DCHP scope comments table

Status	Organisation	Order no.	Section	Comments	Response
SH	Adverse Psychiatric Reactions Information Link (APRIL)			This organisation was approached but did not respond.	
SH	Age Concern England			This organisation was approached but did not respond.	
SH	Ambulance Service Association	1	General	The ambulance service and specifically the Directors of Clinical Care for the Ambulance Service are keen to ensure that front line staff provide optimum emergency care to those with severe mental health problems. 4.5%of one large service's 999 workload is either one of two categories - "overdose" or "abnormal behaviour" which includes suicide, and 30% of their child protection cases involve an adult with mental health problems. A common scenario where 999 is called is attempted suicide in one form or another. Some of these patients have severe chronic depression. Advice on the acute management of their mental health problem by the ambulance service, whether they agree to travel or refuse to go to hospital is important (the call is often made by a third party).to allow us to employ best practice in this area. Thank you for the opportunity to contribute to this important subject.	Thank you; although this is an important issue we feel this is outside of our remit. However, we will refer to the NICE guideline on self harm where suicide, overdose etc. was dealt with in more detail.
SH	Arthritis Care	1	General	We welcome the opportunity to comment on the draft scope for consultation. The clinical evidence for the guidelines recognises the powerful psychological and emotional effect of conditions such as arthritis on the quality	Thank you.

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				of life enjoyed by people with the condition. We have restricted our comments to those areas of most significance to people with arthritis.	
SH	Arthritis Care	2	4.3.1	**a) Identification, recognition and assessment of depression in patients with chronic physical health problems**. Swift and accurate identification of depression is of great importance to patients and guidance on this is therefore greatly welcomed. It is also important that identification and assessment is handled sensitively and with the person's full understanding of the condition, the process of assessment and its purpose. That this is a key moment for the person is not reflected in the current wording and we would suggest that communicating the identification of depression appropriately to the person concerned is included here. **i) Ensuring that people with depression and chronic physical health problems have the information they need and the opportunities to discuss with their clinicians the advantages, disadvantages and potential side effects of treatment so that they can make informed choices about the options for their care.** We strongly support the inclusion of information provision in the scope. The ability of service users to make informed choices about their care and treatment is fundamental in helping empower them to manage their condition. It's critical that such information is provided in a format accessible and appropriate to the individual,	Thank you; we feel this is an issue that can be examined and discussed in more detail during the development of the full guideline rather than in the scope. We will raise this issue with the guideline development group when developing the clinical questions. Thank you for you comment, we will forward on your comments so that the guideline development group can consider them when we look at this issue in greater detail.

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				and also that it is available from a range of sources over time. People with long term conditions will need access to information at different points in their journey through treatment, so it needs to be continually accessible rather than imparted briefly during a consultation. We would add that there is a need to signpost to additional support beyond medical treatment, including emotional support and information on benefits and social support networks. **j) The role of the family in the treatment and support of people with depression.** Family members of people with arthritis are often key to their daily care and/or emotional wellbeing. As such they play a key role in informal care. However, the wording of this statement mentions only the care of people with depression, without acknowledging the chronic condition. Supporting a family member with depression is likely to be significantly different from supporting a family member with rheumatoid arthritis and depression. We would like this description to be amended to make specific mention of the role of the family in supporting individuals with chronic conditions and depression.	 Thank you; we have now added 'people with depression and chronic physical health problems' to the appropriate section.
SH	Arthritis Care	3		In general we would be in favour of the inclusion of family members in supporting people with depression and a chronic condition. However, it would be useful to have more detail on what is proposed for this section. Clearly, family members who	The scope is only intended to introduce the issues. Further details will be provided in the full guideline. We will raise this issue with the guideline development group when considering the clinical questions.

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				have not received training or sufficient information on the chronic condition in question, depression, or the treatment plan of an individual should not be expected to provide a key part of their care. Family members providing care also often need support themselves and this needs to be recognised in any discussion of their role in treatment and support. We would therefore suggest that further information on the proposed content of this section is required.	
SH	Association of British Neurologists	1	General	The concurrent scoping document for the revised guidelines on the treatment of depression in primary and secondary care excludes 'people with physical disorders' from its remit. Should *this* document therefore widen its remit to include 'adults with physical health problems' rather than restricting consideration to 'adults with *chronic* physical health problems'? I have in mind, for example, the problem of depression following acute stroke or in the context of recovery from an acute illness such as Guillain Barre syndrome or encephalitis.	Thank you; though this is an important issue we feel it is beyond the remit of this guideline. We have discussed this matter with NICE and feel that the more acute problems you refer to would be more appropriately dealt with in the relevant physical care guidelines such as that under development for stroke.
SH	Association of British Neurologists	2	4.3.1 (g)	It would be helpful if the guideline could consider interactions between psychotropic medication and the underlying chronic physical disorder and well as interactions between psychotropic medication and drugs used to treat the physical disorder. For example, the possibility that antidepressants may exacerbate co-morbid epilepsy is a common concern in the neurology clinic.	Thank you; we will raise this with the guideline development group when developing the clinical questions.
SH	Association of British Neurologists	3	4.3.2 (a)	The document indicates that the 'diagnosis of depression' will not be considered – but	Diagnosis is concerned more with defining what depression is which we consider outside the

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				4.3.1 (a) states that the guideline will address 'identification, recognition and assessment of depression': how does this differ from diagnosis?	remit of the guideline. However, what is within the remit is identification and recognition which is concerned with detecting depression. Assessment refers to how clinicians assess a patient and covers issues such as review of physical health, social needs and environmental factors which may influence referral and treatment decisions. This is also within the remit of the guideline.
SH	Association of Family Therapy			This organisation was approached but did not respond.	
SH	Association of Professional Music Therapists			This organisation was approached but did not respond.	
SH	Association of Psychoanalytic Psychotherapy in the NHS			This organisation was approached but did not respond.	
SH	Association of the British Pharmaceuticals Industry,(ABPI)			This organisation was approached but did not respond.	
SH	AstraZeneca UK Ltd			This organisation was approached but did not respond.	
SH	Avon and Wiltshire MHP NHS Trust			This organisation was approached but did not respond.	
SH	Avon, Gloucestershire & Wiltshire Cardiac Network			This organisation was approached but did not respond.	
SH	Barnsley Hospital NHS Foundation Trust			This organisation was approached but did not respond.	
SH	Barnsley PCT	1	3c	We have evidence from the South Yorkshire Condition Management Programme (CMP) that clients with 'cardio-vascular' and 'musculo-skeletal' conditions have extremely high co-morbid levels of poor mental health. In a sample 181 people with such conditions starting CMP 100 per cent of cases met 'caseness' on the CORE-OM – i.e. that they have a level of psychiatric functioning that would entail the necessary	Thank you; we will raise this with the guideline development group when developing the guideline.

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				intervention of services. More data is currently being collected and will be published in the near future.	
SH	Barnsley PCT	2	3e	Rates of attendance for clients with such physical conditions were good with clients typically attending 5 out of the 7 sessions offered.	Thank you; we will raise this with the guideline development group when developing the guideline.
SH	Barnsley PCT	3	4.3.1.b	Though guided self-help and psycho education such conditions are observed to benefit from CMP. A rate of 66 per cent clinically significant improvement on the CORE-OM has been recorded. More data is currently being collected.	Thank you.
SH	Barnsley PCT	4	4.1.1 a	Staff working with older adults felt strongly that the scope should include the relationship between chronic pain and depression. Chronic pain related to such conditions as arthritis (all kinds), spondylosis and other chronic back disorders, neuralgia carpal tunnel syndrome etc	Thank you for this comment – we do not think that the guideline should focus on chronic pain per se and feel that the matter of chronic pain or pain management more generally could be dealt with by a separate piece of NICE guidance – we will draw this to the attention of NICE.
SH	Barnsley PCT	5	4.3.1 b	We have done a small pilot with 7 GP practices and Graduate Mental Health Workers aiming to provide guided self-help to people who are identified as having depression via the QOF DEP1 indicator. As a pilot it was unsuccessful, as we did not get many referrals. We did however receive quite a few referrals for clients who were older and quite physically disabled and depressed. Physically they were no longer able to do the things they enjoyed and this contributed to their depression. The guided self help and activity scheduling that is successful with other groups was inadequate, and we would like guidance as to what is the most effective therapeutic approach for this client group.	Thank you; we will raise this with the guideline development group when developing the guideline.

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SH	Bedfordshire & Luton Partnership NHS Trust			This organisation was approached but did not respond.	
SH	Bedfordshire PCT			This organisation was approached but did not respond.	
SH	Berkshire Healthcare NHS Foundation Trust			This organisation was approached but did not respond.	
SH	Birmingham, Sandwell and Solihull Cardiac Network			This organisation was approached but did not respond.	
SH	Boehringer Ingelheim Ltd			This organisation was approached but did not respond.	
SH	British Association for Behavioural & Cognitive Psychotherapies			This organisation was approached but did not respond.	
SH	British Association for Counselling and Psychotherapy			This organisation was approached but did not respond.	
SH	British Association for Psychopharmacology	1	4.1.1	In relation to the population to be covered it is important to distinguish between depression and an adjustment reaction to diagnosis of a significant physical illness. This issue may bear some consideration. It is also important to consider differentiation from a grief reaction. This is often an older population where recent loss of a spouse or other relative may be relevant.	Thank you; we will raise this issue with the guideline development group when considering the clinical questions.
SH	British Association for Psychopharmacology	2	4.1.1	This guideline is aimed at treatment of depression in those with chronic physical health problems. While depression is probably the main psychiatric diagnosis in this group anxiety disorders may also be quite common (e.g. Heaney et al, Respiratory Medicine: 2005, 99, 1152-1159). Is it proposed to have a Guideline for anxiety disorders in this situation or should this be considered within this guideline?	Thank you for your comment, unfortunately anxiety disorders are beyond the remit of this guideline. There are separate guidelines for some anxiety disorders which are planned for an update in the near future.
SH	British Association for	3	4.1.2 (c)	It seems unwise to exclude all depressive	Thank you; although we are aware that

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	Psychopharmacology			disorders occurring primarily as an adverse effect of treatment of the physical disorder. In the treatment of cancer with interferons and steroids depression can be a common adverse effect. Indeed, primary prevention may be relevant here as there is some evidence for the use of antidepressants in the treatment of melanoma with interferon.	depression can be an adverse effect of some medications we feel this issue is beyond our remit.
SH	British Association of Art Therapists	4	General	The guideline could make a clearer distinction between people with a chronic physical health condition, which precedes depression, and those who develop chronic conditions against a background of depression. Experienced Art Therapy clinicians working in mental health settings have observed a tendency for late diagnoses of physical health conditions in people with enduring mental health problems).	Thank you; we will raise this issue with the guideline development group when considering the clinical questions.
SH	British Association of Art Therapists	5	General	No mention of the contribution of AHPs including the Arts Therapies in the prevention and treatment of depression in this group. To use the example of neuro rehabilitation OTs, SLTs , PTs, Arts therapists (Also social workers and psychologists) work together in multidisciplinary or inter-agency settings to provide holistic physical, emotional, communication treatment. Art Therapy is a psychotherapeutic offered in health care settings to people with physical conditions, most widely used by people who have cancer, in neuro rehabilitation. Art therapists also work with people with conditions such as Parkinson's Disease and who have had a stroke. For those with a condition acquired in later life, a degree of reactive depression is seen as a normal response and a painful but	Thank you; we will raise this issue with the guideline development group when considering the clinical questions.

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				often necessary part of the adjustment process. Specialist psychological help should be offered for those who need it. The arts therapies are particularly indicated for those with complex pre existing difficulties, communication or cognitive difficulties and for those for whom it is a treatment of choice.	
SH	British Association of Art Therapists	6	General	AHPs professions have not so far been well represented in the guideline process, though they are often frontline workers	Thank you for your comment. The composition of GDGs is based on specifications set by NICE and this includes AHPs, nurses and others where appropriate for the guideline topic.
SH	British Association of Art Therapists	7	2.c	There has been very limited representation of the range of healthcare professionals involved in patient care and treatment in the guideline development groups, notably AHPs. Art therapists as a profession are concerned that the evidence and research which is currently available and which is appropriate to relational based therapy: practice based evidence, qualitative case based research, observational and grounded theory for example, will not be able to compete with RCTs which are unaffordable to small professions such as ourselves. Established and developing practice, valued by patients may be excluded and not commissioned because it does not meet the NICE definitions of acceptable evidence.	As discussed above the NICE methods for assessing interventions are available from the website (www.nice.org.uk). Where RCTs are not available then other study designs are considered. When appropriate to the particular clinical question qualitative studies are also assessed.
SH	British Association of Art Therapists	8	3.c	This is true also for people with acquired serious brain injury, neurological disorders and spinal cord injury.	As above, where RCTs are not available other study designs will be assessed.
SH	British Association of Art Therapists	9	3.e	People with depression being unable to fully participate in rehabilitation programmes. After newly acquired conditions (traumatic and non traumatic neurological conditions including stroke) there is generally believed	Thank you; we will raise this issue with the guideline development group when considering the clinical questions.

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				to be a time when optimum benefit (physical, cognitive and communication) can be gained form multidisciplinary rehabilitation. Without appropriate treatment for depression optimum time	
SH	British Association of Art Therapists	10	3.f	Does this not indicate that diagnosis needs to be part of this scope?	This suggests identification and recognition is an important part of the guideline and is included in the scope.
SH	British Association of Art Therapists	11	3.h	This is important. There are also gender and sexuality issues, which may need to be addressed. Will the variable provision of resources be looked into? The ability to access psychological help at present depends what is on offer- if anything. In the case of art therapy for example for people with depression and communication difficulties who are unable to access talking therapies but for whom a psychological therapy is indicated, will they be offered the option? In a survey of art therapists (BAAT 2006 for the stroke NSF consultation) showed that only people with strokes whose mental state had become bad enough for them to be in secondary or inpatient the mental health services were able to access art therapy. A look at how services can be offered in a timely and appropriate manner seems crucial as a social inclusion issue and also	Thank you; the scope provides some examples of diversity and social exclusion but they are not intended to be exhaustive. These issues will be dealt with in more detail in the full guideline. Provision of resources is beyond the remit of this guideline.
SH	British Association of Art Therapists	12	3.f	3f begins to describe the variety of presentations and causes of depression in people with cph problems. It does not seem to cover people enduring depression who develop chronic physical problems (See also earlier general comment)	Thank you; people with depression and chronic physical problems will be included in the guideline regardless of whether the physical health problem or depression developed first.
SH	British Association of Art Therapists	13	3.m	If resources are released will parity be looked at. For example, Art and Music Therapy is recommended as part of sub	Thank you for your suggestion. NICE have a separate programme for implementation. Further information is available on their website:

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				acute rehabilitation services in neuro rehabilitaion. This is not avail be across the country and hardly at all in a very comparable- the stroke services.	http://www.nice.org.uk/page.aspx?o=280304
SH	British Association of Art Therapists	14	4.1.1.a	Neuro rehabilitation services take in clients from age 17. Will these slip through the net? Are children and young people with chronic physical health problems with depression to be covered elsewhere? Again neurological disorders don't cover brain injury- the term neurological conditions would do so.	Thank you – you raise a number of important issues but we feel that these are beyond the remit and capacity of the current guideline. We feel that the chronic physical health problems of children and adolescents should be dealt with separately and that the issue of acquired brain injury may warrant separate guidance.
SH	British Association of Art Therapists	15	4.1.1.a	We presume there is no upper age limit	There is no upper age limit.
SH	British Association of Art Therapists	16	4.1.1.a	Will people with learning disability and chronic physical conditions be included?	Thank you for your comment, we have amended the scope to take account the needs of individuals with learning difficulties.
SH	British Association of Art Therapists	17	4.3.1.b	I think the guideline needs to mention more about the emotional, and social impact of the losses involved in chronic physical health conditions.	This is usually dealt with in more detail in the full guideline rather than the scope as it can be addressed more fully in that document.
SH	British Association of Art Therapists	18	4.3.1.a	Agree 'recognition and assessment' is important. The point is that depression can be difficult to spot or can be misdiagnosed. I'm not clear how this differs from diagnosis.	A review of diagnosis would involve consideration of the necessary signs and symptoms to achieve a diagnosis – this is beyond the scope of the guideline. However, what is within the remit is identification and recognition which is concerned with detecting depression. We will address the issue you raise of the additional complexity of diagnosis in people with comorbid physical health problems.
SH	British Association of Art Therapists	19	4.3.1.b	This seems an omission in the case of depression which is a reaction to the physical condition.	We feel this does not omit people with depression which is a reaction to the physical condition.
SH	British Association of Art Therapists	20	4.3.1.i	What does informed choice really mean to? Again we are concerned that the guideline process continues to favour large scale RCTs and only those treatments that have	NICE procedures on evaluating evidence is documented on its website (www.nice.org.uk). RCTs or systematic reviews of RCTs are considered the most rigorous study designs for

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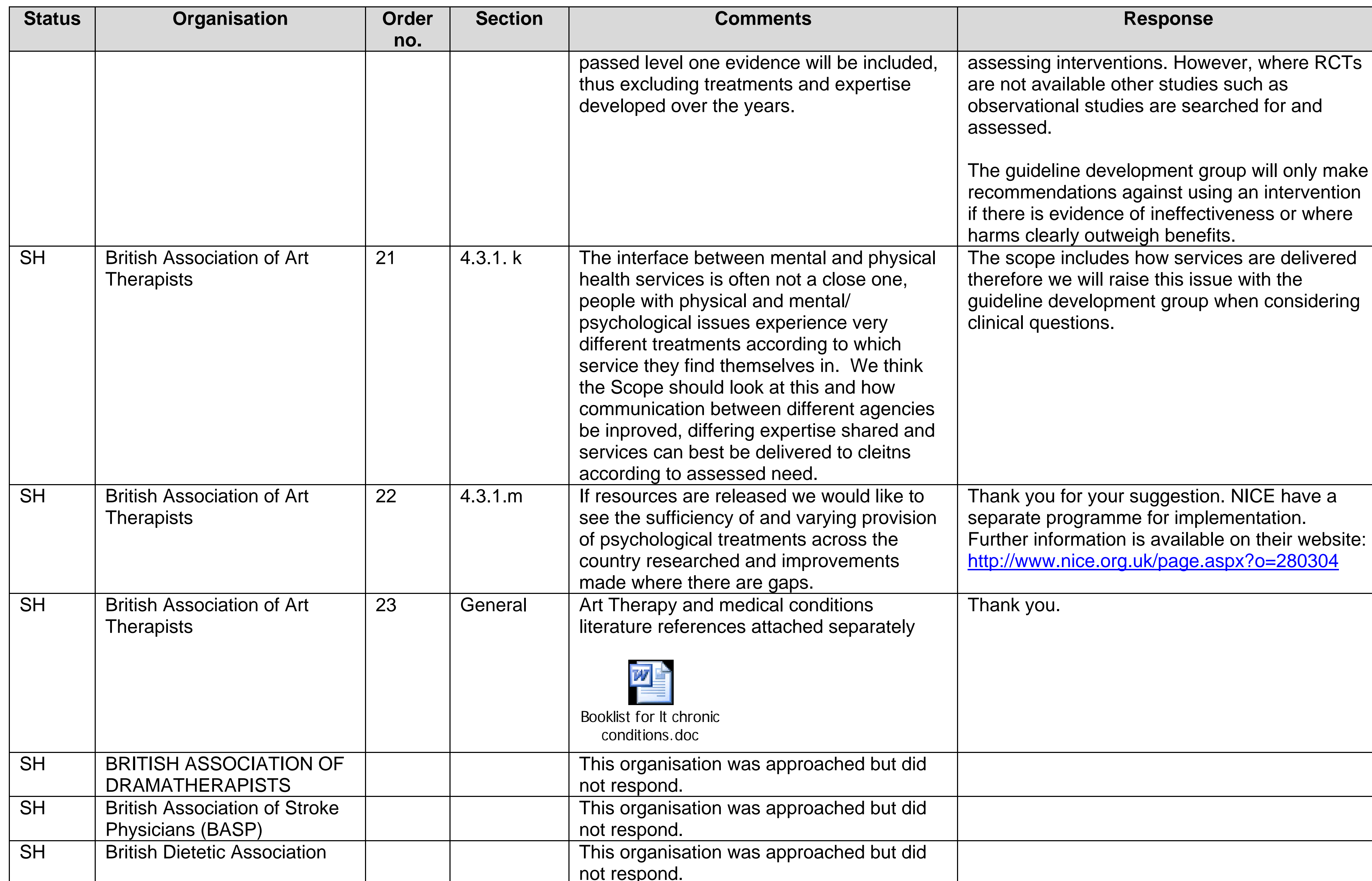
				passed level one evidence will be included, thus excluding treatments and expertise developed over the years.	assessing interventions. However, where RCTs are not available other studies such as observational studies are searched for and assessed. The guideline development group will only make recommendations against using an intervention if there is evidence of ineffectiveness or where harms clearly outweigh benefits.
SH	British Association of Art Therapists	21	4.3.1. k	The interface between mental and physical health services is often not a close one, people with physical and mental/ psychological issues experience very different treatments according to which service they find themselves in. We think the Scope should look at this and how communication between different agencies be inproved, differing expertise shared and services can best be delivered to cleitns according to assessed need.	The scope includes how services are delivered therefore we will raise this issue with the guideline development group when considering clinical questions.
SH	British Association of Art Therapists	22	4.3.1.m	If resources are released we would like to see the sufficiency of and varying provision of psychological treatments across the country researched and improvements made where there are gaps.	Thank you for your suggestion. NICE have a separate programme for implementation. Further information is available on their website: http://www.nice.org.uk/page.aspx?o=280304
SH	British Association of Art Therapists	23	General	Art Therapy and medical conditions literature references attached separately  Booklist for lt chronic conditions.doc	Thank you.
SH	BRITISH ASSOCIATION OF DRAMATHERAPISTS			This organisation was approached but did not respond.	
SH	British Association of Stroke Physicians (BASP)			This organisation was approached but did not respond.	
SH	British Dietetic Association			This organisation was approached but did not respond.	

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SH	British Geriatrics Society			This organisation was approached but did not respond.	
SH	British Homeopathic Association			This organisation was approached but did not respond.	
SH	British National Formulary (BNF)			This organisation was approached but did not respond.	
SH	British Paediatric Mental Health Group			This organisation was approached but did not respond.	
SH	British Thoracic Society			This organisation was approached but did not respond.	
SH	British Thoracic Society	1	D	COPD should also be included in this section as depression has been found in numerous studies in this group of patients.	Thank you; the focus for identifying the relevant physical problems will be the degree of associated physical impairment etc – so could include those with COPD.
SH	British Thyroid Foundation	1	General	A greater awareness of the link between thyroid disorders and depression is required.	Thank you; depression in people with thyroid disorders is considered to be within the limits of the scope. It is not possible to list every chronic physical health condition in the scope therefore only a limited number of examples are provided. However, evidence on treating depression in this group will be considered, if available, by the guideline development group.
SH	British Thyroid Foundation	2	General	Undiagnosed thyroid disorders, and inadequate thyroxine replacement can be a cause of depression. Can this be highlighted?	There are already a number of examples in the scope these are not meant to be exhaustive.
SH	British Thyroid Foundation	3	3 e)	The statement applies also to people with a thyroid disorder. How is it proposed to encourage adherence to physical health treatment?	Thank you; we will raise this issue with the guideline development group when considering the clinical questions.
SH	British Thyroid Foundation	4	4.2 a)	Thyroid patients being managed for depression in secondary care should have their thyroid disorder managed by a GP or physician and not directly by the psychiatric team.	Thank you; we will raise this issue with the guideline development group when considering the clinical questions.
SH	British Thyroid Foundation	5	4.3.1 a)	Patients presenting with depression should be screened for thyroid dysfunction, to ensure the patient is euthyroid before	Thank you; we will raise this issue with the guideline development group when considering the clinical questions.

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				depression is diagnosed.	
SH	British Thyroid Foundation	6	4.3.1 b)	Patients presenting with post-natal depression should be screened for thyroid dysfunction.	Thank you. Screening for thyroid function was recommended in the original depression guideline. The guideline on antenatal and postnatal mental health should be read in conjunction with all other mental health guidelines as appropriate.
SH	Buckinghamshire PCT			This organisation was approached but did not respond.	
SH	BUPA			This organisation was approached but did not respond.	
SH	Cambridge University Hospitals NHS Foundation Trust			This organisation was approached but did not respond.	
SH	Care Services Improvement Partnership			This organisation was approached but did not respond.	
SH	CCBT Ltd			This organisation was approached but did not respond.	
SH	Charlie Waller Memorial Trust	1	General	There is nothing wrong with the existing guidelines but only with the failure to apply them. The best response would be to make them mandatory but we recognise that this would require ring-fenced money for mental health and increased authority to make sure that intent and funding were not diverted elsewhere.	Thank you for your comment but these issues are beyond the remit of the guideline development.
SH	Charlie Waller Memorial Trust	2	General	The guidelines are comprehensive enough, but as with other guidelines we need training and implementation to be given a priority, and some kind of audit to see where they have (and more importantly have not) been) implemented.	Thank you for your suggestion. NICE have a separate programme for implementation. Further information is available on their website: http://www.nice.org.uk/page.aspx?o=280304
SH	Charlie Waller Memorial Trust	3	General	The problem is they are “guidelines” so there is choice as to whether primary care and GP’s in particular use them. We need some form of audit/monitoring system. If not we will see, as with the graduate primary mental health workers, a very good	Thank you for your comment, auditing or monitoring of services is beyond the remit of the guideline.

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				idea/resource mismanaged and a continuation of the "postcode lottery" when it comes to primary mental healthcare.	
SH	Charlie Waller Memorial Trust	4	General	The guidelines are very useful, but there are still some influential psychiatrists who have little regard for the evidence base for effective primary care services and are not convinced that there are any good models for delivering it in primary care. More evidence for psychological therapies is available since the guidance was written and NICE needs to reflect it in any revamped guidance.	Thank you, we will be considering the available evidence since the NICE guideline was written.
SH	Chineham Medical Practice			This organisation was approached but did not respond.	
SH	CIS'ters			This organisation was approached but did not respond.	
SH	CNWL Foundation NHS Trust			This organisation was approached but did not respond.	
SH	Colebrook Housing Society			This organisation was approached but did not respond.	
SH	College of Occupational Therapists	1	3	It could be worth stating information about the direct links between some physical conditions and depression (e.g. tuberculosis can cause depression; e.g. psychosomatic conditions; e.g. conditions such as fibromyalgia).	There are already a number of examples in the scope these are not meant to be exhaustive.
SH	College of Occupational Therapists	2	3b	Whilst there is mention here of 'people's personal, social and occupational functioning', it is hoped that the resulting document reflects these areas in terms of what treatment is mentioned. Should state that it is 'psychosocial' rather than 'psychological' areas that are covered in the scope if it is to cover more than a cursory glance at anything other than medications and CBT. Title of the guideline should reflect its content – unless there is detail of social	Thank you we have amended the scope where appropriate to use the term psychosocial.

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				care, occupational functioning* and occupational performance* aspects of the treatment of depression then the title should be ‘the medical and psychological treatment of depression’ rather than ‘the treatment of depression’. (* I would be happy to help wording.)	
SH	College of Occupational Therapists	3	3d	Occupational therapists are trained in and work across the physical and psychiatric fields and therefore are extremely well placed to deal with people suffering depression who have physical health problems. This population’s needs will be most relevantly served by the occupational therapy approach where lifestyle redesign and reason for living are core to the occupational therapy reasoning.	Thank you for your comment.
SH	College of Occupational Therapists	4	4.3.1b	The list ought to be inclusive and ought to mention laughter therapy. Laughter therapy is well used in the USA as a supplement or alternative to medication for many physical ailments as well as for mood disorders; there is a wealth of research evidence to indicate that this is an efficacious treatment tool.	Thank you; we will raise this issue with the guideline development group when considering the clinical questions.
SH	College of Occupational Therapists	5	general	The speed and ease of re-/accessing secondary services is considered to be necessarily fast and non-bureaucratic; however, in practice this is more often than not not so. This could be usefully addressed through the guidelines.	Thank you; we will raise this issue with the guideline development group when developing the guideline.
SH	College of Occupational Therapists	6	general	Include clear direction on the level of education of patients of how to take the medications and for how long and what to expect and that the side effects experienced at first often abate after a few days; this need not be done by the medic, but should be audited to ensure that it is always carried out. This would help compliance and	Thank you; we will raise this issue with the guideline development group when developing the guideline.

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				therefore improve clinical outcomes.	
SH	Commission for Social Care Inspection	7	General	It will be important to explicitly refer in the guidance to adults who may reside in a social care setting, eg younger adults or older people living in care homes. Whilst it is appreciated they may be included within the current proposals for the guidance under the primary care heading, it would be helpful to specifically mention this group of people who may have depression, as they are reliant on General Practitioners diagnosing and treating the depression. In many instances it is the care staff who recognise that there is depression, or fail to recognise an individual's depression, as many will not be healthcare professionals.	Thank you; we will raise this issue with the guideline development group when considering the clinical questions.
SH	Commission for Social Care Inspection	8	4.3.1j	It may be appropriate to also include what carers can do to support people with depression as well as family. This could be in relation to carers in the home setting as well as those in a residential setting.	Thank you, we have now included carers in the scope.
SH	Commission for Social Care Inspection	9	4.3.1k	It may be appropriate to specifically include that people in social care residential environments, such as care homes, also require support from local services and this needs to be considered when developing models of care.	Thank you; we will raise this issue with the guideline development group when developing the guideline.
SH	Connecting for Health			This organisation was approached but did not respond.	
SH	Cornwall & Isles of Scilly PCT			This organisation was approached but did not respond.	
SH	Counselling Haverhill			This organisation was approached but did not respond.	
SH	Counsellors & Psychotherapists in Primary Care			This organisation was approached but did not respond.	
SH	County Durham PCT			This organisation was approached but did not respond.	

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SH	Critical Psychiatry Network			This organisation was approached but did not respond.	
SH	Cyberonics Europe	1	2.c)	Suggest epilepsy is included in the list of problems as 'anxiety and depressive disorders are common psychiatric conditions in patients with epilepsy (Jacoby 1996; Kohler 1999). About one-third to one-half of patients scored high on anxiety and depression self-reported scales (O'Donoghue 1999).	Epilepsy is included in the scope under the term neurological disorders.
SH	Cyberonics Europe	2	General	Given the size of the patient population with neurological disorders and depression is there not a case for having a separate guideline for depression in neurology?	Thank you; although we accept that neurological disorders is a broad category we feel that such disorders are chronic physical health problems and therefore should be included in the scope.
SH	Cyberonics Europe	3	4.3.1 b)	To ensure that the scope is 'inclusive' - suggest that 'physical interventions' should include other approved therapies/techniques, i.e. Vagus Nerve Stimulation therapy	Thank you; we will raise this issue with the guideline development group when considering the clinical questions.
SH	Cyberonics Europe	4	4.3.2	Given the issue of recognising depression as a co-morbid disorder for these patients, should the scope not include an aid to recognising the problem?	Identification and recognition are included in the scope (4.3.1a).
SH	Cyberonics Europe	5	General / submission of evidence	There is evidence available which we would be able to submit to support the use of Vagus Nerve Stimulation in people with epilepsy and depression including safety, efficacy and cost benefit data.	Thank you, will we raise this with the guideline development group during the development of the guideline.
SH	Department for Work and Pensions			This organisation was approached but did not respond.	
SH	Department of Health	1	3b	According to a recent paper in The Lancet (dated 8 September 2007), depression will be the second highest-ranking cause of disease burden by 2020. We feel that it would be advisable to check the accuracy of this statement.	We have checked the WHO statistics and both statements are correct. The Lancet paper you quote is correct in that depression is predicted to be the second highest-ranking cause of disease burden in *the world.* However, as stated in the scope of this guideline depression is predicted to be the highest ranking cause of disease burden in *developed* (or high income)

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					countries. So they are not contradictory as it might first appear.
SH	Department of Health	2	4.3.1 b	Could you please consider the inclusion of CCBT under the suggested psychological interventions.	Thank you; we will raise this issue with the guideline development group when considering the clinical questions.
SH	Department of Health, Social Security and Public Safety of Northern Ireland			This organisation was approached but did not respond.	
SH	Depression Alliance			This organisation was approached but did not respond.	
SH	Derbyshire Mental Health Services NHS Trust			This organisation was approached but did not respond.	
SH	Devon PCT			This organisation was approached but did not respond.	
SH	Diabetes UK	1	1	Guideline title: The treatment of depression in adults with long term physical health conditions	Thank you; we feel the current title is acceptable as it is.
SH	Diabetes UK	2	1.1	Short title: Depression – long term physical health conditions	Thank you; we feel the current title is acceptable as it is.
SH	Diabetes UK	3	4.1.1a)	The explicit acknowledgement of diabetes in the groups that will be covered is welcome. Diabetes UK recommends that diabetes be explored specifically within this guideline. There are 2.2 million people in the UK who have diabetes. People with diabetes are also three times[1] more likely than the general population to develop depression, and women are more likely to develop depression. It is well documented that the impact of the daily self care routine for diabetes and coping with episodes such as the development of a complication of diabetes can take their toll on the emotional well being of an individual and lead to depression. Studies suggest people with diabetes report diabetes related stress associated with feelings of burn out or being overwhelmed by the demanding self care routine[2,3] People with diabetes are also	Thank you.

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				more prone to developing anxiety.[4] Psychological distress can itself affect diabetes control through the release of counter regulatory hormones which often result in elevated blood glucose levels. Psychological distress has also been demonstrated as the best predictor of non adherence to medical or lifestyle advice.[1],[2],[5,6] 1. Lustman PJ, Anderson RJ, et al. Depression and poor glycaemic control: a meta-analytic review of the literature. *Diabetes Care, 23; 2000: 934-942* 2.Polonsky WH, Anderson Bj, Lohrer PA et al (1995) Assessment of diabetes related distress *Diabetes Care: 18 754-760* 3. Welch GW, Jacobson AM, Polonsky WH (1997) The Problem Areas in Diabetes Scale: an evaluation of its utility *Diabetes Care: 20 760-766* 4.Grigsby AB, Anderson RJ,Freedland KE et al (2002) Prevalence of anxiety in adults with diabetes: a systematic review. *J. Psychosom Res : 53 1053 – 1060* 5. Northern Ireland Task Force on Diabetes, 2003. CREST and Diabetes UK pp3 6. Ciechanowski PS,Katon WJ, Russo JE.(2000) Depression and diabetes:impact of depressive symptoms on adherence, function and costs. *Arch. Intern Med: 160 3278-3285*	
SH	Diabetes UK	4	4.1.1a)	Diabetes UK recommends the needs of carers are also acknowledged within the guideline. Carers can play a significant role in supporting people with long term physical health conditions and may have associated emotional support needs of their own as a	Thank you; we have amended the scope to include carers as providing support for people with long term physical health conditions.

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				result. [1] 1. Holmes AM, Deb P. (2003) The effect of chronic illness on the psychological health of family members. *The Journal of Mental Health Policy and Economics Mar; 6(1):13-22*	
SH	Diabetes UK	5	General comment	The interaction between depression and long term physical health conditions is complex and this interaction must be given explicit attention within the guideline both in terms of how the identification and treatment of depression is undertaken in the context of the physical health condition. Depression and the long term physical health condition must be seen in the context of one another, and how the experience of one interacts and impacts on the other.	Thank you; we will raise this issue with the guideline development group when developing the guideline.
SH	Diabetes UK	6	4.1.1 a)	An overlapping issue is the definition of "depression" used. The “clinical working diagnosis” of depression may limit the remit of the guideline to the detriment of people with long term physical health conditions. Many mental health conditions are only diagnosed if a certain list of criteria are fulfilled to attain a diagnosis within one of the recognised classificatory systems (ICD-10 or DSM-IV). In other words, a certain threshold of severity or duration applies. It is extremely important for the guideline group to remain aware that depression which would be considered in someone without a long term physical health condition as "sub-threshold" may not be appropriately considered to be so in someone with a long term physical health condition. If a person with diabetes is depressed to an extent which might otherwise be considered to be "sub-threshold" it may still have a very	Thank you; we will raise this issue with the guideline development group when considering the clinical questions.

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				significant negative impact upon that person's self-care and, as a direct result, their glycaemic control, risk of medical complications and, therefore, overall morbidity and mortality. Similarly for some other long term physical health conditions, so the guideline will need to require that an adequate degree of importance is given to depression in such groups.	
SH	Diabetes UK	7	4.2.a)	Is there scope for the guidelines to also apply to organisations delivering care for people with depression	This guidance is primarily for the NHS. However many of the recommendations will be applicable to organisations outside of the NHS who are delivering care for people with depression.
SH	Diabetes UK	8	4.3.1 a)	Please clarify the distinction being made between "diagnosis", which you have excluded as a topic, and identification which has been included.	Diagnosis is concerned more with defining what depression is which we consider outside the remit of the guideline. However, what is within the remit is identification and recognition which is concerned with detecting depression. Assessment refers to how clinicians assess a patient and covers issues such as review of physical health, social needs and environmental factors which may influence referral and treatment decisions. This is also within the remit of the guideline.
SH	Diabetes UK	9	4.3.1 b)	Please clarify what is meant by formal psychological interventions	Formal psychological interventions refer to interventions which are based on sound theoretical underpinnings. They are often manualised (i.e., the individual sessions are structured based on a manual). They will have been assessed using rigorous research methods such as randomised controlled trials.
SH	Diabetes UK	10	4.3.1.b)	Consideration must be given to how applicable the formal psychological interventions will be for a person who has both depression and a long term physical health condition. For example some of the tools available will be specifically for	Thank you; we will raise this issue with the guideline development group when developing the guideline.

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				depression but will not consider the impact and relationship of this to a long term physical health condition.	
SH	Diabetes UK	11	4.3.1.i)	Please include other relevant sources of support as well as clinicians, as some organisations will have specific knowledge, experience and expertise in relation to the different interventions available to people with depression.	Thank you we will seek to recruit guideline development group members from a variety of disciplines and to write to researchers and organisations from a variety of fields in order to be as comprehensive as possible within the limits of the scope.
SH	Diabetes UK	12	4.3.1 i)	The statement appears to sound as if it is only considering pharmacological interventions. It is important that non pharmacological interventions are also considered.	Nonpharmacological interventions will be considered in the guideline as explicity stated in the scope (for example 4.3.1a, 4.3.1d)
SH	Diabetes UK	13	General	The scope of the guideline would benefit from broadening out to explore both the risks of developing depression as a result of having a chronic condition, as discussed earlier, and the risks of developing a chronic condition, such as diabetes, as a result of having depression. Evidence exists drawing links between the impact of depression leading to an increased risk in developing diabetes[1]. These need to be considered to ensure practitioners are mindful of these risks and can act appropriately to help reduce these risks and possibly prevent the development of either condition. 1. Knol MJ, Twisk JW, Beekman AT, Heine RJ, Snoek FJ, Pouwer F: Depression as a risk factor for the onset of type 2 diabetes mellitus. A meta-analysis. *Diabetologia* 2006, **49:**837-845	Thank you. Primary prevention is not the role of NICE's guideline programme.
SH	Diabetes UK	14	4.3.2 a)	Diagnosis needs to be included in order to ensure the relationship between depression and chronic physical health conditions is explored holistically and all levels of	Although we agree diagnosis is important unfortunately is beyond the remit of this guideline.

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				intervention are considered. This is particularly important in relation to the comments made regarding the definition of depression in section 4.1.1a) and the impact of this.	
SH	Diabetes UK	15	4.3.2 b)	By excluding primary prevention of depression and co-morbid disorders the guideline will be breaking up a patient's "journey" through their care. From the perspective of implementation this is unhelpful, as it potentially excludes steps 1 and 2 of the stepped approach (CG23 pp 14-15 NICE 2004 updated 2007) in terms of emotional/psychological support, particularly if it is not explicit within the guideline where the guidance on primary prevention is contained. It would be useful for the guideline to cover aspects of primary prevention and the evidence base surrounding the impact of early intervention in terms of information education provision and mindfulness of psychological well being, in reducing risk. There is much evidence to suggest that "resourcefulness" can help reduce the risk of a person going on to develop depression. [1] 1. Huang CY, Sousa VD, et al (2007) Stressors, depressive symptoms, and learned resourcefulness among Taiwanese adults with diabetes mellitus *Research Theory Nursing Practice 21(2):83-97* Zausniewski JA, McDonald PE, et al (2002) Acceptance, cognitions and resourcefulness in women with diabetes *West.J. Nurs Res. 24 (7) : 728-43* Gregg JA, Callaghan GM et al (2007)	Thank you. Primary prevention is not the role of NICE's guideline programme.

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				Improving Diabetes self -management through acceptance, mindfulness and values: a randomized control trial *J. Consult. Clin. Psychol. Apr:75 (2): 336-43* Pouwer F, Snoek FJ, et al (2001) Monitoring of well-being in outpatients with diabetes: effects on mood , HbA (1c), and the patient's evaluation of the quality of diabetes care: a randomized control trial. *Diabetes Care Nov. 24 (11):1929-35* Trief PM, Himes CL et al (2001) The marital relationship and psychosocial adaptation and glycaemic control of individuals with diabetes *Diabetes Care Aug 24 (8):1384-9*	
SH	Diabetes UK	16	4.4.1	How will this guideline link to existing guidance surrounding talking therapies, primary prevention, and the stepped approach described in the original NICE Guideline on depression (CG23). At present this scope seems to suggest step 1 and part of step 2 will be omitted.	Primary prevention was not included in the original depression guideline and will not be included in either of the updates. Where appropriate, the guideline development group will consider how the evidence in the original depression guideline and the update of that guideline will relate to people with depression and chronic physical health problems.
SH	Dorset PCT			This organisation was approached but did not respond.	
SH	Ealing PCT			This organisation was approached but did not respond.	
SH	Ealing Primary Care Trust			This organisation was approached but did not respond.	
SH	East & North Herts PCT & West Herts PCT			This organisation was approached but did not respond.	
SH	Education for Health			This organisation was approached but did not respond.	
SH	Eli Lilly and Company Limited	1	3 f)	'Aches and pains' could be included in your list of examples of physical symptoms.	The physical symptoms listed are examples and are not intended to be exhaustive. We feel a sufficient number of examples have already been included for the purposes of the scope.

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SH	Eli Lilly and Company Limited	2	4.1.1 a)	Rheumatological disorders should also be included here.	This section contains examples of chronic physical health problems these are not intended to be exhaustive. Rheumatological disorders would fit within the limits of the scope.
SH	Eli Lilly and Company Limited	3	4.1.2	We are not sure what you mean by "comorbid physical health problems unexplained by physical pathology" – does this refer to IBS and fibromyalgia? One could argue that the description above is one of "the aches and pains of depression" and the potential for overlap with this and chronic physical health problems is one that we feel should be explored in detail in this NICE guidance. Clinicians should be given lucid guidance to confidently diagnose the aches and pains of depression within an MDD diagnosis, quite distinctly from depression in combination with comorbid physical health problems.	Thank you for your comment. We note your concerns which we will bring to the attention of the depression update guideline development group.
SH	Eli Lilly and Company Limited	4	4.3.1f)	It would be useful to include advice on appropriate switching between classes in addition to withdrawal/discontinuation.	Thank you; we feel this issue is included in 4.3.1d on sequencing of pharmacological interventions and will be considered by the guideline development group where evidence is available.
SH	Eli Lilly and Company Limited	5	4.3.2	The scope includes identification, recognition and assessment of depression (4.3.1a) and yet diagnosis will not be covered. There is significant overlap and it would be much clearer if diagnosis was included in this guideline.	Diagnosis is concerned more with defining what depression is which we consider outside the remit of the guideline. However, what is within the remit is identification and recognition which is concerned with detecting depression. Assessment refers to how clinicians assess a patient and covers issues such as review of physical health, social needs and environmental factors which may influence referral and treatment decisions. This is also within the remit of the guideline.
SH	Faculty of Occupational Medicine			This organisation was approached but did not respond.	

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SH	Faculty of Public Health			This organisation was approached but did not respond.	
SH	Food for the Brain Foundation			This organisation was approached but did not respond.	
SH	General Practice Airways Group			This organisation was approached but did not respond.	
SH	Gloucestershire Partnership NHS Foundation Trust			This organisation was approached but did not respond.	
SH	Hampshire Partnership NHS Trust	1	general	It would be helpful if the document highlighted the need to assess level of depression and to treat with all kinds of chronic illness and disability.	Thank you; we will raise this issue with the guideline development group when considering the clinical questions.
SH	Hampshire Partnership NHS Trust	2	general	I feel that this guideline should be focussed in intent to ensure that depression, as it exists alongside other health problem(s) / disabilities, is accepted and recognised. The issue is not merely one of recognition but of belief that depression in the presence of chronic ill health is a remediable condition.	Thank you; we hope the guideline will contribute to the acceptance and recognition of depression in people with chronic physical health conditions as an important problem. The guideline will make recommendations where appropriate for the treatment of depression for these populations.
SH	Hampshire Partnership NHS Trust	3	general	The guideline should not describe differing approaches for each chronic medical condition - such differences should be referred to in disease specific guidance – as with dementia. An appendix may clarify where such information sits	Thank you; we will raise this issue with the guideline development group when considering the clinical questions.
SH	Hampshire Partnership NHS Trust	4	general	It will be very challenging to gather data and thus make recommendation on this grossly under researched area. I am sure that the end product will reflect the need for high quality research.	Thank you for your comment.
SH	Hampshire Partnership NHS Trust	5	4.1	Those individuals having a diagnosis of 'other psychiatric' disorders are often more at risk from depression if they have a chronic health problem, and therefore the need to assess the level of depression is paramount.	Thank you; however we consider the treatment of other disorders to be outside the remit of the guideline. We would however expect clinicians to draw on their guidelines and other relevant NICE guidance when addressing the problem you identify – we will draw attention to this issue in the guideline.

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SH	Hampshire Partnership NHS Trust	6	4.1.1	Reference needs to be made to those with complex co-morbidities – such people are at higher risk of being diagnostically missed.	Thank you; we will raise this issue with the guideline development group when considering the clinical questions.
SH	Hampshire Partnership NHS Trust	7	4.3.1 h	Social exclusion due to age, gender and disability also	Social exclusion is discussed in 4.1.1b and we feel these groups would fall into this category.
SH	Hampshire Partnership NHS Trust	8	4.3.1.j	Can it read "the role of family and other social support…"?	Thank you; we have amended to take into account other social support.
SH	Hampshire Partnership NHS Trust - Focussed Implementation Site for DRE			This organisation was approached but did not respond.	
SH	Hampshire PCT			This organisation was approached but did not respond.	
SH	Health Commission Wales			This organisation was approached but did not respond.	
SH	Healthcare Commission			This organisation was approached but did not respond.	
SH	Hertfordshire Partnership NHS Trust			This organisation was approached but did not respond.	
SH	Hull PCT			This organisation was approached but did not respond.	
SH	Human Givens Institute			This organisation was approached but did not respond.	
SH	Infermed Ltd			This organisation was approached but did not respond.	
SH	Institute of Neurology	1	4.11	This is a very divergent group with probably different needs. Diabetes is a single condition, neurological disorders comprise a considerable percentage of all NHS referrals. Consideration should be given to looking at neurological disorders separately. Thus, the treatment of depression in epilepsy is quite different from the treatment of depression in Parkinson's Disease, as examples. One might recommend TMS, in the latter, but not in the former because of the potential to provoke seizures.	Thank you; we feel neurological disorders are an important sub-group of chronic physical health problems and therefore feel it should remain in the scope. We will raise the issue on different treatments needed for different neurological disorders with the guideline development group when considering clinical questions.
SH	Institute of Neurology	2	4.31a	Again, identification and recognition and assessment of depression in people with	Thank you; we will raise the issue of assessment for different neurological disorders

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				neurological disorders is confounded much more by the physical symptoms than for example heart disease. Again there are differences between epilepsy and movement disorders.	with the guideline development group when considering clinical questions.
SH	Institute of Neurology	3	4.31b	Limiting the physical interventions to just ECT and TMS may well prejudice patients with chronic neurological disorders from receiving potential treatments, particularly as this subject is not likely to be reviewed again by NICE for some considerable time. Vagus Nerve Stimulation and Deep Brain Stimulation should be included. Vagus Nerve Stimulation is widely used in the management of epilepsy, and has a place in the management of patients with intractable depression alongside intractable epilepsy.	Thank you – the interventions mentioned are given as examples. The final recommendations will depend on the quality of the available evidence.
SH	Kensington and Chelsea PCT			This organisation was approached but did not respond.	
SH	King's College London			This organisation was approached but did not respond.	
SH	Leeds Mental Health NHS Trust	1	4.1.1	Would be helpful include younger patients as problems and treatment approaches may be different in this group.	We feel the age range included in the scope is broad enough within the timescale of the guideline.
SH	Leeds Mental Health NHS Trust	2	4.3.1.a	Guideline will need to emphasise the distinction between a depression which needs treatment and low mood / distress which is likely to improve with information and support from the patient's own treating team or alleviation of physical symptoms. Many patients with chronic health problems have distress labelled as depression which improves with time, support or with alleviation of for example pain or functional disability.	We agree this is an issue therefore we have limited the guideline to people with a 'clinical working diagnosis of a depressive disorder'.
SH	Leeds Mental Health NHS Trust	3	4.3.1	Not just drugs and psychological approaches. Illness makes many people inactive and isolated.	Thank you; we will raise this with the guideline development group when developing the clinical questions.

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				Need much more emphasis on structured activity, mobility, occupation and getting back to work / study. Also more emphasis on social networks, social activities needed.	
SH	Leeds PCT			This organisation was approached but did not respond.	
SH	London Development Centre			This organisation was approached but did not respond.	
SH	Long-term Conditions Alliance			This organisation was approached but did not respond.	
SH	Lundbeck Ltd			This organisation was approached but did not respond.	
SH	Manchester Mental Health and Social Care NHS Trust			This organisation was approached but did not respond.	
SH	ME Association			This organisation was approached but did not respond.	
SH	Medicines and Healthcare Products Regulatory Agency (MHRA)			This organisation was approached but did not respond.	
SH	Mental Health Act Commission	1	2	Development of this guidance is of particular importance for long stay patients, who may develop chronic physical conditions whilst in hospital for their mental disorder. Our experience is that the physical health of this patient group is likely to be significantly worse than for the general population. See Mental Health Act Commission Eleventh Biennial Report 2003-2005 *In Place of Strangers,* paragraphs 4.87-4.91: 4.87 The physical health of seriously mentally disordered people is likely to be significantly worse than that of the general population, for a variety of factors, including: self-neglect;	We acknowledge this is an important issue, however physical health treatment is beyond the remit of this guideline.

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				poor income; exclusion and stigma; lack of exercise or poor diet; damaging behaviours such as heavy smoking, drinking, or illicit drug use; the health-risks associate with some types of psychotropic medication, the effects on the immune system of sustained stress or trauma; a reduced likelihood of seeking medical help for physical problems. Research has consistently found a high risk or premature death in people with mental illness from both natural and unnatural causes, with the mortality ratio in schizophrenia three times that for the general population for all causes, and high levels of morbidity of the circulatory, respiratory, digestive, endocrine and nervous systems. Our own data on deaths from natural causes is outlined at chapter 4.282 et seq. 4.88 Long-stay hospital patients may be particularly at risk of poor health, although such patients also provide a stable population for strategic health-promoting interventions. A study of patients at Rampton Hospital in November 2000 found high levels of obesity and smoking. Of the 250 patients studied (the 54% of the patient population that had consented to take part in the study), obesity levels in male patients (36%) were double that of	
SH	Mental Health Act Commission	2	2	the general male population, with	See comment #1

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				three-quarters of male patients at least registering as overweight to some degree. Three-quarters of the women patients registered as obese or severely obese (roughly 3 ½ times the average in the general UK women population), with a further 12% overweight. Eighty-two per cent of men and 71% of women smoked. The majority of patients had significantly increased their body weight since their admission to the hospital. The reasons for this are likely to be complex, but it is known that some psychotropic medication leads to weight-gain, although low-levels to be a factor. More than a third of the patients reported breathlessness after climbing one flight of stairs. The study led to a number of new initiatives at the hospital to address patients' physical heath, including the involvement of multi-disciplinary teams to review diet and activity levels; encourage and facilitate exercise and weight-loss; and reduce smoking. 4.89 It is a requirement of the National Service Framework for Mental Health that people with severe mental illness should have their physical needs addressed. Despite this, the *Running on Empty* report published in June 2005 highlighted 'an urgent need to ensure that a holistic, supportive, choice-driven, approach is widely adopted into the	

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				everyday provision of care [of people with severe mental illness] and delivered by all healthcare professionals. 4.90 Mentally disordered people in hospital settings should have access to physical health promotion services, including specifically targeted information and support on issues such as exercise; smoking; nutrition; housing; and safe sex. Where a patient has been admitted to hospital involuntarily, we believe that it is imperative that adequate means of healthy living (including diet, opportunity for exercise and fresh air, etc) are provided by the detaining authority. In many hospital wards this duty of care is not being met. It has been suggested that there is often a gap between mental health service users and their professional and lay carers about physical health needs. A study by the charity *Mentality* found that a commonly held view of professions was that mentally disordered persons 'have enough to worry about' whereas service users expressed a strong interest in and commitment to healthy living and achieving better physical health. Whilst we believe that more can be done to promote physical health (and to address physical health problems) amongst detained patients, it is important that	

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				health-promotion and interventions designed to address specific healthcare problems do not undermine detained patients' rights to make autonomous choices over their lifestyle where they have capacity to do so. Even patients who are to some extent incapacitated by their mental disorder should be engaged to the maximum extent in their care and treatment, so that coercion is used as a last resort for proportionate aims. Because the 1983 Act can be taken as authority to provide psychiatric 'nursing care, habilitation and rehabilitation' without a patient's consent, there is a potential for health promotion to involve further and unjustified infringements of detained patients' residual liberties. It would seem both ethically and practically more appropriate that patients be empowered through dietary and lifestyle advice rather than coerced under the cloak of treat- ment for mental disorder. We discuss this in more detail in relation to smoking at paragraph 4.92 below. The practice example given at figure 4.66 below shows how patients may be empowered through health promotion and how this can have positive effects on individual care and treatment and the milieu of psychiatric units. It is essential to ensure this group has access to good physical healthcare and	

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				health promotion in order to minimise the development of, and effectively treat, chronic health problems. NICE guidance should therefore cover the assessment and availability of treatment for chronic health conditions in people diagnosed with depression, as well as the treatment of depression in people with chronic health problems.	
SH	Mental Health Act Commission	3	4.1.1	Consideration should also be given to obesity, which is a contributory factor to many other chronic health conditions, and can reach high levels amongst long stay patients in mental health services (see Mental Health Act Commission Eleventh Biennial Report 2003-2005 *In Place of Strangers* paragraph 4.88 above).	Thank you; we feel this is beyond the remit of the guideline.
SH	Mental Health Act Commission	4	4.3.1	The guidance should also cover assessment of the physical healthcare needs of patients with depression (please see comments on section 2 above.)	Thank you; we will raise this issue with the guideline development group when considering the clinical questions.
SH	Mental Health Act Commission	5	4.3.1	Whilst we understand guidance will not cover prevention of depression, we recommend it should cover health promotion and prevention of chronic healthcare problems in people diagnosed with depression. This is an important issue for long stay patients in mental health services, where smoking and obesity are of greater prevalence than in general population (see Mental Health Act Commission Eleventh Biennial Report 2003-2005 *In Place of Strangers* paragraphs 4.87-4.91 above.)	Thank you. Primary prevention is outside the scope of the NICE guideline programme.
SH	Mental Health Act Commission	6	4.3.1 i)	The section on ensuring people have the information they need to enable them to	Thank you; we will raise this issue with the guideline development group when considering

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				make informed choices should explicitly include patients who are subject to compulsion under the Mental Health Act. The guidance will need to acknowledge the different context of consent regarding treatment for mental disorder for this group, but it is important that they are not excluded from guidance on the promotion of choice and autonomy.	the clinical questions.
SH	Mental Health Foundation			This organisation was approached but did not respond.	
SH	Mental Health Nurses Association			This organisation was approached but did not respond.	
SH	Milton Keynes PCT			This organisation was approached but did not respond.	
SH	MIND			This organisation was approached but did not respond.	
SH	National Childbirth Trust			This organisation was approached but did not respond.	
SH	National Institute for Mental Health in England			This organisation was approached but did not respond.	
SH	National Patient Safety Agency			This organisation was approached but did not respond.	
SH	National Phobics Society			This organisation was approached but did not respond.	
SH	National Public Health Service - Wales			This organisation was approached but did not respond.	
SH	NCCHTA			This organisation was approached but did not respond.	
SH	Newcastle PCT			This organisation was approached but did not respond.	
SH	NHS Direct			This organisation was approached but did not respond.	
SH	NHS Plus			This organisation was approached but did not respond.	
SH	NHS Purchasing & Supply Agency			This organisation was approached but did not respond.	
SH	NHS Quality Improvement			This organisation was approached but did	

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	Scotland			not respond.	
SH	North Lincolnshire PCT			This organisation was approached but did not respond.	
SH	North Staffordshire Combined Healthcare NHS Trust			This organisation was approached but did not respond.	
SH	North Tees PCT			This organisation was approached but did not respond.	
SH	North Yorkshire and York PCT			This organisation was approached but did not respond.	
SH	Nottinghamshire Healthcare NHS Trust	1	general	Does its scope cover people with a learning disability. It kind of hints this but is not explicit.	Thank you for your comment, we have amended the scope to take account the needs of individuals with learning difficulties.
SH	Nottinghamshire Healthcare NHS Trust	2	general	Guideline to include people with a learning disability but no evidence that the document is going to address their specific needs and presentations of depressive illness.	Thank you for your comment, we have amended the scope to take account the needs of individuals with learning difficulties.
SH	Organon Laboratories Ltd			This organisation was approached but did not respond.	
SH	Oxfordshire & Buckinghamshire Mental Health Partnership NHS Trust			This organisation was approached but did not respond.	
SH	Oxleas NHS Foundation Trust			This organisation was approached but did not respond.	
SH	Partnerships for Children, Families, Women and Maternity			This organisation was approached but did not respond.	
SH	Pelvic Pain Support Network	1	3c	I was surprised to see that there was no mention of the link between chronic pain and depression. There is a significant of amount of research and data on this. Depression is a result of chronic pain rather than a cause. It may be pain that is the most important factor in many chronic conditions such as cancer, endometriosis, arthritis etc and I do not see how such a guideline can be produced without recognition of this.	Thank you for this comment – we do not think that the guideline should focus on chronic pain per se and feel that the matter of chronic pain or pain management more generally could be dealt with by a separate piece of NICE guidance – we will draw this to the attention of NICE.

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SH	PERIGON Healthcare Ltd			This organisation was approached but did not respond.	
SH	Pfizer Ltd			This organisation was approached but did not respond.	
SH	PNI ORG UK			This organisation was approached but did not respond.	
SH	Primary Care Mental Health Collaborative			This organisation was approached but did not respond.	
SH	Primary Care Neurology Society	1	4.1.2	The exclusion of dementia is a serious omission. Many would see it as a worthy neurological/physical condition or will NICE say that it is covered in the dementia guideline?	Thank you; we feel the treatment of depression in people with dementia has been assessed in sufficient detail in the dementia guideline.
SH	Primary Care Neurology Society	2	4.2	The importance of lay carers needs to be included as well as families.	Thank you; we have now included carers in the scope
SH	Primary Care Neurology Society	3	General	Please provide rationale for why feedback/suggestions are not incorporated into the scope and also the draft guideline when put out for consultation	Responses to all comments made by registered stakeholders during the consultation period will appear on the NICE website.
SH	Primary Care Neurology Society	4	General	Depression in neurological conditions raises complex issues. Given a specific NSF was developed for Neurological conditions this raises the question as to whether depression in neurological conditions warrants an additional guideline.	Thank you; although we accept that neurological disorders is a broad and complex category we feel that such disorders are chronic physical health problems and therefore should be included in the scope.
SH	Primary Care Pharmacists Association			This organisation was approached but did not respond.	
SH	PRIMIS+			This organisation was approached but did not respond.	
SH	Prince's Foundation for Integrated Health			This organisation was approached but did not respond.	
SH	Public Health Group North East			This organisation was approached but did not respond.	
SH	RCM Consultant Midwives Group			This organisation was approached but did not respond.	
SH	Relatives & Residents Association			This organisation was approached but did not respond.	
SH	Rethink - Accommodation			This organisation was approached but did	

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	Plus			not respond.	
SH	Robert Jones & Agnes Hunt Orthopaedic & District Hospital NHS Trust			This organisation was approached but did not respond.	
SH	Royal College of General Practitioners			This organisation was approached but did not respond.	
SH	Royal College of Midwives	1	General	The antenatal and postnatal mental health clinical guideline does not address pre-conceptual management of psychiatric conditions. The scope of this guideline includes adults (18 years and older) with a clinical working diagnosis of a depressive disorder and a chronic physical health problem with associated impact on function. This would include, for example, cancer, heart disease, neurological disorders and diabetes. The UK Confidential Enquiry into Maternal Deaths (CEMD) reports that psychiatric disorders contributed to 12% of all maternal deaths (10% of which were due to suicide). It would be helpful to raise awareness within the guideline of the importance of the healthcare professional discussing the risks associated with treating and not treating mental disorders during pregnancy; and of lower threshold for non-drug treatments and the cautious prescribing of drugs for women who are planning a pregnancy, are pregnant or who are breastfeeding in line with NICE antenatal and postnatal mental health within the guideline.	Thank you. The guideline will refer clinicians to the antenatal and postnatal mental health guideline, the original depression guideline and the depression update where these issues are dealt with.
SH	Royal College of Nursing	1	4.3.1 b	Cognitive behaviour therapy to include behavioural activation, ACT as well as cognitive therapy should be considered as	Thank you; we will raise this issue with the guideline development group when considering the clinical questions.

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				part of the review.	
SH	Royal College of Nursing	2	4.3.1 c	Consider role of ‘mindfulness’ therapy	Thank you; we will raise this issue with the guideline development group when considering the clinical questions.
SH	Royal College of Pathologists			This organisation was approached but did not respond.	
SH	Royal College of Physicians of London	1	General	Whilst we note that depression due to substance misuse is to be excluded, the coincidence of chronic alcoholism and depression is a major clinical problem that merits consideration.	Thank you; but we feel this would best be addressed in a guideline specifically focusing on the treatment of alcohol misuse.
SH	Royal College of Physicians of London	2	General	We wish to raise the importance of the interaction of Rx for co-morbidity on mental health and depression in particular. It is important to raise the need for a depression assessment before/during Rx with e.g. Rimonabant and Sibutramine for obesity.	Thank you; we will raise this with the guideline development group when developing the clinical questions.
SH	Royal College of Physicians of London	3	General	The Royal College of Physicians has already responded to this consultation but since doing so has had sight of the ABN comments, which we wish to further endorse.	Thank you.
SH	Royal College of Psychiatrists	3	4.31	It would be useful to know about evidence for treatment of depression in the presence of not only 1 but 2 or more physical co-morbidities.	Thank you; we will raise this with the guideline development group when developing the clinical questions.
SH	Royal College of Psychiatrists	4	4.31	In terms of outcome we need to know about the impact of interventions on a)depression outcomes and b) physical health care outcomes.	Thank you both of these outcomes will be assessed where available.
SH	Royal College of Speech and Language Therapists	1	4.1.1. Groups covered	Does the population to be analysed include people with learning disabilities? This group may have a depressive disorder and a chronic physical health problem but their care pathway may be quite different to the rest of the population. This might be	Thank you for your comment, we have amended the scope to take account the needs of individuals with learning difficulties.

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				particularly significant for those people in forensic learning disability services	
SH	Royal Society of Medicine			This organisation was approached but did not respond.	
SH	SACAR			This organisation was approached but did not respond.	
SH	Salisbury NHS Foundation Trust			This organisation was approached but did not respond.	
SH	Sandwell & West Birmingham Hospitals NHS Trust			This organisation was approached but did not respond.	
SH	Sanofi-Aventis			This organisation was approached but did not respond.	
SH	Schering-Plough Ltd			This organisation was approached but did not respond.	
SH	Scottish Intercollegiate Guidelines Network (SIGN)			This organisation was approached but did not respond.	
SH	Sefton PCT			This organisation was approached but did not respond.	
SH	Servier Laboratories	1	4.3.1.d	It would add to the scope if the nature of the side effects were more closely specified. We suggest the wording of this section is amended to read: The assessment and management of the known side effects *(e.g. CV side-effects, weight gain, agitation or sedation, sexual dysfunction)* and other dis-benefits of psychotropic medication and psychological interventions, ...	Thank you; we feel there is sufficient detail in the scope. However we will raise this issue with the guideline development group when considering the clinical questions.
SH	Servier Laboratories	2	4.3.1	This section could make specific reference the issue of the preserving of a patient's daytime alertness whilst restoring normal sleep patterns with psychotropic medications, as this is potentially a major differentiating factor between medications and has a very significant implication for patient quality of life.	Thank you; we will raise this with the guideline development group when developing the clinical questions.

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				There is a very significant quantity of evidence published that suggests that sleep symptoms should be of particular focus of the inquiries of the GDG. For example, Ohayon (2003) detail the commonplace nature of sleep symptoms. While detailing the epidemiology of sleep symptoms in patients with psychiatric disorders, Ford (1989) also points to the increased service use of patients with sleep symptoms and Wilson (2005), Fava (2006) and Lam (2006) outline the effects of different classes and individual pharmacological treatments on these symptoms and the implication for management. Zammitt (1999) demonstrates the impact of these symptoms on patient quality of life and describes a 'direct relationship between sleep disorders and depression'. In the light of this evidence, we would like to encourage the more detailed specification of the Scope to direct the GDG to investigate the issue of sleep disorders and major depression. ***References*** Fava, M. Pharmacological approaches to treatment of residual symptoms *Journal of Psycopharmacology* 2006 (20) 3 pp29-34 Ford *et al* Epidemiologic study of sleep disturbances and psychiatric disorders An opportunity for prevention? *Journal of the American Medical Association* 1989 (262) pp 1479-84. Lam, R.W. Sleep disturbances and	

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				depression: A challenge for antidepressants. *International Journal of Clinical Psychopharmacology* 2006 21 (S1) pp S21-S29 Ohayon ,M., T. Roth., Place of chronic insomnia in the course of depressive and anxiety disorders *Journal of Psychiatric Research*, 2003, 37, pp 9-15 Wilson, S., S. Argyropoulos. Antidepressants and Sleep. A qualitative review of the evidence. *Drugs* 2006. 65 (7) pp 927-47 Zammitt *et al* Quality of life in people with insomnia. *Sleep.* 1999 (22) Supp 2, pp s379-85	
SH	Sheffield PCT			This organisation was approached but did not respond.	
SH	Sheffield Teaching Hospitals NHS Foundation Trust	2	General	We suggest that it consider the role of participation in social activities and vocational opportunities in managing depression	Thank you; we will raise this issue with the guideline development group when considering the clinical questions.
SH	Sheffield Teaching Hospitals NHS Foundation Trust	3	General	We suggest that it considers the impact that chronic depression can have on support or care workers working with the consequences of the double impact of depression and chronic health problem on a daily basis. What support or training is available for those support or care workers within a stepped care model?	Thank you; although this is an important issue we feel it's beyond the remit of the guideline.
SH	Social Care Institute for Excellence (SCIE)	1	4.3.1 (a)	The social determinants of depression should be included in the assessment of depression. These determinants include : housing status (eg homelessness); immigration status (eg asylum seeker); discrimination on grounds of race ,gender, sexual orientation, other factors;	Thank you; unfortunately we feel this is beyond the remit of the guideline.

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				employment status eg employed but on sick leave; strength of informal support networks from family /friends; effects of major life events (eg bereavement of close family member); financial issues eg extreme debt ; and parenthood may be a stressor. The work of Brown and Harris on women and depression should be referred to.	
SH	Social Care Institute for Excellence (SCIE)	2	4.3.1 (h)	Relating to "the varying approaches of different races and cultures" , should refer to : the work of Littlewood and Lipsedge; the work of the Delivering Race Equality on cultural competency of the mental health workforce and other issues; and SCIE Knowledge Review entitled "Mtetezi: Developing Mental Health Advocacy with African and Caribbean Men'. Relating to "issues of internal and external social exclusion" should refer to the work of the National Social Inclusion programme (led by David Morris) on employment, benefits, housing, effects of stigmatisation and other social forces which have a bearing on mental state of the individual. The work on Recovery is also worth referring to. The joint position paper :' A common purpose: Recovery in future mental health services' (collaboration between the Care Services Improvement Partnership (CSIP), Royal College of Psychiatrists (RCPsych) and Social Care Institute for Excellence (SCIE))could serve as a useful starting point. It is intended to make a positive and supportive contribution to the development of ideas, planning, service development and practice based on contemporary concepts of recovery.	Thank you; we will consider this literature with the guideline development group when developing the guideline.

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SH	Social Care Institute for Excellence (SCIE)	3	4.3.1 (j)	Relating to the "role of the family in the treatment and support of people with depression" . It is useful to refer to work done on informal networks of support including the family in building resilience.	Thank you; we will raise this issue with the guideline development group when considering the clinical questions.
SH	Social Care Institute for Excellence (SCIE)	4	General	The guide should refer to work on social models of depression. Brown and Harris provide a reference point with their work on Life Events(1979.1985). This needs a fuller scope to include their more recent and the work of others in this area.	Thank you; we feel this is beyond the remit of the guideline.
SH	Social Care Institute for Excellence (SCIE)	5	4.3.1 (a)	Factor in TUC work on stress at work as a causative factor in depression/ Useful reference: Maria Melchior and others. Work stress precipitates depression and anxiety in young, working women and men, Psychological Medicine, volume 37, issue 8, pages 1119-1129, 2007.	Causative factors in depression are beyond the remit of this guideline.
SH	Social Care Institute for Excellence (SCIE)	6	General	All of the above comments apply to Depression Update: Primary and Secondary Care. Suggest that the updating of the 2 guidelines is combined.	Thank you we agree there is much overlap between the depression update and this present guideline and where appropriate the guideline development groups of both guidelines will consult and collaborate with one another during the development of both guidelines.
SH	Society of Occupational Medicine			This organisation was approached but did not respond.	
SH	Somerset Local Medical Committee			This organisation was approached but did not respond.	
SH	South Central Ambulance Service NHS Trust			This organisation was approached but did not respond.	
SH	South Essex Partnership NHS Foundation Trust			This organisation was approached but did not respond.	
SH	South London and Maudsley NHS Foundation Trust			This organisation was approached but did not respond.	
SH	South Tyneside NHS PCT			This organisation was approached but did not respond.	
SH	South West London and St Georges Mental Health NHS			This organisation was approached but did not respond.	

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	Trust				
SH	South Weston Childrens Centre			This organisation was approached but did not respond.	
SH	Southampton City Council			This organisation was approached but did not respond.	
SH	Tavistock & Portman NHS Foundation Trust	1	2a & (4a also relevant)	The scope refers to 'best available evidence of clinical and cost effectiveness' and the guidelines manual refers to the GDG construction of evidence selection criteria: we are concerned that these criteria may exclude relevant evidence. For example, 4.1.1 refers to 'a clinical diagnosis of major depressive order…' while 4.1.2 refers to the exclusion of sufferers with 'other primary psychiatric disorders'. Are these diagnostic stipulations going to preclude any real consideration of the implications of the co-morbidity and complexity which is very commonly encountered in depressive disorders in clinical practice? As you know the evidence supporting cbt and pharmacotherapy for these populations is weak. Unless this is acknowledged the findings of research studies that are employing clinically unrealistic patient samples exert an undue influence on the guideline's recommendations. Additionally the rigid application of evidence grading system excludes findings from naturalistic effectiveness studies. When evidence relating to studies of mixed, co-morbid disorders is excluded the credibility and equipoise of the guideline suffers. We would urge that the evidence selection enables the inclusion of evidence such as, Leichsenring et al, *The efficacy of short*	Thank you for your comment, although we acknowledge the importance of psychiatric combordities within this population unfortunately this is beyond the remit of the guideline. NICE procedures on evaluating evidence is documented on its website (www.nice.org.uk). RCTs or systematic reviews of RCTs are considered the most rigorous study designs for assessing interventions. However, where RCTs are not available other studies designs are evaluated.

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				term psychodynamic psychotherapy in specific psychiatric disorders, Arch. Gen. Psych. 61, pp1208-1216; Abbass et al, *Short term psychodynamic psychotherapies for common mental disorders,* Cochran Library 2007, issue 1 & Leichsenring et al, *Comparative effects of short term psychodynamic psychotherapy and cognitive-behavioural therapy in depression: a meta-analytic approach.*	Thank you; we will pass on these references for the guideline development group to consider during the development of the guideline.
SH	Tavistock & Portman NHS Foundation Trust	2	2c	Refers to the requirement that service-user' preferences are taken into account: surveys of patient preferences, and feedback from user's organisations, repeatedly indicate a wish for talking therapies. In official documents it has become common practice to qualify to restrict this expression of patient preference to 'evidence based psychological therapies'. This is a distortion of patients' preferences, the reality being that a proportion of patients want dynamic approaches and a proportion wants cognitive ones – quite properly. This is especially pernicious when the evidence base in depression is generally weak and when there is in fact evidence for psychodynamic approaches which has previously been excluded from consideration. Again, it's a matter of equipoise.	Thank you; we will raise this issue with the guideline development group when considering the clinical questions.
SH	Tavistock & Portman NHS Foundation Trust	3	3c	This paragraph gives some of the facts about the frequency of recurrence and chronicity in depression: while there is evidence about the use of CBT and medication in relapse reduction there are few studies examining long term effects in chronic or so called treatment resistant depression. Indeed most RCT's examine short courses of treatment with inadequate	Thank you; we will raise this issue with the guideline development group when developing the guideline.

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				follow-ups and thus offer little useful information to guide recommendations. The GDG needs to be encouraged to exercise clinical realism; only in this way will the guideline earn the respect of knowledgeable clinicians and make a contribution to the improvement of services.	
SH	Tavistock & Portman NHS Foundation Trust	4	4.3.1	Refers to the assessment and classification of depression emphasising the severity, duration and disability associated with the episode: we were concerned that if a narrow approach to taxonomy were adopted (as in the first version) the importance of developmental and ongoing psychosocial factors in the genesis and maintenance of depression would be minimised. This is important from the patient's point of view since in many instances patients know they are depressed about events in their life – past or current. [Of course there are others where this connection does not obtain]. The recommendations of NICE guidelines in the mental health field do need to be able to reflect the impact of psychosocial and developmental factors upon the treatment of the disorder. The Depression in Childhood g/line offers a better way forward with respect to the inclusion of these factors. Similar comments apply to the exclusion of primary prevention in 43.2 One understands that the guideline revision has to be a manageable process but this should not be a pretext for the exclusion of knowledge of the psychosocial matrix out of which much depression arises and which many treatment endeavours have to grapple with.	Thank you; we will raise this issue with the guideline development group when considering the clinical questions. Thank you. Primary prevention is not the role of NICE's guideline programme.
SH	Tavistock & Portman NHS Foundation Trust	5	4.3.1c	Refers to the use of interventions to reduce the risk of relapse after an acute depressive	Thank you; however these issues relate to prevention which is beyond the remit of the

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				episode: should include reference to treatments aiming to increase resilience, or reduce susceptibility to the development of depressive symptoms. Some evidence for these is available from a variety of studies.	guideline.
SH	Tavistock & Portman NHS Foundation Trust	6	4.3.1j	Refers to the consideration of different methods of service organisation: obviously an important issue for PCT's and for service providers when services re-design is so high on the agenda. We are concerned that the guideline should not appear to rubberstamp the latest fad or panacea; the evidence available in relation to new patterns of service delivery is highly context dependant and any attempt to draw general conclusions fraught. We trust the revision will respect the current uncertainties of evidence in this area.	Thank you; we will raise this issue with the guideline development group when developing the guideline.
SH	Tavistock & Portman NHS Foundation Trust	7	4.3.1l	Refers to the GDG taking 'reasonable steps to identify ineffective interventions and approaches to care': again an important issue in a time of service redesign. We would underline that the absence of research studies carries no implication that the therapies concerned are ineffective. Instead, the absence of RCT research findings studies in respect of depression, and its co-morbidities reflects the enormous practical difficulties of carrying out RCT's whose duration may need to be anywhere between 3-5 years. It equally indicates the inappropriateness of aristocratic methods of evaluating efficacy when they applied to real world mental health problems. We would wish the GDG to take a more critical attitude to the current methods of guidelines of the mental health field; for instance it is generally accepted that at the epidemiological level it is very difficult to	Thank you; we will raise this issue with the guideline development group when developing the guideline. We agree that the absence of research studies does not necessarily imply ineffectiveness. The guideline development group will only make recommendations against using an intervention if there is evidence of ineffectiveness or where harms clearly outweigh benefits.

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				sustain a hard and fast distinction amongst the common mental health conditions (Goldberg & Goodyear 2006) and that co-morbidity is the rule rather than the exception. However, evidence criteria continue to specifically exclude co-morbidity and any methods of evidenced gathering which take this in to account. We are concerned lest the guideline suggest that certain treatments are ineffective on the basis its reliance upon flawed evidence selection filters.	
SH	Tees, Esk,and Wear Valley NHS Trust	1	4.3.1 b)	The treatment of depression using psychological therapy: It would be helpful if the guideline considered in more depth the interventions that make up Cognitive Behavioural Therapy (CBT). Rather than using such a broad overarching term more detail would help in which specific CBT interventions are advised. Note is made of the recent meta analysis of Behavioural Therapy indicating its equivalence to full CBT. **Cuijpers, P,. van Straten, A. & Warmerdam, L**. (2007) Behavioural activation treatments of depression: A meta analysis. *Clinical Psychology Review*. 27 (3). 318-326. **Ekers, D. Rihards, D. And Gilbody, S.** (2007) A Meta Analysis of Behavioural Therapy for Depression. *Psychological Medicine*. In Press. Such a breakdown would be of assistance in workforce development.	Thank you; we will raise this issue with the guideline development group when considering the clinical questions.
SH	Tees, Esk,and Wear Valley NHS Trust	2	4.3.1 k)	It is pleasing to see case management and collaborative care included. Can this be highlighted in this guidance with more	Thank you; we will raise this issue with the guideline development group when considering the clinical questions.

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				gravitas. Our concern is that if viewed as a 'mode of delivery' rather than an 'intervention' this will detract from the focus placed upon it as a service development priority post guideline publication. We would welcome a review of the evidence and a clear statement regarding the benefit (or not) of such approaches. It may aide such clarity if they are considered as a defined intervention for depression with associated evidence.	
SH	Terrence Higgins Trust			This organisation was approached but did not respond.	
SH	The Afiya Trust			This organisation was approached but did not respond.	
SH	The British Dietetic Association			This organisation was approached but did not respond.	
SH	The British Pain Society	1	4.1	Chronic pain is highly prevalent in modern British society. Between 30 and 60% of people presenting to a chronic pain clinic have clinical symptoms of depression, and over 50% score above 8 on the Hospital Anxiety and Depression scale. Depression in patients with chronic pain is associated with greater pain intensity, more pain persistence, less life control, more use of passive-avoidant coping strategies, non-compliance with treatment and application for early retirement. In patients with chronic pain, depression is a better predictor of disability than pain intensity or duration. Sickness absence rates and closure of insurance claims are adversely affected by the presence of depression. Rates of suicidal ideation, attempts and completion are increased when depression is associated with chronic pain.	Thank you for this comment – we do not think that the guideline should focus on chronic pain per se and feel that the matter of chronic pain or pain management more generally could be dealt with by a separate piece of NICE guidance – we will draw this to the attention of NICE.

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				CLARK, M. R., & TREISMAN, G. J. Perspectives on pain and depression. In CLARK, M. R., & TREISMAN, G. J. (2006). Pain and depression: an interdisciplinary patient-centered approach. Advances in psychosomatic medicine, v. 25. p 1-28. Basel, Karger.	
SH	The British Pain Society	2	4.1.1.a	Pain is often a significant symptom in patients with cancer, neurological disorders and diabetes and contributes to a depressive disorder. The British Pain Society believes that chronic pain (pain persisting beyond the expected time of healing, or longer than 3 months) should be included as a chronic physical health problem.	Thank you; pain as a symptom of chronic physical health problems such as cancer, neurological disorders etc. is not excluded by the scope. Please see above comment.
SH	The British Pain Society	3	4.1.2.b	Physical pathology is known to exist in many chronic painful conditions e.g. Osteoarthritis, Degenerative spinal disease. Many neuropathic pain syndromes are associated with physical pathology e.g. Chronic Regional Pain Syndrome Type I. Recent research has shown the genetic and phenotypic basis of a number of neuropathic syndromes e.g. NAv 1.7 sodium channel in Erythromelalgia. Whilst the heterogenicity of causes of chronic pain is understandable, it is likely that more defined diseases such as multiple sclerosis will in time be shown to be heterogenic. It does not seem unreasonable to include chronic pain as a diagnostic label for a chronic physical health problem. The British Pain Society is unclear as to the exact meaning of "physical pathology", which would appear to exclude chronic pain	See previous comment.

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				as a chronic physical health problem.	
SH	The British Psychological Society	1	General	We very much agree that depression in the context of chronic physical health problems poses unique challenges which require additional, specific attention in clinical guidelines development, and very much welcome this NICE initiative. We particularly welcome the explicit inclusion all tiers of healthcare services (including specialist medical services, e.g. for end-stage renal failure) in the scope of this review. We are generally pleased to see that there is an interest in this issue (depression and chronic physical illness), particularly the recognition of the link between physical and mental illness, and the urgent need to help those affected by both physical and mental health problems. Depression and other mental health problems are indeed commonly associated with (chronic) physical illness and awareness needs to be raised among both health professionals and the public about this particular issue, and how it could be addressed. For some reason this area has been neglected for a long time. We agree that the content of the document is very reasonable, and covers the most important areas relevant to the raised issue.	Thank you for your comment.
SH	The British Psychological Society	2	General	We would suggest that specific recommendations be made for the training of all relevant staff groups and teams in the screening and management of psychological distress in this population.	Thank you; we will raise this issue with the guideline development group when considering the clinical questions.
SH	The British Psychological Society	3	General	No mention is made of the identification and management of depression in cases where	Thank you; while this is an important issue unfortunately it is beyond the remit of this

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				there may be end-of-life issues, for example the assessment and management of depression in patients with end-stage cancer, renal or heart failure and making decisions about stopping (or not starting) treatment. The NICE Supportive and Palliative Care Manual refers to depression, and we suggest there is an explicit consideration of the links.	guideline.
SH	The British Psychological Society	4	3.c	We think that it may be useful to briefly explain why depression may be more prevalent in people with chronic physical problems than in the general population (giving biological and psychosocial explanations). References to literature would be also helpful here. We also think that it is important to stress that the relationship between physical and mental health can be very complex. In some cases chronic physical illness can lead to depression but it can be also vice versa, and that physical and mental states mutually influence each other (e.g. feeling depressed may worsen the chronic illness by e.g. amplifying its symptoms, duration or recovery from it, which can further worsen the depression). The area of psychoneuroimmunology is relevant here, and much research has been conducted in this area to suggest that negative thinking affects physical health, and may lead to chronic illness incl. CHD, cancer etc.. It's obvious how Health Psychology could be relevant here. Chronic illness could be better defined in this document and perhaps more examples of chronic physical conditions could be given including irritable bowel syndrome,	Thank you; we feel this complex issue should be dealt with in more detail in the full guideline where references to the literature will be provided.

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				chronic pain etc.	
SH	The British Psychological Society	5	3.e	To the sentence "People with depression are less likely to adhere to physical health treatment" should also be added "as well as adapt to and self-manage their condition effectively*".*	Thank you; we have added this to the scope.
SH	The British Psychological Society	6	3.f	It is important to add that somatic symptoms are not adequate to diagnose depression, and certainly more likely to be confounded by illness than its cognitive and emotional components (e.g. negative thinking, hopelessness, worthlessness etc).	This is not meant to be a full discussion of the diagnostic criteria for depression but is simply introducing the difficulties associated with diagnosing depression for people with chronic physical health problems. This will be dealt with in more detail in the full guideline where such issues can be discussed more fully.
SH	The British Psychological Society	7	4.1.1.a	The definition of adults typically includes those 16 years and older not in full-time education. This scope document's definition only covers those 18 years and older, therefore leaving out this age segment. Given the significant adjustment issues that many people with childhood-onset chronic health problems (e.g. diabetes, epilepsy or cystic fibrosis) have, and which are typically dealt with by adult health services, often under the added complication of unclear transition arrangements from paediatric services, we strongly recommend that the 16-18 years age segment be specifically included in this consultation, with a particular section devoted to their needs.	We feel the 16-18 years age group would represent significantly different challenges (as you suggest at the end of your comment). The evidence base for children and adolescents is different, it is not possible to extrapolate from adults and it may be best dealt with by a group with more expertise. Therefore we feel that the chronic physical health problems of children and adolescents should be dealt with separately.
SH	The British Psychological Society	8	4.1.1.a	..and *one or more* chronic physical health problems.	Yes, such populations would be included in the guideline.
SH	The British Psychological Society	9	4.1.2	Chronic physical or mental health problems usually co-exist along other physical/mental health problems and cannot be easily separated (e.g. people who are depressed are more likely to abuse substances or even suffer from a psychotic illness). One needs to be careful about the group inclusion	Thank you; while we agree this is an important issue we feel this is beyond the remit of the guideline.

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				criteria.	
SH	The British Psychological Society	10	4.1.2.b	This exclusion appears to assume that people have *either* explained *or* unexplained physical symptoms. In practice this division is often uncertain and untenable, with people presenting with complex combinations of symptoms, variously explained by medical variables and varying over time. We would argue that these guidelines present a good opportunity to make explicit reference and recommendations for best clinical practice in such cases, and should avoid implicitly supporting dualistic and potentially stigmatising assumptions (explained vs. unexplained symptoms).	Thank you; we agree this is a complex issue in practice and we will forward your comments to the guideline development group to consider during the development of the guideline.
SH	The British Psychological Society	11	4.1.2c	This may need clarifying. We can assume it means depression resulting (as a side effect of) medication. However, depressive disorders will often occur as a result of medical treatment (e.g. depression in patients on dialysis) not as a 'side-effect' but due to the challenge it poses to the person's coping resources. The wording needs to clarify whether this is included.	Depression as a result of the challenges to a person's coping resources of medical treatment would not be outside the scope.
SH	The British Psychological Society	12	4.2.a	We strongly support the guidelines considering these issues across all three tiers of care, explicitly involving specialist medical services in the identification and treatment of depression and not limiting the consideration to primary care alone.	Thank you for your comment.
SH	The British Psychological Society	13	4.3.1.h	We suggest this be rephrased as "The various social, cultural and religious belief systems that influence how the person with a chronic physical health problem experiences and expresses low mood, how this person asks for help, and the types of help they would find acceptable. This will	Issues of socio-cultural diversity and social exclusion are discussed in 4.1.1b and we feel there is sufficient detail there for the scope. However, these issues will be examined in much more detail in the full guideline.

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				include issues of social exclusion and take into account power imbalances that can make accessing appropriate help & support more challenging."	
SH	The British Psychological Society	14	4.3.1.j	We suggest that an important component of clinical management that should be covered, alongside family support, is the support of patient groups and organisations and expert patient programs. These often have a key part in the overall clinical plan for maintaining positive mood through ongoing social support. In addition, we would suggest that assessment includes any young children for whom the person with a long-term health condition and depression has parental responsibility. The effects on children are significant and well-documented, and there would be significant long-term benefits if these could be identified and addressed appropriately, alongside the needs of the parent.	Thank you; we will raise this issue with the guideline development group when developing the guideline. Although we acknowledge this is an important issue it is unfortunately beyond the remit of the guideline.
SH	The British Psychological Society	15	4.3.1 k	Addressing issues regarding service delivery, models of care, case management and collaborative care. This area of the document is very important. Research suggests that there is a need for a better collaboration between primary and secondary services, and between general health professionals and those who provide mental health services. The views of these professionals as well as the patients' views need to be taken into consideration when forming decisions here. We generally think that health professionals need to be better trained to appreciate how mental and physical health/illness mutually influence each other.	Thank you; we will raise this issue with the guideline development group when developing the guideline.

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				Evidence based and cost-effective interventions need to be identified to address the issue of treating depression in those with chronic physical illness. What will matter the most will be the formation of a clear and well structured protocol that should outline how exactly the issue will be addressed and by whom. This protocol should be relevant to all professionals, regardless whether they work in the area of physical or mental health. From research, experience, and the reading literature, we understand that many health professionals are often puzzled about the scope of their responsibility to deal with a certain issue that may not fully appear to be relevant to their work. Thus health professionals will need to become clear about their clinical roles and responsibilities. The problem here is that health professionals are usually trained/highly specialised in either physical or mental health care, and anything different is considered as irrelevant or not their responsibility. This is wrong. Generally, the biggest challenge will be to help health professionals to adopt a holistic approach to the care of their clients with mixed problems, and adequately support them to do so (e.g. by providing them with sound training and support).	
SH	The British Psychological Society	16	4.3.2.a	It is unclear what this exclusion means, given that 3.f states that “identification and recognition of depression in people with chronic physical health problems can be challenging” and 4.3.1.a specifically includes “identification, recognition and assessment of depression in patients with	Diagnosis is concerned more with defining what depression is which we consider outside the remit of the guideline. However, what is within the remit is identification and recognition which is concerned with detecting depression.

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				chronic physical health problems" as a topic to be covered. In fact, we would very much encourage the guidelines to cover issues of diagnosis, which can be complex – for instance, self-administered depress on questionnaires typically suggest much higher rates of depression in medical outpatients than does a clinical interview; and patients may not be prompt to report symptoms of low mood because of various fears about the consequences of a mental health "label". It may also be helpful to consider the frequent co-morbid presentation of depression and anxiety (mentioned in 3.a) as this can be a particularly common comorbidity in people with chronic physical health problems. It is important to examine if this alters the recommendations for assessment and treatment of depression.	Assessment refers to how clinicians assess a patient and covers issues such as review of physical health, social needs and environmental factors which may influence referral and treatment decisions. Thank you; though we are aware co-morbid depression and anxiety is relatively frequent unfortunately this is beyond the remit of the guideline.
SH	The British Psychological Society	17	4.3.2.b	We strongly suggest that the primary prevention of depression in people with chronic physical health problems should not be excluded from consideration. We believe that effective service models for addressing emotional distress cannot ignore the level of prevention. Identifying and disseminating evidence on effective and efficient methods of primary prevention would raise awareness of the issues of psychological adjustment in all medical patients, normalise and destigmatise these issues, and ultimately reduce the burden on patients and services. Instead of a total exclusion of preventative approaches, we would recommend the consideration of evidence for procedures for prevention of depression following the diagnosis of a	Thank you. Primary prevention is outside the scope of the NICE guideline programme.

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				chronic physical health problem, and the timing and content of these (e.g. automatic inclusion in a cardiac rehabilitation program that includes advice on mood after a cardiac event).	
SH	The Chartered Society of Physiotherapy			This organisation was approached but did not respond.	
SH	The Haemophilia Society			This organisation was approached but did not respond.	
SH	The IBS Network			This organisation was approached but did not respond.	
SH	The National Society for Epilepsy			This organisation was approached but did not respond.	
SH	The Sainsbury Centre for Mental Health			This organisation was approached but did not respond.	
SH	The South Asian Health Foundation			This organisation was approached but did not respond.	
SH	The State Hospitals Board For Scotland			This organisation was approached but did not respond.	
SH	The Survivors Trust			This organisation was approached but did not respond.	
SH	Trafford Primary Care Trust			This organisation was approached but did not respond.	
SH	Trident Care and Support			This organisation was approached but did not respond.	
SH	UK Advocacy Network			This organisation was approached but did not respond.	
SH	UK Psychiatric Pharmacy Group			This organisation was approached but did not respond.	
SH	Ultrasis Ltd			This organisation was approached but did not respond.	
SH	Unite / Mental Health Nurses Association			This organisation was approached but did not respond.	
SH	United Kingdom Council for Psychotherapy			This organisation was approached but did not respond.	
SH	Volition			This organisation was approached but did not respond.	

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SH	Welsh Assembly Government	1		Thank you for giving the Welsh Assembly Government the opportunity to comment on the above draft scope. We are content with the technical detail of the evidence supporting the draft scope and have no further comments to make at this stage.	Thank you for your comment.
SH	Welsh Scientific Advisory Committee			This organisation was approached but did not respond.	
SH	West London Mental Health NHS Trust			This organisation was approached but did not respond.	
SH	Wiltshire PCT			This organisation was approached but did not respond.	
SH	Wyeth	1	4.3.1	We would request that women are considered separately within the scope. In particular the effects of age and menopausal status on the incidence and treatment of depression should be included. When transitioning through the menopause, women face increased susceptibility to depression. It is believed that this is partly attributed to a decrease in estrogen levels. Estrogens are known potent neuromodulators of numerous neuronal circuits throughout the central nervous system and are known to reduce serotonin receptor activity in the brain (Van Amelswoort et al 2001; 26:494-502). Thus, changing estrogen levels during menopause impact multiple components including mood. The reduced responsivity to serotonin means that women may become less responsive to serotonergic compounds during the menopause. This has been demonstrated in a reduced response to antidepressant treatment with SSRIs.	We feel the effects of age and gender will best be considered when the guideline development group form the clinical questions. We will raise these issues with them at that stage.

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				In contrast, treatment with dual mechanism SNRIs does not appear to be affected by gender or menopausal status. As such, SNRIs should be considered as treatment of choice for women with reduced estrogen levels (e.g. women in peri/post menopause). This is supported by the evidence below: **1. Transition to the menopause is strongly associated with new onset of depressed mood among women** ***Freemen E et al. Arch Gen Psychiatry 2006;63:375-382*** *Yonkers K Jour Clin Psych 2003; 64:18 8-13* **2. Women of menopausal age do not respond as effectively to SSRIs compared to women of reproductive age.** *Martenyi et al Eur Neuropsychopharmacol 2001; 11:227-232* **3. Antidepressants impacting on both serotonin and noradrenaline are not affected by the menopause.** Duloxetine is effective in treating depression in postmenopausal women. *Joffe et al J Clin Psych 2007;68:943-950* Superiority of SNRI over SSRI in women over 50. *Thase M et al. J of Women's Health 2005;14(7):609-616* There are no significant differences in	

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				treatment outcomes for female patients receiving venlafaxine in older versus younger women. However, for those patients over the age of 50 there was a significant difference in outcome in women treated with an SSRI. This difference in women over 50 taking an SSRI was not seen if the women were taking HRT. This is consistent with reduced oestrogen levels, as seen during the menopause, being associated with reduced responsiveness to serotonin	
SH	Wyeth	2	General	**Equal access to the most appropriate treatment is an imperative** As demonstrated above, gender, age and menopausal status have an important and proven effect on both the incidence of depression and the effectiveness of certain treatments. These characteristics should be taken into account in order that the guideline makes the most appropriate clinical management recommendations for all patients. In the absence of specific recommendations taking into account gender, age and menopausal status, some patients may be disadvantaged because more general recommendations may represent suboptimal care in particular populations.	Thank you; we will raise this issue with the guideline development group when developing the guideline.
SH	Wyeth	3		We have already submitted comments on the Scope of the Depression Guidelines, but thought that you might wish to have the references that were referred to.	Thank you.
SH	York Hospital NHS Foundation Trust			This organisation was approached but did not respond.	