Depression in adults: treatment and management

NICE National Institute for Health and Care Excellence

Consultation on draft guideline – deadline for comments 5pm on 12 June 2018 email: DepressionInAdultsUpdate@nice.org.uk

	Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly. We would like to hear your views on the draft recommendations presented in the short version and any comments you may have on the evidence presented in the full version. We would also welcome views on the Equality Impact Assessment. We would like to hear your views on these questions: 1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. 2. Would implementation of any of the draft recommendations have significant cost implications? 3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) See section 3.9 of Developing NICE guidance: how to get involved for suggestions of general points to think about when commenting.

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Organisation name – Stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):	**UK University Mindfulness Centres** Representing: Oxford Mindfulness Centre (University of Oxford); Sussex Mindfulness Centre (University of Sussex); Centre for Mindfulness Research and Practice (Bangor University) and Clinical Education Development and Research (University of Exeter)
Disclosure Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.	Nothing to disclose
Name of commentator person completing form:	Dr Clara Strauss, School of Psychology, University of Sussex, Falmer, Brighton, BN1 9QH c.y.strauss@sussex.ac.uk
Type	[office use only]

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Comment number	Document (**full** version, **short** version or the **appendices**	Page number Or **'general'** for comments on the whole document	Line number Or **'general'** for comments on the whole document	Comments Insert each comment in a new row. Do not paste other tables into this table, because your comments could get lost – type directly into this table.
Example 1 Example 2 Example 3	Full Full Full	16 16 16	45 45 45	We are concerned that this recommendation may imply that …….. Question 1: This recommendation will be a challenging change in practice because …… Question 3: Our trust has had experience of implementing this approach and would be willing to submit its experiences to the NICE shared learning database. Contact…….
1	Full and Short	General	General	We would like to thank the committee for considering and responding to our comments on the first draft of the revised guideline. We have provided additional comments below on the second draft of the revised guideline and we hope that the committee find these helpful.
2	Full and Short	**Short Version Section 1.8** (Relapse Prevention)	Page 27 line 12 to page 28 line 2	Thank you for your detailed response to our comments following the first consultation on caveats introduced when recommending MBCT as a relapse prevention intervention for depression. This second version of the draft guideline has the following caveats which were not included in the 2004 or 2009 version of the guideline and also represent some slight changes from the first version of the draft guideline. MBCT is recommended only for people (our emphasis): • who have recovered from *more severe depression when treated with medication* (alone or in combination with a psychological therapy), but are assessed as having a higher risk of relapse or *who want to stop taking antidepressant medication* (short version 1.8.4). • who have recovered with initial psychological therapy but are assessed as having a higher risk of relapse *but only if the initial psychological therapy doesn't have an explicit relapse prevention component* (short version 1.8.5). In our response to the first version of the draft guideline we highlighted the most comprehensive individual patient meta-analysis of RCTs of MBCT for relapse prevention to date, published in JAMA Psychiatry (Kuyken et al., 2016). We stated that their analysis showed significantly reduced between-group risk of depressive relapse within 60 weeks

				(hazard ratio, 0.69; 95%CI, 0.58-0.82). Moreover, there was a significantly reduced between-group risk of depressive relapse within 60 weeks when comparing MBCT to anti-depressant medication (hazard ratio, 0.77; 95%CI, 0.60-0.98). In relation to the caveats noted above, it is important to highlight that the trials included in the Kuyken et al. (2016) meta-analysis were: • *not* limited to people who had recovered from more severe depression - people with histories of less severe and more severe depression were included. In your response to our previous comment on this matter you noted that the majority of people in the Kuyken et al. (2016) meta-analysis had severe depression and quote the following from the paper: 'our analyses suggest that the treatment effect of MBCT on the risk of depressive relapse/recurrence is larger in participants with higher levels of depression symptoms at baseline compared with non-MBCT treatments, suggesting that MBCT may be particularly helpful to those who still have significant depressive symptoms.' However, is an understandable misinterpretation of this statement (we agree that this statement is easy to misinterpret). Baseline levels of depression were in the residual symptom range in the included trials (i.e. non-clinical range) as currently being in recovery from depression was an inclusion criterion for the MBCT relapse prevention trials. The analysis referred to in the statement applies to participants with relatively higher residual symptoms at baseline, not severe symptoms of depression. We therefore suggest that our original point stands – that limiting the offer of MBCT to people who have recovered from more severe depression is not based on the evidence from MBCT relapse prevention trials, and that the evidence for MBCT for relapse prevention applies to people who have recovered both from less severe and more severe depression. • *not* limited to people who had recovered following treatment with medication or psychological therapy - people were included who had received no previous treatment. We appreciate your comment that people were included in the MBCT trials who had recovered following medication or psychological therapy. We are not aware however of meta-analytic findings that suggest that the effectiveness of MBCT is moderated by receipt of previous treatment (medication or psychological therapy) and we suggest that such an analysis would be needed if limiting the recommendation of MBCT in this way. We therefore respectfully suggest that the caveat that MBCT is limited to people who have recovered following treatment with medication or psychological therapy is removed. • *not* limited to people who recovered with medication but wanted to stop taking it. We suggest that the evidence to date for MBCT for depressive relapse prevention does not warrant this caveat and that people included in the MBCT relapse prevention trials included people who had never taken medication, were currently taking medication, and who had discontinued medication. We suggest that a meta-analysis exploring the moderating effects of medication continuation or discontinuation on MBCT relapse prevention outcomes would be of interest, but to our knowledge this has not informed this particular caveat. We therefore ask that the caveat that MBCT is limited to people who want to stop taking medication is removed.

				We suggest that the caveat (short version 1.8.5) that MBCT should only be offered if the initial psychological therapy does not have a relapse prevention component limits patient choice. We are not aware of evidence that other psychological therapies with relapse prevention components (you suggest CBT and BA as examples) are more effective at preventing relapse than MBCT. We also suggest that the cost of offering 8 sessions of group MBCT would not be greater than offering 4 more sessions of the initial psychological therapy on an individual basis (see short version 1.8.5). We respectfully ask that this caveat is removed. In summary, based on our review of the evidence to date for relapse prevention, MBCT should be offered as a choice to people who have recovered from less severe and more severe depression and who are assessed as having a higher risk of relapse and that this should be irrespective of severity of previous episodes and whether or not previous treatment has been received.
3	Full and Short	**Short Version Section 1.9** (No or limited response to initial treatment)	General	In the first draft of the revised guideline published in July 2017 MBCT was recommended as a second line intervention for people with limited response and treatment-resistant depression. This was in line with recent evidence from RCTs of MBCT for treatment-resistant depression (Chiesa et al., 2015; Eisendrath et al., 2016). We were therefore surprised to see that this recommendation has been removed in the second draft of the revised guideline. The committee responded to our comment by stating: "Following a further review of the evidence for MBCT in further line treatment we have removed it from the recommendations as the evidence for the effectiveness of other interventions was stronger." It is unclear to which evidence this statement refers to, but this is an area where researchers and funders (see recent NIHR calls) agree that more research is urgently needed. At the current stage, existence of a definitive randomized-controlled trial with positive results (as outlined above) represents a significant piece of evidence in this domain. This would also increase patient choice amongst evidence-based treatments for people not responding to initial treatment and would be in line with the interest from patients and GPs in accessing MBCT in the NHS (Halliwell, 2010).
4	Full and Short	**Short Version Section 1.5** (First-line treatment for less severe depression)	General	Since we submitted our comments on the first draft of the revised guideline in September 2017, a ground breaking systematic review and meta-analysis has been published in Clinical Psychology Review of mindfulness-based interventions for psychiatric disorders, including depression (Goldberg et al., 2018). This review and meta-analysis consolidates outcomes from randomised controlled trials of mindfulness-based interventions for people with a diagnosed psychiatric disorder and we would urge the committee to consider the implications of findings for the revised NICE guideline for depression. We summarise findings and implications of the Goldberg et al. (2018) study below. Goldberg et al. (2018) reviewed 142 randomised controlled trials (RCTs) of mindfulness-based interventions for people with a diagnosed psychiatric disorder, with a total of 12,005 participants. For the 30 RCTs comparing

		Short Version Section 1.6 (First-line treatment for more severe depression		mindfulness-based interventions to inactive control groups specifically for people with a diagnosis of depression there was a medium-large post-intervention between-group effect size on depression outcomes (d=0.56; 95% CI: 0.49-0.73). This effect was maintained at follow-up for the 12 RCTs with follow-up data (d=0.55; 95% CI: 0.25-0.84). When compared to evidence-based treatments (defined as treatments recommended for depression by APA Division 12 or other relevant organisations), findings strongly suggest equivalence. In the 10 included trials the post-intervention effect size on depression outcomes between mindfulness-based interventions and evidence-based treatments for people diagnosed with depression was almost zero (d=-0.01; 95% CI: -0.19-0.16) and this remained true for the seven studies with data at follow-up time points (d=0.04; 95% CI: -0.13-0.20). We suggest that findings from Goldberg et al. (2018) add considerable weight to our comment during the previous consultation that mindfulness-based cognitive therapy (MBCT), the mindfulness-based intervention for depression with the largest and most robust evidence-base (Goldberg et al., 2018; Kuyken et al., 2016), should be offered as a first line treatment for less severe and more severe depression (short version sections 1.5 and 1.6). The Goldberg et al. (2018) study suggests equivalence with evidence-based treatments at post-intervention and follow-up. There is also a compelling economic case for recommending MBCT as a first line intervention alongside other evidence-based treatments. MBCT is a group intervention with a low per participant cost of £112 (Kuyken et al., 2015). This is not significantly more expensive in a robust health economic evaluation than maintenance antidepressants over a two-year period (Kuyken et al., 2015). We therefore respectfully suggest that MBCT should be offered alongside other evidence-based treatments as a first line intervention to provide patients with choice, particularly given the interest that patients and GPs have in accessing MBCT in the NHS (Halliwell, 2010).

Insert extra rows as needed

References

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Checklist for submitting comments

- Use this comment form and submit it as a **Word document (not a PDF).**
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include **page and line number (not section number)** of the text each comment is about.
- Combine all comments from your organisation into 1 response. **We cannot accept more than 1 response from each organisation**.
- **Do not paste other tables into this table** – type directly into the table.
- Underline and highlight any confidential information or other material that you do not wish to be made public.
- Do not include medical information about yourself or another person from which you or the person could be identified.
- Spell out any abbreviations you use
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