Introduction

The rising prevalence and burden of depression worldwide disproportionately affect low- and middle-income countries.¹⁻⁴ Major depressive and bipolar disorders independently increase the risk for other chronic diseases, including cardiovascular disease, metabolic syndrome and obesity.⁵⁻⁶ Higher rates of multimorbidity and poorer physical health outcomes are observed among individuals with mental disorders, relative to those without mental disorders; these factors contribute excess morbidity and mortality among individuals with depression, particularly in low- and middle-income countries.⁷⁻¹²

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Furthermore, the growing awareness of the social determinants of mental disorders provides the impetus to prioritize the development and implementation of evidence-based practices for depression management in low- and middle-income countries.

Clinical practice guidelines translate research into recommendations to standardize care, improve health outcomes and reduce morbidity and mortality. We conducted a systematic review of existing guidelines for the management of depression in adults with major depressive or bipolar disorder. We compared guidelines from low-, middle- and high-income countries to characterize disparities in the development and implementation of guidelines globally.

Methods

We conducted a systematic review concordant with Preferred Reporting Items for Systematic Reviews and Meta-Analyses recommendations. Our protocol was registered in the International Prospective Register of Systematic Reviews (CRD42019124759).

Search strategy

We searched the following online databases from 1994 to January 2019, without language restrictions: Ovid®, MEDLINE®, Embase®, ProQuest PsychINFO®, Web of Science, KCI-Korean Journal, Russian Science Citation Index, and SciELO Citation Index; African Journals Online; PakMediNet; EBSCO CINAHL Plus; and Cochrane Library. We searched titles and abstracts using medical search heading terms and keywords. Text keywords used include, for example: bipolar disorder, depressive disorder, mood disorders, depression*, practice guidelines, evidence-based medicine, guideline*, (medical OR psychiatric association) AND (treatment OR management OR clinical recommendation*). The full search records and details of the grey literature and manual searches are available in the data repository.

Inclusion and exclusion criteria

We included national and international guidelines for the management of depression in adults (aged approximately 18–70 years) with major depressive or bipolar disorder defined by standardized diagnostic criteria. Diagnostic criteria included the International statistical classification of diseases and related health problems, 10th edition (ICD-10) AND the Diagnostic and statistical manual of mental disorders (DSM-IV, DSM-IV-TR and DSM-5). We excluded guidelines published exclusively for the treatment of depressive symptoms in the absence of major depressive or bipolar disorder; developed for use in local regions, hospitals, states or provinces; developed before 1994 (based on, for example, ICD-9 or DSM-III); or with inacessible full-texts (we approached authors for access to full-text publications of relevant guidelines). Guidelines with original and updated recommendations were considered duplicates (the most recent update was reviewed). Additional selection and data extraction processes are available in the data repository.

Quality assessment

We evaluated the quality of the guideline development process by assessing compliance to the Institute of Medicine’s eight standards for clinical practice guidelines: (i) transparency in guideline development processes and funding; (ii) disclosure, management and divestment of conflicts of interest; (iii) multidisciplinary and balanced composition of development group; (iv) recommendations based on a systematic review; (v) rating of evidence quality and strength of recommendation grading; (vi) articulation of recommendations; (vii) external review process; and (viii) schedule for guideline update. A guideline was externally reviewed if it was made available to the general public or target users and relevant stakeholders for comment before its publication. A guideline development group was multidisciplinary and balanced if it included subject-matter experts, clinicians and patient representatives. A guideline met the standard for strength of recommendation grading if all of the following were included for at least three quarters of its recommendations: evidence, harms, benefits, and level of confidence. A guideline clearly articulated its recommendations if each stated recommendation was specific, unambiguous and actionable.

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We adopted measures from the GuideLine Implementability Appraisal and other published criteria to evaluate how amenable each guideline was to implementation. We assessed characteristics of the guideline development process that facilitate the adoption and application of guideline recommendations: attention to ease of implementation; consideration of economic, legal, social and ethical issues; appraisal of economic or resource implications; evaluation of patient preferences; assessment of implementation enablers and barriers; credibility of authoring individuals or organizations; and the provision of tools to facilitate guideline adoption. We assessed a guideline as having considered the ease of implementation if recommendations requiring minimal resources were presented before those requiring more intensive resources. Less intensive interventions were, for example, those with minimal need for highly skilled personnel, medications, and expensive facilities or infrastructure.

We determined the individuals or organizations who authored the guidelines as having credibility if their expertise was concordant with the target audience (for example, a psychiatric association had published recommendations intended for psychiatrists).

The data extraction form is available in the data repository.

**Critical appraisal**

We compared outcome measures between guidelines from high-, upper-middle- and low- or lower-middle-income countries, as classified by the World Bank for the fiscal year of the publication date. We pooled guidelines from low- and lower-middle-income countries for the analysis as there was only one national guideline from a low-income country. Other low-income countries without national guidelines had guidelines as part of international guidelines. We excluded international guidelines from comparisons between income classifications, unless they were developed for countries uniformly belonging to a single income classification.

We evaluated to what extent differences in access to quality health care predict disparities in the quality of guideline development processes observed across income classifications. The median Healthcare Access and Quality index was computed for each income classification group using the most recently published index estimates. The global Healthcare Access and Quality index was 54.4 in 2016; higher indices indicate greater access to quality health care (range: 0–100).

We present numbers and percentages of total number of guidelines across or within income groups, as relevant. We conducted statistical analyses using R software version 3.4.4 (R Foundation for Statistical Computing, Vienna, Austria), with $\alpha = 0.05$. We compared outcomes between income classifications using glm for logistic regressions. We computed incident rate ratios (IRRs) using sandwich::vcovHC to evaluate the association between Healthcare Access and Quality index and guideline development quality.

**Results**

Our database searches yielded 9833 records. After screening the titles and abstracts of non-duplicate records, we reviewed the full texts of 312 records for eligibility (Fig. 1). A total of 95 guidelines from 83 countries met our inclusion criteria (Table 1; available at: http://www.who.int/bulletin/volumes/98/10/20-251405). Fig. 2 (available at: http://www.who.int/bulletin/volumes/98/10/20-251405) illustrates all countries with at least one depression guideline; the countries are grouped by income classification. There were 82 national guidelines and 13 international guidelines.

Of the 13 international guidelines, five were from countries in the same income group. Of the eight guidelines from countries in different income groups, five covered low- or lower-middle-income countries that lacked national guidelines. Guidelines were published in 27 languages, predominantly in the English language (40 guidelines; 42%).

**Target populations and users**

Fifty-two guidelines were specifically developed for major depressive disorder and 33 for bipolar disorder. One guideline was developed for the treatment of mood disorders, four for psychiatric disorders, one for psychiatric and neurological disorders, one for medical and psychiatric disorders, and three for depression in special populations (perinatal depression, major depressive disorder with chronic

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**Fig. 1. Flowchart of the systematic review of guidelines for management of depression**
pain). Guidelines most often targeted psychiatrists (77 guidelines; 81%) and primary care providers (65 guidelines; 68%). Only 19 (20%) and 13 (14%) of guidelines targeted policy-makers and payers (companies or organizations that finance the provision of health services), respectively (Table 2).

### Scope and intent

The majority of guidelines recommended the use of two diagnostic questions to screen for depressive symptoms: “During the past two weeks, have you often been bothered by little interest or pleasure in doing things” and “During the past two weeks, have you often been bothered by feeling down, depressed or hopeless.”125

#### Table 2. Target audience and scope of guidelines for the management of depression, by country-level income classification

| Variable | No. (%) of guidelines by income group | High income | Upper-middle income | Low- and lower-middle income | International |
|----------|--------------------------------------|-------------|---------------------|-----------------------------|---------------|
| **Target audience** | | | | | |
| Psychiatrists | 52 (90) | 15 (68) | 6 (86) | 4 (50) |
| Primary care providers | 43 (74) | 13 (59) | 3 (43) | 6 (75) |
| Other specialists | 34 (59) | 11 (50) | 2 (29) | 2 (25) |
| Psychologists | 32 (55) | 11 (50) | 2 (29) | 0 (0) |
| Nurses | 31 (53) | 9 (41) | 2 (29) | 1 (13) |
| Patients | 19 (33) | 0 (0) | 1 (14) | 0 (0) |
| Policy-makers | 14 (24) | 2 (9) | 1 (14) | 2 (25) |
| Payers | 9 (16) | 3 (14) | 1 (14) | 0 (0) |
| **Scope and intent** | | | | | |
| Comorbidities | | | | | |
| Psychiatric | 41 (71) | 14 (64) | 5 (71) | 5 (63) |
| Cardiometabolic | 41 (71) | 11 (50) | 4 (57) | 2 (25) |
| Screening* | 36 (62) | 17 (77) | 4 (57) | 0 (0) |
| Primary prevention | 10 (17) | 4 (18) | 2 (29) | 0 (0) |
| Work-related decision support | 14 (24) | 1 (5) | 0 (0) | 0 (0) |

* The majority of guidelines recommended the use of two diagnostic questions to screen for depressive symptoms: “During the past two weeks, have you often been bothered by little interest or pleasure in doing things” and “During the past two weeks, have you often been bothered by feeling down, depressed or hopeless.”125

Notes: Country income groups are World Bank classifications.20 International guidelines are from countries in different income groups. Total number of guidelines included: high-income countries: 58; upper-middle-income countries: 22; low- or lower-income countries: 7; international (different income groups): 8.

The recommendations were often limited to the discussion of standardized scales for measuring work-related impairment, factors moderating patients’ return to work, resources for supporting patient employment or occupational rehabilitation and regional disability legislations. The guidelines from Colombia, Finland, Netherlands and Sweden recommended that patients continue to work, unless otherwise indicated, and advised patients and clinicians to discuss work-related factors that may hinder recovery.66,92,102,114,115 Notably, the Swedish bipolar disorder guideline listed an employment rate of 50% among patients as a national target.122

### Development processes

The quality of the guideline development processes varied across country income classifications. The median number of standards met was five (interquartile range: 3–7) for high-income country guidelines, two (interquartile range: 1–4) for upper-middle-income country guidelines and one (interquartile range: 0–1.5) for low- or lower-middle-income country guidelines. The World Health Organization (WHO) guidelines, developed specifically for low- and lower-middle-income countries,21 met all but one Institute of Medicine-defined standard (systematic review of cost-effectiveness).

Sixty-eight guidelines (72%) provided specific, unambiguous and actionable recommendations, representing 44 of 58 (76%), 13 of 22 (59%) and three of seven (43%) of guidelines from high-, upper-middle- and low- or lower-middle-income countries, respectively (Fig. 3).

The guideline development processes and funding sources were explicitly specified in 51 guidelines (54%), only two of which originated in low- or lower-middle-income countries. Potential conflicts of interest were openly declared and managed in a higher proportion of guidelines from high-income (36 guidelines; 62%) versus upper-middle-income (six guidelines; 27%) and low- or lower-middle-income countries (two guidelines; 29%).

Only 25 guidelines (26%) were developed by a multidisciplinary group
comprising subject experts, clinicians and patients or patient advocates. Development groups often lacked patient or patient advocacy representation. None of the low- or lower-middle-income country guidelines had a multidisciplinary development group.

A systematic review of comparative effectiveness of interventions being recommended had been carried out by 57 guidelines (60%), all of which were developed by international authorship groups or in high- or upper-middle-income countries. Some guidelines from low- or middle-income countries were based on recommendations of other published international guidelines. Only 10 guidelines (11%), all from high- and upper-middle-income countries, had conducted a systematic review of cost-effectiveness of a particular intervention or set of recommendations.

Forty guidelines (42%) included with their recommendations ratings of evidence, harms, benefits, and confidence level. More guidelines from high-income countries (27 guidelines; 47%) met the Institute of Medicine’s standard for strength of recommendation grading. Thirty-five guidelines (37%) had been externally reviewed (for example, by being posted for public comment or reviewed by stakeholders external to the development group); none of these guidelines originated in low- or lower-middle-income countries.

Thirty-eight guidelines (40%) stated plans to renew or update their recommendations, excluding three guidelines that were withdrawn past the scheduled updating date. Fewer guidelines provided a scheduled date for renewal (26 guidelines; 27%). The scheduled renewal date of these guidelines was often within 3–5 years of the publication date (mean: 4 years; standard deviation; SD: 2). Notwithstanding, 49 guidelines (52%) were revisions, of which 17 guidelines were published within 5 years of the previous iteration. On average, guidelines were revised within 7 years (SD: 3). How frequently and how recently revisions were published were similar between high- and middle-income countries (Fig. 3). None of the guidelines from low- or lower-middle-income countries stated plans to revise recommendations or included a renewal date.

The median Healthcare Access and Quality index was significantly greater among guidelines from high-income countries.
countries (median: 90.6; interquartile range: 88.8–94.0) relative to those from upper-middle-countries (median: 68.5; interquartile range: 66.3–77.9) and low- or lower-middle-income-country (median: 51.2; interquartile range: 41.2–61.7; $\chi^2 = 156.2$, degrees of freedom $= 72$; $P < 0.001$; Fig. 4). Guidelines from countries with higher Healthcare Access and Quality indices met more Institute of Medicine-defined standards (IRR: 1.03; robust SE: 0.006).

**Facilitators and barriers of implementation**

The target patient population and intended users were clearly defined in 93 (98%) and 79 (83%) guidelines, respectively. The authors of 75 guidelines (79%) met criteria for credibility with the intended audience (Fig. 5). Most of these guidelines originated in high-income countries (52 guidelines).

Target users or patient representatives evaluated enablers and barriers to the implementation of 24 guidelines (25%); 11 guidelines involved both target users and patient representatives, 11 guidelines involved target users without patient representatives and two guidelines involved only patient representatives in the evaluation of enablers and barriers. None of the guidelines from low- or lower-middle-income countries evaluated enablers and barriers to implementation.

Twenty-one guidelines (22%) evaluated patient preferences by conducting literature reviews of patient preferences or by including patient representatives in the guideline development group, as external reviewers or as members of focus groups. None of the low- or lower-middle-income country guidelines evaluated patient preferences.

Twenty-four guidelines (25%) ordered their recommendations by ease of use (for example, using a stepped-care model). For management of mild depression, these guidelines recommended low-intensity psychosocial and psychological interventions (for example, physical activity, psychoeducation, sleep modification or computerized cognitive behavioural therapy) before pharmacological interventions (for example, selective serotonin reuptake inhibitors) or high-intensity psychological interventions (for example, cognitive behavioural therapy or interpersonal psychotherapy). Whether a guideline had ordered recommendations by ease of use varied across income classifications.

Eighteen guidelines (19%), mostly from high-income countries (15 guidelines), evaluated the resource implications of implementing guideline recommendations. Five guidelines described personnel, infrastructure and training requirements for each recommendation in detail. Costs and other economic considerations informed the development of 29 guidelines (30%), 24 of which were from high-income countries. Several European guidelines conducted modelling analyses to project the cost–effectiveness and budget impact of their recommendations.

The number of guidelines that considered legal or ethical issues did not vary across income classifications. Twenty-five guidelines (26%) discussed various legal aspects of patient care, such as involuntary treatment of psychiatric patients, certification requirements for professionals providing psychotherapy, availability of antidepressants across national regulatory agencies, national work or disability legislations and statutory patient rights. Twenty-one guidelines (22%) discussed ethical considerations relevant to care provision, such as risks versus benefits of taking medications while pregnant or breastfeeding and obtaining informed patient consent before initiating electroconvulsive therapy or off-label drug usage.

Thirty-nine guidelines (41%) discussed social aspects affecting patient care or illness presentation, such as race or ethnicity, and advised clinicians to
consider patient factors, such as social support availability, interpersonal relationship quality, workplace or other factors influencing recovery, childhood trauma and developmental disabilities. Other guidelines, for example, emphasized the importance of adapting guidelines to local contexts and training end-users to be culturally sensitive. Some guidelines commented on the lack of availability of personnel with sufficient training in some areas of the country and the implications of this for clinical care. More guidelines from high-income countries (29 guidelines; 50%) were informed by social considerations when compared to upper-middle-income (seven guidelines; 32%) and low- or lower-middle-income (none) countries.

**Monitoring implementation**

Thirty-three guidelines (35%), mostly from high-income countries (25 guidelines), operationalized monitoring or auditing criteria for assessing the implementation of guidelines. These guidelines suggested quality indicators or measures of guideline concordance, such as the proportion of patients prescribed lithium or a selective serotonin reuptake inhibitor for at least four weeks.

Fifteen guidelines (16%), none of which were from low- or lower-middle income countries, described plans for assessing implementation of guidelines or adherence to guideline recommendations (Fig. 4). However, none of these guidelines provided plans to assess whether these actions would improve health or functional outcomes or cost–effectiveness.

Guidelines described, for example, available health administrative data sets or national electronic medical records that could be used to assess measures of guideline implementation and quality indicators. The Swedish National Quality Register for Bipolar Disorder included longitudinal data from 244 active health-care providers and approximately 30% of patients with bipolar disorder in Sweden. Quality indicators included the percentages of patients diagnosed with a structured diagnostic instrument, receiving psychoeducation, currently employed or who relapsed with a recurrent mood episode in 12 months, as well as sex and regional differences in lithium prescription. The National Institute for Health and Care Excellence in England measured the adoption of some recommendations across mental health guidelines, such as the proportion of people with subthreshold or mild-to-moderate depression receiving low-intensity psychosocial interventions. WHO described the adoption of the Mental Health Gap Action Programme in 18 Member States, with a focus on informing future implementation plans and characterizing implementation enablers and barriers.

Sixty-five guidelines (68%) provided tools for guideline application, such as a quick reference summary. More high-income country (47/58) and international (6/8) guidelines provided implementation tools. Twenty-four guidelines (25%) described plans for disseminating guidelines, 29 of which originated in high-income countries.

**Discussion**

We found that many low- and lower-middle-income countries, especially in Africa, lacked published clinical practice guidelines for the management of depression. However, international guidelines exist that cover or specifically target these countries. While the overarching aim of guidelines is to improve health outcomes and cost–effectiveness, it remains unclear to what extent guidelines for the management of depression are being implemented and improving health outcomes, particularly in low- and lower-middle-income countries. Most guidelines lacked plans to assess quality indicators or recommendation implementation. We were unable to identify any national guidelines that included government-sanctioned incentives, such as remuneration, for adhering to guideline recommendations or penalties for not implementing recommendations at point-of-care. A notable exception, not included in the present review, is a guideline for adults with mood disorders from Florida, United States of America. The guideline is integrated into an e-health infrastructure and mandated to be implemented with practitioner concordance monitoring. Government policies that require health-care providers to adhere to recommendations, via health insurance disbursement for example, may facilitate the implementation of guidelines and monitoring of effectiveness.

The disparities in availability, development processes and quality of guidelines underscore an unmet need for decision support in low- and middle-income countries. Due to limitations in access to resources, health-care personnel in low- and middle-income countries are additionally constrained in their ability to provide timely and appropriate patient care. Barriers to the application of standard interventions in many low-resource settings include limitations in the availability of interventions (for example, regulatory approval of certain medicines or acquisition costs) and patient access to health-care professionals (for example, specialist fees, rural regions and private versus public clinics). Limitations in the availability of facilities and resources to monitor serum drug levels and liver or renal function (for example, with lithium treatment) may further limit access to treatments in low-resource settings. Patients receiving medications may further limit access to treatments in low-resource settings.

Low- and middle-income countries are differentially affected by multimorbidity, which drastically reduces life expectancy and increases personal, social and economic burden. Not only is the prevalence of noncommunicable diseases escalating globally, but the risks of infectious diseases have not declined in low- and middle-income countries, further increasing the burden and complexity of managing chronic conditions in these countries. However, only 50–67% of low- and middle-income country guidelines provided recommendations for the assessment and management of psychiatric or cardiometabolic comorbidities in depression. Future guidelines should provide guidance for screening and managing multimorbidity in adults with depression.

Most guidelines for the management of depression provided tools for the application of guideline recommendations, such as a summary document or a quick-reference guide. However, less than one fifth of the guidelines we identified provided materials for patients; fewer targeted policy-makers or payers. Guideline implementation requires diversity in the engagement of target audiences and stakeholders, as well as realistic and relevant implementation plans. Future guidelines, therefore, need to be developed collaboratively by a broader collective of stakeholders.
Guideline development groups should include experts in experimental, observational and contextual evidence and knowledge users (such as clinicians and patient advocates). However, less than one third of guidelines for depression globally included a multidisciplinary development group; in comparison, approximately 64% (36/56) of guidelines for diabetes mellitus and 52% (12/23) of guidelines for hypertension were developed by a multidisciplinary authorship group. Many guidelines for depression identified in our study were developed without target-user representatives or patient advocates who would be able to provide guidance on the appropriateness, translatability, feasibility and acceptability of guideline recommendations.

Guidelines endeavour to comprehensively review and corroborate knowledge of intervention efficacy, effectiveness, safety and tolerability. Guidelines must also be informed by an evaluation of the determinants, processes and outcomes of implementing evidence-based recommendations. However, while 60% of guidelines for the management of depression identified herein were based on a systematic review of intervention efficacy and effectiveness literature, only 25% of guidelines evaluated enablers and barriers to implementation. Such gaps in the development processes of existing guidelines may limit the implementation of guidelines for mood disorders. Future guidelines for the management of depression should involve a combination of international and local collaboration, taking into consideration contextual factors that may facilitate or hinder access to health services or treatments. Contextual factors that may be relevant include, for example, structural or policy aspects of the health-care system, education and training; access to treatment methods for depression; and availability of modern technology.

The main aim of our initiative was to facilitate guideline dissemination, especially in low- and middle-income countries. The integration of technology may also facilitate chronic disease management. The guiding principles include prioritizing the involvement of stakeholder and end-user input in any policy around implementation, identification of those people most at risk, and appraisal of local health-care resources.

The paucity of depression guidelines from low-income countries may reflect limitations in our search strategy (for example, the African Journals Online database primarily includes articles published in English). We were more likely to identify guidelines available online than in print only. To mitigate this possibility, we contacted members of the Global Alliance for Chronic Diseases and members of national psychiatric or other medical associations across geographical and linguistic world regions. Database searches may miss guidelines published as government reports or in formats other than peer-reviewed journal articles or meeting abstracts. To improve the likelihood of detecting such guidelines, we manually searched the websites of multiple national and international medical associations and ministries of health and included experts from 27 countries across all continents in our collaboration. Thus, the possible selection bias in our search is unlikely to confound our findings of differences in guideline quality and development across economic strata.

Our large number of evaluators may have resulted in differences in data extraction. However, we completed blinded evaluations in duplicate using structured evaluation forms; a third reviewer independently evaluated all forms. In addition, guidelines were evaluated by two or three reviewers who had not been involved in their development.

The focus of our analysis on guidelines may inadequately capture separate implementation studies of guidelines. Future research should primarily evaluate implementation studies of guidelines. We limited our inclusion criteria to national and international guidelines, which may not capture more regional or local differences in guideline development or implementation. Our comparison of guidelines by country-level income classification and Healthcare Access and Quality index did not consider differences in the availability and accessibility of health care within individual countries. Much of the available research informing guideline recommendations has been conducted in high-income countries, with an over-representation of Caucasian groups, often overestimating patient access to expensive medications and specialized care.

In conclusion, the implementation of guidelines for the management of depression is inadequately planned, reported and measured. As a result, it remains unknown to what extent guidelines are acceptable to patients and other target users; are feasible and cost-effective; and improve health outcomes. Narrowing the disparities in the development and implementation of guidelines, particularly in low- and middle-income countries, is a priority. Refinement of decision support processes in depression is a critical first step towards the aim of reducing morbidity, especially in low- and middle-income countries. Future guidelines should present strategies to implement recommendations and measure feasibility, cost-effectiveness and impact on health outcomes, co-designed by stakeholders and experts with practical (experiential) knowledge from low- and middle-income countries.

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وضع المبادئ التوجيهية للتعامل مع الاكتئاب وتنفيذها: مراجعة منهجية

المستخلص

الغرض تقييم عملية وضع المبادئ التوجيهية للممارسة السريرية للتعامل مع الاكتئاب وتنفيذها على مستوى العالم. لقد حددنا مبادئ التوجيهية الحالية الخاصة بالتعامل مع الاكتئاب لدى البالغين المصابين بالاكتئاب أو الاكتئاب ثنائي القطب، وتم وضع عدد أقل من المبادئ التوجيهية (29/82%) في البلدان منخفضة الدخل ومتوسطة الدخل، مثل مقاومة البلدان المرتفعة الدخل، وتم وضع عدة أقل من المبادئ التوجيهية (29/22%) في البلدان منخفضة الدخل ومتوازنة الدخل، بالمقارنة مع البلدان منخفضة الدخل. وتم إجراء مراجعة منهجية (35%) للمبادئ التوجيهية ذات الدخل المرتفع. لم يتم التخطيط لعملية تنفيذ المبدأ التوجيهي، وإبلاغ الممارسين، وتقييم المبادئ التوجيهية، وقياس الجدوى، وفعالية التكلفة، والتأثير على النتائج الصحية.

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Systematic reviews
Depression guidelines in low- and middle-income countries
Yena Lee et al.

Résumé
Développement et mise en œuvre des directives pour la gestion de la dépression: revue systématique
Objectif Évaluer le développement et la mise en œuvre des directives de pratique clinique pour la gestion de la dépression dans le monde.
Méthodes Nous avons effectué une revue systématique des directives existantes en matière de gestion de la dépression chez les adultes souffrant de troubles dépressifs majeurs ou de troubles bipolaires. Pour chaque directive identifiée, nous avons vérifié le degré de conformité vis-à-vis des mesures de qualité du développement des directives (transparence des processus d’élaboration des directives et de leur financement, composition multidisciplinaire du groupe d’auteurs, revue systématique des études d’efficacité comparative) ainsi que de la mise en œuvre (indicateurs de qualité). Nous avons confronté les directives des pays à faible et moyen revenu avec celles des pays à haut revenu.
Résultats Nous avons identifié 82 directives de pratique clinique nationales et 13 directives de pratique clinique internationales dans 83 pays et en 27 langues. Les processus d’élaboration des directives et les sources de financement étaient explicitement indiquées dans une moindre proportion chez les pays à faible et moyen revenu (8/29; 28%) par rapport aux pays à haut revenu (35/58; 60%). Le nombre de directives rédigées par un groupe d’auteurs multidisciplinaire était moins élevé dans les pays à faible et moyen revenu (2/29; 7%) que dans les pays à haut revenu (22/58; 38%). Une revue systématique de l’efficacité comparative a été menée pour 31% (9/29) des directives dans les pays à faible et moyen revenu, contre 71% (41/58) des directives dans les pays à haut revenu. Seulement 10% (3/39) des directives émises par les pays à faible et moyen revenu et 19% (11/58) de celles émises par les pays à haut revenu comprenaient un programme d’évaluation des indicateurs de qualité ou de l’adhérence aux recommandations.
Conclusion La mise en œuvre des directives est mal planifiée, mal analysée et mal mesurée. Réduire les disparités de développement et de mise en œuvre des directives dans les pays à faible et moyen revenu est une priorité. À l’avenir, ces directives devraient prévoir des stratégies d’exécution des recommandations, mais aussi d’évaluation de la faisabilité, de la rentabilité et de l’impact sur l’état de santé.

Резюме
Разработка и внедрение рекомендаций по лечению депрессии: систематический обзор
Цель Оценить разработку и внедрение практических клинических рекомендаций по лечению депрессии в глобальном масштабе.
Методы Авторы выполнили систематический обзор существующих практических клинических рекомендаций по лечению депрессии у взрослых с клинической депрессией или маниакальными расстройствами. Всем идентифицированным клиническим рекомендациям была дана оценка по соответствию критериям качества разработки клинических рекомендаций (таких как прозрачность процессов разработки клинических рекомендаций и финансирования, балансировочный состав группы авторов, систематический обзор сравнительных исследований эффективности) и реализации (например, показателя качества). Авторы сравнили клинические рекомендации из стран с низким и средним уровнем доходов и из стран с высоким уровнем доходов.
Результаты Было выявлено 82 национальных и 13 международных клинических рекомендаций из 83 стран на 27 языках. Процессы разработки клинических рекомендаций и источники финансирования были четко указаны в меньшем количестве клинических рекомендаций из стран с низким и средним уровнем доходов (8/29; 28%) по сравнению со странами с высоким уровнем доходов (35/58; 60%). Меньше количество клинических рекомендаций (2/29; 7%) из стран с низким и средним уровнем доходов по сравнению со странами с высоким уровнем доходов (22/58; 38%) было разработано мультиспециалистской группой авторов. Систематический обзор сравнительной эффективности был выполнен в 31% (9/29) клинических рекомендаций из стран с низким и средним уровнем доходов по сравнению с 71% (41/58) клинических рекомендаций из стран с высоким уровнем доходов. Только в 10% (3/39) клинических рекомендаций из стран с низким и средним уровнем доходов и в 19% (11/58) клинических рекомендаций из стран с высоким уровнем доходов описаны планы по оценке показателей качества или приверженности соблюдения рекомендаций.
Вывод В глобальном масштабе при внедрении клинических рекомендаций вопросы планирования, оценки и имерения показателей внедрения решаются неадекватно. Приоритетной задачей является приближение стандартов разработки и внедрения клинических рекомендаций в странах с низким доходами и в странах с высоким уровнем доходов.
Resumen
Elaboración e implementación de directrices para el tratamiento de la depresión: una revisión sistemática

Objetivo
Evaluar la elaboración e implementación de las directrices de práctica clínica para el tratamiento de la depresión a nivel mundial.

Métodos
Se realizó una revisión sistemática de las directrices existentes para el tratamiento de la depresión en adultos con trastorno depresivo mayor o bipolar. Para cada directriz identificada, se evaluó el cumplimiento de las medidas de calidad de elaboración de directrices (como la transparencia en los procesos de elaboración de directrices y su financiamiento, la composición del grupo multidisciplinario de autores, la revisión sistemática del estudio de eficacia comparativo) y la implementación (como los indicadores de calidad). En este contexto, se compararon las directrices de los países de ingresos bajos y medios con las de los países de ingresos altos.

Resultados
Se identificaron las directrices de práctica clínica a nivel nacional (82) y a nivel internacional (13) de 83 países en 27 idiomas. Los procesos de elaboración de directrices y las fuentes de financiamiento se especificaron de manera explícita en un porcentaje menor de directrices de los países de ingresos bajos y medios (8/29; 28%) en relación con las de los países de ingresos altos (35/58; 60%). Un grupo de desarrollo multidisciplinario elaboró menos directrices (2/29; 7%) para los países de ingresos bajos y medios, en relación con las de los países de ingresos altos (22/58; 38%). Además, se realizó una revisión sistemática sobre la efectividad comparativa en el 31% (9/29) de las directrices de los países de ingresos bajos y medios, frente al 71% (41/58) de las directrices de los países de ingresos altos. Solo el 10% (3/29) de las directrices de los países de ingresos bajos y medios y el 19% (11/58) de las directrices de los países de ingresos altos describieron planes para evaluar los indicadores de calidad o el cumplimiento de las recomendaciones.

Conclusión
La implementación de las directrices no se planifica, ni evalúa de manera adecuada a nivel mundial. Es prioritario reducir las desigualdades en la elaboración y la implementación de las directrices en los países de ingresos bajos y medios. Las directrices que se elaboren en el futuro deberán presentar estrategias para implementar las recomendaciones y evaluar la viabilidad, la rentabilidad y el impacto en los resultados sanitarios.

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| Author | Country or territory | Income group | Year | Organization | Scope |
|--------|----------------------|--------------|------|--------------|-------|
| American Psychiatric Association, 2002<sup>a</sup> | USA | High | 2002 | American Psychiatric Association | Bipolar disorder |
| Ibijaro, 2005<sup>b</sup> | United Kingdom | High | 2004 | World Organization of Family Doctors Special Interest Group in Psychiatry & Psychology | Major depressive disorder |
| Bauer, 2007<sup>c</sup> | Argentina, Australia, Austria, Belgium, Brazil, Czechia, Denmark, France, Germany, Hungary, Ireland, Italy, Japan, Mexico, Norway, Poland, Republic of Korea, Romania, Russian Federation, Spain, Switzerland, United Arab Emirates, United Kingdom, USA | International | 2007 | World Federation of Societies of Biological Psychiatry | Major depressive disorder |
| Ministry of Health of Malaysia, 2007<sup>d</sup> | Malaysia | Upper-middle | 2007 | Ministry of Health of Malaysia; Ministry of Education of Malaysia; Malaysian Psychiatric Association; Academy of Medicine | Major depressive disorder |
| Ministry of Health of Sarajevo canton, Institute for Scientific Research & Development, & Clinical Center of the University of Sarajevo, 2007<sup>e</sup> | Bosnia and Herzegovina | Lower-middle | 2007 | Bosnia and Herzegovina Ministry of Health | Major depressive disorder |
| Selslak, 2007<sup>f</sup> | Denmark | High | 2007 | Ministry of Health of Denmark | Major depressive disorder |
| Latin American Psychiatric Association, 2008<sup>g</sup> | Argentina, Bolivia (Plurinational State of), Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Mexico, Paraguay, Peru, Puerto Rico, Uruguay, Venezuela (Bolivarian Republic of) | Upper-middle | 2008 | Latin American Psychiatric Association | Major depressive disorder |
| National Institute for Health and Care Excellence, 2009<sup>h</sup> | United Kingdom (England, Wales) | High | 2009 | National Institute for Health and Care Excellence; National Collaborating Centre for Mental Health; British Psychological Society; Royal College of Psychiatrists | Major depressive disorder |
| Norwegian Medical Association, 2009<sup>i</sup> | Norway | High | 2009 | Ministry of Health of Norway | Major depressive disorder |
| American Psychiatric Association, 2010<sup>j</sup> | USA | High | 2010 | American Psychiatric Association | Major depressive disorder |
| Federal Government Agency & Mexican Social Insurance Institute, 2010<sup>k</sup> | Mexico | Upper-middle | 2010 | Ministry of Health of Mexico; Mexican Social Insurance Institute | Bipolar disorder |
| Grune et al., 2010<sup>l</sup> | Argentina, Australia, Austria, Belgium, Brazil, Chile, Czechia, Denmark, France, Germany, Hungary, India, Italy, Mexico, Netherlands, Norway, Peru, Poland, Russian Federation, Spain, Switzerland, United Kingdom, USA | International | 2010 | World Federation of Societies of Biological Psychiatry | Bipolar disorder |
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| Author | Country or territory | Income group | Year | Organization | Scope |
|--------|----------------------|--------------|------|--------------|-------|
| Ministry of Public Health of Thailand, 2010 | Thailand | Upper-middle | 2010 | Ministry of Public Health of Thailand | Major depressive disorder |
| National Institute for Health and Care Excellence, 2009 | United Kingdom (England, Wales) | High | 2010 | National Institute for Health and Care Excellence; National Collaborating Centre for Mental Health; British Psychological Society; Royal College of Psychiatrists | Major depressive disorder with chronic physical health problem |
| Park et al., 2014 | Republic of Korea | High | 2010 | Korean Neuropsychiatric Association | Major depressive disorder |
| Scottish Intercollegiate Guidelines Network, 2010 | United Kingdom (Scotland) | High | 2010 | Scottish Intercollegiate Guidelines Network; National Health Service Quality Improvement Scotland | Major depressive disorder |
| Strejilevich et al., 2010 | Argentina | Upper-middle | 2010 | Argentine Association of Mood Disorders | Bipolar disorder |
| United States Department of Veterans Affairs, 2010 | USA | High | 2010 | Veterans’ Health Administration, Department of Defense | Bipolar disorder |
| Brazilian Psychiatric Association, Brazilian Federation of Gynecology and Obstetrics & Brazilian Society of Family and Community Medicine, 2011 | Brazil | Upper-middle | 2011 | Brazilian Psychiatric Association, Brazilian Federation of Gynecology and Obstetrics & Brazilian Society of Family and Community Medicine | Major depressive disorder |
| Chinese Medicine Association, Chinese Medicine Association Brain Diseases Professional Committee; National Chinese Medicine Administration National Key Encephalology Key Specialist Depression Collaboration Group, 2011 | China | Upper-middle | 2011 | Chinese Medicine Association Brain Diseases Professional Committee, National Chinese Medicine Administration National Key Encephalology Key Specialist Depression Collaboration Group | Major depressive disorder |
| Mok et al., 2011 | Singapore | High | 2011 | Ministry of Health of Singapore | Bipolar disorder |
| Chua et al., 2012 | Singapore | High | 2012 | Ministry of Health of Singapore | Major depressive disorder |
| Ministry of Health of Portugal, 2012 | Portugal | High | 2012 | Ministry of Health of Portugal | Bipolar disorder |
| Ministry of Health of Portugal, 2012 | Portugal | High | 2012 | Ministry of Health of Portugal | Major depressive disorder |
| Ministry of Health of Serbia, 2012 | Serbia | Upper-middle | 2012 | Ministry of Health of Serbia | Major depressive disorder |
| Ministry of Health, Social Services and Equality, 2012 | Spain | High | 2012 | Ministry of Health, Social Services and Equality of Spain | Bipolar disorder |
| Norwegian Medical Association, 2012 | Norway | High | 2012 | Ministry of Health of Norway | Bipolar disorder |
| Scottish Intercollegiate Guidelines Network, 2012 | United Kingdom (Scotland) | High | 2012 | Scottish Intercollegiate Guidelines Network; National Health Service Quality Improvement Scotland | Peripartum mood and anxiety disorders |
| Bai et al., 2013 | China, Taiwan | High | 2013 | Taiwanese Society of Biological Psychiatry and Psychopharmacology | Bipolar disorder |
### Systematic reviews

#### Depression guidelines in low- and middle-income countries

| Author | Country or territory | Income group | Year | Organization | Scope |
|--------|----------------------|--------------|------|--------------|-------|
| Bauer et al., 2013 | Argentina, Australia, Austria, Belgium, Brazil, China (Taiwan), Czechia, Denmark, Germany, Hungary, Ireland, Italy, Japan, Mexico, Norway, Republic of Korea, Romania, Russian Federation, Poland, Spain, Switzerland, Turkey, United Arab Emirates, United Kingdom, USA | International | 2013 | World Federation of Societies of Biological Psychiatry | Major depressive disorder |
| Begić et al., 2013 | Croatia | High | 2013 | Croatian Psychiatric Association | Major depressive disorder |
| Chinese Medical Association Society of Neurology, Department of Neuropsychology and Behavioral Neurology, Chinese Medical Association Neurology Branch Parkinson's Disease and Movement Disorders Group, 2013 | China | Upper-middle | 2013 | Chinese Medical Association Society of Psychiatry, Department of Neuropsychology and Behavioral Neurology; Chinese Medical Association Neurology Branch Parkinson's Disease and Movement Disorders Group; Chinese Medical Association Neurology Branch, Department of Neuropsychology and Behavioral Neurology | Depressive, anxiety, and psychotic disorders in Parkinson's disease |
| Federation of Medical Specialists; Dutch Association for Psychiatry, 2013 | Netherlands | High | 2013 | Federation of Medical Specialists; Dutch Association for Psychiatry | Major depressive disorder |
| Finnish Medical Association Duodecim, Finnish Psychiatric Association; Finnish Society for Adolescent Psychiatry, 2013 | Finland | High | 2013 | Finnish Medical Association Duodecim; Finnish Psychiatric Association; Finnish Society for Adolescent Psychiatry | Bipolar disorder |
| Gómez-Restrepo et al., 2012 | Colombia | Upper-middle | 2013 | Ministry of Health of Columbia | Major depressive disorder |
| Grunze et al., 2013 | Argentina, Australia, Austria, Chile, Czechia, Belgium, Brazil, Denmark, France, Germany, Hungary, India, Italy, Japan, Mexico, Netherlands, Norway, Peru, Portugal, Russian Federation, Switzerland, Turkey, United Kingdom, USA | International | 2013 | World Federation of Societies of Biological Psychiatry | Bipolar disorder |
| Mental Health Directorate, Ministry of Health of Peru, 2013 | Peru | Upper-middle | 2013 | Peru Ministry of Health, Pan American Health Organization | Major depressive disorder |
| Ministry of Health of Chile, 2013 | Chile | High | 2013 | Ministry of Health of Chile | Major depressive disorder |
| Russian Society of Psychiatrists, 2013 | Russian Federation | Upper-middle | 2013 | Russian Society of Psychiatrists | Bipolar disorder |
| Russian Society of Psychiatrists, 2013 | Russian Federation | Upper-middle | 2013 | Russian Society of Psychiatrists | Major depressive disorder |
| South African Society of Psychiatrists, 2013 | South Africa | Upper-middle | 2013 | South African Society of Psychiatrists | Psychiatric disorders |
| Chinese Medical Association Society of Psychiatry, 2014 | China | Upper-middle | 2014 | Chinese Medical Association Society of Psychiatry | Bipolar disorder |

(continued...)
### Systematic reviews

**Depression guidelines in low- and middle-income countries**

| Author | Country or territory | Income group | Year | Organization | Scope |
|--------|----------------------|--------------|------|--------------|-------|
| Li-Sheng et al., 2014; Chinese Medical Association, Society of Psychiatry | China | Upper-middle | 2014 | Chinese Medical Association Society of Psychiatry | Major depressive disorder |
| Czech Psychiatric Society, 2014 | Czechia | High | 2014 | Czech Psychiatric Society | Psychiatric disorders |
| Kessing et al., 2014 | Denmark | High | 2014 | Ministry of Health of Denmark | Bipolar disorder |
| Ministry of Health of Malaysia, 2014 | Malaysia | Upper-middle | 2014 | Ministry of Health of Malaysia; Ministry of Education of Malaysia; Malaysian Psychiatric Association; Academy of Medicine | Bipolar disorder |
| Ministry of Health of Ukraine, 2014 | Ukraine | Lower-middle | 2014 | Ministry of Health of Ukraine; Ukrainian Psychiatric Association | Major depressive disorder |
| Ministry of Health, Social Services and Equality, 2014 | Spain | High | 2014 | Ministry of Health, Social Services and Equality of Spain | Major depressive disorder |
| National Institute for Health and Care Excellence, 2014 | United Kingdom (England, Wales) | High | 2014 | National Institute for Health and Care Excellence; National Collaborating Centre for Mental Health; British Psychological Society; Royal College of Psychiatrists | Bipolar disorder |
| Romanian Society of Psychiatry and Psychotherapy; Romanian Society of Biological Psychiatry and Psychopharmacology, 2014 | Romania | Upper-middle | 2014 | Romanian Society of Psychiatry and Psychotherapy; Romanian Society of Biological Psychiatry and Psychopharmacology | Psychiatric disorders |
| Samalin et al., 2014 | France | High | 2014 | French Society for Biological Psychiatry and Neuropsychopharmacology | Bipolar disorder |
| Swedish Psychiatric Association, 2014 | Sweden | High | 2014 | Swedish Psychiatric Association | Bipolar disorder |
| Bauer et al., 2015 | Argentina, Australia, Austria, Belgium, Brazil, China (China, Taiwan), Czechia, Denmark, Germany, Hungary, Italy, Ireland, Japan, Mexico, Norway, Poland, Republic of Korea, Romania, Russian Federation, Spain, Switzerland, Turkey, United Arab Emirates, United Kingdom, USA | International | 2015 | World Federation of Societies of Biological Psychiatry | Major depressive disorder |
| Cleare et al., 2015 | United Kingdom | High | 2015 | British Association for Psychopharmacology | Major depressive disorder |
| Council for the Use of Animal Hospital Medicine, 2015 | Denmark | High | 2015 | Council for the use of Animal Hospital Medicine | Bipolar disorder |
| Council for the Use of Animal Hospital Medicine, 2015 | Denmark | High | 2015 | Council for the use of Animal Medicine | Major depressive disorder |
| Dominican Society of Psychiatry, 2015 | Dominican Republic | Upper-middle | 2015 | Dominican Society of Psychiatry | Major depressive disorder |
| Federal Government Agency & Mexican Social Insurance Institute, 2015 | Mexico | Upper-middle | 2015 | Ministry of Health of Mexico, Mexican Social Insurance Institute | Major depressive disorder |

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(continues)
| Author | Country or territory | Income group | Year | Organization | Scope |
|--------|----------------------|--------------|------|--------------|-------|
| Federation of Medical Specialists; Dutch Association for Psychiatry, 2015 | Netherlands | High | 2015 | Federation of Medical Specialists; Dutch Association for Psychiatry | Bipolar disorder |
| Malhi et al., 2015 | Australia, New Zealand | High | 2015 | Royal Australian and New Zealand College of Psychiatrists | Major depressive disorder; bipolar disorder |
| Qaseem et al., 2016 | USA | High | 2016 | American College of Physicians | Major depressive disorder |
| Danish Health Authority, 2016 | Denmark | High | 2016 | Ministry of Health of Denmark | Major depressive disorder |
| Finnish Medical Association Duodecim; Finnish Psychiatric Association, 2016 | Finland | High | 2016 | Finnish Medical Association Duodecim; Finnish Psychiatric Association | Major depressive disorder |
| Goodwin et al., 2016 | United Kingdom | High | 2016 | British Association for Psychopharmacology | Bipolar disorder |
| Japanese Society of Mood Disorders, 2012 | Japan | High | 2016 | Japanese Society of Mood Disorders | Major depressive disorder |
| Jobst et al., 2016 | Austria, Germany, Hungary, Netherlands, Spain, Sweden, Switzerland, United Kingdom | High | 2016 | European Psychiatric Association | Major depressive disorder |
| Kennedy et al. 2016 | Canada | High | 2016 | Canadian Network for Mood and Anxiety Treatments | Major depressive disorder |
| Ministry of Health of Uganda, 2016 | Uganda | Low | 2016 | Ministry of Health of Uganda | Medical and psychiatric disorders |
| Triangle et al., 2016 | USA | High | 2016 | Institute for Clinical Systems Improvement | Major depressive disorder |
| United States Department of Veterans Affairs, 2016 | USA | High | 2016 | Veterans’ Health Administration, Department of Defense | Major depressive disorder |
| World Health Organization, 2016 | World Health Organization Member States | International | 2016 | World Health Organization | Mental, neurological, and substance use disorders |
| Akwa GGZ, 2017 | Netherlands | High | 2017 | GGZ Standards for Dutch Association of Mental Health and Addiction Care | Bipolar disorder |
| Charpeaud, 2017 | France | High | 2017 | French Society for Biological Psychiatry and Neuropsychopharmacology | Major depressive disorder |
| Fountoulakis et al., 2017 | Austria, Brazil, Canada, China (China, Taiwan), Germany, Israel, Japan, Republic of Korea, Sweden, United Kingdom, USA | High | 2017 | International College of Neuropsychopharmacology | Bipolar disorder |
| Gautam et al., 2017 | India | Lower-middle | 2017 | Indian Psychiatric Society | Major depressive disorder |
| German Society for Bipolar Disorder and German Society of Psychiatry, Psychotherapy and Nervous Diseases, 2018 | Germany | High | 2017 | German Society for Bipolar Disorder; German Society of Psychiatry, Psychotherapy and Nervous Diseases | Major depressive disorder |
## Systematic reviews

Depression guidelines in low- and middle-income countries

| Author                                                                 | Country or territory                                                                 | Income group | Year | Organization                                                                 | Scope                      |
|------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------|------|------------------------------------------------------------------------------|----------------------------|
| Grunze et al., 2017<sup>24</sup>                                        | Argentina, Australia, Austria, Canada, Chile, Czechia, Denmark, France, Germany, Hungary, Japan, Netherlands, Poland, Portugal, Romania, Russian Federation, Spain, Switzerland, United Kingdom, USA | International | 2017 | World Federation of Societies of Biological Psychiatry                        | Bipolar disorder           |
| Japanese Society of Mood Disorders, 2017<sup>67</sup>                    | Japan                                                                                | High         | 2017 | Japanese Society of Mood Disorders                                            | Bipolar disorder           |
| Ministry of Public Health of Ecuador, 2017<sup>78</sup>                  | Ecuador                                                                             | Upper-middle | 2017 | Ministry of Public Health of Ecuador                                           | Major depressive disorder  |
| Okasha et al., 2017<sup>22</sup>                                        | Algeria, Bahain, Comoros, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Mauritania, Morocco, Oman, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, West Bank and Gaza Strip, Yemen | International | 2017 | Arab Federation of Psychiatrists                                               | Major depressive disorder  |
| Philippine Psychiatric Association, 2017<sup>69</sup>                    | Philippines                                                                          | Lower-middle | 2017 | Philippine Psychiatric Association                                            | Bipolar disorder           |
| Philippine Psychiatric Association, 2017<sup>69</sup>                    | Philippines                                                                          | Lower-middle | 2017 | Philippine Psychiatric Association                                            | Major depressive disorder  |
| Piotrowski et al., 2017<sup>111</sup>                                    | Poland                                                                               | High         | 2017 | Polish Psychiatric Association – Wroclaw Division, the Polish Society of Family Medicine and the College of Family Physicians | Major depressive disorder  |
| Seo et al., 2018<sup>112</sup>                                           | Republic of Korea                                                                    | High         | 2017 | Korean College of Neuropsychopharmacology; Korean Society for Affective Disorders | Major depressive disorder  |
| Shah et al., 2017<sup>113</sup>                                         | India                                                                                | Lower-middle | 2017 | Indian Psychiatric Society                                                    | Bipolar disorder           |
| Swedish National Board of Health and Welfare, 2017<sup>74</sup>          | Sweden                                                                               | High         | 2017 | Swedish National Board of Health and Welfare                                  | Major depressive disorder  |
| Akwa GGZ, 2018<sup>115</sup>                                            | Netherlands                                                                          | High         | 2018 | GGZ Standards for Dutch Association of Mental Health and Addiction Care       | Major depressive disorder  |
| Chinese Medical Association Chinese Society of Psychiatry, Bipolar Disorder Coordination Group, Chinese Medical Association Psychiatric Branch, 2018<sup>116</sup> | China                                                                                | Upper-middle | 2018 | Chinese Medical Association Psychiatric Branch                                | Bipolar disorder           |
| Japanese Society of Mood Disorders; Japanese Association of Occupational Therapists, 2018<sup>117</sup> | Japan                                                                                | High         | 2018 | Japanese Society of Mood Disorders; Japanese Association of Occupational Therapists | Major depressive disorder  |
| Woo et al., 2018<sup>118</sup>                                          | Republic of Korea                                                                    | High         | 2018 | Korean College of Neuropsychopharmacology; Korean Society for Affective Disorders | Bipolar disorder           |
| Yatham et al., 2018<sup>119</sup>                                        | Australia, Brazil, Canada, Japan, Spain, USA                                        | High         | 2018 | Canadian Network for Mood and Anxiety Treatments; International Society for Bipolar Disorders | Bipolar disorder           |

(continues...)
| Author | Country or territory | Income group | Year | Organization | Scope |
|--------|----------------------|--------------|------|--------------|-------|
| Dutch General Practitioners Association, 2019 | Netherlands | High | 2019 | GGZ Standards for Dutch Association of Mental Health and Addiction Care | Major depressive disorder |
| German Society for Bipolar Disorder and German Society of Psychiatry, Psychotherapy and Nervous Diseases, 2019 | Germany | High | 2019 | German Society for Bipolar Disorder; German Society of Psychiatry, Psychotherapy and Nervous Diseases | Bipolar disorder |
| Samochowiec et al., 2019 | Poland | High | 2019 | Polish Psychiatric Association | Major depressive disorder |

* Country income groups are World Bank classifications. International guidelines are from countries in different income groups.
Fig. 2. Map of countries with published guidelines for management of depression by country income classification

Notes: Country income groups are World Bank classifications. We identified 95 guidelines from 83 countries. Countries without national or international guidelines for depression are depicted in white. World Health Organization (WHO) Member States without at least one national or international guideline (other than the WHO guideline) were excluded from the total count of 83 countries and not shaded in the map.