Anna Freud National Centre for Children and Families

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NICE Guidelines - Depression

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Summary of the 2017 draft NICE guideline, as it relates to IPT

1. Less severe depression – IPT has been relegated to a second line recommendation

First line treatment for less severe depression:

Offer group-based cognitive behavioural therapy (CBT) specific to depression as the initial treatment for people with less severe depression [new 2017] (1.5.1)

Offer individual self-help with support for people with less severe depression who do not want group CBT [new 2017] (1.5.3)

Consider a physical activity programme specifically designed for people with depression who do not want group CBT or self-help with support [new 2017] (1.5.5)

Consider a selective serotonin reuptake inhibitor (SSRI) or mirtazapine for people with less severe depression who choose not to have psychological interventions, or based on previous treatment history for confirmed depression had a positive response to SSRIs or mirtazapine or had a poor response to psychological interventions.

Consider interpersonal therapy (IPT) if a person with less severe depression wo… for interpersonal difficulties that focus on role transitions or disputes or grief and:

- **has had group CBT, exercise or facilitated self-help, antidepressant medic… al CBT previous episode of depression, but this did not work well for them, or**
- **does not want group CBT, exercise or facilitated self-help, antidepressant me…cation, indivi… [new 2017] (1.5.9)**

4-6 weeks

Session 0

Provide individual CBT, BA or IPT to treat less severe depression ove… 16 sessions, each lasting 50–60 minutes, over 3–4 months [new 2017] (1.5.10)

When giving individual CBT, BA or IPT, also consider providing:

- **2 sessions per week for the first 2–3 weeks of treatment for people with less severe depression**
- **3–4 follow-up and maintenance sessions over 3–6 months after finishing the course for all people who have had individual CBT, BA or IPT [new 2017] (1.5.11)**

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2. Person with depression and no response or limited response to initial treatment – IPT is considered only after another treatment has failed.

If a person with depression has had no response or a limited response to initial treatment (within 3–4 weeks for antidepressant medication or 4–6 weeks for psychological therapy or combined medication and psychological therapy), assess:

- whether there are any personal or social factors that might explain why the treatment isn't working
- whether the person has not been adhering to the treatment plan, including any adverse effects of medication.

Work with the person to try and address any problems raised.

If a person has had no response or a limited response to initial treatment after assessing the issues in recommendation 1.9.1, provide more support by increasing the number and length of appointments. Also consider:

- changing to a combination of psychological therapy and medication if the person is on medication only, or
- changing to psychological therapy alone, if the person is on medication only and does not want to continue with medication or
- changing to a combination of 2 different classes of medication, in specialist settings or after consulting a specialist, if the person is on medication only or a combination of medication and psychological therapy and does not want to continue with psychological therapy.

When changing treatment for a person with depression who has had no response or a limited response to initial medication, consider:

- **combining the medication with a psychological therapy (CBT, BA, or IPT), or**
- **switching to a psychological therapy alone (CBT, BA, or IPT) if the person wants to stop taking medication.**

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3. More severe depression – IPT had been removed as a recommended treatment for high moderate to severe depression

First line treatment for more severe depression

Offer individual CBT in combination with an SSRI or mirtazapine as the initial treatment for more severe depression. [new 2017] (1.6.1)

If a person with more severe depression does not want to take medication, offer:

· group CBT, or

· individual CBT or BA if the person does not want group therapy. [new 2017] (1.6.2)

If a person with more severe depression does not want psychological therapy, offer an SSRI or mirtazapine. [new 2017] (1.6.3)

Consider short-term psychodynamic psychotherapy, alone or in combination with an SSRI or mirtazapine, for a person with more severe depression who would like help for emotional and developmental difficulties in relationships and:

· has had individual CBT in combination with an SSRI, group CBT, or individual CBT or BA for a previous episode of depression, but this did not work well for them, or

· does not want individual CBT in combination with an SSRI, group CBT, or individual CBT or BA. [new 2017] (1.6.4)

Behavioural couples therapy

Consider behavioural couples therapy for a person with depression who has problems in the relationship with their partner if:

· the relationship problem(s) could be contributing to their depression or

· involving their partner may help in the treatment of their depression. [new 2017] (1.7.1)

Ensure behavioural couples therapy for people with depression:

· follows the behavioural principles for couples therapy

· provides 15–20 sessions over 5–6 months. [2017] (1.7.2)

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Gateshead Talking Therapies (01.08.16-31.07.17)	IPT referrals n (%)	Recovery Rate ITT (%) IPT alone	Recovery Rate ITT (%) Multiples incl. IPT	Recovery Rate (Completers) IPT alone	Recovery Rate (Completers) Multiples incl. IPT
PHQ-9 (10-17)	58 (4.58%)	74.14%	75%	36.94% of sample 88.64% recovered	23.19% of sample 85.71% recovered
PHQ-9 (18+)	98 (5.79%)	44.9%	56%	62.42% of sample 66.13% recovered	72.46% of sample 69.23% recovered
Steps to Wellbeing Southampton 03.03.15-.03.03.17	IPT referrals n (%)	Recovery Rate	-	-	-
PHQ-9 (10-17)	10 (15%)	70%	-	-	
PHQ-9 (18+)	57 (85%)	46%	-	-	-
North Tyneside Talking Therapies 2016-2017	IPT referrals n (%)	Recovery Rate	-	-	-
PHQ-9 (10-17)	-	-	-	-	-
PHQ-9 (18+)	2016: 74.63% 2017: 72.73%	42% 58%	-	-	-
Talking Mental Health Derbyshire 08.09.16 – 08.09.17	IPT referrals n (%)	Recovery Rate	-	-	-
PHQ-9 (10-17)	72 (58.53%)	75.5%	-	-	-
PHQ-9 (18+)	51 (41.46%)	41.4%	-	-	-
Belfast Trust IPT Service 2016-2017	IPT referrals n (%)				
PHQ-9 (10-17)	20 (35.7%)	-	80%	-	-
PHQ-9 (18+)	36 (64.2%(	-	66%	-	-
Emotional Wellbeing Service, Humber NHS Foundation Trust 2016-2017	IPT referrals n (%)				
PHQ-9 (10-17)	2 (40%)	100%	-	-	-
PHQ-9 (18+)	3 (60%)	66%	-	-	-
Essex IAPT Service 01.9.16 – 31.08.17	IPT referrals n (%)	Recovery Rate			
PHQ-9 (10-17)	50 (46.30%)	64%	-	-	-
PHQ-9 (18+)	49 (45.37)	60%	-	-	-

NICE

The IPTUK response was submitted on 11th Sept and addressed the following key points:

o Lack of transparency and consistent reporting on the evidence used in the network meta-analysis (nma) and failure to include relevant evidence

o Coding errors in the NMA on lower severity depression, raising doubts on the validity of the subsequent conclusions

o Limitations of the lower and higher severity distinction for depression

o Not based on an epidemiologically rationale

o Does not accurately reflect current heuristics for treatment decisions or access to services

o Lack of transparency on the rationale for the hierarchy of measures and cut off scores employed

o Failure to make logical research recommendations to address the lack of evidence underlying the recommendations

o Presentation of non-randomized data from services (Talking Mental Health Derbyshire; Belfast Trust IPT Service; Emotional Wellbeing Service; Humber NHS Foundation Trust; Essex IAPT Service)

o Patient choice based on previous positive experience is limited to CBT and BA and should be extended to all recommended interventions

o A more representative description of the conceptual scope of IPT was provided

o Non-evidence based assumptions underlying the health economics modelling and failure to make corresponding research recommendations to address the gaps in current health economic evidence

o Failure to reflect the reported evidence in the recommendation for more severe depression

o Lack of clarity in the recommendation related to treatment resistant depression

o Lack of clarity on the provision of IPT-M, while welcoming the routine provision of maintenance session following successful treatment

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Implications

- For your services
  - How to ensure IPT is considered at session 0 and after 4-6 weeks?
- For training and supervision
  - What impact on training cases?
  - What resources will be required?
  - What evidence do you need to know?
- How will we have to change if we are primarily working with a treatment population with treatment resistant depression?
- What can services do now in anticipation of the next review?

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