

Prescriber

CURRENT THINKING

Understanding the management of major depressive disorder in the UK: a consensus view of current therapeutic methods and guidance for service improvement

A Prescriber supplement commissioned and sponsored by Janssen-Cilag Ltd (see back page)

Introduction

Depression or major depressive disorder (MDD) is the predominant mental health problem worldwide;¹ in the UK approximately 3.3% of the population aged 16 and over are affected at any time.² Symptoms of depression may include: depressed mood; diminished interest or pleasure in activities; weight loss or weight gain; disturbed sleep; moving very slowly or being restless and agitated; fatigue or loss of energy; feelings of worthlessness or excessive or inappropriate guilt; diminished ability to think or concentrate, or indecisiveness; recurrent thoughts of death; suicidal thoughts.³

A major depressive episode is characterised by five (or more) of these symptoms during the same two-week period (and at least one of the symptoms must be diminished interest/pleasure or depressed mood).³ Depression has a significant impact on the patient including symptoms such as cognitive impairment and social dysfunction, risk of relapse and recurrence and decreased quality of life. The lifetime prevalence of depression is in the range of 10–15% of the general population.⁴

Depression has a significant impact on mortality, with depressed men and women being 20 times more likely to die by suicide

than the general population, and an association between depression and an increased risk of mortality due to cardiac causes.⁴ In England, the total annual cost of depression is £7.5 billion. This includes an NHS cost of £1.7 billion as well as lost earnings of £5.8 billion.⁵ The societal and personal impacts of depression in the UK are therefore significant, but current treatment approaches for MDD are often ineffective:

- Up to 30% of patients do not respond to traditional antidepressant medications.⁶
- Only one third achieve remission after their first antidepressant treatment.⁷
- As many as two thirds do not recover fully while on antidepressant treatment.⁶

As a consequence, lengthy and ineffective treatments can prolong patient suffering, reduce expectations and reinforce negative emotions such as hopelessness.⁸

Despite the scale of the problem presented by depression, there is currently no standard treatment pathway across the UK, potentially contributing to significant variation in service provision and outcomes for patients. It is estimated that half of patients attending GPs with depressive disorders do not have their symptoms recognised and

diagnosed as such, potentially leading to treatment delays.⁹

Treatment resistant depression (TRD) is a recognised subgroup of patients with MDD. World health authorities, including the Food and Drug Administration (FDA)¹⁰ and the European Medicines Agency (EMA),¹¹ define patients with TRD as individuals with MDD who have not responded to at least two different antidepressant treatments given at an adequate dose for an adequate duration in the current episode of depression.

TRD affects up to 30% of all individuals with MDD^{6,11} and imposes a considerable health and economic burden on patients, families (including dependents and carers), health service and wider society.^{4,5} TRD has been associated with poorer patient health-related quality of life and higher rates of relapse within one year of remission compared to non-TRD.^{4,12} The burden of TRD has been found to be on a par with or greater than that of other chronic conditions such as cancer and diabetes.¹³

Patients with MDD, and specifically with TRD, could benefit significantly from improvements in the current pathway, thereby improving outcomes for patients and their carers, and reducing the burden to society.

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Declarations of interest

J White has received honoraria from Otsuka Pharmaceutical UK, Lundbeck Ltd and Janssen-Cilag UK. AJ Cleare has received honoraria for speaking from Astra Zeneca and Lundbeck, honoraria for consulting from Allergan, Livanova, Lundbeck and Janssen, and research grant support from Lundbeck, the Medical Research Council (UK), Wellcome Trust (UK) and the National Institute for Health Research (UK). He leads a clinical service treating patients with depression using both pharmacological and non-pharmacological treatments. A Currie has received fees from the British Association for Psychopharmacology, Lundbeck and Janssen-Cilag Ltd. S Derage has received honoraria from Janssen-Cilag UK. B Dow, no conflicts of interest declared. A Hannan has received honoraria from Janssen-Cilag UK. R Nilforooshan has received honoraria from Janssen, Roche and Lilly. D Taylor has received research funding and speaking honoraria from Janssen, Otsuka, Lundbeck, Sunovion and Angelini.

Consensus view

Objectives

The objectives of this project are to understand the attitudes of key clinical groups and stakeholders to the care pathway for patients with MDD and define a clear consensus from a large sample of respondents. This will provide clarity on the elements in the pathway that leave room for improvement and ways in which improvements to patient, NHS and societal outcomes may be achieved, and to acknowledge/define what constitutes recovery.

In pursuing these objectives, this group intends to understand attitudes to the care pathway and identify challenges within it so that clear calls-to-action may be defined. This may help to support alignment between the views of various roles and widen the understanding of the MDD landscape.

Background

Depression is a broad and heterogeneous illness and its overall severity is determined by the number and intensity of symptoms, and the degree of functional impairment to the patient.¹⁴ Depression has been shown to worsen the health outcomes of other comorbidities, and the combination of depression with other common chronic conditions (angina, arthritis, diabetes and asthma) has been observed to be worse than any other combination of these.¹⁵

Persons with MDD suffer from significant functional impairment in their home life, work, relationships and/or social functioning.¹⁶ Furthermore, poor management of depression in society has an adverse impact that extends beyond the individual. Children of low-income depressed women have been reported to have a three-times greater risk of serious emotional problems compared with children of non-depressed mothers.¹⁷ In 2001, neuropsychiatric conditions accounted for almost 30% of the world's

total years lived with disability, 11% of which was attributable to MDD.¹⁸

It is clear that MDD has a substantial negative impact on both the individual and society as a whole; it is therefore appropriate to understand the current issues surrounding the treatment of MDD in the UK.

In the UK, depression is managed by different providers across varied care settings; as a consequence there are differences in therapeutic approaches across roles.¹⁹ This means that patients may not receive consistent care or advice, ultimately resulting in many patients not receiving any treatment, or receiving inadequate treatment, for their depression.^{19,20} The Adult Psychiatric Morbidity Survey (2014) found that 61% of adults aged 16–74 with depression, surveyed in England, were accessing mental health treatment.²

The most commonly used depression rating scale (the Hamilton Depression Rating Scale or HDRS) was developed and published in 1960.²¹ Objective measurement in depression by, for example, using rating scales is done in only a very limited number of cases and usually only in specialty care at the point of diagnosis (not to monitor improvement or measure outcomes) in NHS clinical practice.

In order to address the issues outlined above, a multidisciplinary steering group of people working in this area of medicine was convened; this consensus seeks to understand the perspectives of various professional groups and offer appropriate recommendations.

Methodology

The steering group met in Winter 2018 to review the current landscape of MDD in the UK and identify key topics in the depression care pathway through discussion:

1. The consultation
2. Treatment outcomes

3. Assessment and treatment review
4. Psychological therapies
5. Single point of access (secondary care referral)
6. Liaison psychiatry services
7. Referrals and communication
8. Lines of therapy.

These topics were each further discussed in order to generate consensus statements that reflected the group's thinking, for testing across a wider audience using a questionnaire. Forty-one consensus statements were identified during this part of the discussion. The statements were constructed in order to explore the issues surrounding MDD and included both those that the group agreed with and those that they did not; it was therefore expected that some of the statements would generate high levels of disagreement and some may not reach consensus thresholds. The statements were then collated into a questionnaire, which was sent to relevant HCPs (Table 1) working in the NHS, and the data collection process was stopped when 150 responses were achieved. Respondents were engaged by an independent agency using a third-party database.

The group wished to cover as many relevant roles as possible whilst ensuring that the sample size for each was not too

Table 1. Sample split by role

Group	n
Mental Health Commissioner	15
GP	40
Psychologist	20
Psychiatrist	40
Psychiatric or Mental Health Nurse	30
Mental Health Pharmacist	5
Total	150

small, so the samples for interview comprised the following roles (see Table 1 for numbers interviewed):

- Mental Health Commissioner
- GP
- Psychologist
- Psychiatrist
- Specialist Psychiatric or Mental Health Nurse
- Specialist Mental Health Pharmacist.

A limitation of this approach is that patients and carers were not involved and therefore conclusions from a service user perspective cannot be made; a clear next step is to validate results with patients and carers.

Professional groups were chosen to identify variation in attitudes between different roles. The sample was collected to give regional spread across the UK (see Table 2 for regional composition of respondents).

Respondents were offered a 4-point Likert scale to rate their agreement with each statement, ranging across ‘strongly disagree’, ‘tend to disagree’, ‘tend to agree’ and ‘strongly agree’. The questionnaire also asked respondents for their locality and their role. While personal details were not used for reporting results, locality and role were used to assess potential differences in responses across the UK. Completed questionnaires were then collated and the individual scores for each statement analysed in order to produce an arithmetic agreement score for each. The responses were broken down further by locality and role in order to identify variances in the respondent’s agreement scores.

The steering group predefined the threshold of agreement for consensus at 66% and over. Consensus was defined as ‘high’ at ≥66% and ‘very high’ at ≥90%. Further rounds of questionnaire distribution were considered; however, due to the high levels of agreement with all but six of the 41 statements, the group elected to work with the original responses to the statements.

Group	n
London	37
East or Midlands	25
South and South West	31
North	24
Scotland	14
Wales	6
Northern Ireland	7
Unknown	6
Total	150

Results

Completed questionnaires were returned by 150 respondents and analysed to define the total level of agreement with each of the 41 statements. Table 3 shows the consensus statements agreed by the group along with the levels of agreement.

The number of responses was limited to 150, due to resource and timescale limitations, as the group felt that the chosen numbers from each respondent group would give a reasonable insight to the views of each discipline. Subanalysis limits statistically valid conclusions but provides consistent observations regarding variance between respondent groups; variations by region are shown in Appendix A and variations by role are shown in Appendix B.

Discussion

Discussion regarding the current model of care in the UK led this group to consider the patient pathway. The group recognised that there are several entry points to the patient pathway and involvement from different organisations. The group mapped out an aspirational pathway for depression in order to provide clarity and a common point of reference for discussion; the agreed pathway is included below to provide context for the results (Figure 1).

The treatment pathway is an integral part of the patient pathway, and clarity regarding the stepwise approach would support clinicians as well as patients. While the National Institute for Health and Care Excellence (NICE) and the British Association for Psychopharmacology (BAP) guidelines on depression are comprehensive, they are also very long. A summary of the treatment pathway has therefore been included in order to clarify these guidelines and present the recommended stepwise approach of the treatment pathway in a concise and clear way (Figure 2).

The patient and treatment pathways (Figures 1 and 2) for the current treatment of MDD provided a robust background for consideration of the respondents’ responses to the consensus statements and the potential for service improvement.

Respondents across all roles and localities showed strong agreement with the majority of consensus statements (83%) developed by this group. Only statement 19 showed strong disagreement with an overall agreement score of only 28.7%. This is further discussed below.

Some statements exposed large variation in agreement scores dependent upon the locality or roles of the respondent (see Appendices A and B), which may illustrate the difference in perspective of the patient journey by different roles or the existence of a concerning geographical variation across the UK. It does suggest that there is a need for greater alignment between roles in order to ensure that patients receive equitable and well-structured care wherever they are treated, irrespective of the role that they engage with.

The Consultation

Communication and agreement between patient and clinician are key to enable shared decision making.

Whilst statement 1 did not achieve consensus, it is reassuring that GPs did not agree that primary care consultations

Table 3. Defined consensus statements and corresponding level of agreement from 150 responses

No.	Topic	Statement	Score %
1	The consultation	Limited consultation time means that primary care assessment of patients with depression has little value	54.7
2		The relationship between patient and clinician is more important than the time available for consultation	80.7
3		Recognition by both parties that clinician and patient are both experts leads to better outcomes	86.0
4		Patients should be provided with all appropriate information to enable shared decision making	97.3
5	Treatment outcomes	Treatment goals should be clearly defined at the initiation of treatment	90.0
6		All treatment strategies for depression should aim for recovery	82.7
7		Functional improvement is undervalued as a treatment outcome	80.0
8		More time should be made for developing individualised patient management plans	94.7
9		An absence of symptoms is the key indicator of remission	53.3
10		Recovery means being symptom free and back to normal functioning level for more than six months	76.7
11	Assessment and treatment review	Severe depression is effectively defined by ICD-11 and DSM-5	80.7
12		Initial assessment should include a comprehensive bio/psycho/social assessment	97.3
13		Patients should be reviewed at minimum two weeks after treatment initiation/change (one week if aged <30 years)	88.0
14		Treatment review should assess treatment response and tolerability	97.3
15		Physical health parameters should be checked annually at minimum	92.0
16		Standardised measurement of clinical treatment response should be no later than six weeks following treatment initiation/change	88.7
17		Measurement-based care is necessary to achieve the best outcomes	54.0
18		It is important to have available validated depression scales that are easy for patients/carers to (self)-administer	76.0
19		Clinicians have no need for validated depression scales to assess severity	28.7
20		Treatment response is best defined as a significant improvement ($\geq 50\%$) in symptoms and function using a validated depression scale	72.0
21		Levels of function should be assessed using a validated scale such as the Work and Social Adjustment Scale	67.3
22	Psychological therapies	Patients accessing IAPT have a choice of a range of evidence-based psychological therapies	63.3
23		Patients should be considered for further active treatment if they do not respond adequately to initial psychological therapies	98.0
24		Psychological therapies should be offered/considered as an adjunct to patients every time regardless of line of pharmacological antidepressant therapy	92.7
25		Psychological therapies are preferred over pharmacological therapies for moderate to severe depression	37.3

Table 3 (cont.). Defined consensus statements and corresponding level of agreement from 150 responses

No.	Topic	Statement	Score %
26	Single point of access (secondary care referral)	Service users with lived experience should be engaged to co-create single point of access services	88.0
27		Single point of access may prevent patients from receiving appropriate therapy	45.3
28		Single point of access services should be culturally sensitive and appropriate to needs of the individual	98.7
29	Liaison psychiatry services	Liaison psychiatry services should perform a comprehensive treatment review for all patients referred with depression	82.7
30	Referrals and communication	When a patient is not accepted for secondary care, clear communication with specific advice should be sent back to the referrer	99.3
31		Functional change should be described in letters back to the referrer/primary care physician	98.0
32		There is a need to have clear criteria for referral from secondary mental health to tertiary mood disorders services	91.3
33	Lines of therapy	Social prescribing should be offered alongside all lines of therapy	86.0
34		Antidepressant treatment should not be routinely used in patients presenting with mild symptoms of less than two months' duration	81.3
35		Choice of first-line antidepressant therapy should consider specific clinical features such as anxiety, poor sleep, weight change, risk of suicide, etc.	95.3
36		After two treatment failures (both pharmacological and psychological), referral to specialist mental health services should be considered	92.7
37		When there is no response to monotherapy, switch is preferred to augmentation	80.7
38		With a partial response to monotherapy, augmentation is preferred over switch	68.7
39		ECT is an important option for later lines of treatment for depression	71.3
40		Neurostimulation treatments should be more widely available in the UK	69.3
41		Relapse prevention should be actively considered in determining treatment maintenance	97.3

The results in bold indicate consensus (ie ≥66% and ≤33%).

have little value. There was overall agreement that the relationship between patient and clinician (statement 2) is more important than the time available for consultation, although commissioners scored this statement lowest (66.7% agreement).

Respondents agree that recognition by both parties that clinician and patient are both experts, leads to better outcomes (statement 3, 86% agreement). This agreement is important as it supports the use of advanced care plans, which reduce disagreement between clinical professional and patients. If all parties recognise the importance of

shared decision making, then the availability of appropriate pharmacological and psychological therapies should be assured. Other roles with less experience in primary care may have lower awareness of the benefits of primary care consultation.

Statement 4 achieved very strong agreement (97.3%) on the importance of providing appropriate information to patients. Provision of appropriate information may be supported by a clear understanding of factors such as access to services, continuity of care, duration of treatment, mode of care, outcomes expected and access to helplines.

Treatment outcomes

Treatment should be initiated with clearly defined goals, and more time should be made available for the development of the individualised patient management plan aimed at meeting these goals.

Respondents agree strongly that treatment goals should be clearly defined at initiation of treatment (statement 5, 90% agreement) and that more time should be made for developing individualised patient management plans (statement 8, 94.7%). All statements in this section of the questionnaire achieved strong consensus with the exception of statement 9, 'An

Figure 1. Schematic patient pathway for depression

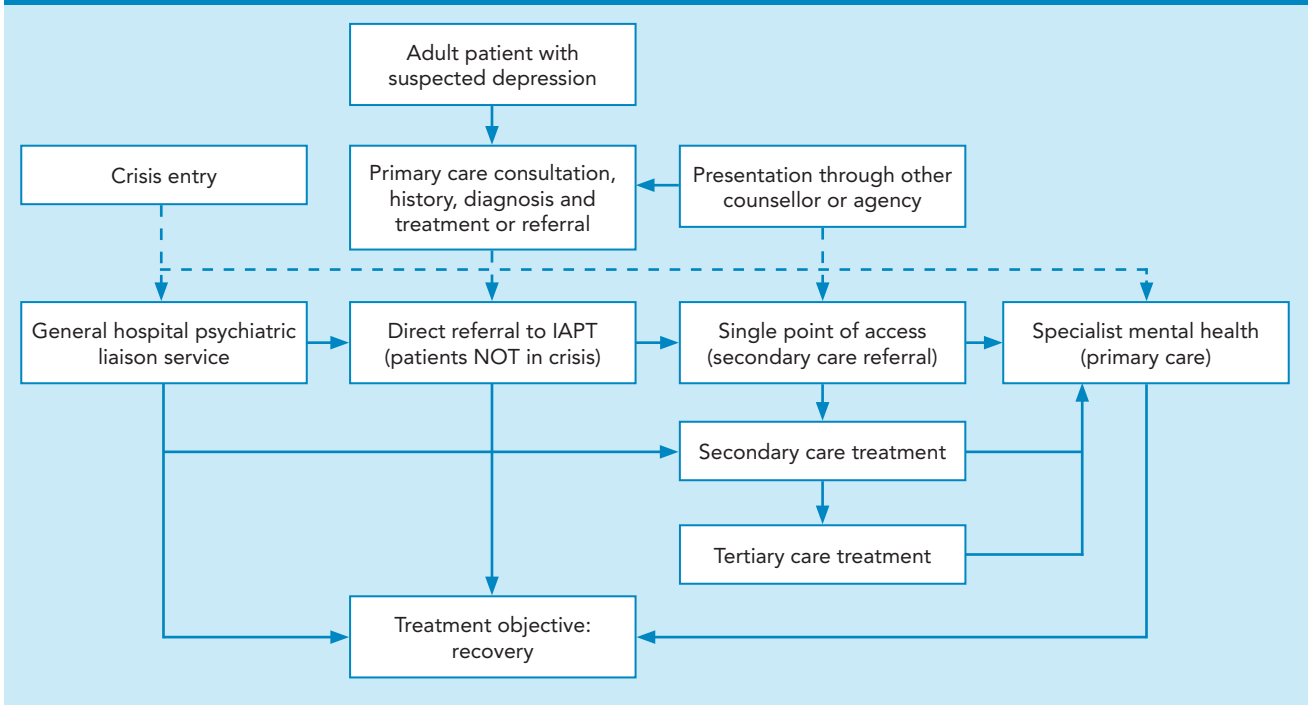
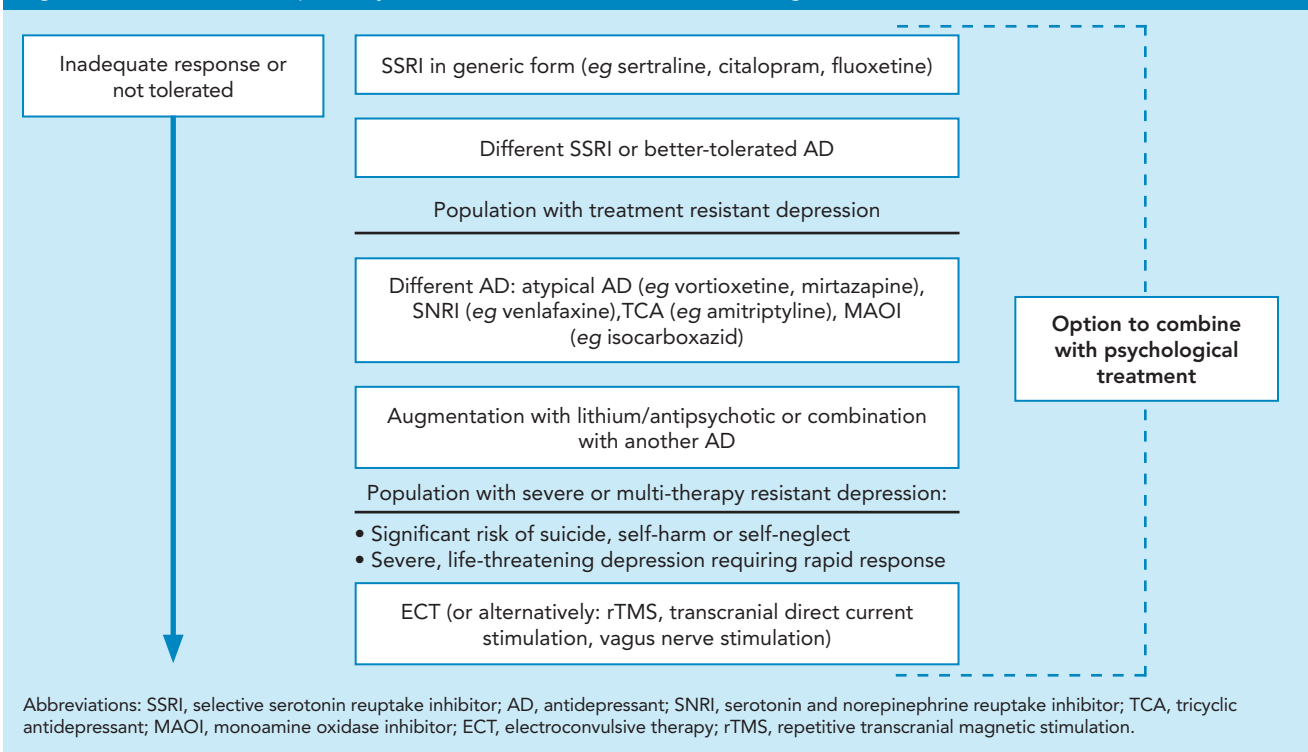


Figure 2. MDD treatment pathway (derived from NICE and BAP clinical guidelines)^{19,20}



Abbreviations: SSRI, selective serotonin reuptake inhibitor; AD, antidepressant; SNRI, serotonin and norepinephrine reuptake inhibitor; TCA, tricyclic antidepressant; MAOI, monoamine oxidase inhibitor; ECT, electroconvulsive therapy; rTMS, repetitive transcranial magnetic stimulation.

absence of symptoms is the key indicator of remission'. Most groups (except pharmacists) were not supportive of this statement, perhaps due to confusion regarding the impact of a reduction of symptoms on functionality and whether a complete absence of symptoms is required to determine the presence of remission (symptoms and function are not always aligned and a small reduction in symptoms may result in a large improvement in function).

Assessment and treatment review

Patients should undergo a comprehensive assessment with regular review using validated measures to assess both symptoms and function.

There was strong agreement that initial assessment should include a comprehensive bio/psycho/social assessment (statement 12, 97.3%) and that treatment reviews should assess both response and tolerability (statement 14, 97.3%).

Statement 17, 'Measurement-based care is necessary to achieve the best outcomes, did not achieve consensus (54%). Clearly, measures are important in clinical decision making, although the use of the word 'necessary' within the statement may have caused responders to not fully agree with the statement. This is demonstrated by the inverse consensus (28.7% agreement) achieved by statement 19, 'Clinicians have no need for validated depression scales to assess severity'. The response to statement 19 suggests that there is a widespread recognition that a validated depression scale is needed in order to assess severity. This is borne out by the consensus achieved by the other statements within the topic (statements 16, 18, 20 and 21), which clearly show that there is wide consensus to use scales more frequently in order to enhance the care pathway and eventually improve outcomes.

The difference between the scores for statements 17 and 19 may also be due to perceived differences in the importance of measurement scales to assess outcome versus severity. Respondents agreed that

treatment response is best defined using a validated depression scale, although there may be confusion regarding the purpose of assessment scales, ie for diagnosis, treatment monitoring or both? Mental Health Commissioners may also use measurable outcomes to determine where best to target limited resources, which may influence the perception of their benefit amongst some groups.

Psychological therapies

Psychological therapies should be offered as an adjunct to patients regardless of active treatment.

Respondents strongly agree that patients should be considered for further active treatment if they do not adequately respond to initial psychological therapies (statement 23, 98% agreement). There is also strong agreement to statement 24 (92.7%) supporting the need for psychological therapies to be available to patients irrespective of the line of pharmacological antidepressant therapy. This was also supported by all role subgroups.

Statement 22, 'Patients accessing IAPT have a choice of a range of evidence-based psychological therapies', failed to reach consensus (63.3%), potentially indicating variability between services in England and Wales (IAPT is an NHS England initiative).

Statement 25 regarding the preference for psychological therapies over pharmacological therapies failed to reach consensus (37.3% agreement) despite being supported by 90% of psychologists. It is of note that psychiatrists strongly disagreed with this statement (2.5% agreement).

Single point of access

Service users should be engaged in the co-creation of single point of access services and these services should be sensitive to the needs of individuals.

Respondents did not agree that single point of access may prevent patients from receiving appropriate therapy (statement 27, 45.3% agreement). With

no overall consensus, it is difficult to draw any conclusions to this other than this may be the case in some circumstances. There were no discernible differences in response to statement 27. The group most likely to agree with this statement are commissioners, whereas psychiatrists are most likely to disagree. It should also be considered that single point of access may be defined differently in different parts of the UK.

Liaison psychiatry services

Patients referred to liaison psychiatry services should undergo a comprehensive treatment review.

82.7% of respondents agree that liaison psychiatry services (ie a team of mental health professionals who have specific expertise in helping people who harm themselves or who may have mental health problems which can cause complications for their physical health care and general hospital discharge) should perform a comprehensive treatment review for all patients referred with depression (statement 29). It should be noted that not all assessments will necessarily be comprehensive dependent on the context. All role groups responded with an above 60% agreement to statement 29. Response by region was above 78% for all regions except Scotland (57.1%, n=14), which did not reach the agreement threshold of 60%. This may reflect a difference in approach in Scotland, which may warrant further discussion.

Referrals and communication

Clear communication between services and with patients is paramount.

Respondents strongly agree with all three statements in this section (statement 30, 99.3%; statement 31, 98.0%; statement 32, 91.3%), reinforcing the importance of communication both between care settings and with the patient. If a referral is not accepted, helpful guidance regarding appropriate next steps should be offered to the referrer.

Functional changes need to be documented and sent back to the referrer to inform conversations with the patient and provide an indication of appropriate next steps in the journey of care.

Clear criteria for referral to tertiary services should be agreed and implemented to ensure appropriate use of resources and minimise disruption to the patient.

Lines of therapy

In moderate-to-severe patients, antidepressant treatment should be specific to the clinical features of the patient. After two treatment failures, patients should be referred to specialist mental health services.

Respondents supported all statements in this section. The strongest agreement was for statements 35, 36 and 41 (95.3%, 92.7% and 97.3%, respectively).

Commissioners did not reach the threshold for agreement with statement 35 (53.3%) or statement 38 (46.7%), perhaps reflecting that the group is heterogeneous in terms of clinical experience.

Psychologists did not reach the agreement threshold for statements 38, 39 and 40 (55%, 45% and 50%, respectively) perhaps reflecting their professional focus on talking therapies. Pharmacists did not agree that ECT is an important option (statement 39, 40%) or that neurostimulation treatments should be more widely available (statement 40, 40%); again this may be expected given their professional focus. Pharmacists also did not agree that medication switch is preferable to augmentation (statement 37, 40%); this may reflect their understanding of the time-scales involved in seeing positive treatment effects and the augmentation options that are available.

Analysis of responses by location reveals no overall pattern, but there are two responses that appear to be substantially different from the mean. The majority of responses from Wales indicated disagreement with statement 38 (33.3%, n=6) that augmentation is preferred over switch

in patients with partial response. This group was represented by psychologists, psychiatrists and GPs – all groups that achieved the 60% agreement threshold for this statement overall. The explanation may be due to differences in policy and approach between localities. Responses from Scotland indicated 100% agreement that ECT is an important option for later lines of treatment (statement 39, 100%, n=14), a notable difference with other regions where agreement ranged from 64.5% to 71.4%. The reasons for this are unknown but are suggestive of a greater belief in the efficacy of ECT in Scotland.

Conclusion

Whilst respondents agree with 83% of the statements presented to them, this work identifies some clear discrepancy between the current patient pathway and a potential improved model. The group discussion identified several areas for service improvement:

IAPT

- IAPT services should be reserved for those patients NOT in crisis.

Secondary care

- Referral and single point of access criteria should be clearly defined, understood and applied across roles.

Tertiary care

- Access to tertiary care should only be through secondary care with clear referral criteria and outcomes.

Single point of access

- Single point of access services should be secondary care led and need to be actively supported by commissioners and providers.
- Services should be designed with input from service users with an aim to improve the co-ordination of communication between primary and secondary care, and need to be actively supported by commissioners and providers.

Patient assessment and treatment response

- There is a clear need for the standard use of validated scales to determine functional levels and response to treatment and measure and monitor treatment outcomes, and therefore improve the care pathway and consequently overall treatment objectives.

These possible opportunities for service improvement are offered in order to provide useful stimulus for the further development of MDD services across the UK.

Recommendations

The following recommendations are offered based on the learnings identified through the consensus exercise:

The consultation

- There should be a treatment plan for each individual, agreed by patient and lead clinician.

Treatment outcomes

- Treatment goals should be a shared responsibility between patient and clinician.
- Time should be made available for the development of individualised patient management plans.
- Recovery should be defined as being symptom free and back to normal function.

Assessment and treatment review

- Patients should be reviewed at minimum two weeks after treatment initiation/change (one week if aged <30 years).
- Physical health parameters should be checked annually at minimum.
- It is important to have available validated depression scales that are easy for patients/carers to (self)-administer.
- Treatment response should be defined as a significant improvement ($\geq 50\%$) in symptoms and function using a validated depression scale.
- Standardised measurement of clinical treatment response should be no later than six weeks following treatment initiation/change.

- An appropriate, efficient and standardised validated depression scale should be used for assessment and outcome monitoring.

Psychological therapies

- Patients accessing IAPT should have access to a range of evidence-based psychological therapies.
- Patients should be considered for further active treatment if they do not respond adequately to initial psychological therapies.
- Psychological therapies should always be considered for patients receiving pharmacological antidepressant therapy.

Single point of access (secondary care referral)

- Service users should be engaged in the design of culturally sensitive single point of access services.

Liaison psychiatry services

- Liaison psychiatry services should perform a comprehensive treatment review for all patients referred with depression.

Referrals and communication

- When a patient is not accepted for secondary care, clear communication with specific feedback should be sent back to the referrer.
- Functional change should be described in letters back to the referrer/primary care physician and patient/carer.
- Clear referral criteria are needed for referral from secondary mental health to tertiary mood disorders services.

Lines of therapy

- Choice of first-line antidepressant therapy should be tailored to the specific clinical

features such as anxiety, poor sleep, weight change, risk of suicide, etc.

- After two treatment failures (both pharmacological and psychological), referral to specialist mental health services should be considered.

Limitations

As with all surveys, potential limitations of this study include the way in which the questions were worded and the order in which they were asked, and how respondents were approached. However, the questions were constructed by the steering group who also ratified the final form of the questionnaire before distribution.

The sample size was limited, but all respondents were healthcare professionals engaged in mental health provision in the UK, within one of several clearly defined roles. A key 'missing voice' is that of the patient (and carers) – future work within this area should include input from patient representatives.

Summary

The results of the consensus have provided a useful snapshot of the treatment pathway for MDD in the UK and allowed the formulation of a set of recommendations that may help to support the alignment between roles involved in the patient pathway with the ultimate goal of either efficiency gain or improved patient experience.

This consensus review should be repeated in five years to assess change and define more appropriate recommendations at that time.

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Appendices

Appendix A: Variation by region

Whilst the majority of statements were scored similarly, irrespective of the respondent's region (Figure 3), 19 statements showed larger regional variation in score >10% from the combined score. The five greatest variations are shown below (Figure 3, Table 4).

Figure 3. Responses by region

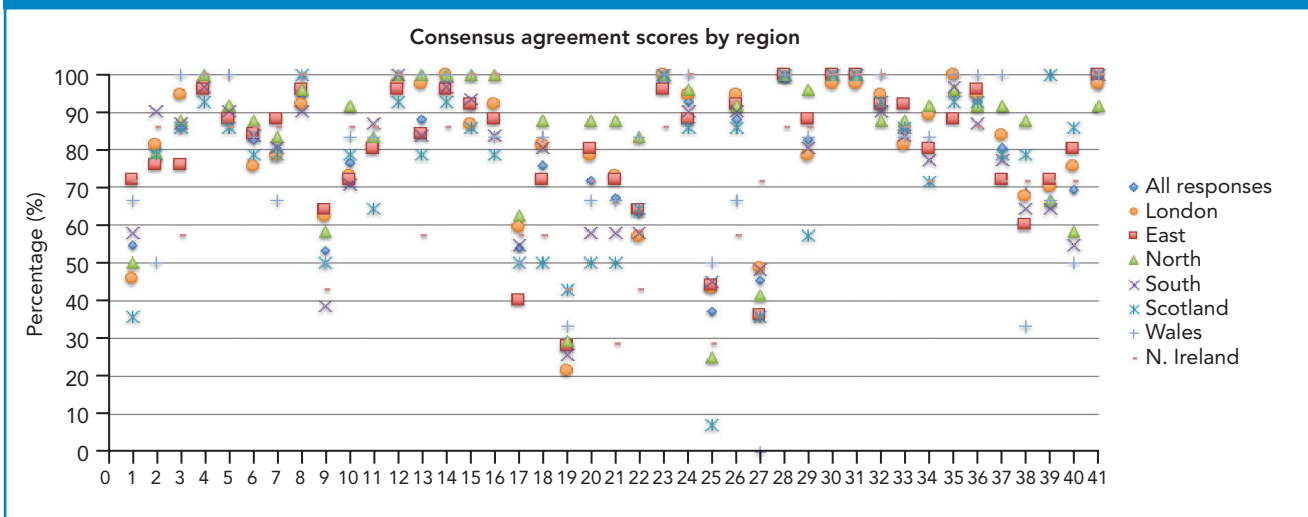


Table 4. Statements showing largest regional variation from the combined score

No.	Topic	Statement	All %	E/M %	S/SW %	Lon %	N %	Sco %
29	Liaison psychiatry services	Liaison psychiatry services should perform a comprehensive treatment review for all patients referred with depression	82.7	88.0	80.6	78.4	95.8	57.1
25	Psychological therapies	Psychological therapies are preferred over pharmacological therapies for moderate to severe depression	37.3	44.0	45.2	43.2	25.0	7.1
18	Assessment and treatment review	It is important to have available validated depression scales that are easy for patients/carers to (self)-administer	76.0	72.0	80.6	81.1	87.5	50.0
20	Assessment and treatment review	Treatment response is best defined as a significant improvement (≥50%) in symptoms and function using a validated depression scale	72.0	80.0	58.1	78.4	87.5	50.0
21	Assessment and treatment review	Levels of function should be assessed using a validated scale such as the Work and Social Adjustment Scale	67.3	72.0	58.1	73.0	87.5	50.0
Number of respondents			150	25	31	37	24	14

Colour coding indicates >10% variation from total score.
Abbreviations: E/M, East or Midlands; S/SW, South or South West; Lon, London; N, North; Sco, Scotland.

Appendix B: Variation by role

Responses were also analysed according to the respondent's role (Figure 4). Whilst the majority of combined scores achieved consensus, there was large variation across roles for most statements (Table 5).

Figure 4. Responses by role

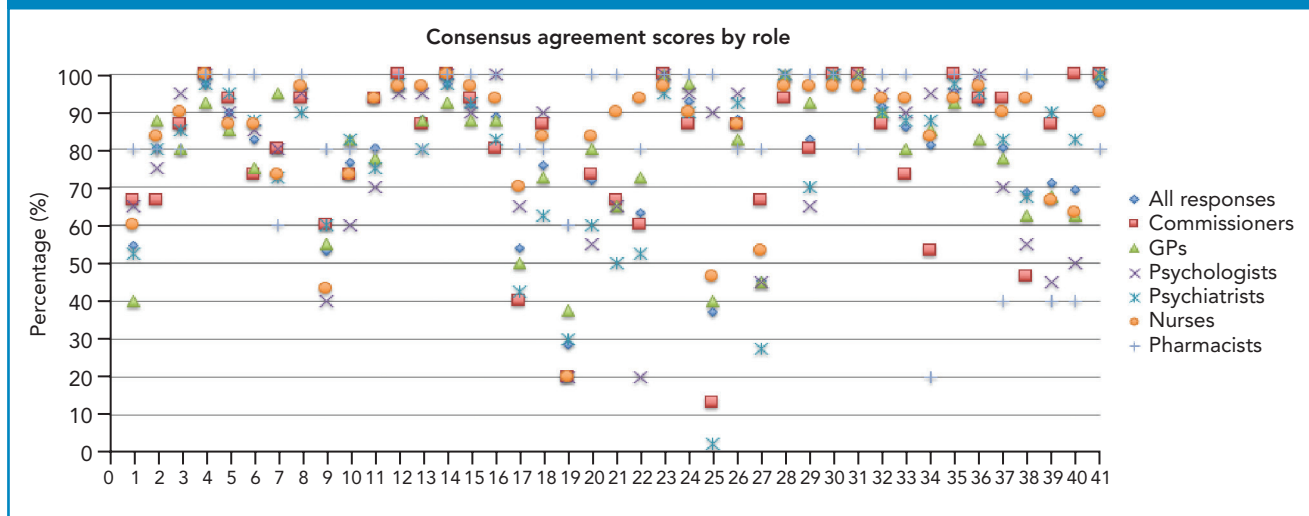


Table 5. Statements showing largest variation by role (eight highest variations only)

No.	Topic	Statement	All %	Com %	GP %	Pcho %	Pchi %	Nu %	Pha %
25	Psychological therapies	Psychological therapies are preferred over pharmacological therapies for moderate to severe depression	37.3	13.3	40	90	2.5	46.7	100
34	Lines of therapy	Antidepressant treatment should not be routinely used in patients presenting with mild symptoms of less than two months' duration	81.3	53.3	85	95	87.5	83.3	20
22	Psychological therapies	Patients accessing IAPT have a choice of a range of evidence-based psychological therapies	63.3	60	72.5	20	52.5	93.3	80
40	Lines of therapy	Neurostimulation treatments should be more widely available in the UK	69.3	100	62.5	50	82.5	63.3	40
37	Lines of therapy	When there is no response to monotherapy, switch is preferred to augmentation	80.7	93.3	77.5	70	82.5	90	40
Number of respondents			150	15	40	20	40	30	5

Colour coding indicates >10% variation from total score. Abbreviations: Com, commissioners; GP, general practitioners; Pcho, psychologists; Pchi, psychiatrists; Nu, nurse; Pha, pharmacist.

Janssen-Cilag Ltd was involved in the outline development and medico-legal approval of this supplement and provided financial support for its publication. Project management and medical writing support was provided by Triducive Ltd and this was funded by Janssen-Cilag Ltd. The supplement is peer reviewed and the authors and publisher retained final editorial control of the content. The opinions expressed in the supplement are not necessarily those of the publisher or Janssen-Cilag Ltd.

Printed and published by **John Wiley & Sons**, The Atrium, Southern Gate, Chichester, West Sussex PO19 8SQ, UK
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