Prescribing for depression in adult mental health services

QI programme

19b

Re-audit

Prepared by POMH-UK for:

East London NHS Foundation Trust

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About POMH-UK

The Prescribing Observatory for Mental Health (POMH) runs clinical audit-based quality improvement (QI) programmes that focus on discrete areas of prescribing practice. Membership of POMH is open to all NHS, private and not-for-profit providers of mental health services (NHS Trusts/healthcare organisations) in the UK.

The aim is to help mental health services improve prescribing practice by providing benchmarked information on their performance against evidence-based practice standards.

Those interested in learning more about the role of POMH should visit the website: http://www.rcpsych.ac.uk/pomh. A 10-year report (2016) on the work of POMH and a 15-year anniversary report (2020) are also available on the website.

There are also reviews of the POMH quality improvement methodology in the following publications:

Barnes TRE, Paton C. The role of the Prescribing Observatory for Mental Health (Editorial). British Journal of Psychiatry 2012; 201: 428-429

Barnes TRE, Paton C. Improving prescribing practice in psychiatry. International Review of Psychiatry 2011; 23: 328-335.

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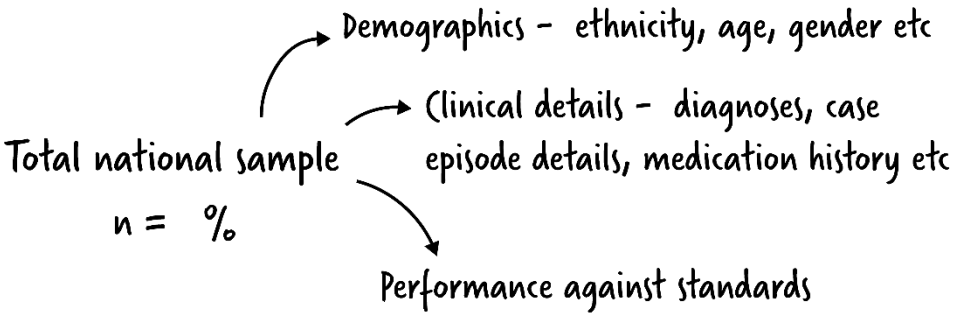
How to read this report



TRUST LEVEL RESULTS ----------p50

The analyses presented in this section allow Trusts to compare the quality of their local practice, in absolute terms, with the practice standards and, in relative terms, with that of the other, anonymous, participating Trusts.

Each of the benchmarked graphs in this section provides evidence of performance on an aspect of prescribing practice across all Trusts individually and the TNS. In each figure, the Trust(s) on the left-hand side is closest to meeting the relevant standard while the Trusts on the right are further away from meeting the standard.

TEAM LEVEL RESULTS ----------p69

The figures in this section allow individual clinical teams in each Trust to compare their practice with each other and against the national data. For each figure, the team(s) on the left-hand side is closest to meeting the standard. The bar on the far right shows the TNS and the bar next to this shows the overall Trust performance.

The results presented in this report allow you to compare your team's/Trust's practice against:

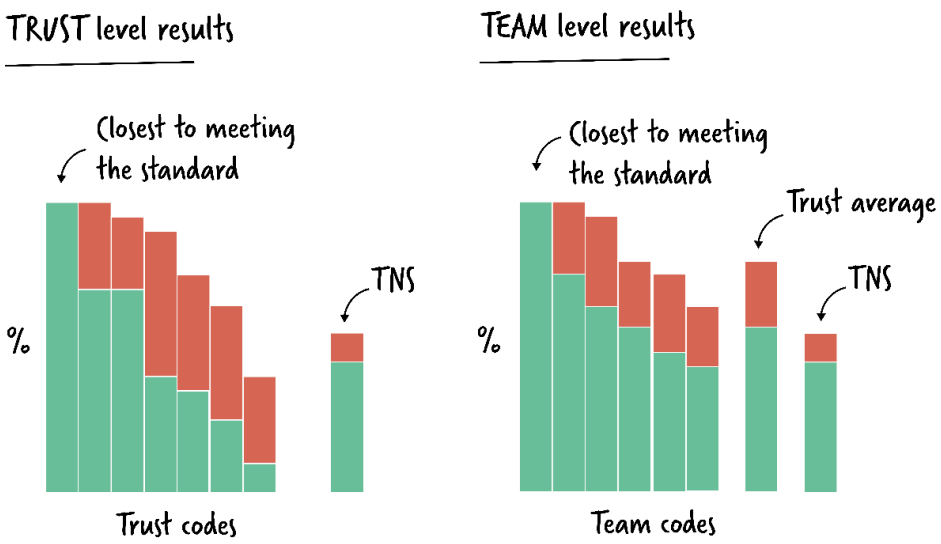
- Treatment recommendations in nationally recognised guidelines, including those published by the National Institute for Health and Care Excellence (NICE) and the British Association for Psychopharmacology (BAP).
- The practice of other participating Trusts.

Further analysis of your Trust's data

An Excel file containing the data submitted by your Trust has been made available to your Local POMH-UK Lead. Please contact this person if you wish to conduct further analyses on your data.

Trust codes

Data from each clinical team or Trust are presented by code only. The POMH-UK Project Team does not know the identity of individual teams. Only the Local POMH-UK Lead for your Trust has the key to team codes for your Trust. You should contact the person if you need to identify data for your own particular team.



These boxes indicate suggested local QI activity that Trusts may wish to consider.

Executive summary

This report presents the results of the re-audit for a quality improvement (QI) programme addressing prescribing for depression in adult mental health services.

During October and November, 60 NHS Trusts/healthcare organisations (See Appendix B) participated in this re-audit, submitting data for 4742 patients under the care of 492 clinical teams.

Practice standards

Number	Practice standards
	Depression should be managed in primary care unless it is complex, severe, treatment-refractory, or places the patient or others at risk.
	If antidepressant medication is stopped for whatever reason: • The dose should be reduced gradually • The patient should be informed about potential discontinuation symptoms
	Patients prescribed continuing antidepressant medication should have a care/crisis plan that: • Identifies potential triggers/precipitating factors that could lead to a worsening of their condition, including psychosocial stressors • Refers to strategies to manage such triggers
	For patients prescribed continuing, long-term antidepressant medication, there should be at least annual review addressing: • Therapeutic response to medication • Medication adherence • Medication side effects • Comorbid conditions, including alcohol and substance use and both psychiatric and physical disorders

Continued

Where the depressive illness has not shown a sufficient response to treatment with an antidepressant medication, the following treatment strategies should be considered:

- Increasing the dose of antidepressant medication
- Switching to another antidepressant medication
- Combining continuing antidepressant treatment with high-intensity psychological/psychosocial interventions, such as individual CBT/interpersonal psychotherapy
- Augmentation with another antidepressant medication
- Augmentation with lithium
- Augmentation with an antipsychotic medication
- Augmentation with ECT treatment

Please note that the inclusion of questions in this data collection tool that refer to 'off-label' prescribing should not be taken as an endorsement of the use of the relevant medication for depression.

Treatment Target

In some cases, the evidence for practice recommendations falls short of supporting an audit standard, i.e. being applicable in 100% of cases. However, the evidence may be sufficient to support general guidance for good practice, allowing that deviation may be appropriate in a proportion of cases. For such treatment targets, clinicians may be particularly interested in how their practice benchmarks with their peers.

Treatment target
 Clinicians should routinely avoid prescribing dosulepin, trimipramine or T3 (liothyronine) for depression.

Summary of key findings

Performance against practice standard 1

Depression should be managed in primary care unless it is complex, severe, treatment-refractory, or places the patient or others at risk

Where patients with a diagnosis of depression had been referred to a short-term community mental health team, the illness was complex, severe, treatment refractory or placed the patient or others at risk in the vast majority (91%) of cases, thus meeting the practice standard. Where the standard was not met, the most common reason for referral was to seek an expert assessment or advice on the treatment plan (see also page 24).

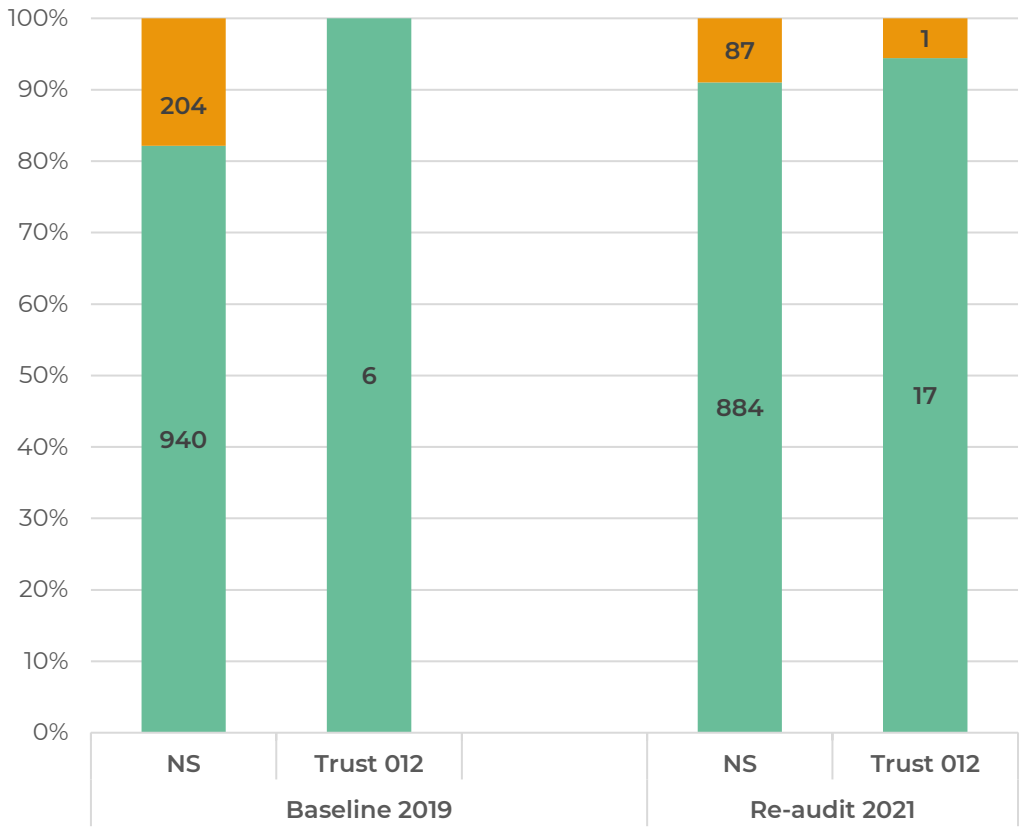


Figure 1: Proportion of cases referred to a short-term CMHT with depression, where the illness was complex, severe, treatment refractory or placed the patient or others at risk: national subsamples and your Trust subsamples, 2019 baseline audit (n=6) and 2021 re-audit (n=18).

- Other reason for referral
- Depression documented as complex, severe, treatment-refractory and/or places the patient or others at risk

Where the patients had been referred from primary care, the proportion of referrals for whom the standard was met was 83%, a figure slightly lower that the figure of 91% for the total national subsample.

Performance against practice standard 2

If antidepressant medication is stopped for whatever reason:

- The dose should be reduced gradually
- The patient should be informed about potential discontinuation symptoms

There are very limited data on which to measure performance against practice standard 2. In the national subsample of 971 patients who had been discharged from the care of a short-term community team, only 156 (16%) were not prescribed any antidepressant medication at this point. In a small number of these cases (n=51, 5% of the national subsample) antidepressant medication had been discontinued in the last 6 months and this was with the knowledge of a healthcare professional in fewer than half (n=23, 45%).

Implications for clinical practice

If a clinician is unaware that the patient is stopping antidepressant medication (for whatever reason) this limits the opportunity to:

1. effectively care plan for the patient
2. ensure that antidepressant doses are titrated down gradually where needed to avoid discontinuation symptoms (as recommended by NICE) and;
3. make the patient aware/remind them that such symptoms may occur (see also pages 34-35).

Trusts may wish to reflect on the systems and processes they have in place to support the development of collaborative treatment/care plans, agreed by both patients and prescribers.

Performance against practice standard 3a

Patients prescribed continuing antidepressant medication should have a care/crisis plan that:

- Identifies potential triggers / precipitating factors that could lead to a worsening of their condition, including psychosocial stressors
- Refers to strategies to manage such triggers

While patient-specific potential triggers were both identified and care planned for in two-thirds of cases, this information was missing from the care plan for one patient in three. This suggests that opportunities to provide patient-specific psychosocial support may be missed.

Performance against this standard was assessed in the subgroup of patient under the long-term care of a CMHT for the management of depression and, given the relatively modest effect size of antidepressant medication and structured psychological therapies in such patients, there is a clear need to care plan effectively to ensure treatment outcomes are optimised.

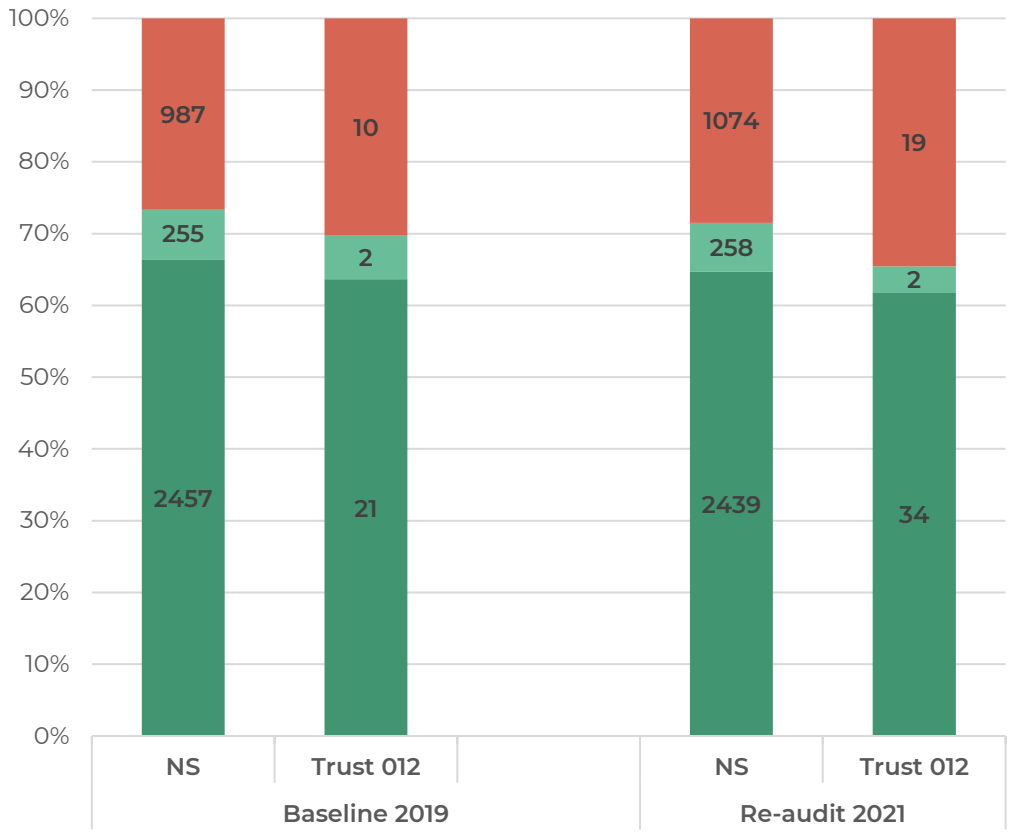


Figure 2: Proportion of patients with depression under the care of a longer-term CMHT for whom the potential triggers/stressors for their illness were identified and care planned for: national subsamples and your Trust subsamples, 2019 baseline audit (n=33) and 2021 re-audit (n=55).

Where local practice does not meet this practice standard, Trusts may wish to reflect on whether their electronic patient records system has sufficient embedded prompts/data fields to support systematic care planning.

Performance against practice standard 3b

For patients prescribed continuing long-term antidepressant medication, there should be at least annual review addressing:

- Therapeutic response to medication
- Medication adherence
- Medication side effects
- Comorbid conditions, including alcohol and substance use and both psychiatric and physical disorders

There was documented evidence that the **symptoms and severity of the depressive illness** were documented in just under 80%, a slightly lower proportion than at the baseline audit. The proportion of cases for whom a standardised rating scale was used was also lower on this occasion. Both NICE (NICE, 2009) and the BAP (Cleare et al, 2015) recommend that standardised rating scales should be used to assess response to treatment and therefore the outcome for each patient; use of these scales also facilitates the communication of the symptom profile and severity to other mental health professionals.

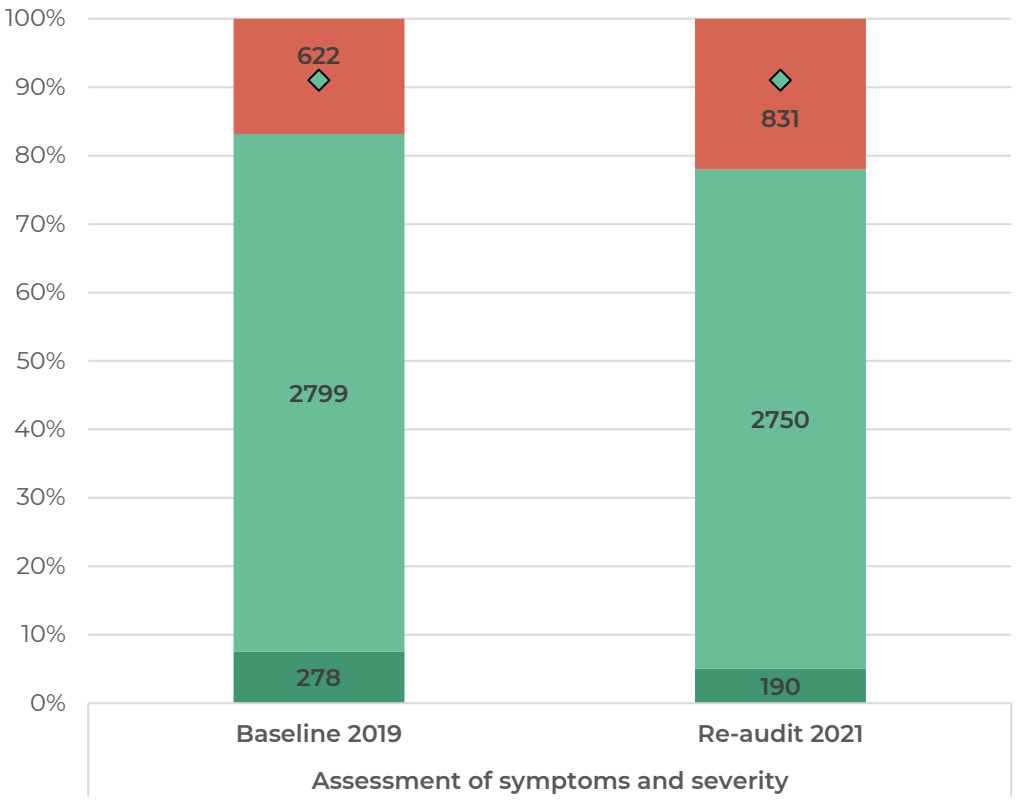


Figure 3: Proportion of patients under the care of a longer-term CMHT who had a documented review in the past year addressing the symptoms and severity of their depression: national subsamples and your Trust subsamples, 2019 baseline audit (n=33) and 2021 re-audit (n=55).

Given the utility of formal rating scales in assessing the symptoms and severity of depression and response to treatment over time, particularly when multiple clinicians are involved with the care of an individual patient, Trusts may like to consider whether their electronic patient records system includes a relevant outcome measure that clinicians can use to inform patient care.

The Figure below shows that the proportions of patients whose **response, adherence to medication and side effects** were assessed are lower than at the baseline audit. One potential explanation for practice moving away from this standard may be the logistical difficulties in providing routine care during the coronavirus pandemic (see page 17).

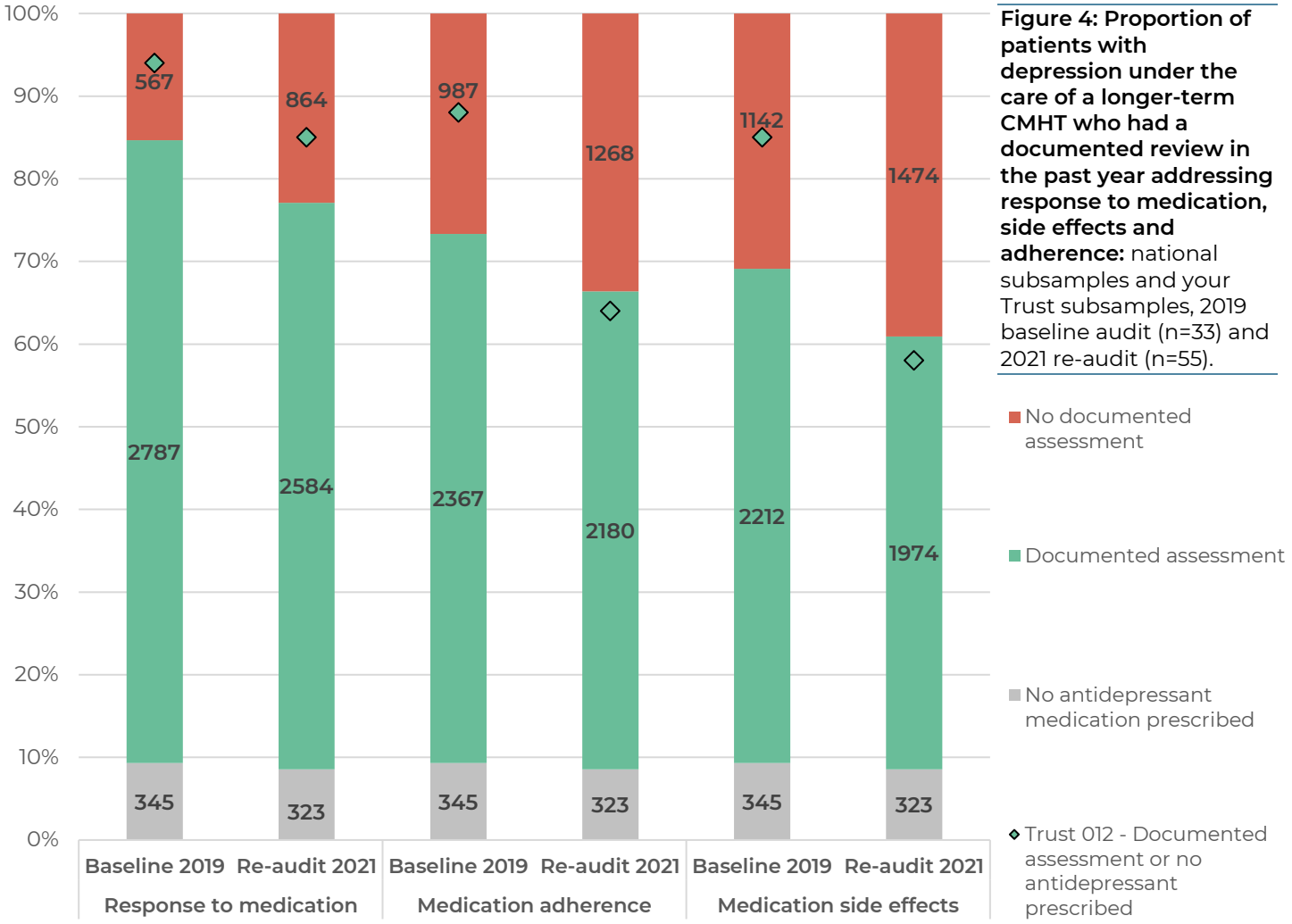


Figure 4: Proportion of patients with depression under the care of a longer-term CMHT who had a documented review in the past year addressing response to medication, side effects and adherence: national subsamples and your Trust subsamples, 2019 baseline audit (n=33) and 2021 re-audit (n=55).

Co-morbid physical and mental illness and the use of alcohol and other substances can complicate the course of a depressive illness and impair recovery.

The Figures below show that, in the total national subsample who were under the care of a longer-term CMHT, there was a documented assessment of substance use in the last year in less than half and this proportion has not changed since the baseline audit. However, the proportions of patients with a documented assessment of co-morbid physical or mental illness were both slightly lower than at the baseline audit.

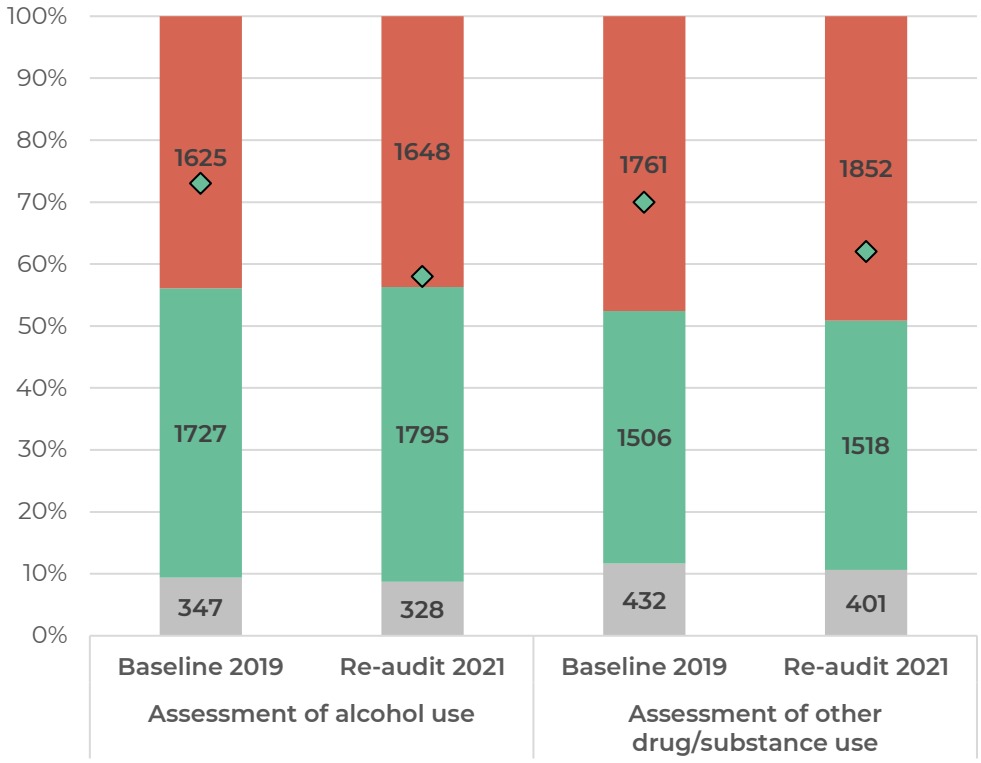


Figure 5: Proportion of patients under the care of a longer-term CMHT who had a documented review in the last year that considered the use of alcohol and other substances in precipitating or maintaining depression: national subsamples and your Trust subsamples, 2019 baseline audit (n=33) and 2021 re-audit (n=55).

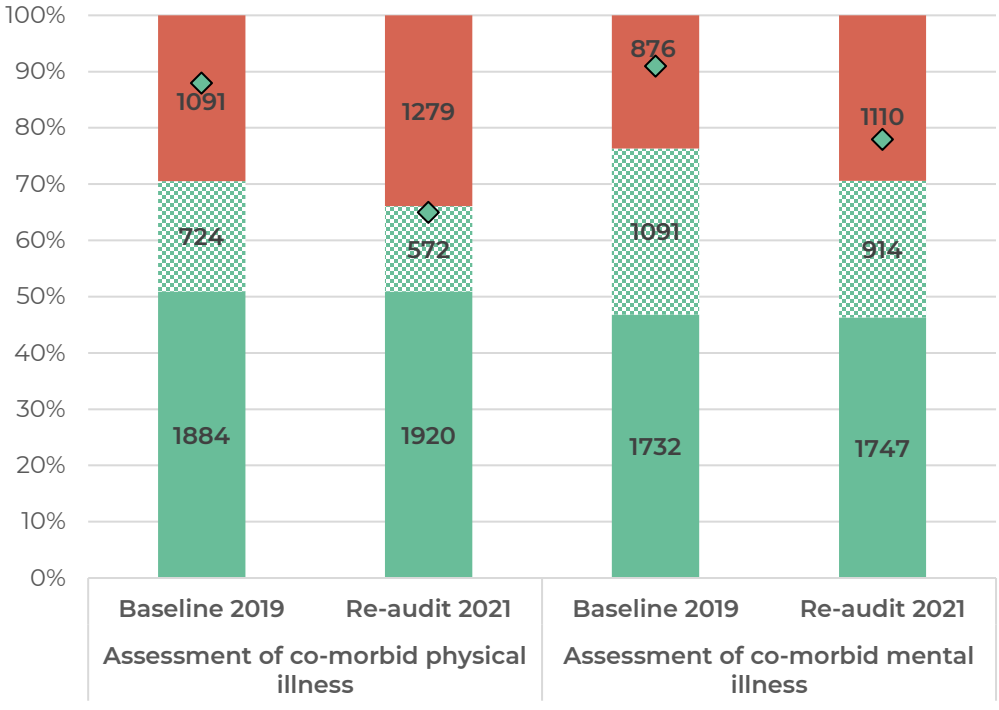


Figure 6: Proportion of patients under the care of a longer-term CMHT who had a documented review in the past year that considered the role of co-morbid physical and mental illness in precipitating or maintaining depression: national subsamples and your Trust subsamples, 2019 baseline audit (n=33) and 2021 re-audit (n=55).

At re-audit, a comprehensive treatment history was documented in less than half of the patients under the care of a longer-term CMHT; this proportion is unchanged from the baseline audit. Given that this group of patients are likely to have complex and treatment-refractory illness, the absence of a documented treatment history potentially compromises effective care planning.

Figure 7: Proportion of patients with depression under the care of a longer-term CMHT who had a documented treatment history: national subsample (n=3771) and your Trust subsample (n=55), 2021 re-audit.

Where local data suggest that not all patients with depression who are under the long-term care of CMHTs have a documented treatment history, Trusts may like to consider whether their electronic patient records system has sufficient embedded prompts/data fields to capture the information required to support systematic care planning.

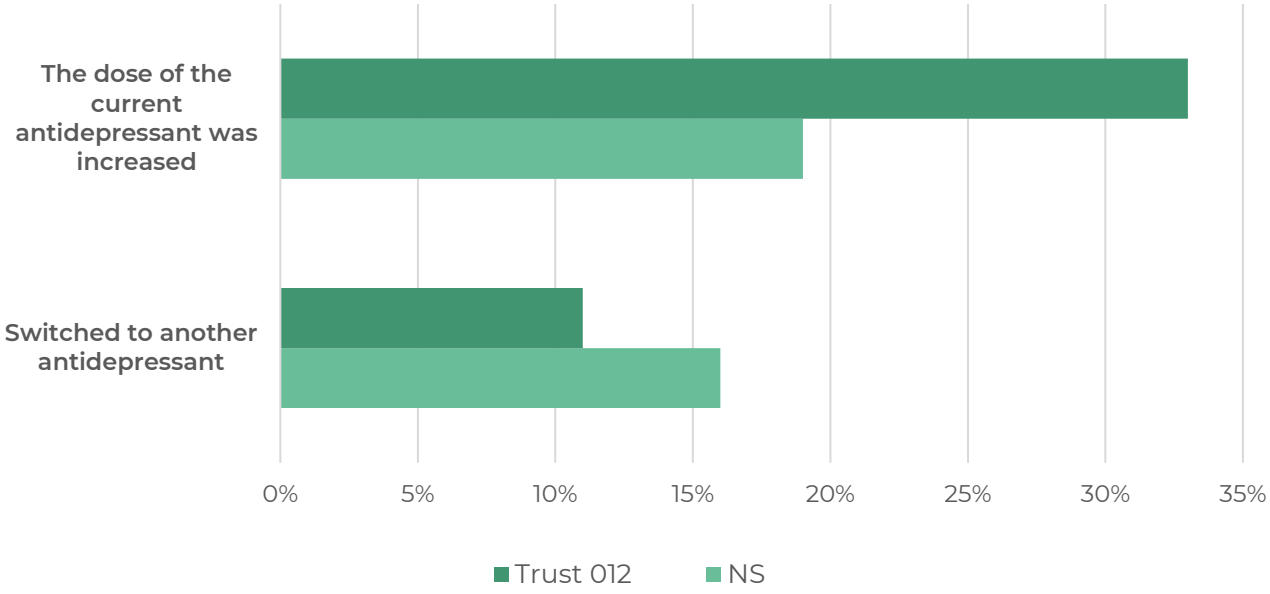
Performance against practice standard 4

Where the depressive illness has not shown a sufficient response to treatment with an antidepressant medication, the following treatment strategies should be considered:

- Increasing the dose of antidepressant medication
- Switching to another antidepressant medication

For those cases referred to mental health services for the management of their depression who had only short-term involvement with a CMHT, the clinical team increased the dose of an antidepressant and/or switched to a different antidepressant in around a third of cases, a slightly larger proportion than at the baseline audit. However, in over four-fifths of cases overall, one or more actions relating to prescribed medication were taken and in almost half of cases a non-medication related action was taken, suggesting that clinical assessment had led to patient-centred care planning. Further details of the range of actions taken can be found in Table 9 on page 28.

Figure 8: Proportion of patients with depression and short-term involvement with a CMHT who had an increase in antidepressant dosage or were switched to another antidepressant: national subsamples (NS: n=971) and your Trust subsample (n=18), 2021 re-audit.



Performance against practice standard 4

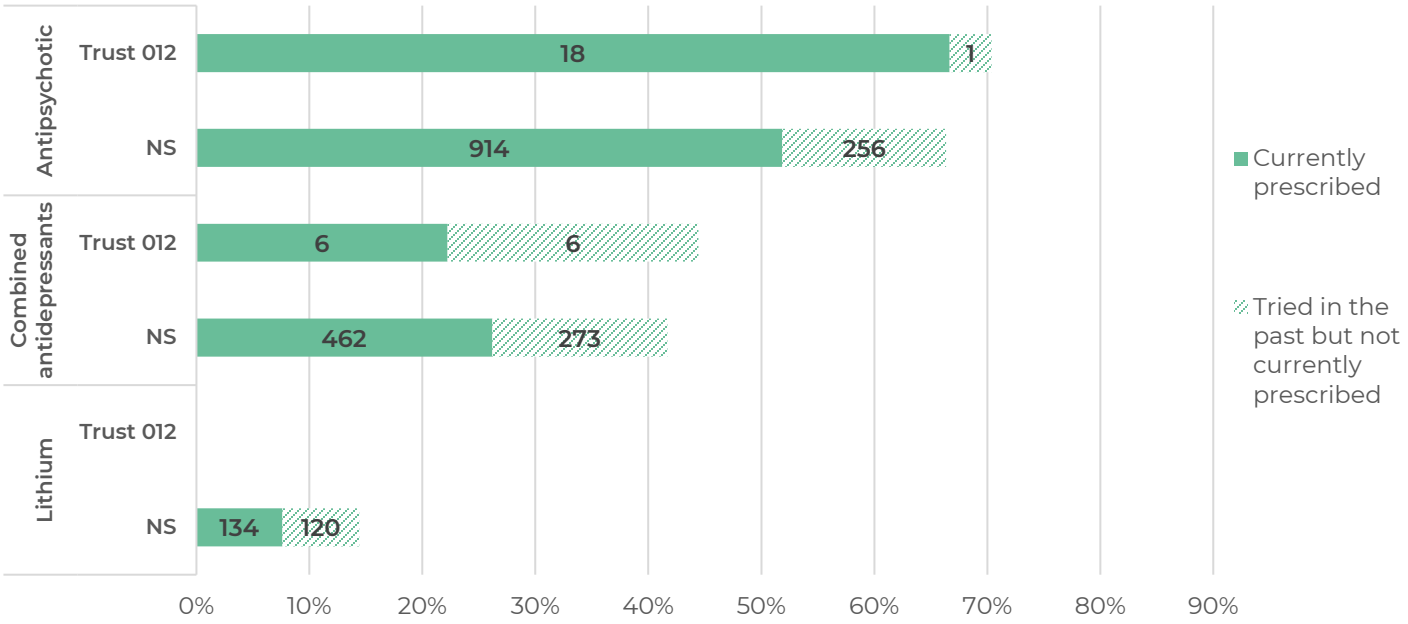
Where the depressive illness has not shown a sufficient response to treatment with an antidepressant medication, the following treatment strategies should be considered:

- Combining continuing antidepressant treatment with high-intensity psychological/psychosocial interventions, such as individual CBT/interpersonal psychotherapy
- Augmentation with another antidepressant medication
- Augmentation with lithium
- Augmentation with an antipsychotic medication
- Augmentation with ECT treatment

At re-audit, augmentation of antidepressant medication with an antipsychotic remained the most commonly tested strategy followed by combined antidepressants (see page 47).

In both the 2019 and 2021 audits, only one patient in seven in the total national subsamples had ever received a trial of lithium augmentation suggesting that opportunities to improve outcomes for some patients with depression may be missed.

Figure 9: Documented past use of pharmacological augmentation strategies supported by NICE, in those patients with depression under the care of a longer-term CMHT who had a comprehensive treatment history: national subsamples (NS: n=1763) and your Trust subsample (n=27), 2021 re-audit.



Other augmentation strategies

Compared with the 2019 audit, in 2021 the use of evidence-based psychological interventions was slightly lower and the use of ECT was slightly higher (see Fig 20 on page 46); these changes may be related to the impact of the Covid pandemic on access to services (see the Covid statement on page 17).

Trusts may like to consider whether developing or adopting a treatment algorithm for refractory depression could improve outcomes for patients under their care with this diagnosis.

Treatment target

Clinicians should routinely avoid prescribing dosulepin, trimipramine or T3 (liothyronine) for depression

The Table below shows that dosulepin, liothyronine and trimipramine were rarely prescribed for patients with depression who were in contact with mental health services. These findings are very similar to the baseline audit.

Medication prescribed	Baseline 2019		Re-audit 2021	
	TNS	Trust 012	TNS	Trust 012
n (%)	n = 4843	n = 39	n = 4742	n = 73
Dosulepin	17 (<1)	-	15 (<1)	-
T3 (liothyronine)	12 (<1)	1 (3)	12 (<1)	-
Trimipramine	3 (<1)	-	1 (<1)	-

Table 1: Prescription of dosulepin, trimipramine or T3: total national samples and your Trust subsamples, 2019 baseline audit (n=39) and 2021 re-audit (n=73).

Introduction

The original clinical background to this QI programme is provided in the Topic 19a baseline report, which can be found in the members' area of the POMH-UK website:

POMH-UK Members' Areas (rcpsych.ac.uk)

Revision of the NICE depression guideline

The clinical practice standards for this QI program were derived from the treatment recommendations in the NICE guideline 'Depression in adults: recognition and management (CG90:2009). While data were being collected for this re-audit, NICE opened a consultation on a draft revision of this guideline. The consultation documents can be found at https://www.nice.org.uk/guidance/indevelopment/gid-cgwave0725/documents There are a number of differences between the treatment recommendations made in 2009 and the draft update that are relevant to this QI program; of particular relevance is the new recommendation supporting the use of liothyronine and lamotrigine as third line treatments for refractory depression and removal of the 2009 'do not' recommendations for dosulepin and lamotrigine. However, the advice given by NHS England that dosulepin and liothyronine should not be routinely prescribed in primary care remains unchanged; it is therefore very unlikely that it will be possible to discharge patients prescribed these medications to primary care and it is important that this is considered when prescribing decisions are taken. While it is not possible to determine whether the draft NICE recommendations will be amended during the consultation process, for the purposes of this report we have assumed they will remain unchanged; we have therefore amended the treatment target to 'clinicians should avoid routinely prescribing dosulepin, trimipramine or T3 (liothyronine) for depression'. There are also a number of changes to recommendations relating to psychological therapies. Where the data collected for this QI program allow, we have reported on how current clinical practice compares with these new recommendations.

COVID pandemic statement

Interpretation of the data collected during this audit should take into account that practice was examined during the coronavirus pandemic. During this period, the threshold of severity for depression to present to medical services may have been higher. Also, Trusts put in place a range of infection control measures including introducing restrictions on face-to-face patient contacts and, where possible, avoiding mental health admissions. In addition, there were fewer available clinical staff due to sickness or redeployment, and a number of practical difficulties associated with providing some aspects of care such as conducting physical examinations and taking blood samples. Nevertheless, for an individual Trust, both absolute and relative performance against the practice standards may be useful indicators of the quality of care that it was able to provide for patients depression during this challenging time.

Method

A clinical records audit was conducted to examine the quality of prescribing for patients with depression under the care of adult mental health services. A bespoke audit tool was sent out to all Trusts/healthcare organisations with instructions that copies should be made available to allow clinical teams to audit their clinical practice (See Appendix D).

Submission of data

Each Trust was allocated a code number that was known only to the Trust and POMH-UK. Trusts were asked to allocate codes to participating services and eligible patients and, if they wished to, individual consultants. The key to these codes is held by the Trust and is not known to POMH-UK. Data coded in this way were entered onto an internet-based form and submitted to POMH-UK via a secure website.

Ownership of data submitted to POMH-UK is retained by the Trust that provided it. See Appendix A for further information on data ownership.

Data collection

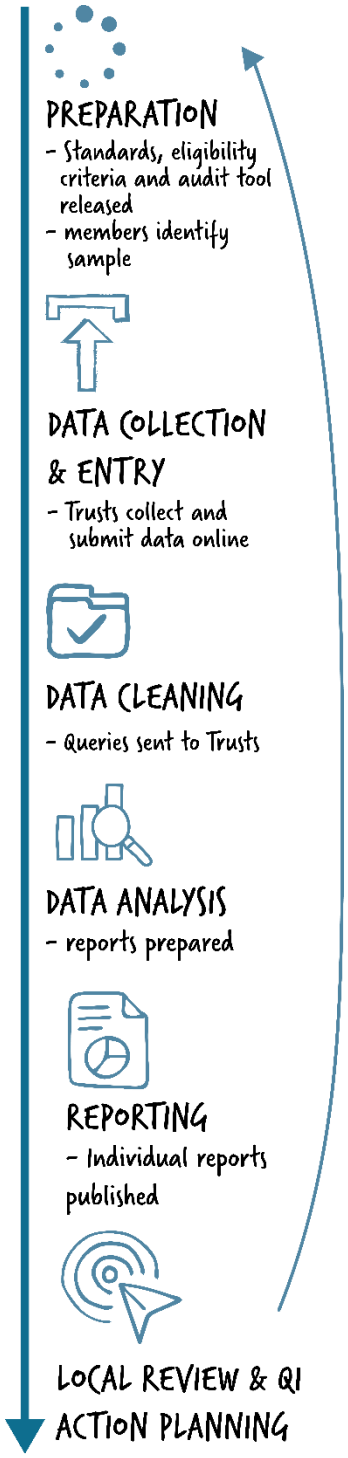
A copy of the data collection tool used for this audit can be found in Appendix D.

All Trusts and clinical teams were self-selected in that they chose to participate. All the participating Trusts/healthcare organisations are listed alphabetically in Appendix B.

Data cleaning

Data were collected using FORMIC (electronic survey software).

Data were cleaned to correct instances of obvious data entry error. Details of corrections are held on file by POMH-UK; please contact pomh-uk@rcpsych.ac.uk if you wish to examine these.



Data analysis

As in previous reports, the data were analysed at three levels:

1) **National level.** This section describes the demographic and clinical characteristics of patients in the total national sample. The data relating to prescribing practice were analysed in a variety of ways to facilitate understanding of the national picture and stimulate discussion in participating clinical teams.
2) **Trust level.** The analyses conducted on the national data were repeated for each Trust/healthcare organisation that submitted audit data. This allows Trusts to compare their performance against the practice standards with the performance of the other, anonymous, participating Trusts.
3) **Clinical service level.** This analysis allows Trusts and individual clinical teams to compare their practice with each other and against the national data.

All the figures presented are rounded up (no decimal places) for simplicity, so in some of the tables and figures in the report the total percentages may add up to 99% or 101%.

The POMH-UK Lead for each participating Trust will be sent an Excel dataset containing their Trust's data. This allows Trusts to analyse their local data further, should they wish to do so.

National level results

This section includes the demographic and clinical characteristics of the total national sample.

The findings of the data analyses are presented in graphs and tables, primarily to show the extent to which clinical prescribing across the participating services is meeting the practice standards.

60 Trusts/healthcare organisations submitted data on the treatment of 4742 patients who had a diagnosis of depression, four-fifths of whom (n=3771: 80%) were under the medium/long-term care of an adult community mental health team (CMHT). The remainder (n=971; 20%) had short-term involvement with mental health services for the management of their depression. In 106 (11%) of these short-term cases, clinical advice only had been given and the patient had not been accepted onto the caseload of a CMHT while in 628 (65%) and 237 (24%) cases respectively the patient had recently been discharged from the care of an adult CMHT or home treatment/crisis team (HTT).

In the Tables that follow on pages 21-23, the data are analysed separately for four subsamples:

- Patients not taken onto a clinical team caseload: advice only provided to referrer.
- Patients discharged after short-term involvement with an adult community mental health team.
- Patients discharged from the care of a home treatment team.
- Patients remaining under the medium to long-term care of an adult community mental health team.

Demographic and clinical characteristics

The demographic profiles of the re-audit sample and subsamples are very similar to those of the baseline audit. On this occasion, where clinical advice only was provided, just under 60% were younger than 45 years of age while the majority of patients recently discharged from an adult community mental health team after short-term involvement or who remained under the medium/long-term care of an adult CMHT were older than 46 years of age (57% and 68% respectively). Almost three-quarters (72%) of those who had been under the care of a HTT were adults of working age (26-65 years old). In the total sample, the proportion of patients under the age of 25 years was relatively low (7%), and one possible explanation is that such patients are more likely to be under the care of other services such as CAMHS, early intervention services, IAPT or primary care.

Table 2: Demographic characteristics: total national sample (n=4742) and clinical subgroups, 2021 re-audit.

Key demographic variables			Not taken onto clinical team caseload (advice only provided to referrer)	Discharged after short-term involvement with an adult CMHT	Discharged from the care of a HTT	Under the medium/long-term care of an adult CMHT	Total national sample re-audit 2021
n(%)			n = 106	n = 628	n = 237	n = 3771	n = 4742
Sex	Male		36 (34)	282 (45)	108 (46)	1561 (41)	1987 (42)
	Female		70 (66)	346 (55)	129 (54)	2210 (59)	2755 (58)
Ethnicity	White/White British		76 (72)	470 (75)	149 (63)	2988 (79)	3683 (78)
	Black/Black British		3 (3)	16 (3)	6 (3)	77 (2)	102 (2)
	Asian/Asian British		9 (8)	18 (3)	17 (7)	163 (4)	207 (4)
	Mixed or other		2 (2)	27 (4)	11 (5)	128 (3)	168 (4)
	Not collected/stated/refused		16 (15)	97 (15)	54 (23)	415 (11)	582 (12)
Age in years	Median age		42.5	50	47	55	53
	Age range		18 - 82	18 - 90	18 - 96	18 - 97	18 - 97
	Age bands	18 or younger	2 (2)	1 (<1)	1 (<1)	13 (<1)	17 (<1)
		19 to 25	11 (10)	67 (11)	28 (12)	206 (5)	312 (7)
		26 to 35	33 (31)	107 (17)	43 (18)	470 (12)	653 (14)
		36 to 45	15 (14)	96 (15)	38 (16)	537 (14)	686 (14)
		46 to 55	25 (24)	102 (16)	53 (22)	758 (20)	938 (20)
		56 to 65	14 (13)	111 (18)	39 (16)	820 (22)	984 (21)
		over 65	6 (6)	144 (23)	35 (15)	967 (26)	1152 (24)

The clinical characteristics of the sample at re-audit are similar to those at baseline. However, the proportion with severe depression (32%) is slightly higher than at baseline (25%).

Note that more than half of the patients in the national sample had a known co-morbid psychiatric diagnosis.

Table 3: Clinical characteristics: total national sample (n=4742) and clinical subgroups, 2021 re-audit.

Key clinical characteristics for total national sample		Not taken onto clinical team caseload (advice only provided to referrer)	Discharged after short-term involvement with an adult CMHT	Discharged from the care of a HTT	Under the medium/long-term care of an adult CMHT	Total national sample Re-audit 2021
	n(%)	n = 106	n = 628	n = 237	n = 3771	n = 4742
Unipolar depression: ICD-10 diagnosis	Mild depression	14 (13)	54 (9)	21 (9)	334 (9)	423 (9)
	Moderate depression	28 (26)	176 (28)	64 (27)	883 (23)	1151 (24)
	Severe depression	16 (15)	219 (35)	84 (35)	1185 (31)	1504 (32)
	Dysthymia	3 (3)	8 (1)	6 (3)	109 (3)	126 (3)
	Other sub-type of depression	28 (26)	137 (22)	42 (18)	1011 (27)	1218 (26)
	Working diagnosis of depression but sub-type not specified	18 (17)	44 (7)	25 (11)	375 (10)	462 (10)
Co-morbid psychiatric diagnosis*	F00-09	3 (3)	20 (3)	5 (2)	129 (3)	157 (3)
	F10-19	4 (4)	52 (8)	27 (11)	261 (7)	344 (7)
	F20-29	-	22 (4)	5 (2)	238 (6)	265 (6)
	F40-48	44 (42)	142 (23)	46 (19)	1057 (28)	1289 (27)
	F60-69	9 (8)	84 (13)	27 (11)	572 (15)	692 (15)
	Unknown	9 (8)	49 (8)	12 (5)	210 (6)	280 (6)
	No other psychiatric diagnosis	38 (36)	263 (42)	128 (54)	1538 (41)	1967 (41)

* *Patients may have more than one co-morbid psychiatric diagnosis.*

Subsample of patients with a completed episode of care from a short-term team (n=971)

Compared with the baseline audit, a smaller proportion of patients on this occasion were referred from primary care and a higher proportion from secondary care teams. Further, compared with baseline, patients were more likely to be discharged to another psychiatric team and less likely to be discharged to primary care. These findings may be indirectly related to the impact of the Covid pandemic on access to services (see the Covid statement on page 17).

As might be expected, the total duration of care was less than 6 months in the vast majority (81%) of cases who were referred to short-term clinical community teams.

Table 4: Referral source, duration of episode of care and discharge destination for patients with depression referred to a short-term CMHT: national subsample (n=971) and clinical subgroups, 2021 re-audit.

Referral source, duration of episode of care and discharge destination		Not taken onto clinical team caseload (advice only provided to referrer)	Discharged after short-term involvement with an adult CMHT	Discharged from the care of a HTT	National subsample 2021
	n(%)	n = 106	n = 628	n = 237	n = 971
Referral source	Primary care (GP)	76 (72)	216 (34)	62 (26)	354 (36)
	Other adult community mental health team	3 (3)	112 (18)	35 (15)	150 (15)
	Psychiatric liaison team	8 (8)	69 (11)	42 (18)	119 (12)
	Inpatient adult mental health team	1 (1)	67 (11)	33 (14)	101 (10)
	A&E	3 (3)	67 (11)	25 (11)	95 (10)
	Self-referral	6 (6)	24 (4)	22 (9)	52 (5)
	Secondary care medical team	3 (3)	25 (4)	10 (4)	38 (4)
	IAPT service	2 (2)	25 (4)	5 (2)	32 (3)
	Other	4 (4)	20 (3)	3 (1)	27 (3)
	Unclear	-	3 (<1)	-	3 (<1)
Duration of the episode of care	Less than a month	37 (35)	85 (14)	88 (37)	210 (22)
	1 - 3 months	59 (56)	264 (42)	116 (49)	439 (45)
	4 - 6 months	10 (9)	110 (18)	13 (5)	133 (14)
	7 - 9 months	-	47 (8)	4 (2)	51 (5)
	10 - 12 months	-	25 (4)	2 (1)	27 (3)
	More than 12 months	-	93 (15)	14 (6)	107 (11)
Discharge destination	Discharged to primary care	46 (43)	388 (62)	106 (45)	540 (56)
	Discharged to other community psychiatric team	7 (7)	186 (30)	105 (44)	298 (31)
	Not taken on to clinical team caseload (advice only provided to referrer)	50 (47)	7 (1)	1 (<1)	58 (6)
	Admitted to inpatient psychiatric ward	1 (1)	25 (4)	17 (7)	43 (4)
	Discharged to secondary care medical team/admitted to medical or surgical bed	-	7 (1)	5 (2)	12 (1)
	Other	2 (2)	15 (2)	3 (1)	20 (2)

Performance against practice standard 1

Depression should be managed in primary care unless it is complex, severe, treatment-refractory, or places the patient or others at risk

Standard 1 was met in 91% of cases. i.e. the level of severity, risk and/or complexity warranted referral to secondary care mental health services. Where the patients had been referred from primary care, the proportion of referrals that met the standard was slightly lower at 83%. As might be expected, in the subgroup of patients who had received an episode of care from a HTT, there was a higher proportion of cases where there was risk to self or others. In the subgroup of patients for whom advice only was provided, there was a higher proportion of patients with treatment-refractory depression.

As can be seen from the Table below, there were 87 cases where Standard 1 was not met. The most common reasons for referral were to seek an expert assessment and/or advice on the treatment plan (n=65, 75%) and to advise on next steps in cases where there has been an insufficient response of the depressive disorder to psychological intervention/counselling (n=12, 14%). There were no referrals for the sole purpose of reviewing non-formulary medication, including dosulepin, trimipramine and liothyronine.

Table 5: Proportion of cases referred to a short-term CMHT with depression, where the illness was complex, severe, treatment refractory or placed the patient or others at risk: national subsample (n=971) and clinical subgroups, 2021 re-audit.

Reason for referral to mental health services n(%)	Not taken onto clinical team caseload (advice only provided to referrer) n = 106	Discharged after short-term involvement with an adult CMHT n = 628	Discharged from the care of a HTT n = 237	National subsample 2021 n = 971
Complex: presence of other mental health and/or physical health needs, presence of psychotic symptoms, pregnancy/planned pregnancy	38 (36)	265 (42)	63 (27)	366 (38)
Diagnosis of severe depression	16 (15)	219 (35)	84 (35)	319 (33)
Treatment refractory depression: an insufficient response to two or more attempts to treat with antidepressant medication	31 (29)	37 (6)	9 (4)	77 (8)
Risk identified: risk of suicide, ask of self-neglect, risk of harm to others	47 (44)	436 (69)	198 (84)	681 (70)
One or more of the above identified: Standard met	89 (84)	568 (90)	227 (96)	884 (91)

Initial assessment

Compared with 2019, the proportion of patients assessed through a telephone interview was higher and the proportion assessed face-to-face was lower. The most likely explanation for this finding is the introduction of remote working as part of the NHS response to the Covid pandemic.

The vast majority of referrals for depression were assessed by a doctor and/or a nurse, with the proportion assessed by a doctor being greater than in 2019.

Table 6: The involvement of members of short-term CMHTs in the initial clinical assessment of patients with depression: national subsample (n=971), 2021 re-audit.

Members of the clinical team involved in the initial clinical assessment n(%)	Patients not directly assessed; advice provided to referrer n = 185	Patients assessed by telephone/teletriage n = 210	Patients seen for face-to-face appointments n = 678
Psychiatrist			
Consultant psychiatrist	106 (57)	47 (22)	233 (34)
Psychiatrist other than a consultant or foundation trainee	38 (21)	39 (19)	159 (23)
Foundation trainee (FY1 or FY2)	13 (7)	7 (3)	72 (11)
Psychiatric nurse	42 (23)	111 (53)	454 (67)
Social worker	27 (15)	21 (10)	82 (12)
Occupational therapist	19 (10)	13 (6)	55 (8)
Other	19 (10)	14 (7)	37 (5)
Psychologist	24 (13)	8 (4)	27 (4)

Referral from primary care

Of the 354 patients referred to a short term CMHT by a GP, a psychiatrist was involved in the initial assessment in 180 (51%). Of the remaining 617 referred from other sources, a psychiatrist was involved in the initial assessment for 353 (57%).

Medication history

There was documented evidence that the symptoms and severity of the depressive illness at the point of referral were documented in just over 80%, a similar proportion to that in the baseline audit. However, the proportion of cases for whom a standardised rating scale was used was lower on this occasion. Both NICE (NICE, 2009) and the BAP (Cleare et al, 2015) recommend that standardised rating scales should be used to assess response to treatment and therefore the outcome for each patient; use of these scales also facilitates the communication of the symptom profile and severity to other mental health professionals.

Patient's treatment preferences were documented in just under half of the short-term subsample, a slightly lower proportion than in the baseline audit.

Table 7: Documentation of the symptoms and severity of illness and treatment preferences in patients with depression referred to a short-term CMHT: national subsample (n=971), 2021 re-audit.

Symptoms and severity of depression and patients' treatment preferences n (%)	Documented in clinical records Baseline 2019 n = 1144	Documented in clinical records Re-audit 2021 n = 971
Symptoms and severity of depression assessed	958 (84)	794 (82)
Using a formal rating scale (e.g. PHQ9, BDI, HADS, HAM-D, QIDS- SR16, MADRS, etc.)	149 (13)	82 (8)
Not using a formal rating scale	809 (71)	712 (73)
Patients' treatment preference	594 (52)	467 (48)

Given the utility of formal rating scales in assessing illness severity and response to treatment over time, particularly when multiple clinicians are involved with the care of an individual patient, Trusts may like to consider whether their electronic patient records system includes a relevant outcome measure that clinicians can use to inform patient care.

There was no documented medication history for one patient in five referred to a short-term community psychiatric team; in such cases, the success and/or failure of previous treatment strategies cannot be used to inform individualised/patient-centred care plans for the current episode of depression. See also page 41.

Where a medication history was available (n=774), prescription of antidepressant medication prior to referral was documented in 687 (89%).

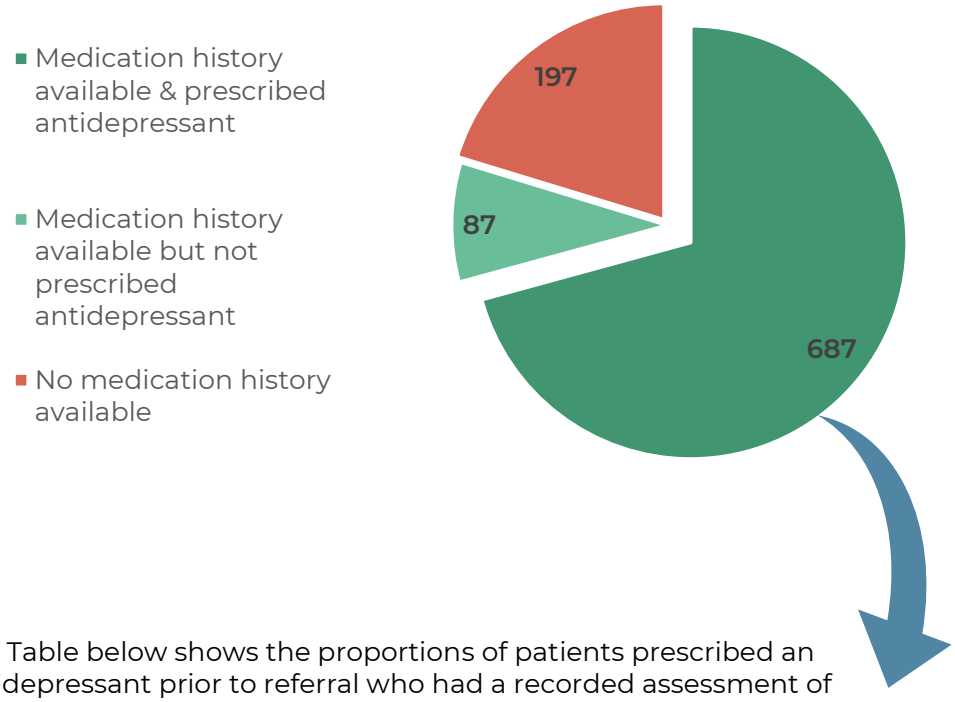


Fig 10: Proportion of patients with depression referred to a short-term CMHT who had a documented medication history: national subsample (n=971), 2021 re-audit.

The Table below shows the proportions of patients prescribed an antidepressant prior to referral who had a recorded assessment of therapeutic response, adherence, and side effects.

Documented assessments n (%)	Patients with documented prescription of an antidepressant prior to referral n = 687
Therapeutic response to antidepressant medication	455 (66)
Medication adherence	404 (59)
Antidepressant side effects	232 (34)

Table 8: Initial treatment assessments in patients referred to a short-term CMHT and prescribed an antidepressant: national subsample (n=687), 2021 re-audit.

Treatment interventions

In this subsample of cases who were outpatients under the care of a short-term CMHT, a pharmacological intervention was used in 85% and a referral was made for psychological therapy in 19%; both of these proportions are very similar to the respective figures in the baseline audit in 2019.

Only a very small proportion of patients received ECT.

Table 9: Actions taken or advised for the treatment of depression in patients with short-term involvement with a CMHT: national subsample (n=971) and clinical subgroups, 2021 re-audit.

Actions taken or advised by mental health services during this episode of care		Not taken onto clinical team caseload (advice only provided to referrer)	Discharged after short-term involvement with an adult CMHT	Discharged from the care of a HTT	National subsample 2021
n(%)		n = 106	n = 628	n = 237	n = 971
Any medication related action	No change to antidepressant medication already being prescribed for this patient	43 (41)	165 (26)	70 (30)	278 (29)
	Antidepressant medication started	5 (5)	139 (22)	43 (18)	187 (19)
	The dose of the current antidepressant was increased	19 (18)	117 (19)	47 (20)	183 (19)
	Another medication was added to treat symptoms of depression	7 (7)	112 (18)	61 (26)	180 (19)
	Switched to another antidepressant	9 (8)	101 (16)	44 (19)	154 (16)
	The dose of the current antidepressant was decreased	6 (6)	34 (5)	5 (2)	45 (5)
	Antidepressant medication stopped	1 (1)	32 (5)	6 (3)	39 (4)
	Switched to a medication other than an antidepressant (for example, a benzodiazepine)	2 (2)	24 (4)	7 (3)	33 (3)
	One or more of the above medication interventions				821 (85)
ECT		-	8 (1)	4 (2)	12 (1)
Non-medication related action	Onward referral to another mental health team (including admission to hospital)	6 (6)	141 (22)	55 (23)	202 (21)
	Referred for psychological assessment/therapy to treat the depressive disorder	32 (30)	122 (19)	34 (14)	188 (19)
	Further assessment and/or investigations	3 (3)	75 (12)	24 (10)	102 (11)
	Onward referral to a medical team	3 (3)	29 (5)	15 (6)	47 (5)
	One or more of the above non-medication interventions				430 (44)
Other specific clinical interventions		5 (5)	12 (2)	7 (3)	24 (2)
None of the above		3 (3)	5 (1)	4 (2)	12 (1)

Performance against practice standard 4

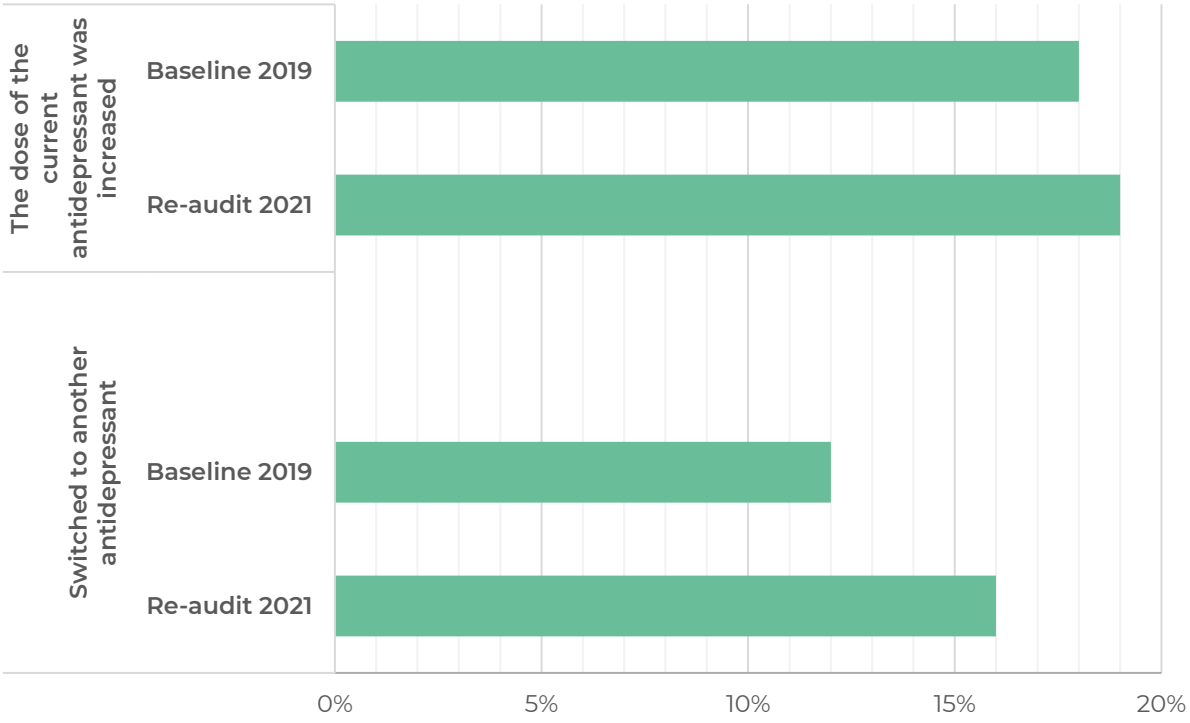
Where the depressive illness has not shown a sufficient response to treatment with an antidepressant medication, the following treatment strategies should be considered:

- Increasing the dose of antidepressant medication
- Switching to another antidepressant medication

For those cases referred to mental health services for the management of their depression who had only short-term involvement with a CMHT, the clinical team increased the dose of an antidepressant or switched to a different antidepressant in around a third of cases, a slightly higher proportion than at the baseline audit.

However, in over four-fifths of cases overall, one or more actions was taken relating to prescribed medication and in almost half of cases a non-medication related action was taken, suggesting that assessment led to patient-centred care planning. Further details of the range of actions taken can be found in Table 9 on page 28.

Figure 11: Proportion of patients with depression and short-term involvement with a CMHT who had an increase in antidepressant dosage or were switched to another antidepressant: national subsamples, 2019 baseline audit (n=1144) and 2021 re-audit (n=971).



Psychological interventions

In 675 (70%) of the 971 patients referred to a short-term CMHT, the recorded clinical diagnosis of depression allowed for the categorisation of illness into mild/moderate (n=356) or severe (n=319). The Table below reports the documentation in the clinical records of psychological interventions for the patients in these two illness categories, identifying those interventions provided that have been recommended in the 2021 draft revision of the NICE depression guidelines.

Table 10: Psychological interventions in patients with depression who had short-term involvement with a CMHT: subgroups with mild/moderate (n=356) or severe (n=319) depressive illness, 2021 re-audit.

Psychological interventions n(%)		Mild/Moderate depression n = 356	Severe depression n = 319
NICE recommended interventions provided	Self-help programme	16 (4)	10 (3)
	Behavioural activation	16 (4)	8 (3)
	Cognitive Behaviour Therapy	23 (6)	20 (6)
	Psychodynamic/psychoanalytic psychotherapy	2 (1)	5 (2)
	Interpersonal therapy	4 (1)	5 (2)
	Counselling	11 (3)	14 (4)
	Mindfulness*	11 (3)	15 (5)
	Structure physical activity programme (exercise)	3 (1)	6 (2)
	Number of patients receiving at least one of the above	55 (15)	51 (16)
Other psychological interventions provided		23 (6)	24 (8)
On a waiting list for psychological assessment/therapy at discharge		41 (12)	21 (7)
Psychological therapy offered but declined by the patient		24 (7)	24 (8)
Psychological intervention provided but nature unclear		22 (6)	21 (7)
Unclear whether psychological therapy was offered/provided		40 (11)	53 (17)
No psychological therapy provided		161 (45)	134 (42)

** Only recommended for less severe depression.*

Where the diagnosis was moderate or severe depression, a NICE recommended psychological intervention had been provided in 106 (16%) cases. This proportion is higher than the 9% reported to have started a recommended psychological therapy in the National Clinical Audit of Anxiety and Depression (NCAAD, 2019); the NCAAD audit included data from 3795 inpatients with a diagnosis of depression or an anxiety disorder and so the population for whom clinical practice was assessed is not directly comparable to the current subsample of outpatients with moderate or severe depression who were under the care of short-term CMHTs. Nevertheless, the data do suggest that access to psychological treatments may have improved over time. Other potential explanations for the differing findings of the two audits are that access to psychological therapies may be better in community settings than in inpatient settings and/or the duration of the episode of care in community settings may be longer allowing more opportunity to provide such interventions.

In 136 (20%) patients, it was unclear which psychological therapy had been provided or if any were provided at all.

Trusts may wish to consider strategies for improving the documentation of all relevant treatment interventions and the therapeutic response, side effects, and acceptability to the patient.

Antidepressant medication prescribed at discharge from the short-term CMHT

The proportion of patients prescribed antidepressant medication at the point of discharge from a short-term community mental health team was similar to that in the baseline audit at just over four-fifths. However, there were some differences in choice of antidepressant medication with relatively fewer prescriptions for SSRIs, particularly sertraline, and relatively more for 'other antidepressants' such as mirtazapine, venlafaxine and trazodone.

Table 11: Antidepressant medication prescribed for patients at discharge from short-term involvement with a CMHT: national subsamples, 2019 baseline audit (n=1144) and 2021 re-audit (n=971).

Antidepressant medication prescribed at discharge n(%)		Baseline 2019 n = 1144	Re-audit 2021 n = 971
Selective serotonin re-uptake inhibitors	Sertraline	297 (26)	204 (21)
	Citalopram	93 (8)	71 (7)
	Fluoxetine	80 (7)	61 (6)
	Escitalopram	21 (2)	24 (2)
	Paroxetine	11 (1)	7 (1)
Tricyclic antidepressants	Amitriptyline	29 (3)	26 (3)
	Lofepramine	3 (<1)	5 (1)
	Dosulepin	5 (<1)	4 (<1)
	Clomipramine	6 (1)	3 (<1)
	Doxepin	1 (<1)	2 (<1)
Monoamine oxidase inhibitors	Phenelzine	1 (<1)	2 (<1)
	Moclobemide	-	2 (<1)
Other antidepressants	Mirtazapine	290 (25)	264 (27)
	Venlafaxine	185 (16)	185 (19)
	Duloxetine	44 (4)	38 (4)
	Vortioxetine	19 (2)	26 (3)
	Trazodone	15 (1)	25 (3)
	Agomelatine	2 (<1)	4 (<1)
	Reboxetine	1 (<1)	4 (<1)
	Bupropion	-	2 (<1)
	Mianserin	-	1 (<1)
More than one antidepressant		152 (13)	136 (14)
No antidepressant medication prescribed		193 (17)	156 (16)

Combined antidepressants

More than one antidepressant was prescribed at discharge in 136 (14%) of cases and in 115 (85%) of these cases the combination included mirtazapine; the most commonly co-prescribed antidepressants with mirtazapine were venlafaxine (n = 59) and sertraline (n = 22). Where depression has not responded adequately to standard treatment, augmentation of the existing antidepressant with mirtazapine is a strategy supported by NICE (2009). Since the publication of this guideline, there have been many more studies that have tested the efficacy and tolerability of combined antidepressants compared with a single antidepressant; a recent meta-analysis confirms the advantage of this strategy, particularly when the combination includes an antagonist such as mirtazapine or mianserin (Henssler et al, 2022).

Other psychotropic medication prescribed at discharge

The profile of prescribing of medication other than an antidepressant was similar at both audits but with a slightly higher proportion of patients receiving a NICE-recommended augmentation strategy on this occasion.

The use of lamotrigine and liothyronine remained low.

Other psychotropic medication prescribed at the point of discharge from the care of a short-term CMHT		Baseline 2019	Re-audit 2021
	n(%)	n = 1144	n = 971
Augmentation strategies specifically **supported** by NICE	Quetiapine	138 (12)	128 (13)
	Benzodiazepine*	110 (10)	113 (12)
	Olanzapine	77 (7)	92 (9)
	Aripiprazole	46 (4)	61 (6)
	Lithium	14 (1)	21 (2)
	Lamotrigine**	18 (2)	17 (2)
	T3 (liothyronine)**	-	2 (<1)
Other medications prescribed	z-hypnotic	68 (6)	80 (8)
	Antipsychotic medication other than above	46 (4)	63 (6)
None of the above		735 (64)	526 (54)

Table 12: Other psychotropic medication prescribed for patients at discharge from short-term involvement with a CMHT: national subsamples, 2019 baseline audit (n=1144) and 2021 re-audit (n=971).

** NICE supports the short-term use of a benzodiazepine (no more than 2 weeks). We did not collect data relating to the intended duration of benzodiazepine prescriptions, but it is unlikely that the NICE recommended maximum duration was adhered to in all cases.*

*** Use supported for treatment-refractory depression in the draft of the revised NICE guideline for depression (2021); neither strategy was recommended in the 2009 NICE guideline.*

Discharged to primary care

At re-audit, 540 patients were discharged from the care of a short-term community psychiatric team to their GP. There was no documented assessment of the symptoms and severity of depression at the point of discharge for more than two patients in every five and the use of a depression rating scale was documented for fewer than one patient in every twenty. There has, therefore, been a modest move away from best practice since the baseline audit in 2018.

Documentation of symptoms and severity of depression in the discharge letter to the GP n(%)	Baseline 2019 n = 740	Re-audit 2021 n = 540
An objective measure of the symptoms and severity of depression at the time of discharge based on a formal rating scale for depression	40 (5)	17 (3)
An objective assessment of the symptoms and severity of depression at the time of discharge NOT based on a formal rating scale for depression	435 (59)	293 (54)
No documented objective assessment of the symptoms and severity of depression at the time of the discharge	265 (36)	230 (43)

Table 13: Documentation of the symptoms and severity of depression in patients discharged to primary care, after short-term involvement with a CMHT: national subsamples, 2019 baseline audit (n=740) and 2021 re-audit (n=540).

At re-audit, 483 (89%) of the 540 patients discharged to primary care were prescribed antidepressant medication, a slightly higher proportion than at the baseline audit (83%). For these patients, a plan relating to antidepressant medication had been communicated to the GP in just over two-thirds of cases (69%), a slightly lower proportion than at the baseline audit (73%).

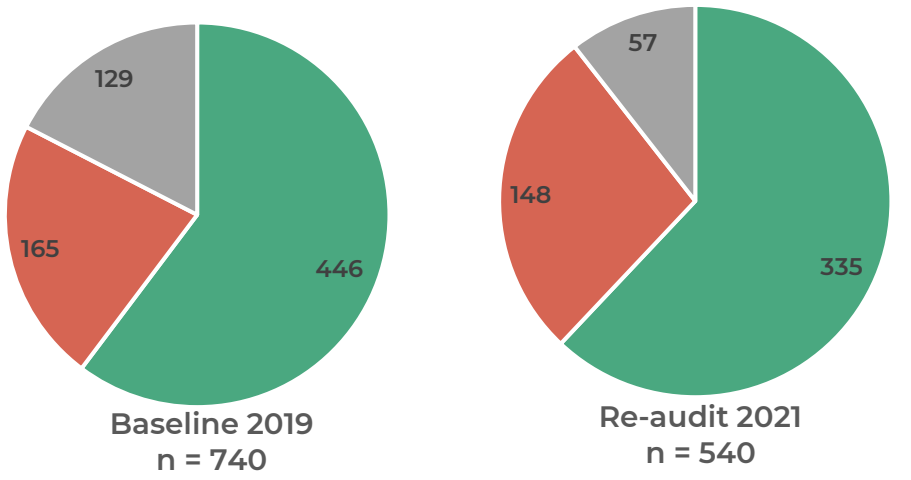


Figure 12: Advice on the antidepressant medication regimen in the discharge letter to primary care, for patents who had short-term involvement with a CMHT: national subsamples, 2019 baseline audit (n=740) and 2021 re-audit (n=540).

Trusts may like to consider whether their electronic patient record system has an embedded structured discharge letter that prompts communication of key elements of the patient's treatment plan, including prescribed medication, to the receiving clinician.

Performance against practice standard 2

If antidepressant medication is stopped for whatever reason:

- The dose should be reduced gradually
- The patient should be informed about potential discontinuation symptoms

There are very limited data on which to measure performance against practice standard 2. In the national subsample of patients who had been discharged from the care of a short-term community team, only 156 (16%) were not prescribed any antidepressant medication at this point and in a small number of these cases (n=51, 5% of the national subsample) antidepressant medication had been discontinued in the last 6 months.

The Figure below shows that where antidepressant medication had been discontinued, a healthcare professional had been involved in the decision in fewer than half of the cases (n=23, 45%), this limits the opportunity to 1. effectively care plan for these patients; 2. ensure that antidepressant doses were titrated down gradually where needed to avoid discontinuation symptoms (as recommended by NICE) and, 3. make the patient aware/remind them that such symptoms may occur. There was a documented account of antidepressant medication being decreased slowly over a period of more than 4 weeks in 3 of the 23 cases.

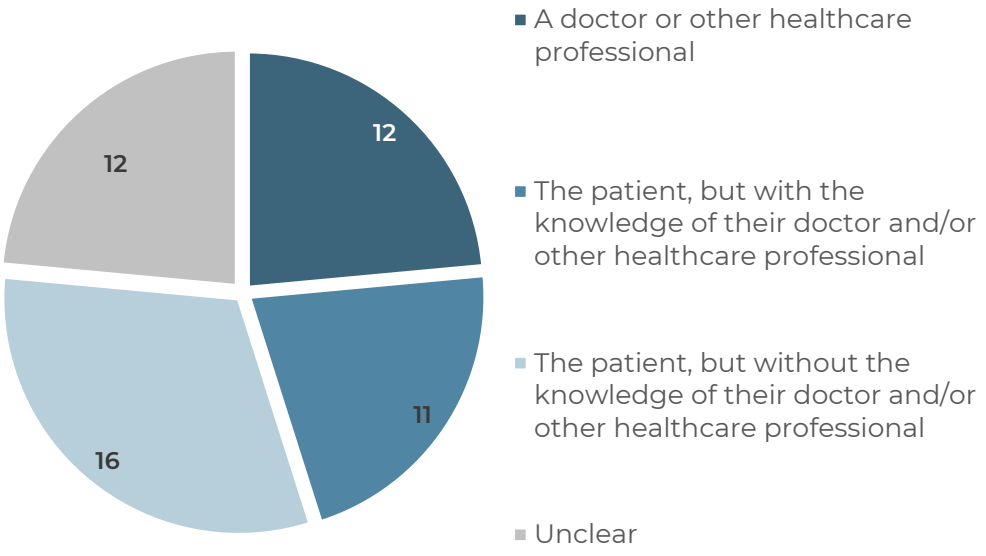


Figure 13: Involvement of a healthcare professional in the discontinuation of antidepressant medication in the past 6 months, in patients under the care of a short-term CMHT: national subsample (n=51), 2021 re-audit.

Antidepressant prescribed* n(%)	Baseline 2019 n = 193	Re-audit 2021 n = 156
Sertraline	12 (6)	15 (10)
Mirtazapine	9 (5)	14 (9)
Venlafaxine	4 (2)	9 (6)
Citalopram	10 (5)	4 (3)
Duloxetine	2 (1)	4 (3)
Fluoxetine	6 (3)	4 (3)
Escitalopram	1 (1)	2 (1)
Amitriptyline	1 (1)	1 (1)
Vortioxetine	2 (1)	1 (1)
Trazodone	1 (1)	1 (1)
Fluvoxamine	-	1 (1)
Paroxetine	-	1 (1)
None of the above antidepressant medication prescribed in the last 6 months	148 (77)	105 (67)

Table 14: Antidepressant medications discontinued in the past 6 months, in patients under the care of a short-term CMHT: national subsamples, 2019 baseline audit (n=193) and 2021 re-audit (n=156).

** More than 1 antidepressant had been discontinued in 6 cases.*

The antidepressant medications that had been recently discontinued are shown in the Table above. Of those antidepressants listed, perhaps the greatest risk of discontinuation symptoms is associated with venlafaxine and paroxetine.

We did not collect data relating to whether patients were informed about discontinuation symptoms when antidepressant treatment was initiated. Such information is included in the patient information leaflets that are inside the manufacturer's packs of antidepressant medication.

Trusts may wish to reflect on the systems and processes they have in place to support the development of collaborative treatment/care plans, agreed by both patients and prescribers.

Subample of patients under the medium/ long-term care of an adult CMHT (n=3771)

Antidepressant medication

As might be expected, compared with patients who had been discharged from the care of a short-term CMHT, those who remained under the care of a longer-term team were more likely to be prescribed antidepressant medication (91% v 84%) and more likely to be prescribed combined antidepressants (25% v 14%) suggesting that illness severity was greater and treatment-refractory illness more common in those under the care of a longer-term CHMT. These findings are very similar to those at the baseline audit and suggest that prescribing practice is consistent over time.

Antidepressant medication prescribed		Re-audit 2021 n = 3771	
		n (%)	Median dose, mg/day
Selective serotonin re-uptake inhibitors	Sertraline	773 (20)	150
	Fluoxetine	264 (7)	40
	Citalopram	173 (5)	20
	Escitalopram	92 (2)	15
	Paroxetine	50 (1)	40
	Fluvoxamine	9 (<1)	50
Tricyclic antidepressants	Amitriptyline	149 (4)	30
	Lofepramine	33 (1)	210
	Clomipramine	25 (1)	150
	Nortriptyline	14 (<1)	25
	Dosulepin	11 (<1)	100
	Imipramine	8 (<1)	50
	Doxepin	1 (<1)	90
	Trimipramine	1 (<1)	50
Monoamine oxidase inhibitors	Moclobemide	8 (<1)	600
	Phenelzine	5 (<1)	45
	Tranylcypromine	4 (<1)	25
	Isocarboxazid	2 (<1)	40
Other antidepressants	Mirtazapine	1245 (33)	30
	Venlafaxine	1004 (27)	225
	Duloxetine	238 (6)	90
	Vortioxetine	170 (5)	20
	Trazodone	120 (3)	150
	Agomelatine	20 (1)	50
	Bupropion	15 (<1)	300
	Reboxetine	6 (<1)	10
More than one antidepressant		961 (25)	
No antidepressant medication prescribed		323 (9)	

Table 15: Antidepressant medications currently prescribed for patients under the care of a longer-term CMHT: national subsample, 2021 re-audit (n=3771).

Where depression has not responded adequately to standard treatment, augmentation of the existing antidepressant with mirtazapine is a strategy supported by NICE (2009). A recent meta-analysis confirms the advantage of combining antidepressants, particularly when the combination includes an alpha-2 autoreceptor antagonist such as mirtazapine or mianserin (Henssler et al, 2022). 749 (78%) of the 961 combinations reported in the Table above include one of these antidepressant medications.

Antipsychotic medication

Where depression fails to respond to treatment with antidepressant medication alone, one of the pharmacological strategies that NICE recommend should be considered is augmentation with an antipsychotic medication 'such as aripiprazole, olanzapine, quetiapine or risperidone'. Oral antipsychotic medication was prescribed for just over half (53%) of the subsample of patients with depression who were under the care of a longer-term CMHT, and in the vast majority (92%) of these cases it was one of the four antipsychotics above.

Oral antipsychotic medication currently prescribed n(%)	Re-audit 2021 n = 3771
Quetiapine	754 (20)
Olanzapine	554 (15)
Aripiprazole	393 (10)
Risperidone	196 (5)
Amisulpride	45 (1)
Haloperidol	25 (1)
Clozapine	25 (1)
Antipsychotic medication prescribed other than listed above	72 (2)
Number of patients prescribed more than one antipsychotic medication	64 (2)
Number of patients not prescribed any antipsychotic medication	1772 (47)

Table 16: Oral antipsychotic medications currently prescribed for patients under the care of a longer-term CMHT: national subsample, 2021 re-audit (n=3771).

A depot/long-acting injectable antipsychotic medication was prescribed in 136 cases.

Other psychotropic medication

Where depression fails to respond to treatment with antidepressant medication alone, one of the pharmacological augmentation strategies recommended by NICE is augmentation with lithium. Fewer than one patient in ten was prescribed lithium augmentation (several-fold fewer than were prescribed antipsychotic medication) and this proportion has not changed since the baseline audit.

NICE also recommend considering the use of lamotrigine or liothyronine to augment antidepressant medication. Use of both of these strategies is low and has not changed since the baseline audit.

NICE cautions against the use of a benzodiazepine for longer than 2 weeks. From the Table below it can be seen that a benzodiazepine remains the most commonly used medication after antipsychotics, being prescribed for almost 1 patient in 5, a slight increase from the baseline audit. Most of this prescribing is unlikely to have been short-term.

Psychotropic medication other than an antipsychotic currently prescribed and the use of ECT n(%)	Baseline 2019 n = 3699	Re-audit 2021 n = 3771
Benzodiazepine	637 (17)	732 (19)
Z-hypnotic	374 (10)	398 (11)
Pregabalin	367 (10)	381 (10)
Promethazine	212 (6)	300 (8)
Lithium	282 (8)	292 (8)
Lamotrigine	139 (4)	123 (3)
Sodium or semi-sodium valproate	57 (2)	72 (2)
Gabapentin	53 (1)	66 (2)
Buspirone	32 (1)	41 (1)
ECT	19 (1)	40 (1)
T3 (liothyronine)	12 (<1)	10 (<1)
Bupropion: a continuing prescription for the treatment of depression	7 (<1)	6 (<1)
Ketamine	1 (<1)	3 (<1)
L-tryptophan	2 (<1)	1 (<1)
Bupropion: short-term to aid smoking cessation	2 (<1)	1 (<1)
None documented	2098 (57)	1968 (52)

Table 17: Psychotropic medications (other than antipsychotic medication) currently prescribed and the use of ECT for patients under the care of a longer-term CMHT: national subsamples, 2019 baseline audit (n=3699) and 2021 re-audit (n=3771).

Smoking cessation

The 2019 NHS Long Term Plan (www.longtermplan.nhs.uk) states that 'By 2023/24, all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services' and that a 'new universal smoking cessation offer will also be available as part of specialist mental health services for long-term users of specialist mental health, and in learning disability services.'

In this audit, in the subsample of patients with medium to long-term involvement with a CMHT, smoking status was documented for three patients in every five, and where smoking status was known, just under a third were smokers. In this latter subgroup, a smoking-cessation intervention had been offered/provided for three patients in every five.

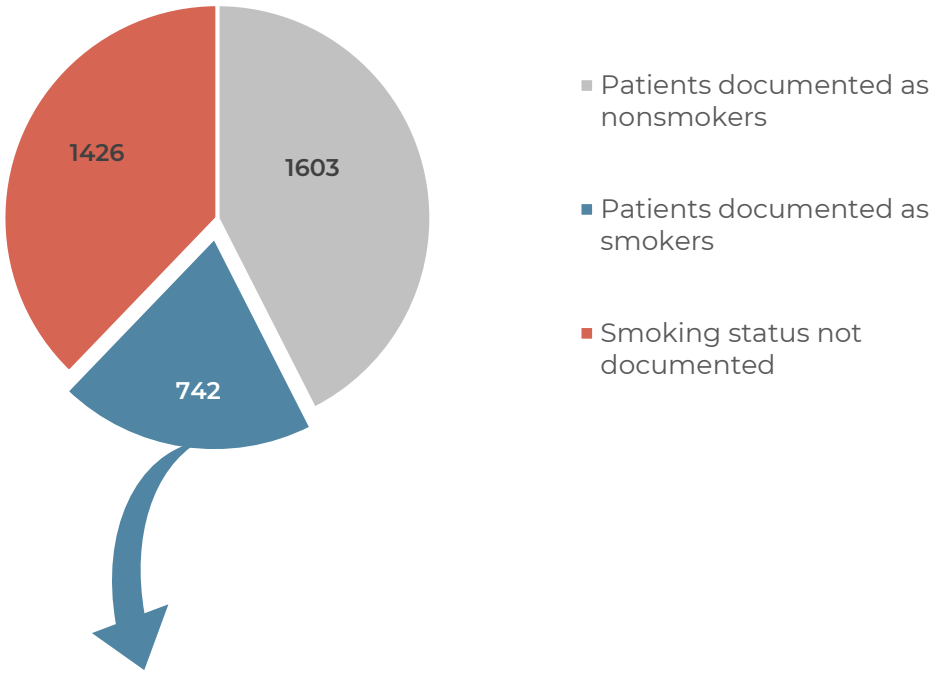


Figure 14: Documentation of tobacco use in patients under the care of a longer-term CMHT: national subsample (n=3771), 2021 re-audit.

Documented interventions n (%)	Patients documented as smokers n = 742
Smoking cessation advice / a brief intervention was provided	238 (32)
The patient was asked if they would like to reduce/stop their tobacco use	214 (29)
Nicotine replacement therapy was offered/provided	70 (9)
A referral to a smoking cessation service was offered/made	52 (7)
Varenicline was offered/provided	2 (<1)
Bupropion was offered/provided	2 (<1)
No documented intervention	291 (39)
Unclear	15 (2)

Table 18: Documented interventions for patients who are known smokers, under the care of a longer-term CMHT: national subsample (n=742), 2021 re-audit.

The findings above suggest that it is not routine clinical practice to inquire about and document smoking status and, for those patients identified as smokers, to offer/provide evidence-based interventions for smoking cessation.

Stopping smoking is associated with improvements in symptoms of anxiety and depression in those diagnosed with depression, with an effect size similar to antidepressant medication (Taylor et al. 2014). It is recommended for those patients with treatment-refractory depression, to improve clinical outcomes (Korchia et al. 2022); the majority of patients with depression who are under the long-term care of community mental health teams are likely to have an illness that has proved at least partially refractory to treatment.

Thus, failure to systematically identify whether such patients are smokers means missing opportunities to discuss stopping smoking with patients and to initiate treatments for smoking dependency that could lead to improved physical, mental and economic health (https://www.nhs.uk/live-well/quit-smoking/stopping-smoking-mental-health-benefits/)

Trusts may like to consider whether their electronic patient record systems prompt routine enquiry about smoking status. This clinical information can facilitate conversations with patients about the known benefits of smoking cessation, with likely improvements in physical, mental and financial health.

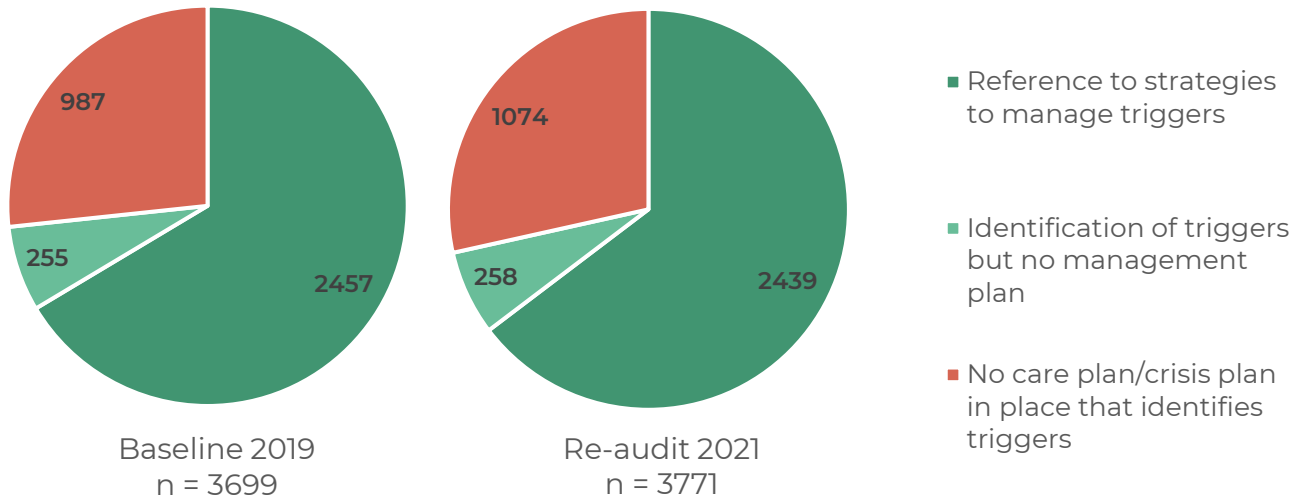
Performance against practice standard 3a

Patients prescribed continuing antidepressant medication should have a care/crisis plan that:

- Identifies potential triggers / precipitating factors that could lead to a worsening of their condition, including psychosocial stressors
- Refers to strategies to manage such triggers

People who have had an episode of depression are more likely to relapse if they are exposed to social or environmental stressors: such as financial worries, unstable accommodation, a poor or abusive relationship with a partner and social isolation. These same stressors may compromise recovery from an acute episode of depression. It is therefore important that all patients with a diagnosis of depression have a care plan that acknowledges known triggers/precipitating stressors specific to that person and outlines the actions that need to be taken to minimise exposure to these stressors and therefore their potential impact on the course of the depressive illness.

Figure 15: Proportion of patients under the care of a longer-term CMHT for whom the potential triggers/stressors for depression were identified and care planned for: national subsamples, 2019 baseline audit (n=3699) and 2021 re-audit (n=3771).



While patient-specific potential triggers were both identified and care planned for in two-thirds of cases, this information was missing from the care plan for one patient in three. This suggests that opportunities to provide patient-specific psychosocial support may be missed. Given the relatively modest effect size of antidepressant medication and structured psychological therapies in people with depression, and that performance against this standard was tested in the subgroup of patient under the long-term care of a CMHT for the management of depression, there is a clear need to improve care planning to ensure treatment outcomes are optimised.

Where local practice does not meet this practice standard, Trusts may wish to reflect on whether their electronic patient records system has sufficient embedded prompts/data fields to support systematic care planning.

Performance against practice standard 3b

For patients prescribed continuing long-term antidepressant medication, there should be at least annual review addressing:

- Therapeutic response to medication
- Medication adherence
- Medication side effects
- Comorbid conditions, including alcohol and substance use and both psychiatric and physical disorders

The Figure below shows that the **assessment of symptoms and severity** of depression was documented in just under four-fifths of cases, a slightly lower proportion than at the baseline audit.

Of the 3771 patients who were under the longer-term care of a CMHT at re-audit, there was documented evidence that treatment had been reviewed in the last year in 3391 (90%) cases which is slightly lower than at baseline audit (92%).

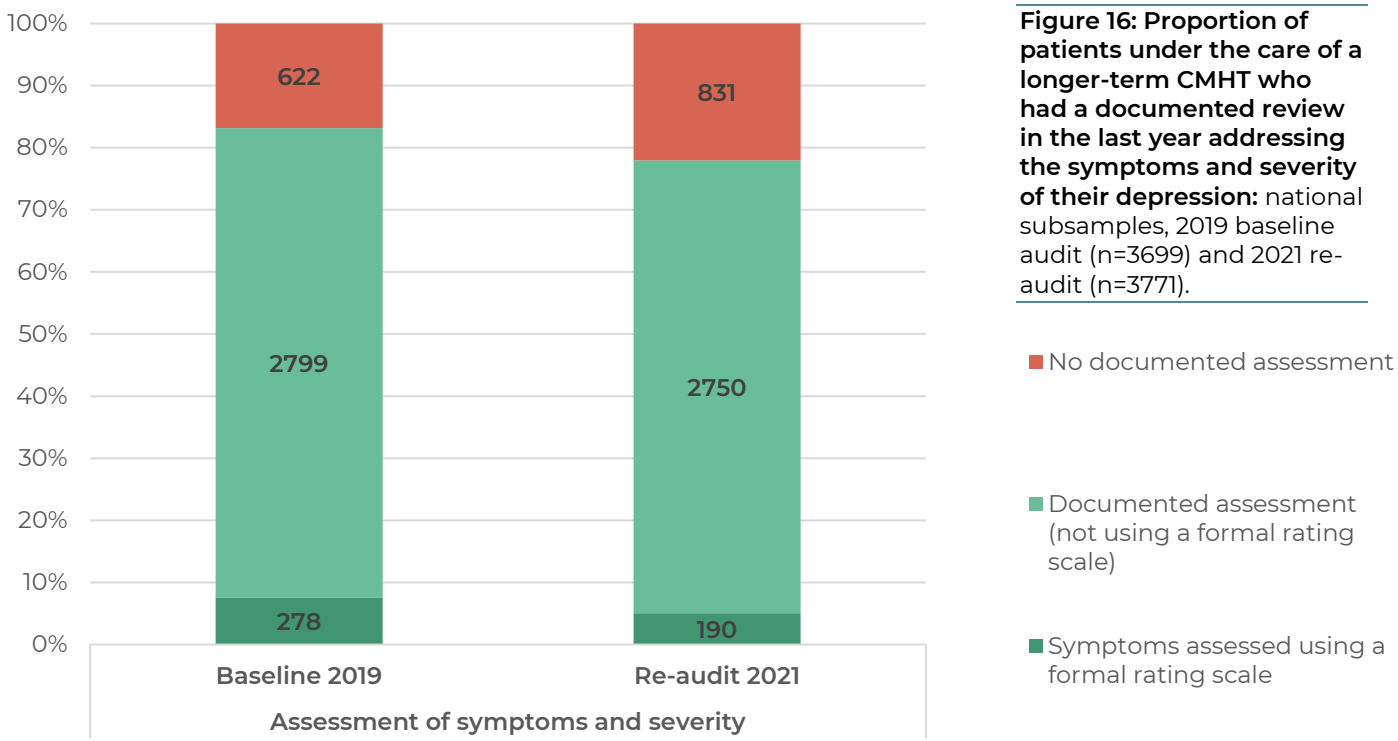


Figure 16: Proportion of patients under the care of a longer-term CMHT who had a documented review in the last year addressing the symptoms and severity of their depression: national subsamples, 2019 baseline audit (n=3699) and 2021 re-audit (n=3771).

Given the utility of formal rating scales in assessing the symptoms and severity of depression and response to treatment over time, particularly when multiple clinicians are involved with the care of an individual patient, Trusts may like to consider whether their electronic patient records system includes a relevant outcome measure that clinicians can use to inform patient care.

The Figure below shows that the proportions of patients whose **response, adherence to medication and side effects** were assessed have decreased since the baseline audit. One potential explanation for practice moving away from this standard may be the logistical difficulties in providing routine care caused by the coronavirus pandemic (see page 17).

Both NICE (NICE, 2009) and the BAP (Cleare et al, 2015) recommend that standardised rating scales should be used to assess response to treatment and therefore the outcome for each patient; they also facilitate the communication of symptom profile and severity to other mental health professionals. Such scales/outcome measures were used in only a small minority of cases at both audits (8% at baseline and 5% at re-audit).

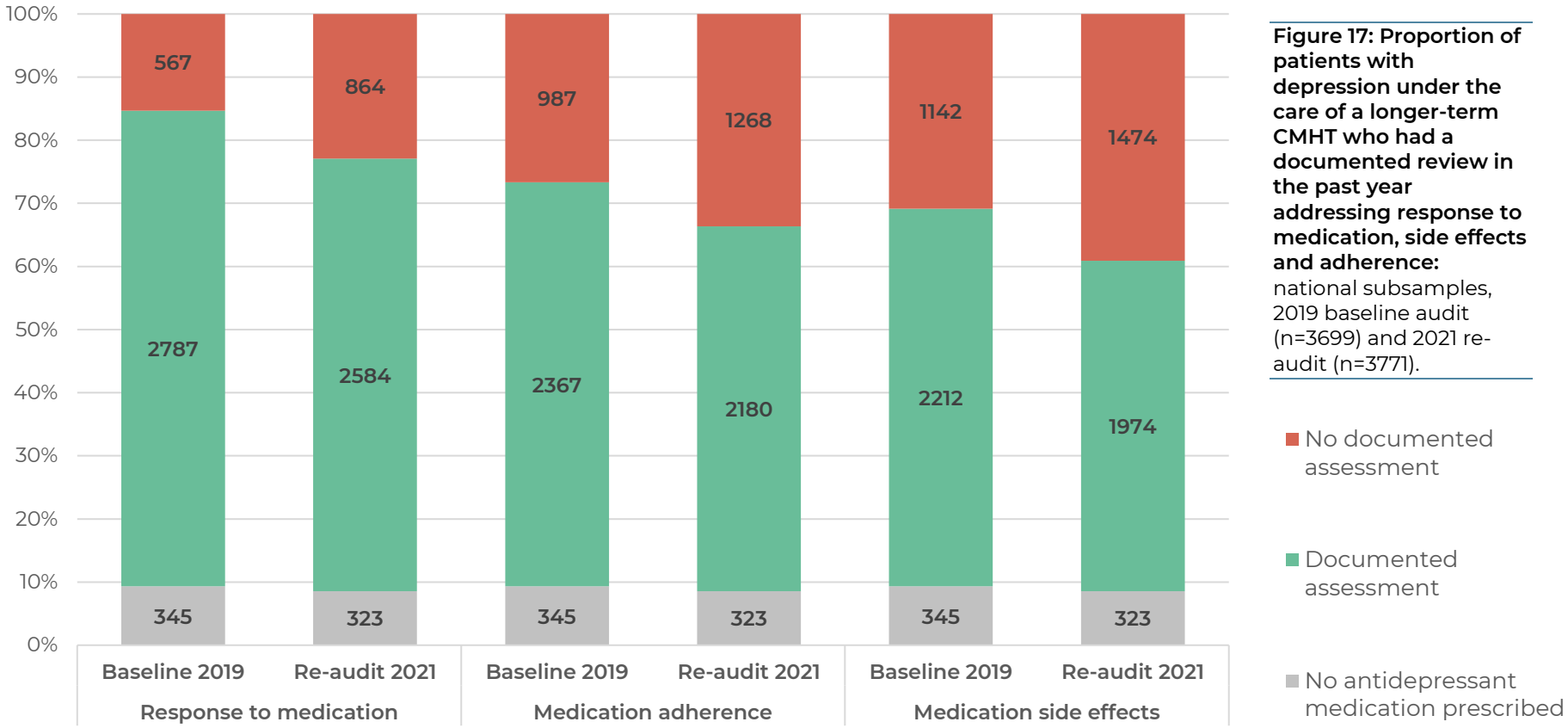


Figure 17: Proportion of patients with depression under the care of a longer-term CMHT who had a documented review in the past year addressing response to medication, side effects and adherence: national subsamples, 2019 baseline audit (n=3699) and 2021 re-audit (n=3771).

Co-morbid physical and mental illness and the use of alcohol and other substances can complicate the course of a depressive illness and impair recovery. In the total national subsample who were under the care of a longer-term CMHT, there was a documented assessment of substance use in the last year in under half and this proportion has not changed since the baseline audit. However, the proportions of patients with a documented assessment of co-morbid physical or mental illness were both slightly lower than at baseline audit.

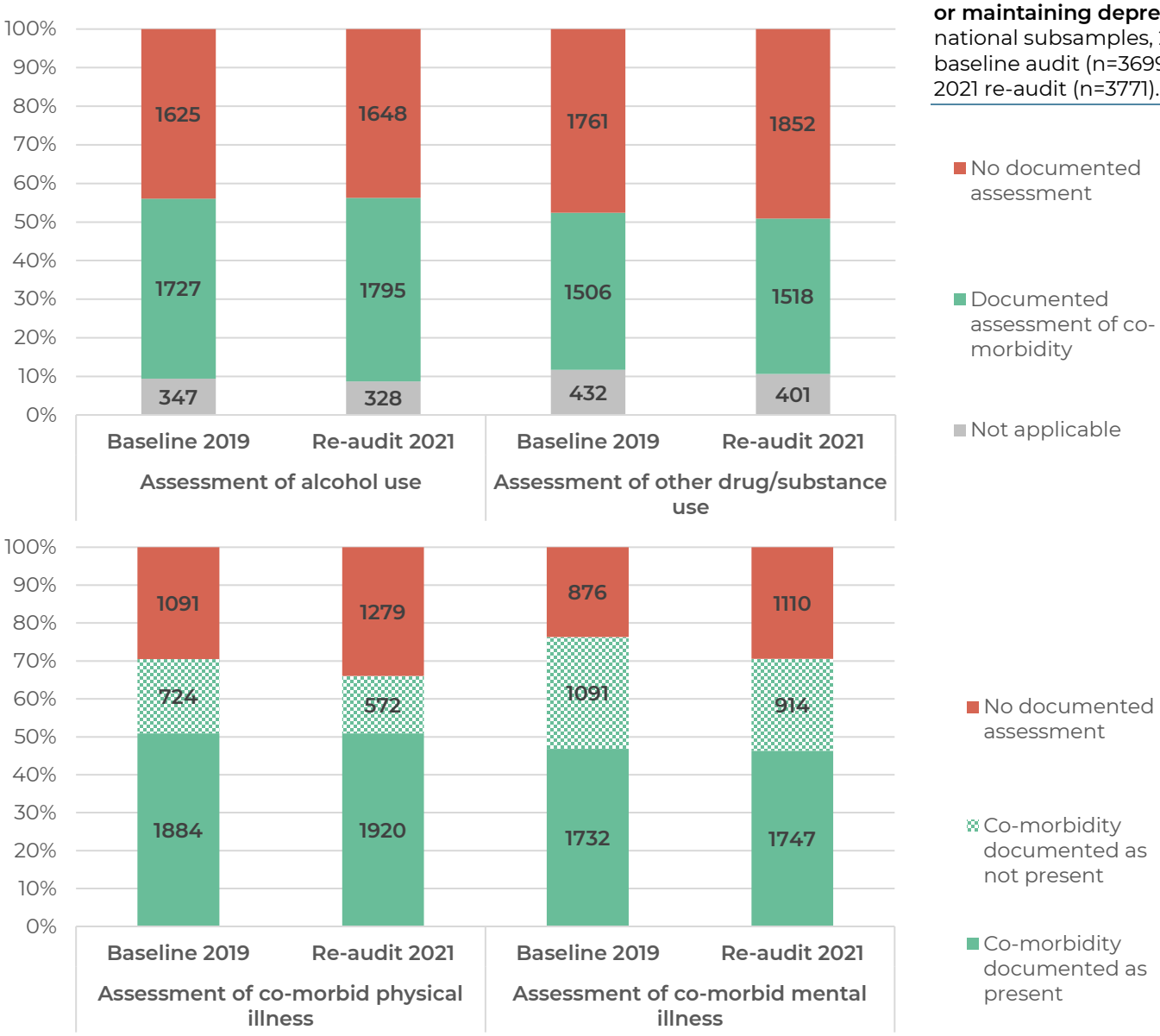


Figure 18: Proportion of patients under the care of a longer-term CMHT who had a documented review in the last year that considered the role of co-morbid physical and mental illness, use of alcohol and use of other substances in precipitating or maintaining depression: national subsamples, 2019 baseline audit (n=3699) and 2021 re-audit (n=3771).

Where assessment of physical illness was documented, this was noted to be present in 77% cases. The respective proportion for co-morbid mental illness was 66%. Both of these proportions are slightly higher than those at the baseline audit (72% and 61% respectively).

Treatment history

At re-audit a comprehensive treatment history was documented in only 1763 (47%) cases under the care of a longer-term CMHT; this proportion is unchanged from the baseline audit. Given that this group of patients are likely to have complex and treatment-refractory illness, the absence of a documented treatment history compromises effective care planning.

Figure 19: Proportion of patients with depression under the care of a longer-term CMHT who had a documented treatment history: national subsamples, 2019 baseline audit (n=3699) and 2021 re-audit (n=3771).

Where local data suggest that not all patients with depression who are under the long-term care of CMHTs have a documented treatment history, Trusts may like to consider whether their electronic patient records system has sufficient embedded prompts/data fields to capture the information required to support systematic care planning.

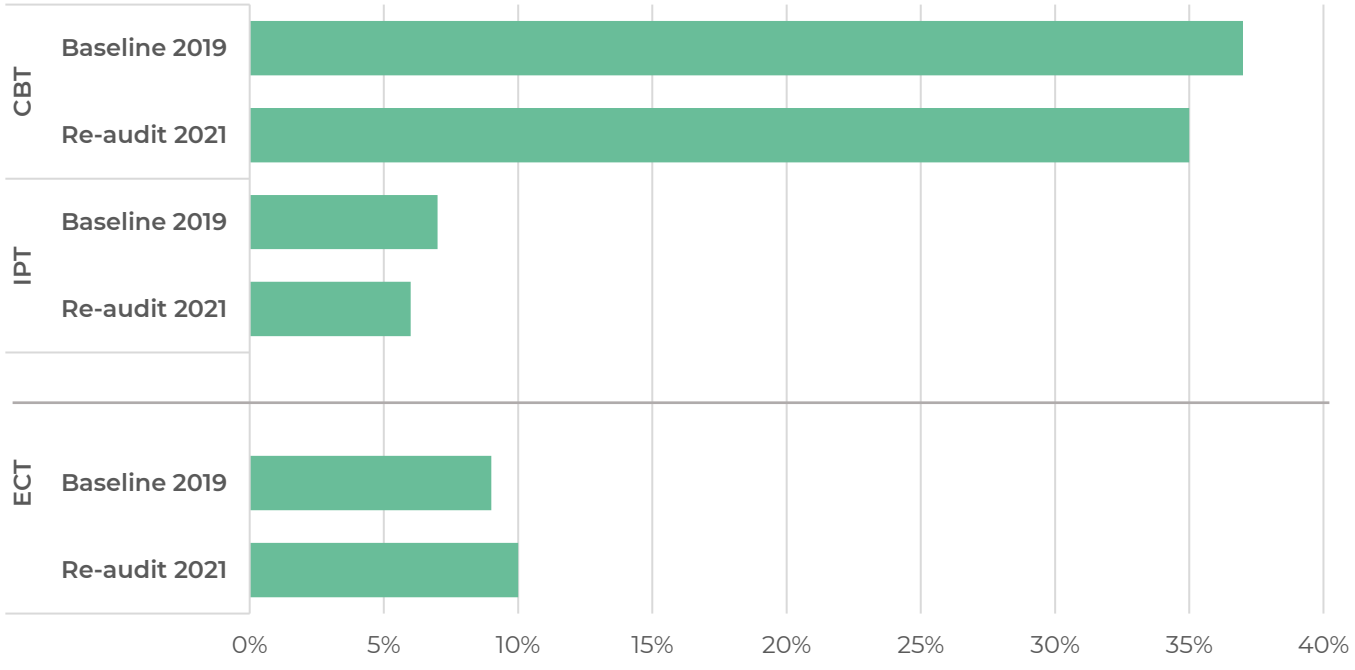
Performance against practice standard 4

Where the depressive illness has not shown a sufficient response to treatment with an antidepressant medication, the following treatment strategies should be considered:

- Increasing the dose of antidepressant medication
- Switching to another antidepressant medication
- Combining continuing antidepressant treatment with high-intensity psychological/psychosocial interventions, such as individual CBT/interpersonal psychotherapy
- Augmentation with another antidepressant medication
- Augmentation with lithium
- Augmentation with an antipsychotic medication
- Augmentation with ECT treatment

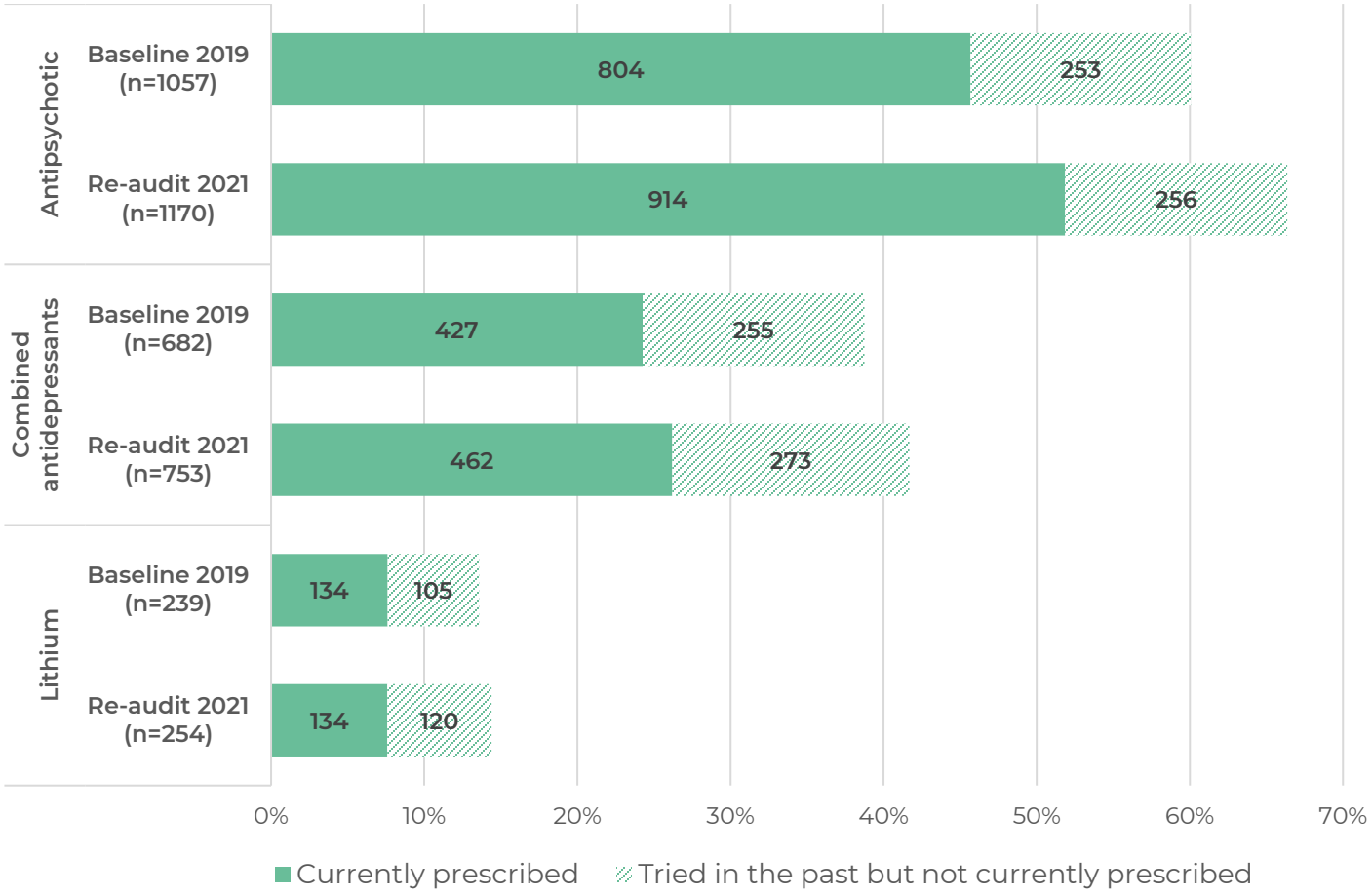
Compared with the 2019 audit, in 2021 the use of evidence-based psychological interventions was slightly lower and the use of ECT was slightly higher; these changes may be related to the impact of the Covid pandemic on access to services (see Covid statement on page 17).

Figure 20: Documented past use of non-pharmacological augmentation strategies supported by NICE, in those patients with depression under the care of a longer-term CMHT who had a comprehensive treatment history: national subsamples, 2019 baseline audit (n=1760) and 2021 re-audit (n=1763).



At re-audit, augmentation of antidepressant medication with an antipsychotic remained the most commonly tested strategy; the small increase in use compared with 2019 may partly reflect the higher proportion of patients with severe depression in the 2021 audit sample (see the Table on page 22). The use of ever prescribed combined antidepressants was also slightly higher in 2021.

Figure 21: Documented use of pharmacological augmentation strategies supported by NICE, in those patients with depression under the care of a longer-term CMHT who had a comprehensive treatment history: national subsamples, 2019 baseline audit (n=1760) and 2021 re-audit (n=1763).



At both audits, only one patient in seven in the total national subsample had ever received a trial of lithium augmentation. Lithium has been found to be more effective than antidepressant medication for relapse prevention in a large cohort study of people with depression (Tiihonen et al, 2017). The data in the Table below therefore suggest that opportunities to improve outcomes for some patients with depression may be missed. (Paton et al, 2020).

Trusts may like to consider whether developing or adopting a treatment algorithm for refractory depression may improve outcomes for patients under their care with this diagnosis.

Past treatment interventions

At both baseline and re-audit, a trial of another antidepressant, an oral antipsychotic and CBT were the most common strategies for the management of depression documented in treatment histories. All are consistent with the recommendations made by NICE.

The documented use of pharmacological strategies was higher at re-audit than at baseline but the use of psychological strategies was not. This latter finding may be at least partially explained by the restrictions placed on face-to-face contact during the coronavirus pandemic which would have made delivering psychological interventions more challenging.

Table 19: Previous pharmacological and non-pharmacological strategies used for those patients with depression under the care of a longer-term CMHT who had a comprehensive treatment history: national subsamples, 2019 baseline audit (n=1760) and 2021 re-audit (n=1763).

Previous pharmacological and non-pharmacological strategies used	n(%)	Baseline 2019 n = 1760	Re-audit 2021 n = 1763
Strategies relating to antidepressant medication	Antidepressant(s) prescribed (other than those listed below)	726 (41)	757 (43)
	Venlafaxine	559 (32)	615 (35)
	Two antidepressant medicines at the same time	503 (29)	517 (29)
	Tricyclic antidepressant (e.g. amitriptlyine, clomipramine)	297 (17)	284 (16)
	Vortioxetine	68 (4)	127 (7)
	Bupropion for depression	24 (1)	31 (2)
	An MAOI antidepressant (tranylcypromine, phenelzine or isocarboxazid)	35 (2)	29 (2)
	Other MAOI antidepressant (moclobemide)	27 (2)	23 (1)
	Number of patients who received one or more of the strategies relating to antidepressant medication listed above	1206 (69)	1300 (74)
Other medical strategies	An oral antipsychotic	720 (41)	790 (45)
	Lithium	176 (10)	201 (11)
	ECT	164 (9)	179 (10)
	Lamotrigine	103 (6)	94 (5)
	TMS (transcranial magnetic stimulation)	8 (<1)	14 (1)
	Liothyronine (T3)	11 (1)	10 (1)
	I-trytophan	8 (<1)	8 (<1)
	Ketamine (intravenous)	2 (<1)	7 (<1)
	Ketamine (intra-nasal)	1 (<1)	5 (<1)
	Vagal nerve stimulation	3 (<1)	1 (<1)
	Number of patients who received one or more of the other medical strategies listed above	823 (47)	931 (53)
Psychological treatments	Cognitive Behavioural Therapy	651 (37)	619 (35)
	Other named specific psychological intervention	264 (15)	227 (13)
	Mindfulness-based cognitive therapy	165 (9)	180 (10)
	Interpersonal therapy	128 (7)	114 (6)
	Other - Psychological intervention but nature unclear	87 (5)	91 (5)
	Number of patients who received one or more of the psychological treatments listed above	984 (56)	927 (53)

Treatment target

Clinicians should routinely avoid prescribing dosulepin, trimipramine or T3 (liothyronine) for depression

NHS England recommend that dosulepin (high cardiac risk and toxicity in overdose), trimipramine (cost) and liothyronine (T3; cost and lack of an evidence base) should not be routinely prescribed in primary care.

However in the draft update of the NICE depression guideline, there is support for the use of liothyronine as a third line option in treatment refractory depression and while the cardiac safety concerns relating to dothiepin are noted, NICE do not specifically recommend against its use.

Perhaps the best way to reconcile these differences is that while these treatment options are available to patients with refractory depression who are under the care of a psychiatrist in secondary care, transfer of prescribing responsibility to primary care is very unlikely to be possible. Patients receiving these treatments will therefore remain under the care of mental health services, irrespective of clinical response, to facilitate supply of medication.

The Table below shows that dosulepin, liothyronine and trimipramine were rarely prescribed for patients with depression who were in contact with mental health services. These findings are very similar to the baseline audit.

Medication prescribed n(%)	Short-term CMHT (at discharge) n = 971	Longer-term CMHT (currently prescribed) n = 3771	Total national sample 2021 n = 4742
Dosulepin	4 (<1)	11 (<1)	15 (<1)
T3 (liothyronine)	2 (<1)	10 (<1)	12 (<1)
Trimipramine	-	1 (<1)	1 (<1)

Table 20: Prescription of dosulepin, trimipramine or T3: total national sample, 2021 re-audit (n=4742).

Trust level results

Analyses presented in this section were conducted for each Trust individually and for the total sample to allow benchmarking.

Data from each Trust are presented by code.

Your Trust code is: 012

Charts in this section are ordered by performance against the practice standards so the position of your Trust will vary in each figure relative to other Trusts.

Summary of national participation levels

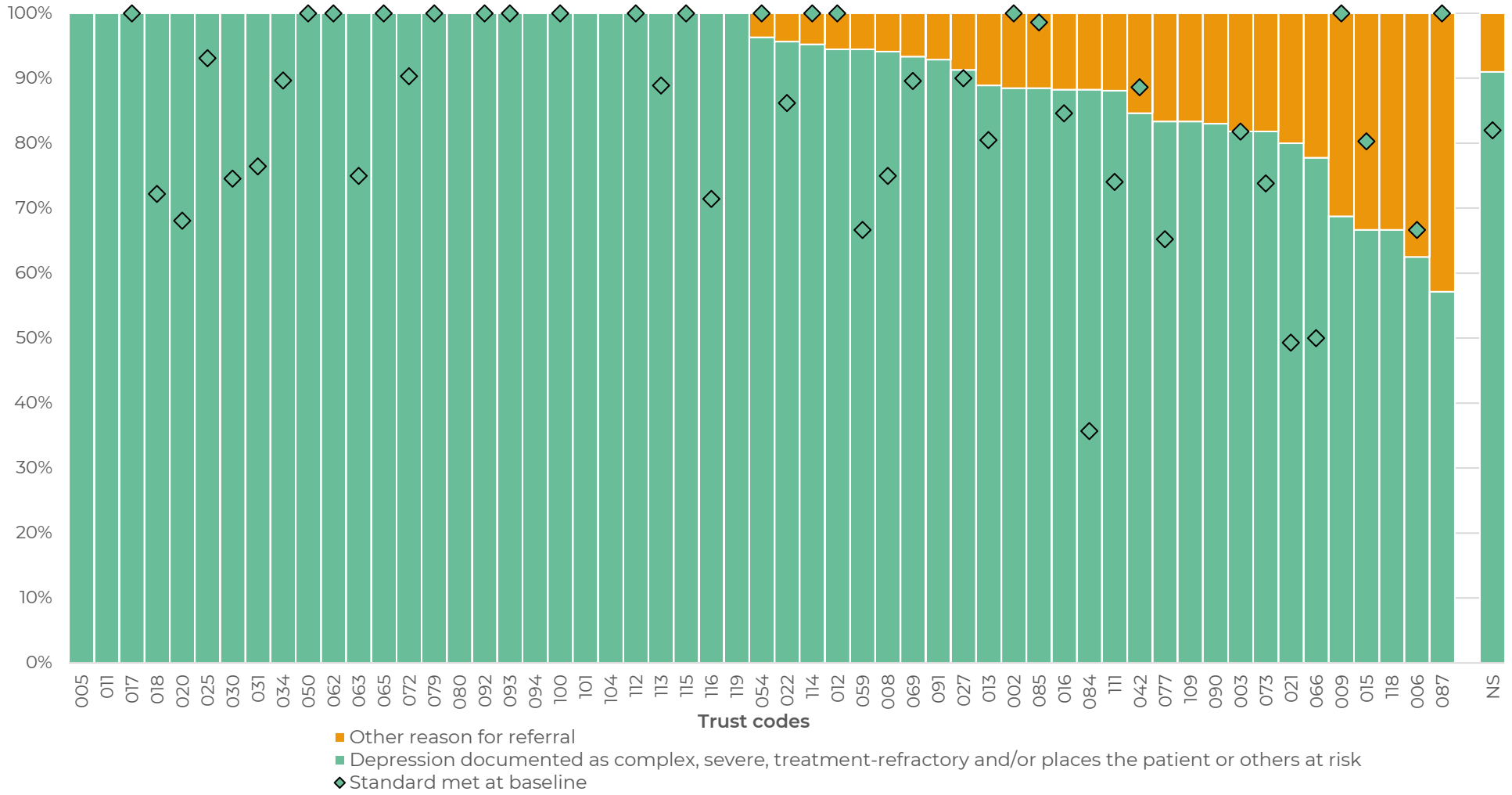
Trust code	Baseline 2019		Re-audit 2021	
	Teams	Cases	Teams	Cases
002	1	3	5	162
003	15	138	17	133
005	8	36	10	61
006	10	134	4	34
008	3	28	7	103
009	8	31	5	26
011	8	55	9	115
012	10	39	21	73
013	7	63	23	82
015	16	254	6	44
016	7	112	11	142
017	3	62	2	25
018	16	59	14	66
020	6	140	2	100
021	15	202	9	142
022	35	117	42	149
025	11	130	9	64
027	7	88	8	52
030	24	132	9	86
031	22	133	3	16
034	10	126	3	23
040	1	20	1	19
042	4	83	17	86
050	1	25	11	294

Table 21: Number of clinical teams and cases submitted by participating Trusts/healthcare organisations, in the 2019 baseline audit and the 2021 re-audit.

054	9	24	22	94
056	2	20	5	64
059	22	100	20	89
062	5	63	5	70
063	2	24	2	19
065	6	28	1	12
066	2	37	3	77
069	30	198	21	79
072	4	206	2	165
073	4	148	5	138
077	2	58	2	49
079	6	43	27	115
080	5	63	3	46
084	1	64	1	61
085	33	251	4	188
087	11	143	5	39
090	-	-	4	196
091	10	32	13	90
092	4	70	8	21
093	13	46	14	57
094	1	2	5	37
100	2	86	2	75
101	6	61	6	43
102	3	65	3	28
104	-	-	6	34
109	2	32	1	34
110	-	-	4	8
111	29	266	16	298
112	3	43	2	35
113	1	17	2	9
114	1	5	8	97
115	4	106	9	102
116	11	162	7	86
118	-	-	1	35
119	-	-	4	33
120	-	-	1	22
Total	**498**	**4843**	**492**	**4742**

Depression should be managed in primary care unless it is complex, severe, treatment-refractory, or places the patient or others at risk

Figure 22: Proportion of cases referred to a short-term CMHT with depression, where the illness was complex, severe, treatment refractory or placed the patient or others at risk: national subsample (n=971) and each participating Trust/healthcare organisation subsample, at re-audit, 2021.



Performance against practice standard 2

If antidepressant medication is stopped for whatever reason:

- The dose should be reduced gradually
- The patient should be informed about potential discontinuation symptoms

Please refer to page 8 in Executive Summary.

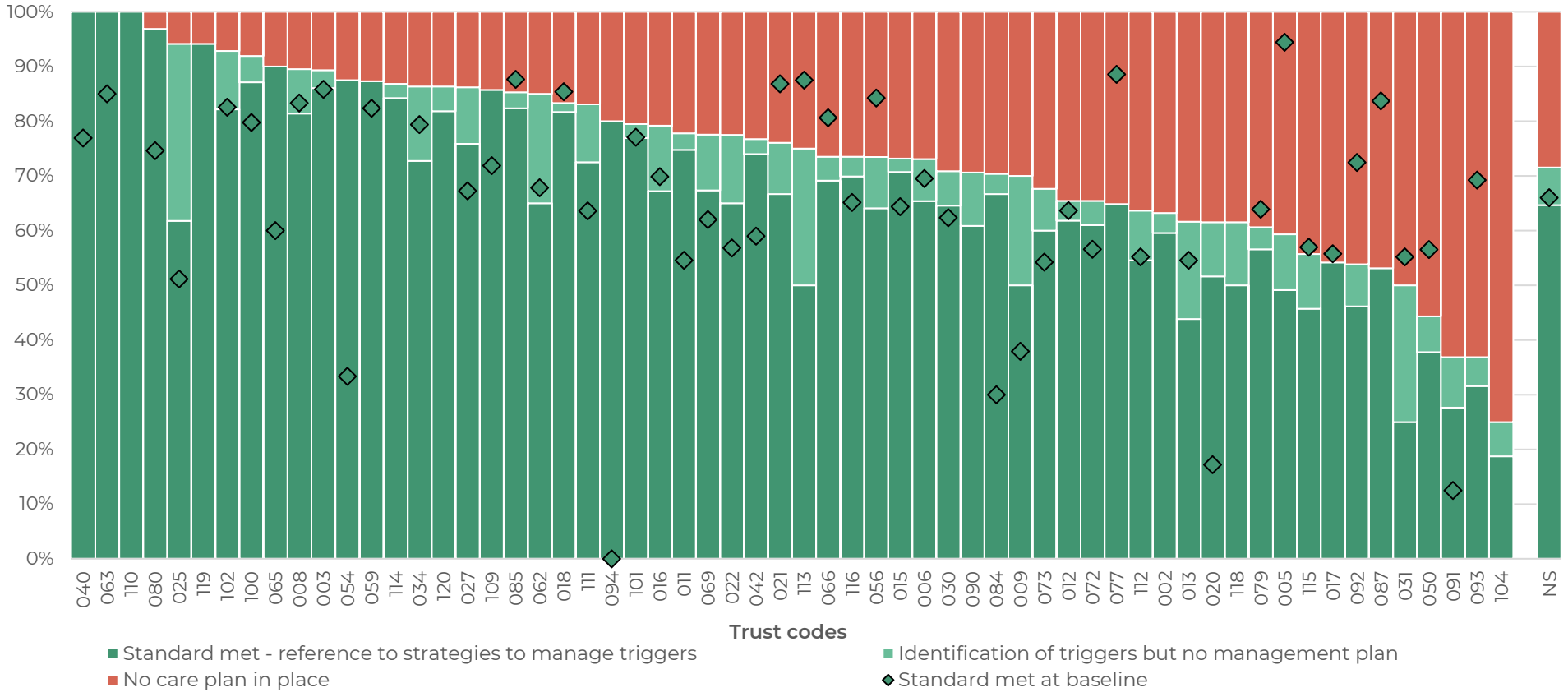
Trusts may wish to reflect on the systems and processes they have in place to support the development of collaborative treatment/ care plans, agreed by both patients and prescribers.

Performance against practice standard 3a

Patients prescribed continuing antidepressant medication should have a care/crisis plant that:

- Identifies potential triggers / precipitating factors that could lead to a worsening of their condition, including psychosocial stressors
- Refers to strategies to manage such triggers

Figure 23: Proportion of patients with depression under the care of a longer-term CMHT for whom the potential triggers/stressors for their illness were identified and care planned for: national subsample (n=3771) and each participating Trust/healthcare organisation subsample, at re-audit, 2021.



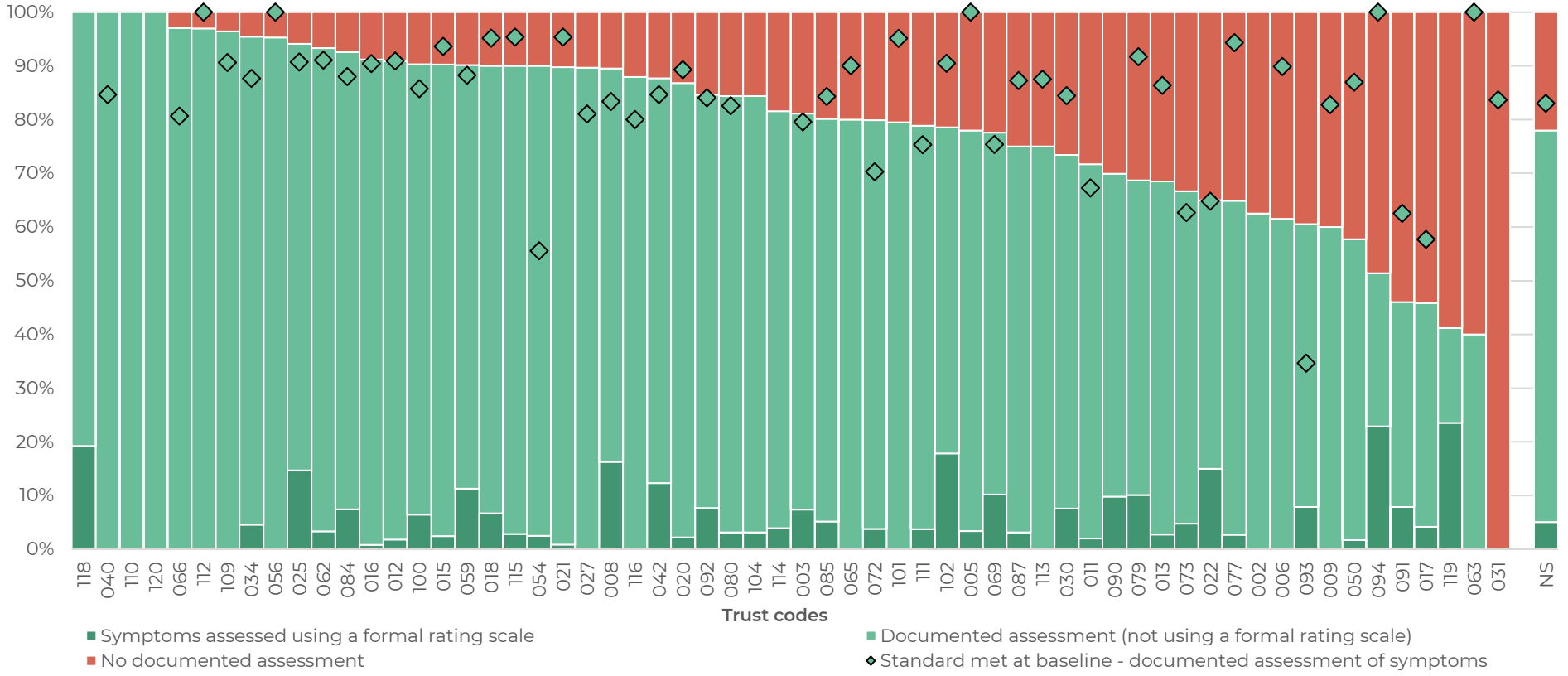
Where local practice does not meet this practice standard, Trusts may wish to reflect on whether their electronic patient records system has sufficient embedded prompts/data fields to support systematic care planning.

Performance against practice standard 3b

For patients prescribed continuing, long-term antidepressant medication, there should be at least annual review addressing:

- **Therapeutic response to medication**
- Medication adherence
- Medication side effects
- Comorbid conditions, including alcohol and substance use and both psychiatric and physical disorders

Figure 24: Proportion of patients under the care of a longer-term CMHT who had a documented review in the past year addressing the symptoms and severity of their depression: national subsample (n=3771) and each participating Trust/healthcare organisation subsample, at re-audit, 2021.

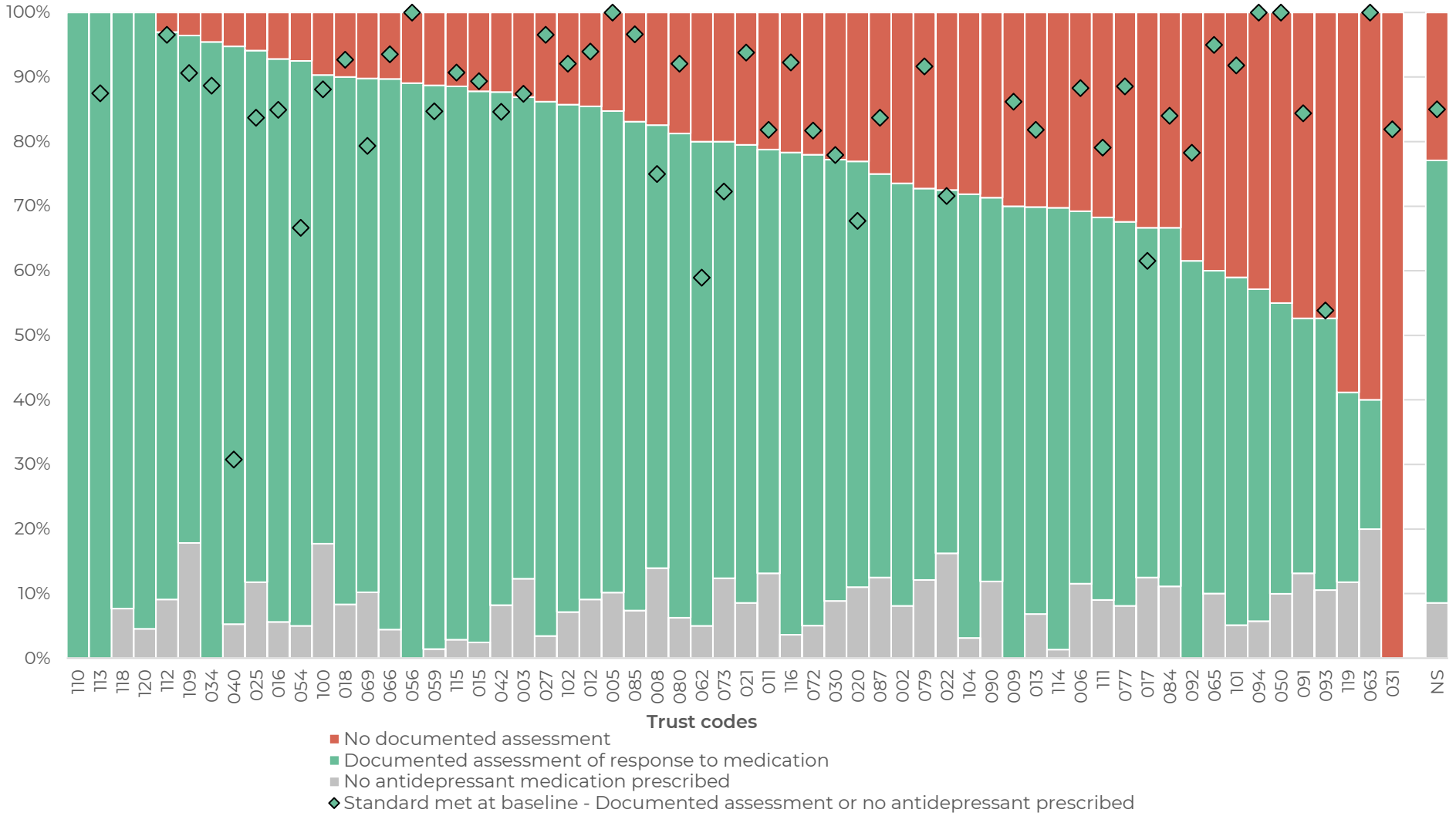


Given the utility of formal rating scales in assessing the symptoms and severity of depression and response to treatment over time, particularly when multiple clinicians are involved with the care of an individual patient, Trusts may like to consider whether their electronic patient records system includes a relevant outcome measure that clinicians can use to inform patient care.

For patients prescribed continuing, long-term antidepressant medication, there should be at least annual review addressing:

- **Therapeutic response to medication**
- Medication adherence
- Medication side effects
- Comorbid conditions, including alcohol and substance use and both psychiatric and physical disorders

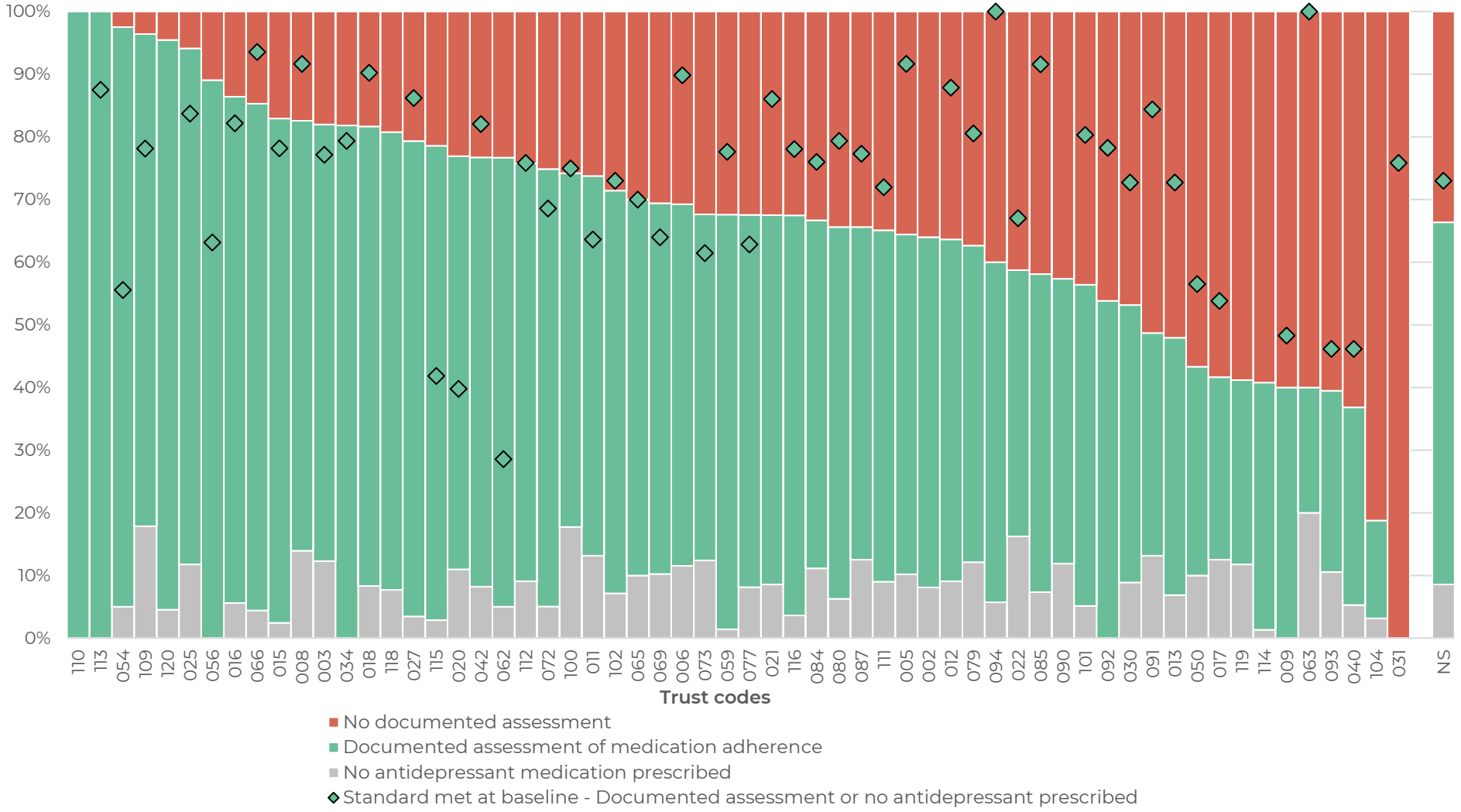
Figure 25: Proportion of patients with depression under the care of a longer-term CMHT who had a documented review in the past year addressing response to medication: national subsample (n=3771) and each participating Trust/healthcare organisation subsample, at re-audit, 2021.



For patients prescribed continuing, long-term antidepressant medication, there should be at least annual review addressing:

- Therapeutic response to medication
- **Medication adherence**
- Medication side effects
- Comorbid conditions, including alcohol and substance use and both psychiatric and physical disorders

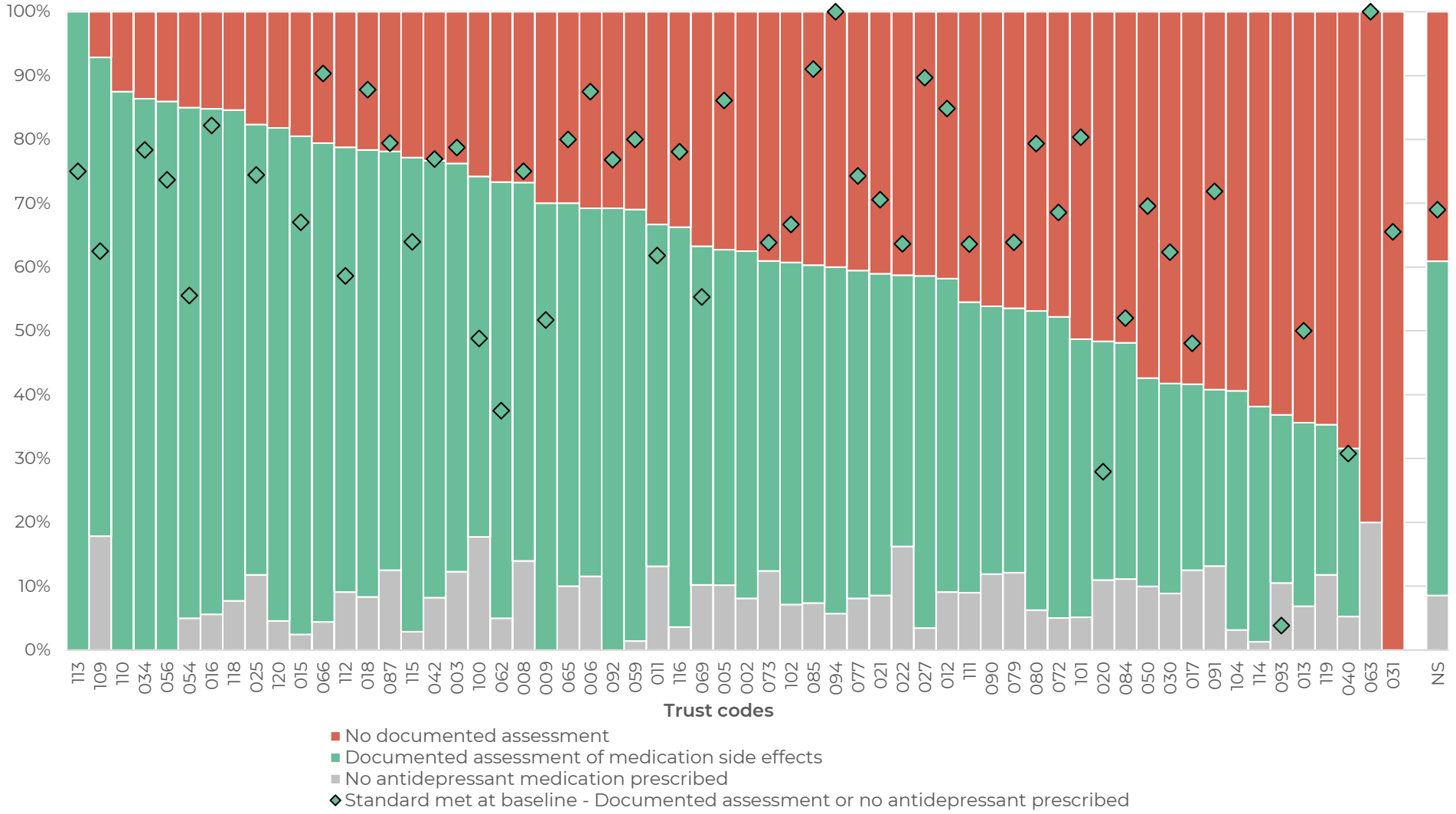
Figure 26: Proportion of patients with depression under the care of a longer-term CMHT who had a documented review in the past year addressing adherence to medication: national subsample (n=3771) and each participating Trust/healthcare organisation subsample, at re-audit, 2021.



For patients prescribed continuing, long-term antidepressant medication, there should be at least annual review addressing:

- Therapeutic response to medication
- Medication adherence
- **Medication side effects**
- Comorbid conditions, including alcohol and substance use and both psychiatric and physical disorders

Figure 27: Proportion of patients with depression under the care of a longer-term CMHT who had a documented review in the past year addressing medication side effects: national subsample (n=3771) and each participating Trust/healthcare organisation subsample, at re-audit, 2021.



For patients prescribed continuing, long-term antidepressant medication, there should be at least annual review addressing:

- Therapeutic response to medication
- Medication adherence
- Medication side effects
- **Comorbid conditions, including alcohol and substance use and both psychiatric and physical disorders**

Figure 28: Proportion of patients under the care of a longer-term CMHT who had a documented review in the last year that considered the use of alcohol in precipitating or maintaining depression: national subsample (n=3771) and each participating Trust/healthcare organisation subsample, at re-audit, 2021.

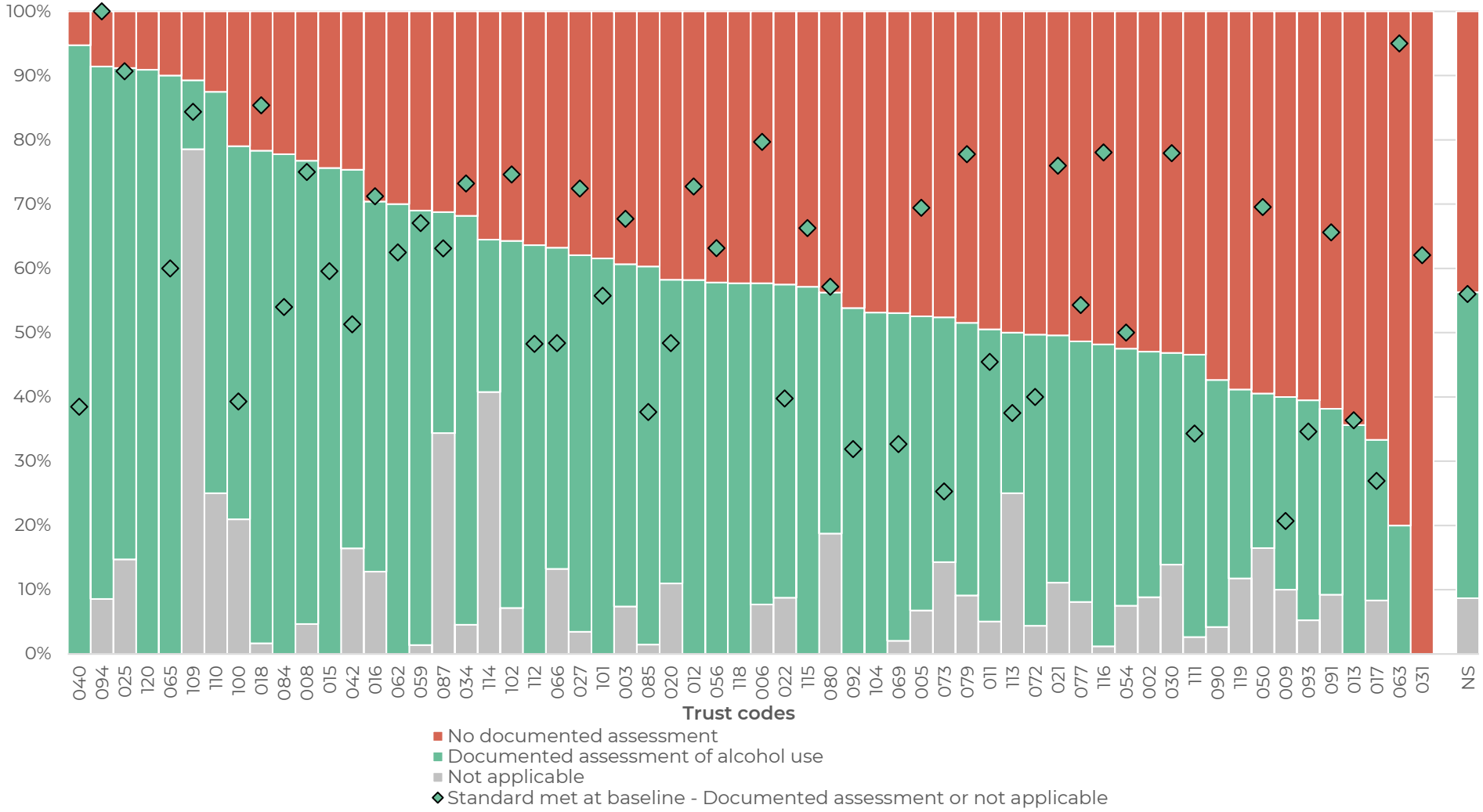
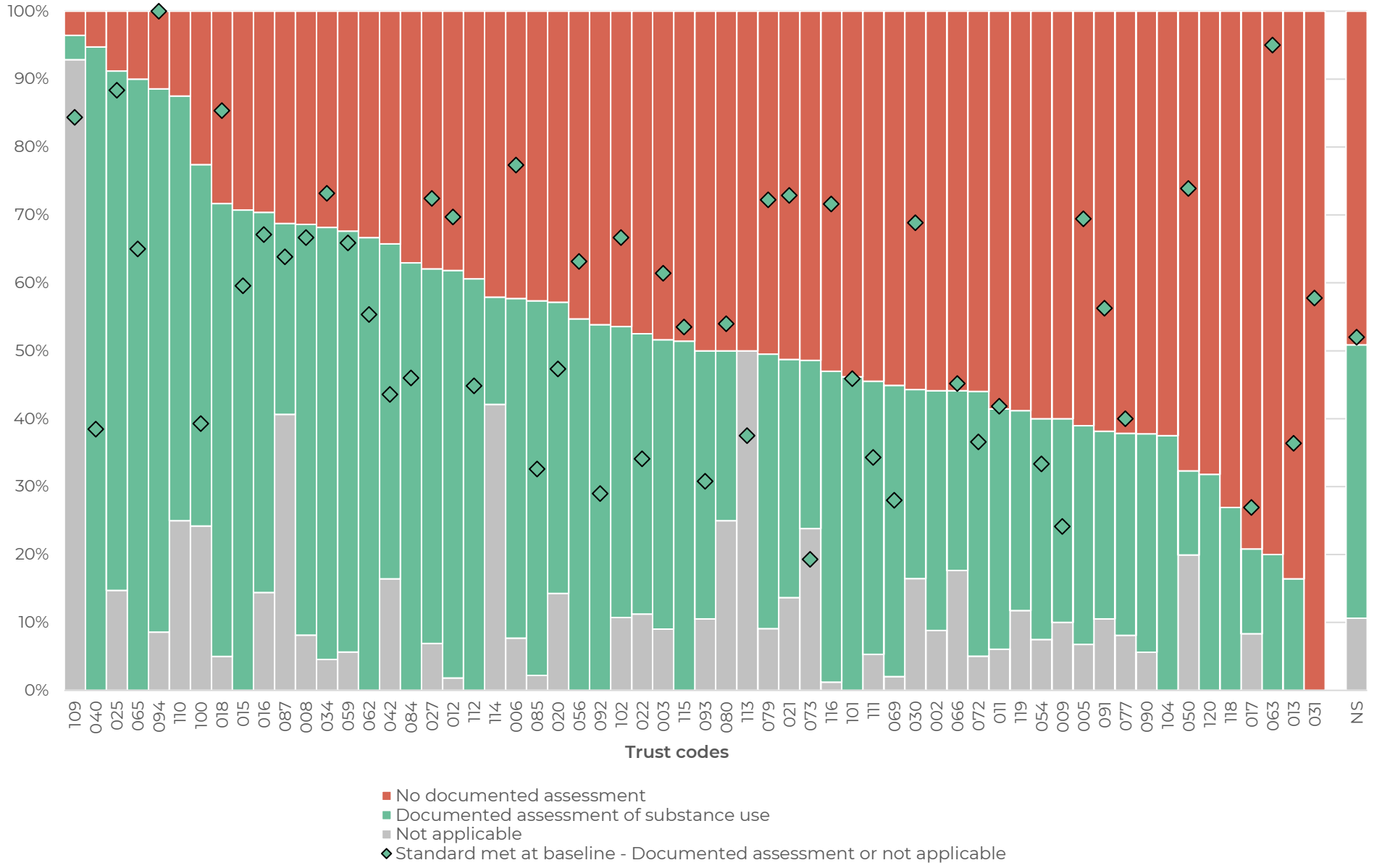


Figure 29: Proportion of patients under the care of a longer-term CMHT who had a documented review in the last year that considered the use of other substances in precipitating or maintaining depression: national subsample (n=3771) and each participating Trust/healthcare organisation subsample, at re-audit, 2021.



For patients prescribed continuing, long-term antidepressant medication, there should be at least annual review addressing:

- Therapeutic response to medication
- Medication adherence
- Medication side effects
- **Comorbid conditions, including alcohol and substance use and both psychiatric and physical disorders**

Figure 30: Proportion of patients under the care of a longer-term CMHT who had a documented review in the last year that considered the role of co-morbid physical illness in precipitating or maintaining depression: national subsample (n=3771) and each participating Trust/healthcare organisation subsample, at re-audit, 2021.

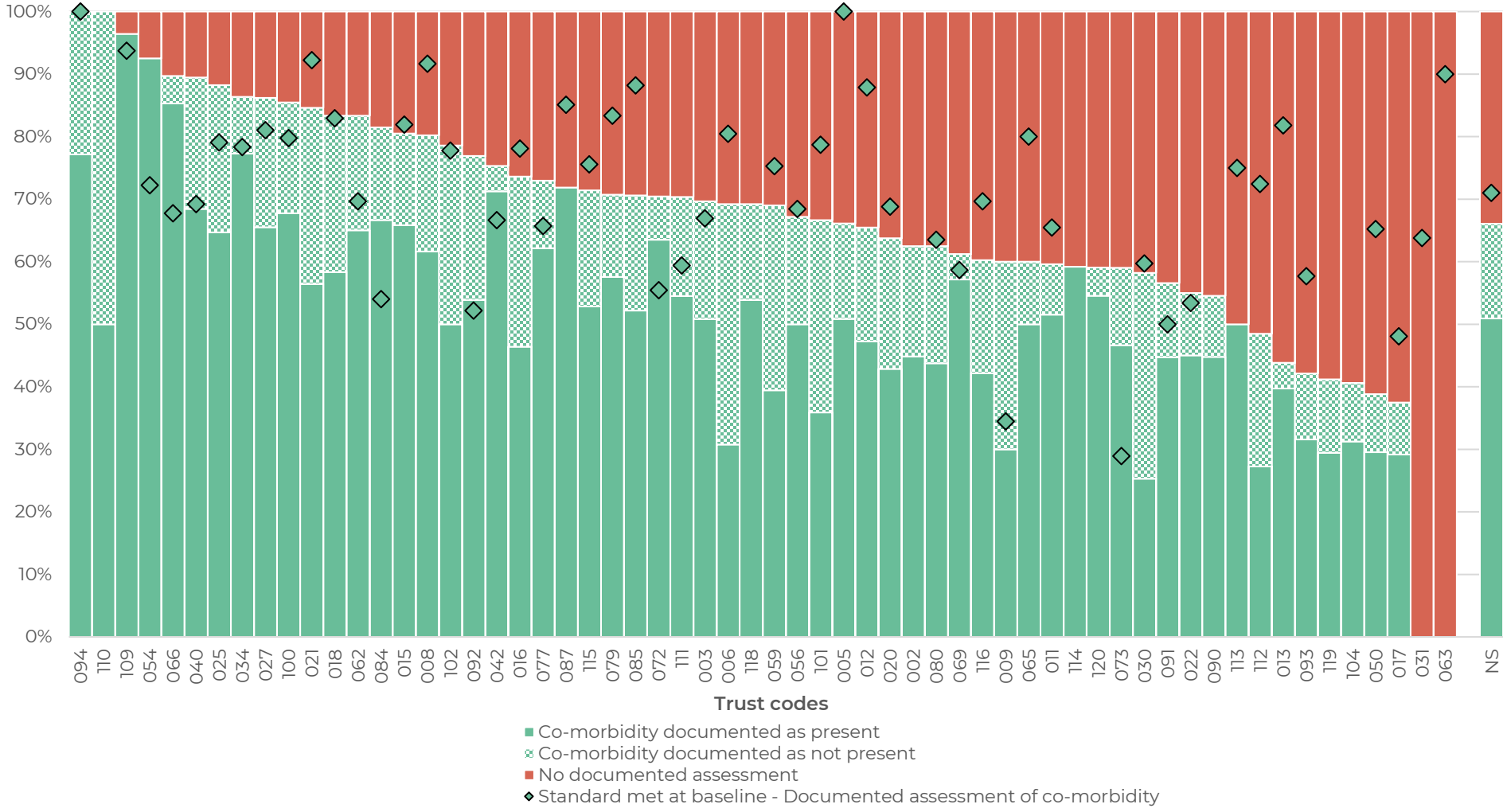
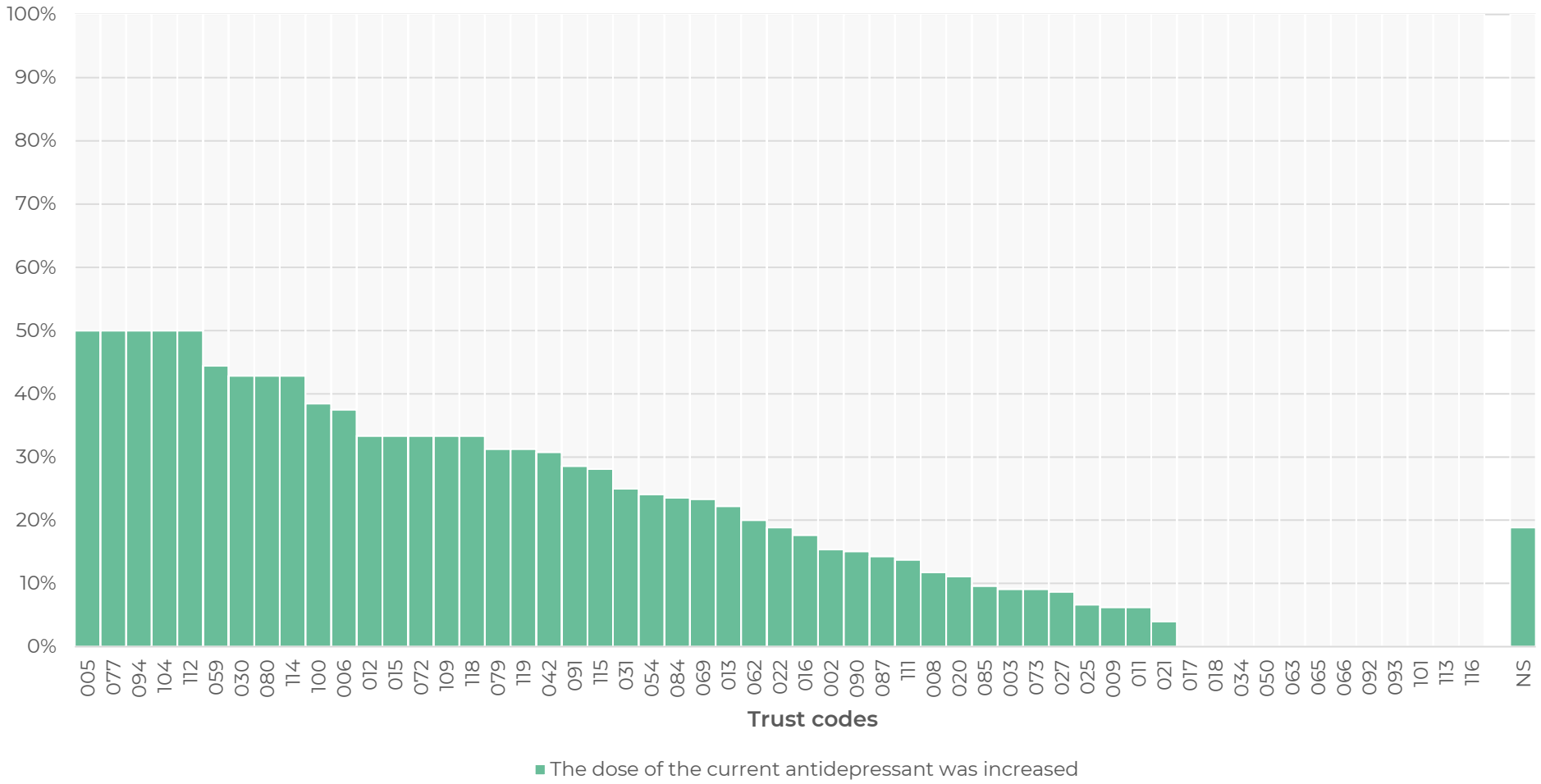


Figure 31: Proportion of patients under the care of a longer-term CMHT who had a documented review in the last year that considered the role of co-morbid mental illness in precipitating or maintaining depression: national subsample (n=3771) and each participating Trust/healthcare organisation subsample, at re-audit, 2021.

Where the depressive illness has not shown a sufficient response to treatment with an antidepressant medication, the following treatment strategies should be considered:

- **Increasing the dose of antidepressant medication**
- Switching to another antidepressant medication

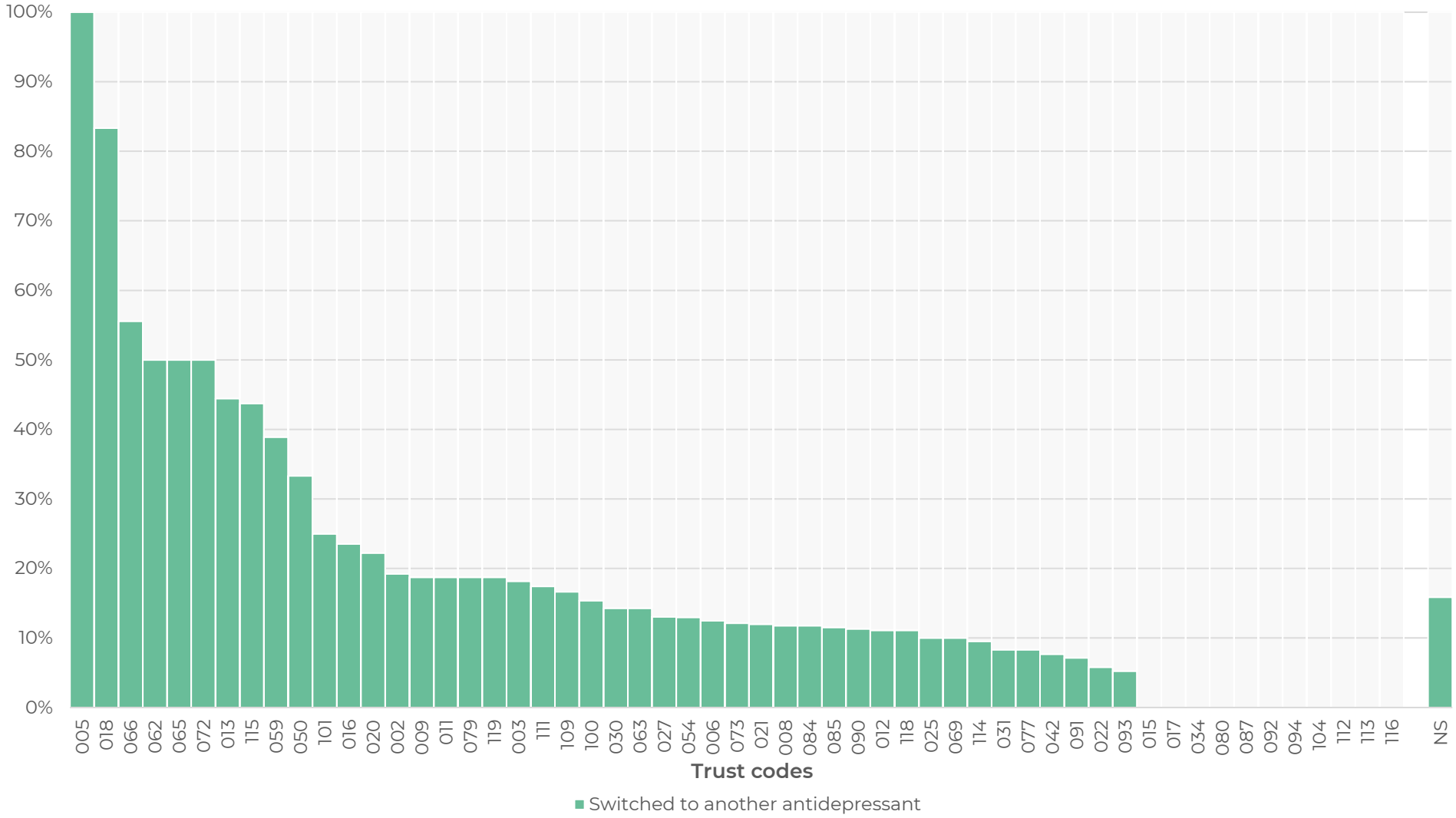
Figure 32: Proportion of patients with depression and short-term involvement with a CMHT who had an increase in antidepressant dosage: national subsample (n=971) and each participating Trust/healthcare organisation subsample, at re-audit, 2021.



Where the depressive illness has not shown a sufficient response to treatment with an antidepressant medication, the following treatment strategies should be considered:

- Increasing the dose of antidepressant medication
- **Switching to another antidepressant medication**

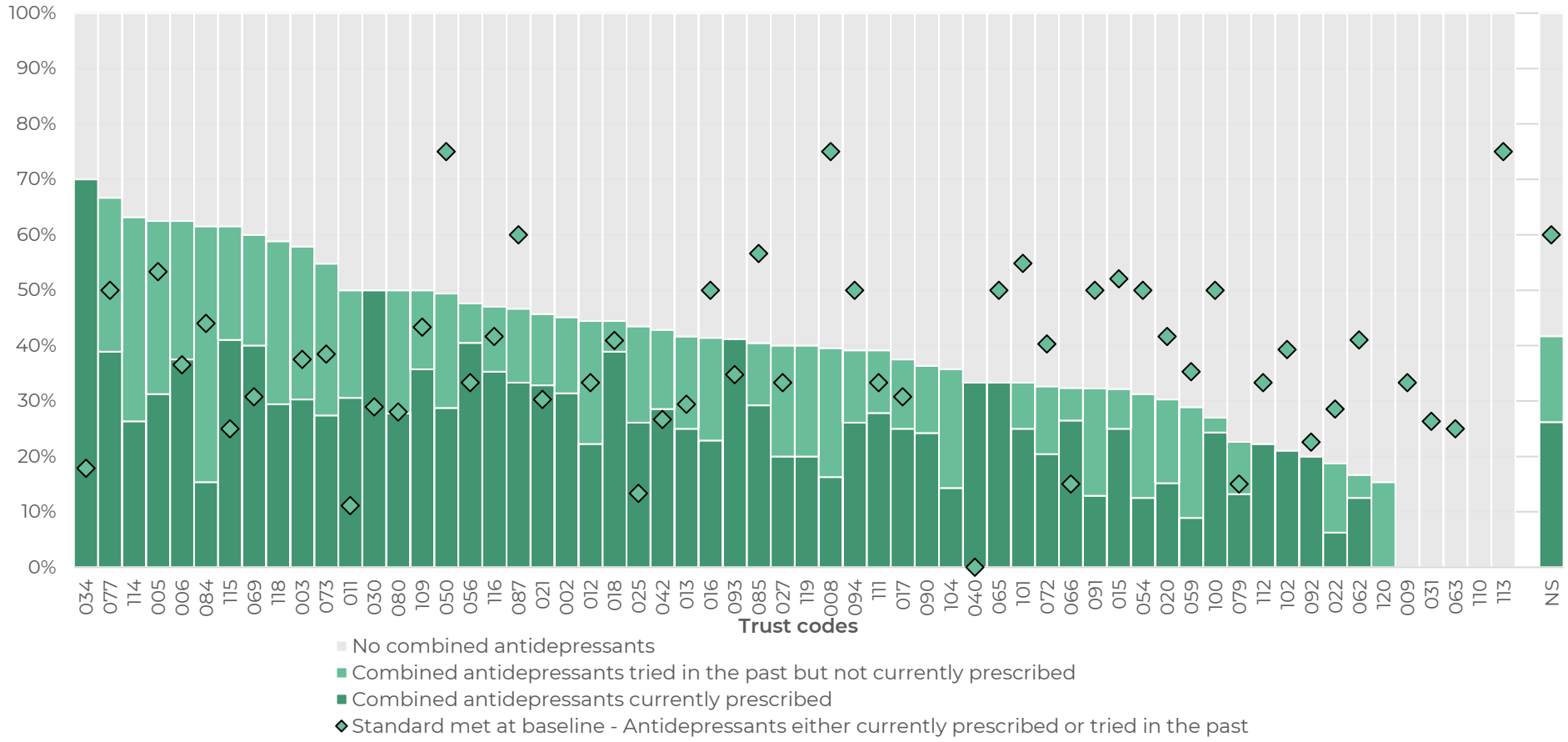
Figure 33: Proportion of patients with depression and short-term involvement with a CMHT who were switched to another antidepressant: national subsample (n=971) and each participating Trust/healthcare organisation subsample, at re-audit, 2021.



Where the depressive illness has not shown a sufficient response to treatment with an antidepressant medication, the following treatment strategies should be considered:

- **Augmentation with another antidepressant medication**
- Augmentation with lithium
- Augmentation with an antipsychotic medication

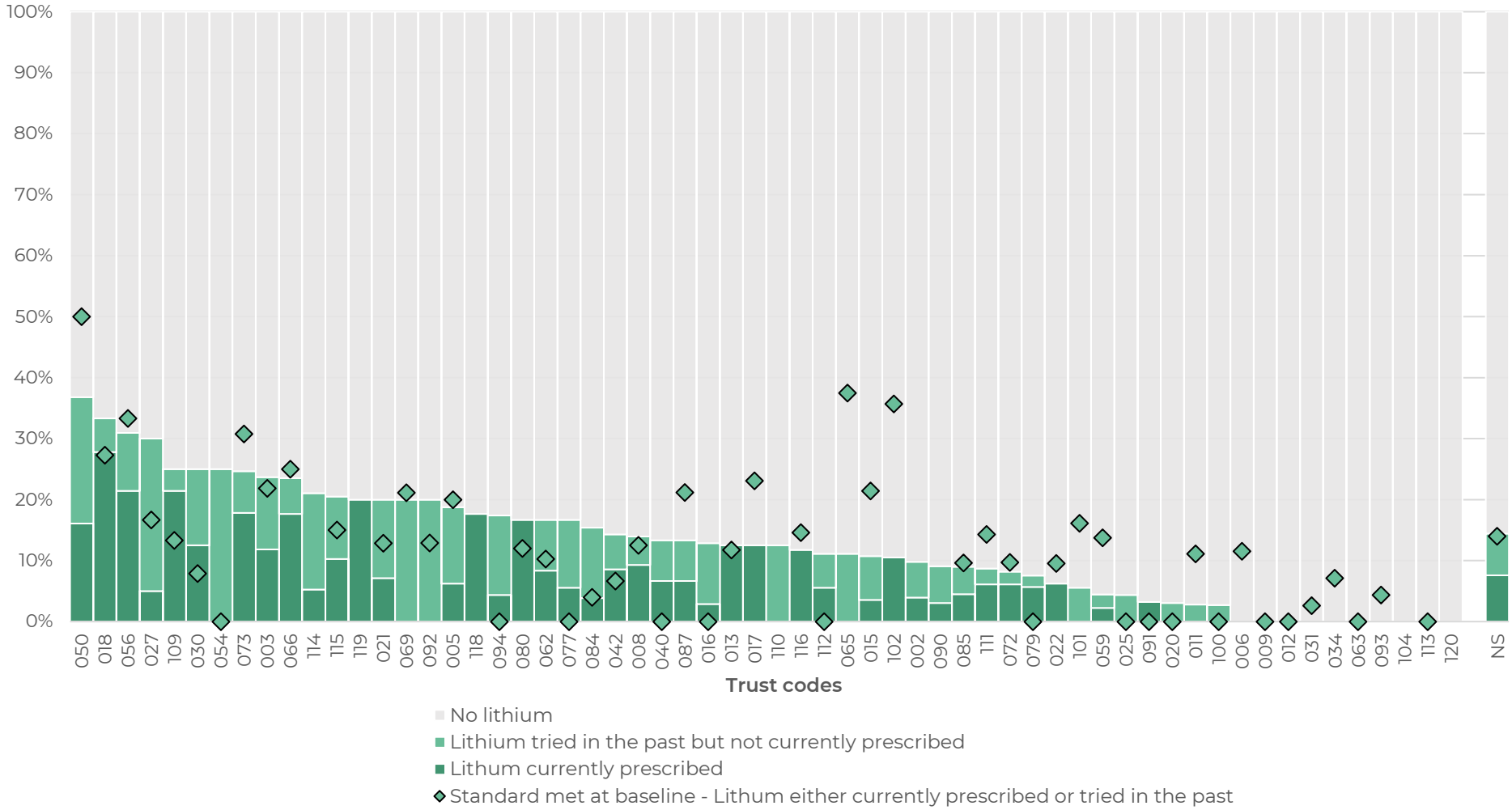
Figure 34: Documented use of pharmacological augmentation strategies supported by NICE (combined antidepressant medications), in those patients with depression under the care of a longer-term CMHT who had a comprehensive treatment history: national subsample (n=1763) and each participating Trust/healthcare organisation subsample, at re-audit, 2021.



Where the depressive illness has not shown a sufficient response to treatment with an antidepressant medication, the following treatment strategies should be considered:

- Augmentation with another antidepressant medication
- **Augmentation with lithium**
- Augmentation with an antipsychotic medication

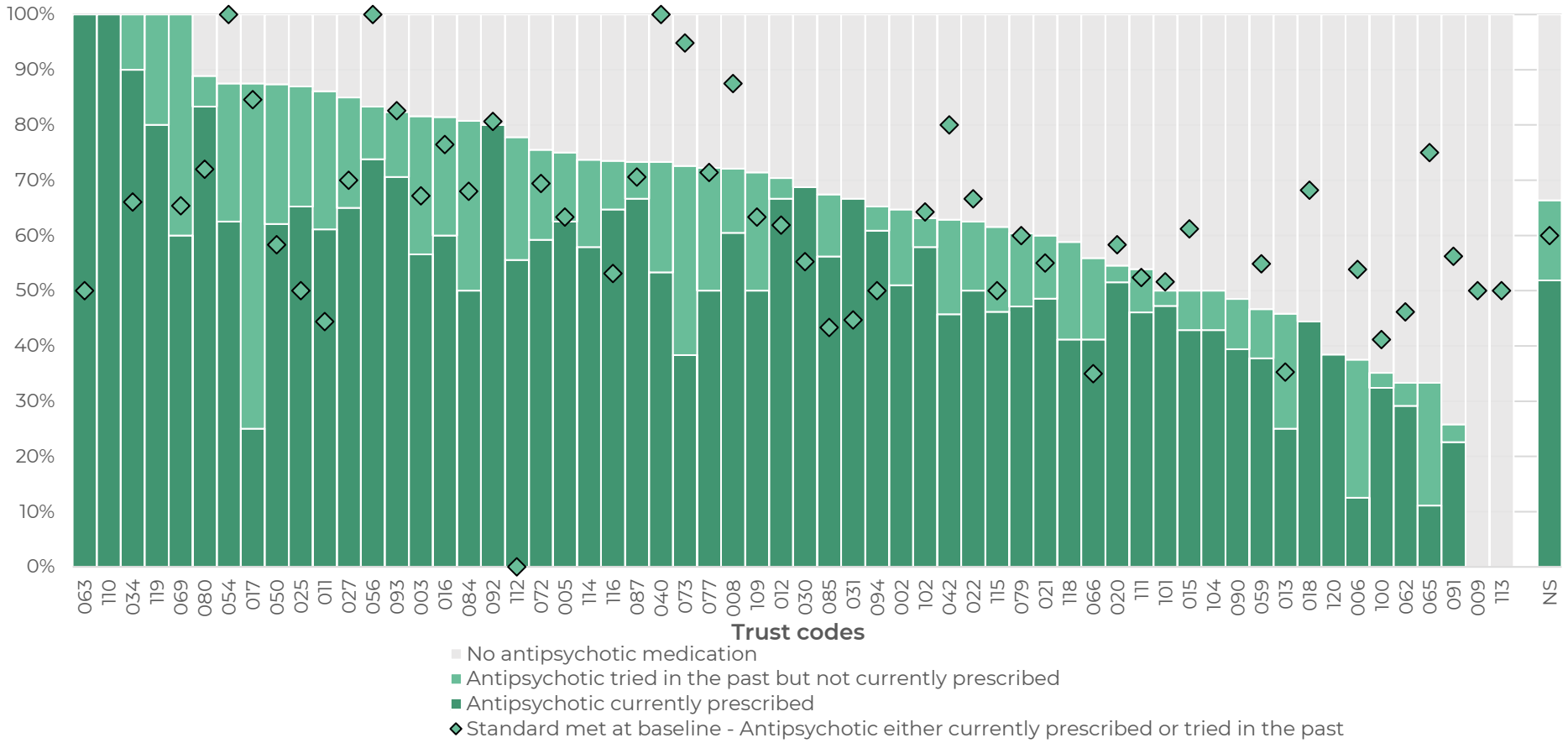
Figure 35: Documented use of pharmacological augmentation strategies supported by NICE (adding lithium), in those patients with depression under the care of a longer-term CMHT who had a comprehensive treatment history: national subsample (n=1763) and each participating Trust/healthcare organisation subsample, at re-audit, 2021.



Where the depressive illness has not shown a sufficient response to treatment with an antidepressant medication, the following treatment strategies should be considered:

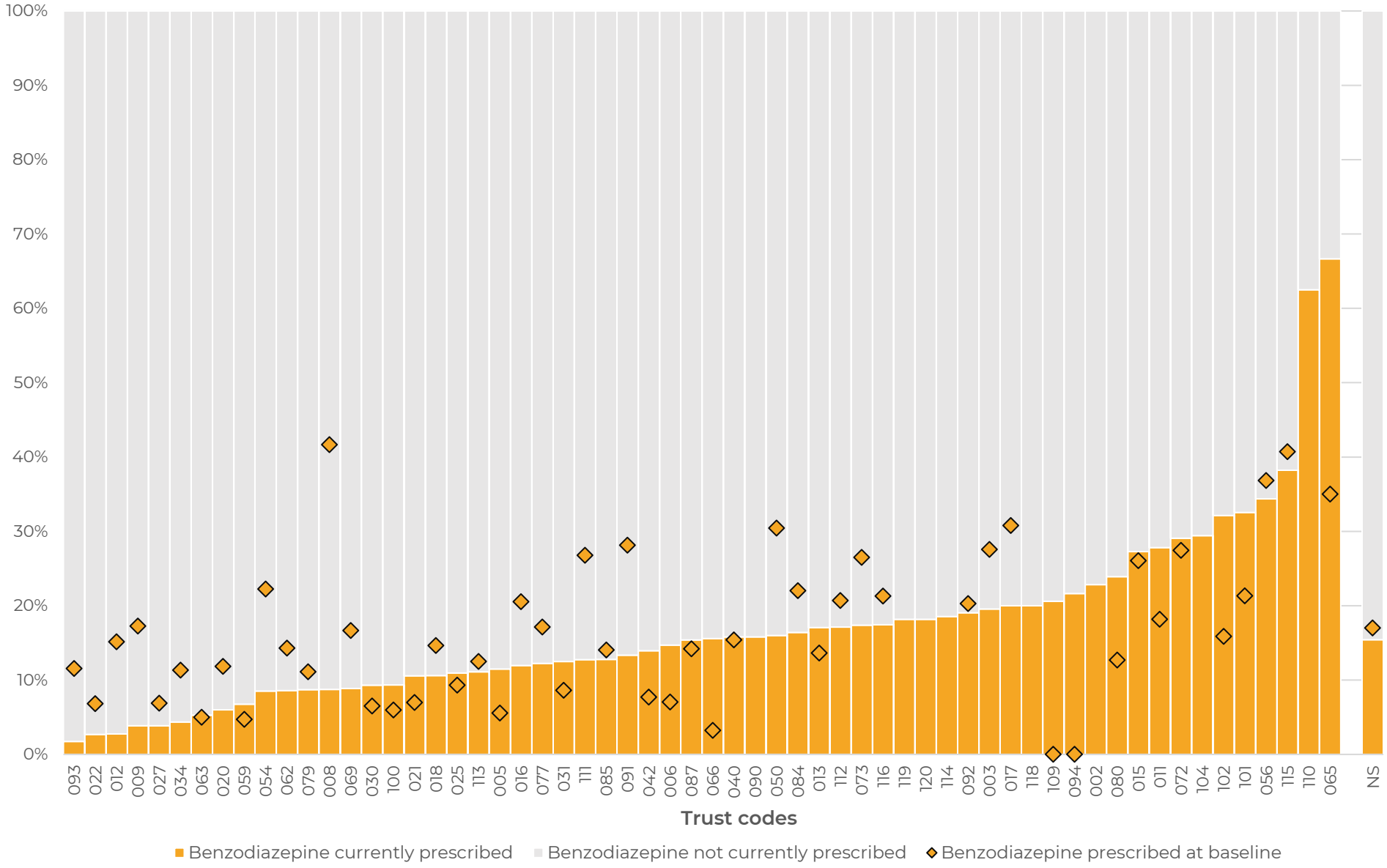
- Augmentation with another antidepressant medication
- Augmentation with lithium
- **Augmentation with an antipsychotic medication**

Figure 36: Documented use of pharmacological augmentation strategies supported by NICE (adding antipsychotic medication), in those patients with depression under the care of a longer-term CMHT who had a comprehensive treatment history: national subsample (n=1763) and each participating Trust/healthcare organisation subsample, at re-audit, 2021.



Trusts may like to consider whether developing or adopting a treatment algorithm for refractory depression could improve outcomes for patients under their care with this diagnosis.

Figure 37: Proportion of cases under the care of a longer-term CMHT currently prescribed benzodiazepine medication: national subsample (n=4742) and each participating Trust/healthcare organisation subsample, at re-audit, 2021.



Clinical team level results

Analyses presented in this section were conducted for each clinical team from your Trust individually, for your total Trust sample and for the total national sample to allow benchmarking.

Data from each Trust clinical team are presented by code only.

The POMH-UK Central Project Team does not know the identity of individual clinical teams.

Only the Local POMH lead for your Trust or organisation has the key to clinical team codes. You should contact this person if you need to identify data for your own clinical team.

Charts in this section are ordered by frequency of key results and so the position of teams in each table will vary.

Performance against practice standard 1

Depression should be managed in primary care unless it is complex, severe, treatment-refractory, or places the patient or others at risk

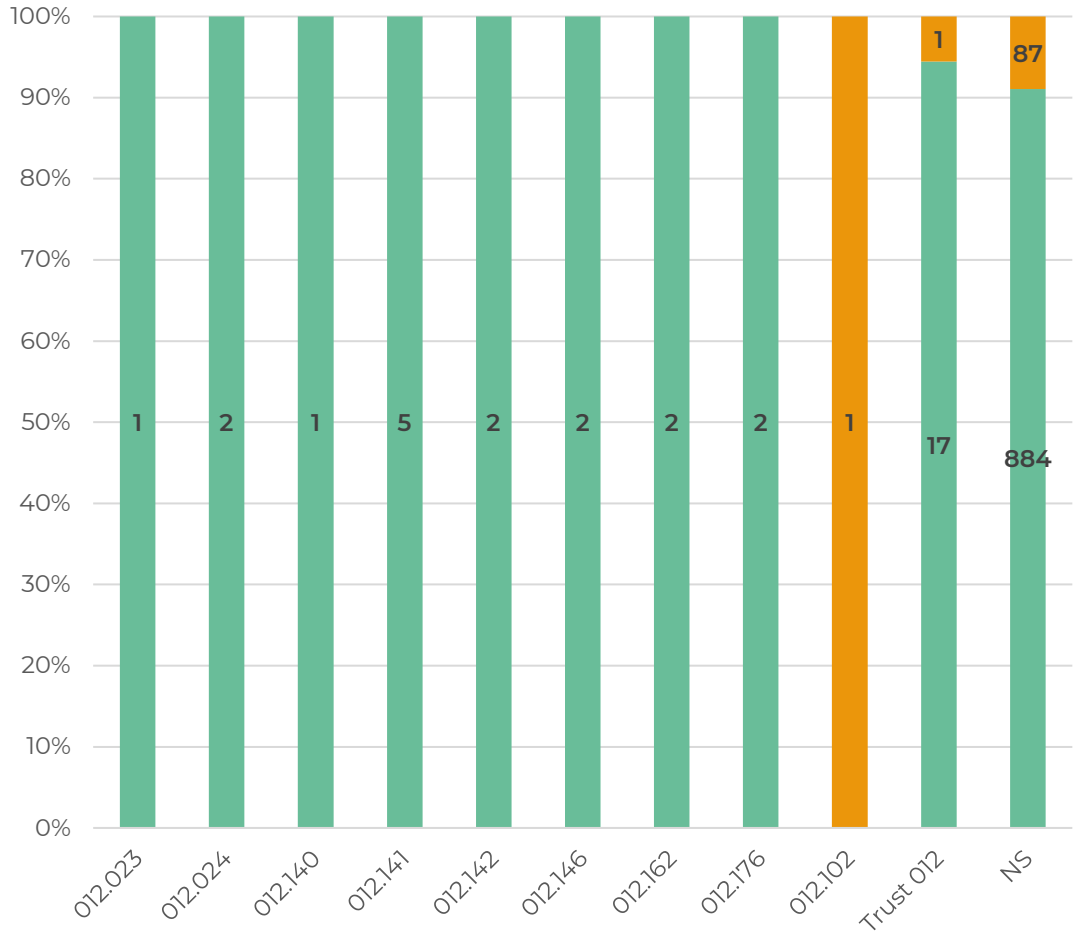


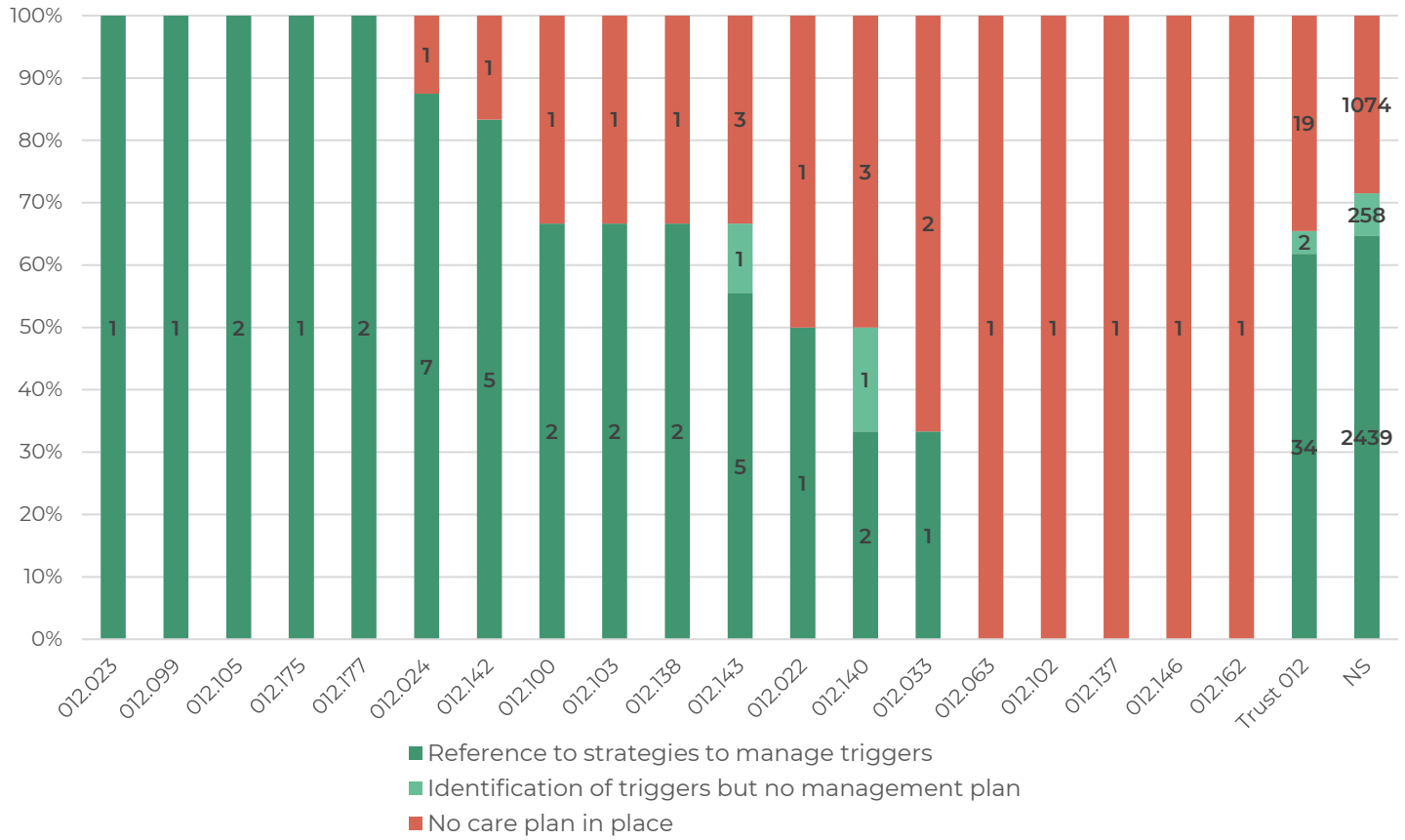
Figure 38: Proportion of cases referred to a short-term CMHT with depression, where the illness was complex, severe, treatment refractory or placed the patient or others at risk: national subsample (n=971) and your Trust teams (n=18), at re-audit, 2021.

Performance against practice standard 3a

Patients prescribed continuing antidepressant medication should have a care/crisis plan that:

- Identifies potential triggers/precipitating factors that could lead to a worsening of their condition, including psychosocial stressors
- Refers to strategies to manage such triggers

Figure 39: Proportion of patients with depression under the care of a longer-term CMHT for whom the potential triggers/stressors for their illness were identified and care planned for: national subsample (n=3771) and your Trust (n=55), at re-audit, 2021.



Performance against practice standard 3b

For patients prescribed continuing, long-term antidepressant medication, there should be at least annual review addressing:

- **Therapeutic response to the medication**
- Medication adherence
- Medication side effects
- Comorbid conditions, including alcohol and substance use and both psychiatric and physical disorders

Figure 40: Proportion of patients under the care of a longer-term CMHT who had a documented review in the past year addressing the symptoms and severity of their depression: total national sample (n=3771) and your Trust (n=55), at re-audit, 2021.

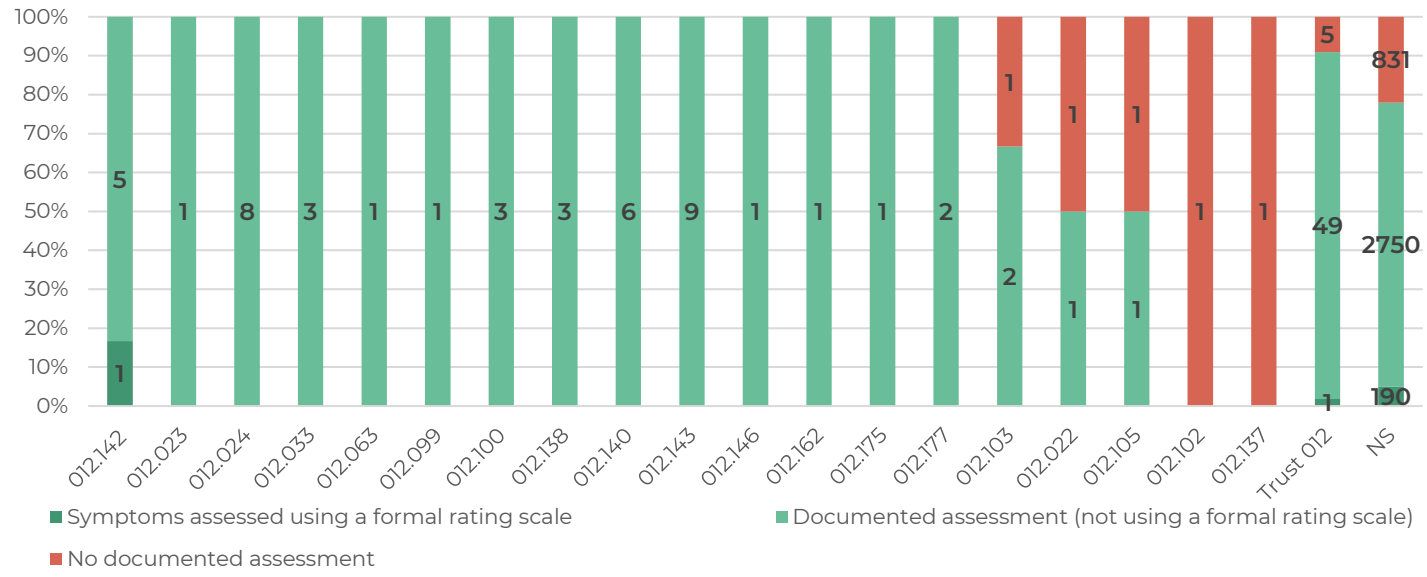
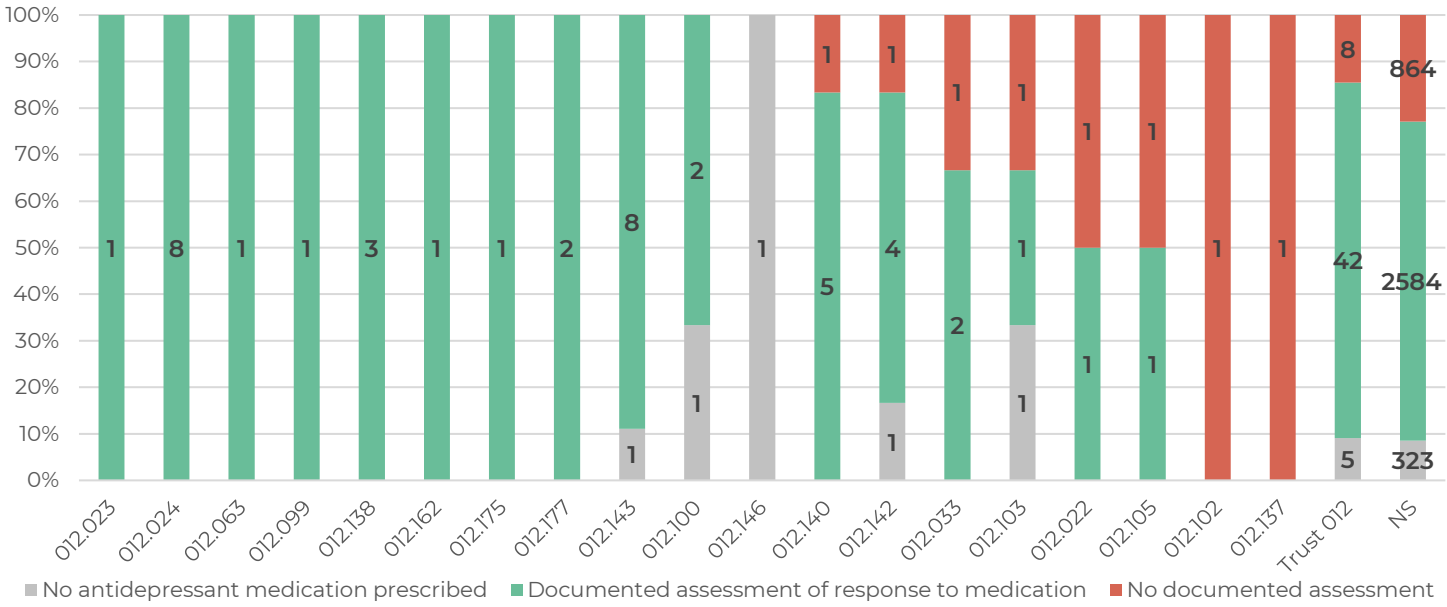


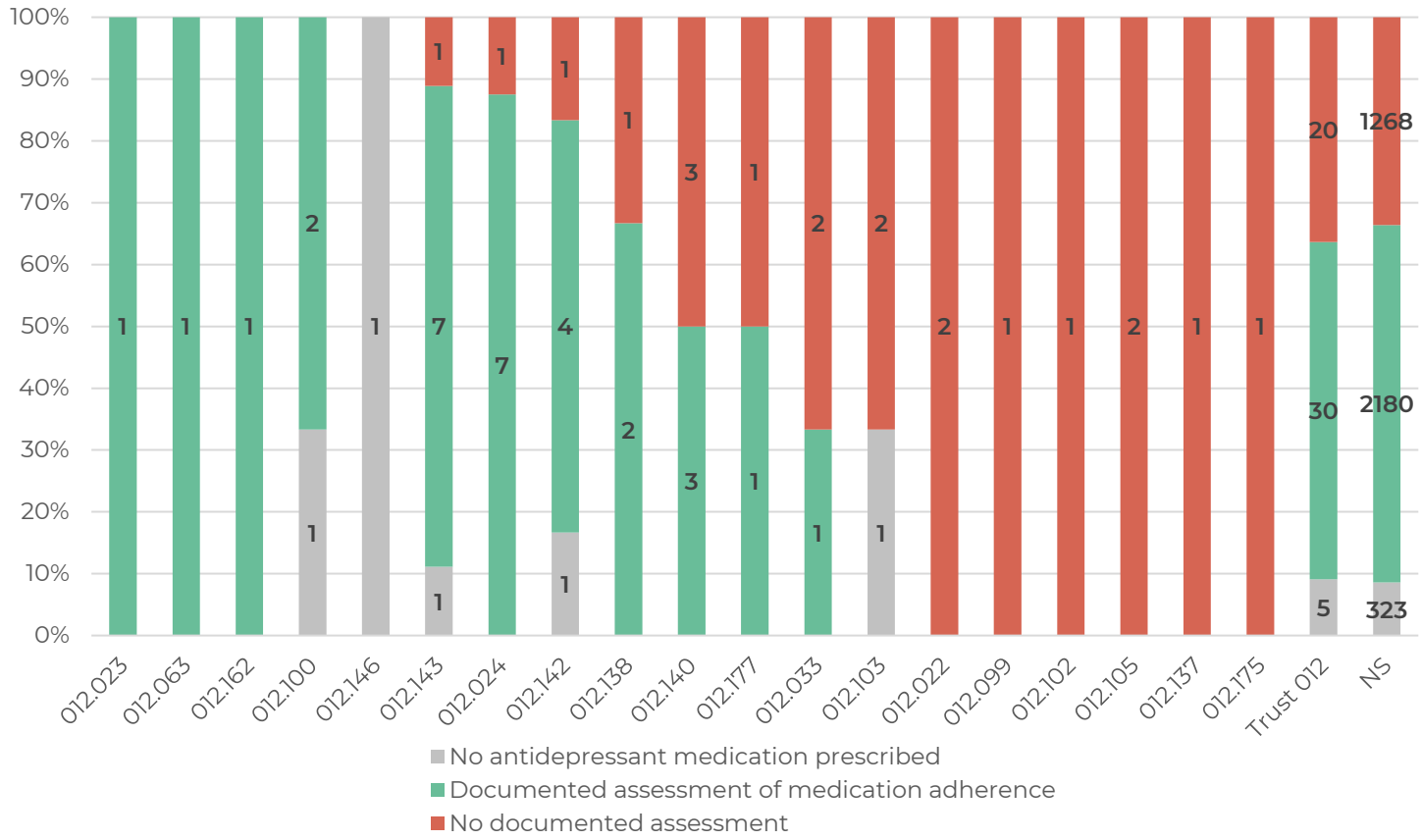
Figure 41: Proportion of patients with depression under the care of a longer-term CMHT who had a documented review in the past year addressing response to medication: total national sample (n=3771) and your Trust (n=55), at re-audit, 2021.



For patients prescribed continuing, long-term antidepressant medication, there should be at least annual review addressing:

- Therapeutic response to the medication
- **Medication adherence**
- Medication side effects
- Comorbid conditions, including alcohol and substance use and both psychiatric and physical disorders

Figure 42: Proportion of patients with depression under the care of a longer-term CMHT who had a documented review in the past year addressing adherence to medication: total national sample (n=3771) and your Trust (n=55), at re-audit, 2021.



For patients prescribed continuing, long-term antidepressant medication, there should be at least annual review addressing:

- Therapeutic response to the medication
- Medication adherence
- **Medication side effects**
- Comorbid conditions, including alcohol and substance use and both psychiatric and physical disorders

Figure 43: Proportion of patients with depression under the care of a longer-term CMHT who had a documented review in the past year addressing medication side effects: total national sample (n=3771) and your Trust (n=55), at re-audit, 2021.

For patients prescribed continuing, long-term antidepressant medication, there should be at least annual review addressing:

- Therapeutic response to the medication
- Medication adherence
- Medication side effects
- **Comorbid conditions, including alcohol and substance use and both psychiatric and physical disorders**

Figure 44: Proportion of patients under the care of a longer-term CMHT who had a documented review in the last year that considered the use of alcohol in precipitating or maintaining depression: total national sample (n=3771) and your Trust (n=55), at re-audit, 2021.

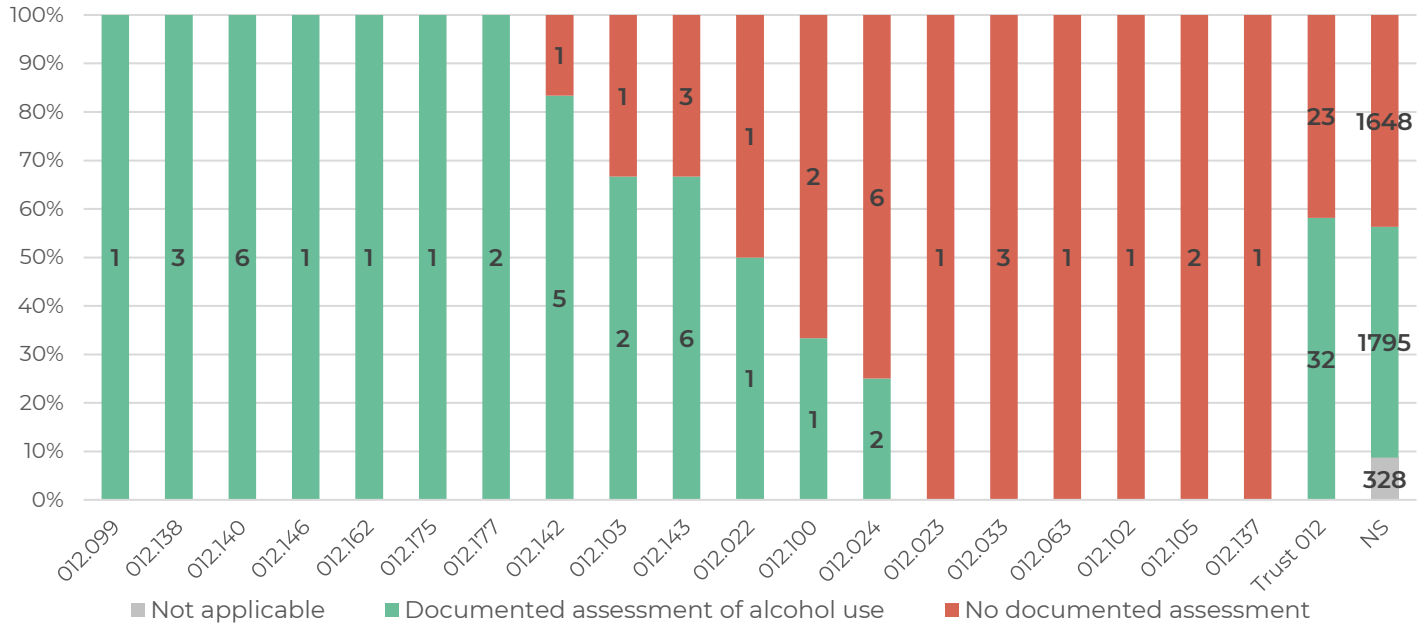


Figure 45: Proportion of patients under the care of a longer-term CMHT who had a documented review in the last year that considered the use of other substances in precipitating or maintaining depression: total national sample (n=3771) and your Trust (n=55), at re-audit, 2021.

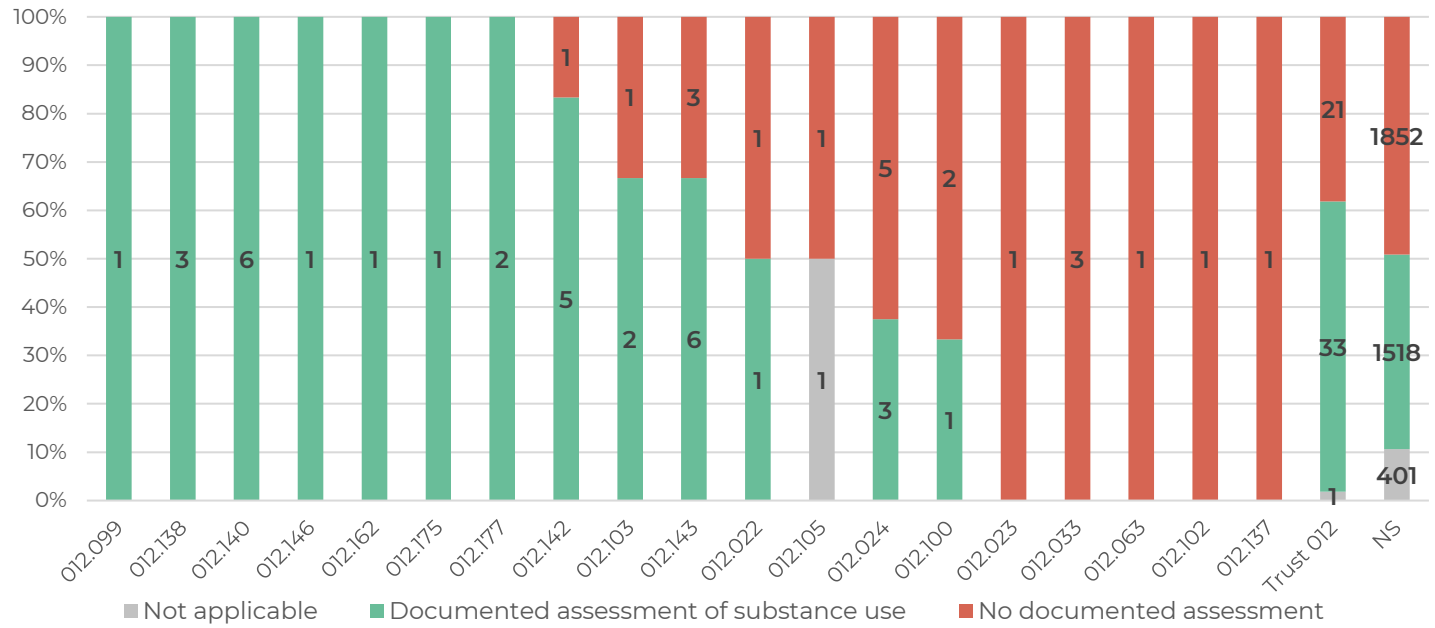


Figure 46: Proportion of patients under the care of a longer-term CMHT who had a documented review in the last year that considered the role of co-morbid physical illness in precipitating or maintaining depression: total national sample (n=3771) and your Trust (n=55), at re-audit, 2021.

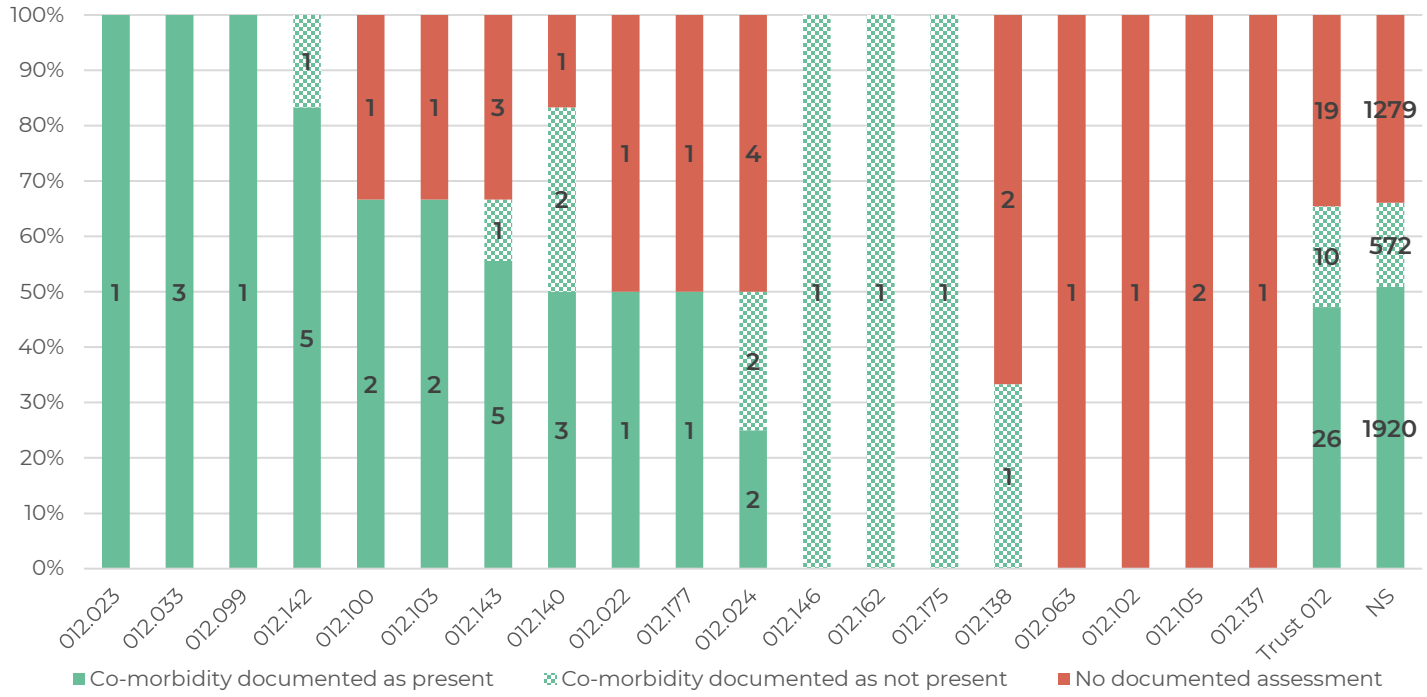
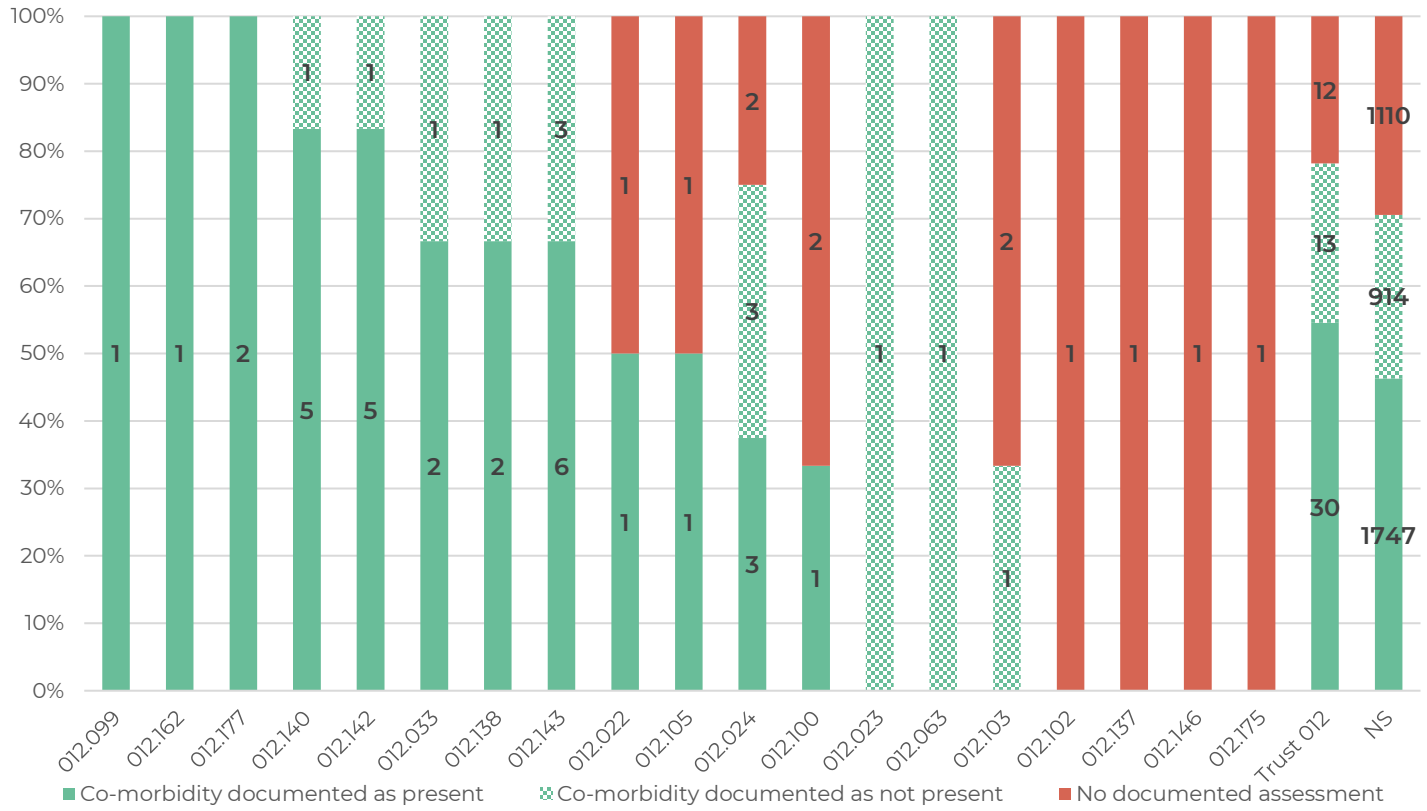


Figure 47: Proportion of patients under the care of a longer-term CMHT who had a documented review in the last year that considered the role of co-morbid mental illness in precipitating or maintaining depression: total national sample (n=3771) and your Trust (n=55), at re-audit, 2021.



Performance against practice standard 4

Where the depressive illness has not shown a sufficient response to treatment with an antidepressant medication, the following treatment strategies should be considered:

- Increasing the dose of antidepressant medication
- Switching to another antidepressant medication

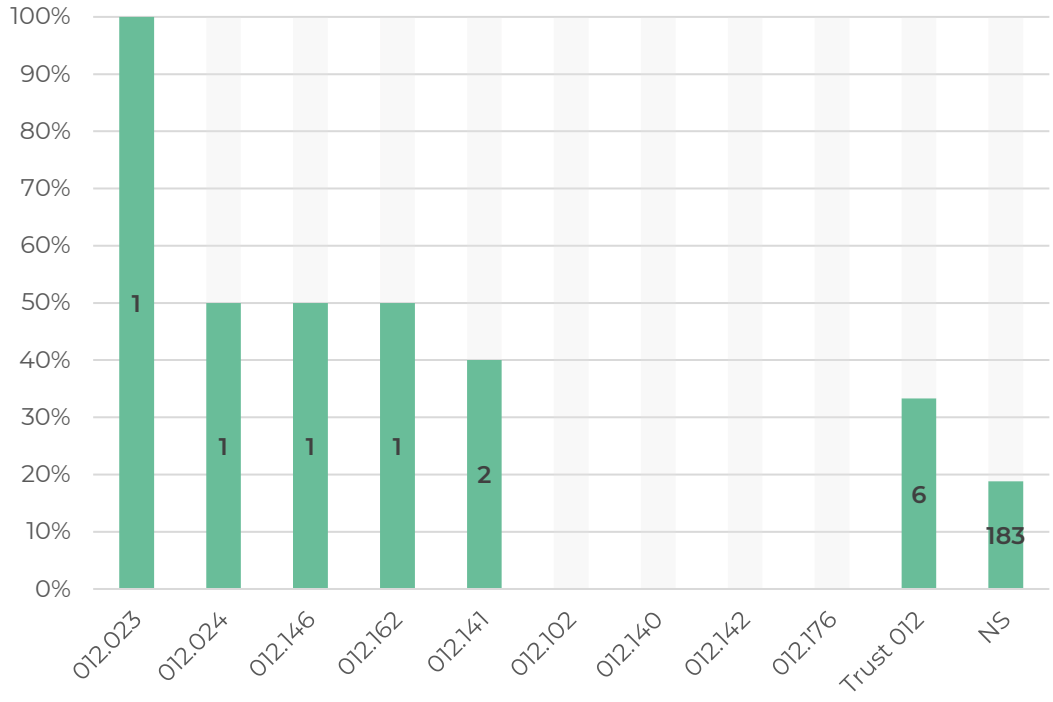


Figure 48: Proportion of patients with depression and short-term involvement with a CMHT who had an increase in antidepressant dosage: national subsample (n=971) and your Trust (n=18), at re-audit, 2021.

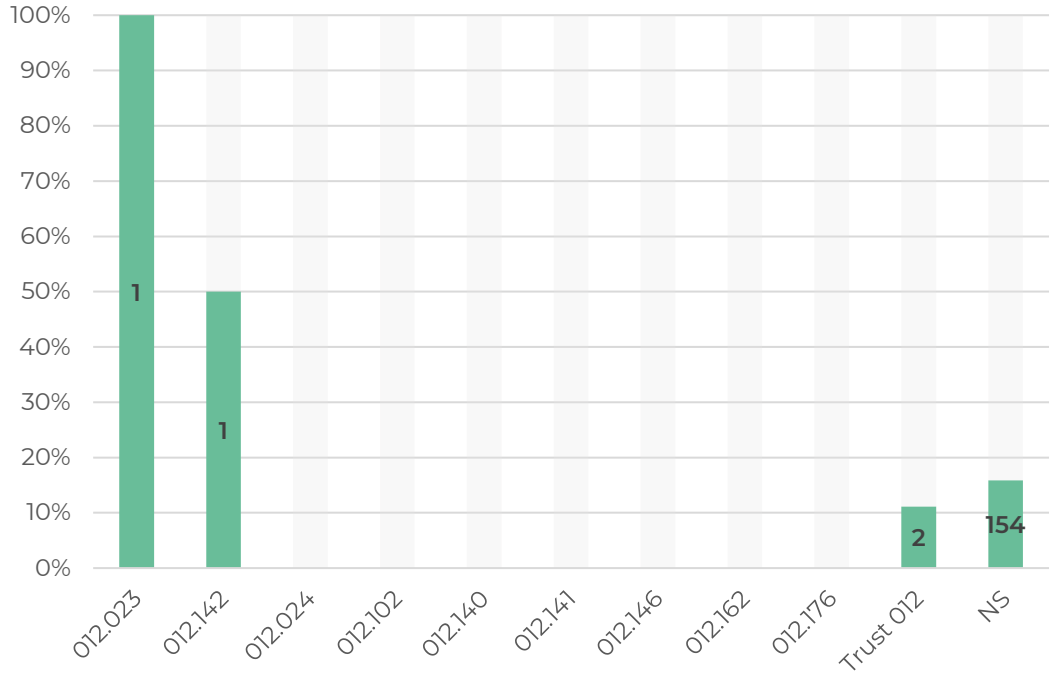


Figure 49: Proportion of patients with depression and short-term involvement with a CMHT who were switched to another antidepressant: national subsample (n=971) and your Trust (n=18), at re-audit, 2021.

Where the depressive illness has not shown a sufficient response to treatment with an antidepressant medication, the following treatment strategies should be considered:

- Augmentation with another antidepressant medication
- Augmentation with lithium
- Augmentation with an antipsychotic medication

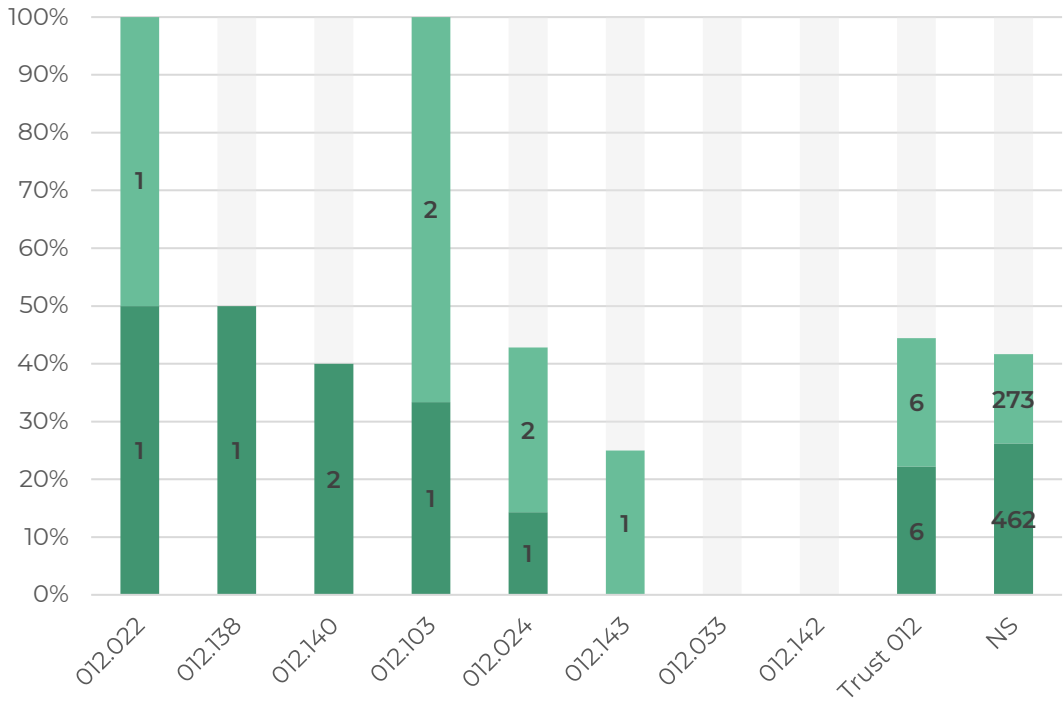


Figure 50: Documented use of pharmacological augmentation strategies supported by NICE (combined antidepressant medications), in those patients with depression under the care of a longer-term CMHT who had a comprehensive treatment history: national subsample (n=1763) and your Trust (n=27), at re-audit, 2021.

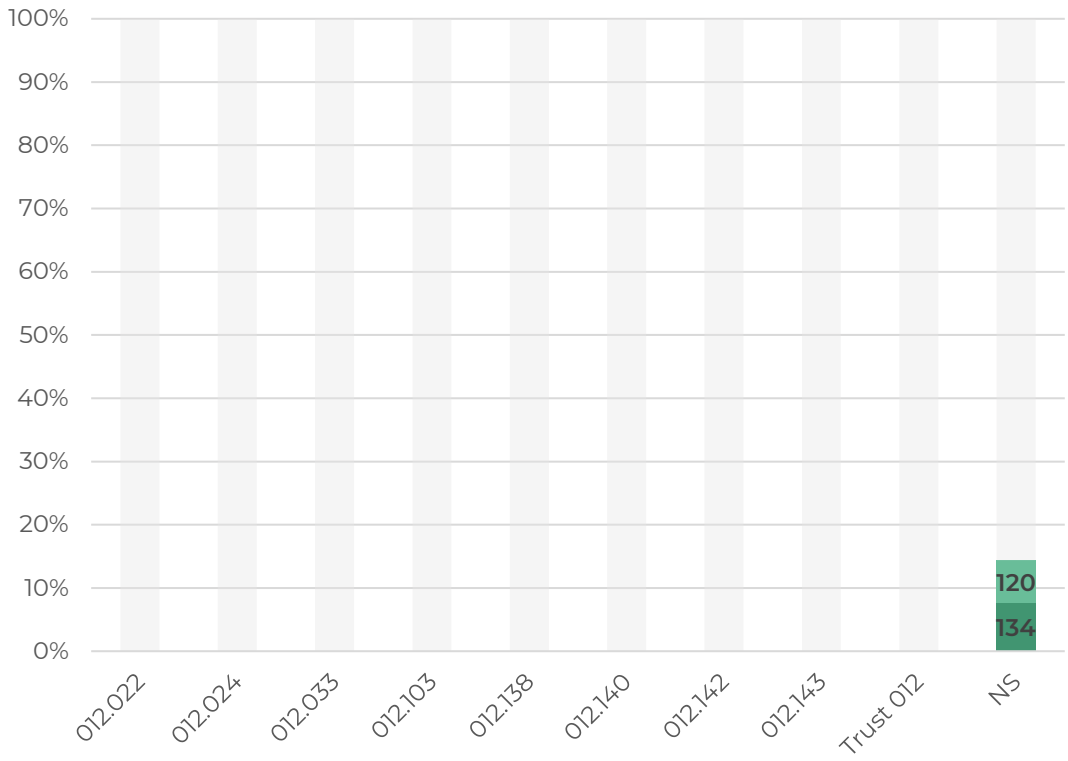


Figure 51: Documented use of pharmacological augmentation strategies supported by NICE (adding lithium), in those patients with depression under the care of a longer-term CMHT who had a comprehensive treatment history: national subsample (n=1763) and your Trust (n=27), at re-audit, 2021.

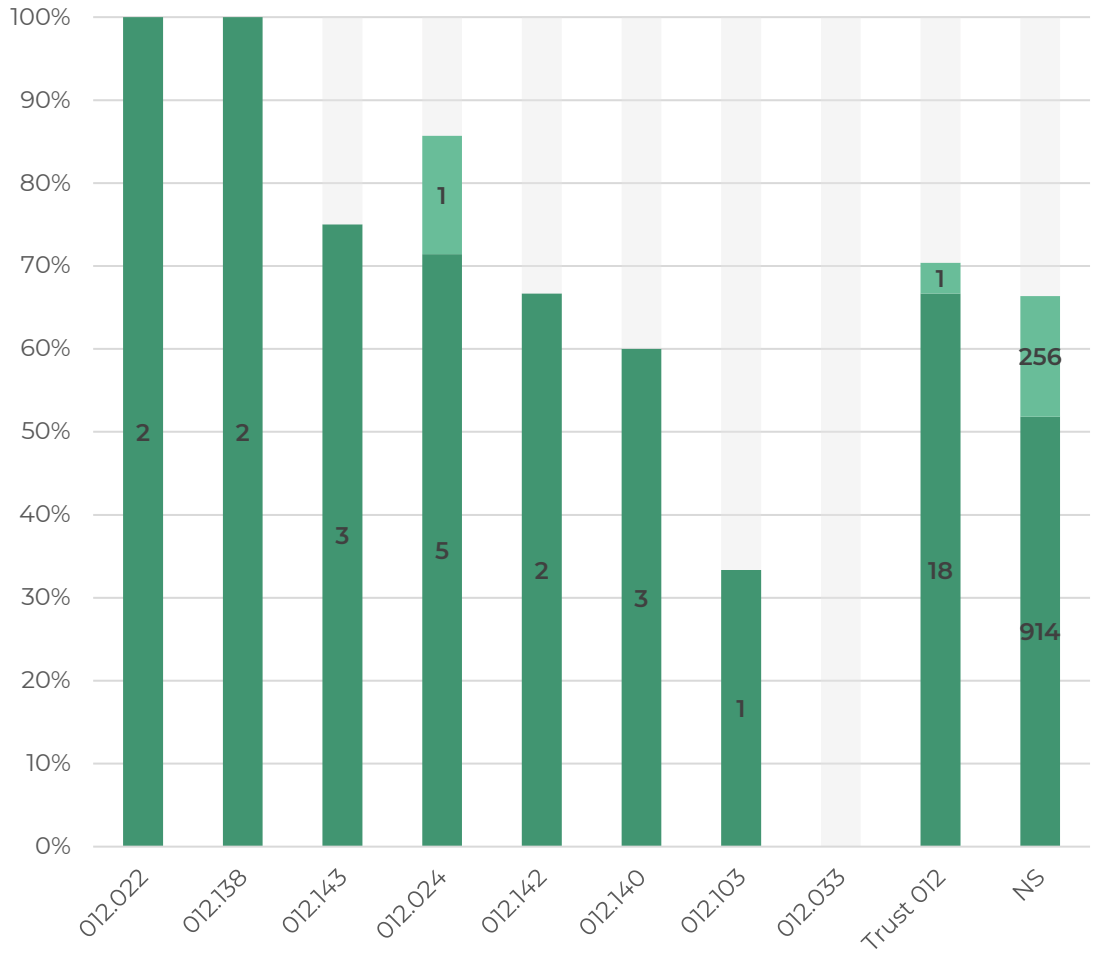


Figure 52: Documented use of pharmacological augmentation strategies supported by NICE (adding antipsychotic medication), in those patients with depression under the care of a longer-term CMHT who had a comprehensive treatment history: national subsample (n=1763) and your Trust (n=27), at re-audit, 2021.

Appendices

Appendix A: Data use and management

Data control statement for POMH-UK quality improvement programme 19b: Prescribing for depression in adult mental health services

Data ownership and control

Control of the local data submitted to POMH-UK is retained by the healthcare organisation that submitted them. These data have been made available to POMH-UK in a way that is pseudonymous, with the exception of the identity of the source organisation. The aggregate data from all participating organisations are analysed by POMH-UK to produce our customised reports. These reports summarise the national results and local results at organisation and clinical team level, benchmarked anonymously against the other organisations taking part.

Data Sharing

There is a publication strategy allowing POMH-UK to publish the aggregated data on its website and/or in appropriate scientific journals. Any organisations requesting these audit data will be referred to the POMH-UK reports appearing in the public domain or provided with a list of member healthcare organisations and asked to approach them individually. Aggregated data may be shared in limited circumstances where there is clear scientific or public benefit, such as in the development of national, evidence-based treatment guidelines.

POMH-UK may occasionally work in collaboration with other groups or organisations on specific topics that are not part of POMH-UK quality improvement programmes. Member organisations choose to participate in data collection for all topics and retain control of their data. Individual datasets of participating organisations will not be shared with third parties. Anonymous and aggregated data may be shared with collaborators and published.

It is each organisation's decision whether, and with whom, to share their data.

Data for Quality Improvement

Given that the data are collected for the purpose of quality improvement they are not necessarily representative of performance across the Trust. The use of data for ranking or judgement at an organisational level may therefore not be appropriate. Participation in POMH QIPs can be considered to indicate engagement in quality improvement. Relative and absolute performance against the practice standards should always be considered with the above caveats in mind.

Reflection by clinical teams on their benchmarked performance is perhaps the most potent element of POMH-UK programmes. In addition to performance against the clinical standards, the audit data include demographic, diagnostic and other relevant clinical information that provide a context for interpretation and understanding of practice, which can inform local strategies and systems to achieve improvement. The data collected are designed to be suitable for this clinical purpose, and not for objective ranking of healthcare organisations, for which they are untested and would not necessarily be appropriate.

Privacy Notice

In accordance with the General Data Protection Regulation (GDPR) we have updated our privacy notice, which provides full details on how we use your data and the data submitted as part of a national clinical audit, along with our legal basis for doing so. Our privacy notice can be found online via the following link:

https://www.rcpsych.ac.uk/about-us/legal/data-protection/ccqi-privacy-notice

This privacy notice is provided in addition to POMH-UK's data control statement. The data collected by POMH-UK are pseudonymous.

Appendix B: Participating Trusts/ healthcare organisations

Avon & Wiltshire Mental Health Partnership NHS Trust
Barnet, Enfield & Haringey Mental Health NHS Trust
Belfast Health and Social Care Trust
Berkshire Healthcare NHS Foundation Trust
Betsi Cadwaladr University Health Board
Birmingham and Solihull Mental Health NHS Foundation Trust
Bradford District Care NHS Foundation Trust
Cambridgeshire and Peterborough NHS Foundation Trust
Camden and Islington NHS Foundation Trust
Cardiff and Vale University Health Board
Cheshire and Wirral Partnership NHS Foundation Trust
Cornwall Partnership NHS Foundation Trust
Coventry and Warwickshire Partnership Trust
Cumbria, Northumberland Tyne and Wear NHS Foundation Trust
Cwm Taf University Health Board
Cygnet Health Care
Department of Health, Isle of Man
Derbyshire Healthcare NHS Foundation Trust
Devon Partnership Trust
Dorset Healthcare University NHS Foundation Trust
East London NHS Foundation Trust
Elysium Healthcare
Essex Partnership University NHS Foundation Trust
Greater Manchester West Mental Health NHS Foundation Trust
Herefordshire and Worcestershire Health and Care NHS Foundation Trust
Hertfordshire Partnership University NHS Foundation Trust
Humber Teaching NHS Foundation Trust
Kent and Medway NHS and Social Care Partnership Trust
Lancashire and South Cumbria NHS Foundation Trust
Leeds and York Partnership NHS Foundation Trust
Leicestershire Partnership NHS Trust
Lincolnshire Partnership NHS Foundation Trust
Mersey Care NHS Trust
Midlands Partnership NHS Foundation Trust
NAViGO Health and Social Care CIC
Norfolk & Suffolk NHS Foundation Trust
North East London NHS Foundation Trust
North Staffordshire Combined Healthcare NHS Trust
Northamptonshire Healthcare NHS Foundation Trust
Northern Health and Social Care Trust
Nottinghamshire Healthcare NHS Trust
Oxford Health NHS Foundation Trust
Oxleas NHS Foundation Trust
Pennine Care NHS Foundation Trust
Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust
Sheffield Health & Social Care NHS Foundation Trust
Solent NHS Trust
Somerset Partnership NHS Foundation Trust
South Eastern Health and Social Care Trust
South London and Maudsley NHS Foundation Trust
South West London and St George's Mental Health Trust

South West Yorkshire Partnership NHS Foundation Trust
Southern Health and Social Care Trust
Southern Health NHS Foundation Trust
Surrey and Borders Partnership NHS Foundation Trust
Sussex Partnership NHS Foundation Trust
Swansea Bay University Health Board
Tees, Esk and Wear Valleys NHS Foundation Trust
West London NHS Trust
Western Health and Social Care

In line with the Royal College of Psychiatrists College Centre for Quality Improvement (CCQI) equality, diversity and inclusion (EDI) action plan, the demographic Figures below are included to inform Trusts about the profile of their sample.

Appendix C: Demographics of Trust samples

Figure 53: Proportion of males and females: national subsample (n=4742) and each participating Trust/healthcare organisation subsample, at re-audit, 2021.

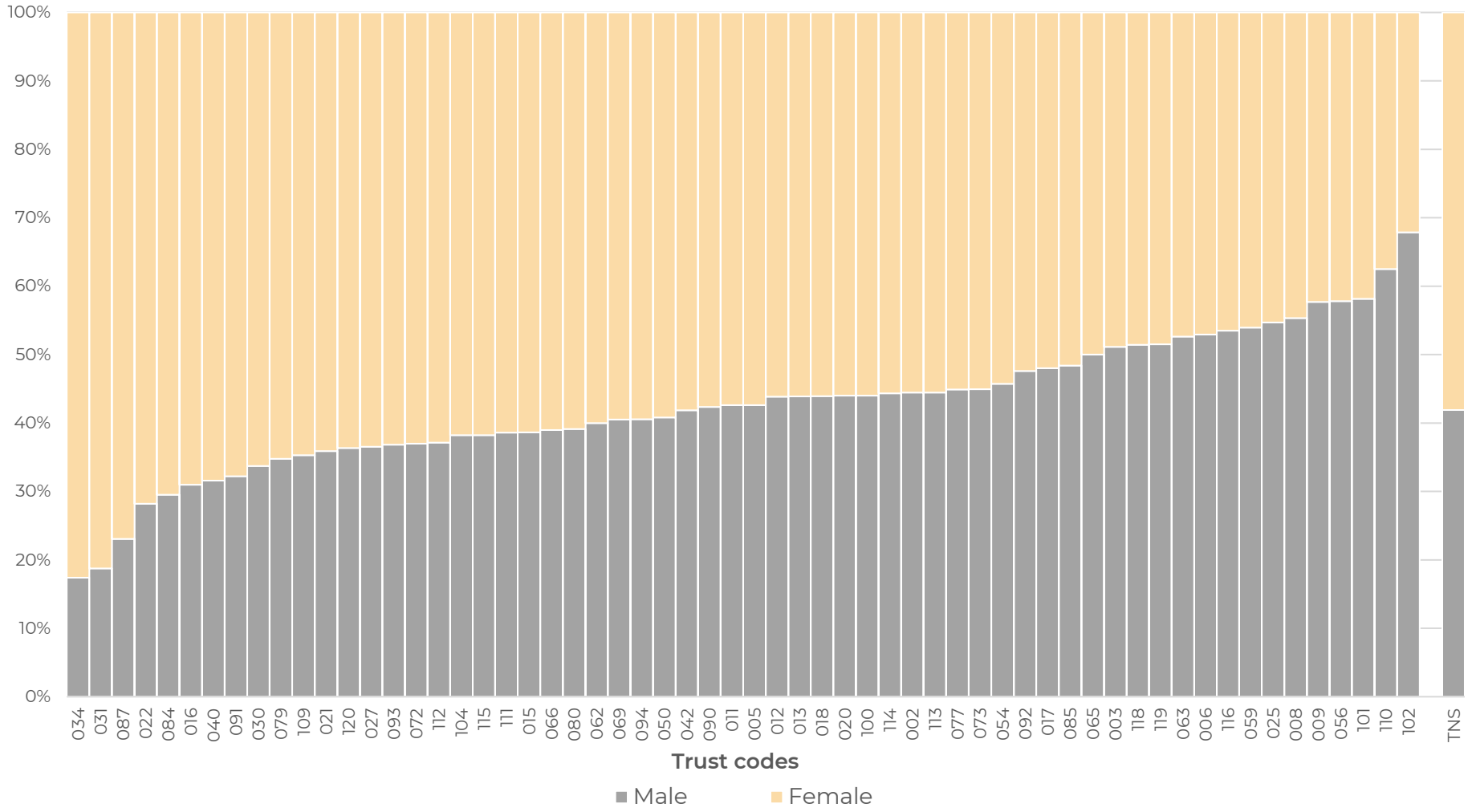


Figure 54: Age bands: national subsample (n=4742) and each participating Trust/healthcare organisation subsample, at re-audit, 2021.

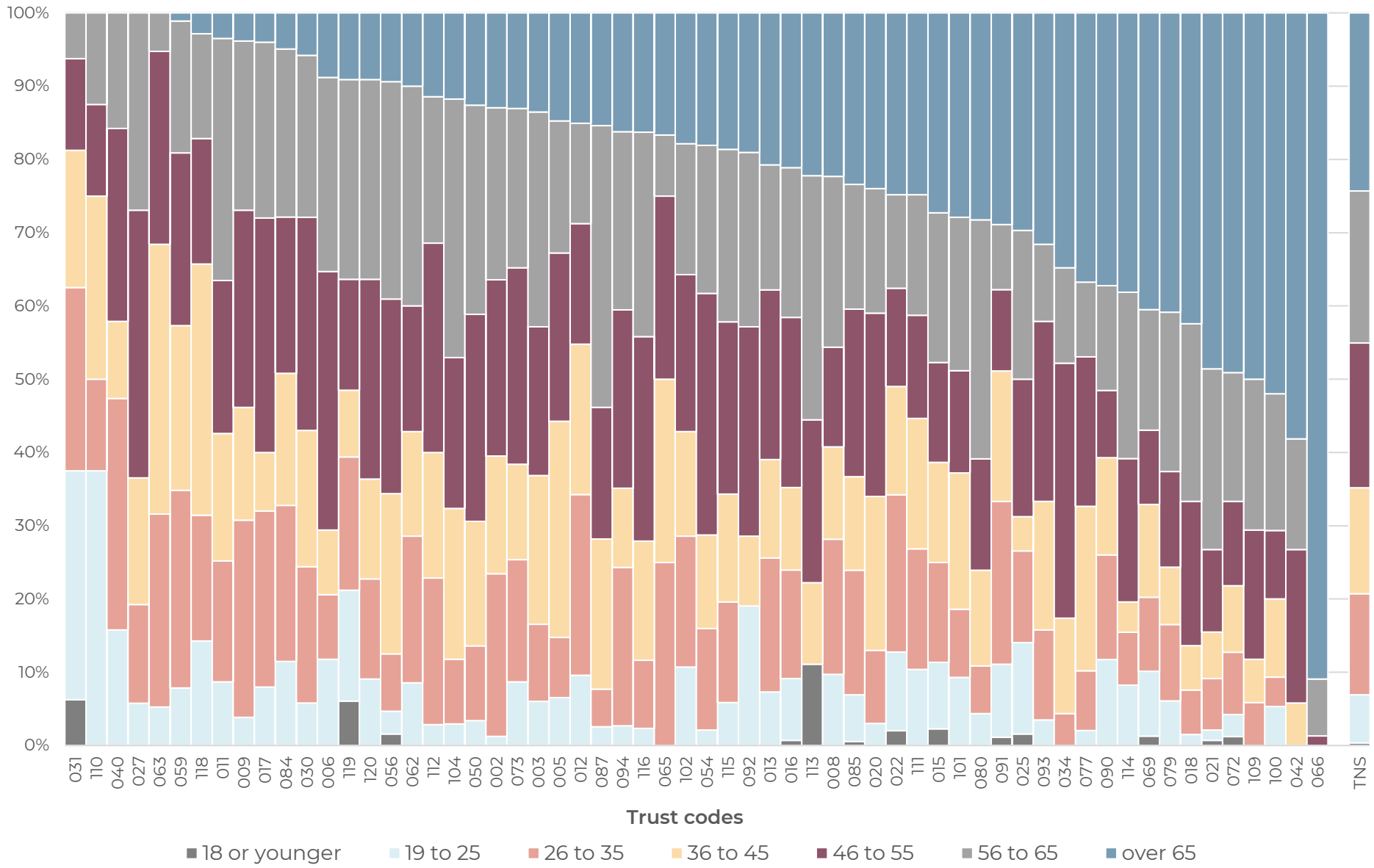
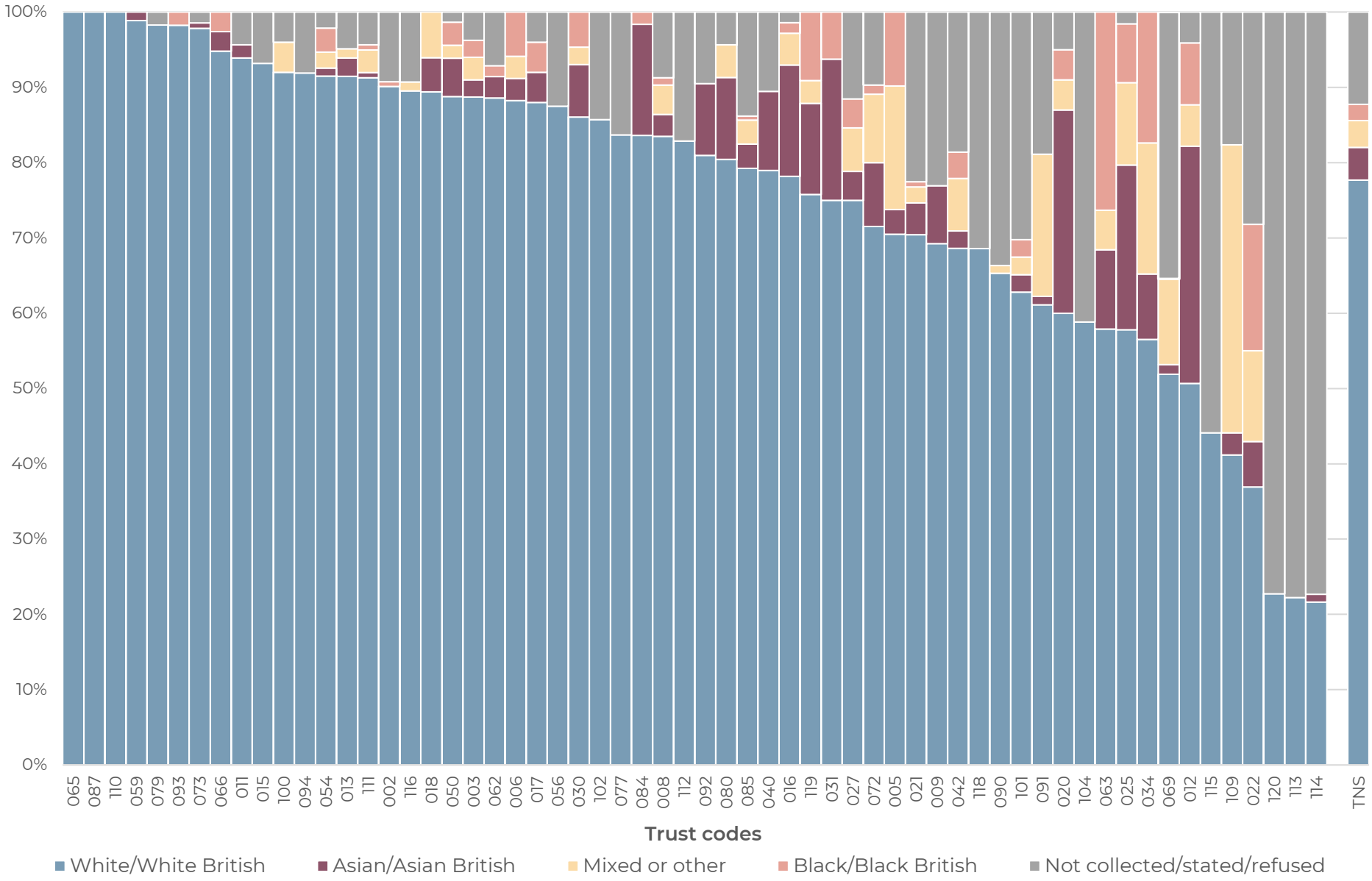


Figure 55: Distribution of ethnic groups: national subsample (n=4742) and each participating Trust/healthcare organisation subsample, at re-audit, 2021.



Appendix D: Audit data collection tool

POMH-UK PRESCRIBING OBSERVATORY FOR MENTAL HEALTH-UK CCQI

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

This data collection tool relates specifically to the following quality improvement programme:

Prescribing for depression in adult mental health services

Topic 19b

Eligibility criteria

Eligible patients will be aged 18 years or older and **EITHER**:

1. Have been discharged, with a diagnosis of depression (ICD10 F32-34), within the last 6 months, with **short-term involvement with an adult community mental health team** (this includes crisis/home treatment teams). This episode of care should NOT have lasted more than 6 months. *Patients referred but not accepted on the team caseload may be included if advice on clinical management was provided to the referrer.*
   OR
2. Have a current diagnosis of depression (ICD10 F32-34) and remain under the care of a **medium** to **long-term adult community mental health team.**

Patients who were admitted to hospital as part of the episode of care are eligible provided that criterion 1 or 2 above is met. Patients with depression in the context of **bipolar disorder are not eligible** for this audit. The presence of comorbid psychiatric disorders will be recorded but they do not render a patient ineligible

Collecting data

To complete this audit form, you should refer to the patient's clinical records. Clinical records include all electronic and paper notes, letters, and other patient information available to the clinical team. Given the nature of the information to be collected, we would advise that a doctor and pharmacist are involved in the completion of this form. Before collecting data, please refer to the **Guidance Notes** at the end of this tool.

Please note that the inclusion of questions in this data collection tool that refer to 'off-label' prescribing should not be taken as an endorsement of the use of the relevant medication for depression.

Submitting data

Data can be submitted online via the POMH Data Entry webpage – you will need your POMH username and password. Before submitting, please read the **Guidance for Online Data Submission** document, available on the POMH Data Entry webpage. If you realise that you have made a mistake in data submission, you will be able to correct this before the data entry period ends. To do this, you will need to ensure you keep a note of the receipt number displayed when the data were submitted. You will not be able to correct your submitted data after the data entry period ends.

To aid the data cleaning process, you may wish to keep a record of the patient ID on the front page of each paper form, for easier identification of cases (you cannot use the submission receipt number for this purpose).

The data collection & data entry: 1 October - 30 November 2021

Data entry closes: 4pm, 30 November 2021

Please contact the POMH-UK team if you have any queries or require further assistance.
Email: pomh-uk@rcpsych.ac.uk / Telephone: 020 8618 4010

Please note that this form is intended for use as part of the POMH-UK Topic 19b quality improvement programme only and may not be suitable for other purposes.

No.	Practice Standards	Sample	Related questions
1	Depression should be managed in primary care unless it is complex, severe, treatment-refractory, or places the patient or others at risk.	All patients discharged from a short-term CMHT in the last 6 months with a diagnosis of depression	10a, 13
2	If antidepressant medication is stopped for whatever reason: • The dose should be reduced gradually • The patient should be informed about potential discontinuation symptoms	All patients not currently prescribed an antidepressant	22 to 26
3a	Patients prescribed continuing antidepressant medication should have a care/crisis plan that: • Identifies potential triggers/precipitating factors that could lead to a worsening of their condition, including psychosocial stressors • Refers to strategies to manage such triggers	All patients currently prescribed an antidepressant, and under the care of a longer-term CMHT	32
3b	For patients prescribed continuing, long-term antidepressant medication, there should be at least annual review addressing: • Therapeutic response to the medication including severity and frequency of depressive episodes • Medication adherence • Medication side effects • Comorbid conditions, including alcohol and substance use and both psychiatric and physical disorders.	All patients currently prescribed an antidepressant and under the care of a longer-term CMHT	33, 34
4	Where the depressive illness has not shown a sufficient response to treatment with an antidepressant medication, the following treatment strategies should be considered: • Increasing the dose of antidepressant medication • Switching to another antidepressant medication • Combining continuing antidepressant treatment with high-intensity psychological/psychosocial interventions, such as individual CBT/interpersonal psychotherapy[3] • Augmentation with another antidepressant medication • Augmentation with lithium • Augmentation with an antipsychotic medication • Augmentation with ECT treatment Please note that the inclusion of questions in this data collection tool that refer to 'off-label' prescribing should not be taken as an endorsement of the use of the relevant medication for depression.	All patients currently prescribed an antidepressant	15, 37

No.	Treatment Target	Sample	Related questions
1	Clinicians should avoid prescribing dosulepin, trimipramine or T3 (liothyronine) for depression.	All patients currently prescribed an antidepressant	13, 21, 28, 31

Data collection

In accordance with the General Data Protection Regulation (GDPR) we have updated our privacy notice, which provides full details on how we use your data and the data submitted as part of a national clinical audit, along with our legal basis for doing so. Our privacy notice can be found online via the following link:

https://www.rcpsych.ac.uk/aboutthecollege/dataprotection/ccqiprivacynotice.aspx

This privacy notice is provided in addition to POMH-UK's data control statement.

The data collected by POMH-UK are pseudonymous. Please ensure the data submitted are limited to data specifically requested by this tool and that you do **not** supply any personally identifiable data, such as a service user's **name**, **full date of birth** or **NHS number**.

If you have any queries concerning the collection and use of personal data, please contact:

Gavin Herrington, Programme Manager Gavin.herrington@rcpsych.ac.uk

Trust and team information

Q1. Trust identifier
Your Trust identifier is a 3-digit code (e.g. 044)

Q2. Team identifier
Your clinical team codes are known only to your Trust. The POMH-UK team does not know your team code.

Q3. Optional additional identifier
This field gives your Trust the option of identifying data by site, directorate, lead consultant, or any other relevant variable. Your Trust can decide whether to use this field.

Enter any numerical code you like in this field and keep a record of what it means. If you don't want to use an additional identifier, simply leave this field blank.

Q4. Initials of data collector
Enter your own initials in this field (e.g. SB). This will enable your team to identify you, should we need to query something about the data that has been entered.

Patient information (complete for ALL patients)

Q5. Patient identifier

Please assign a numerical code to each patient on whom data are collected, for example Joe Bloggs = 1, Jane Bloggs = 2. Keep a record of these codes so you can identify patients for any data cleaning queries.

Q6. Patient's year of birth

(YYYY e.g. 1988)

Q7. Patient's sex as recorded in the clinical records

☐ *Male* ☐ *Female*

Q8. Patient's ethnicity as recorded in the clinical records

☐ *White British/Irish or white other* ☐ *Asian/Asian British* ☐ *Mixed* ☐ *Not collected*

☐ *Black/Black British* ☐ *Other ethnic group* ☐ *Not stated/refused*

Q9. Please indicate which eligibility criterion applies for this patient. Choose one option only.

(See front cover and guidance notes)

- ☐ *A patient who has been discharged, with a diagnosis of depression (ICD10 F32-34), within the last 6 months, with short-term involvement with an adult community mental health team. (Who may or may not have had a short inpatient stay)* **Go to question 10a**
- ☐ *A patient who was referred but not accepted on the caseload of a short-term adult community mental health team but for whom advice on clinical management was provided to the referrer.* **Go to question 10a**
- ☐ *A patient who has been discharged, with a diagnosis of depression (ICD10 F32-34), within the last 6 months, from a home treatment/crisis intervention mental health team.* **Go to question 10a**
- ☐ *A patient with a current diagnosis of depression (ICD10 F32-34) who remains under the care of a medium to long-term community mental health team.* **Go to question 27a**
- ☐ *None of the above**

If 'None of the above', then this patient is not eligible for inclusion in this audit

Please complete the following questions for patients who have been discharged, with a diagnosis of depression (ICD10 F32-34), within the last six months, from a short-term adult community mental health team

Please note that depression in the context of bipolar disorder (F31) is excluded here, as patients who currently have this diagnosis are ineligible for this audit.

Q10a. What was the clinical diagnosis for this episode of depression?

(Please tick all that apply; see guidance notes for further information)

- ☐ *Mild depressive episode (F32.0)*
- ☐ *Moderate depressive episode (F32.1)*
- ☐ *Severe depressive episode without psychotic symptoms (F32.2)*
- ☐ *Severe depressive episode with psychotic symptoms (F32.3)*
- ☐ *Other depressive episode (F32.8)*
- ☐ *Depressive episode unspecified (F32.9)*
- ☐ *Recurrent depressive disorder, current episode mild (F33.0)*
- ☐ *Recurrent depressive disorder, current episode moderate (F33.1)*
- ☐ *Recurrent depressive disorder, current episode severe without psychotic symptoms (F33.2)*
- ☐ *Recurrent depressive disorder, current episode severe with psychotic symptoms (F33.3)*
- ☐ *Recurrent depressive disorder, currently in remission (F33.4)*
- ☐ *Other recurrent depressive disorder (F33.8)*
- ☐ *Recurrent depressive disorder, unspecified (F33.9)*
- ☐ *Dysthymia (F34.1)*
- ☐ *Clinical diagnosis/working diagnosis of depression but no ICD10 code*
- ☐ *None of the above**

If 'None of the above', then this patient is not eligible for inclusion in this audit

Q10b. Other current psychiatric diagnoses *(Please tick all that apply)*

- ☐ *Organic, including symptomatic, mental disorders (F00-F09)*
- ☐ *Mental and behavioural disorders due to psychoactive substance use (F10-F19)*
- ☐ *Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders (F20-F29)*
- ☐ *Other mood (affective) disorders, as defined in ICD-10 F38-39*
- ☐ *Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders (F40-F48)*
- ☐ *Behavioural syndromes associated with physiological disturbances and physical factors (F50-F59)*
- ☐ *Disorders of adult personality and behaviour (F60-F69)*
- ☐ *Intellectual disabilities (F70-F79)*
- ☐ *Disorders of psychological development (F80-F89)*
- ☐ *Behavioural and emotional disorders with onset occurring in early childhood and adolescence (F90-F98)*
- ☐ *Unspecified mental disorder (F99)*
- ☐ *None of the above documented*
- ☐ *Not known/unclear*

Q11. What was the referral source for this patient for this episode of depression?
(Please tick one option only)

- ☐ *Primary care (GP)*
- ☐ *A&E*
- ☐ *Secondary care medical team*
- ☐ *Psychiatric liaison team*
- ☐ *IAPT service*
- ☐ *Other adult community mental health team*
- ☐ *Inpatient adult mental health team*
- ☐ *Self-referral*
- ☐ *Other**

**If other, please specify*

Q12. Month and year of referral to mental health services from the source identified in Q11.

M M Y Y Y Y

Q13. Why was this episode of depression referred to mental health services?
(Please tick all reasons that were identified in the referral)

A risk of suicide	☐
A risk of harm to others	☐
A risk of self-neglect	☐
The presence of psychotic symptoms (hallucinations and/or delusions)	☐
The presence of other mental health and/or physical health needs	☐
Pregnancy or planned pregnancy	☐
An insufficient response of the depressive disorder to two or more attempts to treat with antidepressant medication	☐
An insufficient response of the depressive disorder to psychological intervention/counselling	☐
Patient prescribed dosulepin, trimipramine or T3 (liothyronine) for depression	☐
Review of non-formulary antidepressant medication	☐
An expert assessment and/or advice on the treatment plan was being sought	☐
*Other reason for referral**	☐

**If other, please specify*

Q14a. Which members of the clinical team were involved in the initial clinical assessment?
(Please tick all that apply)

	Patient not directly assessed (advice provided to referrer)	Patient assessed by telephone/ tele-triage	Seen for face-to-face appointment
Consultant psychiatrist	☐	☐	☐
Psychiatrist other than a consultant or foundation trainee	☐	☐	☐
Foundation trainee (FY1 or FY2)	☐	☐	☐
Psychologist	☐	☐	☐
Psychiatric nurse	☐	☐	☐
Social worker	☐	☐	☐
Occupational therapist	☐	☐	☐
*Other**	☐	☐	☐

**If other, please provide details*

Q14b. Which of the following are documented as being included in the referral and/or in the assessment undertaken by the mental health team?

	Yes	No or unclear	Not applicable (as no antidepressant medication prescribed prior to referral)
Medication history	☐	☐	
Therapeutic response to antidepressant medication	☐	☐	☐
Antidepressant side effects	☐	☐	☐
Medication adherence	☐	☐	☐

Q14c. Which of the following are documented as being considered in the referral and/or in the initial assessment undertaken by the mental health team?

	Yes	No or unclear
Patient's treatment preference	☐	☐
The symptoms and severity of the depression using a formal rating scale (e.g. PHQ9, BDI, HADS, HAM-D, QIDS-SR16, MADRS, etc.)	☐	☐
The symptoms and severity of the depression but not using a formal rating scale	☐	☐

Q15. What actions were taken or advised by mental health services during this episode of care?
(Please tick all that apply)

- ☐ *No antidepressant medication prescribed for the patient for this episode*
- ☐ *No change to antidepressant medication already being prescribed for this patient*
- ☐ *Antidepressant medication stopped*
- ☐ *Antidepressant medication started*
- ☐ *The dose of the current antidepressant was increased*
- ☐ *The dose of the current antidepressant was decreased*
- ☐ *Switched to another antidepressant*
- ☐ *Switched to a medication other than an antidepressant (for example, a benzodiazepine)*
- ☐ *Another medication was added to treat symptoms of depression*
- ☐ *Referred for psychological assessment/therapy to treat the depressive disorder*
- ☐ *Further assessment and/or investigations*
- ☐ *Onward referral to another mental health team (including admission to hospital)*
- ☐ *Onward referral to a medical team*
- ☐ *Other**

*If other, please specify

Q16. Was psychological therapy provided during this episode of depression?
(Please tick one option only; see guidance notes)

- ☐ *No psychological therapy provided* ***(go to Q18)***
- ☐ *Psychological therapy offered but declined by the patient* ***(go to Q18)***
- ☐ *On a waiting list for psychological assessment/therapy at discharge* ***(go to Q18)***
- ☐ *Psychological therapy provided by IAPT* ***(go to Q17)***
- ☐ *Psychological therapy provided within mental health services* ***(go to Q17)***
- ☐ *Psychological therapy provided by other organisation, e.g. third sector* ***(go to Q17)***
- ☐ *Unclear whether psychological therapy was offered/provided* ***(go to Q18)***

Q17. Which of the following psychological therapies was provided during this episode of care?
(Please tick all that apply)

- ☐ *Self-help programme*
- ☐ *Behavioural activation*
- ☐ *Cognitive Behaviour Therapy*
- ☐ *Psychodynamic/psychoanalytic psychotherapy*
- ☐ *Interpersonal therapy*
- ☐ *Counselling*
- ☐ *Behavioural couples therapy*
- ☐ *Computerised self-help CBT programme*
- ☐ *Mindfulness*
- ☐ *Don't know/unclear*
- ☐ *Arts therapies (art, music, etc.)*
- ☐ *Other**
- ☐ *Structure physical activity programme (exercise)*

*If other please specify

Q18. Month and year of discharge

M M Y Y Y Y

Q19. What service was the patient discharged to? *(Please tick one option only)*

- ☐ *Not taken on to clinical team caseload. Advice only provided to referrer.*
- ☐ *Admitted to inpatient psychiatric ward*
- ☐ *Discharged to primary care*
- ☐ *Discharged to other community psychiatric team*
- ☐ *Discharged to secondary care medical team/admitted to medical or surgical bed*
- ☐ *Other**

*If other, please specify

Q20a. Did the discharge letter (or letter with clinical advice to referrer at the end of the episode of care) include either of the following? *(Please tick one option only)*

- ☐ *An objective measure of the symptoms and severity of depression at the time of discharge based on a formal rating scale for depression*
- ☐ *An objective measure of the symptoms and severity of depression at the time of discharge NOT based on the use of a formal rating scale for depression*
- ☐ *No documented objective measure of the symptoms and severity of depression at the time of the discharge*

Q20b. Did the discharge letter (or letter with clinical advice to referrer at the end of the episode of care) include the following? *(See guidance notes)*

	Yes	Unclear/ not documented	Not applicable (no medication prescribed for depression)
A treatment plan addressing antidepressant medication/other medication for depression	☐	☐	☐

Q21a. At the point of discharge, was the patient prescribed any of the following medications for depression and/or symptoms associated with depression (or if advice only was provided, were any of the following recommended)?

(Please tick all that apply; see guidance notes)

Aripiprazole ☐	*Lithium* ☐	*Benzodiazepine* ☐
Olanzapine ☐	*T3 (liothyronine)* ☐	*z-hypnotic* ☐
Quetiapine ☐	*Lamotrigine* ☐	*None of the above dcoumented* ☐
Other antipsychotic medication ☐		

Q21b. At the point of discharge, was the patient prescribed any of the following antidepressant medications for the treatment of depression (or if advice only was provided, were any of the following recommended)?

(Please tick all that apply)

Agomelatine ☐	*Fluoxetine* ☐	*Paroxetine* ☐
Amitriptyline ☐	*Fluvoxamine* ☐	*Phenelzine* ☐
Bupropion ☐	*Imipramine* ☐	*Reboxetine* ☐
Citalopram ☐	*Isocarboxazid* ☐	*Sertraline* ☐
Clomipramine ☐	*Lofepramine* ☐	*Tranylcypromine* ☐
Dosulepin ☐	*Mianserin* ☐	*Trazodone* ☐
Doxepin ☐	*Mirtazapine* ☐	*Trimipramine* ☐
Duloxetine ☐	*Moclobemide* ☐	*Venlafaxine* ☐
Escitalopram ☐	*Nortriptyline* ☐	*Vortioxetine* ☐

☐ *One or more of the antidepressants listed above was prescribed/recommended at discharge* ***(go to the end of the form, finish and submit data)***

☐ *None of the above documented* ***(go to Q22)***

Please complete the following questions for patients who were not prescribed antidepressant medication at time of discharge.

Q22. Has this patient received treatment in the last 6 months with any of the following antidepressant medicines? If more than one, please select the most recent. Please enter the treatment dose (that is, the dose prescribed immediately prior to the decision to stop the medication).

Example: 20 mg should be entered as: | | 2 | 0 |

Agomelatine
total oral daily dose, mg

Amitriptyline
total oral daily dose, mg

Bupropion
total oral daily dose, mg

Citalopram
total oral daily dose, mg

Clomipramine
total oral daily dose, mg

Dosulepin
total oral daily dose, mg

Doxepin
total oral daily dose, mg

Duloxetine
total oral daily dose, mg

Escitalopram
total oral daily dose, mg

Fluoxetine
total oral daily dose, mg

Fluvoxamine
total oral daily dose, mg

Imipramine
total oral daily dose, mg

Isocarboxazid
total oral daily dose, mg

Lofepramine
total oral daily dose, mg

Mianserin
total oral daily dose, mg

Mirtazapine
total oral daily dose, mg

Moclobemide
total oral daily dose, mg

Nortriptyline
total oral daily dose, mg

Paroxetine
total oral daily dose, mg

Phenelzine
total oral daily dose, mg

Reboxetine
total oral daily dose, mg

Sertraline
total oral daily dose, mg

Tranylcypromine
total oral daily dose, mg

Trazodone
total oral daily dose, mg

Trimipramine
total oral daily dose, mg

Venlafaxine
total oral daily dose, mg
.

Vortioxetine
total oral daily dose, mg

☐ **None of the above** antidepressant medications prescribed in the last 6 months*

*If 'None of the above', **go to the end of the form, finish and submit data**

13

Q23. For how long had the most recent antidepressant medication been prescribed before it was stopped? *(Please tick one option only)*

☐ *Less than 4 weeks*

☐ *1 month to 3 months*

☐ *More than 3 months*

☐ *Unclear*

Q24. Who made the decision to stop this antidepressant medication?

(Please tick one option only)

☐ *A doctor or other healthcare professional* ***(go to Q25)***

☐ *The patient, but* ***with*** *the knowledge of their doctor and/or other healthcare professional* ***(go to Q25)***

☐ *The patient, but* ***without*** *the knowledge of their doctor and/or other healthcare professional* ***(go to end of form, finish and submit data)***

☐ *Unclear* ***(go to end of form, finish and submit data)***

☐ *Other**

*If other, please specify below, then ***go to end of form, finish and submit data***

Q25. Where the doctor and/or other healthcare professional was involved in the decision to stop antidepressant medication, is there documented evidence that the patient was informed that they could experience antidepressant discontinuation (withdrawal) symptoms?

☐ *Yes*

☐ *Not documented/unclear*

Q26. Where the doctor/other healthcare professional was involved in the decision to stop antidepressant medication, was the antidepressant dose decreased gradually? *(Please tick one option only)*

- ☐ *No, the antidepressant was abruptly stopped*
- ☐ *Yes, the antidepressant dose was decreased in a stepwise manner (i.e. tapered or gradually reduced dose) over a period of* ***less than 4 weeks***
- ☐ *Yes, the antidepressant dose was decreased over a period of* ***more than 4 weeks***

Go to the end of the form. Finish and submit data.

Please complete the following questions for patients who have a current diagnosis of depression ICD10-F32-34 and remain under the care of a medium to long-term adult community mental health team.

Please note that depression in the context of bipolar disorder (F31) is excluded here, as patients who currently have this diagnosis are ineligible for this audit.

Q27a. What was the clinical diagnosis for this episode of depression?

(Please tick all that apply; see guidance notes for further information)

- ☐ *Mild depressive episode (F32.0)*
- ☐ *Moderate depressive episode (F32.1)*
- ☐ *Severe depressive episode without psychotic symptoms (F32.2)*
- ☐ *Severe depressive episode with psychotic symptoms (F32.3)*
- ☐ *Other depressive episode (F32.8)*
- ☐ *Depressive episode unspecified (F32.9)*
- ☐ *Recurrent depressive disorder, current episode mild (F33.0)*
- ☐ *Recurrent depressive disorder, current episode moderate (F33.1)*
- ☐ *Recurrent depressive disorder, current episode severe without psychotic symptoms (F33.2)*
- ☐ *Recurrent depressive disorder, current episode severe with psychotic symptoms (F33.3)*
- ☐ *Recurrent depressive disorder, currently in remission (F33.4)*
- ☐ *Other recurrent depressive disorder (F33.8)*
- ☐ *Recurrent depressive disorder, unspecified (F33.9)*
- ☐ *Dysthymia (F34.1)*
- ☐ *Clinical diagnosis of depression but no ICD10 code*
- ☐ *None of the above**

If 'None of the above', then this patient is not eligible for inclusion in this audit

Q27b. Other current psychiatric diagnosis

- ☐ *Organic, including symptomatic, mental disorders (F00-F09)*
- ☐ *Mental and behavioural disorders due to psychoactive substance use (F10-F19)*
- ☐ *Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders (F20-F29)*
- ☐ *Other mood (affective) disorders, as defined in ICD-10 F38-39*
- ☐ *Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders (F40-F48)*
- ☐ *Behavioural syndromes associated with physiological disturbances and physical factors (F50-F59)*
- ☐ *Disorders of adult personality and behaviour (F60-F69)*
- ☐ *Intellectual disabilities (F70-F79)*
- ☐ *Disorders of psychological development (F80-F89)*
- ☐ *Behavioural and emotional disorders with onset occurring in early childhood and adolescence (F90-F98)*
- ☐ *Unspecified mental disorder (F99)*
- ☐ *None of the above documented*
- ☐ *Not known/unclear*

Medications currently prescribed

Q28. Please indicate which of the following antidepressant medicines the patient is currently, regularly prescribed

Example: 20 mg should be [ ][2][0] entered as:

Agomelatine
total oral daily dose, mg [ ][ ][ ]

Amitriptyline
total oral daily dose, mg [ ][ ][ ]

Bupropion
total oral daily dose, mg [ ][ ][ ]

Citalopram
total oral daily dose, mg [ ][ ][ ]

Clomipramine
total oral daily dose, mg [ ][ ][ ]

Dosulepin
total oral daily dose, mg [ ][ ][ ]

Doxepin
total oral daily dose, mg [ ][ ][ ]

Duloxetine
total oral daily dose, mg [ ][ ][ ]

Escitalopram
total oral daily dose, mg [ ][ ][ ]

Fluoxetine
total oral daily dose, mg [ ][ ][ ]

Fluvoxamine
total oral daily dose, mg [ ][ ][ ]

Imipramine
total oral daily dose, mg [ ][ ][ ]

Isocarboxazid
total oral daily dose, mg [ ][ ][ ]

Lofepramine
total oral daily dose, mg [ ][ ][ ]

Mianserin
total oral daily dose, mg [ ][ ][ ]

Mirtazapine
total oral daily dose, mg [ ][ ][ ]

Moclobemide
total oral daily dose, mg [ ][ ][ ]

Nortriptyline
total oral daily dose, mg [ ][ ][ ]

Paroxetine
total oral daily dose, mg [ ][ ][ ]

Phenelzine
total oral daily dose, mg [ ][ ][ ]

Reboxetine
total oral daily dose, mg [ ][ ][ ]

Sertraline
total oral daily dose, mg [ ][ ][ ]

Tranylcypromine
total oral daily dose, mg [ ][ ][ ]

Trazodone
total oral daily dose, mg [ ][ ][ ]

Trimipramine
total oral daily dose, mg [ ][ ][ ]

Venlafaxine
total oral daily dose, mg [ ][ ][ ] . [ ]

Vortioxetine
total oral daily dose, mg [ ][ ][ ]

None of the above
(please tick) ☐

Other antidepressant
(please specify name)

total oral daily dose, mg [ ][ ][ ] . [ ]

Q29. Please indicate which of the following oral antipsychotic medicines this patient is currently, regularly prescribed.

Amisulpride
total oral daily dose, mg

Aripiprazole
total oral daily dose, mg

Asenapine
total oral daily dose, mg

Benperidol
total oral daily dose, mg

Chlorpromazine
total oral daily dose, mg

Clozapine
total oral daily dose, mg

Flupentixol
total oral daily dose, mg

Haloperidol
total oral daily dose, mg

Levomepromazine
total oral daily dose, mg

Lurasidone
total oral daily dose, mg

Olanzapine
total oral daily dose, mg

Paliperidone
total oral daily dose, mg

Perphenazine
total oral daily dose, mg

Promazine
total oral daily dose, mg

Quetiapine
total oral daily dose, mg

Risperidone
total oral daily dose, mg

Sulpiride
total oral daily dose, mg

Trifluoperazine
total oral daily dose, mg

Zuclopenthixol
total oral daily dose, mg

None of the above (please tick)

Other antipsychotic (please specify)

total oral dose, mg

Q30. Is the patient currently prescribed any of the following depot/long-acting antipsychotic injections? *(Please tick one option only)*

- *Aripiprazole*
- *Flupentixol*
- *Fluphenazine*
- *Haloperidol*
- *Olanzapine*
- *Paliperidone*
- *Risperidone*
- *Pipotiazine*
- *Zuclopenthixol*
- *None of the above documented*

Q31. Are any of the following included in this patient's current medication regimen for the treatment of depression and/or symptoms associated with depression?

(Please tick all that apply and see guidance notes)

- *Benzodiazepine*
- *Bupropion: short term to aid smoking cessation*
- *Bupropion: a continuing prescription for the treatment of depression*
- *Buspirone*
- *ECT*
- *Gabapentin*
- *Ketamine*
- *Lamotrigine*
- *Lithium*
- *L-tryptophan*
- *Pregabalin*
- *Promethazine*
- *Sodium or semi-sodium valproate*
- *St John's Wort*
- *T3 (liothyronine)*
- *Z-hypnotic*
- *None of the above documented*

Q32. Is there a care/crisis plan in place that includes either of the following?

(See guidance notes)

	Yes	**No or unclear**
Identification of potential triggers/precipitating factors that could lead to a worsening of their condition, including psychosocial stressors?		
Reference to strategies to manage such triggers?		

Q33. Has this patient's treatment regimen been reviewed in the past year by the current clinical team?

☐ *Yes* ***(Go to Q34)***

☐ *No or unclear* ***(Go to Q35a)***

Q34. If yes to Q33, were any of the following documented as part of the review?

Q34a. Assessment of symptoms and severity

	Yes	No or unclear
The symptoms and severity of the depression using a formal rating scale (e.g. PHQ9, BDI, HADS, HAM-D, QIDS-SR16, MADRS, etc.)	☐	☐
The symptoms and severity of the depression but not using a formal rating scale	☐	☐

Q34b. Pharmacotherapy issues	**Yes**	**No or unclear** *(See guidance notes)*
Response to medication	☐	☐
Medication adherence	☐	☐
Medication side effects	☐	☐

Q34c. Use of substances	**Yes**	**No or unclear**	**Not applicable** *(see guidance notes)*
Assessment of alcohol use	☐	☐	☐
Assessment of other drug/substance use	☐	☐	☐

Q34d. Presence of comorbid illness

	Co-morbid physical illness
Documented as not present	☐
Documented as present	☐
Unclear	☐

	Co-morbid mental illness
Documented as not present	☐
Documented as present	☐
Unclear	☐

Tobacco smoking

Q35a. Is it documented in the clinical records whether this patient currently smokes tobacco?

☐ *It is documented that the patient is a smoker*

☐ *It is documented that the patient is a non-smoker*

☐ *Smoking status not documented*

Q35b. If this patient does smoke tobacco, have any of the following interventions been documented in the past year? *(Please tick all that apply)*

☐ *Smoking cessation advice/a brief intervention was provided*

☐ *The patient was asked if they would like to reduce/stop their tobacco use*

☐ *A referral to a smoking cessation service was offered/made*

☐ *Nicotine replacement therapy was offered/provided*

☐ *Varenicline was offered/provided*

☐ *Bupropion was offered/provided*

☐ *Other**

**If other please specify*

Medications previously prescribed for depression

Q36. Is there a documented treatment history for this patient? *(See guidance notes)*

☐ *Yes, a comprehensive treatment history is documented* ***(Go to Q37a)***

☐ *Partial treatment history* ***(Please go to the end of this form, finish and submit)***

☐ *No treatment history* ***(Please go to the end of this form, finish and submit)***

Q37a. Excluding the current medication regimen, has this patient been prescribed any of the following treatments for depression in the past?

(Please tick all that apply; see guidance notes)

	Yes (While under the care of the current clinical team)	Yes (Ever)	No or Unclear
An MAOI antidepressant (tranylcypromine, phenelzine or isocarboxazid)	☐	☐	☐
Other MAOI antidepressant (moclobemide)	☐	☐	☐
Two antidepressant medicines (listed in Q28) at the same time	☐	☐	☐
Bupropion for depression	☐	☐	☐
Tricyclic antidepressant (e.g. amitriptyline, clomipramine)	☐	☐	☐
Venlafaxine	☐	☐	☐
Vortioxetine	☐	☐	☐
An antidepressant other than those listed above	☐	☐	☐

Q37b. Excluding the current medication regimen, has this patient been treated with any of the following in the past, either alone or in combination with antidepressant medication?

(Please tick all that apply)

	Yes (While under the care of the current clinical team)	Yes (Ever)	No or Unclear
An oral antipsychotic (listed in Q29)	☐	☐	☐
Lamotrigine	☐	☐	☐
Lithium	☐	☐	☐
ECT	☐	☐	☐
l-trytophan	☐	☐	☐
Ketamine (intra-nasal)	☐	☐	☐
Ketamine (intravenous)	☐	☐	☐
TMS (transcranial magnetic stimulation)	☐	☐	☐
T3 (liothyronine)	☐	☐	☐
Vagal nerve stimulation	☐	☐	☐

Q37c. Has antidepressant medication been combined with any psychological intervention in the past?

(Please tick all that apply)

	Yes	Offered but declined by patient	No	Not known/ unclear
Cognitive Behavioural Therapy	☐	☐	☐	☐
Interpersonal Therapy	☐	☐	☐	☐
Mindfulness-based cognitive therapy	☐	☐	☐	☐
*Other**	☐			

**if other please specify*

END

Finish and submit data

These data should be submitted online to POMH-UK by:

4pm Friday 30 November 2021

If you realise that you have made a mistake submitting the data on this form online, you can edit submitted data before the data entry period ends. Keep a note of the receipt number shown after submission. You will need this to access this submitted form to correct any data entry errors.

You will not be able to correct your submitted data after the data entry period ends.

For further information please contact **POMH-UK@rcpsych.ac.uk**

Guidance notes

Q9 Please note that for one of the first three options to be selected, the patient should have been discharged from the care of the Trust after a short episode of care (not longer than about 6 months). Option four should be chosen when the patient has not been discharged and has continued under care of the Trust for the medium to long-term.

Short-term community teams are known by a variety of names, including Primary Care Plus teams, Community Assessment and Treatment teams, Access and Assessment services, etc.

Some Trusts may not deliver care through short and long-term adult community mental health teams. In such cases, please select the option that best describes the care pathway for the patient. For example, where a patient with depression was referred by a GP and advice was provided by the Trust (perhaps without any face-to-face assessment of the patient), the second option should be chosen.

Q10a The response required here is the current clinical diagnosis. The ICD10 codes are provided as a guide only, and the patient's illness does not need to have been formally allocated an ICD10 code for a diagnosis to be selected. If the sub-type of depression is unclear, please select the option of 'Clinical diagnosis/working diagnosis of depression but no ICD10 code'.

Q16 'Psychological therapy' includes all the specific interventions listed in Q17 but also continuing therapeutic contact with a psychologist where the exact nature of the intervention may be unclear. It does not include clinical assessment or testing by a psychologist.

Q20b The treatment plan regarding medication for depression may be relatively simple. For example, 'to continue on current dose of fluoxetine with regular review' or 'prescribe zopiclone 3.75mg at night for two more weeks then stop'. A treatment plan that does not specify the name of the medication, dose or intended duration of treatment would be considered 'unclear'. For example, 'continue antidepressant treatment'.

Q21a In some cases, it may be helpful to seek the advice of a pharmacist or doctor regarding the appropriate response to select for this question.

Guidance notes (continued)

Q27a The response required here is the current clinical diagnosis. The ICD10 codes are provided as a guide only, and the patient's illness does not need to have been formally allocated an ICD10 code for a diagnosis to be selected. If the sub-type of depression is unclear, please select the option of 'Clinical diagnosis/working diagnosis of depression but no ICD10 code'.

Q31 In some cases, it may be helpful to seek the advice of a pharmacist or doctor regarding the appropriate response to select for this question.

Q32 Potential trigger/precipitating factors might include stress at work, financial worries, relationship difficulties or some other upsetting life event. A more detailed example of a potential trigger/precipitating factor could be the patient's sister coming to stay, which the patient finds stressful and leads to depressive cognitions and insomnia. The care plan could advise that contact with the patient's sister should be of limited frequency and/or duration.

Q34b If this patient was not prescribed any antidepressant medication at the time of the review, please choose the option 'No or unclear'

Q34c 'Not applicable' should be chosen as the option when it has been judged that alcohol and/or substance use are not an issue because of a patient's religious beliefs, social circumstances, etc. and so a formal assessment was not warranted.

Q36 A comprehensive treatment history would include the names, doses and durations of medications previously prescribed, along with some report on symptom response, side effects, and medication adherence. If such details are incomplete or sketchy, then this would be a partial treatment history. For example, 'No response to several trials of SSRI antidepressants'.

Q37a If there is a comprehensive treatment history (often to be found in a hospital discharge summary, a core assessment, court report, or referral letter) then this should allow this question to be answered. If there is no such history available and the data collector is not a member of the patients' clinical team, then it may be helpful to ask a senior member of the team where such information may be found.

Appendix E: POMH-UK central team

Professor Thomas Barnes, Professor Emeritus, Division of Psychiatry, Imperial College London: Joint-Head POMH-UK
Carol Paton, Honorary Research Fellow, Division of Psychiatry, Imperial College London: Joint-Head POMH-UK
Gavin Herrington: Programme Manager
Olivia Rendora: Deputy Programme Manager
Mareeha Khan: Project Officer
Gaia Bove: Project Officer

Expert advisers

Professor Ian Anderson, Professor Emeritus, Division of Neuroscience and Experimental Psychology, The University of Manchester

Professor Phillip Cowen, Professor of Psychopharmacology, Department of Psychiatry, University of Oxford

Professor Sanjay Agrawal, Consultant in Respiratory & Intensive Care Medicine & National Specialty Advisor for Tobacco Dependency NHS England

Appendix F: References

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