NHS
Sussex Partnership
NHS Foundation Trust

Mood and Anxiety Clinical Academic Group

Menu of Care and Interventions for Depression in Adults

Full document

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1. Aims and Objectives

The intention behind this document is to outline **evidence-based care for people living with depression.** This is not a standalone document but should be considered in relation to core standards of care and care packages (see Figure 1). The core standards specify the **nature of care and care approach** that all people should expect to receive when being in care of the Trust. The care packages describe the **types of care that we offer in relation to service user's needs**. This includes more detailed guidance on assessment, care planning and providing continuity of care for someone receiving care in the Trust.

The menus of care and interventions identify **evidence-based bio-psycho-social interventions for particular mental health conditions** that should help to inform care pathways. A care pathway refers to an **individual's journey through the service**, drawing down from the menus of care and interventions and underpinned by care packages and the core standards. An individual's care pathway will be collaboratively visualised within a care planning process; agreed between the service user and their care team, and involving friends and family members where appropriate.

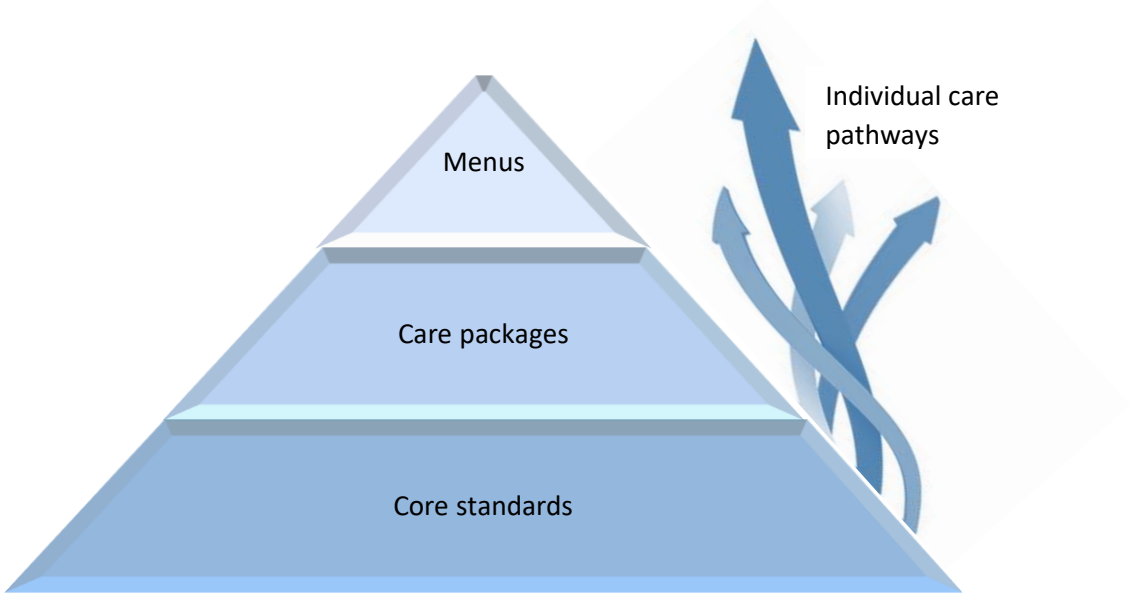

Figure 1: Relationship between service-user, menus of care and interventions, cluster-based care packages and core standards.

Working alongside people with lived experience of depression (and/or caring for people experiencing depression) and other individuals using our services, the menu of care and interventions for depression has been developed by a multi-disciplinary group of staff and service-users including nurses, pharmacists, psychologists, occupational therapists, and psychiatrists.

The menu specifies the range of **evidence-based, NICE-consistent care and interventions that can help people overcome depression and support their recovery**[1], whilst taking account of recourses available. It describes the biopsychosocial care and treatment of depression for adults in primary and secondary care, and for those using acute services[2]. This will contribute towards care planning and the care pathway of each individual. **The NICE Guidelines for Depression are currently under review. They were due for publication in 2018 but this was delayed for a further consultation process that is ongoing. This Menu will be reviewed after publication of the revised NICE Guidelines.**

The menu is presented within a **stepped care** framework[3], to facilitate equitable access to evidence-based care and interventions and to recommend lighter-touch interventions where these are well-evidenced and appropriate. Care and interventions are described at four levels of care within five domains.

The four levels of care are:

1. **Primary Care and Third Sector**. Advice, support and interventions offered by GPs and others in primary care prior to referral to the Trust. This includes signposting to sources of advice, support and interventions available in third sector organisations.

2. **Low Intensity**. Guided self-help and/or light touch evidence based interventions that can help to foster greater self-confidence and self-management skills (NB these will be offered across primary and secondary care).

3. **High Intensity**. Formal psychological therapy, occupational therapy and other more intensive interventions where difficulties are the most complex or severe.

4. **Supporting Recovery**. Support, advice and interventions offered to aid people in their recovery journey, including inpatient care.

The five domains are

1. Daily Life

2. Family and Friends

3. Medication

4. Physical Healthcare

5. Psychological Interventions

[1] Primarily guided by NICE (2009) guideline for depression (www.nice.org.uk/guidance/cg90), however other evidence is included where this is strong but too recent to be included by NICE.
[2] The expectation is that this will be expanded to include children, young people, older people and people using our learning disability and forensic services.
[3] www.nice.org.uk/guidance/cg90/chapter/1-Guidance#stepped-care

Care and interventions are defined in terms of domain (e.g. occupational, physical), and not in terms of professional group involved, as this recognises **the wide range of skills** many of us have to work across these domains (with additional training and supervision where necessary).

We recognise that many people we work with might be experiencing more than one form of difficulty and that in many cases there will not be a straightforward fit between a person's needs and a single menu of care and interventions. As such, our aim is not to fit the person to a menu, but rather to **fit the menu(s) to the person**; following a comprehensive assessment, identification of presenting difficulties and formulation. Care planning will be vital to ensure that needs are appropriately addressed, in order to provide continuity of care and an individualised care pathway.

2. Initial Assessment and Reviews

Before considering which menus of care and interventions are most relevant, a comprehensive assessment should be carried out. Assessment may be facilitated using a proforma where these are available (e.g. such as those available on Carenotes or other electronic record systems). Such guided assessments increase the reliability of the identification of the main presenting problem.

Where difficulties are severe or complex, it would generally be considered **good practice to involve nominated friends and family members** in this process – with the service-users consent.

Assessment should include, where relevant, physical/medical checks in order to identify possible physical factors contributing to mental health difficulties.

Assessment information should inform identification of the person's primary presenting difficulties, secondary presenting difficulties and a holistic formulation.

This process should be revisited at regular intervals, specified in each service, in order to identify changes and to amend care planning where necessary.

3. Identifying Depression

Depression might be an individual's primary presenting difficulty or it may be in the context of other difficulties, such as psychosis or a long term physical health condition. Unless otherwise specified (see co-occurring difficulties section of this document), service-users experiencing significant depression difficulties should be given access to evidence-based care and interventions for depression in line with this document.

Diagnostic Criteria

Clinicians should have a working knowledge of diagnostic criteria for depressive disorders. These are provided in full in Appendix 1, both for ICD-11 and DSM-5.

Keys questions to enquire about depression are:

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

It is important to assess whether the presenting low mood is better considered as part of Bipolar. The Bipolar Menu of Care and Interventions has guidance to make this distinction. A first screening question should be 'Has anyone ever said you are getting too excited?'

Self-Report Measures

The PHQ-9 (see Appendix 2) is a nine item self-report measure providing an indication of depression symptom severity.

This should be used in addition to clinical interview and should not be used as entry criteria for services. The PHQ-9 should also be used to monitor progress throughout treatment (see outcome monitoring 7.0).

4. Care Planning and Role of Lead Practitioner

The assessment/review process will inform care planning and the development of an individualised care pathway for the person concerned. This will include, but is not limited to, appropriate care and interventions from the depression menu – **remembering that the intention is to fit the menu(s) to the person, and not the other way around.**

Where a lead practitioner is allocated[4], they will be responsible for developing the care plan and care pathway with the service user; overseeing its implementation; monitoring and reviewing progress; and amending the care plan and care pathway as necessary. They will also play a crucial role in providing continuity of care. Please refer to the Trust CPA policy for details of this process.

5. Menu of Care and Interventions for Depression

The menu of care and interventions for depression is summarised in Figure 2. This is a higher-order visual representation of the menu and is not intended to be used standalone, but rather to provide an easy-to-follow summary.

Please note that this menu refers only to care and interventions for depression. Depression usually co-occurs with anxiety difficulties, and can co-occur with other mental health difficulties such as psychosis. **Please refer to all menus of care and interventions that are appropriate to the person when collaboratively developing their care plan**. This could mean, for example, that this present menu is considered alongside the menu for obsessive-

[4] A lead practitioner is not allocated in primary care services. In this case, the person assessing difficulties will work with the person to plan their care.

compulsive disorder or other co-morbidities when developing a certain care plan (see also Section 6).

The menu diagram illustrates interventions for depression in the five domains outlined Section 1: Daily Life; Family and Friends; Medication; Physical Healthcare; Psychological Interventions

Each of these are offered at four levels of intensity as outlined in Section 1: Primary Care and Third Sector; Low Intensity; High Intensity; Supporting Recovery.

Each of these domains and levels will be described in more detail below.

Please note that where there are concerns about risk to the service user or others, these should be attended to as a priority. Where necessary, please follow guidelines specified in Trust risk assessment and monitoring policies and procedures, taking immediate action where risk is deemed to be imminent. Where risk is not deemed to be imminent, following the menu of care and interventions as specified may help to alleviate the person's depression and reduce levels of risk.

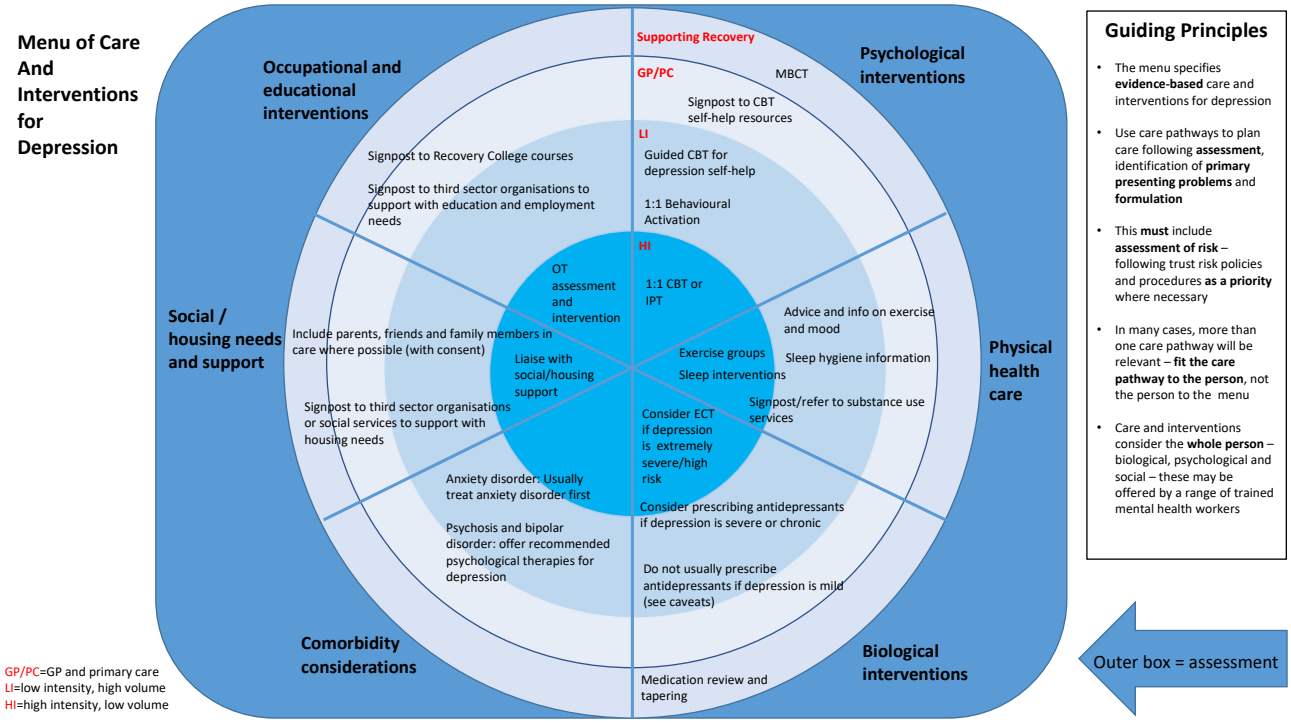

Figure 2: Summary of Depression Menu of Care and Interventions

5.1 Daily Life

Where social, educational, employment or housing needs are related to depression the following should be considered:

1. **Primary Care Services (including Improving Access to Psychological Therapies (IAPT))**[5]

If depression symptoms are mild/moderate

- Where the Recovery College is available, signpost to the Recovery College for the person (and their supporters) to enrol for courses, tasters and workshops.

- Signpost to third sector organisations for education and employment support, or offer in-house education and employment support if necessary.

- Signpost to group-based peer support and self-management programmes to aid occupational re-engagement.

2. **Secondary Care**

Research suggests that occupational, educational and employment interventions can provide valuable benefits for depression Episodes of depression often impact on people's emotional, social, family, academic and financial situation. Early occupational, educational and employment interventions may reduce symptoms, improve quality of life and support people's recovery journeys.

Occupational Interventions

The choice of intervention should be based on person's goals/personal choice and based on Garnham's key Occupational Therapy interventions. Key Interventions that can be delivered in group or one to one work:

- Specialist Occupational Therapy assessment where appropriate e.g. the assessment of motor and process skills (AMPS) to identify service users occupational and support needs.

- Developing/maintaining activities of daily living

- Environmental adaptation including equipment and use of assistive technology

[5] www.healthinmind.org.uk in East Sussex, www.brightonandhovewellbeing.org in Brighton & Hove, and www.sussexcommunity.nhs.uk/services/servicedetails.htm?directoryID=16358 in West Sussex.

- Specific skills development to support engagement in activities, e.g. planning, communication and sensory integration work

- Vocational support, signposting and advice linking with employment specialists.

- Establishing daily routines and roles that support recovery and social inclusion.

- Motivational work to support engagement in meaningful activity

- Enabling recovery and discharge by linking to other community resources in order to develop supportive social relationships and networks.

Employment Interventions

- Referral to Employment specialists to undertake individual placement and support (IPS), support with finding work and job retention.

Educational Interventions

- Individual or group psychoeducation within secondary care services. Supportive and interactive learning about condition and coping strategies. Group approaches aim to provide social support.

- Self-referral to Sussex Recovery College[6] for education, coping strategies and support. Open to service user, family, friends and supporters.

3. Housing Needs

Under the Care Act 2014[7], all local authorities have a duty to assess people who may have care and support needs. This includes a range of provision from residential care and home support, through to supported housing. It may also include access to personalised support and could encompass referrals to projects in the community offering support and activity for people with mental health problems or disabilities.

Each local authority will have a separate assessment process and will offer specific services in the local authority area. It is important to consider the care and support needs of individuals using our services. In areas where services are integrated, the assessments may be undertaken within the integrated mental health teams.

[6] www.sussexrecoverycollege.org.uk/

[7] https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets/care-act-factsheets

5.2 Family and Friends

Service-users are able to decide who to involve from their friendship, family and support network; this may or may not include close family members – the choice is theirs. In some cases, service-users may prefer not to involve anyone from their social network in their care and this decision should be respected. Otherwise, friends and family members should be welcomed to support and encourage their loved ones with engaging in low and high intensity interventions for depression. Friends and family members should feel involved and welcomed at all levels of care.

5.3 Medication[8]

Mild or Moderate Depression

If depression symptoms are subthreshold but persistent, or mild/moderate (equivalent to PHQ-9 score of 5-19 inclusive) in primary care services, IAPT or ATSs:

- Do not routinely use antidepressants to treat persistent subthreshold depression or mild depression (equivalent to PHQ-9 score of <15). The antidepressant side effect checklist should be used before before any medication is started as the symptoms of depression overlap with some side-effects of antidepressants. Without such a baseline assessment, depression symptoms may later be picked up as side-effects and the medication stopped unnecessarily. [https://www.sussexpartnership.nhs.uk/sites/default/files/documents/antidepressant_side-effect_checklist_-_feb_10.pdf]

- However, consider antidepressant medication for patients with:

    - A past history of moderate to severe depression OR;

    - Mild/major depression that complicates the care of a physical health problem OR;

    - Subthreshold depression that has been present for at least two years OR;

    - Subthreshold depression or mild major depression that persist after other interventions

[8] For further details see: (1) British Association for Psychopharmacology (BAP) Guidelines 2008 (update 2015) and/or, (2) NICE guidelines for depression 2009 nice.org.uk/guidance/cg90 and/or (3) SPFT Guidance on the use of Antidepressants for the Treatment of Unipolar Depression and Anxiety Spectrum Disorders in adults 2014 (version 3)

Prescribing:

- 1st line: Generic SSRI

- 2nd line: Different SSRI or a better tolerated second-line antidepressant

- Discuss the choice of drug with the patient; discussion should address therapeutic effects, adverse effects, discontinuation effects and likely time to respond. The Choice and Medication website should be used. This has leaflets for service users including comparison of common side effect profiles.[9]

- Review medication plan if depression has not responded adequately to initial treatment within 6 to 8 weeks, including service user feedback about any adverse effects. Encourage feedback from service users, families and carers earlier than this if they experience increased suicidality. Such feedback and monitoring is especially important in young adults.

- Do not prescribe or advise use of St John's wort for depression. Explain the different potencies of available preparations and potential serious interactions with other drugs (including oral contraceptives, anticoagulants and anticonvulsants).

Severe Depression

If symptoms have been severe (PHQ-9 > 20) for more than two months, if symptoms are chronic (PHQ-9 > 10 for more than two years) or if there are significant concerns about risk in the context of major depression:

- Antidepressants are a first line treatment for:

    - Moderate and severe major depression in adults, irrespective of environmental factors

    - Subthreshold depression that has persisted for two years or more

- Consider generic selective serotonin reuptake inhibitors (SSRIs) as first line

- Discuss choice of drug as highlighted above.

- Titrate the medication to the recognised therapeutic dose

[9] Main website link - www.choiceandmedication.org.uk/sussex; Link to depression handy chart - https://www.choiceandmedication.org/sussex/generate/handychartdepression.pdf

- Assess efficacy after 2 weeks

- Take into account toxicity in overdose if an antidepressant is prescribed or if the patient is taking other medication

There are Trust antidepressant prescribing guidelines, including advice on switching and reducing of antidepressants, available at
https://www.sussexpartnership.nhs.uk/sites/default/files/documents/antidepressant_guidelines_-_2018_revision_-_v4_final_-_jan_18_-_0418_-_minor_update_dec_18.pdf

Stopping or reducing antidepressants

NICE guidance (CG90, April 2016) states:

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

Maudsley Guidelines (12th edition, 2015) has the following advice:

When the antidepressant has been taken for 6 weeks or longer antidepressants should not be stopped abruptly unless a serious adverse effect has occurred.

While abrupt cessation is generally not recommended slow tapering may not reduce the incidence or severity of discontinuation symptoms and so some patients may prefer a shorter/more abrupt cessation.

The onset of discontinuation symptoms after stopping treatment is around 5 days (which can vary) and symptoms differ according to the class of drug prescribed but include:- flu-like symptoms, irritability, sweating, headache, dizziness, insomnia and vivid dreaming.

The table below is an initial guideline that can be used when stopping antidepressants.

Fluoxetine	At 20mg /day just stop. At higher doses reduce over 2 weeks
Venlafaxine, duloxetine, vortioxetine, paroxetine, sertraline, citalopram, escitalopram, MAOIs, selegiline,	Reduce over 4 weeks or longer if necessary
Mirtazapine, reboxetine, trazodone, bupropion, tricyclic antidepressants, fluvoxamine, moclobemide,	Reduce over 4 weeks
Agomelatine	Can be stopped abruptly

Further guidance from NICE in October 2019 states:

"Advise people taking antidepressant medication that, before stopping it, they should discuss this with their practitioner.
Advise people taking antidepressant medication that if they stop taking it abruptly, miss doses or do not take a full dose, they may have discontinuation symptoms such as:
- *restlessness*
- *problems sleeping*
- *unsteadiness*
- *sweating*
- *abdominal symptoms*
- *altered sensations (for example electric shock sensations in the head)*
- *altered feelings (for example irritability, anxiety or confusion).*

Explain that whilst the withdrawal symptoms which arise when stopping or reducing antidepressants can be mild and self-limiting, there is substantial variation in people's experience, with symptoms lasting much longer (sometimes months or more) and being more severe for some patients."

5.3.1 Electroconvulsive therapy (ECT)

- ECT should be considered as a treatment for major depression in urgent and emergency situations such as: depressive stupor; high risk of suicide; extreme levels of distress; and poor fluid intake.

- Bilateral ECT is the preferred choice in such circumstances

- ECT is not recommended as a treatment for major depression in non-urgent circumstances, but could be considered where: patients express a clear choice; or the patient has relapsed and there has been a previous positive response to ECT; or psychotic features are present

- Should be considered for treating major depression where other treatments are not possible or feasible. The risk–benefit balance needs to be evaluated, taking into account depression severity (including the presence of psychotic features) and degree of disability

- Should be followed by continuation pharmacotherapy to reduce risk of relapse or recurrence

5.3.2 Immunopsychiatry research clinic

Immunopsychiatry is a new branch of neuropsychiatry that focuses on the two-way link between the brain and the immune system. In recent years there have been key discoveries in the immunopsychiatry field that might impact the way we understand and treat mood problems associated to inflammation. For example, there is evidence that the presence of inflammation can lead to more severe and persistent mood symptoms, and also evidence that traditional antidepressant medications might be less effective when there is associated inflammation. Understanding the link between brain and immunity can help to *personalise* treatments and therefore offer a better management for these disabling mental health conditions.

Clinical researchers in Brighton and Sussex Medical School and Sussex Partnership NHS Trust are pioneers in this field, and contributed to setup a novel "Immunopsychiatry Research clinic". The clinic's aim is to turn novel research discoveries into new personalised treatments for people experiencing symptoms of mood disorders that are associated to raised inflammation or chronic inflammatory disorders.

Patients with difficult to treat depression and associated inflammation might benefit from referral to the Immunopsychiatry clinic. The clinic accepts referrals of service users with:

- significant depressive symptoms that persist despite at least two adequate pharmacological antidepressant treatments

and

- presence of chronic inflammation (for example a diagnosis of a chronic inflammatory disease eg Rheumatoid Arthritis, Systemic Lupus Erythematous, Multiple Sclerosis); or repeated raised levels of a blood test for inflammation called C-Reactive Protein (also known as CRP). CRP levels can be requested by GPs or Psychiatrists and might be elevated even if there is no formal diagnosis of a chronic inflammatory disease.

Service users referred to the Immunopsychiatry clinic will undergo extensive assessment of their mental health problems, which also includes use of various questionnaires and rating scales, as well as a detailed assessment of their physical conditions. Service users will also receive up-to-date psychoeducation to better understand how to self-manage their problems with chronic inflammation.

In some cases, people suffering from problems with depression that are very difficult to treat, might receive recommendation for medications that are licensed for conditions other than depression (for example, Celecoxib, Minocycline or Bupropion). These medications are not yet recommended by NICE and not currently licensed for depression. However, since they have good evidence basis for improving symptoms of depression associated to inflammation, it is sometimes worth using them in selected cases as additional treatment.

5.4 Physical Health Care

Primary Care

- Advise on role of exercise on mood and signpost to local resources to support exercise (e.g. local gym), including tailoring advice when person is experiencing a long term physical health condition

- Offer physical health checks to rule out physical factors that may be contributing to depression symptoms

- Suggest sleep hygiene advice and signpost to sleep hygiene resources

- Consider role of drugs and alcohol use in causing/maintaining low mood and signpost to support resources and services where necessary

Secondary Care

If symptoms have been severe (PHQ9 20+) for more than two months or if symptoms are chronic (PHQ-9 10+ for more than two years) AND if the person has not responded to the interventions above:

- Proactively support the person to engage in suitable exercise (e.g. gym membership, health walks).

- Offer an evidence-based sleep hygiene intervention where relevant, using established resources.

- Consider role of drugs, both prescribed and illicit, and alcohol use in causing/maintaining low mood and signpost to support resources and services where necessary, ensuring good collaboration between trust services and substance misuse services

- Signpost to Recovery College courses that support use of exercise and sleep hygiene

- Offer physical health checks. All the checks should be focused on physical health problems such as cardiovascular disease, diabetes, obesity and respiratory disease. A copy of the results should be sent to the lead practitioner and psychiatrist, and put in the secondary care records. Identify people with hypertension, abnormal lipid levels, obesity or a risk of obesity, diabetes or are at risk of diabetes (as indicated by abnormal blood glucose levels), or physically inactive, at the earliest opportunity. Follow NICE guidance on hypertension, lipid modification, and prevention of cardiovascular disease, obesity, physical activity and type 2 diabetes. Offer treatment to people who have diabetes and/or cardiovascular disease in primary care in line with the NICE clinical guidelines on type 1 diabetes, type 2 diabetes, newer agents and lipid modification.

5.5 Psychological Interventions

1. Adults not in Trust services who are experiencing sub-threshold or mild depression

If this is the first presentation to primary care, if depression symptoms are subthreshold but persistent (PHQ-9<10), or mild/moderate (i.e. PHQ-9 10-19), and there are no concerns about risk:

- Offer active monitoring (re-review in two weeks' time)
- Signpost to self-help CBT resources (e.g. books on prescription)]

2. Mild to Moderate Depression

If depression symptoms are subthreshold but persistent (PHQ-9 5-9), or mild/moderate (i.e. PHQ-9 10-19), or if symptoms are severe (PHQ-9 > 19) and there are no concerns about immediate risk, offer:

- Clinician guided CBT self-help for depression using well-established self-help resources (2-8 sessions), such as self-help books, work-sheets and/or online-resources based on CBT for depression principles. These will be guided by current service use and contracts, especially in IAPT.
- 1:1 clinician guided Behavioural Activation (8 sessions)

3. Treatment-Resistant or Severe Depression

This recommendation applies in IAPT (Step 3) and in ATSs.

If symptoms have been severe (potentially corresponding to PHQ9 20+) for more than two months, or symptoms are chronic (potentially corresponding to PHQ-9 10+ for more than two years), and if the person has not responded to the interventions above, offer up to 16-20 sessions of psychological therapies. This includes:

- Individual Cognitive Behavioural Therapy (CBT)
- Individual Interpersonal Therapy (IPT)
- Behavioural Couples Therapy (BCT)
- Dynamic Interpersonal Therapy (DIT)
- Counselling for Depression (CfD)

In the first instance only 8-10 sessions should be offered. Where possible, offer two sessions per week for the first two weeks of CBT. More sessions may be offered where the person has made good progress in the first set of sessions and further significant progress is likely.

This should be provided whilst taking into account an individualised psychological formulation, the person's preferences and previous experiences of therapy.

Individual CBT has better efficacy than group treatment, but group CBT could be considered, especially where preferred by the person with depression. *It is expected that further guidance about use of group treatments for depression will be made in the current revision of NICE guidelines for depression.*

Inpatient Care and High Intensity Psychological Interventions

NICE recommend that the full range of psychological interventions for depression should normally be offered in inpatient settings, potentially increasing the intensity and duration of the interventions and encourage that they are provided effectively and efficiently before discharge. Furthermore, NICE recommend considering "crisis resolution and home treatment teams for people with depression who might benefit from early discharge from hospital after a period of inpatient care".

Whilst psychological therapy is often offered in weekly or fortnightly sessions in secondary care teams, there is good evidence that the same number of sessions offered more intensively (twice weekly or more often) can lead to better outcomes. Inpatient settings therefore provide an ideal opportunity to offer intensive psychological interventions, perhaps even daily sessions. This could be achieved, for example, with a psychological therapist offering weekly sessions of Behavioural Activation or CBT, and a health careassistant providing daily support to engage in agreed tasks between therapy sessions.

4. Supporting Recovery

For people with a history of depression who have already been offered psychological therapy for depression (as above), instances where symptoms are not severe (PHQ-9 <20) and where there are no current concerns about risk of suicide:

- Offer a mindfulness-based cognitive therapy (MBCT) group

As practicing mindfulness can temporarily heighten distress for some people, clinical judgement should be used when referring people for MBCT who have a history of psychosis or significant emotional intensity difficulties.

In addition, to support people who have recovered following other treatment (PHQ-9 <10) in order to reduce the risk of relapse.

- Offer a mindfulness-based cognitive therapy (MBCT) group

6. Co-occurring Difficulties

Principles for working with people experiencing co-occurring conditions

1. **Co-occurrence of mental health conditions is the norm,** rather than the exception, so determining which interventions to offer from which menu in the face of co-occurring difficulties is a key decision for clinician and service user.

2. Screening and detection of the full range of current difficulties is challenging and may require use of screening tools and other specialist assessment.

3. These decisions are best made according to:

    a. **Evidence**: In regards to what works best with the particular constellation of difficulties occurring together

    b. **Formulation**: An understanding of what is driving what (including attention to the full range of potential diagnoses and to risk)

    c. **Goals**: Service-user goals for treatment

    d. **Impact**: The possibility for the biggest impact on quality of life

    These should be reviewed as an episode of care proceeds.

4. Menus of care and interventions should be chosen on the basis of these four factors which will vary for each individual at different points in time.

5. There may be a primary condition which is currently the main source of difficulty and possibly contributing to other difficulties. This is often a target for treatment. **It should not be assumed however, that the primary condition is the person's chosen target for treatment**; they may have completely different goals or more immediate needs.

6. It should not be assumed that the presence of a so-called "personality disorder", emotional intensity difficulties, history of psychosis or other complex or enduring difficulty will reduce the effectiveness of treatment – although some adaptations may be necessary.

7. For psychological interventions:

    a. **The strongest evidence base concerns tackling a specific target condition, whilst taking account of interference from other conditions**. The primary condition will often be the target condition, but this is not always the case.

    b. In the presence of extensive co-occurring difficulties, 'transdiagnostic' psychological interventions that tackle underlying common processes might be considered; although the evidence for transdiagnostic psychological

interventions is currently weaker than that for treatment of single target conditions.

8. Resolving a target condition effectively may lead to partial or complete resolution of other conditions (e.g. becoming free of panic disorder may lead to recovery from depression).

9. Treatment for a target condition in the context of co-occurring difficulties may need to be adapted and this adaptation should be based on specific research evidence for those treatments (e.g. longer treatment period or additional treatment focusing on other difficulties).

10. Menus of care and interventions should describe any specific NICE guidance on sequencing of treatment, yet allow for individually tailored treatment plans based on formulation.

11. This document focuses on co-occurring mental health conditions; another common co-occurring problem is substance misuse where co-operation with partner agencies may be required.

12. **With co-occurring difficulties care planning, co-ordination will be particularly important in connecting care so that everyone involved is working to a co-ordinated plan based on a shared understanding of the difficulties**.

<u>Specific NICE guidance for the Depression Menu:</u>

Recommendations regarding sequencing of treatment when co-occurring problems with depression.

NICE Guideline Topic	**Published**	**Recommended to Consider for Sequencing of Treatment**
Depression	2009	For depression accompanied by *symptoms* of anxiety – treat depression first. For anxiety *disorder* and comorbid depression or depressive symptoms, consult the relevant anxiety guideline and consider treating anxiety disorder first – since effective treatment of this can lead to improvement in depression.
Borderline Personality Disorder	2009	Treat comorbid depression, within a well-structured treatment programme for borderline personality disorder following the guidance for depression.

Psychosis and Schizophrenia	2014	In first episode psychosis If the person's symptoms and behaviour suggest an affective psychosis or disorder, including unipolar psychotic depression, follow the recommendations for depression
Generalised Anxiety Disorder	2011	Treat the primary disorder first (in terms of severity and likelihood of improvement to overall functioning when treated).
Panic Disorder with or without agoraphobia	2011	Identify treatment priority by drawing up a timeline of when the different problems developed.
Obsessive Compulsive Disorder	2005	No guidance on sequencing.
Post-Traumatic Stress Disorder	2018	For PTSD and depression – treat PTSD first since effective treatment of this can lead to improvement in depression. With severe depression that makes initial psychological treatment of PTSD very difficult (e.g. with extreme lack of energy and concentration, inactivity, or high suicide risk), treat the depression first.
Social Anxiety Disorder	2013	If depression started before social anxiety disorder, treat depression first. Treat the social anxiety when improvement in depression allows. If social anxiety disorder started before depression, ask the client whether they would still be depressed if the social anxiety disorder was successfully treated. • If they answer “no” – treat social anxiety disorder first (but if severity of depression prevents this, treat depression first) • If they answer “yes” – treat social anxiety and depression, taking account of client preference for what to treat first.

7. Outcome Monitoring

Monitoring clinical outcomesregularly including side effects of medicines, can help with collaboration between, and provide meaningful information for use by, clinician and service

user. Clinicians should work with the person who has depression to establish a preferred way of monitoring outcomes. There will be no single ideal outcome measure in any given clinical situation. Information may be gathered from various sources (e.g. service user, family, clinician, others) and may measure varying aspects of clinical care (patient experience, quality of life, daily functioning, levels of symptoms, staff experience/confidence). This is in line with Trust position statement on use of outcome measures. For symptoms of depression the Patient Health Questionnaire 9 (PHQ-9) is the preferred measure (see Appendix 2). This is a 9-item self-report questionnaire that can be used at initial assessment and at each subsequent appointment.

PHQ score thresholds are as follows

0-4 No depression

5-9 Subclinical depression

10-14 Mild depression

15-19 *Moderate depression*

20-27 Severe depression

These scores are indicative only, and as with any self-report measure should be considered in the context of the wider clinical assessment. Alongside the use of the PHQ-9, measures of functioning (such as the Work and Social Adjustment Scale, WSAS), general wellbeing (such as the Warwick Edinburgh Mental Wellbeing Scale, WEMWBS), and quality of life (such as the Recovering Quality of Life scale, ReQoL) may be useful and important.

8. Implementation

The maCAG are keen to work with Care Delivery Services to support implementation of this menu. It is anticipated that this will include analysis of training needs and support with audits and quality improvement initiatives. Please contact the maCAG to discuss further (maCAG@sussexpartnership.nhs.uk).

This version of the Menu will be expanded to include care and interventions across the lifespan (children, young people and older people) and specific care groups (e.g. learning disability).

This version of the Menu will also be revised in line with publication of new or revised clinical guidelines, such as the NICE Guidelines for Depression, which are overdue.

Appendix 1: Diagnostic Criteria for Depression

DSM-5 criteria for Depressive disorders

Major Depressive Disorder:

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
    1. Depressed mood most of the day, nearly every day, as indicated by either subjective report, or observation made by others.
    2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
    3. Significant weight loss when not dieting or weight gain (e.g. change of more than 5% body weight in a month), or decrease/increase in appetite nearly every day.
    4. Insomnia or hypersomnia nearly every day
    5. Psychomotor agitation or retardation nearly every day (observable by others)
    6. Fatigue or loss of energy nearly every day.
    7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day.
    8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or observed by others).
    9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
B. The Symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.
C. The episode is not attributable to the physiological effects of a substance or to another medical condition.
D. The occurrence of the major depressive episode is not better explained by a schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.
E. There has never been a manic episode or a hypomanic episode.

ICD-11 Depressive disorders

Depressive disorders are characterized by depressive mood (e.g., sad, irritable, empty) or loss of pleasure accompanied by other cognitive, behavioural, or neurovegetative symptoms that significantly affect the individual's ability to function. A depressive disorder should not be diagnosed in individuals who have ever experienced a manic, mixed or hypomanic episode, which would indicate the presence of a bipolar disorder.

Single episode depressive disorder is characterized by the presence or history of one depressive episode when there is no history of prior depressive episodes. A depressive episode is characterized by a period of almost daily depressed mood or diminished interest in activities lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. There have never been any prior manic, hypomanic, or mixed episodes, which would indicate the presence of a bipolar disorder.

Recurrent depressive disorder is characterized by a history or at least two depressive episodes separated by at least several months without significant mood disturbance. A depressive episode is characterized by a period of almost daily depressed mood or diminished interest in activities lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. There have never been any prior manic, hypomanic, or mixed episodes, which would indicate the presence of a Bipolar disorder.

Dysthymic disorder is characterized by a persistent depressive mood (i.e., lasting 2 years or more), for most of the day, for more days than not. In children and adolescents depressed mood can manifest as pervasive irritability. The depressed mood is accompanied by additional symptoms such as markedly diminished interest or pleasure in activities, reduced concentration and attention or indecisiveness, low self-worth or excessive or inappropriate guilt, hopelessness about the future, disturbed sleep or increased sleep, diminished or increased appetite, or low energy or fatigue. During the first 2 years of the disorder, there has never been a 2-week period during which the number and duration of symptoms were sufficient to meet the diagnostic requirements for a Depressive Episode. There is no history of Manic, Mixed, or Hypomanic Episodes.

Single and recurrent depressive disorders can have specifiers as below:

- Mild, moderate, severe,
- With/without psychotic symptoms – i.e. delusions or hallucinations during the episode

Hence a person could be identified as experiencing ‘a moderate single episode depressive disorder without psychotic symptoms’.

Appendix 2: Outcome measure – PHQ9

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every Day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
		PHQ9 total score			

Appendix 3 Useful resources

The information in this appendix is based on clinician and service user feedback. There is little good quality research evidence about the impact of the use of these resources but may be helpful alongside the care and interventions highlighted above. This is a small, limited section of materials. There are other local services, groups and materials available.

Resources for helping suicidal thoughts and intent

Stayingsafe.net

This website has a large range of very helpful resources, including template safety plans.

Stay Alive app

This extremely helpful app provides advice about how to find emergency help, and many ideas to support people with suicide thoughts, and their families, friends and carers. It was developed by the charity Grassroots Suicide Prevention.

Samaritans UK.
Emotional support for anyone feeling down, experiencing distress or struggling to cope.

24-hour helpline: 116 123 (freephone)
Email: jo@samaritans.org
Freepost: RSRB-KKBY-CYJK, PO Box 90 90, Stirling FK8 2SA
Web: www.samaritans.org

Book on Prescription Service

Public libraries participate in this scheme. A prescriber (e.g. GP) can write a prescription using the Prescriber Leaflet, a copy of which can be found here:

https://tra-resources.s3.amazonaws.com/uploads/entries/document/842/Reading_Well_Books_on_Prescription_digital_user_leaflet.pdf

The person with the prescription can then present the form at their local library to borrow the book. The current list of books available on prescription for Depression can be found here:

https://reading-well.org.uk/books/books-on-prescription/young-people-s-mental-health/depression

Other support

Mind Infoline. Offers mental health information and support. Provide details of Mind's Legal Line and help you find local services near you, including local Minds - www.mind.org.uk

Tel: 0300 123 3393 Open from 9am to 6pm, Monday to Friday
Text: 86463
Email: info@mind.org.uk