combination? |
| 3.0 | In adults (18 years and older) at risk of depression or (anxiety disorders) from particular vulnerable groups (older people, BME groups and men) do service developments and interventions which are specifically designed to promote access, increase the proportion of people from the target group who access treatment, when compared with standard care? |

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## F.2 Review protocols 2017

### F.2.1 Service delivery: RQ 1.1 service delivery models

| Topic | Organisation and delivery of services |
|---|---|
| Review question | RQ.1.1 For adults with depression, what are the relative benefits and harms associated with different models for the coordination and delivery of services?<br>• Are different service delivery models appropriate for the care of adults with chronic depression?<br>• Are different service delivery models appropriate for the care of adults with complex depression? |

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| Topic | Organisation and delivery of services |
|---|---|
| | • Are different service delivery models appropriate for the care of adults with psychotic depression?<br>• Are different service delivery models appropriate for the care of older adults?<br>• Are different service delivery models appropriate for preventing relapse in adults whose depression has responded to treatment? |
| Objectives | To identify the optimal model of delivery of services for adults with an acute episode of depression, or adults whose depression has responded fully or partially to treatment. |
| Population | • Adults with a diagnosis of depression according to DSM, ICD or similar criteria, or depressive symptoms as indicated by depression scale score for subthreshold and other groups<br>For studies on relapse prevention:<br>• Adults whose depression has responded fully or partially to treatment according to DSM, ICD or similar criteria, or depressive symptoms as indicated by depression scale score |
| Exclude | • Trials of women with postnatal depression<br>• Trials of people under 18 years<br>• Trials that specifically recruit participants with a particular physical health condition in addition to depression (e.g. depression in people with diabetes). However, trials that recruit participants with depression, which may also include a proportion of participants with coexisting physical health conditions, will be included. |
| Intervention | Models for the coordination and delivery of services<br>Models for the co-ordination and delivery of services will include:<br>• Collaborative care (simple and complex)<br>• Stepped care<br>• Medication management<br>• Care co-ordination<br>• Primary care liaison<br>• Integrated pathways of care |
| Comparison | • Treatment as usual<br>• Waitlist<br>• Any other service delivery model |
| Outcomes | **Critical outcomes:**<br>6 month outcomes<br>• Depression symptomology (e.g. mean endpoint score or change in depression score from baseline)<br>12 month outcomes<br>• Response (e.g. reduction of at least 50% from the baseline score on depression scale)<br>• Remission (e.g. score below a certain a threshold on a depression scale)<br>• Relapse (number of people who returned to a depressive episode whilst in remission)<br>**Important but not critical outcomes**:<br>• service utilisation/resource use (e.g. antidepressant use)<br>Data will be extracted for the following time-points:<br>• 6 months (or closest time point)<br>• 12 months (or closest time point)<br>Outcomes from the following depression scales will be used:<br>• HAMD<br>• MADRS |

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| Topic | Organisation and delivery of services |
|---|---|
| | • QUIDS<br>• BDI<br>• PHQ<br>• CGI<br>• CES-D<br>• SCL (Hopkins symptom checklist) |
| Study design | • Systematic reviews of RCTs<br>• RCTs<br>• Cluster RCTs |
| Include unpublished data? | Unpublished data will only be included where a full study report is available with sufficient detail to properly assess the risk of bias. Authors of unpublished evidence will be asked for permission to use such data, and will be informed that summary data from the study and the study's characteristics will be published in the full guideline<br>Conference abstracts and dissertations will not be included unless the data can be extracted from elsewhere (for instance, from the previous guideline) |
| Restriction by date? | All relevant studies from existing reviews from the 2009 guideline will be carried forward. No restriction on date for the updated search. |
| Minimum sample size | N = 10 in each arm<br>Studies with <50% completion data (drop out of >50%) will be excluded. |
| Study setting | Primary, secondary, tertiary and social care settings |
| The review strategy | **Reviews**<br>Cochrane reviews will be quality assessed and presented if deemed relevant and important.<br>If other reviews are found, the GC will assess their quality, completeness, and applicability to the NHS and to the scope of the guideline. If the GC agree that a systematic review appropriately addresses a review question, we will search for studies published since the review was conducted. If new studies could change the conclusions, we will update the review and conduct a new analysis. If new studies are unlikely to change the conclusions of an existing review, the GC will use the existing review to inform their recommendations.<br>**Coding Strategy**<br>For this review, a coding system for classifying the complexity and type of service delivery model has been developed specifically for the purpose of this guideline. The service delivery model described in each study will be rated on this 17-item coding system which will generate an overall rating between 0-20 (see Table 1). Service delivery models which score above 6 will be considered a collaborative care intervention; those scoring 13+ will be coded as complex collaborative care and those scoring 6-12 will be coded as simple collaborative care. Service delivery models that score below 6 will be classified as an alternative service delivery model (e.g. care co-ordination) or a stand-alone psychological intervention (e.g. self-help with support).<br>**Data Extraction (selection and coding)**<br>Citations from each search will be downloaded into EndNote and duplicates removed. Titles and abstracts of identified studies will be screened by two reviewers for inclusion against criteria, until a good inter-rater reliability has been observed (percentage agreement =>90% or Kappa statistics, K>0.60). Initially 10% of references will be double-screened. If inter-rater agreement is good then the remaining references will be screened by one reviewer. All primary-level studies included after the first scan of citations will be acquired in full and re-evaluated for eligibility at the time they are being entered into a study database (standardised template created in Microsoft Excel). At least 10% of data extraction will be double-coded. Discrepancies or difficulties with coding will be resolved through discussion between reviewers or the opinion of a third reviewer will be sought. |

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| Topic | Organisation and delivery of services |
|---|---|

Non-English-language papers will be excluded (unless data can be obtained from an existing review).

**Data Analysis**

A meta-analysis using a random-effects model will be conducted to combine results from similar studies.

Service delivery models based on similar theories will be grouped together where possible.

For risk of bias, outcomes will be downgraded if the randomisation and/or allocation concealment methods are unclear or inadequate. Outcomes will also be downgraded if no attempts are made to blind the assessors or participants in some way, i.e. by either not knowing the aim of the study or the result from other tests. Outcomes will also be downgraded if there are considerable missing data (see below).

Handling missing data:

Outcomes will be downgraded if there is a dropout of more than 20%, or if there was a difference of >20% between the groups.

For heterogeneity: outcomes will be downgraded once if $I^2$>50%, twice if $I^2$ >80%

For imprecision: outcomes will be downgraded if:

Step 1: If the 95% CI is imprecise i.e. crosses 0.75 or 1.25 (dichotomous) or -0.5 or 0.5 (for continuous). Outcomes will be downgraded one or two levels depending on how many lines it crosses.

Step 2: If the clinical decision threshold is not crossed, we will consider whether the criterion for Optimal Information Size is met, if not we will downgrade one level for the following.

- for dichotomous outcomes: <300 events
- for continuous outcomes: <400 participants

For clinical effectiveness the following criteria will be used:

- SMD <0.2 too small to likely show an effect
- SMD 0.2 small effect
- SMD 0.5 moderate effect
- SMD 0.8 large effect
- RR <0.75 or >1.25 clinical benefit
- For anything less (RR >0.75 and <1.25), the absolute numbers will be looked at to make a decision on whether there may be a clinical effect.

Table 1. Coding system for service delivery models

**Collaborative Care Component Score Method**

| Item | Score |
|---|---|
| 13. Active and integrated case recognition/identification*<br>(Systematic identification- from a clinical database or screened positive for depression) | 1 |
| 14. Collaborative assessment and plan included<br>(Collaborative assessment with the patient) | 1 |
| 15. Case Management<br>(Case manager present- can include pharmacist for medication management) | 0 1 |
| 16. Active liaison with primary care and other services<br>(System set up for structured liaison/ regular meetings) | 0 1 |
| 17. Case Manager has MH training | 0 1 |

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| Topic | Organisation and delivery of services | |
|---|---|---|
| | (A prior mental health background, not just training in mental health) | |
| | 18. Supervision provided for case manager | 0 1 |
| | 19. Senior MH professional consultation/involvement<br>(Broad definition- just need to be available) | 0 1 |
| | 20. Psycho-education delivered | 0 1 |
| | 21. Algorithm(s) used to determine care* | 0 1 |
| | 22. Integration with physical health care where necessary | 0 1 |
| | 23. Social/psychosocial interventions provided | 0 1 |
| | 24. Case manager delivers intervention | 0 1 |
| | 25. Medication management provided | 0 1 |
| | 26. Routine outcome monitoring<br>(Scheduled, using a tool) | 0 1 |
| | 27. Psychological interventions provided<br>• None<br>• Low intensity<br>• High intensity | 0<br>1<br>2 |
| | 28. Duration of programme contact<br>• ≤6 mths<br>• 7-12mths<br>• 1year plus | 0<br>1<br>2 |
| | 29. Number of sessions (F-t-F and Telephone)<br>• ≤6 sessions<br>• 6 – 12 sessions<br>• 13 + sessions | 0<br>1<br>2 |
| | Total (maximum 20) | |
| | ***Including stepped care**<br>**Rating**<br><5 – not collaborative care<br>6-12 – simple collaborative care<br>13+ – complex collaborative care | |
| Heterogeneity (sensitivity analysis and subgroups) | Where substantial heterogeneity exists, sensitivity analyses will be considered.<br>Where possible, the influence of the following subgroups will be considered:<br>For the review of collaborative care only:<br>• type of collaborative care (simple vs complex)<br>• stepped care component included in collaborative care intervention<br>• chronic depression<br>• complex depression<br>• psychotic depression<br>• case manager background<br>• psychological interventions delivered as part of the model of care<br>• number of contacts/sessions/follow-up visits provided as part of intervention (≤12, >13)<br>For all reviews:<br>• older adults | |

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| Topic | Organisation and delivery of services |
|---|---|
| | • BME populations<br>• men |
| Notes | The GC identified one good quality systematic review of RCTs (Coventry et al., 2014) which reviewed collaborative care interventions. The review was used as a source to identify studies for the review on service delivery models. A search for studies published since the Coventry 2014 review was conducted. In addition, studies from the 2009 guideline for other models of service delivery were carried forward from the existing evidence review and an updated search for studies published since these reviews was also conducted.<br>*Coventry PA, Hudson JL, Kontopantelis E, Archer J, Richards DA, et al. (2014) Characteristics of Effective Collaborative Care for Treatment of Depression: A Systematic Review and Meta-Regression of 74 Randomised Controlled Trials. PLoS ONE 9(9): e108114.*<br>Separate reviews (if applicable) will be conducted for service delivery models which were aimed at:<br>1. Treating an episode of depression<br>2. Preventing relapse of a future episode of depression |

## F.2.21 Service delivery: RQ 1.2 settings for care

| Topic | Organisation and delivery of services |
|---|---|
| Review question | RQ.1.2 For adults with depression, what are the relative benefits and harms associated with different settings for the delivery of care?<br>• Are different settings appropriate for the care of adults with chronic depression?<br>• Are different settings appropriate for the care of adults with complex depression?<br>• Are different settings appropriate for the care of adults with psychotic depression?<br>• Are different settings appropriate for the care of older adults? |
| Objectives | To identify the optimal settings for the delivery of care for adults with depression |
| Population | Adults with a diagnosis of depression according to<br>DSM, ICD or similar criteria, or depressive symptoms as indicated by depression scale score for subthreshold and other groups<br>If some, but not all, of a study's participants are eligible for the review and we are unable to obtain the appropriate disaggregated data, then we will include a study if the majority (at least 51%) of its participants are eligible for this review. If the evidence specific to depression is limited then the inclusion criteria may be expanded to include those with mood and anxiety disorders |
| Exclude | • Trials of women with postnatal depression<br>• Trials of people under 18 years<br>• Trials that specifically recruit participants with a particular physical health condition in addition to depression (e.g. depression in people with diabetes). However, trials that recruit participants with depression, which may also include a proportion of participants with coexisting physical health conditions, will be included. |
| Intervention | Settings for the delivery of care, which may include:<br>• primary care<br>• crisis resolution and home treatment teams<br>• inpatient setting<br>• acute psychiatric day hospital care<br>• non-acute day hospital care and recovery centres |

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| Topic | Organisation and delivery of services |
|---|---|
| | • specialist tertiary affective disorders settings<br>• community mental health teams<br>• residential services |
| Comparison | Any other setting for the delivery of care |
| Critical outcomes | **Critical outcomes:**<br>• depression symptomology (e.g. mean endpoint score or change in depression score from baseline)<br>• response (e.g. reduction of at least 50% from the baseline score on depression scale)<br>• remission (e.g. score below a certain a threshold on a depression scale)<br>• relapse (number of people who relapsed)<br>**Important but not critical outcomes:**<br>• service utilisation/resource use (e.g. antidepressant use) |
| Study design | • Systematic reviews of RCTs<br>• RCTs<br>• Cluster RCTs |
| Include unpublished data? | Unpublished data will only be included where a full study report is available with sufficient detail to properly assess the risk of bias. Authors of unpublished evidence will be asked for permission to use such data, and will be informed that summary data from the study and the study's characteristics will be published in the full guideline<br>Conference abstracts and dissertations will not be included unless the data can be extracted from elsewhere (for instance, from the previous guideline) |
| Restriction by date? | All relevant studies from existing reviews from the 2009 guideline will be carried forward. No restriction on date for the updated search. |
| Minimum sample size | N = 10 in each arm<br>Studies with <50% completion data (drop out of >50%) will be excluded. |
| Study setting | Primary, secondary, tertiary and social care settings |
| The review strategy | **Reviews**<br>Cochrane reviews will be quality assessed and presented if deemed relevant and important.<br>If other reviews are found, the GC will assess their quality, completeness, and applicability to the NHS and to the scope of the guideline. If the GC agree that a systematic review appropriately addresses a review question, we will search for studies published since the review was conducted. If new studies could change the conclusions, we will update the review and conduct a new analysis. If new studies are unlikely to change the conclusions of an existing review, the GC will use the existing review to inform their recommendations.<br>**Data Extraction (selection and coding)**<br>Citations from each search will be downloaded into EndNote and duplicates removed. Titles and abstracts of identified studies will be screened by two reviewers for inclusion against criteria, until a good inter-rater reliability has been observed (percentage agreement =>90% or Kappa statistics, K>0.60). Initially 10% of references will be double-screened. If inter-rater agreement is good then the remaining references will be screened by one reviewer. All primary-level studies included after the first scan of citations will be acquired in full and re-evaluated for eligibility at the time they are being entered into a study database (standardised template created in Microsoft Excel). At least |

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| Topic | Organisation and delivery of services |
|---|---|
| | 10% of data extraction will be double-coded. Discrepancies or difficulties with coding will be resolved through discussion between reviewers or the opinion of a third reviewer will be sought.<br>Non-English-language papers will be excluded (unless data can be obtained from an existing review).<br>**Data Analysis**<br>Where appropriate, a meta-analysis will be used to combine results from similar studies. Alternatively, a narrative synthesis will be used.<br>Interventions/settings for the delivery of care based on similar theories will be grouped together where possible.<br>For risk of bias, outcomes will be downgraded if the randomisation and/or allocation concealment methods are unclear or inadequate. Outcomes will also be downgraded if no attempts are made to blind the assessors or participants in some way, i.e. by either not knowing the aim of the study or the result from other tests. Outcomes will also be downgraded if there is considerable missing data (see below).<br>Handling missing data:<br>Outcomes will be downgraded if there is a dropout of more than 20%, or if there was a difference of >20% between the groups.<br>For heterogeneity: outcomes will be downgraded once if $I^2$>50%, twice if $I^2$ >80%<br>For imprecision: outcomes will be downgraded if:<br>Step 1: If the 95% CI is imprecise i.e. crosses 0.75 or 1.25 (dichotomous) or -0.5 or 0.5 (for continuous). Outcomes will be downgraded one or two levels depending on how many lines it crosses.<br>Step 2: If the clinical decision threshold is not crossed, we will consider whether the criterion for Optimal Information Size is met, if not we will downgrade one level for the following.<br>• for dichotomous outcomes: <300 events<br>• for continuous outcomes: <400 participants<br>For clinical effectiveness the following criteria will be used:<br>• SMD <0.2 too small to likely show an effect<br>• SMD 0.2 small effect<br>• SMD 0.5 moderate effect<br>• SMD 0.8 large effect<br>• RR <0.75 or >1.25 clinical benefit<br>• anything less (RR >0.75 and <1.25), the absolute numbers will be looked at to make a decision on whether there may be a clinical effect. |
| Heterogeneity (sensitivity analysis and subgroups) | Where substantial heterogeneity exists, sensitivity analyses will be considered.<br>Where possible, the influence of the following subgroups will be considered:<br>• older adults<br>• BME populations<br>• men<br>• chronic depression<br>• complex depression<br>• psychotic depression |

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## F.2.31 Treatment of depression: RQ 2.1 and RQ 2.2 first line treatment

| Topic | First line treatment of depression |
|---|---|
| Review question | RQ. 2.1 For adults with a new episode of less severe depression, what are the relative benefits and harms of psychological, psychosocial, pharmacological and physical interventions alone or in combination?<br><br>RQ. 2.2. For adults with a new episode of more severe depression, what are the relative benefits and harms of psychological, psychosocial, pharmacological and physical interventions alone or in combination? |
| Objectives | To identify the most effective first line interventions for the treatment of a new episode of depression |
| Population | • Adults receiving first line treatment for a new episode of depression, as defined by a diagnosis of depression according to DSM, ICD or similar criteria, or depressive symptoms as indicated by baseline depression scores on scales (and including those with subthreshold depressive symptoms).<br>If some, but not all, of a study's participants are eligible for the review, for instance, mixed anxiety and depression diagnoses, and we are unable to obtain the appropriate disaggregated data, then we will include a study if at least 80% of its participants are eligible for this review<br>Baseline mean scores are used to classify study population severity according to less severe (RQ 2.1) or more severe (RQ 2.2) using the thresholds outlined in Table 2. If baseline mean scores are not available, severity will be classified according to the inclusion criteria of the study or the description given by the study authors (but only in cases where this is unambiguous, i.e. 'severe' or 'subthreshold' or 'mild').<br>Table 2. Severity thresholds |

| Scale | Threshold |
|---|---|
| HAMD (17-item, 21-item and 24-item) | 24 |
| MADRS (10-item) | 27 |
| MADRS (9-item) | 22 |
| PHQ-9 | 18 |
| BDI (7-item) | 13 |
| BDI-I (21-item) | 25 |
| BDI-II (21-item) | 27 |
| BDI-ICH (21-item) | 28 |
| CES-D (20-item) | 29 |
| QIDS (16-item) | 17 |
| HADS-D (7-item) | 16 |

| | |
|---|---|
| Exclude | • Trials of women with postnatal depression<br>• Trials of people under 18 years<br>• Populations with psychotic symptoms<br>• Populations with Seasonal Affective Disorder (SAD)<br>• Trials that specifically recruit participants with a particular physical health condition in addition to depression (e.g. depression in people with diabetes). However, trials that recruit participants with depression, which may also include a proportion of participants with coexisting physical health conditions, will be included. |
| Intervention | Interventions must be licensed in the UK and routinely used in clinical practice for the treatment of depression. |

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| Topic | First line treatment of depression |
|---|---|
| | The following interventions will be included in the NMA:<br>**Psychological interventions**:<br>• behavioural therapies (including behavioural activation, behavioural therapy [Lewinsohn 1976], coping with depression course [individual and group] and social rhythm therapy [SRT])<br>• cognitive and cognitive behavioural therapies (including CBT individual or group [defined as under or over 15 sessions], problem solving, rational emotive behaviour therapy [REBT] and third-wave cognitive therapies individual or group)<br>• counselling (including directive counselling, emotion-focused therapy [EFT], non-directive counselling and relational client-centred therapy)<br>• interpersonal psychotherapy<br>• psychodynamic psychotherapies (including individual or group-based short-term psychodynamic psychotherapy, long-term psychodynamic psychotherapy and psychodynamic counselling)<br>• psychoeducational interventions (including psychoeducational group programmes, intensive clinical management and lifestyle factors discussion)<br>• self-help with or without support (including cognitive bibliotherapy with or without support, computerised CBT [CCBT] with or without support, computerised problem solving therapy with or without support, computerised psychodynamic therapy with or without support, online positive psychological intervention and self-examination therapy)<br>**Pharmacological interventions:**<br>SSRIs<br>• citalopram<br>• escitalopram<br>• sertraline<br>• fluoxetine<br>TCAs<br>• amitriptyline<br>• lofepramine<br>• Note: Imipramine will be included in the network (because it has been used as a control in many trials) however it will not be considered as part of the decision problem<br>Other antidepressant drugs:<br>• mirtazapine<br>Note that in order to maximise connectivity in the network specific drugs that are excluded and 'any antidepressant' or 'any SSRI' or 'any TCA' nodes will be added where they have been compared against a psychological intervention and/or combined with a psychological intervention but they will not be considered as part of the decision problem.<br>**Physical interventions:**<br>Exercise (including yoga)<br>The following interventions may be compared in pairwise comparisons (however will not be included in the NMA):<br>• acupuncture<br>• attention Bias Modification (ABM) training<br>• behavioural couples therapy<br>• light therapy (for depression but not for SAD)<br>• nortriptyline (for older adults)<br>• omega-3 fatty acids |

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| Topic | First line treatment of depression |
|---|---|
| | **Psychosocial interventions** (including befriending, mentoring, peer support and community navigators) |
| Comparison | • any other intervention<br>• treatment as usual<br>• waitlist<br>• placebo |
| Critical outcomes | **Critical outcomes**<br>**Efficacy**<br>• Depression symptomology (mean endpoint score or change in depression score from baseline)<br>• Remission (usually defined as a cut off on a depression scale)<br>• Response (e.g. reduction of at least 50% from the baseline score on HAMD/MADRS)<br>• Relapse (at follow up for continuation trials)<br>**Acceptability/tolerability**<br>• Discontinuation due to side effects (for pharmacological trials)<br>• Discontinuation due to any reason (including side effects)<br>The following depression scales will be included in the following hierarchy:<br>• MADRS<br>• HAMD<br>• QIDS<br>• PHQ<br>• CGI<br>• CES-D<br>• BDI<br>• HADS-D (depression subscale)<br>• HADS (full scale)I<br>Only one continuous scale will be used per study<br>• For studies reporting response and/or remission, the scale used in the study to define cut-offs for response and/or remission will be used<br>• If more than one definition is used, a hierarchy of scales will be adopted (hierarchy listed above)<br>• For studies not reporting dichotomous data, a hierarchy of scales will be adopted for continuous outcomes |
| Study design | • Systematic reviews of RCTs<br>• RCTs<br>• Cluster RCTs |
| Include unpublished data? | Unpublished data will only be included where a full study report is available with sufficient detail to properly assess the risk of bias. Authors of unpublished evidence will be asked for permission to use such data, and will be informed that summary data from the study and the study's characteristics will be published in the full guideline<br>Conference abstracts and dissertations will not be included unless the data can be extracted from elsewhere (for instance, from the previous guideline) |
| Restriction by date? | All relevant studies from existing reviews from the 2009 guideline will be carried forward. No restriction on date for the updated search. |
| Minimum sample size | N = 10 in each arm<br>Studies with <50% completion data (drop out of >50%) will be excluded. |

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| Topic | First line treatment of depression |
|---|---|
| Study setting | Primary, secondary, tertiary and social care settings. |
| The review strategy | **Reviews**<br>If existing systematic reviews are found, the GC will assess their quality, completeness, and applicability to the NHS and to the scope of the guideline. If the GC agrees that a systematic review appropriately addresses a review question, a search for studies published since the review will be conducted. If new studies could change the conclusions, the reviews will be updated and a new analysis conducted. If new studies are unlikely to change the conclusions of an existing review, the GC will use the existing review to inform their recommendations.<br>**Data Extraction (selection and coding)**<br>Citations from each search will be downloaded into EndNote and duplicates removed. Titles and abstracts of identified studies will be screened by two reviewers for inclusion against criteria, until a good inter-rater reliability has been observed (percentage agreement =>90% or Kappa statistics, K>0.60). Initially 10% of references will be double-screened. If inter-rater agreement is good then the remaining references will be screened by one reviewer. All primary-level studies included after the first scan of citations will be acquired in full and re-evaluated for eligibility at the time they are being entered into a study database (standardised template created in Microsoft Excel). At least 10% of data extraction will be double-coded. Discrepancies or difficulties with coding will be resolved through discussion between reviewers or the opinion of a third reviewer will be sought.<br>Non-English-language papers will be excluded (unless data can be obtained from an existing review).<br>**Data Analysis**<br>**Network meta-analysis**<br>All eligible interventions (which are connected to the network) will be compared using NMA.<br>Continuous outcomes (SMDs) will be combined with dichotomous data to estimate treatment effects.<br>An intention to treat (ITT) approach will be taken. Where possible ITT data will be extracted. If both ITT and completers data is reported both will be extracted. If only completers data is reported this will be extracted.<br>Risk of bias: Outcomes will be classified 'at risk of bias' if the randomisation and/or allocation concealment methods are unclear or inadequate and/or if no attempts are made to blind the assessors or participants in some way, i.e. by either not knowing the aim of the study or the result from other tests. Outcomes will also be classified 'at risk of bias' if there is considerable missing data<br>Handling missing data:<br>• where possible an intention to treat approach will be used<br>• outcomes will be classified at risk of bias if there is a dropout of more than 20%, or if there was a difference of >20% between the groups<br>**Pairwise meta-analysis**<br>Trials including populations or interventions which are not deemed appropriate for the NMA or are not connected to the network will be analysed in pairwise comparisons.<br>Where appropriate, meta-analysis using a random-effects model will be used to combine results from similar studies.<br>For risk of bias, outcomes will be downgraded if the randomisation and/or allocation concealment methods are unclear or inadequate and/or if no attempts are made to blind the assessors or participants in some way, i.e. by either not knowing the aim of the study or the result from other tests. Outcomes will also be downgraded if there is |

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| Topic | First line treatment of depression |
|---|---|
| | considerable missing data (see below).<br>Handling missing data:<br>• where possible an intention to treat approach will be used<br>• outcomes will be downgraded if there is a dropout of more than 20%, or if there was a difference of >20% between the groups.<br>For heterogeneity: outcomes will be downgraded once if $I^2$>50%, twice if $I^2$ >80%<br>For imprecision: outcomes will be downgraded if:<br>Step 1: If the 95% CI is imprecise i.e. crosses 0.75 or 1.25 (dichotomous) or -0.5 or 0.5 (for continuous). Outcomes will be downgraded one or two levels depending on how many lines it crosses.<br>Step 2: If the clinical decision threshold is not crossed, we will consider whether the criterion for Optimal Information Size is met, if not we will downgrade one level for the following.<br>• for dichotomous outcomes: <300 events<br>• for continuous outcomes: <400 participants<br>For clinical effectiveness the following criteria will be used:<br>• SMD <0.2 too small to likely show an effect<br>• SMD 0.2 small effect<br>• SMD 0.5 moderate effect<br>• SMD 0.8 large effect<br>• RR <0.75 or >1.25 clinical benefit<br>• Anything less (RR >0.75 and <1.25), the absolute numbers will be looked at to make a decision on whether there may be a clinical effect. |
| Heterogeneity (sensitivity analysis and subgroups) | Where substantial heterogeneity exists, sensitivity analyses will be considered.<br>Where possible, the influence of the following subgroups will be considered:<br>• inpatients<br>• older adults<br>• mode of delivery of psychological interventions (group-based or individual)<br>• format of delivery of psychological interventions (face-to-face, telephone-based or digital)<br>• first versus recurrent episodes<br>• underlying medication status<br>For the NMA, if the network structure allows, sensitivity analyses may also be considered for:<br>• risk of bias as reflected by publication bias and study size<br>• registration of study |
| Notes | For interventions in the NMA it is assumed that any patient that meets all inclusion criteria is, in principle, equally likely to be randomised to any of the interventions in the synthesis comparator set. |

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## F.2.41 Treatment of depression: RQ 2.3 relapse prevention

| Topic | Relapse prevention |
|---|---|
| Review question | RQ. 2.3 For adults whose depression has responded to treatment, what are the relative benefits and harms of psychological, psychosocial, pharmacological and physical interventions for preventing relapse (including maintenance treatment)? |
| Objectives | To identify the most effective interventions for preventing relapse of |

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| Topic | Relapse prevention |
|---|---|
| | depression in adults who have responded fully or partially to treatment |
| Population | • Adults whose depression has responded to treatment according to DSM, ICD or similar criteria, or depressive symptoms as indicated by depression scale score, who are randomised to relapse prevention intervention whilst in full or partial remission. |
| Exclude | • Trials of women with postnatal depression<br>• Trials of people under 18 years<br>• Populations with psychotic symptoms<br>• Trials that specifically recruit participants with a particular physical health condition in addition to depression (e.g. depression in people with diabetes). However, trials that recruit participants with depression, which may also include a proportion of participants with coexisting physical health conditions, will be included<br>• Trials where participants were not randomised to a relapse prevention intervention following response to initial treatment e.g. continuation trials |
| Intervention | Interventions must be licensed in the UK and routinely used in clinical practice.<br>Interventions will be included either alone or in combination.<br>**Psychological interventions**<br>• self-help (with or without support)<br>• cognitive behavioural therapies<br>• behavioural activation<br>• problem solving<br>• interpersonal psychotherapy<br>• mindfulness-based cognitive therapy<br>• counselling<br>• psychodynamic psychotherapy<br>**Pharmacological interventions**<br>• SSRIs<br>• TCAs<br>• duloxetine/venlafaxine<br>• antipsychotics[1]<br>• lithium augmentation<br>**Physical interventions**<br>• ECT |
| Comparison | • Treatment as usual<br>• Waitlist<br>• Placebo<br>• Any other active comparison |
| Outcomes | **Critical outcomes**<br>• Relapse (the number of participants who relapsed) |
| Study design | • Systematic reviews of RCTs<br>• RCTs<br>• Cluster RCTs |
| Include unpublished data? | Unpublished data will only be included where a full study report is available with sufficient detail to properly assess the risk of bias. Authors of unpublished evidence will be asked for permission to use such data, and will be informed that summary data from the study and the study's characteristics will be published in the full guideline<br>Conference abstracts and dissertations will not be included unless the |

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| Topic | Relapse prevention |
|---|---|
| | data can be extracted from elsewhere (for instance, from the previous guideline) |
| Restriction by date? | All relevant studies from existing reviews from the 2009 guideline will be carried forward. No restriction on date for the updated search. |
| Minimum sample size | N = 10 in each arm<br>Studies with <50% completion data (drop out of >50%) will be excluded. |
| Study setting | Primary, secondary, tertiary and social care settings |
| The review strategy | **Reviews**<br>Cochrane reviews will be quality assessed and presented if deemed relevant and important.<br>If other reviews are found, the GC will assess their quality, completeness, and applicability to the NHS and to the scope of the guideline. If the GC agree that a systematic review appropriately addresses a review question, we will search for studies published since the review was conducted. If new studies change the conclusions, we will update the review and conduct a new analysis. If new studies do not change the conclusions of an existing review, the GC will use the existing review to inform their recommendations.<br>**Data Extraction (selection and coding)**<br>Citations from each search will be downloaded into EndNote and duplicates removed. Titles and abstracts of identified studies will be screened by two reviewers for inclusion against criteria, until a good inter-rater reliability has been observed (percentage agreement =>90% or Kappa statistics, K>0.60). Initially 10% of references will be double-screened. If inter-rater agreement is good then the remaining references will be screened by one reviewer. All primary-level studies included after the first scan of citations will be acquired in full and re-evaluated for eligibility at the time they are being entered into a study database (standardised template created in Microsoft Excel). At least 10% of data extraction will be double-coded. Discrepancies or difficulties with coding will be resolved through discussion between reviewers or the opinion of a third reviewer will be sought.<br>Non-English-language papers will be excluded (unless data can be obtained from an existing review).<br>**Data Analysis**<br>Where appropriate, meta-analysis using a random-effects model will be used to combine results from similar studies<br>For all randomised controlled trials:<br>For risk of bias, outcomes will be downgraded if the randomisation and/or allocation concealment methods are unclear or inadequate. Outcomes will also be downgraded if no attempts are made to blind the assessors or participants in some way, i.e. by either not knowing the aim of the study or the result from other tests. Outcomes will also be downgraded if there is considerable missing data (see below).<br>Handling missing data:<br>Outcomes will be downgraded if there is a dropout of more than 20%, or if there was a difference of >20% between the groups.<br>For heterogeneity: outcomes will be downgraded once if $I^2$>50%, twice if $I^2$ >80%<br>For imprecision: outcomes will be downgraded if:<br>Step 1: If the 95% CI is imprecise i.e. crosses 0.75 or 1.25 (dichotomous) or -0.5 or 0.5 (for continuous). Outcomes will be downgraded one or two levels depending on how many lines it crosses.<br>Step 2: If the clinical decision threshold is not crossed, we will consider whether the criterion for Optimal Information Size is met, if not we will downgrade one level for the following. |

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| Topic | Relapse prevention |
|---|---|
| | • for dichotomous outcomes: <300 events<br>• for continuous outcomes: <400 participants<br>For clinical effectiveness the following criteria will be used:<br>• SMD <0.2 too small to likely show an effect<br>• SMD 0.2 small effect<br>• SMD 0.5 moderate effect<br>• SMD 0.8 large effect<br>• RR <0.75 or >1.25 clinical benefit<br>• Anything less (RR >0.75 and <1.25), the absolute numbers will be looked at to make a decision on whether there may be a clinical effect. |
| Heterogeneity (sensitivity analysis and subgroups) | Where substantial heterogeneity exists, sensitivity analyses will be considered.<br>Where possible, the influence of the following subgroups will be considered:<br>For the review of psychological interventions<br>• prior antidepressant use (prior antidepressant use vs no prior antidepressant use)<br>• comparator (antidepressant vs no antidepressants)<br>• comparator (treatment as usual vs active comparator)<br>• mode of delivery<br>• format of delivery<br>For all interventions<br>• remission status (participants in partial or full remission vs full remission only)<br>• older adults |
| Notes | One good quality systematic review for non-pharmacological interventions for relapse prevention was identified (Clarke et al. 2015), which was used as the basis for the review of psychological interventions.<br>An updated search was conducted to identify any additional studies. Outcomes from this review were the proportion of people who had relapsed at 12 month and 24 month follow up (studies which did not report outcomes for 12 months were excluded)<br>An updated search from 2009 was conducted to update the pharmacological review from the previous guideline. Additional studies identified were added to this meta-analysis. Outcomes were taken at the longest follow-up point.<br>[1]*Note that antipsychotics are not licensed for use in depression (with the exception of quetiapine which is licensed for use as an adjunctive treatment of major depressive episodes with major depressive disorder, but not as monotherapy)* |

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## F.2.51 Treatment of depression: RQ 2.4 and 2.5 further line treatment

| Topic | Further line treatment of depression |
|---|---|
| Review question | RQ. 2.4 For adults with depression following no or limited response to previous treatment (of the current episode), or those not tolerating previous treatment (of the current episode), what are the relative benefits and harms of psychological, psychosocial, pharmacological and physical interventions alone or in combination?<br><br>RQ. 2.5. For adults with treatment-resistant depression, what are the relative benefits and harms of psychological, psychosocial, pharmacological and physical interventions alone or in combination? |

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| Topic | Further line treatment of depression |
|---|---|
| Objectives | To identify the most effective interventions for people who have had no or limited response to previous treatment(s) (for the current episode) or have not tolerated previous treatment(s) (for the current episode) |
| Population | Adults in a depressive episode whose depression has not responded or there has been limited response to previous treatment(s) (for the current episode) according to DSM, ICD or similar criteria, or (residual) depressive symptoms as indicated by depression scale score, or who have not tolerated previous treatment (for the current episode), and who have been randomised to the further line interventions at the point at which they had no/adequate/limited response<br>If some, but not all, of a study's participants are eligible for the review, and we are unable to obtain the appropriate disaggregated data, then we will include a study if at least 80% of its participants are eligible for this review |
| Exclude | • Trials of women with postnatal depression<br>• Trials of people under 18 years<br>• Populations with psychotic symptoms<br>• Trials that specifically recruit participants with a particular physical health condition in addition to depression (e.g. depression in people with diabetes). However, trials that recruit participants with depression, which may also include a proportion of participants with coexisting physical health conditions, will be included. |
| Intervention | The following interventions will be included (alone, in combination or as augmentation strategies):<br>**Psychological interventions:**<br>• cognitive and cognitive behavioural therapies (including CBT, Mindfulness-based Cognitive Therapy [MBCT] and Cognitive Behavioural Analysis System of Psychotherapy [CBASP])<br>• counselling<br>• interpersonal psychotherapy (IPT)<br>• psychodynamic psychotherapy<br>• self-help (with or without support)<br>**Psychosocial interventions:**<br>• Befriending<br>• Peer support<br>**Pharmacological interventions**<br>Antidepressants<br>SSRIs<br>• citalopram<br>• escitalopram<br>• fluvoxamine<br>• fluoxetine<br>• paroxetine<br>• sertraline<br>TCAs<br>• amineptine[1]<br>• amitriptyline<br>• clomipramine<br>• desipramine[2]<br>• imipramine<br>• lofepramine<br>• nortriptyline |

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| Topic | Further line treatment of depression |
|---|---|
| | TeCAs<br>• mianserin<br>SNRIs<br>• duloxetine<br>• venlafaxine<br>Other antidepressant drugs<br>• bupropion[3]<br>• mirtazepine<br>Anticonvulsants<br>• lamotrigine[3]<br>Antipsychotics<br>• amisulpride[3]<br>• aripiprazole[3]<br>• olanzapine[3]<br>• quetiapine<br>• risperidone[3]<br>• ziprasidone[2]<br>Anxiolytics<br>• buspirone<br>Stimulants<br>• methylphenidate[3]<br>Other agents<br>• lithium<br>• omega-3 fatty acids<br>• thyroid hormone[3]<br>**Physical interventions**<br>• ECT<br>• exercise (including yoga)<br>Interventions will be categorised into the following strategies:<br>• dose escalation strategies<br>• switching strategies (including switching to another antidepressant of the same class, switching to another antidepressant of a different class, and switching to a non-antidepressant treatment)<br>• augmentation strategies (including augmenting the antidepressant with another antidepressant, augmenting the antidepressant with a non-antidepressant agent and augmenting the antidepressant with a psychological intervention) |
| Comparison | • Treatment as usual<br>• Waitlist<br>• Placebo<br>• Any other active comparison<br>In addition to placebo and head-to-head comparators, comparator treatment strategies include:<br>• Continuing with the antidepressant at the same dose<br>• Continuing with the antidepressant-only |
| Outcomes | **Critical outcomes**<br>**Efficacy**<br>• Depression symptomology (mean endpoint score or change in depression score from baseline)<br>• Remission (usually defined as a cut off on a depression scale) |

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| Topic | Further line treatment of depression |
|---|---|
| | • Response (e.g. reduction of at least 50% from the baseline score on HAMD/MADRS)<br>**Acceptability/tolerability**<br>• Discontinuation due to side effects (for pharmacological trials)<br>• Discontinuation due to any reason (including side effects)<br>The following depression scales will be included:<br>• MADRS<br>• HAMD<br>• QIDS<br>• PHQ<br>• CGI<br>• CES-D<br>• BDI<br>• HADS-D (depression subscale)<br>• HADS (full scale) |
| Study design | • Systematic reviews of RCTs<br>• RCTs<br>• Cluster RCTs |
| Include unpublished data? | Unpublished data will only be included where a full study report is available with sufficient detail to properly assess the risk of bias. Authors of unpublished evidence will be asked for permission to use such data, and will be informed that summary data from the study and the study's characteristics will be published in the full guideline<br>Conference abstracts and dissertations will not be included unless the data can be extracted from elsewhere (for instance, from the previous guideline) |
| Restriction by date? | All relevant studies from existing reviews from the 2009 guideline will be carried forward. No restriction on date for the updated search. |
| Minimum sample size | N = 10 in each arm<br>Studies with <50% completion data (drop out of >50%) will be excluded.<br>Note: An exception was made on the minimum sample size for lithium trials so as not to exclude a large proportion of the available evidence |
| Study setting | Primary, secondary, tertiary and social care settings |
| The review strategy | **Reviews**<br>Cochrane reviews will be quality assessed and presented if deemed relevant and important.<br>If other reviews are found, the GC will assess their quality, completeness, and applicability to the NHS and to the scope of the guideline. If the GC agree that a systematic review appropriately addresses a review question, we will search for studies published since the review was conducted. If new studies change the conclusions, we will update the review and conduct a new analysis. If new studies do not change the conclusions of an existing review, the GC will use the existing review to inform their recommendations.<br>**Data Extraction (selection and coding)**<br>Citations from each search will be downloaded into EndNote and duplicates removed. Titles and abstracts of identified studies will be screened by two reviewers for inclusion against criteria, until a good inter-rater reliability has been observed (percentage agreement =>90% or Kappa statistics, K>0.60). Initially 10% of references will be double-screened. If inter-rater agreement is good then the remaining references will be screened by one reviewer. All primary-level studies included after the first scan of citations will be acquired in full and re-evaluated for |

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| Topic | Further line treatment of depression |
|---|---|
| | eligibility at the time they are being entered into a study database (standardised template created in Microsoft Excel). At least 10% of data extraction will be double-coded. Discrepancies or difficulties with coding will be resolved through discussion between reviewers or the opinion of a third reviewer will be sought.<br>Non-English-language papers will be excluded (unless data can be obtained from an existing review).<br>**Data Analysis**<br>Where appropriate, meta-analysis using a random-effects model will be used to combine results from similar studies.<br>For all randomised controlled trials:<br>For risk of bias, outcomes will be downgraded if the randomisation and/or allocation concealment methods are unclear or inadequate and/or if no attempts are made to blind the assessors or participants in some way, i.e. by either not knowing the aim of the study or the result from other tests. Outcomes will also be downgraded if there is considerable missing data (see below).<br>Handling missing data:<br>Outcomes will be downgraded if there is a dropout of more than 20%, or if there was a difference of >20% between the groups.<br>For heterogeneity: outcomes will be downgraded once if $I^2$>50%, twice if $I^2$ >80%.<br>For imprecision: outcomes will be downgraded if:<br>Step 1: If the 95% CI is imprecise i.e. crosses 0.75 or 1.25 (dichotomous) or -0.5 or 0.5 (for continuous). Outcomes will be downgraded one or two levels depending on how many lines it crosses.<br>Step 2: If the clinical decision threshold is not crossed, we will consider whether the criterion for Optimal Information Size is met, if not we will downgrade one level for the following.<br>• for dichotomous outcomes: <300 events<br>• for continuous outcomes: <400 participants<br>For clinical effectiveness the following criteria will be used:<br>• SMD <0.2 too small to likely show an effect<br>• SMD 0.2 small effect<br>• SMD 0.5 moderate effect<br>• SMD 0.8 large effect<br>• RR <0.75 or >1.25 clinical benefit<br>• Anything less (RR >0.75 and <1.25), the absolute numbers will be looked at to make a decision on whether there may be a clinical effect. |
| Heterogeneity (sensitivity analysis and subgroups) | Where substantial heterogeneity exists, sensitivity analyses will be considered.<br>Where possible, the influence of the following subgroups will be considered:<br>• Older adults<br>• Mode of delivery of psychological interventions<br>• Format of delivery of psychological interventions |
| Notes | If trials specifically recruited populations with chronic depressive symptoms they would be included in this review (as opposed to RQ 2.6) if the treatment was further-line and if they reported a critical outcome.<br><br>*[1]Amineptine is not available to prescribe as a medicine (although it falls under Class C of the Misuse of Drugs Act 1971, and listed as Schedule 2 under the Controlled Drugs Regulations 2001). However, this drug is included in this review in order to assess the class effect of pharmacological interventions for depression* |

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| Topic | Further line treatment of depression |
|---|---|
| | *[2]Desipramine and ziprasidone are not available in the UK to prescribe. However, these drugs are included in this review in order to assess the class effect of pharmacological interventions for depression*<br>*[3]None of these drugs are licensed for use in depression. However, they are included in the review in order to assess harms and efficacy for off-label use and to assess the class effect of pharmacological interventions for depression* |

## F.2.61 Treatment of depression: RQ 2.6 chronic depression

| Topic | Treatment of chronic depression |
|---|---|
| Review question | RQ. 2.6 For adults with chronic depression what are the relative benefits and harms of psychological, psychosocial, pharmacological and physical interventions alone or in combination? |
| Objectives | To identify the most effective strategy for treatment of adults with chronic depression or persistent subthreshold symptoms |
| Population | Adults with chronic depression, defined by a diagnosis of depression according to DSM, ICD or similar criteria, or depressive symptoms as indicated by baseline depression scores on scales<br>The definition of chronic depression includes: meeting criteria for full MDD for 2 years; persistent subthreshold symptoms (dysthymia); double depression (an acute episode of MDD superimposed on dysthymia)<br>In the case of mixed populations, if the study reports data for a subgroup with chronic depression, data for this subgroup will be extracted. If the study does not report data separately we will only include studies where over 75% of the population have a diagnosis of chronic depression. Studies with mixed populations where less than 75% of the population have chronic depression will be included in other reviews. |
| Exclude | • Trials of women with postnatal depression<br>• Trials of people under 18 years<br>• Trials that specifically recruit participants with a particular physical health condition in addition to depression (e.g. depression in people with diabetes). However, trials that recruit participants with depression, which may also include a proportion of participants with coexisting physical health conditions, will be included. |
| Intervention | Interventions listed below are examples of interventions which may be included either alone or in combination.<br>**Psychological interventions:**<br>• cognitive and cognitive behavioural therapies (including CBT individual or group [defined as under or over 15 sessions], Cognitive behavioural analysis system of psychotherapy (CBASP), Mindfulness-based cognitive therapy (MBCT), and problem solving)<br>• counselling<br>• interpersonal psychotherapy (IPT)<br>• psychodynamic psychotherapies<br>**Psychosocial interventions:**<br>• befriending<br>• mentoring<br>• peer support<br>• community navigators<br>**Pharmacological interventions:**<br>Antidepressants<br>SSRIs<br>• citalopram<br>• escitalopram |

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| Topic | Treatment of chronic depression |
|---|---|
| | • fluvoxamine<br>• fluoxetine<br>• paroxetine<br>• sertraline<br>TCAs<br>• amineptine[1]<br>• amitriptyline<br>• clomipramine<br>• desipramine[2]<br>• imipramine<br>• lofepramine<br>• nortriptyline<br>MAOIs<br>• phenelzine<br>TeCAs<br>• mianserin<br>SNRIs<br>• duloxetine<br>• venlafaxine<br>Other antidepressant drugs<br>• bupropion[3]<br>• mirtazepine<br>• moclobemide<br>• nefazadone[2]<br>Antipsychotics<br>• amisulpride[3]<br>• aripiprazole[3]<br>• olanzapine[3]<br>• quetiapine[4]<br>• risperidone[3]<br>• ziprasidone[2]<br>**Physical interventions:**<br>• acupuncture<br>• ECT<br>• exercise (including yoga) |
| Comparison | • Treatment as usual<br>• Waitlist<br>• Placebo<br>• Any other active comparison |
| Outcomes | **Critical outcomes:**<br>• depression symptomology<br>• response (e.g. reduction of at least 50% from the baseline score on HAMD/MADRS)<br>• remission<br>• relapse<br>• discontinuation due to side effects<br>• discontinuation due to any reason (including side effects)<br>The following depression scales will be included in the following hierarchy: |

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| Topic | Treatment of chronic depression |
|---|---|
| | • MADRS<br>• HAMD<br>• QIDS<br>• PHQ<br>• CGI<br>• CES-D<br>• BDI<br>• HADS-D (depression subscale)<br>• HADS (full scale) |
| Study design | • Systematic reviews of RCTs<br>• RCTs<br>• Cluster RCTs |
| Include unpublished data? | Unpublished data will only be included where a full study report is available with sufficient detail to properly assess the risk of bias. Authors of unpublished evidence will be asked for permission to use such data, and will be informed that summary data from the study and the study's characteristics will be published in the full guideline<br>Conference abstracts and dissertations will not be included unless the data can be extracted from elsewhere (for instance, from the previous guideline) |
| Restriction by date? | All relevant studies from existing reviews from the 2009 guideline will be carried forward. No restriction on date for the updated search. |
| Minimum sample size | N = 10 in each arm<br>Studies with <50% completion data (drop out of >50%) will be excluded. |
| Study setting | Primary, secondary, tertiary and social care settings |
| The review strategy | **Reviews**<br>Cochrane reviews will be quality assessed and presented if deemed relevant and important.<br>If other reviews are found, the GC will assess their quality, completeness, and applicability to the NHS and to the scope of the guideline. If the GC agree that a systematic review appropriately addresses a review question, we will search for studies published since the review was conducted. If new studies change the conclusions, we will update the review and conduct a new analysis. If new studies do not change the conclusions of an existing review, the GC will use the existing review to inform their recommendations.<br>**Data Extraction (selection and coding)**<br>Citations from each search will be downloaded into EndNote and duplicates removed. Titles and abstracts of identified studies will be screened by two reviewers for inclusion against criteria, until a good inter-rater reliability has been observed (percentage agreement =>90% or Kappa statistics, K>0.60). Initially 10% of references will be double-screened. If inter-rater agreement is good then the remaining references will be screened by one reviewer. All primary-level studies included after the first scan of citations will be acquired in full and re-evaluated for eligibility at the time they are being entered into a study database (standardised template created in Microsoft Excel). At least 10% of data extraction will be double-coded. Discrepancies or difficulties with coding will be resolved through discussion between reviewers or the opinion of a third reviewer will be sought.<br>Non-English-language papers will be excluded (unless data can be obtained from an existing review).<br>**Data Analysis**<br>Where appropriate, meta-analysis using a random-effects model will be |

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| Topic | Treatment of chronic depression |
|---|---|
| | used to combine results from similar studies.<br>For all randomised controlled trials:<br>For risk of bias, outcomes will be downgraded if the randomisation and/or allocation concealment methods are unclear or inadequate. Outcomes will also be downgraded if no attempts are made to blind the assessors or participants in some way, i.e. by either not knowing the aim of the study or the result from other tests. Outcomes will also be downgraded if there is considerable missing data (see below).<br>Handling missing data:<br>Outcomes will be downgraded if there is a dropout of more than 20%, or if there was a difference of >20% between the groups.<br>For heterogeneity: outcomes will be downgraded once if $I^2$>50%, twice if $I^2$ >80%<br>For imprecision: outcomes will be downgraded if:<br>Step 1: If the 95% CI is imprecise i.e. crosses 0.75 or 1.25 (dichotomous) or -0.5 or 0.5 (for continuous). Outcomes will be downgraded one or two levels depending on how many lines it crosses.<br>Step 2: If the clinical decision threshold is not crossed, we will consider whether the criterion for Optimal Information Size is met, if not we will downgrade one level for the following.<br>• for dichotomous outcomes: <300 events<br>• for continuous outcomes: <400 participants<br>For clinical effectiveness the following criteria will be used:<br>• SMD <0.2 too small to likely show an effect<br>• SMD 0.2 small effect<br>• SMD 0.5 moderate effect<br>• SMD 0.8 large effect<br>• RR <0.75 or >1.25 clinical benefit<br>• Anything less (RR >0.75 and <1.25), the absolute numbers will be looked at to make a decision on whether there may be a clinical effect. |
| Heterogeneity (sensitivity analysis and subgroups) | Where substantial heterogeneity exists, sensitivity analyses will be considered.<br>Where possible, the influence of the following subgroups will be considered:<br>• older adults<br>• mode of delivery<br>• format of delivery |
| *Note: [1]Amineptine is not available to prescribe as a medicine (although it falls under Class C of the Misuse of Drugs Act 1971, and listed as Schedule 2 under the Controlled Drugs Regulations 2001). However, this drug is included in this review in order to assess the class effect of pharmacological interventions for depression*<br>*[2]These drugs are not available in the UK to prescribe. However, they are included in this review in order to assess the class effect of pharmacological interventions for depression*<br>*[3]None of these drugs are licensed for use in depression. However, they are included in the review in order to assess harms and efficacy for off-label use and to assess the class effect of pharmacological interventions for depression*<br>*[4]Quetiapine is licensed for use as an adjunctive treatment of major depressive episodes with major depressive disorder but not as monotherapy* | |

Update 2017

## F.2.71 Treatment of depression: RQ 2.7 complex depression

| Topic | Treatment of complex depression |
|---|---|
| Review question | RQ. 2.7 For adults with complex depression (defined as depression with coexisting personality disorder) what are the relative benefits and harms of psychological, psychosocial, pharmacological and physical interventions alone or in combination? |
| Objectives | To identify the most effective treatment strategy for adults with complex |

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| Topic | Treatment of complex depression |
|---|---|
| | depression |
| Population | • Adults with complex depression (defined as depression with coexisting personality disorder)<br>If some, but not all, of a study's participants are eligible for the review and we are unable to obtain the appropriate disaggregated data, then we will include a study if the majority (at least 51%) of its participants are eligible for this review. |
| Exclude | • Trials of women with postnatal depression<br>• Trials of people under 18 years<br>• Trials that specifically recruit participants with a particular physical health condition in addition to depression (e.g. depression in people with diabetes). However, trials that recruit participants with depression, which may also include a proportion of participants with coexisting physical health conditions, will be included. |
| Intervention | Interventions listed below are examples of interventions which may be included either alone or in combination.<br>**Psychological interventions:**<br>• self-help (with or without support)<br>• CBT<br>• behavioural activation<br>• problem solving<br>• family interventions/couples therapy<br>• counselling<br>• psychodynamic psychotherapy<br>**Psychosocial interventions**<br>• befriending<br>• mentoring<br>• peer support<br>• community navigators<br>**Pharmacological interventions:**<br>• tricyclic antidepressants<br>• serotonin-norepinephrine reuptake inhibitors<br>• selective serotonin reuptake inhibitors<br>• antipsychotics<br>• lithium<br>• fatty acids<br>**Physical interventions**<br>• acupuncture<br>• ECT<br>• exercise (including yoga) |
| Comparison | • Treatment as usual<br>• Waitlist<br>• Placebo<br>• Any other active comparison |
| Outcomes | **Critical outcomes:**<br>• depression symptomology<br>• response (e.g. reduction of at least 50% from the baseline score on HAMD/MADRS)<br>• remission<br>• relapse |

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| Topic | Treatment of complex depression |
|---|---|
| | • discontinuation due to side effects<br>• discontinuation due to any reason (including side effects) |
| Study design | • Systematic reviews of RCTs<br>• RCTs<br>• Cluster RCTs |
| Include unpublished data? | Unpublished data will only be included where a full study report is available with sufficient detail to properly assess the risk of bias. Authors of unpublished evidence will be asked for permission to use such data, and will be informed that summary data from the study and the study's characteristics will be published in the full guideline<br>Conference abstracts and dissertations will not be included unless the data can be extracted from elsewhere (for instance, from the previous guideline) |
| Restriction by date? | All relevant studies from existing reviews from the 2009 guideline will be carried forward. No restriction on date for the updated search. |
| Minimum sample size | N = 10 in each arm<br>Studies with <50% completion data (drop out of >50%) will be excluded. |
| Study setting | Primary, secondary, tertiary and social care settings |
| The review strategy | **Reviews**<br>Cochrane reviews will be quality assessed and presented if deemed relevant and important.<br>If other reviews are found, the GC will assess their quality, completeness, and applicability to the NHS and to the scope of the guideline. If the GC agree that a systematic review appropriately addresses a review question, we will search for studies published since the review was conducted. If new studies change the conclusions, we will update the review and conduct a new analysis. If new studies do not change the conclusions of an existing review, the GC will use the existing review to inform their recommendations.<br>**Data Extraction (selection and coding)**<br>Citations from each search will be downloaded into EndNote and duplicates removed. Titles and abstracts of identified studies will be screened by two reviewers for inclusion against criteria, until a good inter-rater reliability has been observed (percentage agreement =>90% or Kappa statistics, K>0.60). Initially 10% of references will be double-screened. If inter-rater agreement is good then the remaining references will be screened by one reviewer. All primary-level studies included after the first scan of citations will be acquired in full and re-evaluated for eligibility at the time they are being entered into a study database (standardised template created in Microsoft Excel). At least 10% of data extraction will be double-coded. Discrepancies or difficulties with coding will be resolved through discussion between reviewers or the opinion of a third reviewer will be sought.<br>Non-English-language papers will be excluded (unless data can be obtained from an existing review).<br>**Data Analysis**<br>Where appropriate, meta-analysis using a random-effects model will be used to combine results from similar studies<br>For all randomised controlled trials:<br>For risk of bias, outcomes will be downgraded if the randomisation and/or allocation concealment methods are unclear or inadequate. Outcomes will also be downgraded if no attempts are made to blind the assessors or participants in some way, i.e. by either not knowing the aim of the study or the result from other tests. Outcomes will also downgraded if there is considerable missing data (see below). |

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| Topic | Treatment of complex depression |
|---|---|
| | Handling missing data:<br>Outcomes will be downgraded if there is a dropout of more than 20%, or if there was a difference of >20% between the groups.<br>For heterogeneity: outcomes will be downgraded once if $I^2$>50%, twice if $I^2$ >80%.<br>For imprecision: outcomes will be downgraded if:<br>Step 1: If the 95% CI is imprecise i.e. crosses 0.75 or 1.25 (dichotomous) or -0.5 or 0.5 (for continuous). Outcomes will be downgraded one or two levels depending on how many lines it crosses.<br>Step 2: If the clinical decision threshold is not crossed, we will consider whether the criterion for Optimal Information Size is met, if not we will downgrade one level for the following.<br>• for dichotomous outcomes: <300 events<br>• for continuous outcomes: <400 participants<br>For clinical effectiveness the following criteria will be used:<br>• SMD <0.2 too small to likely show an effect<br>• SMD 0.2 small effect<br>• SMD 0.5 moderate effect<br>• SMD 0.8 large effect<br>• RR <0.75 or >1.25 clinical benefit<br>• Anything less (RR >0.75 and <1.25), the absolute numbers will be looked at to make a decision on whether there may be a clinical effect. |
| Heterogeneity (sensitivity analysis and subgroups) | Where substantial heterogeneity exists, sensitivity analyses will be considered.<br>Where possible, the influence of the following subgroups will be considered:<br>• older adults<br>• mode of delivery<br>• format of delivery |

Update 2017

## F.2.81 Treatment of depression: RQ 2.8 psychotic depression

| Topic | Treatment of psychotic depression |
|---|---|
| Review question | RQ. 2.8 For adults with psychotic depression what are the relative benefits and harms of psychological, psychosocial, pharmacological and physical interventions alone or in combination? |
| Objectives | To identify the most effective treatment strategy for adults with psychotic depression |
| Population | • Adults with psychotic depression, a depressive episode with psychotic features (i.e. delusions and/or hallucinations) in the context of a major depressive disorder |
| Exclude | • Trials of women with postnatal depression<br>• Trials of people under 18 years<br>• Trials that specifically recruit participants with a particular physical health condition in addition to depression (e.g. depression in people with diabetes). However, trials that recruit participants with depression, which may also include a proportion of participants with coexisting physical health conditions, will be included.<br>• Depression occurring in a primary psychotic illness, such as schizophrenia or dementia |
| Intervention | Interventions listed below are examples of interventions which may be included either alone or in combination.<br>**Psychological interventions:** |

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| Topic | Treatment of psychotic depression |
|---|---|
| | • self-help (guided and non-guided)<br>• CBT<br>• behavioural activation<br>• problem solving<br>• family interventions/couples therapy<br>• counselling<br>• psychodynamic psychotherapy<br>**Psychosocial interventions**<br>• befriending<br>• mentoring<br>• peer support<br>• community navigators<br>**Pharmacological interventions:**<br>• tricyclic antidepressants<br>• serotonin-noradrenaline reuptake inhibitors<br>• selective serotonin reuptake inhibitors<br>• antipsychotics<br>• lithium<br>• fatty acids<br>**Physical interventions:**<br>• acupuncture<br>• ECT<br>• exercise (including yoga) |
| Comparison | • Treatment as usual<br>• Waitlist<br>• Placebo<br>• Any other active comparison |
| Outcomes | **Critical outcomes**:<br>• depression symptomology<br>• response (e.g. reduction of at least 50% from the baseline score on HAMD/MADRS)<br>• remission<br>• relapse<br>• discontinuation due to side effects<br>• discontinuation due to any reason (including side effects) |
| Study design | • Systematic reviews of RCTs<br>• RCTs<br>• Cluster RCTs |
| Include unpublished data? | Unpublished data will only be included where a full study report is available with sufficient detail to properly assess the risk of bias. Authors of unpublished evidence will be asked for permission to use such data, and will be informed that summary data from the study and the study's characteristics will be published in the full guideline<br>Conference abstracts and dissertations will not be included unless the data can be extracted from elsewhere (for instance, from the previous guideline) |
| Restriction by date? | All relevant studies from existing reviews from the 2009 guideline will be carried forward. No restriction on date for the updated search. |
| Minimum sample size | N = 10 in each arm<br>Studies with <50% completion data (drop out of >50%) will be excluded. |

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| Topic | Treatment of psychotic depression |
|---|---|
| Study setting | Primary, secondary, tertiary and social care settings |
| The review strategy | **Reviews**<br>Cochrane reviews will be quality assessed and presented if deemed relevant and important.<br>If other reviews are found, the GC will assess their quality, completeness, and applicability to the NHS and to the scope of the guideline. If the GC agree that a systematic review appropriately addresses a review question, we will search for studies published since the review was conducted. If new studies change the conclusions, we will update the review and conduct a new analysis. If new studies do not change the conclusions of an existing review, the GC will use the existing review to inform their recommendations.<br>**Data Extraction (selection and coding)**<br>Citations from each search will be downloaded into EndNote and duplicates removed. Titles and abstracts of identified studies will be screened by two reviewers for inclusion against criteria, until a good inter-rater reliability has been observed (percentage agreement =>90% or Kappa statistics, K>0.60). Initially 10% of references will be double-screened. If inter-rater agreement is good then the remaining references will be screened by one reviewer. All primary-level studies included after the first scan of citations will be acquired in full and re-evaluated for eligibility at the time they are being entered into a study database (standardised template created in Microsoft Excel). At least 10% of data extraction will be double-coded. Discrepancies or difficulties with coding will be resolved through discussion between reviewers or the opinion of a third reviewer will be sought.<br>Non-English-language papers will be excluded (unless data can be obtained from an existing review).<br>**Data Analysis**<br>Where appropriate, meta-analysis using a random-effects model will be used to combine results from similar studies<br>For all randomised controlled trials:<br>For risk of bias, outcomes will be downgraded if the randomisation and/or allocation concealment methods are unclear or inadequate. Outcomes will also be downgraded if no attempts are made to blind the assessors or participants in some way, i.e. by either not knowing the aim of the study or the result from other tests. Outcomes will also be downgraded if there is considerable missing data (see below).<br>Handling missing data:<br>Outcomes will be downgraded if there is a dropout of more than 20%, or if there was a difference of >20% between the groups.<br>For heterogeneity: outcomes will be downgraded once if $I^2$>50%, twice if $I^2$ >80%.<br>For imprecision: outcomes will be downgraded if:<br>Step 1: If the 95% CI is imprecise i.e. crosses 0.75 or 1.25 (dichotomous) or -0.5 or 0.5 (for continuous). Outcomes will be downgraded one or two levels depending on how many lines it crosses.<br>Step 2: If the clinical decision threshold is not crossed, we will consider whether the criterion for Optimal Information Size is met, if not we will downgrade one level for the following.<br>• for dichotomous outcomes: <300 events<br>• for continuous outcomes: <400 participants<br>For clinical effectiveness the following criteria will be used:<br>• SMD <0.2 too small to likely show an effect<br>• SMD 0.2 small effect<br>• SMD 0.5 moderate effect |

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| Topic | Treatment of psychotic depression |
|---|---|
| | • SMD 0.8 large effect<br>• RR <0.75 or >1.25 clinical benefit<br>• Anything less (RR >0.75 and <1.25), the absolute numbers will be looked at to make a decision on whether there may be a clinical effect. |
| Heterogeneity (sensitivity analysis and subgroups) | Where substantial heterogeneity exists, sensitivity analyses will be considered.<br>Where possible, the influence of the following subgroups will be considered:<br>• older adults<br>• mode of delivery<br>• format of delivery |

## F.2.91 Access: RQ 3.0 access to services

| Topic | Access to Services |
|---|---|
| Review question | RQ.3.0 In adults (18 years and older) at risk of depression (or anxiety disorders) from particular vulnerable groups (older people, BME groups and men) do service developments and interventions which are specifically designed to promote access, increase the proportion of people from the target group who access treatment, when compared with standard care? |
| Objectives | To identify the most effective service developments and interventions which are specifically designed to promote access |
| Population | Adults (18 years and older) identified as at risk of depression (or anxiety disorders*) from the following vulnerable groups:<br>• older adults<br>• BME groups<br>• men<br>*Note: due to limited depression-specific evidence, a broader evidence base (including anxiety disorders) will be used. An update of the review conducted for the common mental health problems: identification and pathways to care NICE guideline CG123 (2011) will be undertaken. |
| Exclude | • Trials of women with postnatal depression<br>• Trials of people under 18 years<br>• Trials that specifically recruit participants with a particular physical health condition in addition to depression (e.g. depression in people with diabetes). However, trials that recruit participants with depression, which may also include a proportion of participants with coexisting physical health conditions, will be included. |
| Intervention | • Service developments or changes which are specifically designed to promote access.<br>• Specific models of service delivery (that is, community-based outreach clinics, clinics or services in non-health settings).<br>• Methods designed to remove barriers to access (including stigma, misinformation or cultural beliefs about the nature of mental disorder) |
| Comparison | • Standard care |
| Critical outcomes | **Critical outcomes:**<br>• proportion of people from the target group who access treatment<br>• uptake of treatment<br>**Important but not critical outcomes:**<br>• satisfaction, preference<br>• anxiety about treatment |

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| Topic | Access to Services |
|---|---|
| Study design | • Systematic reviews of RCTs<br>• RCTs<br>• Cluster RCTs |
| Include unpublished data? | Unpublished data will only be included where a full study report is available with sufficient detail to properly assess the risk of bias. Authors of unpublished evidence will be asked for permission to use such data, and will be informed that summary data from the study and the study's characteristics will be published in the full guideline<br>Conference abstracts and dissertations will not be included unless the data can be extracted from elsewhere (for instance, from the previous guideline) |
| Restriction by date | All relevant studies from existing reviews from the Common Mental Health Disorders guideline will be carried forward. No restriction on date for the updated search (from 2010) |
| Minimum sample size | N = 10 in each arm |
| Study setting | Primary, secondary, tertiary and social care settings |
| The review strategy | **Reviews**<br>Cochrane reviews will be quality assessed and presented if deemed relevant and important.<br>If other reviews are found, the GC will assess their quality, completeness, and applicability to the NHS and to the scope of the guideline. If the GC agree that a systematic review appropriately addresses a review question, we will search for studies published since the review was conducted. If new studies change the conclusions, we will update the review and conduct a new analysis. If new studies do not change the conclusions of an existing review, the GC will use the existing review to inform their recommendations.<br>**Data Extraction (selection and coding)**<br>Citations from each search will be downloaded into EndNote and duplicates removed. Titles and abstracts of identified studies will be screened by two reviewers for inclusion against criteria, until a good inter-rater reliability has been observed (percentage agreement =>90% or Kappa statistics, K>0.60). Initially 10% of references will be double-screened. If inter-rater agreement is good then the remaining references will be screened by one reviewer. All primary-level studies included after the first scan of citations will be acquired in full and re-evaluated for eligibility at the time they are being entered into a study database (standardised template created in Microsoft Excel). At least 10% of data extraction will be double-coded. Discrepancies or difficulties with coding will be resolved through discussion between reviewers or the opinion of a third reviewer will be sought.<br>Non-English-language papers will be excluded (unless data can be obtained from an existing review).<br>**Data Analysis**<br>Where appropriate, meta-analysis using a random-effects model will be used to combine results from similar studies.<br>For all randomised controlled trials:<br>For risk of bias, outcomes will be downgraded if the randomisation and/or allocation concealment methods are unclear or inadequate. Outcomes will also be downgraded if no attempts are made to blind the assessors or participants in some way, i.e. by either not knowing the aim of the study or the result from other tests. Outcomes will also be downgraded if there is considerable missing data (see below).<br>Handling missing data:<br>Outcomes will be downgraded if there is a dropout of more than 20%, or if there was a difference of >20% between the groups. |

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| Topic | Access to Services |
|---|---|
| | For heterogeneity: outcomes will be downgraded once if $I^2$>50%, twice if $I^2$ >80%.<br>For imprecision: outcomes will be downgraded if:<br>Step 1: If the 95% CI is imprecise i.e. crosses 0.75 or 1.25 (dichotomous) or -0.5 or 0.5 (for continuous). Outcomes will be downgraded one or two levels depending on how many lines it crosses.<br>Step 2: If the clinical decision threshold is not crossed, we will consider whether the criterion for Optimal Information Size is met, if not we will downgrade one level for the following:<br>• for dichotomous outcomes: <300 events<br>• for continuous outcomes: <400 participants<br>For clinical effectiveness the following criteria will be used:<br>• SMD <0.2 too small to likely show an effect<br>• SMD 0.2 small effect<br>• SMD 0.5 moderate effect<br>• SMD 0.8 large effect<br>• RR <0.75 or >1.25 clinical benefit<br>• anything less (RR >0.75 and <1.25), the absolute numbers will be looked at to make a decision on whether there may be a clinical effect. |
| Heterogeneity (sensitivity analysis and subgroups) | Where substantial heterogeneity exists, sensitivity analyses will be considered. |

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# F.3 1 Review questions 2009

## 2 Clinical questions 2009

| Clinical questions for Depression Update Guideline | |
|---|---|
| **A** | **Service configuration for people with depression** |
| A1 | What methods are effective in identifying people with depression in primary care and community settings, including sexual health clinics, emergency departments, and drug and alcohol services?<br>In which populations (excluding those with chronic physical health problems) should identification methods be used? |
| A2 | In the treatment of depression (major depressive disorder, dysthymia, subthreshold depression and subthreshold depressive symptoms), which models of care produce the best outcomes?<br>– collaborative care<br>– stepped care<br>– case management<br>– stratified (matched) care<br>– attached professional model<br>Are different models appropriate to the care of people in different phases of the illness, such as treatment resistant depression and relapse prevention? |
| **B** | **Psychology/psychosocial interventions for people with depression** |
| B1 | In depression, does guided self-help improve outcomes compared with other interventions? |
| B2 | Does computerised CBT (CCBT) improve patient outcomes compared with other treatments? |
| B3 | In the treatment of depression (major depressive disorder, dysthymia, subthreshold depression and subthreshold depressive symptoms), do any of the following improve outcomes compared with other interventions?<br>– exercise<br>– support including groups, befriending, and non-statutory provision |

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| Clinical questions for Depression Update Guideline | |
|---|---|
| | – programmes to facilitate employment |
| B4 | Do non-statutory support groups improve outcomes? |
| B5 | In the treatment of depression (major depressive disorder, dysthymia, subthreshold depression and subthreshold depressive symptoms), do any of the following (either alone or in combination with pharmacotherapy) improve outcomes compared with other interventions (including treatment as usual): |
| | – CBT<br>– BT/behavioural activation<br>– counselling/person-centred therapy<br>– problem solving<br>– psychodynamic psychotherapy<br>– family interventions/couples therapy<br>– ACT (acceptance and commitment therapy)<br>– systemic interventions<br>– psychoeducation<br>– cognitive analytic therapy (CAT)<br>– solution-focused therapy<br>– self-help, including guided self-help<br>– CCBT<br>Does mode of delivery (group-based or individual) impact on outcomes?<br>Are there specific therapist characteristics that improve outcomes?<br>Are there specific patient characteristics (for example, anxiety, previous episodes) that predict outcomes?<br>Are brief interventions (for example, 6 to 8 weeks) effective?<br>Are psychological interventions harmful? |
| B6 | Following poor response to treatment of depression (major depressive disorder, dysthymia, subthreshold depression and subthreshold depressive symptoms), which psychological or psychosocial interventions are appropriate? |
| B7 | In people whose depression has responded to treatment, what psychological and psychosocial strategies are effective in preventing relapse (including maintenance treatment)? |
| **C** | **Pharmacological/physical interventions** |
| C1 | In the treatment of depression (major depressive disorder, dysthymia, subthreshold depression and subthreshold depressive symptoms), which drugs (either not covered by the previous guideline or where significant new evidence exists) improve outcomes compared with other drugs and with placebo?<br>– TCAs<br>– duloxetine<br>– desvenlafaxine<br>– escitalopram<br>– agomelatine<br>– St John's wort<br>– antipsychotics (for example, quetiapine) |
| C2 | In the treatment of depression (major depressive disorder, dysthymia, subthreshold depression and subthreshold depressive symptoms), to what extent do the following factors affect the choice of drug?<br>– adverse events (in particular, cardiotoxicity), including long-term adverse events<br>– discontinuation problems |
| C3 | In the pharmacological treatment of depression, what are the most effective strategies for treating patients experiencing treatment side effects, including sexual dysfunction and weight gain? |
| C4 | In people whose depression has responded to treatment, what strategies are effective in preventing relapse (including maintenance treatment)? |

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| Clinical questions for Depression Update Guideline | |
|---|---|
| C5 | In people whose depression has atypical features, what are the most effective treatment strategies? |
| C6 | In the treatment of depression (major depressive disorder, dysthymia, subthreshold depression and subthreshold depressive symptoms), do any of the following improve outcomes compared with other interventions?<br>– ECT<br>– TMS (integrate NICE Interventional Procedure Guidance)<br>– light therapy<br>– VNS<br>– neurosurgery<br>– deep brain stimulation |
| C7 | For people with depression (major depressive disorder, dysthymia, and so on), who are receiving pharmacological treatment, does therapeutic drug monitoring improve outcomes? |
| C8 | What are appropriate ways to promote adherence?<br>(Link to NICE guideline on medicines adherence, CG76) |
| C9 | In the treatment of depression (major depressive disorder, dysthymia, subthreshold depression and subthreshold depressive symptoms), how can equal access to services for all be ensured? [What promotes access to effective care particularly for people with learning difficulties, acquired cognitive impairment and language difficulties?] |
| **D** | **General** |
| D1 | In the treatment of depression, which patient characteristics predict response and relapse? For example, childhood trauma, age of onset, number of previous episodes, gender, and so on. |
| D2 | In the treatment of depression, are there specific clinician approaches that improve outcomes? |

# Appendix G: Research recommendations

The Guideline Committee has made the following recommendations for research.

## G.1 Treatment of a new depressive episode

**1. Is peer support an effective and cost effective intervention in improving outcomes, including symptoms, personal functioning and quality of life in adults as a stand-alone intervention in people with less severe depression and as an adjunct to other evidence based interventions in more severe depression?**

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**Statement:** A series of randomised controlled trials should be conducted to assess the effectiveness of different models of peer support which examine the effectiveness and cost effectiveness of peer support for different severities of depression alone or in combination with evidence-based interventions for the treatment of depression. The studies should report on depressive symptoms, personal functioning and quality of life and any adverse events. They should have a follow-up period of at least 12 months.

**Rationale:** Not all people with depression respond well to first-line treatments and for some people the absence of good social support systems may account for the limited response to first line interventions. A number of models for the provision of peer support have been developed in mental health which aim to provide direct personal support and help with establishing and maintaining supportive social networks. Peer support is provided by people who themselves have personal experience of a mental health problem. However, to date few studies have established and tested peer support models for people with depression. Peer support models, including both individual and group interventions, should be tested in a series of randomised controlled trials which examine the effectiveness of peer support for

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different severities of depression alone or in combination with evidence-based interventions for the treatment of depression.

**2. What are the mechanisms of action of effective psychological interventions for acute episodes of depression in adults?**

**Statement**: A series of experimental studies to identify potential mechanisms associated with current effective treatments for depression should be undertaken and used to inform the development of new treatments. These novel treatments should then be tested in large scale RCTs against current most effective psychological treatments.

**Rationale:** Depression is a debilitating and highly prevalent condition in adults. Despite significant investment, the most effective and well-established treatments have only modest effects on depressive symptoms, and the majority of treatment is for recurrent depressive episodes. Research is required to identify the mechanism of action of the effective individual psychological treatments for depression, which would allow for the isolation of the most effective components and the development of better treatments. The research will need to be able to fully characterise the nature and range of depressive symptoms experienced by people and relate these to any proposed underlying neuropsychological mechanisms. The studies will also need to take into account the impact of any moderators of treatment effect. This research is necessary to improve clinical outcomes and quality of life for patients, as well as to reduce the financial burden upon the NHS.

## G.2 Chronic depression

**3. Are psychological, pharmacological or a combination of these interventions effective and cost effective for the treatment adults aged over 75 with chronic depression?**

**Statement:** A series of randomised controlled trials should be conducted to assess the effectiveness and cost effectiveness of anti-depressants, psychological therapies and the combination of the two in treating people over the age of 75 years with chronic depression. The studies should report on depressive symptoms, personal functioning and quality of life and any adverse events. They should have a follow-up period of at least 12 months.

**Rationale:** Depression in older people is often not recognised and therefore may go untreated for a significant period of time. The consequences of this are serious as depression, and chronic depression in particular, is associated with an increased risk of developing physical health problems in addition to the burden resulting from the depression. Even when depression is recognised, treatment can be sub-optimal and there is uncertainty about the most effective interventions. Although there are research studies investigating interventions for depression in older adults, many of these study populations have mean ages between 60 and 70 years and the focus is primarily on people with recent onset depression. Randomised controlled trials of psychological, pharmacological or a combination of these interventions in those over 75 with chronic depression are required to assess the relative effectiveness and safety of these interventions.

## G.3 Relapse prevention

**4. What is the rate of relapse in people with depression who present, and are treated, in primary and secondary care, and what factors are associated with increased risk of relapse?**

**Statement:** A large-scale, long-term cohort study should be undertaken to establish the rate of relapse in adults with depression who are successfully treated in primary care and

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secondary care, and the factors associated with an increased risk of relapse in this population.

**Rationale:** The current understanding of the rate of relapse in depression is that it is high and may be up to 50% after a first episode, rising to 80% in people who have had three or more episodes of depression. However, most studies have been undertaken in the secondary care setting and whether these figures represent the actual rate of relapse in primary care populations is uncertain. In addition, beyond the number of previous episodes and the presence of residual symptoms, there is also considerable uncertainty about what other factors (biological, psychological or social) might be associated with an increased risk of relapse. This cohort study will enable clinicians to more accurately identify those at risk of relapse, and provide relapse prevention strategies for these individuals. Accordingly, this would improve clinical outcomes and quality of life in patients as well as facilitating more targeted use of NHS resources.

**5. What is the comparative effectiveness and cost effectiveness of group based psychological treatments in preventing relapse in people with depression (compared to each other and antidepressant medication) for people who have had a successful course of treatment with antidepressants or psychological therapies?**

**Statement:** A randomised controlled trial should be conducted to establish whether, in adults in remission from depression following either antidepressant treatment or psychological therapies, group CBT, MBCT or medication results in lower incidence of depressive relapse.

**Rationale:** Depressive relapse is a frequent occurrence with implications for the wellbeing and quality of life for the individual and financial implications for the NHS. Antidepressants can be effective in preventing relapse but not all service users can tolerate them or wish to take them long-term. Two, group based psychological interventions (group CBT and mindfulness based cognitive therapy) have been developed and shown to be effective primarily in trials when compared to treatment as usual. However, they have not been compared with each other and only in a limited way against antidepressants. The randomised controlled trial should be designed to identify both moderators and mediators of treatment effect, have a minimum follow up period of two years, assess any adverse events and the relative cost-effectiveness of the interventions and test for both superiority and equivalence.

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## G.4 Psychotic depression

**6. What are the most effective and cost effective interventions for the treatment and management of psychotic depression (including consideration of pharmacological, psychological and psychosocial interventions)?**

**Statement:** A series of randomised controlled trials should be conducted to determine whether pharmacological, psychological or psychosocial interventions are the most effective and cost effective at achieving remission from depression with psychotic features and improving quality of life, in adults experiencing a psychotic depressive episode.

**Rationale:** There is limited evidence on the most effective interventions for the treatment of psychotic depression. All identified evidence examined different pharmacological strategies, with no evidence identified for psychological or psychosocial interventions. Additionally, the current evidence for pharmacological interventions consisted primarily of small, low quality RCTs. The lack of evidence for psychological or psychosocial interventions alone or in combination with pharmacological is a further limitation. There is very little data on the long-term outcomes for people with psychotic depression. Therefore, a series of RCTs are required to compare novel pharmacological interventions and psychological and

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psychosocial interventions with the established treatment strategy (antidepressant treatment augmented with antipsychotic medication), to determine clinical and cost effectiveness. Follow-up should be adequate to determine the risk of relapse associated with each strategy. This study would probably require a coordinated recruitment strategy across several treatment settings and services in order to achieve adequate statistical power.

## G.5 Access to services

**7. What are the most effective and cost effective methods to promote increased access to, and uptake of, interventions for people with depression who are under-represented in current services?**

**Statement:** A series of randomised controlled trials should be conducted to determine what are the most effective and cost effective methods for promoting access or treatment for people with depression. The studies should address the needs of groups who are under-represented in services including older people and people from black, Asian and minority ethnic communities.

**Rationale:** There is general under-recognition of depression but the problem is more marked in certain populations. In addition, even where depression is recognised by the person with depression or by health professionals, access to treatment can still be difficult. A number of factors may relate to this limited access including a person's view of their problems, the information available on services and the location, design and systems for referral to services. A number of studies have addressed this issue and a number of strategies have been developed to address it but no consistent picture has emerged from the research which can inform the design and delivery of services to promote access. Little is also known about how these systems might be tailored to the needs of particular groups such as older people, people from black, Asian and minority ethnic communities, and people with disabilities who may have additional difficulties in accessing services.

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