National Institute for Health and Clinical Excellence

Depression in chronic health problems
Guideline Consultation Comments Table
3rd March – 28th April 2009

Type (NB this is for internal purposes – remove before posting on web)
SH = Registered Stakeholders. These comments and responses will be posted on the NICE website when the guideline is published.
PR = Peer Reviewers or Experts. These comments and responses will be posted on the NICE website when the guideline is published.
GRP = Guidelines Review Panel member. These are added to this table for convenience but will not be posted on the web.
NICE = Comments from NICE. These are added to this table for convenience but will not be posted on the web.
NR = Comments from organisations and people who have not registered as stakeholder. These are added for convenience but will not be posted on the web.
Colour coding key: Rec no's highlighted blue = taken from Dep Up
Rec no's highlighted grey = taken from original Depression

No	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
11	SH	Association for Family Therapy and Systemic Practice	1	Full	General		We are pleased to comment on the draft guideline.	Thank you for your comment.
12	SH	Association for Family Therapy and Systemic Practice	2	Full	General		The evidence base for Family and Systemic Psychotherapy is sound, covering a range of problems for adults and children, often using research methods that fit psychological therapies rather than RCT. ▪ The Report on the Evidence Base of Systemic Family Therapy (Stratton, P) can be found on the AFT website: www.aft.org.uk. ▪ Asen, E. (2002): Outcome research in family therapy. Advances in Psychiatric Treatment. 8.230-238. ▪ Carr, A. (2009): The effectiveness of family therapy and systemic interventions for adult focused problems. Journal of Family Therapy. 31. 46-74. **A review of the costs:** Russell Crane, D., Payne, S.H. (in press): Individual and Family Therapy in Managed Care: Comparing the costs of treatments of the mental health professions	Thank you for your comment, however many of the studies you refer to are beyond the scope of the guideline.
13	SH	Association for Family Therapy and Systemic Practice	3	Full	General		The Tavistock Clinic offers a various relevant courses, including: Working With Families With Physical Illness: A Systemic Approach.	Thank you for your comment however specific reference to courses is beyond the scope of the

								guideline.
102	SH	Association for Family Therapy and Systemic Practice	4	Full	4.3.3	59 - 63	Family & Systemic therapy can be used to address the experiences that are described, since this would strengthen supportive relationships, and address the way that people deal with their distress about serious illness, and the impact on individuals and families.	Thank you for your comment, however no studies on depression and chronic physical health problems were identified concerning systemic therapy.
103	SH	Association for Family Therapy and Systemic Practice	5	Full	4.3.4	63	Dilemmas about how to maintain important family roles (partners, parents, siblings and children) are important when the severity of chronic illness demands caring roles and responsibilities, particularly when these are stressful or distressing. These can be addressed by Family and Systemic therapy.	Thank you for your comment, however no studies on depression and chronic physical health problems were identified concerning systemic therapy.
104	SH	Association for Family Therapy and Systemic Practice	6	Full	4.4.3 4.4.7	66 – 69 72 – 75	Many of the psychosocial issues covered would be addressed within Family & Systemic Therapy, if this could be more available, with an emphasis on helping families to manage their feelings and recognise their strengths, so that they are able to sustain the roles demanded of them during depression + chronic health problems.	Thank you for your comment, however no studies on depression and chronic physical health problems were identified concerning systemic therapy.
106	SH	Association for Family Therapy and Systemic Practice	7	Full	4.6	77-79	One important issue needs to be included, the impact of a parent's depression on children. The literature below focuses on depression, but the issues are likely to be relevant for those with chronic health problems too, since support systems will be important for both the parent with depression and chronic health problems and his / her children, as well as offering ways to address shift issues associated with emotional problems in children of depressed parents. ▪ Pickering, C. (2004): When a parent suffers from an affective disorder: effect on the child. In Göpfert, M, Webster, J. & Seeman, M.: Parental psychiatric disorder: Distressed parents and their families (2nd ed) Cambridge University Press. Cambridge. ▪ Keitner & Miller (1990): Family functioning and major depression: an overview. American Journal of Psychiatry. 9. 1128-1137. ▪ Goodman, S.H. & Gotlib, I.H. (2002): Children of depressed parents: mechanisms of risk and implications for treatment. American Psychological Association. Washington DC	Thank you for your comment, the detail you suggest is beyond the scope of the guideline. We feel the recent guidance by SCIE addresses this issue.
107	SH	Association for Family Therapy and Systemic Practice	8	Full	4.8	80	Parenting roles need to be included, so that the needs of the children can be considered and assessed because of the significant impact of a parent's depression on their children. 'A checklist for professionals coming into contact with	Thank you for your comment, the detail you suggest is beyond the scope of the guideline. We feel the recent guidance by SCIE addresses this issue.

							children of parents with mental health problems:' http://www.carers.org/data/files/checklist-professionals-2357.pdf Resources on policies and good practice for work with children can be found on the Parental Mental Health and Child Welfare Network website: www.pmhcwn.org.uk	
128	SH	Association for Family Therapy and Systemic Practice	9	Full	5.3	94	AFT places emphasis on cultural competence, sensitivity and respect for different within family therapy training, in order to engage families as well as to understand and work with the needs and experiences of BME families (including for refugees). South London and Maudsley NHS Trust is currently in discussion with BME carers contributing to the development of a family and carer strategy for the Trust. One of the themes is the fear amongst the BME community of psychiatric services and how difficult / racist experiences of mental health services in the past still influence the BME community's overall trust of mental health professionals.	Thank you for your comment, but we feel that recommendation 1.1.3.3 covers these issues.
208	SH	Association for Family Therapy and Systemic Practice	10	Full	7	148	There is evidence that Family and Systemic Therapy is effective with depression addressing various issues within family relationships and depression. Working with families opens up a range of problems that extend beyond the primary referral issue. ▪ Leff, Vearnals, Brewin, Wolff, Alexander, Asen, Dayson, Jones, Chisholm and Everitte (2000): The London Depression Intervention Trial: Randomised controlled trial of antidepressants v, couple therapy in the treatment and maintenance of people with depression living with a partner: clinical outcome and costs. British Journal of Psychiatry. 177. 95-100. ▪ Jones, E. and Asen, E. (2002): Systemic couple therapy and depression. Karnac. London ▪ Lemmens, G., Eisler, I., Migerode, L., Heireman, M., Demyttenaere, K. (2007): Family discussion group therapy for major depression: Journal of family therapy. 29.1.49-68. ▪ Lemmen, et al (in press): The effects on mood of adjunctive single family and multi-family group therapy in the treatment of hospitalised patients with major depression: a 15 month follow up study. Psychotherapy and psychosomatics.	Thank you for your comment, these studies were not included as in the case of Leff and colleagues (2000) it did not meet inclusion criteria (as it did not relate to those with Depression with Chronic Health Problems) and Lemmens and colleagues (2007) was not a randomised controlled trial and was not related to those with Depression and Chronic Health Problems.
209	SH	Association for Family Therapy and Systemic Practice	11	Full	7	148	There is evidence of the effectiveness of multiple family groups with chronic physical health problems: Steinglas, P. (1998): Multiple family discussion groups for patients	Thank you for drawing our attention to this reference. However, the study does not meet our inclusion

							with chronic medical illness. Families, Systems and Health. 16: 55-70.	criteria as it is not a RCT.
218	SH	Association for Family Therapy and Systemic Practice	12	Full	7.2	155	Family and Systemic Therapy should be included, which includes systemic couple therapy. Family and Systemic Therapy helps families to support each other and acknowledge their different experiences, beliefs and perspectives so they can move forward. Depending on the nature of the relationship problems associated with depression and chronic health problems, work can be done with individuals, couples and /or families, with single families or in multifamily groups, to find ways of addressing their problems and develop resilience.	Thank you very much for this comment. We have reviewed the data and we were unable to find any convincing evidence for family and systemic therapy to support its inclusion in this guideline. Of course this does not mean that such interventions are not indeed very helpful. However it is difficult for us to make specific recommendations about this when we have been unable to find any evidence with which to support such a recommendation.
109	SH	Association for Family Therapy and Systemic Practice	13	Full NI CE	4.8.1 1.1.3	80 11	The families may have young children who feel responsible for a caring role and therefore consideration needs to be given to their needs and the wider support networks, see issues covered in 4.3 of the full version	Thank you for your comment, unfortunately this is beyond the scope of the guideline.
134	SH	Association for Family Therapy and Systemic Practice	14	Full NI CE	5.6.1 1.1.4	101 12	Given the evidence of negative consequences for children who have a parent with depression, the assessments should include consideration of the impact of depression and chronic health problems on parenting (see comments 7, 8)	Thank you for your comment, the detail you suggest is beyond the scope of the guideline.
101	SH	Association for Family Therapy and Systemic Practice	15	Full NI CE	4.3 1.1.5	80 13 - 14	Given the impact of depression and chronic health problems on close relationships addressed in some detail in the Full version (4.3), consideration should be given to systemic therapy with partners, the family or the social networks.	Thank you for your comment, however no studies on depression and chronic physical health problems were identified concerning systemic therapy. We have however amended the guideline to include couples therapy.
234	SH	Association for Family Therapy and Systemic Practice	16	Full NI CE	7.4.1 6.5.1 6.5.1 1.5.3 1.6 1.7	194 146 146 29 31 32	Given the impact of depression and chronic health problems on family relationships, including parenting, systemic & family therapy should be included: ▪ Leff, Vearnals, Brewin, Wolff, Alexander, Asen, Dayson, Jones, Chisholm and Everitte (2000): The London Depression Intervention Trial: Randomised controlled trial of antidepressants v, couple therapy in the treatment and maintenance of people with depression living with a partner: clinical outcome and costs. British Journal of Psychiatry. 177. 95-100. ▪ Jones, E. and Asen, E. (2002): Systemic couple therapy and depression. Karnac. London ▪ Lemmens, G., Eisler, I., Migerode, L., Heireman, M., Demyttenaere, K. (2007): Family discussion group	Thank you for this comment. We have excluded these studies for the following reasons. 1. Leff et al. (2000) This study was not concerned with people with a chronic physical health problem. In addition it had very high attrition rates from two arms of the trial which posed major problems in the interpretation of the outcome of the trial. 2. Lemmens et al. (In

							therapy for major depression: Journal of family therapy. 29.1.49-68. ▪ Lemmen, et al (in press): The effects on mood of adjunctive single family and multi-family group therapy in the treatment of hospitalised patients with major depression: a 15 month follow up study. Psychotherapy and psychosomatics.	press)This was not a randomised controlled trial but an initial exploratory study looking at the development of multi family groups in the treatment of major depression. Neither study met inclusion criteria for this guideline.
14	SH	British Association for Counselling and Psychotherapy	1	Full	General		The British Association for Counselling and Psychotherapy (BACP) thanks NICE for the opportunity to comment on the guideline Our comments are the result of extensive consultation with BACP's Research Committee (http://www.bacp.co.uk/research/research committee.php), external stakeholders, BACP members and colleagues.	Thank you for your comments
15	SH	British Association for Counselling and Psychotherapy	2	Full	General		The GL contains numerous typos and at times the text doesn't make sense. For example on page 15 the GL states 'The first three chapters provide an introduction to guidelines, the topic of schizophrenia and to the methods used to update this guideline'.	Thank you for your comments, these instances have been amended in the text (see for example p15).
67	SH	British Association for Counselling and Psychotherapy	3	Full	2.1	17	The GL states that ' …in developing recommendations for depression in physical health care the Guideline Development Group (GDG) both explicitly drew on [the updated 2009 Depression in Adults] evidence and extrapolated from it where this was concised appropriate' (sic) (p. 17). BACP would like to point out that the evidence and recommendations presented in the depression update (2009) are currently under review following stakeholder consultation and that we have raised concerns about both the search strategy (which we believe resulted in an under representation of the existing outcomes literature) and the synthesis of evidence used to develop guidance for counselling and other treatments (which we believe to be inconsistent). It is BACP's contention that the recommendations in the depression in adults guideline privilege some treatments (e.g. CBT) over others (such as non directive counselling) as a result of the methodological weaknesses of the updated review. This criticism of the 2009 update thus applies to the physical health care guideline, in that many of the recommendations for the treatment of depression for those with chronic health conditions rely on the 2009 evidence review. In particular, we are concerned about the lack of a recommendation for counselling.	Thank you for this comment. We have amended the text in Chapter 3 to make our methods more explicit regarding how we linked together the work from both guidelines. As you may be aware we have amended the depression update guideline and have taken care to ensure that the two guidelines are appropriately coordinated. We do not agree that CBT is unreasonably privileged over counselling because of methodological weaknesses. Rather in the DCHP guideline the evidence base for CBT included 19 RCTS compared to 4 relevant counselling trials which yielded uncertain results. This evidence was also supplemented by the evidence base for CBT from the depression in adults update which

								included over 65 RCTs on CBT compared to 5 relevant counselling trials which also yielded uncertain results. Thank you also for pointing out this typo, it has now been amended.
85	SH	British Association for Counselling and Psychotherapy	4	Full	3.3	2 - 4 and 33	The GDG does not include any counselling or psychotherapy professionals (p. 2 - 4 and p.33). Given that counselling is delivered nationally in 80% of NHS primary care services and is a treatment of choice for patients (p. 72) and professionals (p. 64), BACP believes that a counselling representative should have been included on GDG.	Thank you for your comments. The GDG composition is in line with the agreed scope and the NICE guidelines manual 2007, and composed of a wide range of practitioners. Stakeholders had the opportunity to comment on the constituency during the scope consultation during early 2007. The specific roles and interests of the GDG members are as follows: **Professor Sir David Goldberg (Chair, Guideline Development Group)** - Psychiatric epidemiology, case identification of common mental health problems, CCBT **Dr. Neil Andrews** - Consultant Cardiologist and Electro physiologist, - Cardiac electrophysiology **Professor Francis Creed** - Professor of Psychological Medicine, University of Manchester - Liaison psychiatry, brief interventions and psychodynamic therapy in psychosomatic disorders **Professor Christopher Dowrick** - Professor of Primary Medical Care, University of Liverpool - Conceptualisation of depression in primary care, problem solving therapy and antidepressant treatment in primary care **Dr. Gwyneth Grout** - Consultant Nurse, Mental Health Liaison (Older People),

								Hampshire Partnership NHS Trust (until May 2008) - Development of care systems for people with depression and chronic physical health problems **Dr. Mark Haddad** - Clinical Research Fellow, Health Service and Population Research Department, Institute of Psychiatry - Case identification and assessment tools in primary care **Dr. John Hindle** - Consultant Physician Care of the Elderly, Clinical Director of Medicine, North West Wales NHS Trust - Parkinson's disease **Dr. David Kessler** - Walport Clinical Lecturer - Primary Care, Bristol University - Case identification of common mental health problems in primary care, brief interventions and CBT in depression in primary care **Professor James Lindesay** - Professor of Psychiatry for the Elderly, University of Leicester - Classification of disorders in the elderly, drug treatments and institutional care **Ms. Margaret Ogden** - None **Dr. Jonathan Packham** - Consultant Rheumatologist, Haywood Hospital. Senior Lecturer, Primary Care Musculoskeletal Research Centre, Arthritis Research Campaign National Primary Care Centre, Keele University - TNF and the treatment of rheumatoid arthritis **Professor David Taylor** - Chief Pharmacist, South London

								and Maudsley NHS Trust - Professor of Psychopharmacology, King's College, London Effectiveness of psychotropic drugs, drug interactions.
87	SH	British Association for Counselling and Psychotherapy	5	Full	3.5.1	37	BACP would ask that detailed information is provided on the search strategy used for clinical interventions. Specifically, the guideline omits the inclusion of the search terms for psychosocial interventions, which makes it difficult to assess if the appropriate evidence has been identified.	Thank you for your comment. The search for clinical interventions was exhaustive and consisted of terms relating to the clinical condition and study design only. This strategy facilitated research effort by ensuring coverage in all areas, which might otherwise have been missed by more specific searches, formed around additional elements of the question, including interventions and outcomes of interest. See Appendix 9 for full details concerning the search strategy.
88	SH	British Association for Counselling and Psychotherapy	6	Full	3.5.2	37	The GL states that '… the initial evidence base was formed from well-conducted randomised controlled trials (RCTs)' (p.37). BACP notes that this directly contradicts the considered views of the NICE Chair, Professor Sir Michael Rawlins (The Harveian Oration of 2008, Royal College of Physicians) and of the NCCMH Director, Professor Steve Pilling (Therapy Today, November 2008). BACP questions the GDG's continued reliance on mainly RCT evidence given NICE's statements to the contrary and the GL states 'Although there are a number of difficulties with the use of RCTs in the evaluation of interventions in mental health, the RCT remains the most important method for establishing treatment efficacy' (p.37). RCTs tend to have narrow inclusion and exclusion criteria based on diagnosis, which limits the generalisability of the findings in clinical settings. We would respectfully suggest there are two remedies here: one is the expansion of the evidence base to include robust practice based evidence and other methodologies; the second is to be more circumspect in making recommendations based primarily on RCT evidence. BACP's view is that the recommendations do not reflect the caution highlighted here.	Thank you for this comment however we do not feel that the statements in the guideline directly contradict either what Sir Michael Rawlins or Dr Stephen Pilling has said in relevant lectures and/or interviews. In both cases there is an attempt to acknowledge that simplistic hierarchies of evidence are not a basis on which to devise recommendations for guidelines and this is the method that was followed within the depression guideline group. Other sources of evidence were used in the guideline for example, qualitative evidence of patient experience. Where substantial high quality evidence is drawn to the attention of the guideline development group it will be reviewed and considered carefully. Submissions of other practice based evidence that have been submitted were considered as

								part of the consultation process.
97	SH	British Association for Counselling and Psychotherapy	7	Full	4	53 - 81	BACP commends the inclusion of the section on the experience of care, which includes patients', families', carers' and healthcare professionals' experiences of care, along with a qualitative analysis of these personal accounts. In this section, the GL states that 'Of the service users who had received some form of psychosocial intervention, the majority had counselling or peer (self-help) support and most of these had positive experiences of the interventions and found it largely beneficial' (p.72). A further quote from a patient states 'I had counselling from the January until I decided that I didn't want to do it anymore…And so I did it for about 6 months and it was fantastic'. These accounts suggest that counselling is a valued psychosocial intervention, which is found to be beneficial for some patients. However, despite the GDG's emphasis that 'Treatment and care should take into account patients' needs and preferences' (p. 4 – NICE guideline version), it is difficult to see how the accounts of service users cited here impact upon the GL's final recommendations. The GDG now needs to demonstrate how the perspectives of patients impact on the clinical recommendations, rather than basing recommendations solely on effect sizes from RCTs.	Thank you very much for this comment. However individual perspectives on treatment cannot determine a whole recommendation. We do take patient views into account and patient members of the GDG also shape the recommendations. In a number of the recommendations that we make, discussion of patient preference clearly indicates that we do not base recommendations solely on effect sizes, important though such considerations are.
163	SH	British Association for Counselling and Psychotherapy	8	Full	6.2.2	108 - 112	The GLs note that in relation to the stepped care model 'the review identified no high-quality studies of stepped care in depression and chronic physical health problems' (p. 108). Nonetheless, the GDG's view is that '…the stepped care model remains the best developed system for ensuring access to cost effective interventions …' (p. 111) although 'further research is clearly needed' (p. 112). BACP's reading of the evidence cited here suggests that the Van Stratten study cited as providing 'direct support of the model' was inconclusive, though 'it is possible' (BACP italics) (p. 108) that the …stepped care models were more cost effective' (Hakkaart-van Roojen, p. 109). In addition, the GL cites a non RCT paper, Clark et al, 2008 (p. 111) as direct support of the model: BACP courteously requests the GDG to explain the rationale and recommendations for stepped care despite a lamentable lack of evidence.	Thank you very much for this comment. You do not specify the problems associated with stepped care. A number of stakeholders have pointed to the limited evidence base for stepped care. This is common to many organisational structural changes within the NHS. However after careful consideration of the evidence available, the additional evidence of benefit in other areas of health care and the positive impact that the stepped care programme has already had on the development of services for people with depression and associated common mental disorders the guideline development group made only minor revisions to the overall structure of the stepped care model.

								For example, Newham and Doncaster IAPT pilots (Clark et al, 2008) adopted a stepped care approach and significantly improved patients flows and delivered outcomes in line with controlled trials. Taken as a whole we consider the evidence to be of some real value and certainly as good as that for any comparable system of service organisation.
215	SH	British Association for Counselling and Psychotherapy	9	Full	7.1	149	The GL clearly states (p. 64) that 'healthcare professionals' first choice of treatment for people with depression and chronic physical health problems was a psychosocial intervention, depending on available resources (BACP italics). Healthcare professionals described the relative ease of prescribing antidepressants, but indicated that these were often not taken up by patients' (BACP italics). Again, as we noted above, 'Of the service users who had received some form of psychosocial intervention, the majority had counselling or peer (self-help) support and most of these had positive experiences of the interventions and found it largely beneficial' (p. 72). Given the GL aims 'to improve access and engagement (BACP italics) with treatment and services for people with depression and chronic health problems (p. 14) the lack of any recommendation for counselling is surprising and appears to contradict professionals' and patients' experiences. In addition, while the GL states 'Where established therapies are not recommended, this should not be taken to justify the withdrawal of provision but rather to suggest the need for research to establish their effectiveness or otherwise' (p.149) the lack of any recommendations for counselling in the current depression with chronic physical health problems GL will result in de-commissioning of these services which will have a significant impact on two important aspects of clinical care: patient choice and access.	Thank you very much for this comment. We are aware of a rather limited range of interventions that we have recommended. We should also point out that there are a range of low intensity psychological interventions such as guided self-help, CCBT and peer support that we have also recommended. We have clear criteria on how we extrapolated from the depression guideline and this did allow us to include some but not all interventions. These included when there was evidence of efficacy from trials in the depression and chronic physical health care problems guideline. Where we were not confident in our extrapolations, we did not extrapolate from the depression update guideline. This was the case for a number of interventions including IPT, psychodynamic therapy and counselling. Clearly there is a limited range of treatments but we did not feel able, in the absence of good evidence, to recommend others. Individual clinicians may of course decide to offer other individual interventions beyond this. We appreciate the importance of offering choice other than anti-depressant medication for people

								with depression with chronic physical health problems. However we felt that we should make recommendations where we have some evidence for some level of efficacy. Beyond those interventions currently listed in the guideline we find little evidence within people with depression and chronic physical health problems to support an extrapolation. However this of course would not prevent healthcare professionals using their clinical judgement and where appropriate using interventions outside of those recommended within this guideline. Of course in these circumstances it is important to make clear to the patient that there is some uncertainty about the likely benefit. We would expect any competent healthcare professional to do this.
223	SH	British Association for Counselling and Psychotherapy	10	Full	7.2.12	181	BACP concurs that the evidence is limited for psychosocial interventions for chronic physical health, including CCBT, CBT, IPT and counselling. We note however, that while three trials cited in the review (p. 181) demonstrate no difference between counselling and individual based CBT, the lack of a recommendation for counselling appears to rest on the finding from one RCT which failed to demonstrate a difference between counselling and standard care (Manne 2007). The GDG comment that the 'evidence base for the effectiveness of counselling … when compared to standard care failed to demonstrate a difference in contrast to that for individual or group CBT' (p.1.81). BACP queries the exclusion of the Ward (2000) study which compares CBT, non directive counselling and usual care, which in fact demonstrated superiority of counselling over usual care and demonstrated no differences between counselling and CBT. The trial was excluded from the analysis of CBT therapies in the Depression update (2009) and appears to be excluded again here. We respectfully request an explanation for the exclusion of this trial from the CHP GL. Finally, it is important to note that even where there is a	Thank you very much for this comment. We have revised our analysis in light of yours and other comments. Firstly of the 4 trials we originally labelled as counselling, one in fact (Markowitz *et al.,* 1998) is supportive psychotherapy and has since been removed from the analysis. Although there is no statistically significant difference between individual CBT and counselling the evidence is unclear. In the meta-analysis containing two of the counselling studies, the direction of effect was in favour of individual CBT (SMD = -0.23; 95% CI -0.62 to 0.17). Whilst in one study where only a change score could be calculated, this found differing results (SMD = 0.34, -0.44 to 1.11).Due to the inconsistent evidence in the comparison between the two interventions we

							larger evidence base for certain psychological therapies, for example for CBT, not everyone gets better and there is remission. Hollon's research (2005) showed that less than half of treated patients will achieve full remission and sustain it over a period of two years following treatment. Despite this uncertainty, counselling, an established intervention commonly preferred by patients, is not recommended in the GL.	looked to the evidence base for these interventions versus standard care. In the case of CBT we were also able to find clear evidence of a substantial and clear difference from standard care. This is not the case for the one counselling trial (SMD = -0.14; 0.40 to 0.12). Looking at an indirect comparison of individual CBT and counselling versus standard care, there was no evidence to support the use of counselling in this population whilst there was strong evidence to support the use of individual CBT. In addition taken together the small trials with no difference between the two interventions and a lack of consistent findings of benefit against treatment as usual raises questions about our need to extrapolate from the depression guideline. A recommendation for counselling would be possible if there were a strong evidence base within the main depression guideline. However as you will be aware from a review of that guideline, the GDG took the view that the evidence base for counselling was significantly more limited than that for other interventions such as IPT and CBT. Given the uncertainty in this guideline about the effectiveness of counselling and the uncertainty in the depression update guideline it did not seem to us appropriate to recommend counselling in depression for people with chronic physical health problems. We therefore do not intend to vary this recommendation. However we should point out that this does not preclude clinicians, in their clinical

								judgement offering counselling for people with depression with chronic physical health problems where appropriate. You also mention the Ward et al study. This study was initially excluded from the depression update because only 62% of people actually met criteria for depression, significantly below our usual cut-off of 80%. However in the depression update guideline we have now included Ward 2000 in a sensitivity analysis. However the inclusion of this study still does not remove the certainty about the effectiveness of counselling. You point to the Hollon data on limited outcomes and limited data on long term remission. Whilst this might be the case this in itself does not seem to us a strong argument for offering an intervention with evidence of effectiveness is considerably less certainty than CBT. To assume that a patient will not benefit from one intervention must, in some way significantly and differentially benefit from another is simply not proven. In these circumstances it seems unwise to us to recommend counselling in this context.
16	SH	British Association for Counselling and Psychotherapy	12	Full	General		In the NICE Guidance on 'Improving Supportive and Palliative Care for Adults with Cancer', the guidelines states that 'A range of psychological interventions can be offered by both the statutory and voluntary sectors. Health and social care professionals offering day-to-day care provide much general psychological support to patients and carers and play a key role in psychological assessment and prevention and amelioration of distress. More specialised services include counselling, clinical and health psychology, liaison psychiatry and social work' (p. 79).	Thank you for this comment. The NICE "manual" on 'Improving Supportive and Palliative Care for Adults with Cancer' had a different remit and was not concerned specifically with depression and physical health problems. They were developed prior to the establishment of the current NICE approach to guideline development and are referred to as "inherited

							This guideline further suggests 'While the exact benefit derived from good communication and psychological interventions is difficult to quantify, counselling and specialist psychological and psychiatric interventions have been found to confer moderate to major benefit on those who receive them. They produce significant improvements in psychosocial functioning and overall quality of life for particular individuals' (p. 88) and 'Specific psychological therapies such as counselling and cognitive behavioural therapy (Level 4) have been evaluated in the context of cancer care with positive outcomes on a range of variables, including coping, anxiety, depression and self-esteem' (p. 88). However the current guidelines being consulted on, do not mention counselling at all. BACP would suggest that there needs to be consistency in the recommendations made between GL's, and GDG should have extrapolated from other GL's, which look at chronic illnesses, such as cancer.	guidance". We believe that the search strategies adopted, the evidence identified and the means of evaluation on this guideline has resulted in a proper evaluation of the evidence. There may be a number of important functions for counselling in people with suffering from a range of chronic physical health problems including cancer but we do not think that the evidence we have reviewed supports a specific recommendation for counselling.
283	SH	British Association for Counselling and Psychotherapy	13	Full NICE	7.4.1.16 1.4.2.2	198 19	BACP would concur with a common sense approach that patients with depression may benefit from advice on sleep hygiene but cannot identify the evidence base for this clinical recommendation (p 198) in the GL?	Thank you for you comment but this recommendation is based on the expert opinion of the GDG.
293	SH	British Association for Counselling and Psychotherapy	14	Full	7.5	199 - 200	The GL states that 'In the research recommendations (Section 7.4.2) we suggest priorities for further research to establish more definitively what therapies work for what people, especially in enabling people's longer term recovery, a pressing concern for many people who suffer recurrent depression' p.149). There is a need to draw attention to the weakness of the guideline recommendations in not addressing the different underlying factors that may be causing the depression, individual differences in patients, and the impact this may have on the appropriate choice of treatment. Given that the GD further states 'Where established therapies are not recommended, this should not be taken to justify the withdrawal of provision but rather to suggest the need for research to establish their effectiveness or otherwise' (p.149), BACP would suggest that the research recommendations should be expanded to include under researched therapies, including non directive counselling and psychodynamic psychotherapy. Despite the evidence available for counselling, compared to CBT, counselling is one of the most widely practiced forms and preferred forms of psychological therapy in the NHS, and many clients – including service	Thank you very much for this comment. We have made a number of research recommendations including those for counselling, please see recommendation 4.7. We agree that evidence for the effectiveness of psychological interventions is urgently needed in this area and would hope that the research recommendations that we made for a wide range of psychological interventions are adopted.

							users in Chapter four of the present draft guidelines – testify to its value, it would seem imperative to further investigate its efficacy. In addition, while definitions of counselling have previously lacked rigour, the emergence of Skills for Health competences for humanistic therapies means that it can now be carefully checked for adherence to manualised procedures. Given that a significant proportion of clients do not improve with CBT, there is a need to understand more of the moderators and mediators that relate to positive benefit for different psychological therapies. For instance, there is knowledge that more resistant clients do better in nondirective therapies, while clients who are less defensive do better in directive therapies (Beutler, Blatt et al., 2006). Further randomised trials should consider stratifying clients by variables known to be associated with positive outcomes for different therapies, so that a greater understanding can be established of what works for whom. We have very little knowledge at the current time of the kinds of psychological therapies that clients prefer, and the choices that they would make when faced with a range of options. There is a need for research, therefore, on the kinds of treatments that clients would opt for – and moderating and mediating factors amongst clients.	
559	SH	British Association for Psychopharmacology	1	NI CE	General		We wish to make a general point about these guidelines which is also covered in some more detail in our comments regarding section 1.5.2.1 (see below). We believe that the guidelines as currently constituted represent a missed opportunity. The management of depression in specific chronic physical illnesses has been addressed in a small but significant body of research. This has led to, for example, some clinicians considering sertraline to be the antidepressant of choice in post-MI depression and Parkinson's disease, and SNRIs in the management of depression with significant comorbid pain. However there is much uncertainty about the robustness of such views. It would be helpful in the presence of uncertainty for NICE to provide guidance either that such strategies are, or are not, supported by the evidence base. Currently the guidelines make few if any recommendations about the management of depression in specific physical illnesses. If the view is that the evidence does not support any differentiation between antidepressant in different conditions this needs to be stated explicitly.	Thank you very much for this comment. We were unable to find any specific evidence for certain drugs being more or less effective for particular diseases. The concern with regards to diseases as you will no doubt be aware of are the potential interactions with other medication provided for the particular disease conditions. We have amended one of our recommendations to make this point clear.

630	SH	British Association for Psychopharmacology	2	NI CE	1.2 and 1.6		If the stepped care model is to be clinically, with clinicians being aware of its nature, it is unhelpful having differences in the number of the steps between this guideline (5 steps) and the depression guideline (4 steps). We suggest that step 4 in the chronic illness guideline be divided up between steps 3 and 5 to bring models in line.	Thank you for this comment. In light of yours and other comments we have revised the guideline and gone for a 4 step programme that addresses your comments and also ensures consistency with the depression update guideline.
633	SH	British Association for Psychopharmacology	3	NI CE	1.3, 1.4, 1.5		The updated depression guideline has moved away from specifying the location of where care is provided in the different steps of the stepped care model. This however is present in the chronic illness guideline. This again is unhelpful and inconsistent. A discussion of where care might be provided however would be helpful within the body of section 1.2.	Thank you we have revised the model to be in line with the Depression Update guideline.
339	SH	British Association for Psychopharmacology	4	Full NI CE	8.5.2.3 1.5.2.1	244 23	This section is very brief and there is a lack of detail. It is not clear which and how "other physical health disorders" " should be taken into account". Are we to assume that some previous research on the use of specific drugs has not been shown to be rigorous enough? For example what about the evidence to support the use of sertraline in depression post-MI or in unstable angina? How should post stroke depression be treated - surely TCAs should be avoided in such cases? Is there any evidence to use sertraline in Parkinson's disease as some work suggests? Does the evidence that SSRIs are less effective in depression in the presence of severe pain whereas dual action drugs (SNRIs and TCAs) have some efficacy in treating pain in the context of depression not stand up to an EBM approach? The use of these drugs is commonplace in the above situations so if there are convincing negatives they should be included in such a Guideline. On the same heading, the reference to hyponatraemia is unclear and potentially confusing. Is it saying that SSRIs should not be used in the elderly at all? Is the risk sufficient to say this? Or is the concern only in these with a history or current presence of hyponatraemia? If the latter, what is the serum sodium cut–off?	Thank you for your comment. As discussed in Chapter 8 there was insufficient data to draw firm conclusions concerning pharmacological interventions for specific conditions. The evidence for dual action drugs in relation to pain is inconclusive. Concerning SSRIs in the elderly, 1.5.2.1 states that they may be used but serum sodium should be monitored. Stating cut-offs for serum sodium was considered by the GDG to be too detailed for a recommendation.
406	SH	British Association for Psychopharmacology	5	Full NI CE	8.5.2.5 1.5.2.3	244 24	This should state what the lower risk of interactions is compared to (e.g. fluoxetine and paroxetine).	Thank you very much for this comment. We have revised the interactions table in light of yours and other comments.
409	SH	British Association for Psychopharmacology	6	Full NI CE	8.5.2.6 1.5.2.4	244 24	The statement about dosulepin is that it should "not [be] routinely initiated". While we agree with this statement it is not exactly what the depression guideline says which in effect is "never". Our feedback to the depression	Thank you very much for this comment. We agree, we have checked to ensure that in this case both guidelines are now making the

							guideline was to slightly modify their statement. What ever is done, the two guidelines should be consistent. It would be helpful to include combinations of antidepressants in the list of treatments that would normally be provided by specialists.	same recommendation.
501	SH	British Association for Psychopharmacology	7	Full NI CE	8.5.2.7 1.5.2.5	245 24	This point could imply that anybody on an NSAID should be treated with mianserin, mirtazepine, moclobemide or reboxetine. We don't agree that this is an absolute. We also believe that there should be some caveats raised regarding the drugs suggested (e.g. blood dyscrasias with mianserin, weight gain and sedation with mirtazepine, interactions with moclobemide and the poor level of data to support reboxetine). Is there any evidence to support the use of gastro-protective agents to lower the risk of GI bleeding with SSRIs that stands up to scrutiny? This is important as this has been recommended in some guidelines especially if the patient is elderly or on aspirin.	Thank you very much. The options listed in 1.5.2.5 are for consideration only, and should not be considered as an absolute. In regards to the caveats that you mentioned this is too much detail for the NICE guideline however a systematic review of the side effects of these medications are discussed in Chapter 8 of the full guideline. There is some modest evidence for the value of gastro protective agents.
502	SH	British Association for Psychopharmacology	8	Full NI CE	8.5.2.7 1.5.2.5	245 24	This just refers to the need for treatment for 6 months following an episode of depression. However some patients require longer periods of treatment (see section 1.8.2 of the depression guideline). There should be some reference to the points made in section 1.8.2.3 of the depression guideline that discusses when longer treatment is needed. This is important since many patients with chronic physical illness are at high risk of relapse given the chronicity of their physical illness.	Thank you very much for this comment, this section is now consistent with the depression update guideline.
506	SH	British Association for Psychopharmacology	9	Full NI CE	8.5.2.8 & .9 1.5.2.6 and 1.5.2.7	245 24	These sections talk of "fails to respond……..within 2 to 4 weeks" and "response….[is] …inadequate after 4 weeks". While we agree that there should be some evidence of an onset of response within 2 to 4 weeks with first line treatment to justify continuing with it, these statements seem to imply that a full response is expected. We suggest consideration be given to the wording used in the BAP guidelines around this issue (section 3.1 of Anderson et al. 2008, Journal of Psychopharmacology).	Thank you very much for this recommendation. We have made some adjustments to the recommendations to reflect the concerns raised in yours and other comments.
532	SH	British Association for Psychopharmacology	10	Full NI CE	8.5.2.21 1.5.2.19	247 28	This does not seem to include the possibility of the need for augmentation or combination treatment in patients who have failed more than one treatment.	Thank you very much. These issues are dealt with in the depression update guideline. We will ensure effective cross-referencing between the guidelines to ensure that people know where to seek advice on these strategies.
17	SH	British Association of	1	Full	General		This update is a welcome addition to the NICE	Thank you for this comment

		Art Therapists, British Association of Dramatherapists and the Association of Professional Music Therapists					developing portfolio of world-class clinical Guidelines for the treatment of Mental health conditions. (Of note the comments here are an iteration of response made for Depression in adults)	
1	SH	British Association of Art Therapists, British Association of Dramatherapists and the Association of Professional Music Therapists	3	Full and NICE	General	General	Whilst we endorse the improving access to psychological therapies initiative through which these guidelines and others will be delivered, we have concerns as to the potential de-professionalisation of those providing therapies (low intensity workers). The likelihood of poor governance given the lack of proper professional structures is great, as is the case for non professional groups. Significantly to what extent does such a workforce strategy put the general public at risk?	Thank you for this comment. This is a matter for NHS implementation but our view is that the training programmes and supervision system in the IAPT programme are of high quality.
57	SH	British Association of Art Therapists, British Association of Dramatherapists and the Association of Professional Music Therapists	3	Full	General	11 & 12	Guideline implementation, ethos and rationale as described in NICE documents may appear to be at odds with the intention of Baroness Young of the Care Quality Commission who states “Providers will be expected to demonstrate compliance with NICE and other national guidance unless they can show good reason to vary from them” she continues “The steps we can take range from a formal warning notice to prosecution and imposition of restrictions, or even closure of a service”. * This would suggest guidelines are to become compulsory, and no longer guidelines as such? *Chair, Care Quality Commission. Dec 2008	Thank you for this comment – this is outside the remit of the guideline but we would wish to re-assure you that guidelines remain an aid to, and not a substitute for clinical judgement.
152	SH	British Association of Art Therapists, British Association of Dramatherapists and the Association of Professional Music Therapists	4	Full NICE	5.6.1.10 1.3.1.5	102 7 & 17	We welcome the inclusion of a point referring to clients with Learning Disability and depression on page 7 of NICE GL. However more needs to be made of their inclusion throughout the document in particular during assessment. Given that this client group may well attend and are entitled to seek treatment within main stream NHS services, their persistent exclusion from such consideration across NICE guidelines continues to warrant concern.	Thank you for your comment, we have added three recommendations specific to those with learning disabilities.
285	SH	British Association of Art Therapists, British Association of Dramatherapists and the Association of Professional Music Therapists	5	Full NICE	7.4.1.17 1.4.2.3	198 20	Given that physical activity programmes are recommended for people with persistent, minor and mild-moderate depression, we believe that the evidence for dance movement psychotherapy should also be considered. In one study dance movement psychotherapy was shown to be more effective than exercise alone (Koch, S C et al (2007) The Joy Dance: Specific Effects of a Single Dance intervention on psychiatric patients with depression. The Arts In Psychotherapy 34: 340-349)	Thank you very much for this comment. However this trial did not meet our inclusion criteria for the depression update guideline. As far as we are aware none of the patients included in this trial had a chronic physical health disorder. We therefore do not think it is appropriate to consider dance movement psychotherapy.
18	SH	British Thoracic	1	Full	General	Gene	Psychological Morbidity in Chronic Obstructive	Thank you for your comment; we

		Society				ral	Pulmonary Disease (COPD). COPD is a major cause of disability and use of health care resources. As medical treatments have made limited inroads, patients experience recurring acute exacerbations, frequent hospital admissions, have poorer survival, impaired physical functioning and reduced quality of life (Seemungal et al, 1998; Mannino, 2002 & Ng, 2007). Physical variables thought to influence functional status include length of illness, age, lung function, exercise capacity and breathlessness (Moore & Zebb, 1998). Psychological variables include depression, anxiety and low self esteem (Moore & Zebb, 1998). The NICE COPD Guidelines (2004) estimated that the prevalence of depression is 40% in this group. Therefore it is important to recommend screening both in primary and secondary care. The COPD Clinical Strategy is due to be published within the next year and this also recognises the importance of psychological management of the condition.	agree that COPD is associated with increased risk of depression and we have stated this in chapter 2. Also chapter 5 discusses case identification in patients with chronic physical health problems. We have included a number of recommendations regarding the identification of depression in chronic physical health problems, which would include COPD and agree that case identification is an important area for implementation.
73	SH	British Thoracic Society	2	Full	2.2.2		The impact of pulmonary disease on activities of daily life is adversely affected by depression & anxiety even after controlling for the effects of dyspnoea (Weaver et al, 2007). There are numerous studies highlighting impairment and disability in COPD.	Thank you, however the details suggested are beyond the scope of the guideline. The risk of depression in COPD has already been discussed in Chapter 2.
80	SH	British Thoracic Society	3	Full	2.3.1		Depression and anxiety in COPD is related to lower levels of self-efficacy, impaired health status, poorer treatment outcomes and reduced survival (Aydin & Ulsahin, 2001; Kunik et al, 2005 & Ng, 2007). This is a very important point that could be emphasised in the guidelines. Non-compliance with asthma medication is an important point to highlight as this has been found to be a risk factor for death (BTS/SIGN Guidelines, 2008).	Thank you for your comment, however the issue of non-compliance has been dealt with in detail in a recent NICE guideline, reference to which is made in the NICE guideline.
81	SH	British Thoracic Society	4	Full	2.3.2		It was highlighted by the British Lung Foundation (2006) that patients focus on feeling unwell, their ability to perform everyday activities and on the emotional consequences of the disease. The are a number of studies on quality of life in COPD which can be used to highlight the impact of COPD on quality of life. Diseases such as pulmonary fibrosis also have significant impact on quality of life. Gore et al also highlighted that patients with COPD had a worse QOL than patients with cancer.	Thank you for the comment; we have limited space in the guideline to discuss a number of disorders and their association with depression and quality of life. COPD was discussed in the introduction but it is not possible to discuss each disorder in the amount of detail you are suggesting.
105	SH	British Thoracic Society	5	Full	4.4.3		Several patient quotes can be provided if needed re the impact of COPD on daily living, body image, interpersonal relationships, mood (depression) and carers e.g. British Lung foundation and many others.	Thank you for offering more patient quotes. However, we do not think it is necessary to add more quotes at this stage.
127	SH	British Thoracic	6	Full	5.2.4		HADS – Numerous validation studies have been	Thank you for your comment. We

		Society					undertaken on this tool. Dowson (2001) found that more severe COPD (FEV1 predicted) correlated with higher depression (r=0.34, p<0.005) scores. The study concluded that the use of HADS with COPD patients may improve identification and treatment of depressed patients. A RCT is planned and will compare the use of HADS & BDI for patients with COPD.	considered over 20 studies on the HADS. The considerable heterogeneity found when combining studies on this measure suggests it would be problematic to draw conclusions on its validity.
183	SH	British Thoracic Society	7	Full	6.4.3		Page 133 – Figure 5. Not clear what comes after Collaborative Care – continue treatment – no response ????what next. Page 137 – There is some evidence supporting the use of CBT in patients with COPD. A case series has been published & a non-randomised case control series is awaiting publication. Details can be provided if needed. It may be that patients with COPD need less than 12 sessions of CBT. Our early experience shows that CBT provided by a respiratory nurse required on average 3 session. Many health care professionals working within respiratory care have recognised the importance of depression and anxiety in COPD. As a result we are working on developing ways to develop their skills and expertise in this area. The COPD Clinical Strategy will be used to do this.	Thank you for your comment. The no response state is an end point of the model. However patients who do not respond were assumed to continue consuming healthcare resources until the end of the model. We are pleased to hear of the development you describe we hope that they will support implementation of this guideline.
195	SH	British Thoracic Society	8	Full	6.4.5		A RCT is to commence looking into the management of depression (and anxiety) in patients with COPD.	Thank you for your comment unfortunately it will be too late to include such a trial in our evaluation. But it will be considered in subsequent updates of the guideline.
216	SH	British Thoracic Society	9	Full	7.1.3	153	A RCT is available looking at the skills of nurses working in the physical health setting following basic skills training in CBT techniques. This confirmed that skills training plus supervision had a significant effect on competence.	Thank you for your comment. We agree that training and supervision is an important area, as is therapist competence. We would be grateful if you could make available the reference to any published papers arising from this trial, if the trial has been completed.
280	SH	British Thoracic Society	10	Full NICE	7.4.1.15 1.4.2.1	198 18	Often respiratory patients experience anxiety and depression. Several references have notes this. Addressing panic attacks may be a priority for patients to reduce immediate distress. This work is best run concurrently with treatment for depression.	Thank you for your comment, the detail you suggest is beyond the scope of the guideline.
19	SH	British Thoracic Society	11	Full	General		Holistic Approach – a holistic approach must involve assessing psychological, social and physical symptoms. In the context of the physical health setting it is important	Thank you, we agree with your comment. We feel this is reflected in both chapters 5 and 6 of the full

							to highlight the fact that at times it is difficult to identify if symptoms are due to low mood (e.g. lack of energy, tiredness or poor appetite) or if they may be due to worsening COPD which would require different treatment e.g. non-invasive ventilation for respiratory failure.	guideline, where additional barriers to identification of depression and accessing services due to chronic physical health problems have been discussed.
20	SH	British Thoracic Society	12	Full	General		**References for the above** ▪ Aydin, I.O. and Ulusahin, A. Depression, anxiety comorbidity, and disability in tuberculosis and chronic obstructive pulmonary disease patients: applicability of GHQ-12. General Hospital Psychiatry. (2001). 23, 77-83. ▪ British Lung Foundation. (2006) Lost in Translation: Bridging the Communication Gap in COPD. London, BLF. ▪ British Thoracic/SIGN (2008) Asthma Guidelines ▪ Kunik, M.E., Roundy, K., Veazey, C., Souchek, J., Richardson, P., Wray, N.P. and Stanley, M.A. (2005) surprisingly high prevalence of anxiety and depression in chronic breathing disorders. Chest. 127, 120. ▪ Mannino DM. (2002) COPD: Epidemiology, prevalence, morbidity and mortality and disease heterogeneity. Chest. 121 (supplement 5): 121S - 126S. ▪ Moore MC & Zebb BJ. (1998) Functional Status in Chronic Obstructive Pulmonary Disease: The Moderating Effects of Panic. International Journal of Rehabilitation and Health. 4, 2, 83 - 93. ▪ Murray, C.J. and Lopez, A.D. (1997) Alternative projections of mortality and disability by cause 1990-2020: Global Burden of Disease Study. Lancet. 349, 1498-1504. ▪ National Institute for Clinical Excellence. Clinical Guidelines for the management of Chronic Obstructive Pulmonary Disease. (2004) Thorax. 59, 1-232. ▪ Ng (2007) Ng, T. N., M. Tan, W. Cao, Z. Ong, K. Eng, P (2007). Depressive symptoms and chronic obstructive pulmonary disease. Internal Medicine 167: 60-67. ▪ Seemungal TARE; Donaldson GC, Paul EA, Bestall JC, Jeffries DJ & Wedzicha JA. (1998) Effect of exacerbation on quality of life in patients with chronic obstructive pulmonary disease. American Journal of Critical Care Medicine. 157: 1418 - 1422. ▪ Weaver TE & Narsavage GL. (1997) An explanatory model of functional status in chronic obstructive pulmonary disease. Nursing Research. 46, 26 - 31.	Thank you for the references. However we did not include these references for the following reasons: 1)It is beyond the scope of the guideline to consider the physical management and burden of COPD, other than where it specifically impacts on depression. The following references were not primarily concerned with depression: (British Lung Foundation, 2006; British Thoracic/SIGN, 2008; Manino, 2002; Moore & Zebb, 1988; Murray & Lopez, 1997; NICE, 2004; Seemungal et al., 1988; Weaver & Narsavage, 1997). 2) Kunik et al (2005) was considered but was excluded as it did not meet our study quality criteria. However, Aydin & Ulusahin (2001) was included in the guideline chapter concerned with case identification.
590	SH	College of Mental Health Pharmacists	1	NICE	Introduction	3	low mood, loss of enjoyment and interest in both ICD-10 and DSM- should be DSM-IV	Thank you for your comment. We have now amended the text.

		(CMHP), UK Psychiatric Pharmacy Group (UKPPG)						
623	SH	College of Mental Health Pharmacists (CMHP), UK Psychiatric Pharmacy Group (UKPPG)	2	NI CE	1.2 Figure 1 step 2	15	Step 2 Minor, mild to moderate depression intervention includes medication but the guideline states Antidepressants are not recommended for the initial treatment of minor and mild depression in patients with chronic physical health problem It should be made clear when medication is indicated as this implies medication is indicated for minor and mild depression.	Thank you very much for this comment. We have revised the structure and format of the guideline in order to address this comment and other similar comments made on the guideline.
288	SH	College of Mental Health Pharmacists (CMHP), UK Psychiatric Pharmacy Group (UKPPG)	3	Full NI CE	7.4.1.19 1.5.1.2	199 23	The choice should be based on patient preference, the likelihood of adherence to the treatment, interactions with concomitant medication and the likely side effects.	Thank you very much for your comment. We have made a number of changes to our recommendations concerning issues around patient preferences which we hope reflect some of your comments.
503	SH	College of Mental Health Pharmacists (CMHP), UK Psychiatric Pharmacy Group (UKPPG)	4	Full NI CE	8.5.2.7 1.5.2.5	245 24	Mianserin is suggested as a second line agent when SSRIs are not appropriate. Mianserin however is associated with rare blood dyscrasis and additional monitoring requirements. It would be safer to restrict its use to a third line option and by specialist mental health practitioners only.	Thank you very much for this comment. The guideline group did consider carefully the issues regarding blood dyscrasis which are a rare event with Mianserin. We feel that the recommendation should stand as it is and that additional monitoring is not onerous and does not require its limitation to specialist mental health practitioners only.
507	SH	College of Mental Health Pharmacists (CMHP), UK Psychiatric Pharmacy Group (UKPPG)	5	Full NI CE	8.5.2.9 1.5.2.7	245 25	Consider adding – Benzodiazepines should be used in caution in those who are at risk of falls (Lawlor et al BMJ 2003;327:712-717 showed hypnotics and anxiolytics were implicated in significantly increasing the risk of falls.)	Thank you very much for your comments here. We have made some adjustments to the recommendations in light of your comments.
510	SH	College of Mental Health Pharmacists (CMHP), UK Psychiatric Pharmacy Group (UKPPG)	6	Full NI CE	8.5.2.11 1.5.2.9	245 25	Please add: that physical and psychological dependence does not occur with antidepressants.	Thank you very much for your comment, the GDG have decided to leave this bullet point unchanged as issues surrounding psychological dependence are still a contentious issue and were considered not sufficiently resolved to be included in the recommendation.
511	SH	College of Mental Health Pharmacists (CMHP), UK Psychiatric Pharmacy Group (UKPPG)	7	Full NI CE	8.5.2.11 1.5.2.9	245 25	minimised, particularly with (a) shorter half-life drugs, such as need to omit the word a	Thank you very much. We have amended this guideline in light of yours and other comments

407	SH	College of Mental Health Pharmacists (CMHP), UK Psychiatric Pharmacy Group (UKPPG)	8	Full NICE	8.5.2.5 1.5.2.3	244 24	When a patient with depression and a chronic physical health problem is assessed to be at a high risk of suicide, healthcare professionals should consider: ▪ the prescription of a limited quantity of antidepressants ▪ Should we not consider a limited quantity of all medication prescribed? Some medications prescribed for chronic health conditions are also dangerous in overdose such as morphine in chronic pain.	Thank you very much for this comment. We have revised the interactions table in light of yours and other comments.
302	SH	College of Mental Health Pharmacists (CMHP), UK Psychiatric Pharmacy Group (UKPPG)	9	Full	8.2.4 Table 47	204	The table goes slightly off the page on the right hand side	Thank you for your comment. We have now amended the table.
304	SH	College of Mental Health Pharmacists (CMHP), UK Psychiatric Pharmacy Group (UKPPG)	10	Full	8.2.4 Table 47	206	The table goes slightly off the page on the right hand side	Thank you for your comment. We have now amended the table.
305	SH	College of Mental Health Pharmacists (CMHP), UK Psychiatric Pharmacy Group (UKPPG)	11	Full	8.2.4 Table 47	207	The table goes slightly off the page on the right hand side	Thank you for your comment. We have now amended the table.
306	SH	College of Mental Health Pharmacists (CMHP), UK Psychiatric Pharmacy Group (UKPPG)	12	Full	8.2.4 Table 47	210	The table goes slightly off the page on the right hand side	Thank you for your comment. We have now amended the table.
308	SH	College of Mental Health Pharmacists (CMHP), UK Psychiatric Pharmacy Group (UKPPG)	13	Full	8.2.4 Table 47	211	The table goes slightly off the page on the right hand side	Thank you for your comment. We have now amended the table.
301	SH	College of Mental Health Pharmacists (CMHP), UK Psychiatric Pharmacy Group (UKPPG)	14	Full	8.2.3 Line 1 and 2	203	States: 35 involving a comparison of SSRIs with placebo but in table 47 and later on pg 212 line 3 states 36	Thank you for your comments. The text has now been amended.
320	SH	College of Mental Health Pharmacists (CMHP), UK Psychiatric Pharmacy Group (UKPPG)	15	Full	8.2.6 Paragraph 1	224	Kalogjera-Sackellares, D. et al. Improvement in depression associated with partial epilepsy in patients treated with lamotrigine Epilepsy & Behavior Vol 3 (6);2002:510-516 not considered	Thank you for your comment. The primary aim of the review was to consider licensed treatments for depression and not medication for the physical health problem. The paper you cite was excluded from the review as the drug is not a licensed antidepressant. We have now added the reference to this study in the excluded studies list.
314	SH	College of Mental	16	Full	8.2.6	226	Having considered some physical benefits of taking	Thank you for your comment,

		Health Pharmacists (CMHP), UK Psychiatric Pharmacy Group (UKPPG)			ENRICHD Line 17		antidepressants Consider commenting on the findings of this Meta-Analysis Duloxetine Does Not Relieve Painful Physical Symptoms in Depression: A Meta-Analysis. Glen I. Spielmans. Psychother Psychosom 2008;77:12-16	however this is beyond the scope of the guideline as it does not consider patients with chronic physical health problems as defined by the scope.
324	SH	College of Mental Health Pharmacists (CMHP), UK Psychiatric Pharmacy Group (UKPPG)	17	Full	8.4	237	Lithium is mentioned in this section but has not been discussed as a treatment option as such should it be included in this part of the guideline? This would seem to fit better in the bipolar guidance. Is there evidence for Lithium use in this group?	Thank you for your comment, there is no evidence concerning lithium in chronic physical health problems.
6	SH	College of Mental Health Pharmacists (CMHP), UK Psychiatric Pharmacy Group (UKPPG)	18	Full & NICE	General		The Full guideline uses DSM-IV-TR yet the Nice guideline uses DSM-IV – should there not be consistency between the two?	Thank you for this – we will use DSM-IV throughout for ease of reference.
22	SH	Department of Health	1	Full	General		We are happy with the draft guideline. However, it appears to be based around DSM-IV diagnosis (because most research studies use it) whereas across the NHS, ICD-10 is used. It is stated that this should not make much difference, as the distinction between them for depression is slight, which is true. In our opinion however, it may cause some confusion. Could you please therefore consider emphasising in the introduction that there is no expectation that everyone switches over to DSM-IV. We feel that it should be made clear in the introductory text what the difference is, rather than use a small footnote. We believe that a significant problem could potentially arise if people are expected to start using DSM as a matter of course.	Thank you we have revised both the introduction, appendix C and the full guideline to take account of your comment and those of others. We are not proposing that DSM-IV should replace ICD-10 but wanted to make clear to readers the basis on which studies were evaluated and provide clear advice on the classification of depression, albeit along a continuum, from subthreshold through to severe depression. The adoption of the DSM frame work facilitated this.
23	SH	Department of Health	2	Full	General		Many people with long-term conditions will be elderly. However, there appears to be no mention of a crucial need to identify dementia which, we feel, can present with depression. Could you please consider this point for future reference?	Depression in people with dementia was explicitly excluded from the scope as this was dealt with in the NICE Dementia guideline (CG42).
24	SH	Department of Health	3	Full	General		We are aware that many people experience emotional difficulties after a stroke, and that that can lead to depression. A third of those who have had a stroke become depressed at some stage during their recovery. The National Stroke Strategy recognises that depression is a component of a multi-faceted approach to stroke rehabilitation and support. Unfortunately, the necessary professional input in stroke teams remains seriously under-resourced, according to the RCP Stroke Sentinel Audit. In our opinion, it would be helpful if greater attention could be given to the psychological needs of stroke survivors, and also their carers (who may also	Thank you for your comment. We agree greater attention could be given to the psychological needs of stroke survivors and hope that this guideline will contribute to improvements in this area. We have made special reference to stroke in recommendation 1.3.1.6 but feel that the key means by which your concerns will be addressed will be through the implementation of this guideline.

							become depressed when, for example, they have difficulty coping).	
560	SH	Diabetes UK	1	NICE	General		As the focus of the guidance is depression management for people with long term conditions, it is important that this is emphasised throughout the guidance, particularly in recognition of the interrelation between depression and living with a long term condition that can occur and is identified in section 2 of the full guideline. Diabetes UK welcomes the development of NICE guidance that focuses on the psychological aspects of living with a long term condition. However, the development of guidance that focuses on one psychological condition (depression) also risks compartmentalising the emotional well being of a person living with a long term condition, rather than exploring their emotional and psychological well being as a whole and in the context of their long term condition. The approach taken could have an impact on the interventions chosen to help manage any psychological need. A one size fits all approach to providing emotional and psychological care for people with long term conditions must therefore not be taken.	Thank you for your comment. We acknowledge the limitations of only looking at depression in long term conditions and that patients will often experience other psychological conditions. However, we hope this guideline contributes to an increased awareness and better treatment of the psychological needs of people with long term conditions.
110	SH	Diabetes UK	2	Full NICE	4.8.1.1 1.1.1.1	80 10	A recommendation is needed that identifies the skills and support a practitioner requires in order to deliver recommendation 4.8.1.1	Thank you we have commented on the skills of practitioners in recommendation 1.1.5.1.
112	SH	Diabetes UK	3	Full NICE	4.8.1.4 1.1.1.4	80 11	Please insert the word “national” to reflect national sources of support as well as local, for example national help lines and organisations.	Thank you for your comment, we have adjusted the recommendation as you have suggested.
113	SH	Diabetes UK	4	Full NICE	4.8.1.5 1.1.1.5	80 11	In this recommendation and throughout the guideline, the recommendations refer to informed consent but the ethos of joint decision making, where there is a partnership between the person and the professional involved in their care, is missing and needs to be reflected in the recommendations of the guidance. This would bring the NICE guidance more in line with its opening section on person centred care, the recognition of the therapeutic alliance identified in 7.1.3 of the full guideline and recognition of the collaborative care model which encourages joint planning and goal setting as identified in 6.1 of the full guideline. Work has been undertaken that identifies the benefits of a partnership approach to decision making and the care planning process:	Thank you for this comment we believe that at a number of points throughout the guideline we have emphasised the need for patient involvement in decision making. Specific issue of informed consent are outside the scope of the guideline.

							http://www.diabetes.org.uk/Professionals/Information_resources/Reports/Care_planning_in_diabetes/ http://www.diabetes.nhs.uk/news-1/Partners%20in%20Care.pdf	
114	SH	Diabetes UK	5	Full NICE	4.8.1.6 1.1.2.1	80 11	A recommendation is needed that ensures practitioners develop the skills to meet the relevant competencies identified as required in this recommendation.	Thank you we have made comment on the skills of a practitioner in recommendation 1.1.5.1.
115	SH	Diabetes UK	6	Full NICE	4.8.1.7 1.1.3.1	81 11	The statement about negotiating confidentiality and information sharing with carers is open to interpretation and requires clarification to ensure the individual is involved in this process.	Thank you for this comment we believe that at a number of points throughout the guideline we have emphasised the need for patient involvement in decision making. We have amended our recommendation on privacy in light of yours and other comments
116	SH	Diabetes UK	7	Full NICE	4.8.1.9 1.1.4.5	81 13	Recognition of the need to provide assessment in a person's preferred language as well as at the intervention stage is needed in the recommendation to ensure individuals are supported to express their experiences.	Thank you for your comment, we feel this is already covered by recommendation 1.1.5.2.
135	SH	Diabetes UK	8	Full	5.6.1.1	101	This recommendation needs to consider depression in the context of the long term health condition. For example, it would be valuable to consider whether the depression predated the long term health condition, and the person's current health perceptions, and management of the long term condition. It would also be valuable to consider whether diagnosis of the long term health condition or a particular milestone has been reached, such as the development of a long term complication, and whether the person's psychological need is an adaptation reaction to these. The prevalence of depression is twice that of the general population in people with diabetes. Depression can relate to acceptance of diagnosis, adjusting to the requirements and responsibilities of the self care routine, coping with condition progression or the development of the complications of the condition or side effects of medication. Recognition of these factors is made in section 2 of the full guideline and the recommendations would benefit from better reflecting these factors. An understanding is also needed of a person's life circumstances and recent events, for example bereavement. 1.Frostholm,L. et al (2005) The patient's perceptions and	Thank you, (but within the context of depression) we think we have done this in this guideline. We are unsure what you would wish changed from your comments.

							the use of primary healthcare Psychosom Med 67(6) :997-1005 2.http://www.diabetes.org.uk/About_us/Our_Views/Position_statements/Prioritising-Emotional-Well-being-/ 3. Lustman PJ, Anderson RJ, et al. Depression and poor glycaemic control: a meta-analytic review of the literature. Diabetes Care, 23; 2000: 934-942	
136	SH	Diabetes UK	9	Full NICE	5.6.1.2 1.1.4.2	101 12	It is understood that the increased prevalence of some long term conditions amongst older people and people from BAME communities informed the GDG's exploration of specific issues/ assessment tools to help identify depression. Increased prevalence of some long term conditions is also of further relevance, for example there is an increased risk of diabetes amongst people with learning disabilities. Other populations, such as young adults may also have specific needs that require consideration as part of assessment. Lindsay P & Burgess D (2006) Care of patients with intellectual or learning disability in primary care: no more funding so will there be any change? British Journal of General Practice. February 2006: 84-86	Thank you but we feel we have addressed this is in a number of recommendations including 1.1.2.1, 1.1.4.2, 1.1.4.5, 1.1.5.2, 1.3.1.6. We have also added 3 new recommendations regarding learning difficulties.
137	SH	Diabetes UK	10	Full NICE	5.6.1.3 1.1.4.3	101 12	This recommendation also needs to include a bullet point to assess recent life events and circumstances and their impact on the person's emotional well being.	Thank you but we consider this too detailed a comment to include in a recommendation.
138	SH	Diabetes UK	11	Full NICE	5.6.1.3 1.1.4.3	101 12	The bullet point on history of depression should include any other long term conditions and assess whether or not the physical health condition came before or after the depression and the inter-relation between these.	Thank you but we consider this too detailed a comment to include in a recommendation.
139	SH	Diabetes UK	12	Full NICE	5.6.1.3 1.1.4.3 And general	101 12	As mentioned previously, the reference to "preference" is not enough to capture the ethos of partnership. It does not reflect providing information to support a person to make an informed choice and reach a joint decision about treatment as a result of this. The ethos of partnership must be better reflected throughout all the recommendations, including those where reference to patient preference is made. This would be in line with statements in the full guideline in sections 7.1.3, 6.1 and the section in the NICE guidance on person centred care.	Thank you but we consider this too detailed a comment to include in a recommendation. However, we have made some adjustment to the recommendations to reflect your comments.
141	SH	Diabetes UK	13	Full NICE	5.6.1.4 1.1.4.6	101 13	This recommendation would benefit from clarification which demonstrates the types of further help that would be available to an individual, should their situation deteriorate, for example out of hours crisis services.	Thank you; the depression update guideline deals with such situations and we have included a cross reference to that guideline.

142	SH	Diabetes UK	14	Full NI CE	5.6.1.4 1.1.4.6	101 13	This recommendation also needs to consider the context of the long term condition. Professionals need to understand and be able to assess the impact of depression and risk of self harm in terms of the affect on self care of the long term condition, and whether this could be linked to self harm. The guideline has identified the increased risk for suicidal ideation in section 2.	Thank you but we consider this too detailed a comment to include in a recommendation – we expect clinicians to exercise some judgement when following the recommendations.
144	SH	Diabetes UK	15	Full NI CE	5.6.1.5 1.1.4.7	102 13	It is important to identify proactive measures in this recommendation that can be taken by professionals, rather than leaving significant responsibility with the person to seek help at a time when they may not feel able to do so.	Thank you but in other recommendations, for example those concerned with risk of suicide, we clearly set out what is expected of professionals.
145	SH	Diabetes UK	16	Full NI CE	5.6.1.6 1.3.1.1	102 16	Whereas the importance of screening questions is recognised, a recommendation about how the questions are delivered in practice will be important. Practitioners will need to be skilled and confident to ask these questions in a supportive and engaging manner to ensure that the questions do not deter individuals from sharing how they are feeling. At present the questions themselves are closed questions and there is a risk they could be used as "tick box" questions only. Practitioners will need to feel confident that they have the skills to support an individual if they express emotional distress. The recent "Minding the Gap" report on the provision of psychological support and care for people with diabetes in the UK states: "…but with increasing psychological or psychosocial complexity there was a significant drop in the perceived skill of teams to manage these issues, such as depression, anxiety, eating disorders/problems, psychosexual problems and drug and alcohol abuse. With regard to what might be considered more difficult psychiatric issues to manage, such as psychosis or suicidal patients, responders felt that these issues would be poorly managed by their teams. Diabetes teams feel they need help with managing almost all psychological presentations and an opportunity to involve, or refer on to, specialist services for a whole range of conditions." http://www.diabetes.org.uk/Documents/Reports/Minding_the_Gap_psychological_report.pdf	Thank you for your comment, the detail you suggest is beyond the scope of the guideline.
121	SH	Diabetes UK	17	Full NI CE	4.8.1.10 1.1.5.3	81 14	This recommendation would benefit from explicit mention of a co-ordinated approach to care planning that recognises the need for liaison between the different professionals involved in the care of the individual.	Thank you for this comment but we feel this issue is best dealt with in the recommendation for collaborative care in section 1.6.
122	SH	Diabetes UK	18	Full	4.8.1.10	81	The wording of the recommendation would benefit from	Thank for your comment – however

				NICE	1.1.5.3	14	re-phrasing as at present it could appear to imply that the person has not been involved in developing, deciding and agreeing their treatment plan in partnership with the relevant professionals. Further clarification is also needed regarding who decides it is appropriate to share the plan with families and carers.	we feel that what you are requesting is at a level of detail that it is not possible to specify in a guideline. These details are better dealt with through careful local implementation of the standards derived from this guideline.
155	SH	Diabetes UK	19	Full NICE	5.6.1.11 1.3.1.6	103 17	The recommendation regarding the Distress Thermometer needs to be complemented by a recommendation for further contextual questions to help identify what the distress relates to. This reflects the statement in the guidance that identifies that scores of 4 or more warrant further investigation.	Thank you for your comment. We have now amended the recommendation to include further contextual information.
158	SH	Diabetes UK	20	Full NICE	5.6.1.13 1.3.2.2	103 17	A recommendation is needed to ensure that patients are informed of what side effects to expect and how to seek help. It is highly likely that such symptoms are distressing therefore please end the sentence at “how to seek help promptly”.	Thank you for your comment. The first point is covered in another recommendation (1.5.2.9). How to seek help will need discussion on an individual basis depending on local arrangements. We agree that it is better to finish recommendation 1.3.2.2 as you suggest and have amended the recommendation accordingly.
159	SH	Diabetes UK	21	Full NICE	5.6.1.13 1.3.2.2	103 17	Consideration should also be given to the relationship between self perception of poor health and the risk of suicidal ideation. If a person with a long term condition perceives their health outcomes and prognosis as poor, an intervention that included good health information could be valuable in helping with health perception. The guideline has identified the increased risk for suicidal ideation in section 2.	Thank you – we have amended the guideline in light of your comment.
160	SH	Diabetes UK	22	Full NICE	5.6.1.14 1.3.2.3	103 18	Please add third party support such as national help lines or local sources of support, to the 2nd bullet point.	Thank you – this is outside the scope of the guideline.
243	SH	Diabetes UK	23	Full NICE	7.4.1.1 1.1.5.1	194 13	As not all interventions are delivered with reference to a treatment manual(s), the inclusion of this phrase in this way could have the implication of limiting the options for treatment offered. Further clarity of what is meant by “treatment manuals” is required within the recommendation	Thank you for this comment. All healthcare professionals and those involved in the provision of psychological treatment will be familiar with the term treatment manual, we therefore do not think it is necessary to specify this in the way you suggest.
244	SH	Diabetes UK	24	Full	7.4.1.1	194	Please consider changing the wording of the third bullet point to:	Thank you for this comment we see no reason to adjust the

				NICE	1.1.5.1	13	"use routine outcome measures and work alongside the person with depression to review the efficacy of the treatment".	recommendation.
245	SH	Diabetes UK	25	Full NICE	7.4.1.1 1.1.5.1	194 13	Add into the fourth bullet point that permission from the individual for use of video and audio recording will be needed.	Thank you very much for this comment. It is routine practice in the NHS to obtain patient consent when using video and audio recording. All healthcare professionals will be aware of the need to do this. Therefore we do not think it is necessary to point it out in this guideline.
246	SH	Diabetes UK	26	Full NICE	7.4.1.1 1.1.5.1	194 13	Consideration should also be given to the outcomes important to the individual receiving the support.	Thank you very much for your comment. It is routine practice to discuss the outcome of treatments with patients. We would expect this to be done and do not think it is necessary to spell this out. To do so would result in an over-long recommendation which already has several clauses.
247	SH	Diabetes UK	27	Full NICE	7.4.1.1 1.1.5.1	194 13	This recommendation would benefit from identifying the need for interventions that consider the long term condition as well psychological aspects of need.	Thank you very much but we take it as implicit that this issue is dealt with within the guideline.
284	SH	Diabetes UK	28	Full NICE	7.4.1.16 1.4.2.2	198 19	In discussing sleep hygiene, it would be beneficial to include a recommendation regarding informing individuals about the affect of depression on sleep as this may help an individual's understanding of any experiences related to sleep such as waking tired or poor sleep.	Thank you very much for this comment. Psycho-education about the nature of the disorder is included under recommendation 1.1.1.1.
286	SH	Diabetes UK	29	Full NICE	7.4.1.17 1.4.2.3	198 20	First bullet point: an assessment of underlying issues is also beneficial as part of opening up discussion. Understanding the underlying issues might prompt suggestion of alternative support, for instance bereavement counselling where the underlying issue is found to be a bereavement.	Thank you very much for this comment. However your suggestion concerns a broader based mental health assessment. Our concerns are primarily the assessment for depression and the identification of appropriate treatment options. Bereavement counselling is outside the scope of this guideline.
252	SH	Diabetes UK	30	Full NICE	7.4.1.3 and general 1.4.3.1	194 20	Diabetes UK questions the limited inclusion of psychological therapies throughout this guidance. The recommendations exclude the use of other solution focussed interventions. Evidence has demonstrated that these too are effective interventions and should be included to enable more choice of psychological	Thank for this comment – we could find no evidence for solution focused therapy and the references you cite are not concerned with solution focused therapy but with counselling.

							therapies and interventions, which are at present limited to CBT. ▪ King M, Sibbald B, et al (2000) ▪ Randomised controlled trial of non-directive counselling, cognitive-behaviour therapy and usual general practitioner care in the management of depression as well as mixed anxiety and depression in primary care. Health Technol Assess. 4(19):1-83 ▪ Bower P, Byford S,et al (2000)Randomised controlled trial of non-directive counselling, cognitive-behaviour therapy, and usual general practitioner care for patients with depression. II: cost effectiveness. BMJ. Dec 2;321(7273):1362-3. ▪ Wampold, B. (2001). The great psychotherapy debate. Mahwah, NJ: Lawrence Erlbaum.	
256	SH	Diabetes UK	31	Full NI CE	7.4.1.4 1.4.3.2	195 20	A recommendation should be included that professionals and the individual liaise with the health care team providing care for the physical health condition(s), to ensure that an appropriate physical activity programme is tailored to the person's requirements and conditions.	Thank you very much for this comment – we have revised the recommendation in light of this.
257	SH	Diabetes UK	32	Full NI CE	7.4.1.5 1.4.3.3	195 20	Facilitation of the support groups should be supported by a health care professional who has knowledge of the physical health conditions lived with by those attending the group and the relationship between depression and these conditions.	Thank you very much for this comment – we have revised the recommendation in light of this.
258	SH	Diabetes UK	33	Full NI CE	7.4.1.5 1.4.3.3	195 20	The recommendation should also reflect the qualitative evidence in section 4 that identified the beneficial effects of guest speakers who could provide information and answer questions.	Thank you very much – however we do not think it appropriate to combine the qualitative evidence as you suggest from section 4 with that for the data on peer support. The peer support groups did not necessarily adopt this strategy and we therefore think it would be going beyond the evidence of effectiveness to do so.
259	SH	Diabetes UK	34	Full NI CE	7.4.1.5 1.4.3.3	195 20	There is a risk with this recommendation that individuals will be made to wait for help and support until there are enough participants for a group.	Thank you for this comment. However as you may be aware rehabilitation facilities run groups routinely, for example those for cardiac rehabilitation. In addition many specialist physical health centres, for example those for diabetes, have a very large number of patients so acquiring sufficient numbers for a group should not

								take long.
263	SH	Diabetes UK	35	Full NICE	7.4.1.6 1.4.3.4	194 21	Appropriate written materials – these should also be available in other formats.	Thank you very much for your comment. We have made adjustments to the recommendation in light of yours and other comments.
264	SH	Diabetes UK	36	Full NICE	7.4.1.6 1.4.3.4	194 21	The materials could also include appropriately tailored information about managing the long term condition.	Thank you very much for this comment. We agree that it would be desirable if information were tailored in this way. We believe the detail for this is a matter for NHS implementation.
265	SH	Diabetes UK	37	Full NICE	7.4.1.6 1.4.3.4	194 21	Facilitation should be supported by a health care professional who has knowledge of the physical health conditions lived with by those attending the group and the relationship between depression and these conditions.	Thank you very much for this comment. We agree that it would be desirable if information were tailored in this way. We believe the detail for this is a matter for NHS implementation.
267	SH	Diabetes UK	38	Full NICE	7.4.1.7 1.4.3.5	196 22	Appropriate training should include knowledge of the physical health conditions lived with by the person completing the course.	Thank you for this comment. We would expect this to form part of the appropriate training for any healthcare professional working with a person with a specific physical health condition. We think specific recommendations about training are outside the scope of the guideline.
268	SH	Diabetes UK	39	Full NICE	7.4.1.8 1.4.3.6	196 22	The provision of information in appropriate formats about the risks and benefits of different interventions should be included in this recommendation.	Thank you very much for this comment. This recommendation has been removed from the guideline, as the same information was included elsewhere. The points you have raised have been covered in other recommendations.
640	SH	Diabetes UK	40	NICE	1.4 and general		The guidance would benefit from further emphasis on reviewing and supporting individuals with the management of their physical health condition both during and following treatment for depression.	Thank you – we believe the recommendations emphasise this through all 4 steps.
210	SH	Diabetes UK	41	Full	7	General	Recommendations are included in the general guideline for depression that have been excluded from this guideline. Whereas the GDG has offered a rationale for this, they also state that “the nature of depression in chronic physical health problems is not fundamentally different from depression in the absence of such problems”, therefore it would be valuable to offer more choice in access to psychological therapies, and at least	Thank you for this comment – we have clear criteria on what we extrapolated from the depression guideline and this did allow us to include some but not all interventions. This is important as we have some evidence that some interventions for depression such as

							include the recommendations from the general depression management guideline in this guideline.	IPT were not very effective in comparison with standard care in depression and chronic physical health problems.
211	SH	Diabetes UK	42	Full	7	General	▪ Diabetes UK made the following suggested changes for recommendations in the general depression guideline, that could also be included in this guideline. ▪ Recommendation 6.5.3.1 – full draft depression guideline : The way this recommendation is phrased at present could have the effect of deterring an individual from effectively engaging with counselling or considering it as a treatment option. Instead of stating "take care to explain about the uncertainty about the effectiveness", it would be helpful if the recommendation included a discussion about the what the intervention is, what the benefits and any issues are with the intervention, and provide the person with information to enable them to weigh up whether or not they feel the intervention is suitable for them. ▪ Recommendation 6.5.3.2 – full draft depression guideline: All counselling should take a non-directive, person centred approach, therefore clarity is needed to identify whether this is about a model specifically. If it is, this is again restricting the choice of counselling approaches on offer. ▪ Recommendation 1.5.4 – NICE draft depression guideline - If IPT and Couples therapy are also seen as effective interventions, it is unhelpful to introduce the interventions in the current context, with a primary focus on one intervention in particular. ▪ Recommendation 6.5.5.1 – full draft depression guideline: The recommendation should explicitly state that people are offered information about the therapies available to support them in making an informed decision in partnership with their healthcare professional. ▪ Recommendation 6.5.5.2 – full draft depression guideline: This recommendation does not make reference to the involvement of the partner in wishing to participate in Couples Therapy. Again the ethos of joint decision making is not present. The recommendation would benefit from being re-written to ensure it is not misread as implying the clinician's opinion would be taken in isolation of that of the person and their partner. ▪ Recommendation 6.5.6.1 – full draft depression guideline: The way this recommendation is phrased at	Thank you for these comments – we have considered their implications for this guideline and have adjusted where appropriate. For a full response – please refer to the Depression Update guideline.

							present could have the effect of deterring an individual from effectively engaging with this therapy or considering it in the first instance. Instead of stating "take care to explain the uncertainty about the efficacy", the recommendation should include a discussion about the what the intervention is, what the benefits and any issues are with the intervention, and provide the person with information to enable them to weigh up whether or not they feel the intervention is suitable for them.	
25	SH	Diabetes UK	43	Full	General		In recommendations where timescales for interventions are offered, it should be explicit that this is also tailored to an individual's need.	Thank you for your comment. Although we agree with an individual approach, the recommendations in the guideline reflect the current evidence base. Clinicians will of course always seek to tailor any intervention to the needs of an individual.
272	SH	Diabetes UK	44	Full NI CE	7.4.1.12 1.5.3.4	197 30	Fourth bullet point - please could this read "appropriately trained healthcare professionals". Again knowledge and understanding of physical health conditions is important here.	Thank you very much for this comment. However we have made a general recommendation at the front of these guidelines concerning the competence of people delivering these recommendations.
26	SH	Diabetes UK	45	Full	General		Statements that refer to depression as complicating the management of the physical health condition also need to reflect that the physical health condition can complicate the depression.	Thank you, we explicitly state this in the introduction to Chapter 2.
289	SH	Diabetes UK	46	Full NI CE	7.4.1.19 1.5.1.2	199 23	Please add the terms "risk or issues" to the discussion of the relative merits.	Thank you very much for this comment. We have made some amendments to this recommendation but we are unclear as to precisely why you want the term "risk or issues". We find the term "issues" too vague to include.
290	SH	Diabetes UK	47	Full NI CE	7.4.1.19 1.5.1.2	199 23	It is important that the statement regarding patient choice is not diluted by the statement on the likelihood of adherence, as this could imply the individual has not been involved in reaching the decision about treatment intervention.	Thank you very much for this comment. We think we have made considerable efforts in the recommendations throughout this guideline to specify the importance of patient involvement. We do not think therefore that the simple promotion of adherence would take priority over anything else in terms of the development of any shared treatment plan.
326	SH	Diabetes UK	48	Full	8.5	242 -	It is important to consider that, whereas no particular	Thank you for your comment, we

						243	drug can be recommended for all clinical conditions", there may be some that can be better recommended for some conditions.	agree advice on interactions and contra-indications leads to an appropriate choice of medication.
331	SH	Diabetes UK	49	Full NI CE	8.5.2.1 1.4.4.1	243 22	Consider making the third bullet point he first, in recognition of the focus of this guideline.	Thank you very much for this comment. We have revised the recommendation in light of your comment.
335	SH	Diabetes UK	50	Full NI CE	8.5.2.2 1.4.4.2	243 22	In order to make the recommendations about St. Johns Wort clearer, it might be better to re-arrange the bullet points, so that the second becomes the first. It would also be useful for healthcare professionals to enquire if an individual is already taking it, so that advice and information, in line with the existing recommendations can be provided. This is important in the context of increased use of these preparations in the population.	Thank you for this comment but it is not part of the consultation as the review was not updated.
400	SH	Diabetes UK	51	Full NI CE	8.5.2.3 1.5.2.1	244 23	It would be valuable to include a bullet point which highlights the importance of considering the direct effects of antidepressants on certain conditions. This could help inform the choice of antidepressants.	Thank you very much for this comment. However there is no clear evidence for a direct effect of a specific antidepressant on particular on a chronic physical health problem. We have added this point to the recommendation.
401	SH	Diabetes UK	52	Full NI CE	8.5.2.3 1.5.2.1	244 23	It would be useful to include reference to the increased hypoglycaemic effects of some diabetes medications when the person is also taking monoamine-oxidase inhibitors.	Thank you very much for this comment. However, it is not possible to make explicit reference to all known interactions in the recommendation.
512	SH	Diabetes UK	53	Full NI CE	8.5.2.11 1.5.2.9	245 25	It is important that a person's concerns are also discussed at the stage at which a person is exploring treatment options.	Thank you very much. We have amended this guideline in light of yours and other comments
513	SH	Diabetes UK	54	Full NI CE	8.5.2.11 1.5.2.9	245 25	Information should be provided in a format appropriate to the individual	Thank you very much. We have amended this guideline in light of yours and other comments.
514	SH	Diabetes UK	55	Full NI CE	8.5.2.11 1.5.2.9	245 25	Again, it would be valuable to include a bullet point which highlights the importance of considering the direct effects of antidepressants on certain conditions.	Thank you very much. We have considered in some considerable detail the issue of interactions between drugs. However we think the detailed consideration of the relative risks and interactions of anti-depressant drugs with a range of other physical conditions is beyond the scope of this guideline.

519	SH	Diabetes UK	56	Full NICE	8.5.2.13 1.5.2.11	245 26	This recommendation should include the need to tailor this to the needs and wishes of the individual.	Thank you very much. We have revised this recommendation in light of yours and other comments.
27	SH	Diabetes UK	57	Full	General		Where recommendations are made about the prescription of medications, a recommendation should be included to raise awareness of the Yellow Card reporting system and encourage patients and practitioners to report any side effects experienced.	Thank you for your comment, the detail you suggest is beyond the scope of the guideline.
296	SH	Diabetes UK	58	Full	8	201	In sections referring to medication prescribing an explicit recommendation is required to ensure that a person's weight, blood glucose, blood pressure and lipid levels are monitored. This is particularly important for people with diabetes and those at risk of developing Type 2 diabetes. Good diabetes control is required to prevent the development of acute complications and delay the development of long term complications, such as Cardio vascular disease (people with diabetes have a higher prevalence of CVD). Furthermore overweight and obesity are a risk factor for the development of Type 2 diabetes. http://www.diabetes.org.uk/About_us/Our_Views/Position_statements/Early_identification_of_people_with_Type_2_diabetes/	Thank you very much for this comment. We agree with you about careful monitoring in regard to people with diabetes. We believe that this matter should already be effectively managed in terms of the general care of people with diabetes.
523	SH	Diabetes UK	59	Full NICE	8.5.2.15 1.5.2.13	246 26	Add third party support to the first bullet point.	Thank you for this recommendation. We thought it appropriate as this recommendation concentrates on the role of healthcare professionals and that they be expected to provide the proper support. It may be for healthcare professionals to consider involving a third party but this may not always be either desirable or feasible and in such circumstances we felt it appropriate to concentrate our recommendation on healthcare professionals.
524	SH	Diabetes UK	60	Full NICE	8.5.2.16 1.5.2.14	246 26	A recommendation is needed to ensure that patients are informed of what side effects to expect and how to seek help. It is highly likely that such symptoms are distressing therefore please end the sentence at "how to seek help promptly".	Thank you very much, but this recommendation has now been removed from the guideline because it had already been covered, please see recommendation 1.3.2.2.
528	SH	Diabetes UK	61	Full NI	8.5.2.18 & .19	247	Consideration should be given to the need to re-assess an individual's circumstances and whether or not, and why, the original intervention was not effective for the	Thank you very much. We think that the issues that you raised in your comments are in fact encompassed

				CE	1.5.2.16 & .17	27	person.	within the recommendation that we have made.
539	SH	Diabetes UK	62	Full NI CE	8.5.2.22 1.5.2.20	247 28	It is important that where an individual has other long term conditions that these are taken into consideration, and there is liaison between healthcare professionals involved in the person's care to ensure that all side effects and prescribing are considered in context. As an example some features of the serotonin syndrome are similar to symptoms of hypoglycaemia in people with diabetes.	Thank you very much. We think the detailed commentary comparing serotonin syndrome with hypoglycaemia are beyond the scope of this guideline.
203	SH	Diabetes UK	63	Full NI CE	6.5.1.1 6.5.1.1	146 31	Clarity is needed regarding what occurs in cases where there is not "associated functional impairment"	Thank you for you comment; the cases you refer to would be treated in line with the recommendations set out in the guideline.
196	SH	Diabetes UK	64	Full	6.5	146	The co-ordination of mental and physical healthcare should be undertaken throughout each step, and not only at steps 4 and 5.	We agree and a number of recommendations point to this, such as 1.1.5.3, 1.3.1.3 and 1.3.2.1. We have revised the model in light of yours and others comments - but we did not make a specific recommendation as we consider such activity (except for collaborative care) to be part of routine care in the NHS.
198	SH	Diabetes UK	65	Full NI CE	6.5.1 1.6	146 31	Fourth line - this needs to reflect the bullet point later on and demonstrate a "co-ordinated approach to healthcare" overall, not just mental healthcare as it currently reads.	Thank you very much for this comment but it is beyond the scope of the guideline.
553	SH	Diabetes UK	66	Full	Appendix 16	342	Under Diabetes – need to include reference to diabetes controlled through diet and physical activity as complications such as hypo and hyperglycaemia can be affected regardless of whether the person is taking medications for blood glucose control.	Thank you very much for this comment. We have made a number of changes to Appendix 16 following comments from stakeholders. A number of stakeholders have suggested the appendix was too long in order to be practically useful to clinicians. Therefore we did not think it appropriate to add further details as you suggest.
554	SH	Diabetes UK	67	Full	Appendix 16	342	Insulin and tricyclics– further detail is required regarding how hypotension may mimic hyperglycaemia. Oral hypoglycaemics and tricyclics - further detail is required regarding how hypotension may mimic hypoglycaemia. These details need to be checked and clarified.	Thank you for these comments, however commenting on this area is outside the scope of the guideline.
555	SH	Diabetes UK	68	Full	Appendix 16	342	Other newer agents, for managing blood glucose levels also need to be included and recommendations	Thank you very much for this comment. However it should be

							provided: See NICE Type 2 newer agents guideline http://www.nice.org.uk/Guidance/CG/Wave16/3	pointed out that we can only advise on interaction with current NICE products. The newer agents you discuss currently don't have a license.
556	SH	Diabetes UK	69	Full	Appendix 16	342	Exenatide and similar compounds have a side effect of vomiting - this could have an impact on the efficacy of antidepressants.	Thank you very much for this comment. This is an example of a set of compounds whose frequency of use we think does not warrant a specific interaction recommendation. As you will be aware there are a very great number of interactions. Our concern was identifying only those interactions which were relatively common and for which there was good evidence. We have made clear in our revision of the draft guideline that individual clinicians should consult relevant sources of information such as the BNF.
28	SH	Diabetes UK	70	Full	General		What approach will NICE be taking to post natal depression in women with long term conditions such as diabetes?	Thank you for your comment, the detail you suggest is beyond the scope of the guideline. It is covered in the NICE APMH guideline (CG45).
199	SH	Diabetes UK	71	Full NICE	6.5.1 1.7		Again, it would be valuable to include a bullet point which highlights the importance of considering the direct effects of antidepressants on certain conditions.	Thank you for your comment. As discussed in Chapter 8 there was insufficient data to draw firm conclusions concerning pharmacological interventions for specific conditions.
29	SH	Diabetes UK	72	Full	General		Diabetes UK questions the exclusion of Recommendation 9.2.1.1 of full draft depression general guideline. A suggested change was also made to this recommendation: Add to the first bullet point: general physical health, "other physical and long term conditions".	Thank you for this comment – the recommendation you refer to has been superseded in this guideline by more detailed recommendations on the issues which were covered in 9.2.1.1 at a more general level.
200	SH	Diabetes UK	73	Full NICE	6.5.1 1.7		The following changes were suggested by Diabetes UK regarding the full draft general depression guideline. These may impact on the care for people with depression and long term conditions as the depression and long term conditions guideline refers back to the draft general depression guideline, and so have been	Thank you for these comments – we have considered their implications for this guideline and have adjusted where appropriate.

							included in our comments on this guideline: ▪ Recommendation 10.1.16.5– full general depression draft guideline: Please add long term conditions and eating disorders to the bullet list ▪ Recommendation 10.1.16.6– full general depression draft guideline: Again re-assessment is required to understand why a treatment/ intervention was not effective for that individual at that time. ▪ Recommendation 10.1.16.8 – full general depression draft guideline: Consideration of medications taken as a result of other conditions should also be included in this recommendation. ▪ Recommendation 10.1.16.11– full general depression draft guideline: Please add “increased appetite” to the list ▪ In cases where the person has a long term condition other than diabetes, awareness of diabetes and risk factors for developing Type 2 diabetes are relevant here, as overweight is a risk factor for developing Type 2 diabetes, and depression and eating disorders are more prevalent amongst people with diabetes than the general population. ▪ Goodwin Rd, Hoven CW, Spitzer RL (2003) Diabetes and Eating Disorders in Primary Care Int. J Eat Disord: 33(1) 85-91 ▪ Anderson RJ, Freedland KE, Clouse RE, Lustman PJ: The prevalence of comorbid depression in adults with diabetes: a meta-analysis. Diabetes Care 24:1069–1078, 2001 ▪ Recommendation 10.3.6.1 – full general depression draft guideline: Please add long term conditions to the list of considerations regarding review. ▪ full general depression draft guideline: Reassessment of what is underlying the depression would be valuable at this stage as part of review, and to ensure choice of treatment options are not removed ▪ 5.3.4.2 – full general depression draft guideline: This recommendation needs to acknowledge the need for integration with any existing care plans an individual may have, for example as a result of having a long term condition. ▪ When referring to a crisis plan this recommendation should also include strategies to tackle any triggers identified.	

							▪ The recommendation needs to reflect that care planning will be undertaken with the person, rather than a copy of the plan shared with them after it has been drawn up. ▪ 10.4.6.1 – full general depression draft guideline: ▪ The recommendation needs to reflect that this is a treatment option when other avenues have been fully explored. At present the recommendation is open to interpretation. The discussion of the risks and benefits should come at the beginning of the recommendation.	
7	SH	Diabetes UK	74	Full and NICE	General	General	The recommendation in NICE draft general depression guidance 1.6.1.5 could also be relevant to this guideline and Diabetes UK questions why it has been excluded.	Thank you for this comment we have revised a number of recommendations in each guideline in light of your comments.
8	SH	Eli Lilly and Company Limited and Boehringer Ingelheim	1	Full & NICE	General	General	Eli Lilly and Company Limited and Boehringer Ingelheim commend the Guideline Development Group (GDG) on work conducted and the quality of the draft guideline recommendations. We believe that the guidelines reflect current practice and offer a sensible approach to the pharmacological treatment and management of depression in adults with chronic physical health problems. We do however have a number of comments which we would like to draw to the attention of the GDG for consideration. These relate to the clarification of remission as the primary goal of treatment and switching treatment. Primary goal of treatment No explicit reference is made within the guideline to the primary goal of treatment. We consider this to be a fundamental omission and recommend that for the guidelines to be considered valid a recommendation is included within both the full and NICE guidelines, which clearly specifies that the primary goal of treatment is to achieve remission. This recommendation would bring the NICE guidelines in line with the globally recognised treatment guidelines produced by the American Psychiatric Association 2000, The Canadian Psychiatric Association 2004, Australian and New Zealand Clinical Practice Guidelines 2004 and the WHO Regional Office for Europe 2005. In addition to achieving remission a further goal of treatment is the restoration of function. A recommendation highlighting this important goal should also be included within the final guideline with reference made to those drugs which have demonstrated to be effective in achieving this goal. In an open label	Thank for these comments we have revised the NICE introduction to clarify the goal of treatment. We have an extensive review and a number of recommendations of switching strategies in the updated Depression guideline and have cross referenced clearly to that guideline following your comment.

							naturalistic study duloxetine significantly improved function and quality of life in a diverse population of patients with major depressive disorder (Wohlreich et al. 2007). Presentation of switching data The current recommendations do not include any information on the choices available to the patient and clinician in terms of switch method and/or switch medication. We would recommend that further recommendations are included within both the Full and NICE versions. Additional information and suggested text is provided below in comments 5 and 6. Our comments on specific areas of both the full and NICE guidelines are provided below.	
161	SH	Eli Lilly and Company Limited and Boehringer Ingelheim	2	Full NICE	6.1.1 1.2	107/ 3 to 5/ 14 to 15	These sections would benefit from the inclusion of a subsection which clearly defines remission as the primary goal of treatment. Reference should also be made to the restoration of function as a further important goal of treatment.	Thank you – we have amended the introduction of the guideline in light of this comment.
313	SH	Eli Lilly and Company Limited and Boehringer Ingelheim	3	Full	8.2.4	215	We would draw GDGs attention to the additional data which is available for duloxetine above the Wise et al. (2007) study considered within the full guideline. In addition to being licensed for the treatment of major depressive disorders duloxetine is also licensed for the treatment of diabetic peripheral neuropathic pain (DPNP) and generalised anxiety disorder (Cymbalta Summary of Product Characteristics March 2009). In the treatment of patients with diabetic peripheral neuropathic pain duloxetine has been demonstrated to be safe and well tolerated in patients with and without cardiovascular conditions (Wernicke et al.2008). The use of duloxetine in the treatment of DPNP is associated with modest increases in fasting plasma glucose however these do not impact on the significant improvement in pain which is observed with duloxetine treatment (Hardy et al. 2007). Other metabolic changes are limited (Hardy et al. 2007). Duloxetine is also licensed for the treatment of women with moderate to severe stress urinary incontinence (at a dose of 40mg twice daily under the brand name Yentreve) (Yentreve Summary of Product Characteristics April 2008). Data is also available supporting the safety and tolerability of duloxetine in patients with fibromyalgia with or without major depressive disorder (Arnold et al 2005 and Russell et al. 2005). In summary there is	Thank you for this comment the review of duloxetine was undertaken by the group responsible for the updating of the Depression guideline. The review they undertook failed to find any convincing evidence to support a recommendation for the use of duloxetoine for the treatment of neuropathic pain. On a number of issues you raised we do not feel able to take up your suggestions. In most cases we do not feel there is sufficiently robust evidence to support your recommendation. For example, there are only single studies supporting the case (e.g. Wernicke et al, Raskin et al), they are outside the scope of the guideline (urinary incontinence), or they were not randomised controlled trials (Karp et al).

							significant data on the safety and tolerability of duloxetine in various different clinical conditions. We would also draw the GDG's attention to the fact that duloxetine is one of the few antidepressants that has been tested in double-blind, placebo controlled trial in elderly patients. In a study comparing the effects of duloxetine versus placebo in elderly patients with recurrent major depressive disorder Raskin et al. 2007 demonstrated that duloxetine improved cognition, depression and some pain measures and was well tolerated. In addition the efficacy and safety of duloxetine has been demonstrated in elderly patients with major depressive disorder who had failed to respond to an SSRI. . Approximately 67% of patients who had failed to response to an SSRI showed a full or partial response to duloxetine (Karp et al. 2008). While neither of these two studies were designed to evaluate the efficacy of duloxetine on patients with specific comorbid studies the patient populations included patients with a range of comorbid conditions. Duloxetine was effective and well tolerated in all patients irrespective of any comorbid conditions.	
323	SH	Eli Lilly and Company Limited and Boehringer Ingelheim	4	Full	8.3.4	235	For this section on the clinical evidence on adverse effects of antidepressants while the GDG have reviewed duloxetine and highlighted that 'Duloxetine is associated with small increases in diastolic blood pressure, tachycardia and cholesterol compared with placebo' in order to fully inform the reader additional information should be included highlighting that duloxetine was however not associated with any significant cardiovascular risks (Wernicke et al. 2007)	Thank you for your comment, however the GDG concluded that large-scale, long-term naturalistic studies are needed before a firmer conclusion on the absence of cardiovascular risk could be confirmed.
533	SH	Eli Lilly and Company Limited and Boehringer Ingelheim	5	Full NICE	8.5.2.21 1.5.2.19	247 28	In order to clarify that switching is an option in patients who have not responded or tolerated a treatment this recommendation should be amended as follows, 'If an antidepressant has not been effective or is poorly tolerated.....then another single antidepressant (including within the same class) should be prescribed. The choice should be made between using an antidepressant within the same class or switching to another antidepressant.'	Thank you very much. We have made some amendments to the recommendation following yours and other comments.
534	SH	Eli Lilly and Company Limited and Boehringer Ingelheim	6	Full NICE	8.5.2.21 1.5.2.19	247 28	The current recommendation does not include any information on the choices available to the patient and clinician in terms of switch method and/or switch medication options. ▪ A number of duloxetine studies (Karp et al. 2008,	Thank you very much for this recommendation. We have reviewed the evidence for the efficacy of duloxetine in the depression update guideline. This

							Perahia et al. 2008 and 2009, Wohlreich et al. 2005) have demonstrated that switching to duloxetine is well tolerated and safe: ▪ Following an immediate switch from an SSRI or venlafaxine (Wohlreich et al. 2005) ▪ Following an immediate or start-taper switch (Perahia et al. 2008 and 2009) ▪ In elderly patients (Karp et al. 2008) ▪ In patients with painful physical symptoms (Perahia et al. 2008 and 2009) ▪ In order to fully inform the reader on the options which are available when considering a switch in medication we suggest the following recommendation is added after 8.5.2.21 (Full Guideline) and 1.5.2.19 (NICE Guideline) 'When switching to another antidepressant reasonable choices for a second antidepressant include: ▪ Initially a different SSRI or better tolerated newer generation antidepressant ▪ Subsequently switching to an antidepressant pharmacological class that may be less well tolerated, for example venlafaxine , a TCA or an MAOI ▪ Subsequently switching an antidepressant of a different class which is known to be well tolerated, for example duloxetine	evidence was drawn in the development of this guideline. In line with the recommendations in that guideline we do not think it appropriate given the evidence base to make the specific recommendation for duloxetine that you suggest.
540	SH	Eli Lilly and Company Limited and Boehringer Ingelheim	7	Full NICE	8.5.2.22 1.5.2.20	247 28	The current recommendation while highlighting that prescribers should be aware of the need for 'gradual and modest incremental increases in dose' make no reference to the fact that immediate switching is possible when switching from an SSRI to duloxetine. In a study comparing two switching techniques (direct switch and start-taper switch) Perahia et al. 2008 demonstrated that switching to duloxetine was well tolerated and safe regardless of the switch method used. The option of this immediate switch opportunity should be reflected by the addition of the following text to 8.5.2.22 and 1.5.2.20 'When switching from one antidepressant to another.....While for most antidepressants switching can normally be achieved in a week immediate switching is an option for patients switching from an SSRI to duloxetine.	Thank you very much for this recommendation. However we think it is too specific an issue to warrant a recommendation and we are uncertain as to the efficacy of duloxetine (please see previous comments on duloxetine).
591	SH	Eli Lilly and Company Limited and Boehringer Ingelheim	8	NICE	Introduction	3 to 5	Examples of chronic physical health problems associated with depression would be useful to the reader.	Thank you very much for this comment. We regard this as too much detail to include in the NICE guideline but however these

								matters are dealt with in some detail in the NICE full guideline (please see chapter 2).
30	SH	Eli Lilly and Company Limited and Boehringer Ingelheim	9	Full	General		**References** ▪ American Psychiatric Association. Practical guidelines for the treatment of patients with major depressive disorder (revision). American Journal of Psychiatry 2007; 157 (4): 1-45 ▪ Arnold LM et al. A randomized, double-blind, placebo-controlled trial of duloxetine in the treatment of women with fibromyalgia with or without major depressive disorder. International Association for the study of pain 2005; 119: 5-15 ▪ Cymbalta. Summary of Product Characteristics. Lilly ; March 2009 ▪ Hardy T et al. Does treatment with duloxetine for neuropathic pain impact glycemic control? Diabetes Care 2007; 30: 21-26 ▪ Karp JF et al. Rescue pharmacotherapy with duloxetine for selective serotonin reuptake inhibitor nonresponders in late-life depression: Outcome and tolerability. Journal of Clinical Psychiatry 2008; 69: 457-463 ▪ Möllher HJ. WHO Regional Office for Europe. Health Evidence Network Report 2005 ▪ O'Donovan C. The Canadian Psychiatric Association in conjunction with the Canadian Network for Mood and Anxiety Treatments. Canadian Journal of Psychiatry 2004; 49 (1); 5S-9S ▪ Perahia DGS et al. Switching to Duloxetine From Selective Serotonin Reuptake Inhibitor Antidepressants: A Multicenter trial Comparing 2 Switching Techniques. Journal of Clinical Psychiatry 2008; 69: 95-105 ▪ Perahia DGS et al. Switching to duloxetine in selective serotonin reuptake inhibitor non- and partial-responders: Effects on painful physical symptoms ▪ Journal of Psychiatric Research 2009;43: 512-518 ▪ Raskin J et al. Efficacy of duloxetine on cognition, depression, and pain in elderly patients with major depressive disorder: An 8-week, double-blind, placebo-controlled trial. American Journal of Psychiatry 2007; 164: 900-909 ▪ Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Depression. Australian New Zealand Journal of Psychiatry 2004; 38: 389-407 ▪ Russell IJ et al. Efficacy and safety of duloxetine for the	Thank you for the references. However we did not consider these references in the guideline for the following reasons: 1) most references are not specifically focused on depression and chronic physical health problems and therefore beyond the scope of the guideline (APA, 2007; Lilly, 2009; Hardy et al., 2007; Karp et al. 2008; Mollher 2005; O'Donovan 2004; Perahia et al 2008; Perahia et al 2009; Raskin et al 2007; Royal Australian and New Zealand College of Psychaitrists, 2004; Wernick et al 2007; Wohreich et al 2005; Eli Lilly, 2008) 2) Two reference concern fibromyalgia with is outside the scope of the guideline: Arnold et al (2005); Russell et al. (2008) Two references were on combined populations of people with and without physical health problems

							treatment of fibromyalgia in patients with or without major depressive disorder: Results from a 6-month, randomized, double-blind, placebo-controlled fixed-dose trial. International Association for the Study of Pain 2008; 136: 434-444 ▪ Wise TN et al. The safety and tolerability of duloxetine in depressed elderly patients with and without medical comorbidty. International Journal of Clinical Practice 2007; 61: 1283-1293 ▪ Wernicke J et al. An evaluation of the cardiovascular safety profile of duloxetine. Drug Safety 2007; 30(5): 437-455 ▪ Wernicke JF et al. Safety and tolerability of duloxetine treatment of diabetic peripheral neuropathic pain between patients with and without cardiovascular conditions. Journal of Diabetes and Its Complications 2008. doi:10.1016/j.jdiacomp. 2008. 07.004 ▪ Wohlreich MM et al. An open-label study of duloxetine for the treatment of major depressive disorder: comparison of switching versus initiating treatment approaches. Journal of Clinical Psychopharmacology 2005; 25: 552-560. ▪ Yentreve. Summary of Product Characteristics. Eli Lilly and Company, April 2008	
402	PR	Expert Reviewer Dr Peter Trigwell		Full NI CE	8.5.2.3 1.5.2.1	244 23	States “people started on antidepressants who are not considered to be at increased risk of suicide should normally be seen after two weeks”. Why should this necessarily be so? A judgement should be made based upon a full understanding of the clinical situation and need, whilst also taking into account patient choice and preference.	Thank you very much for this recommendation. We consider that this is important because there was some evidence that people were not being seen frequently enough. Where there is an increased risk of suicide we think it quite reasonable that a two week limit is set. As you will be aware, risk of suicide is increased in the first weeks prior to and after engaging in treatment.
535	PR	Expert Reviewer Dr Peter Trigwell		Full NI CE	8.5.2.21 1.5.2.19	247 28	The word “/withdrawal” should be deleted every time it appears, as it does not make sense to tell patients that antidepressants are not associated with tolerance or dependence but then use the phrase “discontinuation / withdrawal”. The word discontinuation should be used alone.	Thank you very much for this comment as a result of which we have amended our recommendations. The word ‘withdrawal’ no longer appears in the guideline in relation to antidepressants.
546	PR	Expert Reviewer Dr Peter Trigwell		Full NI CE	8.5.2.25 1.5.2.23	248 29	Same comments re deleting ”/withdrawal”.	Thank you for your comment. We have revised the recommendation in light of yours and others’ comments.

65	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NI CE	1.5.2.19 1.5.2.17	247 27	First element uses the word “inadequate” whereas second bullet point uses “still no response”, which does not make these two statements compatible or able to read well.	Thank you we have amended these in light of your and other comments.
66	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NI CE	1.5.2.19 1.5.2.17	247 27	Second bullet point. “Switching to another antidepressant if … the person expresses a preference for changing treatment”, may put practitioners in a very difficult position if the patient’s preference is irrational or ill-informed, so that there should be some wording to emphasise that this needs to be an “appropriate” decision.	Thank you – we have not amended the text as you suggest as we feel that this kind of detail has to be left to individual clinicians to decide on.
201	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NI CE	6.5.1 1.6	146 31	Fourth line need to either delete “to mental healthcare,” or add to this so that it reads “…to mental and physical healthcare,”	Thank you for your comment, we have corrected the text.
250	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NI CE	7.4.1.2 1.1.5.2	194 14	This seems, at least from the perspective of working in a large city with a very broad range of language preferences, to read as unrealistic, so that specifying at this early / high level of guidance the need to consider giving all interventions in the preferred language sounds to be politically correct but not necessarily achievable / meaningful.	Thank you for this comment. We have made some changes to the recommendation in light of your comments. We would expect clinicians to use their judgement when implementing any NICE guideline but do consider that developing materials in the language preference of significant groups representative of local communities would be helpful.
260	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NI CE	7.4.1.5 1.4.3.3	195 20	First bullet point states that group programmes should be “delivered to groups of individuals with a shared chronic health problem”, but this may not be the best or a possible approach. If we encourage services to wait until they have collected enough people together who have both depression and the same chronic health problem to form a group we will be getting in the way of providing effective services on a day to day basis, as we may prevent attempts to help people with depression and varied chronic physical health problems when that would be more likely to be possible. The third bullet point re “sharing experiences and feelings of having a chronic physical health problem” is possible without the physical health problem needing to be the same for all patients involved in the group.	Thank you very much for this comment, however the evidence base suggests that people with common physical health problems do indeed benefit from peer support groups as was suggested. Rehabilitation facilities such as those for cardiac rehabilitation, run groups routinely. Many specialist physical health centres, for example those for diabetes, have a very large number of patients so acquiring sufficient numbers for a group should not take long.
261	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NI CE	7.4.1.5 1.4.3.3	195 20	Fourth bullet point. It would be helpful to add a suggestion that those facilitating meetings should have knowledge and experience of working with / helping people with both depression and physical health problems.	Thank you very much. We agree that this would indeed be desirable and we would expect any healthcare professional or other individuals supporting a peer

								support group for people with a chronic physical health problem to indeed be familiar with the nature of the disorder. We do not feel this needs to explicitly stated.
273	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NICE	7.4.1.12 1.5.3.4	197 30	First bullet point, add “where possible / appropriate” - with regard to expecting groups to be delivered for people”with a common chronic health problem”, as this may not be possible. See comment on line 8 above.	Thank you but the change you suggest does not fit with the evidence from the trials.
274	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NICE	7.4.1.12 1.5.3.4	197 30	Third bullet point, change “and” to “plus”.	Thank you for your comment, however we concluded changing ‘and’ to ‘plus’ would not substantively add anything to the content of the recommendation.
275	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NICE	7.4.1.12 1.5.3.4	197 30	Fourth bullet point; I would suggest “delivered by healthcare professionals with knowledge and experience of helping people with physical health problems” or something similar.	Thank you very much for this comment. We have made a general point about the competence of individuals delivering these treatments at the beginning of the guideline, see recommendation 1.1.4.1.
279	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NICE	7.4.1.14 1.5.3.6	197 30	Need to add the word “depression” after “severe” as it is missing.	Thank you for your comment, this has been amended in the text.
291	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NICE	7.4.1.19 1.5.1.2	199 23	Second bullet point, I suggest alter “and” to “or”.	Thank you for your comment, this recommendation has been revised.
327	PR	Expert Reviewer 1 Dr Peter Trigwell		Full	8.5	242	Line 29 states “interaction potential differs somewhat between individual antidepressants, but generally speaking, no particular drug can be recommended for all clinical conditions.” Having said that, some particular drugs can be better recommended for some particular conditions, e.g. those with less potential to reduce seizure threshold in patients with epilepsy, those with less active or inactive metabolites (post liver metabolism) in patients with renal failure, etc. It would be helpful to have consideration of this in the Full and NICE documents if possible.	Thank you very much for your comment. As you will see in our recommendations and in the interaction table we have tried to identify specific drugs for specific disorders where we think the likelihood of interactions will be reduced. We hope this addresses your comments.
328	PR	Expert Reviewer 1 Dr Peter Trigwell		Full	8.5	243	Lines 1 through 7 make a very important point which is entirely reasonable and appropriate. This relates to lines 22 through 26 and certainly fits with accepted practice within liaison (general hospital) psychiatry, and is of particular practical value. As such, it would be helpful to include it as a statement in the NICE	Thank you very much for this comment. This is a summary of the evidence therefore is more appropriate for the full guideline. However the recommendations regarding pharmacology in the

							Guideline.	NICE guideline were developed on the basis of this summary.
332	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NICE	8.5.2.1 1.4.4.1	243 22	Third bullet point "minor and mild to moderate depression complicates care and management of the physical health problem" should, in my view, be moved to become the first in this list of three. This is important to increase the emphasis on the significant problems / increased morbidity / mortality / cost / etc, of depression affecting the management and course of physical health problems (an example would be the impact of depression upon self-care in diabetes…)	Thank you very much for this comment. We have revised the recommendation in light of your comment.
333	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NICE	8.5.2.1 1.4.4.1	243 22	Third bullet point should be moved to become the first of this list of three bullet points, in order to increase the emphasis on this crucial fact in relation to the focus of this particular guidance.	Thank you very much for this comment. We have revised the recommendation in light of your comment.
336	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NICE	8.5.2.2 1.4.4.2	243 22	Perhaps include St John's Wort advice in the NICE Guidance document, as again it is of practical value and important in the context of increased use of such preparations in the population.	Thank you but this recommendation is not part of the consultation as the review was not updated.
521	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NICE	8.5.2.13 1.5.2.11	245 26	States "people started on antidepressants who are not considered to be at increased risk of suicide should normally be seen after two weeks". Why should this necessarily be so? A judgement should be made based upon a full understanding of the clinical situation and need, whilst also taking into account patient choice and preference.	Thank you – the view of the GDG was that the risk of suicide is greatest in the period immediately before and after starting treatment therefore we considered a 2 week guideline for monitoring was the prudent thing to do.
525	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NICE	8.5.2.17 1.5.2.15	246 27	Specifies taking antidepressant "for 6 months after remission of an episode", although if this was a second episode, for example, longer than that would be preferable, therefore state "at least six months"?	Thank you very much. We have amended these recommendations in the light of yours and other comments.
542	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NICE	8.5.2.23 1.5.2.21	247 28	The word "/withdrawal" should be deleted every time it appears, as it does not make sense to tell patients that antidepressants are not associated with tolerance or dependence but then use the phrase "discontinuation / withdrawal". The word discontinuation should be used alone.	Thank you for your comment. We have revised the recommendation in light of yours and others' comments.
598	PR	Expert Reviewer 1 Dr Peter Trigwell		NICE	Key priorities	7	Second bullet point may create problems as it specifies all interventions being "based on the relevant treatment manual(s), which practitioners should follow…". This is despite the first sentence stating importantly, "all interventions for depression should be delivered by practitioners who are competent to deliver the intervention", and of course not all interventions are necessarily treatment manual based. The issues of	Thank you very much for this comment however we believe that all the recommendations and variations as developed in this guideline have associated treatment manuals. We do not believe that individuals should be developing interventions without familiarity with

							treatment manuals is particularly pertinent within IAPT / Primary Care, but within the general hospital setting those involved in treating depression may be specialist practitioners who may deliver interventions which are not necessarily manual based, so that this wording could potentially prevent such interventions being seen as valuable and, ultimately, being available.	the basic procedures for their delivery. Competence comes from a thorough understanding of the nature and duration of the intervention. We therefore think that this recommendation is entirely reasonable.
603	PR	Expert Reviewer 1 Dr Peter Trigwell		NI CE	Key priorities	8	Comments under "Drug treatment", first bullet point, I would suggest altering the order of the inset three bullet points, so that "minor and mild to moderate depression complicates care and management of the physical health problem" should be moved to become the first rather than the third of these.	Thank you very much for this comment. We have amended our guidance in light of yours and other comments.
607	PR	Expert Reviewer 1 Dr Peter Trigwell		NI CE	Key priorities	9	We have seen Step 1, and here arises Step 4, but without a subheading for Steps 2 or 3.	Thank you for your comment, this has been corrected
624	PR	Expert Reviewer 1 Dr Peter Trigwell		NI CE	1.2	15	The bold statement with asterisk, beneath the step care diagram, should, considering the nature of this guidance and its main focus, also specify that "complex" includes in the presence of physical health problems!	Thank you for this comment. Complex depression may or may not involve the presence of physical health problems but the complexity may reflect other difficulties including co-morbid conditions, co-morbid axis 1 disorders, co-morbid axis 2 disorders and other factors physical and psychiatric which complicate the presentation. The whole of the guideline relates to physical health problems and is as implicit that complexity would where necessary include these issues.
654	PR	Expert Reviewer 1 Dr Peter Trigwell		NI CE	Appendix C	47	Under point four, first bullet point, "actively suicidal ideas" should read "active suicidal ideas".	Thank you for your comment but we prefer the original wording.
592	PR	Expert Reviewer 1 Dr Peter Trigwell		NI CE	Introduction	3	I would suggest an additional second paragraph to clarify / stress / give examples of the importance of the relevance of depression in people with chronic physical health problems, perhaps along the lines of paragraph 3 in the **Full** version, section 8 (Pharmacological…). The reason I am suggesting this is because it does feel like quite a long time into the NICE Guidance Draft before the specific focus on depression in physical health problems is evident (i.e. section 1.2).	Thank you very much for this comment. We have rewritten the introduction to the NICE guideline in light of your comments.
235	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NI CE	7.4.1 1.1.5	194 13	Again, if not manual based therapy, such as primary care IAPT, this could exclude other useful interventions.	Thank you very much for this comment. Most psychological interventions which are subject to careful evaluation have associated treatment manuals. This includes interventions such as CBT, IPT,

								psychodynamic psychotherapy and counselling. Given that this is the case we therefore do not agree with your comment that the requirement of interventions to form manuals could lead to the exclusion of other useful interventions.
266	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NI CE	7.4.1.6 1.4.3.4	194 21	Second bullet point. It would be helpful to add a suggestion that those facilitating meetings should have knowledge and experience of working with / helping people with both depression and physical health problems.	Thank you very much for this comment. We agree that it would be desirable if information were tailored in this way. We believe the detail for this is a matter for NHS implementation.
641	PR	Expert Reviewer 1 Dr Peter Trigwell		NI CE	1.4		I would suggest that there should be more in the 1.4 section to emphasise the importance of reviewing and optimising management of the chronic physical health problem (i.e. from a physical perspective, both during and following treatment for depression).	Thank you but this is beyond the scope of the guideline.
403	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NI CE	8.5.2.3 1.5.2.1	244 23	Regarding choice of antidepressants, need to add or expand upon a bullet point to emphasise the importance of taking into account direct effects (rather than necessarily side effects / interactions) of antidepressants upon certain conditions, e.g. lowering seizure threshold in epilepsy, the importance of avoiding antidepressant with active metabolites in renal failure, etc, in terms of choosing the correct antidepressant.	Thank you very much. In light of yours and other comments we have revised the interactions table and made a number of specific recommendations.
404	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NI CE	8.5.2.3 1.5.2.1	244 23	Possibly add increased hypoglycaemic effects of antidiabetic medication when patient also taking monoamine-oxidase inhibitors, as per BNF interactions section.	Thank you very much for this recommendation. However the GDG did not consider the frequency of such a complication, given the low use of MAOIs, warranted such a recommendation. .
515	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NI CE	8.5.2.11 1.5.2.9	245 25	Again, perhaps add a bullet point regarding specific effects of antidepressants when interacting with the person's physical health problem (rather than necessarily other medication as in interaction) as per line 14 above.	Thank you for your comment. As discussed in Chapter 8 there was insufficient data to draw firm conclusions concerning pharmacological interventions for specific conditions.
504	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NI CE	8.5.2.7 1.5.2.5	245 24	Specifies taking antidepressant "for 6 months after remission of an episode", although if this was a second episode, for example, longer than that would be preferable, therefore state "at least six months"?	Thank you very much for this comment. In light of yours and other comments we have revised our recommendations concerning the duration for which anti-

								depressants should be taken.
529	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NI CE	8.5.2.19 1.5.2.17	247 27	First element uses the word “inadequate” whereas second bullet point uses “still no response”, which does not make these two statements compatible or able to read well.	Thank you very much. We have made a number of changes to this and other recommendations in light of yours and other comments in order to ensure greater consistency in our recommendations.
530	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NI CE	8.5.2.19 1.5.2.17	247 27	Second bullet point. “Switching to another antidepressant if … the person expresses a preference for changing treatment”, may put practitioners in a very difficult position if the patient’s preference is irrational or ill-informed, so that there should be some wording to emphasise that this needs to be an “appropriate” decision.	Thank you very much. This is of course correct but we would expect any sensible healthcare professional to exercise judgement in this area and to not support a patient in making a preference for a treatment which is not in the patient’s best interests.
650	PR	Expert Reviewer 1 Dr Peter Trigwell		NI CE	1.6	31	Fourth line need to either delete “to mental healthcare,” or add to this so that it reads “…to mental and physical healthcare,”	Thank you, this has been corrected.
207	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NI CE	6.5.1.3 1.7.1.1	146 32	Same comments as lines 14 and 16. 14: Regarding choice of antidepressants, need to add or expand upon a bullet point to emphasise the importance of taking into account direct effects (rather than necessarily side effects / interactions) of antidepressants upon certain conditions, e.g. lowering seizure threshold in epilepsy, the importance of avoiding antidepressant with active metabolites in renal failure, etc, in terms of choosing the correct antidepressant 16: Again, perhaps add a bullet point regarding specific effects of antidepressants when interacting with the person’s physical health problem (rather than necessarily other medication as in interaction) as per line 14 above.	Thank you for your comment. The GDG considered this issue but in light of the resources available decide to focus on the issue of drug interactions. We will draw this to the attention of NICE and consider this in future updates.
516	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NI CE	8.5.2.11 1.5.2.9	245 25	Third bullet point states, regarding providing information (in writing where appropriate) about antidepressants, “information on any potential side effects”. This statement is too open / broad, as it may be interpreted as clinicians needing to always provide the full list of anything known to be a possible side effect, e.g. as per BNF side effects lists, no matter how rare or unlikely. This can be unhelpful in the clinical setting where it is more appropriate to make a judgement as to how much emphasis to give to the various levels of likelihood of particular side effects, rather than list all those which have been reported in relation to that particular medication.	Thank you very much for this comment. We have revised it both in light of yours and other comments. This is also consistent with what is in the depression update guideline.
520	PR	Expert Reviewer 1		Full	8.5.2.13	245	See comment line 17 above (States “people started on	Thank you very much for this

		Dr Peter Trigwell		NICE	1.5.2.11	26	antidepressants who are not considered to be at increased risk of suicide should normally be seen after two weeks". Why should this necessarily be so? A judgement should be made based upon a full understanding of the clinical situation and need, whilst also taking into account patient choice and preference).	comment. We consider the risk of suicide to be greatest in the immediate period before and after the initiation of treatment. It is on the basis of this that we made the recommendation for two week monitoring. This recommendation is adopted in the 2004 depression guideline and we see no reason to change this. Of course individuals would make individual judgements and may indeed see people earlier than two weeks.
522	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NICE	8.5.2.14 1.5.2.12	246 26	This suggests that **all** patients who are younger than 30 years should be seen after one week after starting an antidepressant and frequently thereafter, but this should be something for clinical judgement to take into account all elements of the case and patient choice.	There is some increased evidence of individuals in adolescence with increased risk of suicidality associated with the use of some antidepressants. This was reviewed in the 2004 guideline. Given the potentially serious risks involved here we thought a proper caution was to extend the age up to 30. We did that in the 2004 guideline and we have not reviewed the evidence further and intend to stick with the recommendation as it is stated. Of course individuals may exercise clinical judgement but we felt a proper and cautious approach was to set out the advice we have done in this recommendation.
531	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NICE	8.5.2.19 1.5.2.17	247 27	See previous comment line 19 above (First element uses the word "inadequate" whereas second bullet point uses "still no response", which does not make these two statements compatible or able to read well).	Thank you very much. We have made some changes to this in light of your comment.
536	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NICE	8.5.2.21 1.5.2.19	247 28	States that an alternative antidepressant should be a single antidepressant including from within the same class: what is the evidence for the latter part of this statement, and is there evidence to suggest that trying an alternative class is at all better than staying with the same class? I am not sure this is clear in the literature or literature review.	Thank you very much for this recommendation. The data which was examined closely in the depression update guideline (see that guideline for further details on the evidence) suggested that evidence for switching within or between class was rather inconclusive. We therefore did not feel able to make definite

								recommendations within this area.
543	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NICE	8.5.2.23 1.5.2.21	247 28	Need to delete "/withdrawal "and use simply the phrase "discontinuation symptoms", in line with comments on line 21above.	Thank you for your comment. We have revised the recommendation in light of yours and others' comments.
541	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NICE	8.5.2.23 1.5.2.21	247 28	Need to delete "/withdrawal "and use simply the phrase "discontinuation symptoms", in line with comments on line 21above.	Thank you for your comment. We have revised the recommendation in light of yours and others' comments.
545	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NICE	8.5.2.24 1.5.2.22	248 28	Need to delete "/withdrawal "and use simply the phrase "discontinuation symptoms", in line with comments on line 21above.	Thank you for your comment. We have revised the recommendation in light of yours and others' comments.
547	PR	Expert Reviewer 1 Dr Peter Trigwell		Full NICE	8.5.2.25 1.5.2.23	248 29	Need to delete "/withdrawal "and use simply the phrase "discontinuation symptoms", in line with comments on line 21above.	Thank you for your comment. We have revised the recommendation in light of yours and others' comments.
236	PR	Expert Reviewer 2 Linda Gask		Full NICE	7.4.1 1.1.5	194 13	While I understand the importance of formal therapy being provided by competent practitioners according to manuals, the brief psychological interventions that can and are provided by primary and general health care workers (i.e. not only GPs but also nurses working with patients with a diagnosis of diabetes and CHD for example as in the new stepped care model for psychological care of people with diabetes being developed by Diabetes UK), is largely ignored by these guidelines, and if anything may discourage them from learning or using the basic skills which are important in the management of people with mild to moderate depression are not, for a number of reasons, referred on to formal services. It is difficult, nigh impossible, to see how all 'talking treatment' for people with mild to moderate depression can or should be provided by low intensity therapists.	Thank you very much for this comment. It is not our intention when developing these recommendations to exclude any particular group of healthcare professionals and we agree with you that a range of individuals including primary care nurses could provide the interventions we have described in this guideline. We believe there is nothing in the way that the guideline is currently constructed that would preclude them from doing so. However I am sure you would agree that if these interventions were to be developed by anyone be it low intensity IAPT workers or practice nurses that it should be delivered in a competent manner.
508	PR	Expert Reviewer 2 Linda Gask		Full NICE	8.5.2.9 1.5.2.7	245 25	The recommendation for prescription of a benzodiazepine should be accompanied by a rider that this carries a risk of the person becoming dependent if the anxiety has already become chronic.	Thank you very much. We have amended this guideline in light of your comments.
609	PR	Expert Reviewer 2 Linda Gask		NICE	1.1.1 and general	10	It would be helpful to have an acknowledgement that for some people with co-morbid depression, the diagnosis of depression may be an unwanted additional label and there will need to be negotiation by the primary or general health care worker about the emotional	Thank you very much; we have changed the recommendation in light of your comment. We have encouraged some thoughtfulness and caution in relation to the use of

							component of the co-morbidity- and what it should be called. The need for good channels of communication between those involved in the physical, emotional and social care of people with co-morbid problems should also be emphasized.	labels and the way in which issues associated with stigma may be dealt with particularly with people with chronic physical health problems.
625	PR	Expert Reviewer 2 Linda Gask		NI CE	1.2	15	While the inclusion of collaborative care is very welcome- it is extremely confusing that this guideline has 4 steps and the guideline for co-morbid depression has 5. Services are not designed around co-morbid and non-comorbid depression- but around 'mental health care'. The ethos behind NICE with different guidance for different types of depression, and anxiety misses the point that most people in primary care present with co-morbid depression and anxiety and many of them also have physical illness. The key role of the patient's GP in co-ordination and continuity of care at all steps is not acknowledged – this is particularly important given the likelihood that co-morbidity will mean multiple medications.	Thank you for this comment. In light of yours and other comments we have reviewed the structure of the guideline and reverted to a 4 step framework which is also consistent with the depression update guideline.
297	PR	Expert Reviewer 3 Robert Peveler		Full	8	201	I have now looked at this and I think it has been done well. I have no major comments, just two thoughts/suggestions. Firstly I am not sure if the guideline group was aware that Prof Matt Hotopf and colleagues have completed a systematic review of antidepressant treatment for people with physical illness? I am not sure if this is published yet?	Thank you very much for this comment. We are not aware of the review produced by Professor Hotopf. Searches of all relevant databases have failed to locate the review, suggesting it has not yet been published.
79	PR	Expert Reviewer 4 Else Guthrie		Full	2.3	27	Regarding the relationship between depression and physical illness (page 27) this seems rather simplistic and Wayne Katon has developed a very useful model for understanding depression in physical illness which not only looks at direction of causality, but common underlying pathways.	Thank you for your comment, we have amended the introduction to make reference to Katon's work.
98	PR	Expert Reviewer 4 Else Guthrie		Full	4	53	The qualitative sections are very good.	Thank you for your comment
123	PR	Expert Reviewer 4 Else Guthrie		Full	5	82	Re case identification: this seems to be primarily about identifying the correct instrument. I couldn't find any reference to studies which have actually looked at detection rates of depression in the general hospital setting. There has been a recent systematic review of this which shows detection is less than 50% (Cepoiu et al 2008). It would be helpful to add this background as it strengthens the later case for screening for depression in the gen hosp setting which is not done routinely.	Thank you for this comment – the systematic review you cite does report low detection rates but did include subthreshold states where the diagnosis is both difficult and its value questionable. We do not think this should therefore lead to an alteration in our recommendations but we have amended the text to

							CISIP also have a tool for detecting depression in the elderly.	discuss the implications of the paper.
212	PR	Expert Reviewer 4 Else Guthrie		Full	7	148	Regarding recommendations for treatment for depression. I am surprised that the only treatment recommended is CBT or group CBT. The quality of evidence for other psychological treatments is not as robust as for CBT but there are RCTs (eg of IPT) which have shown promising results and head to head against CBT , CBT does not outperform some of the other psychological treatments. There should be some recognition of this, in the recommendations. In reality…the evidence is not very strong for any psychological intervention.	Thank you very much for this comment. We are aware of a rather limited range of interventions that we have recommended. We should also point out that there are a range of low intensity psychological interventions such as guided self-help, CCBT and peer support that we have also recommended. We developed criteria by which we would extrapolate from the database for effective interventions identified within the depression update guideline. This included when there was evidence of efficacy from trials in the depression and chronic physical health care problems. We did not extrapolate when we were not able to demonstrate efficacy. This is the case of a number of interventions including IPT, psychodynamic therapy and counselling. Although one trial (Markowitz *et al.,* 2008) found IPT to have a modest benefit against individual-based cognitive and behavioural interventions our review on IPT in comparison to standard care was less promising (please see section 7.2.11). Three interventions (Mossey *et al.,* 1996*;* Ransom *et al.,* 2008; (Lesperance, 2006) did not find IPT to have a statistically significant difference between IPT and standard care or enhanced standard care. We appreciate that there is a limited range of treatments recommended but we did not feel able, in the absence of good evidence, to recommend others. Individual clinicians may of course decide to offer other individual interventions

								beyond this.
213	PR	Expert Reviewer 4 Else Guthrie		Full	7	148	I think there also needs to be consideration given to other factors which affect treatment outcome but have not been considered in the systematic reviews. Moorey et al's study on cancer showed that one of the main problems in delivering psychological treatments to people who are physically unwell is that they may be too sick to receive the treatment. The guideline assumes that all patients who are depressed with and co-morbid physical illness are well enough to attend several sessions of psychological treatment. Many patients who are depressed and have co-morbid physical illness are actually very unwell physically and are unable to participate in psychological treatment interventions. This is a very important point which the guidelines need to address	Thank you very much for this comment. There are a number of options for treatment recommended, including a range of psychological and pharmacological treatments. Using the guideline and other available evidence a clinician should determine what the best treatment is and if a patient is too unwell to receive treatment.
214	PR	Expert Reviewer 4 Else Guthrie		Full	7	148	There is also no recognition in this section between the different in treating in hospital and the community. Given the promise shown by other psychological treatments, I am surprised in the recommendations for further research that there isn't a recommendation which suggests further trials of psychological treatments (other than CBT) in chronic physical disease, which have shown promise. In relation to the recommendations for antidepressants: they do not take account of the physical status of the patient which is crucial in people are physically unwell. I think a further recommendation should be. The patient's physical health status prevents them form active engagement in non-pharmacological treatments. Otherwise I think the guideline is extremely helpful.	Thank you very much for this comment. We agree that the current research recommendations in the NICE guidelines are rather limited. We have amended these recommendations and included a range of other psychological interventions which we hope will promote the development of more effective psychological interventions in the treatment of depression in this group of individuals.
298	PR	Expert Reviewer 4 Else Guthrie		Full	8	201	Secondly I note that the group have ducked the issue of whether or not "dual acting" antidepressants have any advantages in this group? I don't think there is much strong evidence either way but this is a claim which is often heard from the industry so it may be worth addressing even if only to dismiss it?	Thank you very much for this comment. We were unable to find any evidence as to whether or not dual acting antidepressants were any more efficacious in this group. Indeed the recent Cipriani et al review suggests that mode of action does not predict efficacy. Potential increase in efficacy, if it were identified, would of course need to be offset by the potentially higher propensity for interactions and other associated physical problems with drugs such as Venlofaxine.

593	PR	Expert Reviewer 5 Prof D Sharp		NI CE	intro	P3	Typo – symptoms should be systems before second DSM1V	Thank you for your comment we have amended the text as appropriate.
594	PR	Expert Reviewer 5 Prof D Sharp		NI CE		3 and 4	Need some further clarity re definitions of minor depression and core/symptoms	Thank you for your comment. Please refer to appendix 12. For further information regarding the classification of depression.
599	PR	Expert Reviewer 5 Prof D Sharp		NI CE		7	Under the staff section: this really alludes to 2 types of staff - those delivering care and those appointing staff/ supervising them – this should be made clearer - ? split into 2 sections	Thank you very much for this comment. The intention is not to develop two different kinds of staff but to acknowledge that staff have different responsibilities. Of course all those involved in supervising staff may themselves also be involved in delivering care.
604	PR	Expert Reviewer 5 Prof D Sharp		NI CE		8	? not going for the 3 questions?	Thank you for your comment. The Arroll (2005) study was a single study and has not been replicated as far as we are aware. The GDG decided the original recommendation should not be substantially changed.
605	PR	Expert Reviewer 5 Prof D Sharp		NI CE		8	? consider previous response to a particular AD?	Thank you very much for this comment. We have amended our recommendations in light of yours and other comments.
606		Expert Reviewer 5 Prof D Sharp		NI CE		9	Goes from step 1 to step 4 is this right?	Thank you for your comment, this has been corrected.
632	PR	Expert Reviewer 5 Prof D Sharp		NI CE	1.3	16-17	I don't get the sense as I read this that it has fully taken the QOF requirements (for GPS another PHC staff) into account	Thank you for your comment, the detail you suggest is beyond the scope of the guideline.
636	PR	Expert Reviewer 5 Prof D Sharp		NI CE	1.3.2.1	17	Need to define akathisia here	Thank you for your comment, this term has now been removed.
639	PR	Expert Reviewer 5 Prof D Sharp		NI CE		19	I am not sure of the usefulness of what appears to be the distinction between the whole focus of the GL ie depression in people with chronic physical problems and the occasional focus on depression complicating the care of the chronic physical health problem.	Thank you we have reviewed the structure and format of the guideline to address this issue.
648	PR	Expert Reviewer 5 Prof D Sharp		NI CE	1.5.2.10	25	What does this mean exactly?	Thank you we have clarified this recommendation in light of you comment.
649	PR	Expert Reviewer 5 Prof D Sharp		NI CE	1.6 and 1.7		It all ends rather abruptly with very little advice/info for steps 4 and 5	Thank you we have included additional cross-references to link with the depression update guideline.

<table>
<tr>
<td>517</td>
<td>SH</td>
<td>GlaxoSmithKline UK Ltd</td>
<td>1</td>
<td>Full

NICE</td>
<td>8.5.2.11

1.5.2.9</td>
<td>245

25</td>
<td>“the risk of discontinuation symptoms and how these can be minimised, particularly with a shorter half-life drugs, such as paroxetine and venlafaxine”
The most current evidence provided by manufacturers and approved by the MHRA indicates the risk of discontinuation amongst SSRIs and SNRIs are generally similar irrespective of half-life.
The Paroxetine (Seroxat) SmPC was updated in June 2003 to include advice regarding the likelihood of discontinuation symptoms in % terms. It currently provides that in clinical trials adverse events seen on treatment discontinuation occurred in 30% of patients treated with paroxetine compared to 20% of patients treated with placebo.
The dates in brackets in the table below indicate when the various SPCs were updated to include advice regarding the likelihood of discontinuation symptoms in % terms:

<table>
<tr><th>Medicine</th><th>Active</th><th>Placebo</th></tr>
<tr><td>Paroxetine (June 2003)</td><td>30%</td><td>20%</td></tr>
<tr><td>Fluvoxamine (2004)</td><td>12%</td><td>No rate provided</td></tr>
<tr><td>Fluoxetine (Nov 2005)</td><td>60%</td><td>60%</td></tr>
<tr><td>Citalopram (June 2007)</td><td>40%</td><td>No rate provided</td></tr>
<tr><td>Escitalopram (July 2007)</td><td>25%</td><td>15%</td></tr>
<tr><td>Sertraline</td><td>No rate provided</td><td>No rate provided</td></tr>
<tr><td>Venlafaxine (June 1998)</td><td>31%</td><td>17%</td></tr>
<tr><td>Duloxetine (May 2006)</td><td>45%</td><td>23%</td></tr>
<tr><td>Mirtazapine</td><td>15%</td><td>No rate provided</td></tr>
</table>

3) The MHRA convened a meeting in September 2008 for the purposes of providing “Guidance on the Management of Withdrawal from Seroxat (Paroxetine) and Other SSRIs”. The final paragraph of the note states:
“The meeting concluded by recognising that though the focus had been on Seroxat, there were other SSRIs that</td>
<td>Thank you. We are not aware of any evidence on this and the GDG did not think that it would be helpful to give a recommendation when it is likely to depend on individual circumstances and negotiation between the person with depression and the practitioner.</td>
</tr>
</table>

							posed similar problems, and that changes in prescribing practices, such as a reduction in prescriptions for Seroxat in recent years and increases for other drugs, for example Venfalaxine, mean that some of the issues deserve to be dealt with in terms of the class of drugs (emphasis added) rather than in relation to individual members of that class." http://www.mhra.gov.uk/Yourviews/Consultations/Medicinesconsultations/Othermedicinesconsultations/Discussionswithstakeholders/CON025699	
544	SH	GlaxoSmithKline UK Ltd	2	Full NI CE	8.5.2.23 1.5.2.21	247 28	"they should take the drug as prescribed, particularly with drugs with a shorter half-life, such as paroxetine and venlafaxine, in order to avoid discontinuation/withdrawal symptoms" Please see Order number 1 above.	Thank you for your comment. We have revised the recommendation in light of yours and others' comments.
518	SH	GlaxoSmithKline UK Ltd	3	Full NI CE	8.5.2.11 1.5.2.9	245 25	"the risk of discontinuation symptoms and how these can be minimised, particularly with a shorter half-life drugs, such as paroxetine and venlafaxine" Please see Order number 1 above.	Thank you. We are not aware of any evidence on this and the GDG did not think that it would be helpful to give a recommendation when it is likely to depend on individual circumstances and negotiation between the person with depression and the practitioner.
537	SH	GlaxoSmithKline UK Ltd	4	Full NI CE	8.5.2.21 1.5.2.19	247 28	"they should take the drug as prescribed, particularly with drugs with a shorter half-life, such as paroxetine and venlafaxine, in order to avoid discontinuation/withdrawal symptoms" Please see Order number 1 above.	Thank you for your comment. We have revised the recommendation in light of yours and other comments.
31	SH	Guide Dogs for the Blind Association	1	Full	General		General Comments that relate to the whole document. These guidelines do not make specific reference to visual impairment as a chronic health problem. Evidence suggests that there is a clear and reciprocal relationship between depression and visual impairment, echoing many of the points made in the guidelines. However, the guidelines do not go so fare as to make reference to visual impairment, instead paying attention to other physical health problems, which are referred to in the above mentioned draft guidelines, such as cancer, heart disease and diabetes. It is the opinion of key stakeholder that visual impairment should also be addressed in this analysis for the following reasons:	Thank you for your comment. We agree visual impairment constitutes a chronic physical health problem and that the guideline is relevant for people in this population who experience depression.
32	SH	Guide Dogs for the Blind Association	2	Full	General		Visual Impairment as a chronic illness One of the obstacles placed in the way of making links between depression and chronic health problems is that	Thank you for your comment, as stated in our response to your previous comment; we agree that

							many physical illnesses have symptoms that overlap with depression (eg. osteoarthritis, cancer, stroke, Parkinson's disease) and this therefore confounds attempts to establish causality. In order to consider this link effectively, it would be necessary to consider depression and a physical illness that share no symptoms. This is exemplified in studies of depression and age-related macular degeneration (AMD), where visual impairment is taken as an example of a disease which shares no symptoms with depression (Rovner & Casten, 2001). This is also evidenced in a study by Bazargan & Hamm-Baugh (1995), who investigated the effect of eleven common chronic conditions on depressive symptoms and found that visual impairment was one of only three conditions, (in addition to kidney and circulation problems) which independently predicted depression when all other demographical factors were controlled for. A further study by Vergrugge & Jette, (95) found a similar result. They identified visual impairment as one of only three independent predictors for depression based on an analysis of the relationship between depression and functional disability on the one hand and vision impairment and functional disability on the other. They noted that the primary link between chronic illness and depression is the association of chronic illness with functional disability and since there is a growing body of research which has found a link between vision impairment and functional disability, they state that it is not surprising to see a link between visual impairment and depression. It is therefore argued that depression and chronic health problems should also be examined in terms of visual impairment and functional disability.	visual impairment constitutes a chronic physical health problem. However, we disagree that causal pathways cannot be established for chronic physical disorders, and have enumerated them in the Full Guideline.
33	SH	Guide Dogs for the Blind Association	3	Full	General		The Link Between Visual Impairment and Depression. Population based studies give clear evidence of a link between visual impairment and risk of depression among community dwelling orlde people, even after controlling for factors such as age, gender, race and co-morbidity. (Hahm et al., 2008; Chou, 2008). Indeed research suggests that visual impairment can make an older adult between 2 and 5 times more likely to experience depressive symptoms than a non impaired peer (Horowitz, 2004), making visual impairment a much stronger risk factor for depression than other common age-related health conditions. This is reflected in statistics from various studies (Horowitz et aol., 2002);	Thank you – we have amended the text to take account of your comments.

							Reinhardt, 1996; Rovner & Castern, 2001) which tell us that between one fourth and one third of all visually impaired older adults report clinically significant depressive symptoms, compared with 8% and 16% of their peers without visual impairment. Even moderate vision impairment can have a profound effect on an individual's ability to carry out everyday tasks, and this in turn can deeply impact on the individual's self-esteem, worth and autonomy (Horowitz & Reinhart, 2002). We as stake holders would therefore like to see reference in these guidelines to the fact that, in some cases, vision loss can lead to loss of functionality, and loss of functionality can lead to depression.	
68	SH	Guide Dogs for the Blind Association	4	Full	2.1	17 - Line 21	Reference should be made to visual impairment and this should be backed up within the document with some specific reference to the incidence of depression amongst those with sight loss. It is widely acknowledged that the population is ageing. It is within the over 75s that the greatest concentration of visual impairment is found. In other words, sight loss and the associated (but often unrecognised) depression that frequently accompanies it is set to become increasingly common over the next decade and beyond. It is imperative therefore that clinicians and those responsible for clinical management are aware of this association. We would be happy to work with NICE to develop appropriate reference to visual impairment within the guidelines.	Thank you we agree visual impairment is an important issues however it is not possible to make reference to every chronic physical health disorder in the guideline. Though clearly the guideline will be relevant to this population.
69	SH	Guide Dogs for the Blind Association	5	Full	2.2	17 - Line 10	Typographical errors. Change "thr" to "the" and "take" to "taken".	Thank you for your comments, these instances have been amended in the text.
70	SH	Guide Dogs for the Blind Association	6	Full	2.2	17 - Lines 18-20	In or around lines 18-20. We suggest that the guidelines exemplify some of the studies cited in our consultation response with regard to visual impairment and AMD as an example of a disease which shares no symptoms with depression.	Thank you we agree visual impairment is an important issuehowever it is not possible to make reference to every chronic physical health disorder in the guideline.
34	SH	Guide Dogs for the Blind Association	7	Full	General		**References:** ▪ A step in the right direction (September 2008) in Health Director Volume 5 Issue 10. Published by Govnet Communications. ▪ Bazargan M & Hamm-Baugh V P (1995) "The relationship between chronic illness and depression in a community of urban black elderly persons". J Gerontol B Psychol Sci Soc Sci , 50(2):S119-27 ▪ Brody, BL et al (2001) "Depression, visual acuity,	Thank you for the references

							comorbidity, and disability associated with age-related macular degeneration", Ophthalmology, 108(19):1893-1901. ▪ Chou, K-L. (2008) "Combined effect of vision and hearing impairment on depression in older adults: Evidence from the English Longitudinal Study of Ageing", Journal of Affective Disorders, 106: 191-196. ▪ Guide Dogs (2008) Independence and Wellbeing in Sight: Investing in the potential of blind and partially sighted adults in England. Published by Guide Dogs on behalf of the Rehabilitation Project Group. ▪ Hahm, BJ (2008)"Depression and the vision-related quality of life in patients with retinitis Pigmentosa", Br J Ophthalmol. 92(5):650-4. ▪ Horowitz, A., Reinhart, JP. & Kennedy, G. (2002) "Major and subthreshold depression among elders in community-based rehabilitation." Paper presented at: Annual Scientific Meeting of the Geronotological Society of America; November 26, 2002. Boston, MA. ▪ Horowitz, A. & Reinhart, JP. (2002) "Mental health issues in visual impairment: research in depression, disability and rehabilitation" in Silverstone, B. et al (eds.) (2002) The Lighthouse Handbooks on Visual Impairment and Vision Rehabilitation. New York ▪ Horowitz, A (2004) "The Prevalence and Consequence of Vision Impairment in Later Life", Topics in Geriatric Rehabilitation 20 (3): 185-195. ▪ Pey T, Nzegwu F, Dooley G (2008) Functionality and the Needs of Blind and Partially Sighted Adults in the UK. Published by Guide Dogs on behalf of the Rehabilitation Project Group. ▪ Reinhardt, JP. (1996) "Importance of friendship and family support in adaptation to chronic visual impairment", J Gerontol B Psychol Sci Soc Sci, 51B:268-278. ▪ Rovner, BW. & Casten, RJ. (2001) "Neuroticism predicts depression and disability in age-related macular degeneration", J Am Geriatr Soc, 49(8):1097-1100. ▪ Verbrugge, LM & Jette, AM. (1995) "Seven chronic conditions: their impact on US adults´activity levels and use of medical services", Am J Public Health, 85(2): 173-182. ▪ Vision 2020UK (2008) UK Vision Strategy: Setting the direction for eye health and sight loss services. Published by RNIB on behalf of Vision 2020 UK	

35	SH	Headway – the brain injury association	1	Full	General		A major predictive factor of depression after brain injury is a previous history of depression.	Thank you for your comment, the detail you suggest is beyond the scope of the guideline.
74	SH	Headway – the brain injury association	2	Full	2.2.5	24	The table should contain reference to acquired brain injury. The prevalence of depression is similar after both stroke and traumatic brain injury (TBI), with the order of 20%-40% affected at any point in time in the first year, and about 50% of people experience depression at some stage. (Taken from Fleminger, Oliver, Williams, Evans 'The neuropsychiatry of depression after brain injury', Neuropsychological Rehabilitation, 2003, 13 (1/2), 65-87.)	Thank you for your comment, the detail you suggest is beyond the scope of the guideline.
77	SH	Headway – the brain injury association	3	Full	2.2.9	26	Whilst this section concentrates on three important causes of depression, brain injury survivors often become depressed due to other factors, including: The effects of brain injury often leads to the breakdown of previous social relationships and difficulty creating new ones. It is important people are given access to support services, including charities such as Headway, to help their social rehabilitation. Brain injury can lead to a lack of insight and self awareness. As a person's awareness of their own situation returns in the weeks and months following brain injury, they can become depressed, especially after rehabilitation and medical intervention comes to an end. There should be regular follow-ups to ensure people are adequately supported during this time. Some studies have shown that after moderate to severe brain injury 24%-56% of people experience endocrine dysfunction. People should be routinely screened for this after brain injury and placed on appropriate treatment. (Leal-Cerro et. al. (2005) 'Prevalence of hypopituitarism and growth hormone deficiency in adults long-term after severe traumatic brain injury', Clinical Endocrinology vol. 62, issue 5.	Thank you for your comment, the detail you suggest is beyond the scope of the guideline.
72	SH	Headway – the brain injury association	4	Full	2.2.1	19	We agree that when a chronic physical disease is either found or is known to be present, attention may shift to this disease, and the depression may then be overlooked. However, it is important to be aware that there is significant overlap between the symptoms of acquired brain injury and depression, for example fatigue and poor concentration. These factors may be attributed to depression where they are in fact symptoms of the brain injury. Neuropsychological rehabilitation should always be the treatment of choice after acquired brain injury. The cause of depression may also be hormonal,	Thank you for your comment, the detail you suggest is beyond the scope of the guideline.

							as a result of damage to the pituitary gland after brain injury. Patients should be screened and treated accordingly if this is the case, rather than using treatments such as antidepressants etc.	
36	SH	Headway – the brain injury association	5	Full	General		Practitioners should be aware that depression is a common symptom of brain injury. Differential diagnosis of minor head injury should be considered for patients presenting with depression and consideration given to referral to clinical psychology and Headway. If minor head injury is thought to be the cause patient information literature should be provided with information on coping strategies. Headway can provide this information in the form of a booklet.	Thank you for your comment, although we agree with your point, we considered brain injury to be outside the scope of the present guideline. We will draw NICE's attention to the need for such guidance – perhaps focusing a wider range of problems than just depression.
37	SH	Headway – the brain injury association	6	Full	General		Medical history of moderate/severe brain injury is a very common cause of depression and this can be due to physical damage to the brain as well as social and personal factors. If this is considered to be the cause then referral should be made to neurorehabilitation services and relevant charities.	Thank you for your comment. Please see our response to your previous comment.
131	SH	Headway – the brain injury association	7	Full	5.6	101	CBT is considered to be the most useful form of therapy for depression in those with brain injury. However, other forms of therapy may be more helpful in individual cases and neurorehabilitation services should be consulted if not available for referral.	Thank you for your comment, the detail you suggest is beyond the scope of the guideline.
38	SH	Headway – the brain injury association	8	Full	General		Endocrine dysfunction commonly results in depression. If depression occurs with other symptoms indicative of endocrine dysfunction then appropriate blood tests and referral to an endocrinologist should be considered. Hormone treatment is then a possibility. Practitioners should be aware of the increased risk of endocrine dysfunction after moderate/severe brain injury and routine endocrine function tests should be performed.	Thank you for your comment, the detail you suggest is beyond the scope of the guideline.
39	SH	Headway – the brain injury association	9	Full	General		Patients treated for both brain injury and pituitary dysfunction should be routinely asked whether they are suffering from symptoms of depression.	Thank you for your comment. Brain injury was outside the scope of the present guideline.
40	SH	Headway – the brain injury association	10	Full	General		Written information is very important and patients should be referred to useful booklets and factsheets available from organisations such as Mind, Rethink and the Royal College of Psychiatrists. If brain injury or pituitary dysfunction is the cause written information can be obtained from Headway and the Pituitary Foundation.	Thank you for your comment, we feel this is already covered in 4.8.1.2 and in the production of the related Understanding NICE Guidance booklet for this guideline.
99	SH	Headway – the brain injury association	11	Full	4.2	53	The personal accounts could possibly include case studies of a brain injury survivor with depression.	Thank you for your comment, the detail you suggest is beyond the scope of the guideline.
82	SH	Headway – the brain injury association	12	Full	2.3.4	29	We agree with the comments on antidepressant medication. We also feel that, particularly in the case of	Thank you for your comments

							mild brain injury, antidepressants fail to address the underlying cause of depression so should be used with caution.	
75	SH	Headway – the brain injury association	13	Full	2.2.6	25	We question whether this section is entirely necessary as it seems to serve very little purpose.	Thank you we agree – it was carried over from an earlier draft, and we have now deleted it.
552	SH	Herpes Viruses Association	1	Full	16.5.3	341	Please change 'herpes' to 'herpes simplex'. The word 'herpes' is the family name for nine humanherpes viruses which include herpes varicella (shortened to varicella in this Guideline) and cytomegalovirus.	Thank you very much for your comment, we have made these amendments in the guideline.
405	SH	Lundbeck	1	Full NICE	8.5.2.4 8.5.2.5 1.5.2.2 1.5.2.3	244 24	The draft guideline states 'When prescribing an SSRI, consideration should be given to using a product in generic form. Citalopram and sertraline, for example, would be reasonable choices because they are generally associated with lower potential for interactions.' We believe this information does not reflect the most up to date evidence base. The following publication highlights new evidence that needs to be considered for both parts of the review of the NICE guidance for Depression. Comparative efficacy and acceptability of 12 new-generation antidepressants: a multiple-treatments meta-analysis by Cipriani et al, published in The Lancet on the 29th January 2009. This new landmark meta-analysis indicates that clinically important differences do exist between new generation antidepressants in terms of both efficacy and acceptability. Lundbeck draws the attention of the GDG to this vital part of the evidence base for a number of reasons: This is a large, robust and independent meta-analysis of 117 RCTs conducted between 1991 and 2007 with 25,928 patients. The meta-analysis included not only published RCTs, but also unpublished data and data submitted to regulatory authorities. The study was designed to address the inconsistency of results for efficacy of second-generation antidepressants. The author's interpretation of the study findings includes 'Clinically important differences exist between commonly prescribed antidepressants for both efficacy and acceptability in favour of escitalopram and sertraline.' Although this study does not directly address depression associated with physical illness, we note from the Full guideline in section 8.5.1, the GDG's view was that the	Thank you very much for this recommendation. Based on the Cipriani et al review for the depression update guideline we conducted a separate preliminary economic analysis, which is very briefly summarised in this guideline. The analysis ranked mirtazapine as the most cost-effective antidepressant, followed by sertraline, escitalopram and citalopram.

							nature of depression in chronic physical health problems is not fundamentally different from depression in the absence of such problems. The GDG also considered it appropriate to draw on the evidence base for depression more generally in drawing up its recommendations. Cipriani et al demonstrate that clinically important differences exist between commonly prescribed antidepressants for both efficacy and acceptability in favour of escitalopram and sertraline. Based on the best balance of efficacy and patient acceptability we believe the GDG should recommend both escitalopram and sertraline as first line choices. Requiring a practitioner to consider a generic would exclude escitalopram and therefore contradicts the evidence base. Cipriani also brings into question the value of prescribing some of the generic SSRIs where the balance between efficacy and tolerability is questionable. The current wording also recommends discussing antidepressant treatment options with the person with depression. Restricting first line treatment options to generics limits choice for both the person with depression and the clinician, in particular when these first line recommendations are not the best available according to the up to date evidence base. We also believe that there is an error in section 8.5.1 of the Full guideline which is detailed in point 2 below. This supports the use of escitalopram as a first line choice as it is generally associated with lower potential for interactions. We propose the NICE guideline wording in section 1.5.2.2 & 3 is amended to: '1.5.2.2 Where interactions do not preclude the use of an SSRI they should be first choice, because SSRIs have a favourable risk-benefit ratio compared with other antidepressants and are less likely to be discontinued because of side effects. Clinically important differences exist between the SSRIs for both efficacy and acceptability in favour of escitalopram and sertraline. 1.5.3.3 When prescribing an SSRI, practitioners should consider a treatment which offers an appropriate balance of efficacy and acceptability to the person with depression. Practitioners should also consider whether a product is available in generic form'.	
330	SH	Lundbeck	2	Full	8.5.1	243	We believe that there is an error in section 8.5.1 of the	Thank you for your comment,

							Full guideline. This section currently states 'Of the SSRIs, sertraline and citalopram probably have the lowest interaction potential…' We have highlighted a similar point to the GDG for the depression in adults update which appears in section 8.3.1.1 on page 232 of that draft Full guideline. The corrected wording should be 'Sertraline is less problematic although enzyme inhibition is dose-related while both citalopram and escitalopram are relatively safe in this regard'. We would therefore propose that the wording in the draft Full guideline for depression and chronic physical health problems in section 8.5.1 is amended to reflect this correction and incorporate the key findings from the Cipriani et al study: 'Of the SSRIs, sertraline, citalopram and escitalopram probably have the lowest interaction potential. When all the evidence is considered, sertraline and escitalopram should be drugs of first choice.'	however, the Cipriani meta-analysis was not conducted on a chronic physical health population. We have noted the review and briefly summarised it in this guideline. However, for a fuller critique of the paper please refer to the relevant section in the depression update guideline. Furthermore, there is evidence that the effect of citalopram/escitalopram is dose-related. This is a complex area with many conflicting data[1-8] References 1. Alfaro CL et al. CYP2D6 status of extensive metabolizers after multiple-dose fluoxetine, fluvoxamine, paroxetine, or sertraline. J Clin Psychopharmacol 1999; **19**:155-163. 2. Sproule BA et al. CYP2D6 inhibition in patients treated with sertraline. J Clin Psychopharmacol 1997; **17**:102-106. 3. von Moltke LL et al. Escitalopram (S-citalopram) and its metabolites in vitro: cytochromes mediating biotransformation, inhibitory effects, and comparison to R-citalopram. Drug Metab Dispos 2001; **29**:1102-1109. 4. Gram LF et al. Citalopram: interaction studies with levomepromazine, imipramine, and lithium. Ther Drug Monit 1993; **15**:18-24. 5. Nemeroff CB et al. Newer antidepressants and the cytochrome P450 system. Am J Psychiatry 1996; **153**:311-320. 6. von Moltke LL et al. Citalopram and desmethylcitalopram in vitro: human cytochromes mediating transformation, and cytochrome inhibitory effects. Biol Psychiatry 1999; **46**:839-849. 7. Jeppesen U et al. Dose-dependent

								inhibition of CYP1A2, CYP2C19 and CYP2D6 by citalopram, fluoxetine, fluvoxamine and paroxetine. Eur J Clin Pharmacol 1996; **51**:73-78. 8. Ozdemir V et al. The extent and determinants of changes in CYP2D6 and CYP1A2 activities with therapeutic doses of sertraline. J Clin Psychopharmacol 1998; **18**:55-61. In addition, we thought that the outcome of the Cipriani review largely concurred with the outcomes in relation to the references to SSRIs that we had already made. However as can be noted from a review of the Cipriani meta-analysis they explicitly state that they did not consider side-effects in the interactions with other drugs. In depression in chronic physical health problems these are important factors to consider and the guideline development group took the view that these should be important in determining the recommendations that we made.
237	SH	Lundbeck	3	Full NICE	7.4.1 1.4.2	194 18	We note that the GDG's advice for treatment of depression with anxiety includes the statement that 'treatment for depression often reduces anxiety symptoms'. This is an important section in the guideline since the majority of people with mood disorders suffer from mixed depression and anxiety (Kessler, R et al. Prevalence, Severity, and Comorbidity of 12-month DSM-IV Disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry 2005; 62: 617-627.) We believe the GDG should highlight that many of the antidepressants licensed for the treatment of depression are not licensed for the various anxiety disorders. NICE guidelines for the treatment of Generalised Anxiety Disorder (GAD) and Panic Disorder (PD) specifically recommend those SSRIs licensed for these indications. To clarify this point, the GDG should draw attention in the NICE depression guideline to those treatments	Thank you very much for this comment regarding licensed drugs. It would not be appropriate to comment on specific interventions (pharmacological or psychological) for anxiety disorders in this guideline.

							currently available with licensed indications for depression and the different anxiety disorders GAD, PD, OCD and PTSD.	
597	SH	Lundbeck	4	NICE	Patient - centred Care	6	We welcome and support the GDG's advice on patient-centred care for people with depression and the role of evidence-based written information tailored to the patient's needs. For consistency with the depression in adults update guideline, we propose this section is titled 'Person-centred care'.	Thank you for your comment, but the guideline development group for this guideline preferred the word 'patient'.
562	SH	Mental Health Nurses Association	1	NICE	general		This updated guideline will be particularly useful for those working in primary care and general hospital settings, for example, for Community Matrons. The stepped model is clear and easy to grasp.	Thank you for your comments.
563	SH	Mental Health Nurses Association	2	NICE	general		Whilst it is not within the scope of this guideline, it might be useful to signpost practitioners to resources concerning mental health promotion for people with physical health problems (and particularly those with long-term conditions)	Thank you for your comment, the detail you suggest is beyond the scope of the guideline.
269	SH	Mental Health Nurses Association	3	Full NICE	7.4.1.9 1.5.3.1	196 29	CBT tends to be offered within clinical settings. Access to such settings might be problematic for those with physical health problems. Could home visits be recommended?	Thank you very much for this comment. We agree that there may be problems with access to a wide range of interventions recommended in this and other guidelines. However we think the specific details of this are outside the remit of the guideline but should be a matter for NHS implementation. Considerable success in engaging people in a range of psycho-social interventions has been achieved by a number of rehabilitation clinics and perhaps they would form an effective model for the active engagement of individuals in these programmes.
253	SH	Mental Health Nurses Association	4	Full NICE	7.4.1.3 1.4.3.1	194 20	Depressed patients with physical impairment may require adapted technology for using CCBT	Thank you for this comment – we agree and it is a matter that we think that the NHS and the developers of CCBT products should take seriously in considering when implementing the recommendations in this guideline.
564	SH	Mental Health Nurses Association	5	NICE	general		There is far more discussion concerning drug treatment as compared to any other interventions. The latter	The guideline recommends a variety of different interventions

							seems to be dealt with by recommending attention to the specific manual. Does this give a message regarding the value of different interventions?	including psychosocial and pharmacological interventions. The number of recommendations concerning drug treatment reflects the difficult issues and cautions required when prescribing anti-depressant medication to people who have chronic physical health problems rather than any value judgment concerning psychosocial or pharmacological treatments.
651	SH	Mental Health Nurses Association	6	NICE	3 Implementation	33	It will be good to see these tools when they become available. Will it be possible to recommend a lead agency? In our experience such matters can fall between the gaps between PCTs and specialist mental health services.	Thank you for your comment, the detail you suggest is beyond the scope of the guideline.
565	SH	Mental Health Nurses Association	7	NICE	general		There are many vulnerable patient groups where a huge capacity problem exists in relation to mental health care. For eg, older people in care homes and psycho-oncology services.	Thank you very much for this comment. We accept that there may be significant need out there. We hope that the recommendations in this guideline will set standards whereby improved care is delivered to a wide range of people including vulnerable patients groups of which you identify.
561	SH	Mental Health Nurses Association	8	NICE	general		Thank you for giving us the opportunity to comment.	Thank you for your comments.
41	SH	Mental Health Providers Forum		Full	General		We welcome the guidelines inclusion of psychological therapies as a treatment option for patients experiencing depression and chronic health problems, however we are concerned at the limited range of therapies recommended and the consequences for patient choice. Our concerns: • The methodology applied in the evaluation of psychological therapies recommended to treat depression in adults with chronic health problems did not allow for a comprehensive assessment of a broad range of available treatments • Many established therapies were excluded from the Guideline Development Group (GDG) research review • The GDG did not review all available evidence, looking only at RCTs which bias types of treatment aligned to the medical model and disadvantage those which are based on e.g. the therapeutic relationship and social factors.	Thank you for this comment. We believe that in making recommendations for a number of treatments including guided self help, exercise, peer support, CBT and CCBT we have not unnecessarily restricted choice. You raise a number of other concerns which we deal with in turn. 1. We believe that our method for identifying effective treatments is a robust one that has been tested in a number of guidelines and has generally been well supported. 2. We are unsure which established therapies you consider were excluded from the review. Our review included

							• Only limited conclusions can be drawn from RCTs; too few therapists are involved to be able to determine whether effects are attributable to the therapist or the therapy. Patient samples are often too small for results to be representative of wider patient groups. • Meta analyses have been excluded, however these studies show equivalence between most therapies • Naturalistic evidence has been excluded from consideration, yet evidence from tens of thousands of patient outcomes collected from practice based 'real world' settings show that all therapies are equally effective, with most significant changes being due to the therapist. • Therapies supported by extensive practice based evidence, but not reviewed by the GDG may be withdrawn as non inclusion undermines the therapeutic validity of the intervention • Bias in the methodology produces reductive guidelines which promote behaviour modification and 'medically' aligned therapies to the exclusion of a broad range of establish psychological therapies currently provided by the NHS and backed by extensive practice based evidence. • These biases significantly reduce patient choice which is essential as different people respond better to differing treatments depending on the stage of recovery. No therapy is universally suitable for all patients at all times. • Due to the limited range of evidence referred to, the results maybe misleading and give a distorted view of the value of some therapies, based on an evaluation process which many legitimate academic researchers contest is inappropriate for psychological therapies. • 1000's of trained and practicing psychotherapists and counsellors, with a track record of proven outcomes will be disenfranchised by these guidelines. Our recommendations • Review of methodology used to evaluate psychological therapies • GDG to make full use of all types of evidence including, Cohort studies, practice based evidence, qualitative evidence; case studies and client feedback • Review of procedures of guideline development group, ensuring group follows its stated procedures	potentially all therapies currently available in the NHS and there was no a priori assumption to exclude any of them. A review of our search strategies will confirm this. 3. We focussed our searches on randomised controlled trials as we believe that they provide the most unbiased indication of the effectiveness of any intervention. However, in both reviewing the evidence and developing the recommendations a number of studies were drawn on including qualitative studies, cohort studies and studies, as well as RCTs and meta-analyses. Relationship factors are of course crucial to the effective delivery of any therapy. 4. Randomised controlled trials are designed to have internal validity and to test the effectiveness of a particular therapy. A number of studies attempt to account for the therapist variable by maintaining common therapists across different treatment arms. There are a number of studies for example CBT and interpersonal therapy which have demonstrated advantages for particular therapies over and above those factors connected with therapies. However we agree that therapist factors can be a considerable source of variance particularly in the implementation in routine practice. In order to deal with this we have made specific recommendations around

								therapist competence. 5. In this instance we disagree that data on tens of thousands of patients shows that outcomes are equally effective. 6. Estimates from the Martin et al. 2000 meta-analysis indicate that the therapeutic alliance may account for no more than a correlation of 0.25 between alliance and outcome. In the light of such evidence we think it unlikely that therapist factors alone will be the main driver of change. Even if this were the case this does not preclude a review of which treatments are most likely to be effective. As you do not specify which therapies may be withdrawn as a result of the recommendations it is difficult to comment. 7. The question about biased and reductive guidelines is difficult to comment on but it is appropriate to say that the guidelines do not promote behaviour modification – by this we assume you mean operant conditioning – this is not recommended in this guideline. We believe that the clinical guidelines do offer choice and are likely to support a choice between evidence based treatments. We expect the patients with depression who are outside the scope of this guideline to be in a small minority perhaps no more than 15% of all patients. We have had considerable success in developing our methods for the evaluation of psychological therapies and the

								recommendations that we have made have been generally welcomed. 8. We expect that as the guidelines are implemented there will be changes in practice that will promote further implementation of evidence based recommendations, and that will not disenfranchise trained practitioners and practising psychotherapists. However you should note that we have made a number of research recommendations concerning these therapies. We think this can be taken as a clear indication that we would regard the withdrawal of these therapies from the NHS as premature. 9. We are unclear what changes you would like us to make to our methodology. We have followed all stated procedures, in line with the NICE Guideline Development Manual. 10. We developed a strategy which is set out in our methods chapter that focussed on a review of high quality evidence. We believe that RCTs are generally the best method for this as they are most likely to reduce bias. We will consider other high quality practice based evidence which directly addresses the psychological treatment of depression. 11. We have reviewed our methodological chapter and have made some adjustments to set out clearly our rationale for doing so. With regards to your comments on method we

								have moved away from a system where we allocate a rating to evidence based on a simple hierarchy whether the top of that hierarchy be single case studies as some may argue or randomised controlled trials. Instead our preferred method for evaluating evidence is to use GRADE profiles. These take into account not just the nature of the trial but the setting in which the interventions were delivered, the robustness of the findings and the general applicability to the context. In addition, we take into account evidence on cost effectiveness as well. The details of the move away from a simplistic evidence hierarchy which we followed in this guideline can be clearly found in the NICE technical manuals. As we have already indicated if high quality observational/practice based evidence were available that related directly to the clinical we could consider it where we believe the evidence to be of sufficient quality and robustness. However in relation to this guideline we have not seen any evidence of this nature, including that submitted by stakeholders, that we believe is of sufficiently high quality for us to change our recommendations.
42	SH	Mental Health Providers Forum		Full	General		Restatement of Aims of Guidelines In this document we will outline our concerns that the methodology applied in the evaluation of psychological therapies recommended to treat depression in chronic health problems did not allow for a comprehensive	Thank you very much for your comment. We have made a number of research recommendations to address the issues where uncertainty in evidence exists

							assessment of a broad range of available treatments. We are also concerned that the Guideline Development Group did not fulfil their stated duties in conducting a review of available research. • Despite the acknowledgement in the guidelines that "where established therapies are not recommended, this should not be taken to justify the withdrawal of provision but rather to suggest the need for research to establish their effectiveness or otherwise," we are concerned that therapies supported by extensive practice based evidence may be withdrawn as a consequence of exclusion from the guidelines research review and recommendations. As NICE itself acknowledges "there is ongoing debate among researchers, therapists and policy makers in psychological therapies about what constitutes evidence and how evidence should be used and it would be unrealistic to assume that there is consensus." However no justification is given for the current methodology used by NICE in the development of this guideline. At this historic time in the mainstreaming of psychological therapies within the NHS we would like to see real engagement from NICE with the research controversies. Legitimate and alternative scientific views are held by a substantial number of academic scientists. It is not sufficient to merely reference the debate and continue to dismiss, without giving justification, valid and dissenting opinions. Change then needs to be implemented within the methodology employed by the Guideline Development Group. • Contemporary research methods are moving on from the RCT hierarchy, as a national centre of clinical excellence it is essential that the GDG methodology remains up-to- date and cutting edge. • In 2005 the American Psychological Association APA recognised that a true scientific appraisal of the evidence requires the consideration of naturalistic effectiveness studies as well as RCTs. • Chair of NICE, Sir Mike Rawlins, has stated that RCTs do not deserve to be the sole method of evaluation or indeed placed at the top of an evidence hierachy; "The notion that evidence can be reliably placed in	around the effectiveness of psychological therapies and as such we believe this supports our view that withdrawal of the interventions would be premature. We expect that the people who develop the research programmes arising out of these recommendations will develop methodologies appropriate to the questions that they seek to address. The guideline development group did not only rely on randomised controlled trials and meta-analyses. In both reviewing the evidence and developing the recommendations a number of studies were drawn on including, in addition to randomised controls and meta-analysis, qualitative studies, cohort studies and studies examining process outcome relationships in psychotherapy (see chapter on psychological interventions for more detail on this). In relation to comments by Sir Michael Rawlins the NICE technical manual has moved away from simple evidence hierarchies and these are not used in this guideline and now employ the GRADE method. Depending on the size and design of an RCT it would be possible to take account of therapist effect size, and indeed researchers have examined therapist effects within randomised controlled trials in the past. We therefore feel that randomised controlled trials are not only relevant to medical problems/ the medical discipline and that methods developed to evaluate healthcare interventions can be applied to psychological interventions.

							hierarchies is illusory. Hierarchies place RCTs on an undeserved pedestal for, as I discuss later, although the technique has advantages it also has significant disadvantages. Observational studies too have defects but they also have merit. Decision makers need to assess and appraise all the available evidence irrespective as to whether it has been derived from RCTs or observational studies, and the strengths and weaknesses of each need to be understood if reasonable and reliable conclusions are to be drawn." Based on the methodological process followed by the GDG, we are concerned that this statement has not been adopted as policy or practice. We have concerns about the composition of the GDG. It is not appropriate for the GDG to represent only a few disciplinary roles and orientations in its challenging task to provide comprehensive and fair evaluation of a broad range of therapies. There is no consensus that psychological therapy constitutes a medical discipline. Many orientations of psychological therapies hold that emotional well being should not be medicalised.	The GDG composition is in line with the agreed scope and the NICE guidelines manual 2007, and composed of a wide range of practitioners. The specific roles and interests of the GDG members are as follows: **Professor Sir David Goldberg (Chair, Guideline Development Group)** - Psychiatric epidemiology, case identification of common mental health problems, CCBT **Dr. Neil Andrews** - Consultant Cardiologist and Electro physiologist, - Cardiac electrophysiology **Professor Francis Creed** - Professor of Psychological Medicine, University of Manchester - Liaison psychiatry, brief interventions and psychodynamic therapy in psychosomatic disorders **Professor Christopher Dowrick** - Professor of Primary Medical Care, University of Liverpool - Conceptualisation of depression in primary care, problem solving therapy and antidepressant treatment in primary care **Dr. Gwyneth Grout** - Consultant Nurse, Mental Health Liaison (Older People), Hampshire Partnership NHS Trust (until May 2008) - Development of care systems for people with depression and chronic physical health problems **Dr. Mark Haddad** - Clinical Research Fellow, Health Service and Population Research Department, Institute of Psychiatry

								- Case identification and assessment tools in primary care **Dr. John Hindle** - Consultant Physician Care of the Elderly, Clinical Director of Medicine, North West Wales NHS Trust - Parkinson's disease **Dr. David Kessler** - Walport Clinical Lecturer - Primary Care, Bristol University - Case identification of common mental health problems in primary care, brief interventions and CBT in depression in primary care **Professor James Lindesay** - Professor of Psychiatry for the Elderly, University of Leicester - Classification of disorders in the elderly, drug treatments and institutional care **Ms. Margaret Ogden** - None **Dr. Jonathan Packham** - Consultant Rheumatologist, Haywood Hospital. Senior Lecturer, Primary Care Musculoskeletal Research Centre, Arthritis Research Campaign National Primary Care Centre, Keele University - TNF and the treatment of rheumatoid arthritis **Professor David Taylor** - Chief Pharmacist, South London and Maudsley NHS Trust - Professor of Psychopharmacology, King's College, London Effectiveness of psychotropic drugs, drug interactions.
43	SH	Mental Health Providers Forum		Full	General		Guideline Development Group: Process We are concerned that the Guideline Development Group has not followed its own stated procedures in evaluating psychological therapies and that the process	Thank you for this comment. We believe that we have followed the recommendations within the technical manual. Inevitably the

							for developing recommendations in this draft guideline can not be considered fair or impartial. We are concerned that justifications given for non-compliance of the guideline development groups own stated procedures regarding reviewing available evidence was cited as being due to lack of time and resources. • It is essential that guidelines of this significance be afforded the adequate resources to produce comprehensive guidelines that the public can have trust in. • In effect this means that only RCT's were considered. RCT's rely on a very small number of participants in an artificial, clinical environment and can not be considered to be an accurate reflection of effects in routine practice. • Many types of therapy are more easily evaluated with practice based evidence from routine settings, in some cases as they are not oriented to a medical model. Excluding practice based and other types of evidence automatically puts a broad range of therapies at a disadvantage in establishing their effectiveness. • In the production of the draft guidelines we have seen a split between what the Guideline Development Group does in theory and in practice, which erodes trust and weakens NICE's claim to conduct rigorous assessments in accordance with 'robust criteria'.	scope reflects the time constraints available to the guideline. This is reflected in the decision not to review various interventions covered in the guideline in 2002, for example the efficacy of anti-depressant drugs. We consider that this represents sound judgement regarding the effective use of the guideline development resource. In both reviewing the evidence and developing the recommendations a number of studies were drawn on including, in addition to randomised controls and including meta-analyses, qualitative studies and cohort studies. Also, epidemiological data was drawn on in developing the introduction, we made specific reference to patient experience in Chapter 4 and patient experience has also influenced our reviews of the efficacy of psychological treatments. It may be that you are referring to more practice based evidence. All the treatments commonly available in the NHS including CBT, IPT, counselling and psychodynamic psychotherapy have been subject to randomised controlled trials. We are not aware of any studies where this seems not possible.
44	SH	Mental Health Providers Forum		Full	General		Very few client's present with depression alone, the majority present with co-morbidity. Basing guidelines on a diagnostic system may not be an appropriate way to approach the provision of treatment due to the complexity of 'symptoms' experienced by patients.	Thank you for your comment. However, to be manageable (both from the development point of view and that of clinicians) the guideline cannot feasibly deal with a range of specific comorbidities. Many patients do present with comorbidities and these patients are also represented in the clinical trials. Current evidence supports the treatment of depression as

								being of benefit despite the presence of comorbidities. The management of depression in the presence of comorbidities is covered in other NICE guidelines where sufficient evidence exists on which to base recommendations (for example, PTSD, borderline personality disorder, dementia). We have amended our recommendation to make this clearer.
45	SH	Mental Health Providers Forum		Full	General		Only a limited list of therapeutic treatments was searched for as part of the GDG research review. • Many established therapies were excluded from consideration without rationale or justification, e.g Humanistic (Gestalt, Person centred), Integrative, Family systemic, Transpersonal and Body Psychotherapy. • No justification is given for the inclusion or exclusion of therapies.	Thank you for your comment. The search was exhaustive, using several databases and other sources. For RCTs the search consisted of terms relating to the clinical condition (i.e. depression) and study design only, thereby yielding the largest number of relevant papers that might otherwise be missed by more specific searches, formed around additional elements of the question, including interventions and the outcomes of interest. This strategy would have identified RCTs of the interventions you mention if they had been published. Our criteria for evaluating studies are set out in our methods chapter and the review protocols are included in each chapter. For further information regarding included and excluded studies, please see Appendix 18.
217	SH	Mental Health Providers Forum		Full	7.1.3	153	Examples in the guideline draw repeatedly, only from CBT sources, e.g. Personal accounts and in discussion of Therapist Competence. This further gives the impression of impartiality and makes the reader question how well informed NCCMH staff and the GDG are of other types of therapy? If the GDG recruited from a wider pool of disciplinary expertise more use of examples from alternative therapies may be made, avoiding the perception of CBT bias.	Thank you for this comment. We do not accept your suggestion that we have been impartial in this recommendation. Staff in the NCCMH are acquainted with a wide range of other psychological interventions and a reading of the existing NICE mental health guidelines would show that NICE guidelines have recommended a wide range of other psychological

								interventions. Members of the guideline development group have interest in providing and indeed have published research on a range of other interventions beyond CBT. The GDG composition is in line with the agreed scope and the NICE guidelines manual 2007, and composed of a wide range of practitioners. The specific roles and interests of the GDG members are as follows: **Professor Sir David Goldberg (Chair, Guideline Development Group)** - Psychiatric epidemiology, case identification of common mental health problems, CCBT **Dr. Neil Andrews** - Consultant Cardiologist and Electro physiologist, - Cardiac electrophysiology **Professor Francis Creed** - Professor of Psychological Medicine, University of Manchester - Liaison psychiatry, brief interventions and psychodynamic therapy in psychosomatic disorders **Professor Christopher Dowrick** - Professor of Primary Medical Care, University of Liverpool - Conceptualisation of depression in primary care, problem solving therapy and antidepressant treatment in primary care **Dr. Gwyneth Grout** - Consultant Nurse, Mental Health Liaison (Older People), Hampshire Partnership NHS Trust (until May 2008) - Development of care systems for people with depression and chronic physical health problems

								Dr. Mark Haddad - Clinical Research Fellow, Health Service and Population Research Department, Institute of Psychiatry - Case identification and assessment tools in primary care **Dr. John Hindle** - Consultant Physician Care of the Elderly, Clinical Director of Medicine, North West Wales NHS Trust - Parkinson's disease **Dr. David Kessler** - Walport Clinical Lecturer - Primary Care, Bristol University - Case identification of common mental health problems in primary care, brief interventions and CBT in depression in primary care **Professor James Lindesay** - Professor of Psychiatry for the Elderly, University of Leicester - Classification of disorders in the elderly, drug treatments and institutional care **Ms. Margaret Ogden** - None **Dr. Jonathan Packham** - Consultant Rheumatologist, Haywood Hospital. Senior Lecturer, Primary Care Musculoskeletal Research Centre, Arthritis Research Campaign National Primary Care Centre, Keele University - TNF and the treatment of rheumatoid arthritis **Professor David Taylor** - Chief Pharmacist, South London and Maudsley NHS Trust - Professor of Psychopharmacology, King's College, London Effectiveness of psychotropic drugs,

								drug interactions.
219	SH	Mental Health Providers Forum		Full	7.2.1	155	We are concerned that only RCTs were reviewed as part of this guideline, which contradicts the GDG's stated procedure. • There is no consensus and much debate about whether a medical model is appropriate for evaluating psychological therapies. • Sir Mike Rawlins has contested the notion that RCT's should be seen as the gold standard, he further states that "decision makers need to assess and appraise all the available evidence irrespective as to whether it has been derived from RCTs or observational studies" • RCTs contain only small samples sizes of patients compared to other types of evidence. • It is not consistent with stated procedures of GDG to look only at RCT's and Meta analyses • RCTs do not allow the measurement of therapist effects - it is impossible to isolate therapist variance within an RCT. RCTs focus on specific ingredients rather than the relationship or common factors which research shows is more significant in achieving positive outcomes. Evidence shows that the therapist it is the individual therapist rather than the therapy which makes the most significant difference in treatment outcome. We are concerned that a trend is emerging within NICE guidelines on mental health conditions, in which evidence which provides proof of the effectiveness of a broad range of therapies and which indicates that it is the therapist rather than the therapy which is most significant is ignored. Such as qualitative studies, case studies, practice based evidence, efficacy studies and cohort studies. Meta analyses shows equivalence between therapies (Ahn and Wampold 2001, Styles 2006) Routine measurement in naturalistic settings, case studies and qualitative data are appropriate research methodologies for evaluating psychological therapies, as they enable common, social and contextual factors to be explored.	Thank you very much for this comment. We have not only reviewed RCTs for this guideline. An examination of the chapter on patient experience would show for example that we drew extensively on qualitative patient experience in order to construct this chapter. In addition when looking at, for example, stepped care we drew on a variety of studies including but not exclusive to RCTs in arriving at our decisions. We are convinced, as indeed are many international experts, of the value of the randomised controlled trial in evaluating psychological therapies. A very wide range of psychological therapies including counselling, psychodynamic psychotherapy, systemic therapy, CBT and IPT have all been successfully evaluated using randomised controlled trials. We are careful in arriving at our decisions based on RCTs or other evidence to properly evaluate the quality of this evidence. We follow the process set out in the NICE technical manual and make use of the GRADE method in order to evaluate our evidence. You contest that the randomised trials contained only small samples of patients compared to other types of evidence, however you offer no such other types of evidence by which this statement can be judged. Randomised controlled trials are designed to have internal validity and to test the effectiveness of a particular therapy. A number of

								studies attempt to account for the therapist variable by maintaining common therapists across different treatment arms. Indeed as you will see in our discussion of therapist competence and the variance in therapist outcomes some of this data was drawn from randomised controlled trials. There are existing RCTs which have tested different models of therapy using the same therapists and have found differences between the therapies. This would suggest that your assertion that all differences are accounted for by therapist variables is not correct. We have made very specific recommendations around therapist competence. We would expect that all NICE recommended psychological interventions will be implemented by competent therapists. It seems to us difficult to argue against such a position. The Styles et al (2006) paper to which you refer is not a meta-analysis. There is considerable debate as to whether the equivalence between all therapies is the case. We have seen no convincing evidence both in this guideline and elsewhere which would lead us to conclude that all therapies actually are equivalent. A number of NICE guidelines have consistently and clearly demonstrated additional benefits attributed to different therapies.
221	SH	Mental Health Providers Forum		Full	7.2.4 – 7.2.16	161-187	Although listed as a therapy under review within the guidelines, we were not able to find a 'clinical evidence' section for psychodynamic psychotherapy? Therefore we were not able to establish why this therapy is not	Thank you for your comment, unfortunately no clinical evidence was identified to support a recommendation for

							recommended by the guideline.	psychodynamic psychotherapy.
238	SH	Mental Health Providers Forum		Full	7.4.1	195	Patient choice is essential as different people respond better to differing treatments depending on the stage of recovery. No therapy is universally suitable for all patients at all times. The choice of treatment options offered to patients (drugs or behaviour modification) is a false choice, especially when compared with over 14 established therapies currently provided within the NHS. Research shows that a patient's perception of presenting symptoms, possible solutions and conception of how change can happen form a theory of change which can be used to determine which approach, delivered by whom, would be most effective for the patient. Research also shows that success is more likely and greater when the treatment offered is in accord with the patient's theory. Hubble, Duncan, Miller (Eds.) The Heart and Soul of Change: What Works in Therapy, APA Publications, 1999	Thank you for this comment. The evidence that individuals respond to different treatments at different times depending on the stage of their illness is limited. This applies to both pharmacological and psychological treatments. There was an active position taken throughout this guideline to promote patient choice. We did not recommend behaviour modification at all in these guidelines. Instead we made available a range of options including peer support, guided self-help, CCBT and group and individual CBT. The comments you make regarding the nature of change in psychotherapy are not supported by any solid evidence, nor by the references that you provide. Indeed high quality studies of patient preference (e.g. King et al 2005) show that patient preference does not necessarily align very strongly with treatment outcomes.
281	SH	Mental Health Providers Forum		Full NICE	7.4.1.15 1.4.2.1	198 18	Recommendations to treat depression first in cases of 'co-morbidity' is a symptom orientated approach. This is a somewhat distorted understanding of human emotions which arises from trying to apply a medical model to psychological interventions. An emotional cause may trigger a number of different symptoms, addressing the cause will help alleviate all symptoms rather than working back to front by addressing symptoms and leaving original cause 'untreated'.	Thank you very much for this comment. However your description of the mechanisms underlining human emotions does not fit with the evidence that we have available. The evidence that we have available would suggest that depression and the presence of co-morbid symptoms is a treatable disorder. In other guidelines to which we refer for example a number of anxiety guidelines, there is clear evidence that the treatment of the specified anxiety disorder, for example PTSD will lead to the effective remission of depressive symptoms. We feel that this approach based on evidence of

								effectiveness is better than speculation on the underlying nature of causes.
294	SH	Mental Health Providers Forum		Full	7.5	199	Research recommendations should include further research on the effectiveness of therapies not included in this guideline	Thank you very much for this comment. We have made a number of additional research recommendations in light of yours and other comments.
566	SH	Mind	1	NI CE	General		Mind welcomes the attention to depression in adults with chronic health problems and the recognition of the relationship between the two. Research supported by Mind [Jenny Morris (2004) One town for my body, another for my mind, Joseph Rowntree Foundation] shows the barriers facing people with mental health support needs and physical impairments. Thirty-eight per cent of the people in this survey had a diagnosis of depression. Issues raised included coordination of services, being treated as a whole person, awareness of the impact of physical impairments and disabling barriers including their psychological impact, and understanding the effects of medication on the physical condition and/or interactions. Therefore there are several issues that we are pleased to see covered, including: checking that optimal physical health care is being provided (1.3.1.3), drug reactions and interactions (1.5.2) and the coordination of mental and physical health care (1.6).	Thank you for your comments.
567	SH	Mind	2	NI CE	General		However it may be helpful to spell out more the importance of a 'whole person' approach. For example in the Morris research, one person spoke about how their psychiatrist always asked about the health condition, another referred to a psychotherapist who had a "good grasp" of all issues, including the physical impairment, and another spoke highly of a counselling service as the "only space where I try and look at everything, mental and physical".	Thank you very much for this comment. We agree it's important to take a 'whole person' approach and have sought to address this in recommendations such as 1.3.1.3. In addition, recommendations were made concerning collaborative care which explicitly seeks to integrate physical and mental health care.
568	SH	Mind	3	NI CE	General		It would also be helpful to be more explicit about the intrinsic link between mental and physical health and the need to address both.	Thank you very much for this comment. We have made some additions to the introduction to the guideline to address the concerns that you raise.
644	SH	Mind	4	NI CE	1.4.3.3	20	We particularly welcome the inclusion of group peer support (self-help) programmes, and consider that this would be a valuable inclusion in the depression guideline as well.	Thank you for your comments.
262	SH	Mind	5	Full	7.4.1.5	194	However we consider that it would be helpful to give specific attention to self-management. This can be	Thank you very much for this comment. We have made a

				NICE	1.4.3.3	20	assisted by peer group support, but takes the concept further and also combines the mental and physical.	number of recommendations including those for guided self-help which we think would address this point that you raise. We have not covered other areas concerning self-management which are outside the scope of the guideline.
239	SH	Mind	6	Full NICE	7.4.1 1.5.3	194 29	We have concerns that the only high intensity psychosocial interventions are forms of CBT, given the importance of choice and the ineffectiveness or unacceptability of CBT for some people. If the evidence cannot support any other approaches we suggest that this should form part of the research agenda in this guideline.	Thank you very much for this comment. We accept that there is a limited choice of high intensity interventions made available in this guideline but unfortunately that reflects the current state of the evidence. We agree with you that further research in this area to identify other active interventions is required. We have made a number of research recommendations in light of this, for example please see recommendation 4.7.
569	SH	Mind	7	NICE	General		Mind submitted comments on the depression draft guideline and these comments are also relevant to this guideline where the same text is used.	Thank you for your comment. We have reviewed all of the comments submitted for the depression update and amended any recommendations or text in the present guideline as appropriate.
124	SH	NCCHTA Methodological Referee (1)	1	Full	5		As set out below (5.6.1.6) in my opinion there is a specific limitation to the evidence synthesis method used for the identification of depression in people with chronic physical health problems.	Thank you for your comment, we disagree with your conclusions and will respond specifically to the concerns raised in your comments.
146	SH	NCCHTA Methodological Referee (1)	2	Full NICE	5.6.1.6 1.3.1.1	102 16	It is recommended that that the Whooley 2 depression screening questions (as recommended for antenatal and postnatal mental health by NICE) should be administered by NHS health practitioners and if either is answered yes a clinical evaluation of depression conducted. It is acknowledged that the effect of introducing these questions has not been tested in this population. These questions are recommended because of good sensitivity and specificity against gold standard comparators. This is not correct, based on my reading of the supplied review material and appendices.	The Whooley questions have been tested on people with MS (Mohr 2007). The sensitivity was very high in this population, and very similar to people without chronic physical health problems. In response to your second point, case identification requires the use of an instrument with high sensitivity. The review found a sensitivity of 0.95 (0.91, 0.97) this is undoubtedly very high (the most sensitive of all the depression measures).

								In terms of specificity, the clinical summary and evidence to recommendations in Chapter 5 both highlight the lack of specificity of this measure (so we are not claiming it has high specificity). That is why further recommendations suggest the need for a more comprehensive assessment.
147	SH	NCCHTA Methodological Referee (1)	3	Full NI CE	5.6.1.6 1.3.1.1	102 16	The comparators used (the CIDI, DSM criteria alone but without a standardized assessment procedure) are not standardized clinical evaluations, with the exception, appendix 2.1, of the study by Mohr 2007, (here the comparator was the clinical interview SCID DSM-IV), in which sensitivity was 0.51 (0.38 – 0.63) in adults with MS with a mean age of 51.	All included studies used valid measures of DSM or ICD depression. Thank you for pointing out an inscription error in appendix 2.1. The sensitivity is in fact 0.98 which is very high.
148	SH	NCCHTA Methodological Referee (1)	4	Full NI CE	5.6.1.6 1.3.1.1	102 16	In my opinion the recommendation is over stated. It may be a reasonable short term recommendation to make pending further evaluation but its limitations should be noted and discussed. See also my recommendations below.	The use of the Whooley questions was recommended in the previous depression guideline and has been widely implemented since. The evidence since the previous guideline has further supported the use of this instrument.
149	SH	NCCHTA Methodological Referee (1)	5	Full NI CE	5.6.1.6 1.3.1.1	102 16	If the depression screen recommended for primary care is highly sensitive the majority of positives will be false positives – how realistic is it to expect that in current NHS practice treatments for depression will not be commenced before a more complete clinical evaluation has been performed each time this happens, bearing in mind that a high proportion of the relevant population will be older adults?	In primary care, the Whooley questions have been implemented successfully through the QoF. Therefore the GDG feel that NHS employees are able to conduct a comprehensive clinical evaluation following the use of this measure.
130	SH	NCCHTA Methodological Referee (1)	6	Full	5.4		A restatement of the comment set out above in relation to section 5.6.1.6	Thank you for your comment, please see below for the response under section 5.6.1.6.
46	SH	NCCHTA Methodological Referee (1)	7	Full	general		This report appears to be lengthier and more detailed than previous reports on depression topics by NICE. It is likely to place greater demands on the knowledge and skills of readers and may be less accessible to service users and carers and non specialists.	The full guideline is approximately the same length as the previous guideline for depression. While we appreciate your concerns, NICE produces a document 'Understanding NICE guidance' that summarises the main issues of the guideline and is designed to be more accessible for service users,

								carers and non specialists.
197	SH	NCCHTA Methodological Referee (1)	8	Full	6.5		I struggled to find how the positive recommendation for the use of stepped care is to be implemented. A similar recommendation is very clearly set out in the original depression guideline by NICE.	Thank you for your comment. A close reading of the 2004 guideline shows that there are no specific recommendations for stepped care. The stepped care model is used as a structure within which care should be delivered, and therefore feel it will help the guideline to be implemented
76	SH	NCCHTA Methodological Referee (1)	9	Full	2.2.6		Heading: Reasons for the increased prevalence… The word prevalence is potentially misleading – it would be less misleading to say increased association.	Thank you for your comment. We have used the term prevalence throughout the guideline as this is the common term used within the literature reviewed.
132	SH	NCCHTA Methodological Referee (1)	10	Full NICE	5.6 1.4		My advice is to add a research recommendation, which is that screening questions for depression, such as the Whooley (2 item) questions, should be evaluated prospectively in this population against a semi-structured clinical comparator such as the SCID-I, SCAN, or an equivalent interview linked to ICD-10 and or DSM-IV, and that the effects of using such a potential screening tool in NHS clinical practice on later clinical outcomes should be evaluated in a randomized controlled trial. This recommendation should be inserted at or following Section 5.6. Such research could be commissioned by NIHR-HTA.	Thank you for your comment. There is good evidence for the sensitivity (it was the most sensitive instrument of all the scales reviewed) of the Whooley questions from 7 studies and the use of this measure has been widely implemented in the NHS since the previous NICE depression guideline. In the judgement of the GDG there were much greater needs for further research on other issues.
125	SH	NCCHTA Methodological Referee (1)	11	Full	5		Methods for detecting and diagnosing mental disorders: Henceforth systematic reviews of the identification of depression and or other mental disorders undertaken by NICE should clearly distinguish between evaluative studies using comparators (i.e. gold standard methods) that make use of lay (e.g. the CIDI, or 'fully structured' or 'self-report') and clinician evaluated (e.g. the SCID, SCAN etc. or 'semi-structured') diagnostic assessments.	It is true there are limitations concerning what constitutes a 'gold standard' depression diagnosis. This is a limitation consistent across most mental health conditions. In the judgment of the GDG all included studies used a valid measure of DSM/ICD diagnosis of depression.
126	SH	NCCHTA Methodological Referee (1)	12	Full	5		Reviews should also specify whether a diagnostic algorithm has been used based on a published classification system such as DSM-IV or ICD-10 Chapter V in conjunction with a method of assessment; in the review only a classification system is mentioned. The reason for this is partly that the method of assessment (e.g. an interview, clinical ratings, self completion by a service user) and the method of classification (e.g. ICD-	As already stated in a previous comment, all included studies used a valid method of determining a DSM or ICD diagnosis. Whilst we agree it would be helpful to add further detail to the study information table it should be noted the table is already over 100 pages

							10) can both affect thresholds for disorders (and prevalence estimates) and the relationship with another instrument such as a screening question.	long. Therefore it does not seem prudent to significantly add to what is already a very large table.
86	SH	NCCHTA Methodological Referee (2)	1	Full	3.4	36	Best primary study design for costs stated as naturalistic prospective cost study. Should this also be cost-effectiveness study/economic evaluation?	Thank you for your comment. We have omitted this point from the textbox since we are discussing health economics methods separately, in section 3.6.
90	SH	NCCHTA Methodological Referee (2)	2	Full	3.6	48	Stated that the review covers only areas with likely major resource implications. These major resource implications are never defined in the review – what are they and how do they impact on the inclusion/exclusion criteria?	Thank you for your comment. Areas with major resource implications were identified based on GDG expert judgment. At early stages of guideline development the GDG members are asked to identify topics for economic analysis. The decision is made jointly with the health economists, and should be influenced by: •the overall 'importance' of the recommendation (which is a function of number of patients affected and the potential impact on costs and health outcomes per patient) •the current extent of uncertainty over cost effectiveness •the likelihood that analysis will reduce this uncertainty." [NICE Guideline Manual, 2007; p52]. We have clarified the above issues in the final guideline text. Searches are done on all areas covered in the guideline and all relevant literature is included and reviewed. The selected areas for modelling have no effect on which areas are searched or included or excluded.
91	SH	NCCHTA Methodological Referee (2)	3	Full	3.6	49	Lines 38-39 states that the search strategy for economic studies are provided in appendix 17, however this contains details of included studies, think appendix 13 is correct one.	Thank you for pointing this error out. We have corrected this.
92	SH	NCCHTA	4	Full	3.6	50	First para: the search strategy found 35000 references.	Thank you for your comment.

		Methodological Referee (2)					Is this correct? I'd be concerned at the ability of anyone to go through so many refs and pick out the relevant ones. I'd have thought that at this point it would be worth checking the search strategy to ensure that it couldn't be made any tighter, which might result in fewer references being identified.	35000 references were retrieved from the health economic searches for the depression and DCHP guideline, and the combined hit rate was shared between the two teams, in order to achieve a reasonable completion time while maintaining consistency of performance. It should also be noted that, in the initial searching stage, records containing the most relevant and specific health economic terms were pooled into separate databases of references, thereby reducing the likelihood of studies being missed.
93	SH	NCCHTA Methodological Referee (2)	5	Full	3.6	50	The inclusion criteria doesn't make any reference to the inclusion of areas with "likely major resource implications" – is this relevant here?	Thank you for this comment. The inclusion criteria mentioned refers to methodological quality of studies, rather than relevance to the topic. Searches were done in all areas covered in the guideline.
180	SH	NCCHTA Methodological Referee (2)	6	Full	6.4	144	I'm interested by the exclusion of productivity losses from the model and the explanation that a NICE (NHS/PSS) perspective was used. I had understood that wider societal costs should be included in evaluations when they are considered important/substantial. The Thomas and Morris (2003) article makes clear the importance of productivity losses in depression.	Thank you for your comment. Please refer to the excerpts form the NICE technical manual and Guide to technology appraisals below. We are required to use the NHS/PSS perspective and if other costs are important, then they should be covered in secondary analysis. This does not include productivity losses, which are important in all areas and not only depression, so there is no specific reason to include them particularly in this guideline. The NICE guideline Manual suggests that : For the reference case, the perspective on outcomes should be all direct health effects, whether for patients or, when relevant, other people (principally carers). The perspective on costs should be that of the NHS and PSS.

								Some interventions may have a substantial impact on non-health outcomes or costs to other government bodies (for example, treatments to reduce illicit drug misuse may have the effect of reducing drug-related crime). If costs to other government bodies are believed to be significant, they may be included in a sensitivity analysis and presented alongside the reference case results. *Productivity costs and costs borne by patients and carers that are not reimbursed by the NHS or PSS should not be included in any analyses.* Guide to the Methods of Technology Appraisal 2004: - The reference case perspective on outcomes is consistent with an objective of maximising health gain from available resources. Some features of healthcare delivery that are often referred to as 'process characteristics' may ultimately have health consequences – for example, the length of waiting lists for elective surgery. When there are significant characteristics of healthcare technologies that have a value to individuals that is independent of any direct effect on health, these should be noted. These characteristics include the convenience with which healthcare is provided and the level of information available for patients. 5.3.3.3 *The Institute works in a specific context; in particular, it does not influence the budget that is set for the NHS. Hence, the appropriate objective of the Institute is to offer guidance that represents an efficient use of limited NHS and PSS resources. For these*

								pragmatic reasons, the appropriate reference case perspective on costs is that of the NHS and PSS. In non-reference case analyses, significant resource costs imposed outside the NHS may also be considered and in offering guidance the Institute may take account of these costs. The resource costs that come under this heading could include direct costs on patients or carers (for example, travel costs) or costs to other public sector organisations, but will not normally include productivity costs.
228	SH	NCCHTA Methodological Referee (2)	7	Full	7.3.2	191	I wonder why collaborative care was selected for modelling when it might also have been used to consider the relevance of the evidence in this patient group for other interventions. For example, the cost of guided self-help is estimated using existing salary costs and its cost-effectiveness against the NICE threshold is discussed but only using very simple back of the envelope style modelling. Why weren't more complex approaches used here? What about some sensitivity analyses?	Thank you for your comment. The aim of the clinical review was to assess the efficacy of any service level intervention or configuration aimed at treating depression in people with chronic physical health problems. There was a lack of evidence for most of the interventions considered. The most notable exception was the evidence base for collaborative care, which has grown considerably in the past 10 years and has led some experts to call for the widespread implementation of collaborative care. There has been growing interest in the development of systems of care for managing depression, including managing depression in people with chronic physical health problems. This is due to the fact that for many people depression is a chronic and disabling disorder. Furthermore, comorbid depression has detrimental effects on the prognosis of physical health conditions. In particular, comorbid depression has been linked to an increase in healthcare utilisation, disability and work absenteeism in people with chronic physical illness, even after

								controlling for the varying burden of the physical health condition (Stein, *et al.* 2006). Therefore, collaborative care was selected for modelling. It was assumed that the low intensity psychological and psychosocial interventions recommended in the DCHP guideline were similarly effective, based on this premise the costs of such interventions were looked at, with the view that a prescriber would take these into account, together with patient preference etc. when making a decision.
83	SH	NCCHTA Methodological Referee (2)	8	Full	2.4	30	Lines 42-43 "additional burden on patients" – surely the burden of additional health care cost and productivity losses is on society rather than individuals	Thank you for your comments. The text has been amended and should refer to the additional burden on patients and society in general.
165	SH	NCCHTA Methodological Referee (2)	9	Full	6.3.6	127	Lines 15-23: This para considers a paper examining DMP for major depression in elderly primary care patients. It is not clear whether or not these elderly patients have chronic physical health problems. Are we to assume that they do because they are elderly?	The study by Bosmans and colleagues (2006) has been excluded as the population does not meet the inclusion criteria.
166	SH	NCCHTA Methodological Referee (2)	10	Full	6.3.6	127	Line 28-31. States that cost-effectiveness planes were presented and that they indicated no significant differences in cost-effectiveness. CE planes do not compare interventions statistically; statistics do. In addition, economic evaluations do not look for differences in cost-effectiveness, rather they seek to examine which intervention is cost-effective compared to another. Some clarification in the reporting of this paper is needed.	The study by Bosmans and colleagues (2006) has been excluded as the population does not meet the inclusion criteria
167	SH	NCCHTA Methodological Referee (2)	11	Full	6.3.6	127	Lines 33-39. I agree that it is worth considering whether the representativeness of the Dutch findings in a UK setting, but I don't think that the remainder of this paragraph adequately addresses this. I would think that issues regarding different health systems, cost structures and incentives would be more relevant.	The study by Bosmans and colleagues (2006) has been excluded as the population does not meet the inclusion criteria
168	SH	NCCHTA Methodological Referee (2)	12	Full	6.3.6	128	line 24-25 – This section repeatedly mentions the limited generalisability of the findings to the UK setting, given the importance of this not only to the results presented	Thank you. We have taken this into consideration.

							here but also to the modelling presented in the next section I really think that this should be explored and expanded further.	
169	SH	NCCHTA Methodological Referee (2)	13	Full	6.3.6	129	Lines 23-24. The statement “DM may or may not be considered a suitable representative of other chronic physical health conditions” needs some expanding, again given the importance of the limited evidence available. What are the issues involved? Costly ongoing treatment, expensive long-term complications with large impacts on quality of life etc.	Thank you for this comment. This issue has been expanded on.
170	SH	NCCHTA Methodological Referee (2)	14	Full	6.3.6	129	The whole premise of the modelling is that the data presented are not useful for the guideline because of the different health care setting. However, without a proper exploration of these issues, it is difficult to understand the motivation for the modelling and indeed the methods you have used in them.	Thank you for this comment. We have taken it into consideration and have explored the relevant issues in the text.
184	SH	NCCHTA Methodological Referee (2)	15	Full	6.4.3	134	The section titles and table titles would benefit from some cleaning up, see point below on structure of this section	Thank you. This has been taken in to consideration.
185	SH	NCCHTA Methodological Referee (2)	16	Full	6.4.3	136	Line 5. The 2007 Unit cost publication was edited by Curtis and Netten, rather than Netten alone.	Thank you for your comment. This has been changed.
186	SH	NCCHTA Methodological Referee (2)	17	Full	6.4.3	136	Line 8-9. Discounting should be applied to all costs that are incurred over 12 months, so technically the costs incurred in the period between 12 and 15 months should be discounted. It can be quite easily argued that the impact on any discounting on a small proportion of costs over a short period of time is minimal and can therefore be ignored, but it is untrue to say that discounting was unnecessary.	Thank you. We assumed that the omission of discounting over this short period would likely to have a very small impact on the overall results. This has been made more explicit in the text.
187	SH	NCCHTA Methodological Referee (2)	18	Full	6.4.3	139	The McCrone costs are from a previous financial year to the one used for the other unit costs – you might consider inflating these using a relevant inflator.	Thank you for your comment. The costs have been inflated and this has been reflected in the text.
188	SH	NCCHTA Methodological Referee (2)	19	Full	6.4.3	139	The data analysis and presentation of results section is important and would benefit from some expansion and further explanation eg. ‘an ICER was calculated for the pair of options’ – which options? At the end of this para, there is a section stating that the treatment option with the highest ICER below the cost-effectiveness threshold is considered the most cost-effective option, but this is only relevant when comparing a range of treatments. It would be useful to make clear the decision rules for the evaluations presented here first.	Thank you for your comment. Collaborative care was compared to usual care. The additional text has been removed and the relevant text has been clarified.
189	SH	NCCHTA Methodological Referee (2)	20	Full	6.4.3	140	The sensitivity analyses are really important therefore I think a separate section and some further explanation is	Thank you for your comment. Sensitivity analysis was used to

							warranted here. Why were these variables chosen? What were the min/max values and where did they come from? Also, did the authors consider a probabilistic sensitivity analysis, and if not, why not?	explore the impact of potential sources of bias and uncertainty on model results. Potential biases resulting from key structural assumptions were explored, testing whether and how the model results change under alternative plausible scenarios. Deterministic sensitivity analysis was also used to test the impact of potential bias resulting from the selection of data sources for key model parameters. Where available the 95% confidence intervals were used. If these were not available an upper and lower value was chosen in conjunction with the GDG. A PSA has been conducted and reported. However the results of the simple sensitivity analysis were also quite robust.
193	SH	NCCHTA Methodological Referee (2)	21	Full	6.4.4	140	Line 35 - It would be useful if the mean values for costs and outcomes were reported in the text	Thank you. This information has been added.
177	SH	NCCHTA Methodological Referee (2)	22	Full	6.4	142	First statement in the discussion is that collaborative care is likely to be more cost-effective than usual care. The results of the model however are that collaborative care is cost-effective compared to usual care. It's only a small difference but important when reporting the results of economic evaluations, which are always comparative in nature.	Thank you.
178	SH	NCCHTA Methodological Referee (2)	23	Full	6.4	142	All models have many limitations, and I think that some further exploration of the limitations of this model is warranted.	Thank you. This has been taken into consideration and the limitations of the model have been expanded upon.
179	SH	NCCHTA Methodological Referee (2)	24	Full	6.4	143	Lines 18-20 – why and how is the UK system significantly different from the US? Why might these differences result in possible over-estimation of successful outcomes for the intervention? I'm not clear from the paragraph.	The economic evidence presented is all conducted in the US health care setting and adopts the perspective of the 3rd party payer. Healthcare in the US is provided predominantly by separate private entities such as health maintenance organisations and to receive care patients often require private health insurance. This is very different to

								the UK where health care is predominantly publicly funded and there is free universal coverage. Therefore, this results in differences in access to healthcare and the resultant health care use patterns may differ too. The treatments received and cost of the treatments may also differ as healthcare providers may face different financial incentives. Cost estimates used in the studies would also vary greatly not only across different countries but also across different healthcare providers in the US alone, as prices for larger institutional purchasers may be lower than average wholesale prices due to their ability to negotiate lower prices. For the reasons stated above, the results of the economic studies reviewed have limited generalisability to the UK setting. Usual care in the UK may be more intensive and possibly more effective than usual care offered in such a setting. Therefore, the use of such efficacy data may result in a possible over-estimation of successful outcomes for the intervention.
181	SH	NCCHTA Methodological Referee (2)	25	Full	6.4	144	Some clarity over the conclusions is needed. The analysis undertaken for this guideline shows that collaborative care is more cost-effective than usual care. BUT, then need to list caveats – i.e. data from sources of variable quality, difficulties in transferring results from different health systems etc.	Thank you. The text has been amended.
225	SH	NCCHTA Methodological Referee (2)	26	Full	7.3.1	189	Lines 32-24. Why is it likely that if CBT is cost-effective in depression it will be cost-effective in depression and chronic health problems? What are the hypotheses/reasons for this? Given the importance of this area some much deeper exploration of the issues involved is warranted.	Thank you for your comment. The text now contains more detailed discussion of the transferability of the findings of the cost-effectiveness analysis to patients with depression in chronic health problems.
229	SH	NCCHTA	27	Full	7.3.2	192	I don't think that the issues surrounding the cost-	Thank you. This has been taken

		Methodological Referee (2)					effectiveness of CCBT interventions in this population was explore fully enough in this section.	into consideration and the text has been amended. The group drew on evidence from the depression update guideline when there was no evidence available but the GDG considered the recommendation to be of importance in part because of the increased access it offered to patients who may be confined to the home or to bed. Therefore the economic aspects of the CCBT intervention, as discussed in the depression update guideline, have been highlighted in this guideline.
321	SH	NCCHTA Methodological Referee (2)	28	Full	8.2.8	227	Again, I'm not clear here why the cost-effectiveness of pharmacological management of depression in people with chronic health problems was not chosen for further and fuller exploration, particularly as it was highlighted as an important area by the GDG. A model based on the results of the trial but using UK-specific assumptions and costs may give a better idea of cost-effectiveness and lead to more specific and better backed recommendations.	Thank you for your comment. The economic evidence reported in O'Connor et al. 2005 is based on the SADHART trial on patients with acute coronary syndrome. This particular population was not considered to be representative of all patients with depression and chronic physical health problems. It has been noted that treating depression in people with physical health problems is potentially more challenging in terms of adverse effects of medication (as the physical illness may make physical adverse effects of much greater consequence). A person in this population is likely to be on a range of medications related to their physical condition and therefore is a greater likelihood of potential interactions with antidepressants. The guideline currently supports the following based on the clinical review: SSRIs should be first-line treatment for depression associated with physical illness. Of the SSRIs, sertraline and citalopram probably have the lowest interaction potential, appear to be safe and possibly protective of further cardiac

								events so generally should be the drugs of first choice. These are generic drugs and are available relatively cheaply. Their low interaction potential and possible protective properties make it potentially worthwhile from a cost-effectiveness perspective, as it may result in cost savings due to potential adverse events that are prevented and offer a potential for additional QALY gains. Sertraline was the drug evaluated in this trial and using UK based costs would have been informative. However, the overriding concern for the GDG was the potential for adverse events and it was pointed out that there would be many instances where SSRIs would not be suitable. The guideline offers a list of suitable alternatives. The choice of the drug can be expected to be largely dependent upon relevant contra-indications related to the physical illness and potential for interaction with co-administered drugs. It is on these latter issues that many of the GDG's recommendations focus. Nevertheless, a table of the drug acquisition costs has been added. Costs of the drug, patient safety and choice should all be considered before prescribing.
232	SH	NCCHTA Methodological Referee (2)	29	Full	7.4	194	Given the limited exploration of the issues surrounding the cost-effectiveness of CCBT and self-help, I think the recommendations may need some further justification.	Thank you this has been taken into consideration.
233	SH	NCCHTA Methodological Referee (2)	30	Full	7.4		I think the guideline would benefit generally from a clear acknowledgement of the limitations in evidence (lack of a UK focus) and more importantly HOW that impacts on any recommendations. For example, given that evidence is from the US, what is useful and what can't be considered comparable, why?	Thank you. The points highlighted have been discussed in the model write-up.
84	SH	NCCHTA Methodological	31	Full	2.4	29-30	This section could do with some tidying up. Many paragraphs e.g. p30 lines 29-40 seem to be written in	Thank you for your comments. The text has been amended.

		Referee (2)					note form and the sentences don't link well together.	
94	SH	NCCHTA Methodological Referee (2)	32	Full	3.6	49	Why use Latin (de novo)?	Thank you very much for this comment. The limited economic data from UK-based studies pointed to the need for de novo economic modelling for this guideline. Though the word de novo' has Latin roots it has been incorporated into the English language and is included in the Oxford English Dictionary. We therefore consider the use of term entirely appropriate for a technical document
95	SH	NCCHTA Methodological Referee (2)	33	Full	3.6	49	Title "Key economic issues" – The relevance of this title may need to be considered given the content. It seems to be giving an overview of the approach taken to the collection of information on cost-effectiveness and the modelling approach where there are gaps in the literature. Given the importance of this section for the whole of the economic evidence, it might benefit from being re-written as isn't very readable at present.	Thank you for this comment. We have amended the text.
96	SH	NCCHTA Methodological Referee (2)	34	Full	3.6	51	Lines 6-14: I'm afraid I read this paragraph and number of times and couldn't make much sense of it. It would be helpful if this could be re-written as I think it's an important section which 'signposts' the rest of the economic evidence.	Thank you for the comment. We have amended the text.
171	SH	NCCHTA Methodological Referee (2)	35	Full	6.3.6	126	Lines 29-45 – This paragraph would benefit from re-drafting to help ease of reading. Does 'telephonically' mean by telephone, who phones who? Antidepressant treatment for 'most' – who are 'most' and how are they identified? What is the algorithm based treatment?	Thank you for your comment. This has been amended to 'by telephone'. Antidepressants ar prescribed to those patients who are thought to require them by the clinician in charge of care. Algorithm based treatment (a commonly used term) refers to the process or set of rules used to deliver the disease management program.
172	SH	NCCHTA Methodological Referee (2)	36	Full	6.3.6	127	Lines 9-13. I'm not sure how useful it is to just quote the conclusion of the study directly from the paper. The role of a systematic review is to identify the conclusions that are relevant to the review and put them in context of what else is known on the subject.	Thank you. We have taken this into consideration.
173	SH	NCCHTA Methodological Referee (2)	37	Full	6.3.6	128 and 129	There are lots of repeated phrases/words in the same paragraphs/sentences. E.g. Simon and colleagues twice in p128 lines 27-29 and settings twice in p129 lines 16-17. For me, it just makes things a little more difficult to	Thank you. The text has been amended.

							read.	
176	SH	NCCHTA Methodological Referee (2)	38	Full	6.4	131 onwards	Having read the modelling section(s) a couple of times, I now have a clear idea of what was done and why. However, the model is not at all easy to follow at first. I think it would benefit from much more signposting and explanation of the different elements. Decision model needed Decision tree chosen and why Overview of structure of tree and reasoning e.g. choice of comparator, drop-out etc Need for information/data to populate tree, transitions, costs and outcomes at terminal nodes How were these data identified? First literature in depression plus chronic physical health problem, then depression alone, then expert opinion. Note decreasing validity of evidence Modelling must be transparent, this section needs to be re-drafted to meet this criteria.	Thank you for your comment. This has been taken into consideration and relevant text has been redrafted.
548	SH	NCCHTA Methodological Referee (2)	39	Full	8.6	249-250	Yes, I agree with the general research recommendations and would emphasise the importance of including an economic evaluation in each.	Thank you for your comments.
47	SH	NHS Direct	1	Full	General		Considered by NHS Direct. The comprehensive guidance is welcomed	Thank you for your comments.
574	SH	Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust		NICE	General		The guideline makes no reference to the role of occupational therapy, in terms of the support they can offer someone with depression to develop and maintain life skills and roles that are supportive them. In particular a work role, or another social role such as student, parent, volunteer etc. and ADL skills to maintain their well being.	Thank you very much for this comment – unless there are specific indications regarding the interventions that we are recommending we as a general rule make no specific reference to any particular professional group within the guideline.
50	SH	Royal College of Nursing	1	Full	General		The RCN welcomes proposals to develop this guideline. The document is comprehensive.	Thank you for your comments.
614	SH	Royal College of Nursing	2	NICE	1.1.3	11	We welcome that the guidelines recognise the role of families and carers in the treatment and support of people with depression.	Thank you for your comments.
618	SH	Royal College of Nursing	3	NICE	1.1.4.5	13	It is also welcomed that the guidelines recognise the need for practitioners to be competent in working with people with depression who are from diverse ethnic and cultural backgrounds.	Thank you for your comments.
578	SH	Royal College of Physicians		NICE	General		This appears to be comprehensive. However, there is a long way to go as access to anything approaching this level of support for patients is currently lacking. We would have liked to see a specific section on alcohol support - although this may be out of scope.	Thank you for your comment we agree these are important issues. However, implementation of the guideline is beyond the scope of the document. In addition, alcohol support is also outside the scope of

								the guideline.
579	SH	Social Care Institute for Excellence (SCIE)	1	QRG	general		This is a very useful guide which highlights the evidence base for effective psychological, social, psychotherapeutic and pharmacological interventions via a 5 step model of care for people with different diagnoses of severity of depression. With reference to the issue of co-existing physical health problems the main point centres around the need for increased awareness of the need to take into account medication being administered for physical health problems, when prescribing medication for depression. The guideline also makes some research recommendations, noting for instance that there is a high incidence of depression amongst those diagnosed with pulmonary disease. The guidance has sufficient reference to social factors within the model of care outlined. It makes clear that there is a need for assessing professionals to consider: the quality of interpersonal relationships; living conditions and degree of social isolation present. There is also reference to the need to use culturally appropriate assessment skills and different explanatory models depending on cultural and ethnic differences of person with depression and carers. Reference to the work on culturally competent practice done by the Delivering Race Equality (DRE) programme of work would be useful here. With regards to suicidal ideation/intention, social factors are taken adequately into account in that the guidelines advise that practitioners should always ask a person with depression directly about suicidal ideas and intention and if risk is present assess whether there is adequate social support and awareness of sources of help. Throughout the guidelines there is a consistent reference to social factors and the importance of working in collaboration with carers.	Thank you very much for your comments. With regard to the delivering race equality programme, we feel that specific reference to this programme is outside the scope of the guideline but we hope that with our concentration on cultural and ethnic issues we have addressed some of your concerns.
60	SH	South West London & St George's NHS Trust	1	Full	1.2.3	14	Refers to schizophrenia	Thank you for your comments, these instances have been amended in the text.
62	SH	South West London & St George's NHS Trust	2	Full	1.2.4	15	Refers to schizophrenia	Thank you for your comments, these instances have been amended in the text.
51	SH	South West London & St George's NHS Trust	3	Full	General		At least one additional reference to schizophrenia that might need to read 'depression'	Thank you, we have amended all instances.
71	SH	South West London & St George's NHS Trust	4	Full	2.2	18	States guidelines do not refer to those with chronic physical illness	Thank you for your comment. This section has now been amended.

580	SH	St Mungos	1	NICE	General		We are astonished that the guidance seems to treat depression in people with chronic physical health problems as if it were some discrete 'illness' which happens to be comorbid with the chronic health problem. You note in the introduction that depression is two to three times more common in those with chronic health problems than in a physically healthy population: recommended treatment options should take this into account. Clinicians need to try to find out what the depression means for the patient, socially, emotionally and psychologically: this enables them to work on lasting solutions rather than masking or displacing the symptoms. It is not cost-effective to have people with chronic health problems developing a range of secondary conditions that require medical treatment: this is what happens with unresolved depression. We think your guidance is likely to increase the overall burden on GPs and secondary medical services.	Thank you very much for this comment. We feel that you misrepresented our account of depression in the guidelines and that you have misread the draft guideline, for example pages 13-14 suggests your description of our position is incorrect. We do not understand the final section of your comment, nor in fact its implications for the guideline. We are however confident that the treatments we recommend in this guideline would crucially reduce the burden on patients. This may or may not entail additional demands on GP and secondary care mental health services but if this is to lead to effective interventions then we consider it appropriate.
601	SH	St Mungos	2	NICE	Key Priorities	7	The guidance recommends the use of PHQ2 to ascertain depression: evidence suggests this is not as reliable a measure as PHQ9. As depression in people with chronic health conditions is likely to be more severe than depression in the general population, then PHQ9 should be an absolute minimum. Even then, it should only serve as a trigger for referral to e.g. the GP counselling service for a more holistic assessment. As stated above, thorough clinical work demands that a much rounder assessment is engaged in, with a view to ascertaining what the depression means to the patient; why they have developed it now, and therefore what can be done to render it unnecessary. Depression in people with chronic health problems is reactive: it is a response to a set of circumstances, including elements that are intrapersonal and elements that are interpersonal and elements that are social and cultural. This whole set of meanings requires treatment for it to be effective.	Thank you very much for this comment. A careful reading of the guideline would show that the intention of the use of the Whooley questions (not the PHQ-2) is not to ascertain depression as you state but rather is to prompt a further more detailed interview as you suggest.
581	SH	St Mungos	3	NICE	General		The guidance recommends drug treatment or CBT. This narrow range of treatments, with limited evidence to support it, reflects the composition of the NICE advisory board, and the dominant position of the Royal College of Psychiatrists and the British Psychological Society, not the best clinical options for patients. It is in fact politically determined, not clinically. If implemented as it stands, it	Thank you very much for this comment. We do not agree with your comment that the recommendations reflect the dominant position of the Royal College of Psychiatrist or the British Psychological Society. It is

							will reduce patient choice, increase health inequalities, and increase demands on GP and secondary medical care.	important to point out that they are not dominant in the membership of the guideline development group. More importantly our view is that the dominant determinant of the recommendations of the guideline is the evidence. You offer no alternative suggestions, nor do you cite any evidence concerning such interventions. We believe that a significant number of the interventions that we have recommended in this guideline are not widely available. This guideline will therefore make a significant difference by making additional treatments more widely available.
582	SH	St Mungos	4	NICE	General		The guidance's narrow vision of treatment stems from a view that depression in people with chronic health conditions is an intrapersonal phenomenon. This is not the experience of patients, and treatment options based on this false premise go against patient preference. In doing so, they are likely to be counter-productive. As antidepressants fail to work, or ever more complicated mixtures of medication are required because of interreactions between them, patients are likely to become more depressed. Similarly, treatment with CBT, which begins from the premise that the patient's thinking requires change (not their circumstances, or their interactions), becomes a causal factor in deeper depression when it does not work. Even the most pro-CBT evidence suggests that it will not work in around 40% of cases (in reality, because of researcher bias, the true figure of effectiveness is likely to be lower): this is a significant amount of potentially increased ill health. More integrative approaches, based on interpersonal or psychodynamic principles, are far more likely to be effective, and to generate longlasting effects, and accord with patient preference. Our own experience is that even short-term psychodynamically informed interventions can change patients' understanding of their condition, and alleviate depression.	Thank you very much for this comment. We believe we have set out the number of interactions that the potential roles for chronic physical health problems in the development of depression in the introduction in Chapter 2 of the full guideline. We also set out recommendations for the sequencing of anti-depressant care both in this guideline and more particularly in the depression update guideline. The evidence for CBT is as you describe with a number of people not benefiting from treatment. However your assertion that this is likely to be lower because of researcher bias is not substantiated by the evidence. Your suggestion that integrative approaches are more likely to be effective is not supported by the evidence. The evidence for psychodynamic psychotherapies or related therapies, for example the group existential treatments, was that they were not effective for this group. Your assertions therefore in the absence of any other evidence

								cannot lead to any changes in our recommendations.
583	SH	St Mungos	5	NICE	General		The evidence there is does not support CBT as the best form of psychological therapy treatment in the long run, and this guidance is about treating people with chronic conditions. More evidence supports psychodynamic interventions when you look at longevity of effect (>12 months). We are not saying that you should not recommend CBT: we are saying that it is clinically wrong – bad for people's health - to recommend just CBT. There needs to be far more research, including good clinical research and 'real life' action research, not just RCTs, before such definitive positions are tenable. All the evidence so far suggests that an integrated approach, taking into account both intrapersonal and sociocultural factors, is the most likely to have longlasting effect. It is inefficient and less effective to have different people administering different aspects of a holistic psychological treatment: narrow clinical approaches such as CBT are therefore less well able to deal with the wider issues of a 'person in their situation', which is what is required for a person with depression and a chronic physical health problem.	Thank you very much. We failed to find any evidence for the effectiveness of long term psychodynamic psychotherapy in this group. We agree that there needs to be more research and have made a number of research recommendations please see for example recommendation 4.7 in the NICE guideline. We do not agree that CBT is a narrow clinical approach and is less able to deal with the 'wider issues of a person in their situation' as we were unable to find any.
584	SH	St Mungos	6	NICE	General		In aligning itself so firmly with a narrow medical model of depression in people with chronic physical health conditions, and a narrow set of treatments as if it were a discrete condition, the guidance is likely to exacerbate health inequalities. Many cultures have broader approaches to the set of feelings we call depression, and WHO research and medical anthropology have demonstrated that many cultures have better outcomes. Using such a narrow approach is likely to alienate many ethnic minority patients from treatment altogether.	Thank you very much for this comment. We believe we have given a broad and accurate characterisation of the problem with depression both in this guideline and the depression update guideline and we have taken into account the significant role that social and cultural factors may play in the development of the disorder. We have made specific reference to this in recommendation 1.1.4.5. We do not know of any evidence that this would necessarily alienate people from ethnic minorities from treatment altogether.
585	SH	St Mungos	7	NICE	General		We believe that this guidance is totally inadequate for the treatment of the complex condition of people experiencing depression alongside chronic physical health problems. The guidance is partisan, political, and likely to result in poorer health for many people with chronic conditions. It should be replaced with something	Thank you very much for these comments, we do not agree with your suggestion that the guidance is partisan and political and likely to produce poor outcomes. The constituency of the GDG was

							far more inclusive and comprehensive, designed by a panel that includes more patients, a broader ethnic experience, and a much wider range of clinicians (with no one perspective dominant).	included in the scope which went out to stakeholders for consultation before development began.
595	SH	Tees Esk & Wear Valleys NHS Foundation Trust	1	NI CE	Introduction	4	Whilst understanding the reasons for recommending DSM IV as the diagnostic criteria this will cause some difficulty (and potentially some confusion) in clinical practice. Clinicians are familiar with (and required to code according to) ICD10, and our IT systems are set up to support ICD not DSM.	Thank you very much for this comment. We are not suggesting that DSM IV is to be adopted as diagnostic criteria for the characterisation of depression in routine care within the NHS. This is explicitly stated in the NICE guideline. Rather we are drawing attention to the usefulness of the DSM criteria in arriving at a distinction between sub-threshold and mild, moderate and severe depression. We feel that the system set out in DSM IV lends itself to this more easily than that just developed in ICD-10.
596	SH	Tees Esk & Wear Valleys NHS Foundation Trust	2	NI CE	Introduction	4	A description of dysthymia would also be of benefit here.	Thank you very much for this comment, however the detail here is too much for the introduction of the NICE guideline.
602	SH	Tees Esk & Wear Valleys NHS Foundation Trust	3	NI CE	Key Priorities	7	Liked the inclusion of 'general hospitals' alongside primary care in Step 1, and the screening questions – but would argue that these should not be restricted to post-rehabilitation situations, what about people who are in palliative care for example? Or those who have a chronic health problem but are not in a rehabilitation programme?	Thank you very much for this comment. The list is not intended to be exclusive. Rather to be an indication of the areas where the guideline may have as its primary focus. We would of course expect people who work in rehabilitation settings and in palliative care to be aware of these issues as well.
608	SH	Tees Esk & Wear Valleys NHS Foundation Trust	4	NI CE	Key Priorities	9	Failure of treatment to provide benefit – would be 6 weeks for older people rather than the 4 stated here.	Thank you very much for this comment. However we have no evidence that older people take longer to respond and we think that remaining with the recommendations as they stand is a proper and effective way forward.
156	SH	Tees Esk & Wear Valleys NHS Foundation Trust	5	Full NI CE	5.6.1.11 1.3.1.6	103 17	Does distress equate to depression? Should we have a 'depression thermometer'? For me, 'distress' can be more episodic / instantaneous / likened to anxiety (e.g. during an unpleasant procedure) whereas depression is more pervasive.	Thank you for your comment. We have now amended the recommendation to include further contextual information to specify that further investigations should be

								conducted into the nature of the distress should an individual screen positive.
645	SH	Tees Esk & Wear Valleys NHS Foundation Trust	6	NI CE	1.5	22	Liked the inclusion of 'general hospitals' alongside primary care in Step 3	Thank you for your comments.
505	SH	Tees Esk & Wear Valleys NHS Foundation Trust	7	Full NI CE	8.5.2.7 1.5.2.5	245 24	For older people we would usually continue treatment with an antidepressant for 12 months or 24 months if the depression was severe or complicated	Thank you very much for this comment. In light of yours and other comments we have revised our recommendations concerning the duration for which anti-depressants should be taken.
205	SH	Tees Esk & Wear Valleys NHS Foundation Trust	8	Full NI CE	6.5.1.2 1.6.1.2	146 31	Would include 'social inclusion, social support and recovery' in the description of collaborative care.	Thank you but we do not think this would help clarify the definition as we feel these are methods and aims potentially common to all kinds of interventions, and not specific to collaborative care.
9	SH	The British Pain Society	1	Full & NI CE	General	General	The NICE guideline, as intended, does not contain any reference to the evidence. The NICE guideline is presented as stepped care, whilst the Full guideline is structured around clinical questions. Thus, it is not at all easy to cross reference between the documents and hence very difficult to determine the evidence for the statements in the NICE guideline. Given the size of the Full guideline, few are likely to read it thoroughly and realise that the evidence for many of the recommendations is the expert opinion of the guideline development group and not trial based data.	Thank you for your comment. The organisation of the full guideline reflects the evidence reviews conducted for the guideline, which are organised around the different clinical questions. The evidence for recommendations in different steps occurs in the same part of the guideline. For example, CBT recommendations occur in multiple steps in the NICE guideline yet derive from the same evidence review. It would therefore not be practical to organise the full guideline around the stepped care model, as this would cause additional repetition of the evidence base.
64	SH	The British Pain Society	2	Full NI CE	1.3.1.3 5.6.1.8	16 102	The British Pain Society would strongly support the recommendation to seek specialist advice if optimal treatment for the physical health problem is not being provided. It is difficult, however, to determine on what evidence this is based The evidence reviewed in section 5 of the Full guideline appears to be only psychometric scales to identify depression and their utility in black and ethnic minority populations. Of the fourteen recommendations in section 5, only two concern psychometric scales.	Thank you for your comment and strong support for the recommendation. This recommendation was based on the clinical experience and judgment of the GDG.

230	SH	The British Pain Society	3	Full	7.4	193	It is stated “Given that the GDGs view was that the nature of depression in chronic physical health problems is not fundamentally different from depression in the absence of such problems the group considered it appropriate to draw on the evidence base for depression more generally in drawing up its recommendations.” In the absence of evidence, but not disagreeing with this general view, there may be particular concerns in relation to the delivery of Cognitive Behaviour Therapy to the treatment of depression in adults with chronic health problems. Many of the cognitive factors that contribute to depression and distress in individuals with chronic health problems relate to their knowledge and beliefs about the condition, treatments, prognosis etc. The Cognitive Behaviour Therapist not only needs competence in delivering the therapy but may also need a reasonable knowledge of the health condition itself. Non randomised studies have shown good results in improving depression scales using behaviour modification and supportive psychological treatment within a pain management programme (1). 1. Maruta, T et al. Pain 1989; 36: 335-337.	Thank you very much for this comment. We agree with you and would expect any therapist, cognitive behavioural therapist, psychotherapist etc. to ensure that they are familiar with the chronic physical health problems faced by an individual. Providing treatments in the absence of some basic knowledge of the problems would seem to us unwise.
78	SH	The British Pain Society	4	Full	2.2.9 5.6.1.8	26 102	The Full Guideline recognises that the relationships between pain, disability and depression are complex, but pain is reported as a key factor in the causal chain leading from chronic physical health problems to depression. As mentioned, we fully support the recommendation “Healthcare professionals should also check to see if the optimal treatment for the physical health problem is being provided, where necessary seeking specialist advice.” We feel that optimal treatment for pain is a fundamental issue to be considered and addressed in the prevention and treatment of depression associated with many chronic health problems. It is disappointing that the recognition and management of pain as part of the assessment and treatment of any chronic health problem is not specifically addressed in the NICE version of the guideline.	Thank you for your comment, the detail you suggest is beyond the scope of the guideline. We will discuss with NICE the development of separate guidance on pain – your organisation might also wish to consider this.
63	SH	The British Pain Society	5	Full	1.2.4 1.2.4 Appendix 2	15, line 14 15, line 29 259,	There are references to schizophrenia, which appear out of context. Chapter 10 in this document contains references and Appendix 16 is drug interactions, not as stated in the text.	Thank you for your comments, these instances have been amended in the text.

						line 2		
10	SH	The British Psychological Society	1	Full & NICE	General	General	We very much welcome the attention to the psychological distress of people with long-term physical health conditions. However, we have a number of significant reservations about the overall approach adopted by the guidelines, and the resulting recommendations: The narrow focus on depression alone overlooks the broad range of psychological adjustment difficulties that people with LTCs experience, and does not adequately place distress in the context of illness and the adjustment process The unsupported premise regarding the "nature" of depression being equivalent regardless of context, that directly leads to the main recommendations being imported from CG23 with inadequate adaptation The failure to highlight patient-led approaches to self-managing, and link to other important guidance in LTCs e.g. The Expert Patient The key caveats about diagnostic complexities and adequacy of the evidence-base discussed in the Full version are missing in the NICE version, thus unduly biasing recommendations. The guidelines mistakenly assume homogeneity within CBT as applied clinically, and equivalence of CBT in mental health to CBT in physical health. This also leads to failing to examine which components are effective, for which LTC, at what stage in the illness adjustment process Although there are positive indications for the efficacy of peer support groups in enhancing aspects of coping with a LTC, there is little credible evidence upon which to recommend them as an effective treatment option for patients with LTC and depression Our comments are given in more detail below, for the Full and NICE guidelines separately.	Thank you for your comment. The guideline has been inclusive in our criteria of depression used throughout the evidence reviews. Throughout the guideline, participants were not required to have a formal diagnosis of depression, but instead had baseline measures that were indicative of depression. The guideline has also included people with subthreshold depressive symptoms. Although we acknowledge the importance of other forms of psychological distress and adjustment difficulties, these were beyond the scope of the guideline. The NICE guideline is a summary of the recommendations and inevitably cannot go into the detail seen in the full guideline. However, the "caveats" in the full guideline of course influenced the development of the recommendations. We note your comments on the context and one of the key purposes of the DCHP guideline was to ensure that we take into account the difference, both in terms of presentation of the problems and the context in which it would be treated. In making recommendations about treatment we were careful not to simply extrapolate from the evidence in the depression guideline. For example, in making the recommendations for CBT we first identified that there was some evidence of benefit in population specific trials before extrapolating. This meant that we made recommendations for CBT but not for IPT (which features strongly in the Depression Update

								guideline). Our review on randomised controlled trials shows peer (self-help) support to have a modest effect on reducing depression at end of treatment in comparison to standard care (SMD -0.58; -1.2 to 0.05) for people with depression and chronic physical health problems. The evidence was of moderate quality and therefore was sufficient to recommend this intervention.
61a	SH	The British Psychological Society	2	Full	1.2.3	14	This guidance is scheduled to be in the topic area 'Mental health and behavioural conditions'. Other NICE guidance (e.g. Supportive & Palliative Care, MS) highlights the importance of attending to individuals' emotional and psychological needs without labelling them as having a mental health condition. Our collective clinical experience suggests that people with LTCs are acutely aware of being seen as not coping / having a "mental" problem, and this can be a significant barrier to seeking help from any mental health source. Formal and informal psychological support in coping with a LTC should be normalised; setting the guidance within this topic area, subsumed under the diagnostic label of depression, is antithetical to the guidelines' own aim of "improve access and engagement with treatment and services"	Thank you for your comment. We are aware of this issue - see recommendation 1.1.4.4
52	SH	The British Psychological Society	3	Full	General		This guidance is restricted to people with LTCs and depression. There is also good evidence that people with LTCs frequently experience psychological difficulties related to loss and grief / bereavement, anxiety, body image, relationship difficulties, coping with and making decisions about treatment, pain and other physical symptoms, coping with the effects of stigma and discrimination, developing and maintaining good working relationships with healthcare and social care providers, managing deteriorating physical function, end of life preparation and support, coping with cognitive and multiple impairments, disturbances in social and family roles and functions, maintaining motivation for adherence with treatment, specific health anxieties, etc.	Thank you for this comment – we have developed a guideline in line with the agreed scope. We feel that a broader guideline would lead to recommendations that are too general to provide high quality guidance for either professionals or patients.

							Indeed, the first-person accounts (4.2 p53) illustrate that people with LTCs experience just such an array of psychological responses. We feel that subsuming all these under the label of 'depression', or even attempting to carve out 'depression' as a singular focus is not helpful. As clearly there cannot be separate guidance for each of these domains, we feel it would be more clinically useful to develop a comprehensive guidance on the full range of psychological needs of people with LTCs, in the same way that, for example, Supportive & Palliative Care refers to psychological needs as a whole.	
53	SH	The British Psychological Society	4	Full	General		Throughout the document the term 'people with depression and chronic physical health problems' is used. These terms should be the other way round: we are talking about people who have chronic physical health problems (or for more consistency, long term conditions) as their 'primary' problem, who become depressed.	Thank you for your comment. Although we accept that for some people the chronic health problem may be their primary problem, the focus of the guideline was on the treatment and management of depression in this population.
59	SH	The British Psychological Society	5	Full	1.2.1	13	People with LTCs are supported by interdisciplinary teams which include, amongst others, Occupational Therapists, Physiotherapists, Speech & Language Therapists, particularly if there are mobility and communication impairments. These professionals will often be working more closely with people with LTCs than GPs, and are very likely to be contributing to how depression is managed through e.g. activity scheduling and exercise. It is a significant weakness of the guidelines that these professions have not been represented on the GDG.	Thank you for your comments. The GDG composition is in line with the agreed scope and the NICE guidelines manual 2007, and composed of a wide range of practitioners. The specific roles and interests of the GDG members are as follows: **Professor Sir David Goldberg (Chair, Guideline Development Group)** - Psychiatric epidemiology, case identification of common mental health problems, CCBT **Dr. Neil Andrews** - Consultant Cardiologist and Electro physiologist, - Cardiac electrophysiology **Professor Francis Creed** - Professor of Psychological Medicine, University of Manchester - Liaison psychiatry, brief interventions and psychodynamic therapy in psychosomatic disorders **Professor Christopher Dowrick**

								- Professor of Primary Medical Care, University of Liverpool - Conceptualisation of depression in primary care, problem solving therapy and antidepressant treatment in primary care **Dr. Gwyneth Grout** - Consultant Nurse, Mental Health Liaison (Older People), Hampshire Partnership NHS Trust (until May 2008) - Development of care systems for people with depression and chronic physical health problems **Dr. Mark Haddad** - Clinical Research Fellow, Health Service and Population Research Department, Institute of Psychiatry - Case identification and assessment tools in primary care **Dr. John Hindle** - Consultant Physician Care of the Elderly, Clinical Director of Medicine, North West Wales NHS Trust - Parkinson's disease **Dr. David Kessler** - Walport Clinical Lecturer - Primary Care, Bristol University - Case identification of common mental health problems in primary care, brief interventions and CBT in depression in primary care **Professor James Lindesay** - Professor of Psychiatry for the Elderly, University of Leicester - Classification of disorders in the elderly, drug treatments and institutional care **Ms. Margaret Ogden** - None **Dr. Jonathan Packham** - Consultant Rheumatologist, Haywood Hospital. Senior

								Lecturer, Primary Care Musculoskeletal Research Centre, Arthritis Research Campaign National Primary Care Centre, Keele University - TNF and the treatment of rheumatoid arthritis **Professor David Taylor** - Chief Pharmacist, South London and Maudsley NHS Trust - Professor of Psychopharmacology, King's College, London Effectiveness of psychotropic drugs, drug interactions.
61b	SH	The British Psychological Society	6	Full	1.2.3 & 4	14 & 15	The term 'schizophrenia' appears twice, apparently pasted from another document. This is not only irrelevant but also deeply disappointing, as this document is on a publicly accessible website, and potentially prejudicial to the normalisation agenda. We are also concerned that such errors may be symptomatic of a tendency to import mental health guidance wholesale into a very different context.	Thank you for your comments, these instances have been amended in the text.
89	SH	The British Psychological Society	7	Full	3.5.2	37	RCTs often explicitly exclude a large number of people with complex comorbidities and who are not native speakers, as well as implicitly excluding those with more complex social difficulties. Given the high proportion of LTC comorbidities and the objective to generate guidance that acknowledges diversity, this limitation to the evidence should be highlighted and added to recommendations for research.	Thank you for this comment. Although we recognise there are limitations to randomised controlled trials and indeed these are discussed in the guidelines we consider them to be the most unbiased way of assessing the effectiveness of the interventions under review in this guideline. There are a number of studies and meta-analyses for example Shallish et al, 2002 and a series of individual studies, for example Franklin et al (2000) which support our opinion that the provision of evidence based psychological interventions effects do generalise to routine care settings. The work of Gillespie et al (2002) in routine NHS care which also replicated trial results in the treatment of the victims of the Omagh bomb. The evidence from

								these studies includes both RCTs and non-RCT challenges your view that the high internal validity of randomised control significantly limits the application of the results of these studies to routine care.
100	SH	The British Psychological Society	8	Full	4.2.1	53	While it is laudable to include first person accounts in guideline development, both are by people who had past experiences of depression and subsequently developed a long term physical condition and a recurrence of depression. Though some will fit this pattern, the majority of people with LTCs do not have pre-existing mental health conditions. Simple noting that these accounts are not representative is entirely inadequate; purposive sampling should have been undertaken from the outset. The GDG should seek personal accounts of depression following LTC diagnosis, for a range of disorders. These should be duly added and analysed, and the recommendations in 4.8 amended accordingly.	Thank you for your comment. Whilst acknowledging the limitations of first person accounts, it should also be noted that a review of the service user and carer experience literature was conducted. Moreover, a qualitative analysis of over 400 patient accounts was undertaken using the purposive sampling methods you refer to. It was the judgement of the GDG that this data provides a detailed and representative account of patient and carer experience for this population.
108	SH	The British Psychological Society	9	Full	4.8	80	It is surprising that these recommendations do not mention LTCs at all. This seems to suggest that communicating about depression can be taken out of the context of the LTC and its management, and this is directly opposed to best clinical practice and the document's intended holistic approach. For instance, in 4.8.1.1 "recovery" should be specified as recovery from depression not the LTC per se; in 4.8.1.5 consent may be more often complicated by cognitive, communication or neurological impairments (as acknowledged in 5.6.1.11) than by the MHA but these are not mentioned; in 4.8.8.1, there should be reference to paid carers and the confidentiality implications in situations where people require carer support to manage everyday activities.	Thank you for your comments but this is a guideline on depression and chronic physical health problems not long-term conditions per se. We have however clarified the issue concerning recovery.
119	SH	The British Psychological Society	10	Full NICE	4.8.1.9 1.1.4.5	80 13	We would add that practitioners working with people with LTCs from minority groups also need to ensure they are aware of relevant cultural discourses of disability and disease which will be shaping the client's experience and may be contributing to the depression.	Thank you for your comment, the recommendation has been amended to include reference to potential differences regarding the expression of psychological distress across different cultural and ethnic groups.
129	SH	The British	11	Full	5.3.1	94	The first paragraph of this section should be talking	Thank you for your comment. The

		Psychological Society					about the ways that culture and ethnicity influences attitudes towards physical disease and disability. LTCs, not depression per se, should be at the heart of this document and the mental health focus can be misleading.	focus of the guideline was on the treatment and management of depression in a population of people with chronic physical health problems. The focus of the guideline was not on the treatment of the chronic physical health problem. Although we acknowledge throughout the importance of the chronic physical health problem and the impact that it has on depression and vice versa.
157	SH	The British Psychological Society	12	Full NICE	5.6.1.12 – 14 1.3.2.1-3	103 17-8	Risk assessment and management should be explicitly and firmly placed in the context of LTC management – ie, many people with LTC will need medication e.g. analgesics, insulin, opiates etc that is lethal in overdose but whose supply cannot be limited i.e. because of mobility and pharmacy access problems. Assessing and managing such risks may be outside the scope and skills of mainstream mental health services; it would be helpful if explicit reference to these aspects of risk is included in the guidelines.	Thank you – we have amended the recommendation in light of your comments.
206	SH	The British Psychological Society	13	Full NICE	6.5.1.2 & 3 1.6.1.2	146 31	We firmly believe that clinical health psychologists, as highly specialist mental health specialists embedded in physical healthcare systems, are ideally placed for the role of “senior mental health professional” as suggested here. Clinical health psychologists are already typically deployed in exactly this capacity and we would welcome a more explicit reference to this specialist role in the guidelines.	Thank you for this comment.
231	SH	The British Psychological Society	14	Full	7.4	193	The guidelines state that “the nature of depression in chronic physical health problems is not fundamentally different from depression in the absence of such problems”. This radically reductive statement, which we find highly contentious, is not supported by any given evidence, is in direct conflict with section 4.6 page 78 that suggests a holistic approach (ie, taking distress in context), disregards the different sources, types and courses of distress that different physical illnesses demonstrate and also disregards the cogent reservations expressed in Appendix 12 about the “nature” of depression. This statement then forms a key premise in supporting the extrapolation from the depression guidelines with minimal adjustment, which we feel is a failure to acknowledge the complex biopsychosocial determinants	Thank you very much for this comment. The basic symptoms and phenomenology of depression in chronic physical health problems are very similar to the depression in people without them. We fully accept that a range of other factors including the nature of the physical health problem, the associated functional impairment and indeed other biological and social factors may play a part in the aetiology and maintenance of depression. We have tried to include a discussion of these factors in the introduction to the guideline (please see Chapter

							of distress in physical illness.	2). We do believe that treatments that are effective for depression may reasonably be effective in depression for people with chronic physical health problems. Indeed this is the case in our review of the evidence. The main pharmacological interventions (SSRIs) and psychological interventions (CBT) appear to be effective in depression with chronic physical health problems as well. In developing our strategies for extrapolating from one guideline to the other we were careful to consider that before extrapolation there was independent evidence within the chronic physical health field to support that extrapolation. The criteria by which we determined the extrapolation are set out in the methods chapter. Complex biosocial determinants characterise all depressive disorders.
249	SH	The British Psychological Society	15	Full NICE	7.4.1.1 1.1.5.1	194 13	Though we do support the general principle that good quality care can be promoted through the use of treatment manuals, we strongly believe that manualised approaches cannot be imported unmodified directly from a mental health context, as the guidelines here seem to suggest. For instance, the recommendation in 7.4.1.15 that depression should be prioritised over anxiety fails to acknowledge common anxiety-provoking situations for people with LTCs e.g. uncertainty about further surgery over which one has limited control – in such a scenario addressing anxiety directly would be clinically more relevant. This recommendation should also have been based on a prior analysis of the specific components found to be effective to address distress in each particular illness. CBT and other “brand name” therapies are best seen as broad groupings of a range of therapeutic techniques, and may have been configured differently within the various trials presented, depending on the specific challenges posed by the specific illness. We are also concerned that this recommendation follows	Thank you very much for this comment. We think you may have misunderstood the recommendation. We are not proposing that treatment guidelines be imported and modified direct from a mental health context. We would suggest that for the delivery of specific interventions for example group CBT for people with chronic physical health problems is based on manuals used in the trials that focus on people with chronic physical health problems (there are a number described in this study). You raise a separate point in our view concerning recommendation 7.4.1.15. We have revised this recommendation in light of yours and other comments.

							from the assumption that “the nature of depression is not fundamentally different” (p.193) which we find contentious as a premise (see above).	We agree with your comment regarding the specific components of treatment and would expect competent therapists to take the time and care to determine specifically what aspects of a CBT or other programme be used in the treatment of depression in a specific illness.
550	SH	The British Psychological Society	16	Full	Appendix 12	301	We welcome this cogent critical analysis of the inherent difficulties and limitations of systems for classifying human experience and the acknowledgement that “diagnosis only provides a partial description of the experience” (p. 312). We believe the scientific limitations and caveats discussed here are not given due reference in the main sections and particularly in the brief guidelines, and thus likely to lead to an unduly uncritical approach to diagnosis. In addition, it is unclear why DSM code 309.x Adjustment Disorder (“a debilitating reaction to an event or situation..”) is not considered or discussed, when clearly relevant. In our view, the label of Adjustment Disorder is useful in conceptualising distress in the context of a major, chronic stressor such as illness, helps to de-stigmatise distress and is pragmatically useful in clinical practice.	Thank you very much for these comments. You would appreciate the structure of the NICE guideline precludes any detailed discussion of the scientific limitations of the diagnostic symptoms. Whether or not adjustment disorder would be useful in conceptualising the distress of many people experiencing chronic illnesses is unfortunately a matter that is outside the scope of this guideline.
586	SH	The British Psychological Society	17	NICE	General		These guidelines prioritise a professional-led approach to managing distress, which we find at odds with key DH guidance, e.g. “The Expert Patient”, and good clinical practice, which highlights the importance of building on what the patient can do for themselves with their own expertise and resources. For example, in 4.8.1.10 (p81), the treatment plan should not only be shared with the patient / client; it should be actively constructed with them. We would have also expected to see frequent references (e.g. in 1.2.2 p14) to working in partnership with service users, and also reference to Expert Patient Programmes / Self Management Programmes / Condition Management Programmes / Co-Creating Health etc. This guidance appears to overlook these developments in working with people with LTCs to enable them to self-manage symptoms, including psychological symptoms.	Thank you very much for this comment. We are disappointed that you find that it seems very professional led and at odds with involving the patient. We have made a number of recommendations throughout the guideline for involving patients and where appropriate their families and carers. We pay considerable attention to patient choice and place considerable emphasis on self-help. We could find no direct evidence of the impact of LTC programme or expert patient programmes on depression.
58	SH	The British	18	Full	1.1.1.3	80	The guidance to provide information to patients and	Thank you but we feel the current

		Psychological Society		NI CE	4.8.1.3	10	carers would be more consistent with the current evidence-base if mention were made of " biological, psychological and social factors" along with the "use and likely side-effect profile of medication".	phrasing of this recommendation is clear and would not benefit from being specific in the detail that you suggest.
140	SH	The British Psychological Society	19	Full NI CE	5.6.1.3 1.1.4.3	101 12	This section has a helpful list of factors which may affect the development, course and severity of depression. It would be a more complete list if the following were added from the established evidence-base: significant life-events (eg., loss, past trauma), social adversity (eg., unemployment), acculturative stress (eg., migration).	Thank you but we consider this too detailed a comment to include in a recommendation.
120	SH	The British Psychological Society	20	Full NI CE	4.8.1.9 1.1.4.5	80 13	Two further points could be mentioned in this section on working with people from diverse ethnic and cultural backgrounds: 1. attending to different idioms of distress and 2. providing information on appropriate physical risk factors (eg., diabetes, hypertension).	Thank you. We have now amended the recommendation in light of your comments to take account of the differences in experiences of psychological distress. However, the focus of the guideline is on the management of depression in people with chronic physical health problems, and although we understand the importance of physical risk factors, including any ethnic and cultural differences in physical risk factors (see section 5.1.1), the management of the physical health condition is beyond the scope of the guideline.
627	SH	The British Psychological Society	21	NI CE	1.2	15	The rationale for the additional step to the model used in CG23 is not explicitly stated. Since collaborative care is explicitly an important aspect of Step 5, there seems a strong argument for simply combining steps 4 & 5 and thereby making this guidance directly comparable to CG23. The danger of separating stages 4&5 is to add ambiguity to the management of patients with severe depression (who are referred to in both steps 4&5) and possibly delays in intervention.	Thank you for this comment. In light of yours and other comments we have revised the guideline and gone for a 4 step programme that addresses your comments and also ensures consistency with the depression update guideline.
150	SH	The British Psychological Society	22	Full NI CE	5.6.1.6 1.3.1.1	102 16	Specific guidance to aid in the detection of depression is indeed helpful, particularly as the initial detection of depression in patients with physical health problems is likely to be by non-mental health professionals who may lack confidence to enquire about mood. However, as noted in the Full guideline, the detection of depression in patients with physical health problems presents specific complexities, for instance mobility problems which prevent a patient from engaging in the activities that they usually find pleasurable. Given this is a separate guideline created specifically for patients with	Thank you for this comment. Your second point relates to specific treatment interventions – we agree that interventions should take into account the physical health problems - the detection question relates to loss of interest or pleasure in activity not in the ability to undertake them per se.

							long term conditions, this should be reflected in the guidance to aid detection.	
153	SH	The British Psychological Society	23	Full NICE	5.6.1.10 1.3.1.5	102 17	Bearing in mind the importance of culturally competent practice, it is suggested that the second line in this section reads: "…practitioners should consider the culturally sensitive use of a validated.."	Thank you for your comment, but we feel that recommendation 1.1.3.3 which recommends that all assessments are culturally sensitive is adequate.
255	SH	The British Psychological Society	24	Full NICE	7.4.1.3 1.4.3.1	194 19	It is not made clear by what combination of effectiveness and cost-effectiveness evidence the emphasis on group approaches is derived. The recommendation for group based peer support is not based on extrapolating evidence for treatment of depression generally and indeed is not a recommendation in CG23 for depression of any level of severity. The evidence base for the use group peer support for treatment of mild-moderate depression in people with physical health problems is minimal to say the least; three relatively small scale studies are identified in the Full Guidance. The largest of these studies, by Simoni and colleagues (2007), was not designed as a depression treatment trial but rather to improve adherence to medication in patients with HIV. Participants were not selected for the study on the basis of a diagnosis of depression nor even high scores on self report measures of depression. Neither of the two other studies cited (Kelly et al 1993 and Evans & Connis 1995) used DSM or any other diagnostic criteria to identify participants with depression but relied exclusively patients scoring above threshold on a self-report questionnaire. Both of these studies described the intervention as "social support groups" but in both cases these were led by experienced therapists and thus were not truly "peer social support" groups. Furthermore, several other (non-cited) studies conducted since have found no effect of peer support groups on depression (e.g. Messmer Uccelli et al, 2004). A recent systematic review of 60 papers describing peer support interventions for cancer patients (including 8 randomized controlled trials) but found little evidence of reduction of psychological distress (Hoey et al, 2008). The Full guidance also reviews a number of studies of existential group therapy which is defined as non-directive groups focussing on "development of a supportive network, grief, improve problem solving	Thank you very much for this comment. As you will be aware we make use of the best available evidence. In some cases the evidence for effectiveness may not be of the highest quality but nevertheless may in the view of the guideline development group be of sufficient quality to support its inclusion. The fact that peer support groups are not recommended in the depression guideline is because we have found no evidence for their efficacy. In contrast we did find evidence which is described below and in the guideline for the efficacy of peer support groups. The papers included in the peer (self-help) support review meet our inclusion criteria as identified in our 'Definition and Aim of Review', 7.2.1. This includes healthcare professionals providing structure to groups but the main emphasis remains for the main input to be provided by peers to offer emotional or practical support to each other. In regards to the reference, Messmer, Ucceli *et al.* (2004), this was not a controlled trial. Our review on randomised controlled trials shows peer (self-help) support to have a modest effect on reducing depression at end of treatment in comparison to standard care (SMD -0.58; -1.2 to 0.05).

							improve coping, enhance a sense of mastery over life and re-evaluate priorities for the future" (Full guidance p159) which is (contentiously) almost an identical description of the stated aims of the "peer-support" group studies. Even so, the review found no evidence that existential group therapy was effective in the treatment of depression. In summary, although there is good research evidence and positive clinical consensus for the efficacy of peer support groups in enhancing aspects of coping with a chronic physical health problem, there is no credible evidence upon which to recommend them as an effective treatment option for patients with major depression. Hoey, LM et al (2008) Systematic review of peer-support programs for people with cancer. Patient Education and Counselling, 70(3), 315-37. Messmer Uccelli et al (2004) Peer support groups in multiple sclerosis: current effectiveness and future directions. Multiple Sclerosis, 10(1):80-4.	Likewise, Hoey *et al. (*2008) consists of a different population to the studies reviewed in our guideline. Out of the 8 randomized controlled trials included in Hoey *et al.* (2008), only one study looked at depression as an outcome and included a population which met our criteria for depression. We do not agree that existential group therapy is similar to peer support. However, we agree with you that the evidence for existential group therapy was limited. We are unsure of what you mean with regard to the definition of major depression. Within this guideline we have used 4 categories – sub threshold, we consider this to be an important group where sub-threshold symptoms can have a negative impact on long term outcomes, mild depression, moderate depression and severe depression. We have limited our recommendations to persistent sub-threshold depressive symptoms and mild to moderate depression. We have made no recommendation with regard to moderate to severe depression or severe depression. We are not sure in your reference to major depression if you are referring to severe depression or anybody meeting DSM criteria for depression. To summarise, we think it is credible to recommend peer (self-help) support for subthreshold depressive symptoms and mild to moderate depression. We make no claims that this is an effective

								treatment option for patients with major depression.
270	SH	The British Psychological Society	25	Full NICE	7.4.1.9 1.5.3.1	196 29	The guideline recommends individual CBT is offered to patients with moderate depression only "for those who decline group-based CBT or for whom it is not appropriate, or where a group is not available". The review of evidence in the Full guidance clearly demonstrates a large effect of individual CBT on depression compared to a relatively small effect size of group based interventions. Since NICE guidelines CG23 recommend individual psychological therapy if patients do not have a chronic physical health problem, it is hard to see why the recommendation for group therapy as the first line treatment for patients with moderate depression (or mild depression that has not responded to initial interventions) is made here.	Thank you very much for this recommendation. We have made a recommendation for group CBT on the grounds of its increased cost-effectiveness. A review of the current depression update guideline will show that this is the case. This is also demonstrated in this guideline. We believe that it is important to consider not just the clinical but also the cost-effectiveness of interventions when generating recommendations.
277	SH	The British Psychological Society	26	Full NICE	7.4.1.12 1.5.3.4-7	197 30	The draft update of CG23 recommends exactly double the treatment duration (12-16 weeks as opposed to 6-8 weeks) for treatment of patients with lower severity of depression (minor & mild-moderate as opposed to moderate depression or mild-moderate depression with limited response to initial interventions). Also, these guidelines suggest the "typical duration" for individual CBT of 6-8 weeks for moderate depression and a maximum duration of 16-18 weeks for moderate or severe depression. This is again at odds to CG23 which states "For all people with depression receiving individual CBT, the duration of treatment should typically be in the range of 16 to 20 sessions over 6 to 9 months." There is a very limited evidence base for individual CBT in people with chronic health problems; however there is no evidence to suggest that the duration of treatment in this population would be any lower than patients without physical health. Clinical experience of treating people with depression with and without physical health problems does not suggest the latter respond to CBT more quickly and indeed therapy often progresses more slowly because of set-backs related to rapid changes in physical symptoms, too many hospital appointments, access difficulties etc.	Thank you very much for this comment. The duration of treatments is based on that in the individual trials that we have reviewed. We felt it is best to follow closely the evidence base for the recommended duration of interventions. However you will see that we have included recommendation number 1.5.3.3 which suggests that the duration of treatment should be tailored to the needs of the individual.
240	SH	The British Psychological Society	27	Full NICE	7.4.1 1.5.3	194 29	Mindfulness-based approaches are neglected. This is a new but rapidly growing area and some relevant RCTs have been published recently, notably in relation to the benefits of such approaches for relapse prevention in depression in the general population (Kuyken et al,	Thank you very much for this comment and drawing our attention to the study by Zautra *et al* (2008). We considered this study in our review but it was excluded as the

							2008) and the superiority of a mindfulness-based intervention to CBT on several measures among participants with rheumatoid arthritis and recurrent depression (Zautra et al, 2008). Kuyken, W., Byford, S., Taylor, R.S.,Watkins, E. Holden, E., White, K., Barrett, B., Byng, R., Evans, A., Mullan, E. & Teasdale, J.D. (2008). Mindfulness-based cognitive therapy to prevent relapse in recurrent depression, Journal of Consulting and Clinical Psychology, 76, 966-978. Zautra, A.J., Davis, M.C., Reich, J.W., Nicassario, P., Tennen, H., Finan, P., Kratz, A., Parrish, B. & Irwin, M.R. (2008). Comparison of cognitive behavioral and mindfulness meditation interventions on adaptation to rheumatoid arthritis for patients with and without history of recurrent depression. Journal of Consulting and Clinical Psychology, 76, 408-421.	population did not meet our criteria for depression. In addition, the study did not use a validated scale to measure depressive symptoms. For further details please see Appendix 18 for a full list of excluded studies.
271	SH	The British Psychological Society	28	Full NICE	7.4.1.9 1.5.3.1	196 29	The Full version of the guidance notes “It is important to note the limitations of this available data for making recommendations about treatments, particularly when many have been developed for people with depression but not with an accompanying physical health problem….Just because an approach is not recommended here does not mean that it is not effective or that it should never be provided” (p149). The Full guidance also points out that there are a limited number of (small) physical health-relevant CBT studies whose advantages over controls are markedly reduced when the controls are active eg psychosocial education (p188). It states: “In the relatively few studies available no clinically important differences were identified between these interventions and other psychosocial interventions (p188)” However, such caveats are notable by their absence from the NICE version, effectively privileging CBT and making it difficult to develop services in other therapeutic modalities. There should be a prominent statement in this section in the NICE Guidance (1.5.3.1) that reinforces that these are tentative suggestions and do not preclude other approaches.	Thank you very much for this comment. We do not routinely produce statements about the quality of evidence in the NICE guideline. The NICE guideline represents a distillation of all the evidence and the recommendations and their relative strength and importance. It is neither possible nor desirable to include statements about the quality of the evidence within the NICE guideline itself as this would produce a lengthy document that would be unhelpful to readers.
54	SH	The Pernicious Anaemia Society	1	Full	General		Depression can be a characteristic of B12 deficiency and therefore is not an imaginary illness. In this case, it cannot be ‘cured’ by drugs, or ‘managed’ by counselling,	Thank you for this comment – this is outside the scope of this guideline. The guideline is premised on the

							lectures, or computer programs. The real costs of this are people losing their jobs, with attendant miseries for their families and themselves. The costs of this are not factored into the NHS costs, but will appear in other costs to the state, possibly for years to come. At best, failure to treat the underlying cause delays a full recovery to an indeterminate time in the future. Since a six month course of B12 injections costs £28, it is a very false economy to resort to other, supposedly money saving, measures which do not work.	fact that the physical health care people receive will be of a good standard. It would not be possible for this guideline to comment on the nature of the interventions required to address the physical disorder.
151	SH	The Pernicious Anaemia Society	2	Full NI CE	5.6.1.8 1.3.1.3	102 16	So why don't healthcare professionals do this? Pernicious Anaemia patients who have neurological damage obviously will have mild depression, some worse than others and if they have a folate deficiency, it can be even worse. Would it go away with optimal treatment of increased B12 injections? Yes - but B12 and folate are never considered.	Thank you but this is outside the scope of the guideline.
154	SH	The Pernicious Anaemia Society	3	Full NI CE	5.6.1.10 1.3.1.5	102 17	B12 and folate deficiencies should always be considered as a cause of depression, regardless of whether or not they have been diagnosed and particularly if their B12 level is below 550 pmol/L.	Thank you but this is outside the scope of the guideline.
549	SH	The Pernicious Anaemia Society	4	Full	11	136	There are no recommendations with regards to B12 here at all. We recommend that B12/folate should be considered as an alternative to the high cost of pharmaceutical drugs. We are dealing with chronic disease associated depression - it would be cheaper to do a trial of B12 and folate to see if it helped.	Thank you very much but to comment on the regime of B12/folate is beyond the scope of this guideline.
282	SH	The Pernicious Anaemia Society	5	Full NI CE	7.4.1.15 1.4.2.1	198 18	It would be useful to add the comments in blue to the sentence “When depression is accompanied by symptoms of anxiety, the first priority should usually be to treat the depression, provided any medical condition such as B12 deficiency has been ruled out.”	Thank you very much for this comment. We have revised the recommendation in light of yours and other comments.
292	SH	The Pernicious Anaemia Society	6	Full NI CE	7.4.1.19 1.5.1.2	199 23	It would also be useful to add the comment in blue to the sentence “combination of antidepressants and CBT, provided there is no underlying B12/folate deficiency”	Thank you very much for your comment. We do not think it appropriate to include your suggestion here and consider the assessment of B12/folate deficiency to be outside the scope of the guideline.
337	SH	The Pernicious Anaemia Society	7	Full NI CE	8.5.2.2 1.4.4.2	243 22	It would be helpful to include a sentence here which states that Vitamin B12 should also be suggested as there is no known toxicity to the vitamin and research has proved that low B12/folate levels will cause depression	Thank you very much for this comment. However your suggestion is outside the scope of the guideline.
56	SH	The Royal College of Psychiatrists	1	Full &	1.1.1 and	10	It would be helpful to have an acknowledgement that for some people with co-morbid depression, the diagnosis	Thank you the stigma of associated with depression is discussed in the

				NICE	general		of depression may be an unwanted additional label and there will need to be negotiation by the primary or general health care worker about the emotional component of the co-morbidity- and what it should be called. The need for good channels of communication between those involved in the physical, emotional and social care of people with co-morbid problems should also be emphasized.	chapter on experience of care. In addition, the interaction between the physical, emotional and social factors are discussed throughout the introduction and is considered repeatedly throughout the document.
241	SH	The Royal College of Psychiatrists	2	Full NICE	7.4.1 1.1.5	194 13	While I understand the importance of formal therapy being provided by competent practitioners according to manuals, the brief psychological interventions that can and are provided by primary and general health care workers (i.e. not only GPs but also nurses working with patients with a diagnosis of diabetes and CHD for example as in the new stepped care model for psychological care of people with diabetes being developed by Diabetes UK), is largely ignored by these guidelines, and if anything may discourage them from learning or using the basic skills which are important in the management of people with mild to moderate depression are not, for a number of reasons, referred on to formal services. It is difficult, nigh impossible, to see how all 'talking treatment' for people with mild to moderate depression can or should be provided by low intensity therapists.	Thank you very much for this comment. It is not our intention in developing these recommendations to exclude any particular group of healthcare professionals and we agree with you that a range of individuals including primary care nurses could provide the interventions we have described in this guideline. We believe there is nothing in the way that the guideline is currently constructed that would preclude them from doing so. However we are sure you would agree that if these interventions were to be delivered by anyone be it low intensity IAPT workers or practice nurses that it should be delivered in a competent manner.
628	SH	The Royal College of Psychiatrists	3	NICE	1.2	15	While the inclusion of collaborative care is very welcome- it is extremely confusing that this guideline has 4 steps and the guideline for co-morbid depression has 5. Services are not designed around co-morbid and non-comorbid depression- but around 'mental health care'. The ethos behind NICE with different guidance for different types of depression, and anxiety misses the point that most people in primary care present with co-morbid depression and anxiety and many of them also have physical illness. The key role of the patient's GP in co-ordination and continuity of care at all steps is not acknowledged – this is particularly important given the likelihood that co-morbidity will mean multiple medications.	Thank you for this comment. In light of yours and other comments we have revised the guideline and gone for a 4 step programme which addresses your comments and also ensures consistency with the depression update guideline.
509	SH	The Royal College of Psychiatrists	4	Full NICE	8.5.2.9 1.5.2.7	245 25	The recommendation for prescription of a benzodiazepine should be accompanied by a rider that this carries a risk of the person becoming dependent if the anxiety has already become chronic.	Thank you very much. We have amended this guideline in light of your comments.

	Adverse Psychiatric Reactions Information Link (APRIL)					This organisation was invited to register but no response was received	
	Advisory Committee for Community Dentistry					This organisation was invited to register but no response was received	
	Afiya Trust, The					This organisation was invited to register but no response was received	
	Age Concern England					This organisation was invited to register but no response was received	
	Alder Hey Children's NHS Foundation Trust					This organisation was invited to register but no response was received	
	All About Nocturnal Enuresis Team					This organisation was invited to register but no response was received	
	Ambulance Service Association					This organisation was invited to register but no response was received	
	Anxiety UK					This organisation was invited to register but no response was received	
	Arthritis Care					This organisation was invited to register but no response was received	
	Association for Cognitive Analytic (ACAT) Therapy					This organisation was invited to register but no response was received	
	Association for Improvements in the Maternity Services					This organisation was invited to register but no response was received	
	Association of British Neurologists					This organisation was invited to register but no response was received	
	Association of Psychoanalytic Psychotherapy in the NHS					This organisation was invited to register but no response was received	
	Association of the British Pharmaceuticals Industry (ABPI)					This organisation was invited to register but no response was received	
	AstraZeneca UK Ltd					This organisation was invited to register but no response was received	
	Autistic People Against Neuroleptic Abuse (APANA)					This organisation was invited to register but no response was received	
	Avon and Wiltshire MHP NHS Trust					This organisation was invited to register but no response was received	
	Avon, Gloucestershire & Wiltshire Cardiac Network					This organisation was invited to register but no response was received	
	Barnet Enfield and Haringey Mental Health Trust					This organisation was invited to register but no response was received	
	Barnsley Hospital NHS Foundation Trust					This organisation was invited to register but no response was received	
	Barnsley PCT					This organisation was invited to register but no response was received	
	Bedfordshire & Luton					This organisation was invited to register but no	

	Partnership NHS Trust					response was received	
	Berkshire Healthcare NHS Foundation Trust					This organisation was invited to register but no response was received	
	Birmingham, Sandwell and Solihull Cardiac Network					This organisation was invited to register but no response was received	
	Boehringer Ingelheim Ltd					This organisation was invited to register but no response was received	
	Bournemouth and Poole PCT					This organisation was invited to register but no response was received	
	British Association for Behavioural & Cognitive Psychotherapies					This organisation was invited to register but no response was received	
	British Association for the Person-Centred Approach (BAPCA)					This organisation was invited to register but no response was received	
	British Association of Cardiac Rehabilitation					This organisation was invited to register but no response was received	
	British Association of Psychodrama and Sociodrama (BPA)					This organisation was invited to register but no response was received	
	British Association of Stroke Physicians (BASP)					This organisation was invited to register but no response was received	
	British Association of Stroke Physicians (BASP)					This organisation was invited to register but no response was received	
	British Geriatrics Society					This organisation was invited to register but no response was received	
	British Homeopathic Association					This organisation was invited to register but no response was received	
	British National Formulary (BNF)					This organisation was invited to register but no response was received	
	British National Formulary (BNF)					This organisation was invited to register but no response was received	
	British Paediatric Mental Health Group					This organisation was invited to register but no response was received	
	British Psychoanalytic Council					This organisation was invited to register but no response was received	
	British Psychodrama Association					This organisation was invited to register but no response was received	
	British Thyroid Foundation					This organisation was invited to register but no response was received	
	Brook London					This organisation was invited to register but no response was received	
	Buckinghamshire PCT					This organisation was invited to register but no response was received	
	BUPA					This organisation was invited to register but no response was received	
	Cambridge University Hospitals NHS Foundation Trust (Addenbrookes)					This organisation was invited to register but no response was received	

	Care Quality Commission (CQC)					This organisation was invited to register but no response was received	
	Care Services Improvement Partnership					This organisation was invited to register but no response was received	
	CCBT Ltd					This organisation was invited to register but no response was received	
	Central & Eastern Cheshire PCT					This organisation was invited to register but no response was received	
	Central & North West London NHS Foundation Trust					This organisation was invited to register but no response was received	
	Centre for Mental Health Research					This organisation was invited to register but no response was received	
	Charlie Waller Memorial Trust					This organisation was invited to register but no response was received	
	Chartered Society of Physiotherapy (CSP)					This organisation was invited to register but no response was received	
	Chineham Medical Practice					This organisation was invited to register but no response was received	
	CIS'ters					This organisation was invited to register but no response was received	
	CNWL Foundation NHS Trust					This organisation was invited to register but no response was received	
	College of Occupational Therapists					This organisation was invited to register but no response was received	
	Commission for Social Care Inspection					This organisation was invited to register but no response was received	
	Connecting for Health					This organisation was invited to register but no response was received	
	CORE Information Management Systems Ltd					This organisation was invited to register but no response was received	
	Cornwall & Isles of Scilly PCT					This organisation was invited to register but no response was received	
	Counselling Haverhill					This organisation was invited to register but no response was received	
	Counsellors & Psychotherapists in Primary Care					This organisation was invited to register but no response was received	
	County Durham & Darlington PCT					This organisation was invited to register but no response was received	
	Critical Psychiatry Network					This organisation was invited to register but no response was received	
	Cyberonics Europe					This organisation was invited to register but no response was received	
	Department for Communities and Local Government					This organisation was invited to register but no response was received	
	Department for Work and Pensions					This organisation was invited to register but no response was received	
	Department of Health,					This organisation was invited to register but no	

	Social Security and Public Safety of Northern Ireland					response was received	
	Depression Alliance					This organisation was invited to register but no response was received	
	Depression in Pregnancy					This organisation was invited to register but no response was received	
	Derbyshire Mental Health Services NHS Trust					This organisation was invited to register but no response was received	
	Devon PCT					This organisation was invited to register but no response was received	
	Dorset PCT					This organisation was invited to register but no response was received	
	Ealing PCT					This organisation was invited to register but no response was received	
	Ealing Primary Care Trust					This organisation was invited to register but no response was received	
	Eastern Health & Social Services Board					This organisation was invited to register but no response was received	
	Education for Health					This organisation was invited to register but no response was received	
	EMDR UK and Ireland Association					This organisation was invited to register but no response was received	
	Faculty of Occupational Medicine					This organisation was invited to register but no response was received	
	Faculty of Public Health					This organisation was invited to register but no response was received	
	Food for the Brain Foundation					This organisation was invited to register but no response was received	
	General Practice Airways Group					This organisation was invited to register but no response was received	
	Gloucestershire Partnership NHS Foundation Trust					This organisation was invited to register but no response was received	
	Gut Trust, The					This organisation was invited to register but no response was received	
	Guys and St Thomas NHS Trust					This organisation was invited to register but no response was received	
	Hampshire Partnership NHS Trust					This organisation was invited to register but no response was received	
	Hampshire Partnership NHS Trust - Focussed Implementation Site for DRE					This organisation was invited to register but no response was received	
	Hampshire PCT					This organisation was invited to register but no response was received	
	Harrogate and District NHS Foundation Trust					This organisation was invited to register but no response was received	
	Health Sciences Research Institute					This organisation was invited to register but no response was received	
	Hertfordshire Partnership					This organisation was invited to register but no	

	NHS Trust					response was received	
	Hull PCT					This organisation was invited to register but no response was received	
	Human Givens Institute					This organisation was invited to register but no response was received	
	Infermed Ltd					This organisation was invited to register but no response was received	
	Institute of Neurology					This organisation was invited to register but no response was received	
	Journeys					This organisation was invited to register but no response was received	
	Kensington and Chelsea PCT					This organisation was invited to register but no response was received	
	King's College London					This organisation was invited to register but no response was received	
	Kingston Hospital NHS Trust					This organisation was invited to register but no response was received	
	Leeds PCT					This organisation was invited to register but no response was received	
	London Development Centre					This organisation was invited to register but no response was received	
	Long-term Conditions Alliance					This organisation was invited to register but no response was received	
	Manchester Mental Health and Social Care NHS Trust					This organisation was invited to register but no response was received	
	Manchester Metropolitan University					This organisation was invited to register but no response was received	
	Marlborough Pharmaceuticals Ltd					This organisation was invited to register but no response was received	
	Maternity Health Links					This organisation was invited to register but no response was received	
	ME Association, The					This organisation was invited to register but no response was received	
	Medicines and Healthcare Products Regulatory Agency (MHRA)					This organisation was invited to register but no response was received	
	Mental Health Act Commission					This organisation was invited to register but no response was received	
	Mental Health and Substance Use: dual diagnosis					This organisation was invited to register but no response was received	
	Mental Health Foundation					This organisation was invited to register but no response was received	
	Mental Health Providers Forum					This organisation was invited to register but no response was received	
	Mersey Care NHS Trust					This organisation was invited to register but no response was received	
	Milton Keynes PCT					This organisation was invited to register but no response was received	

	MK ADHD					This organisation was invited to register but no response was received	
	Mothersvoice					This organisation was invited to register but no response was received	
	National Childbirth Trust					This organisation was invited to register but no response was received	
	National Hospital for Neurology & Neurosurgery (NHNN)					This organisation was invited to register but no response was received	
	National Institute for Mental Health in England					This organisation was invited to register but no response was received	
	National Patient Safety Agency (NPSA)					This organisation was invited to register but no response was received	
	National Public Health Service - Wales					This organisation was invited to register but no response was received	
	National Society for Epilepsy					This organisation was invited to register but no response was received	
	National Spinal Injuries Centre					This organisation was invited to register but no response was received	
	NCC for Acute Care					This organisation was invited to register but no response was received	
	NCC for Cancer					This organisation was invited to register but no response was received	
	NCC for Chronic Conditions					This organisation was invited to register but no response was received	
	NCC for Mental Health					This organisation was invited to register but no response was received	
	NCC for Nursing & Supportive Care					This organisation was invited to register but no response was received	
	NCC for Primary Care					This organisation was invited to register but no response was received	
	NCC for Women & Children					This organisation was invited to register but no response was received	
	Newcastle PCT					This organisation was invited to register but no response was received	
	Newham Primary Care Trust					This organisation was invited to register but no response was received	
	NHS Bedfordshire					This organisation was invited to register but no response was received	
	NHS Clinical Knowledge Summaries Service (SCHIN)					This organisation was invited to register but no response was received	
	NHS Improvement					This organisation was invited to register but no response was received	
	NHS Kirklees					This organisation was invited to register but no response was received	
	NHS Knowsley					This organisation was invited to register but no response was received	
	NHS Plus					This organisation was invited to register but no response was received	

	NHS Purchasing & Supply Agency					This organisation was invited to register but no response was received	
	NHS Quality Improvement Scotland					This organisation was invited to register but no response was received	
	NHS Sheffield					This organisation was invited to register but no response was received	
	NICE - CPHE					This organisation was invited to register but no response was received	
	NICE - IMPLEMENTATION CONSULTANT Region - East					This organisation was invited to register but no response was received	
	NICE - IMPLEMENTATION CONSULTANT - Region London/SE					This organisation was invited to register but no response was received	
	NICE - IMPLEMENTATION CONSULTANT - Region SW					This organisation was invited to register but no response was received	
	NICE - IMPLEMENTATION CONSULTANT Region NW & NE					This organisation was invited to register but no response was received	
	NICE - IMPLEMENTATION CONSULTANT Region West Midlands					This organisation was invited to register but no response was received	
	NICE - IMPLEMENTATION CO-ORDINATION for info					This organisation was invited to register but no response was received	
	NICE - IMPLEMENTATION CO-ORDINATION for info					This organisation was invited to register but no response was received	
	NICE - Technical Appraisals (Interventional Procedures) FOR INFO					This organisation was invited to register but no response was received	
	North East London Mental Health Trust					This organisation was invited to register but no response was received	
	North Lincolnshire PCT					This organisation was invited to register but no response was received	
	North Staffordshire Combined Healthcare NHS Trust					This organisation was invited to register but no response was received	
	North Tees PCT					This organisation was invited to register but no response was received	
	North Yorkshire and York PCT					This organisation was invited to register but no response was received	
	North Yorkshire and York PCT					This organisation was invited to register but no response was received	
	Northamptonshire					This organisation was invited to register but no	

	teaching PCT					response was received	
	Northumberland Tyne & Wear Trust					This organisation was invited to register but no response was received	
	Northumbria Diabetes Service					This organisation was invited to register but no response was received	
	Nottinghamshire Healthcare NHS Trust					This organisation was invited to register but no response was received	
	Oklahoma State University					This organisation was invited to register but no response was received	
	Organon Laboratories Ltd					This organisation was invited to register but no response was received	
	Oxfordshire & Buckinghamshire Mental Health Partnership NHS Trust					This organisation was invited to register but no response was received	
	Oxleas NHS FoundationTrust					This organisation was invited to register but no response was received	
	Partnerships for Children, Families, Women and Maternity					This organisation was invited to register but no response was received	
	Pelvic Pain Support Network					This organisation was invited to register but no response was received	
	PERIGON Healthcare Ltd					This organisation was invited to register but no response was received	
	Pfizer Limited					This organisation was invited to register but no response was received	
	Plymouth Local Involvement Network					This organisation was invited to register but no response was received	
	Plymouth PCT					This organisation was invited to register but no response was received	
	Plymouth Teaching Primary Care Trust					This organisation was invited to register but no response was received	
	PNI ORG UK					This organisation was invited to register but no response was received	
	PRIAE Policy Research Institute on Ageing and Ethnicity					This organisation was invited to register but no response was received	
	Primary Care Mental Health Collaborative					This organisation was invited to register but no response was received	
	Primary Care Neurology Society					This organisation was invited to register but no response was received	
	Primary Care Pharmacists Association					This organisation was invited to register but no response was received	
	Prince's Foundation for Integrated Health					This organisation was invited to register but no response was received	
	Public Health Group North East					This organisation was invited to register but no response was received	
	RCM Consultant Midwives Group					This organisation was invited to register but no response was received	
	Relatives & Residents					This organisation was invited to register but no	

	Association					response was received	
	Rethink - Accommodation Plus					This organisation was invited to register but no response was received	
	Robert Jones & Agnes Hunt Orthopaedic & District Hospital NHS Trust					This organisation was invited to register but no response was received	
	Royal College of General Practitioners					This organisation was invited to register but no response was received	
	Royal College of Midwives					This organisation was invited to register but no response was received	
	Royal College of Midwives					This organisation was invited to register but no response was received	
	Royal College of Paediatrics and Child Health					This organisation was invited to register but no response was received	
	Royal College of Physicians London					This organisation was invited to register but no response was received	
	Royal College of Speech and Language Therapists					This organisation was invited to register but no response was received	
	Royal Pharmaceutical Society of Great Britain					This organisation was invited to register but no response was received	
	Royal Society of Medicine					This organisation was invited to register but no response was received	
	SACAR					This organisation was invited to register but no response was received	
	Salisbury NHS Foundation Trust					This organisation was invited to register but no response was received	
	Sandwell & West Birmingham Hospital NHS Trust					This organisation was invited to register but no response was received	
	Sandwell PCT					This organisation was invited to register but no response was received	
	SANE					This organisation was invited to register but no response was received	
	Sanofi-Aventis					This organisation was invited to register but no response was received	
	Schering-Plough Ltd					This organisation was invited to register but no response was received	
	Scottish Intercollegiate Guidelines Network (SIGN)					This organisation was invited to register but no response was received	
	Sefton PCT					This organisation was invited to register but no response was received	
	Servier Laboratories					This organisation was invited to register but no response was received	
	Sheffield Care Mental Health Trust					This organisation was invited to register but no response was received	
	Sheffield PCT					This organisation was invited to register but no response was received	

	Sheffield Teaching Hospitals NHS Foundation Trust					This organisation was invited to register but no response was received	
	Shrewsbury & Telford Hospital NHS Trust					This organisation was invited to register but no response was received	
	Social Perspectives Network					This organisation was invited to register but no response was received	
	Society of Occupational Medicine					This organisation was invited to register but no response was received	
	Solvay Healthcare Limited					This organisation was invited to register but no response was received	
	Somerset Local Medical Committee					This organisation was invited to register but no response was received	
	South Asian Health Foundation					This organisation was invited to register but no response was received	
	South Central Ambulance Service NHS Trust					This organisation was invited to register but no response was received	
	South Essex Partnership NHS Foundation Trust					This organisation was invited to register but no response was received	
	South London and Maudsley NHS Foundation Trust					This organisation was invited to register but no response was received	
	South Staffordhire & Shropshire NHS Foundation Trust					This organisation was invited to register but no response was received	
	South Tyneside NHS PCT					This organisation was invited to register but no response was received	
	South Weston Childrens Centre					This organisation was invited to register but no response was received	
	Southampton City Council					This organisation was invited to register but no response was received	
	St Ann's Hospital					This organisation was invited to register but no response was received	
	St Helens Hospital					This organisation was invited to register but no response was received	
	Staffordshire University					This organisation was invited to register but no response was received	
	State Hospitals Board For Scotland, The					This organisation was invited to register but no response was received	
	Survivors UK					This organisation was invited to register but no response was received	
	Sussex Partnership NHS Trust					This organisation was invited to register but no response was received	
	Tavistock & Portman NHS Foundation Trust					This organisation was invited to register but no response was received	
	Terrence Higgins Trust					This organisation was invited to register but no response was received	
	Teva UK Limited					This organisation was invited to register but no response was received	
	The British Dietetic					This organisation was invited to register but no	

	Association					response was received	
	The Haemophilia Society					This organisation was invited to register but no response was received	
	The Royal College of Pathologists					This organisation was invited to register but no response was received	
	The Royal College of Psychiatrists					This organisation was invited to register but no response was received	
	The Sainsbury Centre for Mental Health					This organisation was invited to register but no response was received	
	The South Asian Health Foundation					This organisation was invited to register but no response was received	
	Trafford Primary Care Trust					This organisation was invited to register but no response was received	
	Trident Care and Support					This organisation was invited to register but no response was received	
	UK Advocacy Network					This organisation was invited to register but no response was received	
	Ultrasis Ltd					This organisation was invited to register but no response was received	
	Unite / Mental Health Nurses Association					This organisation was invited to register but no response was received	
	United Kingdom Council for Psychotherapy					This organisation was invited to register but no response was received	
	Volition					This organisation was invited to register but no response was received	
	Welsh Assembly Government					This organisation was invited to register but no response was received	
	Welsh Scientific Advisory Committee (WSAC)					This organisation was invited to register but no response was received	
	West Hertfordshire PCT & East and North Hertfordshire PCT					This organisation was invited to register but no response was received	
	West London Mental Health NHS Trust					This organisation was invited to register but no response was received	
	Western Cheshire Primary Care Trust					This organisation was invited to register but no response was received	
	Western Health and Social Care Trust					This organisation was invited to register but no response was received	
	Wiltshire PCT					This organisation was invited to register but no response was received	
	Wyeth					This organisation was invited to register but no response was received	
	York NHS Foundation Trust					This organisation was invited to register but no response was received	
	Youth Access					This organisation was invited to register but no response was received	