Depression in children and young people: identification and management

Consultation on draft guideline - Stakeholder comments table

23 January 2019 – 20 February 2019

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Addaction	Guideline	General	General	Guideline covers age 5 -18yrs- developmentally a wide span. Although there is reference to enquiry about drug and alcohol use in the assessment section (point 1.1.12). The use of alcohol and drug use, **including New Psychoactive Substances**, should be enquired about/considered throughout, as use may not be readily disclosed and remain hidden from others (e.g. due to fears of the reactions and actions of others, e.g. during early contact a trusted relationship may not have established, sufficient for disclosure to feel 'safe' e.g. lack of awareness of the potential relevance of substances to their depression/ how substances can impact on mood etc) The use of substances is important to consider on an ongoing basis as they have the potential to significant impact mood and compromise the effectiveness of standard interventions and any psychotropic medication prescribed.	Thank you for your comment. The committee recognised that children and young people with depression and with drug and alcohol use may require a different approach. Drug and alcohol use was not mentioned specifically in the recommendations, but were expected to be taken into account when personal/social history is taken as part of the process of choosing a psychological therapy. This is reflected in the recommendations to base the choice of therapy on a list of factors, including the full assessment of needs.
Addaction	Guideline	General	General	Guideline covers 5-18 years- developmentally a wide span. Although the guidance contains references to special considerations according to age,	Thank you for your comment. The committee agreed that there was limited evidence for 5-11 year olds and we welcome your support for a research recommendation aimed at identifying effective therapies for this age group.

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				overall there seems to be a limited evidence base for some of the recommended approaches, especially for the younger age group 5-11yrs. We echo the importance of more research to enable the considerations according to age to be more robust and explicit.	
Addaction	Guideline	11	Table 1 – mild depression	Group CBT would appear to be quite an intensive intervention as a first line offer, after 'watchful waiting', for mild depression - especially for ages 5-11. In practice adaptation of this approach would be required to ensure low intensity and accessibility for this age group / developmental range.	Thank you for your comment. Based on consultation comments and the lack of evidence for 5-11 year olds, the committee made a new recommendation for 5-11 year olds with mild depression to consider therapies that had been recommended for 12-18 year olds with developmental adaptation where needed.
Addaction	Guideline	11	Table 1 Moderate to severe depression	In a stepped care approach brief psychosocial intervention would appear to be a less intensive intervention than the first line offer of individual CBT or family therapy (and compared to the other options of psychodynamic psychotherapy and IPT plus parent sessions) for moderate to severe depression. It may be the latter is to be offered first as the evidence for them is stronger than for brief psychosocial intervention? As a less well established approach it would be important that	Thank you for your comment. The recommendation about the full assessment of needs is not intended to be prescriptive, but rather to highlight some important considerations for the shared decision-making process. If the healthcare professional, together with the child or young person (CYP) with depression and their family members, agree that a psychological therapy (either from first or second-line options) is the most appropriate choice of therapy to meet the CYPs needs then the hierarchy of the recommendations should not be a barrier to their receiving the chosen psychological therapy. To ensure this is the case the committee specifically noted the role of individual preferences for the CYP and their family members in the choice of therapy and stated that if the first line options would not meet the CYP's clinical needs or are unsuitable

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				readers understand what a brief psychosocial intervention comprises.	for their circumstances, to consider one of the following options including the chosen psychological therapy. In an analysis of a large body of evidence for 12-18 year olds with moderate to severe depression, individual CBT was better at reducing depression symptoms and improving functional status, quality of life and suicidal ideas compared to waiting list/ no treatment or usual care, and at increasing remission compared to attention control and other therapies (such as family therapy) at the end of treatment. Based on this information and the magnitude of the effects, the committee agreed to recommend individual CBT as the first line treatment for young people with moderate to severe depression. However, the committee recognised that individual CBT might not be suitable or meet the needs of all young people with moderate to severe depression and so they agreed that additional options should be available. They chose to include IPT-A (IPT for adolescents), family therapy, brief psychosocial intervention and psychodynamic psychotherapy as second line options that were evidence based but where effectiveness was less certain. The committee has included a definition of the brief psychosocial intervention as requested.
Anna Freud National Centre for Children & Families	Evidence review	20	Table 7	The guidelines have incorrectly considered the study by Dietz et al. (2015) as a study of family therapy. This is a study of family-based interpersonal psychotherapy. The committee should thus re-evaluate the study with respect to its support for IPT based approaches.	Thank you for your comment. The committee agreed to reclassify the study by Dietz (2015) as family based IPT. The NMAs were reanalysed and provided some evidence that family based IPT could be effective for the treatment of moderate to severe depression in children aged 5 to 11 years. The committee agreed to add a separate recommendation for this group including family based IPT as one of the recommended psychological therapies.

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Anna Freud National Centre for Children & Families	Guideline	General	General	IPT is described as a single treatment modality, while there is evidence for IPT in a range of formats (individual IPT, group IPT, IPT with parent). This is misrepresenting the range of formats of IPT (compared with CBT which is accurately represented with respect to its various format – i.e. individual CBT, Group CBT, CBT with separate parent sessions).	Thank you for your comment. We have amended Table 1 to list the different formats for IPT.
Anna Freud National Centre for Children & Families	Guideline and Evidence Review	General	General	We have concerns about the interchangeable use of terms in the guidance: 'psychodynamic' 'child psychodynamic' 'child psychotherapy'. In the Evidence Review the intervention list includes 'child psychodynamic' and 'child psychoanalytic'. It appears unclear in the guideline what form of treatment (psychodynamic, psychoanalytic psychotherapy, individual child psychotherapy) is being recommended and who should be providing it. This is critical for future service and workforce planning, so we would urge the committee to review the terminology.	Thank you for your comment. The committee discussed the interchangeable use of terms in the draft guideline. They agreed to use the term psychodynamic psychotherapy and to add a paragraph to the discussion of the benefits and harms section in the evidence review to clarify this issue.
Anna Freud National Centre for	Guideline	19	6	The revised guideline (1.6.4) proposes that CBT or family therapy should be offered for moderate to severe depression, which downgrades	Thank you for your comment. The recommendation about the full assessment of needs is not intended to be prescriptive, but rather to highlight some important considerations for the shared decision-making process. If the healthcare professional, together with the

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Children & Families				psychodynamic psychotherapy and IPT-A, compared with the current recommendation: *1.6.1.2 Offer children and young people with moderate to severe depression a specific psychological therapy (individual CBT, interpersonal therapy, family therapy, or psychodynamic psychotherapy) that runs for at least 3 months. [new 2015]* We consider this significant change to the guidelines inconsistent with current evidence for moderate to severe depression. With respect to IPT-A, there is no new evidence to suggest it is not as effective as previously concluded or that CBT and family therapy are more effective than previously concluded. It also contrasts with the well-respected network meta-analysis which concludes that IPT-A and CBT (and not family therapy) are the only effective treatments compared to active controls at short-term follow-up for adolescent depression; that IPT is significantly more effective than CBT at long-term follow-up; and that IPT-A	child or young person (CYP) with depression and their family members, agree that a psychological therapy (either from first or second-line options) is the most appropriate choice of therapy to meet the CYPs needs then the hierarchy of the recommendations should not be a barrier to their receiving the chosen psychological therapy. To ensure this is the case the committee specifically noted the role of individual preferences for the CYP and their family members in the choice of therapy and stated that if the first line options would not meet the CYP's clinical needs or are unsuitable for their circumstances, to consider one of the following options including the chosen psychological therapy. In an analysis of a large body of evidence for 12-18 year olds with moderate to severe depression, individual CBT was better at reducing depression symptoms and improving functional status, quality of life and suicidal ideas compared to waiting list/ no treatment or usual care, and at increasing remission compared to attention control and other therapies (such as family therapy) at the end of treatment. Based on this information and the magnitude of the effects, the committee agreed to recommend individual CBT as the first line treatment for young people with moderate to severe depression. However, the committee recognised that individual CBT might not be suitable or meet the needs of all young people with moderate to severe depression and so they agreed that additional options should be available. They chose to include IPT-A (IPT for adolescents), family therapy, brief psychosocial intervention and psychodynamic psychotherapy as second line options that were evidence based but where effectiveness was less certain.

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				leads to significantly fewer discontinuations than CBT (Zhou et al., 2015). Further, several RCTs of IPT for depressed adolescents have been excluded from the review, nor were they listed as excluded studies (Bolton et al., 2007; Roselló. et al., 2008; Tang et al., 2009). These studies are within the scope of this review, so should have been included or listed as excluded studies with the reasons for exclusion. In particular, Tang et al. (2009) demonstrated IPT to be significantly better than TAU for depressed adolescents. With respect to psychodynamic psychotherapy, a major additional study has been published since the previous NICE guidelines – the IMPACT trial (Goodyer et al, 2017). This demonstrated the equivalence of psychodynamic psychotherapy and CBT in the relapse prevention of moderate to severe depression in adolescents. This would suggest psychodynamic psychotherapy should be upgraded to be one option as a first-stage treatment, but in fact the opposite has happened,	We have checked the references you mention in your comment. Please below our response to each reference: - Bolton (2007) we have included this study only for the outcome of discontinuation because depression symptoms and functional status were not measured using validated tools - Roselló (2008) compared individual and group CBT with individual and group IPT but we excluded this study because results were not reported separately (results were only reported as combined individual and group CBT and combined individual and group IPT) - Tang (2009) was excluded because participants were not required to have symptoms of depression at recruitment

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				with CBT and family therapy being prioritised. We do not understand why the findings and implications from this large pragmatic RCT do not appear to have been taken into account in the revised NICE guidelines- particularly as the committee acknowledge that psychodynamic psychotherapy "*was as effective as individual CBT across a range of outcomes and follow-up times*" (p37, line 6). It would therefore appear to be inconsistent with the latest evidence to amend the guideline in the way that is proposed in the revised guidelines. In summary, we are concerned about whether all of the relevant evidence was accounted for in these revised guidelines. The downgrading of IPT-A and psychodynamic psychotherapy will have significant impact on how services invest in and prioritise therapies, and this should be based on clear and robust evidence to justify a change to the existing guidance. Is the committee confident this is the case?	
Anna Freud National Centre for	Guideline	19	10	The revised guideline (1.6.5) proposed that if 'the options in recommendation 1.6.4 would not meet the child or young	Thank you for your comment. The committee agreed that brief psychosocial intervention could be considered as an alternative treatment to individual CBT for 12-18

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Children & Families				person's clinical needs or are unsuitable for their circumstances', then brief psychosocial intervention may be considered (alongside psychodynamic psychotherapy or IPT plus parent sessions). The inclusion of brief psychosocial intervention is based on the evidence solely from the IMPACT trial (Goodyer et al., 2017). The study demonstrated the equivalence of outcomes in this treatment compared with CBT and psychodynamic psychotherapy. The revised guideline appears to be emphasising the use of brief psychosocial intervention on the basis of a single study, where the intervention was delivered by child psychiatrists. There is currently no evidence to demonstrate whether brief psychosocial intervention is as effective when delivered by a wider range of practitioners. Accordingly, we would question whether the guidelines should emphasise the need for brief psychosocial intervention should be delivered by a child psychiatrist.	year olds with moderate to severe depression. But they acknowledged that further research would be helpful to determine the effectiveness of brief psychosocial intervention when delivered by practitioners other than psychiatrists and in other settings such as primary care. The results of such a trial could provide evidence to support the wider use of BPI. The committee also recognised that brief psychosocial intervention was recommended based on the IMPACT trial. Therefore, they agreed to include a description for brief psychosocial intervention as delivered in the IMPACT trial. This description has been added to the section of 'Terms used in this guideline'.

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Anna Freud National Centre for Children & Families	Guideline	19	15	We are concerned about the revised guideline that recommends IPT plus parent sessions is recommended over individual IPT (1.6.5 in the current draft guideline). We consider this conclusion highly inappropriate, given that it is based on a single small-scale feasibility study (N=15). Treatment recommendations cannot be drawn from a study that was not designed or powered to compare the efficacy of treatments (Gunlicks-Stoessel & Mufson, 2016).	Thank you for your comment. The committee agreed that the RCT by Gunlicks-Stoessel (2016) artificially manipulated the involvement of parents in both arms of the study. Therefore, this RCT was not connected to the network meta-analyses anymore and it was removed from the NMAs. Gunlicks-Stoessel (2016) was only reported in the pairwise analysis. IPT-A (IPT for adolescents) was kept in the recommendations for moderate to severe depression but without any specific involvement of parents. The committee also recognised that IPT-A is designed to include parents on a flexible basis.
Anna Freud National Centre for Children & Families	Guideline	37	9	It is incorrectly stated that: 'only 1 study included psychodynamic psychotherapy', referring to the IMPACT study by Goodyer et al. (2017). This is an error as the Trowell et al (2007) study also provides evidence for the effectiveness of psychodynamic psychotherapy and must also be considered.	Thank you for your comment. The committee discussed the study by Trowell (2007) and they agreed to add a paragraph to the discussion of the "benefits and harms" section in the evidence review to clarify this issue. Trowell (2007) also tested psychodynamic psychotherapy intervention in 9-15 year olds, but was included in the analysis of the 5-11 age group. This trial showed that psychodynamic psychotherapy could not be differentiated from family therapy for functional status post treatment and at 6 months, while depression symptoms were reduced by family therapy compared to psychodynamic psychotherapy post treatment, but could not be differentiated at 6 months follow up. These findings provide extra support for the inclusion of psychodynamic psychotherapy in the recommendations for 12-18 year olds with moderate to severe depression.

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Anna Freud National Centre for Children & Families	Guideline	38	6	The guidelines state that: 'The recommendations are likely to result in an increased use of individual CBT and family therapy and a decrease in other individual therapies.' This emphasises why recommendation 1.6.4 must be carefully considered by the committee. The rationale is unclear as to why the recommendations should lead to a decrease in the use of psychodynamic psychotherapy, given that there is greater evidence of its effectiveness (Goodyer et al., 2017) compared with the available evidence in the previous guideline review. This will have important implications for service commission and provision.	Thank you for your comment. The committee agreed to amend the section "How the recommendations might affect practice". They recognised that recommendations for moderate to severe depression are unlikely to change resource use, apart from the brief psychosocial intervention which is not commonly delivered in current practice but it is expected to be a lower intensity intervention than other individual therapies.
Anna Freud National Centre for Children & Families	Evidence Review	110	3	The evidence review refers to the use of the Network Meta-Analysis by Zhou et al (2015). Important evidence has been published since the Zhou et al. paper, namely Goodyer et al (2017). We would ask the committee to ensure that the Zhou et al evidence was updated to reflect latest evidence from Goodyer et al.	Thank you for your comment. We included Zhou (2015) as a published NMA on this topic and have referred to their results in an evidence statement to enable comparison to our results. We did not use the evidence from Zhou (2015) directly because this NMA did not cover all the outcomes of interest for this update, did not report results by age group, and did not separate interventions by the type of psychological therapy and method of delivery. We carried out a systematic search to identify randomised controlled trials published after 2015. The Goodyer (2017) study was found in the updated search.
Association for Dance	Guideline	General	General	**General comments:**	Thank you for your comment. Creative therapies, such as dance therapy, music therapy and psychodrama, were included in the

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Movement Psychotherapy UK				We have serious concerns about this draft guideline on several levels. We are surprised that the guideline makes no reference to the arts therapies, that is dance movement, music, drama/play and art psychotherapy. These are psychological therapies that have been used extensively with children who struggle emotionally because of their capacity to meet them where they are developmentally and enable them to process difficulties through artistic media in ways. Because of their creative methods, they provide interventions that talking and/or cognitive psychological therapies are not able to do. Furthermore, the guideline omits evidence drawn from systematic reviews in the field of dance movement psychotherapy and arts therapies that include studies with children with depression (e.g. Meekums Karkou and Nelson 2015; Koch, Kunz, Lykou and Cruz 2014; Geipel Koenig, Hillecke et al 2018; Mrazova and Celec 2010; Gold, Voracek and Wigram 2004; Wethington, Hahn, Fuqua-Whitley, et al 2008; Joronen, Rankin, & Åstedt-Kurki, 2008;	protocol for this update (see Table 1 for the PICO in the evidence review) under the heading of 'arts/creative psychotherapies'. We therefore included arts/creative psychotherapies in the search for this update. There was only one study meeting the inclusion criteria for this review (Jeong 2005). We have checked the references you mention in your comment. Please see below our response to each reference: Systematic reviews in arts therapies: - Meekums (2015) was excluded, but we used it as a reference for individual RCTs. There were 3 RCTs included by Meekums (2015). One of these RCTs was Jeong (2005). The other 2 RCTs were on adults - Koch (2014) was excluded because we found a more recent systematic review on dance therapy - Geipel (2018) was excluded because there was another systematic review on music-based interventions focused on depression (Aalbers 2017) - Mrázová (2010) was excluded but we used it as a reference for individual RCTs - Gold (2004) was excluded because their meta-analysis did not include depression - Wethington (2008) was excluded because the interventions aimed to reduce psychological harm among children and adolescents exposed to traumatic events - Joronen (2008) was excluded because the review was on the effects of school-based drama interventions in health promotion - Cornish (2013) was a literature review but not a systematic review. RCTs in arts therapies:

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				Cornish 2013), randomised controlled trials (RCTs and related studies in the field (Karkou, Fullarton and Scarth 2010; Jeong, Hong, Lee et al 2005; Gold, Saarikallio Crooke and McFerran, K 2017; McArdle, Moseley Quibell et al 2002; Porter, Holmes, McLaughlin et al 2012; Rosal 1993; Hilliard 2007; Rousseau, Benoit Lacroix and Gauthier 2009; Rousseau et al 2007; Baker and Jones 2006). It ignores common practice in schools, primary care and CAMHs teams (Cornish 2013; Karkou and Sanderson 2000, 2001; Karkou 1999), the large number of creative arts therapies work that takes place with parents and families (Taylor Buck, Dent-Brown & Parry 2013. Finally, it neglects to draw upon recent edited publications that indicate a wide-ranging contribution of the arts therapies in the mental health of children and adolescents (Karkou 2010; Moon 2003; Tortora 2005; Derrington, Oldfield and Tomlinson 2011; Goodman 2011; Leigh, Gersch and Haythorne 2012; Stuart and Trevarthan 2017; French & Klein 2013).	- Karkou (2010) was published in a book and the search strategy for reviews of the effectiveness of interventions does not include databases of books - Jeong (2005) was already included - Gold (2017) was excluded because the study recruited students at risk of developing mental health problems and self-reporting unhealthy music use but without depression - McArdle (2002) was excluded because the study recruited children at risk for behavioural or emotional problems but without depression - Porter (2012) was excluded because this is a protocol for a trial without results - Rosal (1993) was excluded because the study recruited children with behaviour disorders but without depression - Hilliard (2007) was excluded because the study recruited bereaved school-aged children - Rousseau (2009) was excluded because the study recruited immigrant and refugee preschoolers without depression - Rousseau (2007) was excluded because the study recruited immigrant and refugee adolescents without depression - Baker (2006) was excluded because the study recruited refugee students without depression Other types of research studies We only included RCTs. Therefore, we would not include any of the following studies: - Karkou (2001) observational study - Karkou (2000) observational study Karkou (1999) observational study - Cobbett (2016) non-RCT & qualitative study

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				Finally, the guideline suggests a stepped approach that need considerable re-thinking on a number of levels as it is indicated in the comments following. References: Systematic reviews in arts therapies: Meekums B, Karkou V, Nelson EA. (2015) Dance movement therapy for depression. Cochrane Database of Systematic Reviews, Issue 2. Art. No.: CD009895. DOI: 10.1002/14651858.CD009895.pub2. Koch, S., Kunz, T., Lykou, S., & Cruz, R. (2014). Effects of dance movement therapy and dance on health-related psychological outcomes: A meta-analysis. The Arts in Psychotherapy, 41(1), 46-64. Geipel, J Koenig, J Hillecke, T Resch F and Kaess M (2018) Music-based interventions to reduce internalizing symptoms in children and adolescents: A meta-analysis, Journal of Affective Disorders, 225, (647). Mrázová M and Celec, P (2010) A Systematic Review of Randomized Controlled Trials Using Music Therapy for Children, The Journal of Alternative	- Taylor Buck (2013) was a survey and we only included RCTs Regarding the books that you cite, the search strategy for reviews of the effectiveness of interventions does not include databases of books.

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				and Complementary Medicine, 16, 10, (1089). Gold, C., Voracek, M., & Wigram, T. (2004). Effects of music therapy for children and adolescents with psychopathology: a meta-analysis. Journal of Child Psychology and Psychiatry, 45(6), 1054-1063. Wethington, H. R., Hahn, R. A., Fuqua-Whitley, D. S., Sipe, T. A., Crosby, A. E., Johnson, R. L., ... & Kalra, G. (2008). The effectiveness of interventions to reduce psychological harm from traumatic events among children and adolescents: a systematic review. American journal of preventive medicine, 35(3), 287-313. Joronen, K., Rankin, S. H., & Åstedt-Kurki, P. (2008). School-based drama interventions in health promotion for children and adolescents: systematic review. Journal of advanced nursing, 63(2), 116-131. Cornish, S. (2013). Is There a Need to Define the Role of Art Therapy in Specialist CAMHS in England? Waving not Drowning. A Systematic Literature Review. Art Therapy Online, 4(1).	

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				Examples of RCTs in arts therapies: Karkou, V., Fullarton, A., & Scarth, S. (2010). Finding a Way out of the Labyrinth through Dance Movement Psychotherapy. Karkou V (ed) Arts therapies in schools: Research and Practice. London: Jessica Kingsley 59-84. Jeong, Y.-J., Hong, S.-C., Lee, M. S., Park, M.-C., Kim, Y.-K., & Suh, C.-M. (2005). Dance movement therapy improves emotional responses and modulates neurohormones in adolescents with mild depression. International Journal of Neuroscience, 115(12), 1711–1720. Gold, C Saarikallio S, Crooke A H D and McFerran, K (2017) Group Music Therapy as a Preventive Intervention for Young People at Risk: Cluster-Randomized Trial, Journal of Music Therapy, 54, 2, (133) McArdle, P., Moseley, D., Quibell, T., Johnson, R., Allen, A., Hammal, D., & LeCouteur, A. (2002). School-based indicated prevention: a randomised trial of group therapy. Journal of Child	

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				Psychology and Psychiatry, 43(6), 705-712. Porter, S., Holmes, V., McLaughlin, K., Lynn, F., Cardwell, C., Braiden, H.-J., … Rogan, S. (2012). Music in mind, a randomized controlled trial of music therapy for young people with behavioural and emotional problems: study protocol. Journal of Advanced Nursing, 68(10), 2349–2358. https://doi.org/10.1111/j.1365-2648.2011.05936.x Rosal, M. L. (1993). Comparative group art therapy research to evaluate changes in locus of control in behavior disordered children. The Arts in Psychotherapy, 20, 231–241. Hilliard, R. E. (2007). The effects of Orff-based music therapy and social work groups on childhood grief symptoms and behaviors. Journal of Music Therapy, 44(2), 123-138. Rousseau C, Benoit M, Lacroix L, Gauthier M (2009) Evaluation of a sandplay program for preschoolers in a multiethnic neighborhood. J Child Psychol Psychiatry 50: 743–750. Rousseau, C., Benoit, M., Gauthier, M. F., Lacroix, L., Alain, N., Viger Rojas, M.,	

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				... & Bourassa, D. (2007). Classroom drama therapy program for immigrant and refugee adolescents: A pilot study. Clinical child psychology and psychiatry, 12(3), 451-465. Baker F, Jones C (2006) The effect of music therapy services on classroom behaviours of newly arrived refugee students in Australia - A pilot study. Emotional and Behavioural Difficulties 11: 249–260. Other types of research studies: Karkou, V., & Sanderson, P. (2001). Dance movement therapy in the UK: a field emerging from dance education. *European physical education review*, *7*(2), 137-155. Karkou, V., & Sanderson, P. (2000). Dance movement therapy in UK education. Research in Dance Education, 1(1), 69-86. Karkou, V. (1999). Art therapy in education findings from a nationwide survey in arts therapies. International Journal of Art Therapy: Inscape, 4(2), 62-70. Cobbett, S. (2016). Reaching the Hard to Reach: Quantitative and qualitative	

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				evaluation of school-based arts therapies with young people with social, emotional and behavioural difficulties. Emotional and Behavioural Difficulties, 21(4), 403-415. Taylor Buck, E, Dent-Brown K & Parry G (2013) Exploring a dyadic approach to art psychotherapy with children and young people: A survey of British art psychotherapists, International Journal of Art Therapy, 18:1, 20-28, DOI: 10.1080/17454832.2012.749293. Hall, P. (2008). Painting together: An art therapy approach to mother-infant relationships. In C. Case & T. Dalley (Eds.), Art therapy with children: From infancy to adolescence (pp. 20-35). New York, NY, US: Routledge/Taylor & Francis Group. Books: Karkou V (2010) Arts Therapies in Schools: Research and Practice. London: Jessica Kingsley Moon B L (2003) Essentials of Art Therapy Education and Practice. Springfield Illinois: Charles Thomas Tortora S (2005) The Dancing Dialogue: Using the Communicative Power of	

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				Movement with Young Children. Baltimore, Maryland: Paul H Brookes. Derrington P, Oldfield A and Tomlinson J (2011) Music Therapy in Schools: Working with Children of All Ages in Mainstream and Special Education. London: Jessica Kingsley Goodman K D (2011) Music Therapy Education and Training: From Theory to Practice. Springfield Illinois: Charles Thomas. McFalane P and Harvey J (2012) Dramatherapy and Family Therapy in Education: Essential Pieces of the Multi-Agency Jigsaw. London: Jessica Kingsley. Leigh L Gersch I, Dix A and Haythorne D (2012) Dramatherapy with Children, Young People and Schools: Enabling Creativity, Sociability, Communication and Learning. London: Routledge and Taylor and Francis. Stuart D and Trevarthan C (2017) Rhythms of Relating in Children's Therapies: Connecting Creatively with Vulnerable Children. London: Jessica Kingsley. French, L., & Klein, R. (Eds.). (2013). Therapeutic practice in schools: Working	

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				with the child within: a clinical workbook for counsellors, psychotherapists and arts therapists. Routledge.	
Association for Dance Movement Psychotherapy UK	Guideline	General	General	**Depression as a comorbid diagnosis to medical conditions:** There is evidence to suggest that dance movement psychotherapy and arts therapies can also address depression, self-esteem and anxiety for children who are faced with different medical conditions (e.g. Darewych 2009; Dvorak 2015; Hartling, Newton, Liang et al 2013; Heijden, van der Jeekel, Rode 2018; Jo, Hong, Ran Park 2018; Madden, Mowry, Gao, 2010; Oelkers-Ax, Leins, Parzer 2008; Siegel, Iida, Rachlin, & Yount, 2016; Beebe, Gelfand, & Bender 2010). This body of evidence is also missing from the guideline. References: Darewych, O. (2009). The Effectiveness of Art Psychotherapy on Self-Esteem, Self-Concept, and Depression in Children with Glaucoma. Canadian Art Therapy Association Journal, 22(2), 2–17. https://doi.org/10.1080/08322473.2009.11434779	Thank you for your comment. Creative therapies, such as dance therapy, music therapy and psychodrama, were included in the protocol for this update (see Table 1 for the PICO in the evidence review) under the heading of 'arts/creative psychotherapies'. We therefore included arts/creative psychotherapies in the search for this update. There was only one study meeting the inclusion criteria for this review (Jeong 2005). We have checked the references and they cannot be included in the current review because they do not meet the review protocol for the following reasons: - Darewych (2009) was excluded because it was not an RCT. - Dvorak (2015) was excluded because the participants did not have depression at baseline - Dvorak (2011) was excluded because this is a dissertation and we do not include dissertations as evidence - Hartling (2013) was excluded because participants were children without depression - Heijden (2018) was excluded because participants were children with burns after wound care without depression - Jo (2018) was excluded because this was a non-RCT in siblings of children with cancer experiencing negative feelings rather than depression - Madden (2010) was excluded because participants were children receiving chemotherapy without depression - Oelkers-Ax (2008) was excluded because participants were children with migraine without depression

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				Dvorak, Abbey L. (2015). Music Therapy Support Groups for Cancer Patients and Caregivers: A Mixed-Methods Approach/Groupes De Soutien En Musicothérapie Auprès De Patients Atteints De Cancer et D'aidants Naturels : Approche À Méthodes Mixtes. Canadian Journal of Music Therapy, 21(1), 69. Dvorak, Abbey Lynn. (n.d.). Music therapy support groups for cancer patients and caregivers, 278. Hartling, L., Newton, A. S., Liang, Y., Jou, H., Hewson, K., Klassen, T. P., & Curtis, S. (2013). Music to Reduce Pain and Distress in the Pediatric Emergency Department: A Randomized Clinical Trial. JAMA Pediatrics, 167(9), 826–835. https://doi.org/10.1001/jamapediatrics.2013.200 Heijden, M. J. E. van der, Jeekel, J., Rode, H., Cox, S., Rosmalen, J. van, Hunink, M. G. M., & Dijk, M. van. (2018). Can live music therapy reduce distress and pain in children with burns after wound care procedures? A randomized controlled trial. Burns, 44(4), 823–833. https://doi.org/10.1016/j.burns.2017.12.013	- Siegel (2016) was excluded because participants were hospitalised children without depression - Beebe (2010) was excluded because participants were children with asthma without depression.

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				Jo, M.-J., Hong, S., & Ran Park, H. (2018). Effects of Art Intervention Program for Siblings of Children With Cancer: A Pilot Study. Journal of Pediatric Oncology Nursing, 35, 104345421876270. https://doi.org/10.1177/1043454218762702 Madden, J. R., Mowry, P., Gao, D., McGuire Cullen, P., & Foreman, N. K. (2010). Creative Arts Therapy Improves Quality of Life for Pediatric Brain Tumor Patients Receiving Outpatient Chemotherapy. Journal of Pediatric Oncology Nursing, 27(3), 133–145. https://doi.org/10.1177/1043454209355452 Oelkers-Ax, R., Leins, A., Parzer, P., Hillecke, T., Bolay, H. V., Fischer, J., … Resch, F. (2008). Butterbur root extract and music therapy in the prevention of childhood migraine: An explorative study. European Journal of Pain, 12(3), 301–313. https://doi.org/10.1016/j.ejpain.2007.06.003 Siegel, J., Iida, H., Rachlin, K., & Yount, G. (2016). Expressive Arts Therapy with Hospitalized Children: A Pilot Study of	

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				Co-Creating Healing Sock Creatures©. Journal of Pediatric Nursing, 31(1), 92–98. https://doi.org/10.1016/j.pedn.2015.08.006 Beebe, A., Gelfand, E. W., & Bender, B. (2010). A randomized trial to test the effectiveness of art therapy for children with asthma. Journal of Allergy and Clinical Immunology, 126(2), 263-266.	
Association for Dance Movement Psychotherapy UK	Guideline	General	General	In all cases, the CBT and medication focus on this guideline has the same bias and bears very similar limitations with problems identified in the guideline for adults for depression and fails to address a methodology of capturing evidence that is sufficiently robust and offer, a range of developmentally appropriate and relevant interventions for children and adolescents. The creative and child-friendly character of arts therapies and any research related to these interventions are missing along with diverse provision relevant to children from diverse backgrounds, ethnicity, verbal and/or cognitive age and so on. This guideline needs to be seriously re-drafted. Some references relevant to this guideline are:	Thank you for your comment. Medication was out of scope of this update. Creative therapies, such as dance therapy, music therapy and psychodrama, were included in the protocol for this update (see Table 1 for the PICO in the evidence review) under the heading of 'arts/creative psychotherapies'. We therefore included arts/creative psychotherapies in the search for this update. There was only one study meeting the inclusion criteria for this review (Jeong 2005). The recommendations concerning factors to take into account when choosing psychological therapy includes the circumstances of the child or young person and their carer(s), their clinical and personal/social history and presentation, their maturity and developmental level and the context in which treatment is to be provided. This recommendation aims to ensure that children and young people are guided toward the therapies that meet their individual needs. We have checked the references you mention in your comment. Systematic reviews in arts therapies:

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				References: Systematic reviews in arts therapies: Meekums B, Karkou V, Nelson EA. (2015) Dance movement therapy for depression. Cochrane Database of Systematic Reviews, Issue 2. Art. No.: CD009895. DOI: 10.1002/14651858.CD009895.pub2. Koch, S., Kunz, T., Lykou, S., & Cruz, R. (2014). Effects of dance movement therapy and dance on health-related psychological outcomes: A meta-analysis. The Arts in Psychotherapy, 41(1), 46-64. Geipel, J Koenig, J Hillecke, T Resch F and Kaess M (2018) Music-based interventions to reduce internalizing symptoms in children and adolescents: A meta-analysis, Journal of Affective Disorders, 225, (647). Mrázová M and Celec, P (2010) A Systematic Review of Randomized Controlled Trials Using Music Therapy for Children, The Journal of Alternative and Complementary Medicine, 16, 10, (1089). Gold, C., Voracek, M., & Wigram, T. (2004). Effects of music therapy for children and adolescents with	- Meekums (2015) was excluded but we used it as a reference to search for individual RCTs There were 3 RCTs included by Meekums (2015). One of these RCTs was Jeong (2005). The other 2 RCTs were on adults - Koch (2014) was excluded because we found a more recent systematic review on dance therapy - Geipel (2018) was excluded because there was another systematic review on music-based interventions focused on depression (Aalbers 2017) - Mrázová (2010) was excluded but we used it as a reference for individual RCTs - Gold (2004) was excluded because their meta-analysis did not include depression - Wethington (2008) was excluded because the interventions aimed to reduce psychological harm among children and adolescents exposed to traumatic events - Joronen (2008) was excluded because the review was on the effects of school-based drama interventions in health promotion - Cornish (2013) was a literature review but not a systematic review RCTs in arts therapies: - Karkou (2010) was published as a book and the search strategy for reviews of the effectiveness of interventions does not include databases of books - Jeong (2005) was already included - Gold (2017) was excluded because the study recruited students at risk of developing mental health problems and self-reporting unhealthy music use but without depression at baseline

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				psychopathology: a meta-analysis. Journal of Child Psychology and Psychiatry, 45(6), 1054-1063. Wethington, H. R., Hahn, R. A., Fuqua-Whitley, D. S., Sipe, T. A., Crosby, A. E., Johnson, R. L., ... & Kalra, G. (2008). The effectiveness of interventions to reduce psychological harm from traumatic events among children and adolescents: a systematic review. American journal of preventive medicine, 35(3), 287-313. Joronen, K., Rankin, S. H., & Åstedt-Kurki, P. (2008). School-based drama interventions in health promotion for children and adolescents: systematic review. Journal of advanced nursing, 63(2), 116-131. Cornish, S. (2013). Is There a Need to Define the Role of Art Therapy in Specialist CAMHS in England? Waving not Drowning. A Systematic Literature Review. Art Therapy Online, 4(1). Examples of RCTs in arts therapies: Karkou, V., Fullarton, A., & Scarth, S. (2010). Finding a Way out of the Labyrinth through Dance Movement Psychotherapy. Karkou V (ed) Arts	- McArdle (2002) was excluded because the study recruited children at risk of behavioural or emotional problems but without depression - Porter (2012) was excluded because this is a protocol for a trial without results - Rosal (1993) was excluded because the study recruited children with behaviour disorders but without depression - Hilliard (2007) was excluded because the study recruited bereaved school-aged children, who did not have depression - Rousseau (2009) was excluded because the study recruited immigrant and refugee preschoolers without depression - Rousseau (2007) was excluded because the study recruited immigrant and refugee adolescents without depression - Baker (2006) was excluded because the study recruited refugee students without depression - Lyshak-Stelzer (2007) was excluded because the study recruited children with PTSD symptoms without depression - Kim (2015) was excluded because the study was observational - Hartz (2005) was excluded because the study recruited female juvenile offenders without depression - Martin (2013) was excluded because the study recruited young women with non-suicidal self-injury without depression - Sandmire (2012) was excluded because the study recruited undergraduate students without depression Other types of research studies: We only included RCTs. Therefore, we would not include any of the following studies: - Karkou (2001) observational study - Karkou (2000) observational study

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				therapies in schools: Research and Practice. London: Jessica Kingsley 59-84. Jeong, Y.-J., Hong, S.-C., Lee, M. S., Park, M.-C., Kim, Y.-K., & Suh, C.-M. (2005). Dance movement therapy improves emotional responses and modulates neurohormones in adolescents with mild depression. International Journal of Neuroscience, 115(12), 1711–1720. Gold, C Saarikallio S, Crooke A H D and McFerran, K (2017) Group Music Therapy as a Preventive Intervention for Young People at Risk: Cluster-Randomized Trial, Journal of Music Therapy, 54, 2, (133) McArdle, P., Moseley, D., Quibell, T., Johnson, R., Allen, A., Hammal, D., & LeCouteur, A. (2002). School-based indicated prevention: a randomised trial of group therapy. Journal of Child Psychology and Psychiatry, 43(6), 705-712. Porter, S., Holmes, V., McLaughlin, K., Lynn, F., Cardwell, C., Braiden, H.-J., … Rogan, S. (2012). Music in mind, a randomized controlled trial of music	- Karkou (1999) observational study - Cobbett (2016) non-RCT & qualitative study - Taylor Buck (2013) was a survey and we only included RCTs Regarding the books you cite, the search strategy for reviews of the effectiveness of interventions does not include databases of books.

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				therapy for young people with behavioural and emotional problems: study protocol. Journal of Advanced Nursing, 68(10), 2349–2358. https://doi.org/10.1111/j.1365-2648.2011.05936.x Rosal, M. L. (1993). Comparative group art therapy research to evaluate changes in locus of control in behavior disordered children. The Arts in Psychotherapy, 20, 231–241. Hilliard, R. E. (2007). The effects of Orff-based music therapy and social work groups on childhood grief symptoms and behaviors. Journal of Music Therapy, 44(2), 123-138. Rousseau C, Benoit M, Lacroix L, Gauthier M (2009) Evaluation of a sandplay program for preschoolers in a multiethnic neighborhood. J Child Psychol Psychiatry 50: 743–750. Rousseau, C., Benoit, M., Gauthier, M. F., Lacroix, L., Alain, N., Viger Rojas, M., ... & Bourassa, D. (2007). Classroom drama therapy program for immigrant and refugee adolescents: A pilot study. Clinical child psychology and psychiatry, 12(3), 451-465.	

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				Baker F, Jones C (2006) The effect of music therapy services on classroom behaviours of newly arrived refugee students in Australia - A pilot study. Emotional and Behavioural Difficulties 11: 249–260. Forrest-Bank, S. S., Nicotera, N., Bassett, D. M., & Ferrarone, P. (2016). Effects of an Expressive Art Intervention with Urban Youth in Low-Income Neighborhoods. Child and Adolescent Social Work Journal, 33(5), 429–441. https://doi.org/10.1007/s10560-016-0439-3 Francie Lyshak-Stelzer ATR-BC, C., LCAT, CASAC, Pamela Singer MA, L., ATR-BC, St. John Patricia EdD, L., ATR-BC, & PhD, C. M. C. (2007). Art Therapy for Adolescents with Posttraumatic Stress Disorder Symptoms: A Pilot Study. Art Therapy, 24(4), 163–169. https://doi.org/10.1080/07421656.2007.10129474 Kim, J. (2015). Music therapy with children who have been exposed to ongoing child abuse and poverty: A pilot study. Nordic Journal of Music Therapy, 24(1), 27–43.	

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				https://doi.org/10.1080/08098131.2013.872696 Liz Hartz MA, A., & Thick, L. (2005). Art Therapy Strategies to Raise Self-Esteem in Female Juvenile Offenders: A Comparison of Art Psychotherapy and Art as Therapy Approaches. Art Therapy, 22(2), 70–80. https://doi.org/10.1080/07421656.2005.10129440 Martin, S., Martin, G., Lequertier, B., Swannell, S., Follent, A., & Choe, F. (2013). Voice movement therapy: evaluation of a group-based expressive arts therapy for nonsuicidal self-injury in young adults. Faculty of Law, Humanities and the Arts - Papers, 31–38. https://doi.org/10.1177/1943862112467649 Porter, S., Holmes, V., McLaughlin, K., Lynn, F., Cardwell, C., Braiden, H.-J., … Rogan, S. (2012). Music in mind, a randomized controlled trial of music therapy for young people with behavioural and emotional problems: study protocol. Journal of Advanced Nursing, 68(10), 2349–2358.	

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				https://doi.org/10.1111/j.1365-2648.2011.05936.x Sandmire, D. A., Gorham, S. R., Rankin, N. E., & Grimm, D. R. (2012). The Influence of Art Making on Anxiety: A Pilot Study. Art Therapy, 29(2), 68–73. https://doi.org/10.1080/07421656.2012.683748 Other types of research studies: Karkou, V., & Sanderson, P. (2001). Dance movement therapy in the UK: a field emerging from dance education. European physical education review, 7(2), 137-155. Karkou, V., & Sanderson, P. (2000). Dance movement therapy in UK education. Research in Dance Education, 1(1), 69-86. Karkou, V. (1999). Art therapy in education findings from a nationwide survey in arts therapies. International Journal of Art Therapy: Inscape, 4(2), 62-70. Cobbett, S. (2016). Reaching the Hard to Reach: Quantitative and qualitative evaluation of school-based arts therapies with young people with social, emotional and behavioural difficulties.	

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				Emotional and Behavioural Difficulties, 21(4), 403-415. Taylor Buck, E, Dent-Brown K & Parry G (2013) Exploring a dyadic approach to art psychotherapy with children and young people: A survey of British art psychotherapists, International Journal of Art Therapy, 18:1, 20-28, DOI: 10.1080/17454832.2012.749293. Hall, P. (2008). Painting together: An art therapy approach to mother-infant relationships. In C. Case & T. Dalley (Eds.), Art therapy with children: From infancy to adolescence (pp. 20-35). New York, NY, US: Routledge/Taylor & Francis Group. Books: Karkou V (2010) Arts Therapies in Schools: Research and Practice. London: Jessica Kingsley Moon B L (2003) Essentials of Art Therapy Education and Practice. Springfield Illinois: Charles Thomas Tortora S (2005) The Dancing Dialogue: Using the Communicative Power of Movement with Young Children. Baltimore, Maryland: Paul H Brookes.	

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				for counsellors, psychotherapists and arts therapists. Routledge.	
Association for Dance Movement Psychotherapy UK	Guideline	11	Table 1	**Prevention:** It does not consider prevention as a first step. Watchful waiting indicates that problems are allowed to arise before there is an active engagement in prevention and mental health promotion that involves interventions for the whole classroom and in the whole school. It also ignores evidence relating to prevention from the arts therapies (e.g. Gold et al 2017; Karkou et al 2010; McArdle et al 2002) and the long documented value of a whole school approach to good mental health (Wells, Barlow, & Stewart-Brown, 2003; Durlak and Well 1997). References: Gold, C Saarikallio S, Crooke A H D and McFerran, K (2017) Group Music Therapy as a Preventive Intervention for Young People at Risk: Cluster-Randomized Trial, Journal of Music Therapy, 54, 2, (133). Karkou, V., Fullarton, A., & Scarth, S. (2010). Finding a Way out of the Labyrinth through Dance Movement	Thank you for your comment. Prevention of depression is not within the scope of this guideline and therefore we are unable to make recommendations on this topic.

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				Psychotherapy. Karkou V (ed) Arts therapies in schools: Research and Practice. London: Jessica Kingsley 59-84. McArdle, P., Moseley, D., Quibell, T., Johnson, R., Allen, A., Hammal, D., & LeCouteur, A. (2002). School-based indicated prevention: a randomised trial of group therapy. Journal of Child Psychology and Psychiatry, 43(6), 705-712. Joronen, K., Rankin, S. H., & Åstedt-Kurki, P. (2008). School-based drama interventions in health promotion for children and adolescents: systematic review. Journal of advanced nursing, 63(2), 116-131. Wells, J., Barlow, J., & Stewart-Brown, S. (2003). A systematic review of universal approaches to mental health promotion in schools. Health Education, 103(4), 197-220. Durlak, J. A., & Wells, A. M. (1997). Primary prevention mental health programs for children and adolescents: A meta-analytic review. American journal of community psychology, 25(2), 115-152.	

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Association for Dance Movement Psychotherapy UK	Guideline	11	Table 1	**Mild depression:** The guideline offers digital or group intervention which either CBT or IPT or mindfulness but excludes other creative psychotherapy interventions such as dance movement psychotherapy, music, drama, play or art psychotherapy. The absence of creative psychological interventions with children with depression indicates a clear bias towards talking and cognitive therapies, types of intervention that are often hard to reach children and adolescents and can be inappropriate for their development needs and/or capacities. Published studies in the field (e.g. Karkou et al 2010; Joeng et al 2005; Gold et al 2017; McArdle et al 2002; Rosal 1993; Hillard 2007; Rousseau et al 2007 and 2009; Baker and Jones 2006) indicate that the arts therapies can be particularly effective in the treatment of mild depression and/or with children at risk of developing more serious mental health problems including depression. References:	Thank you for your comment. Creative therapies, such as dance therapy, music therapy and psychodrama, were included in the protocol for this update (see Table 1 for the PICO in the evidence review) under the heading of 'arts/creative psychotherapies'. We therefore included arts/creative psychotherapies in the search for this update. There was only one study meeting the inclusion criteria for this review (Jeong 2005). We included Jeong (2005) in the pairwise meta-analysis and the NMA for depression symptoms at post-treatment in young people aged 12 to 18 years with mild depression. However, the NMA showed that dance therapy was not more effective than waiting list/no treatment. We have checked the studies you mention in your comment. Please see below for our response to each reference: - Karkou (2010) was published in a book and the search strategy for reviews of the effectiveness of interventions does not include databases of books - Jeong (2005) was already included - Gold (2017) was excluded because the study recruited students at risk of developing mental health problems and self-reporting unhealthy music use but without depression - McArdle (2002) was excluded because the study recruited children at risk for behavioural or emotional problems but without depression - Porter (2012) was excluded because this is a protocol for a trial without results - Rosal (1993) was excluded because the study recruited children with behaviour disorders but without depression

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				and refugee adolescents: A pilot study. Clinical child psychology and psychiatry, 12(3), 451-465. Baker F, Jones C (2006) The effect of music therapy services on classroom behaviours of newly arrived refugee students in Australia - A pilot study. Emotional and Behavioural Difficulties 11: 249–260.	
Association for Dance Movement Psychotherapy UK	Guideline	11	Table 1	**Moderate to severe depression:** The guideline continues to prioritise individual CBT and introduces family therapy as an additional option for moderate to severe depression. When issues persist, the guideline suggests that brief psychosocial intervention or psychodynamic psychotherapy or IPT plus parent sessions. However, it ignores common practice in CAMHs teams that use creative methods and arts therapies as a way of supporting children/adolescents who find it difficult to engage through verbal and/or cognitive means (McLachlan & Laletin 2015; Cornish 2013; Karkou and Sanderson 2001???; Karkou ??). It also neglects to acknowledge that there is a large number of arts therapists who work with	Thank you for your comment. Creative therapies, such as dance therapy, music therapy and psychodrama, were included in the protocol for this update (see Table 1 for the PICO in the evidence review) under the heading of 'arts/creative psychotherapies'. We therefore included arts/creative psychotherapies in the search for this update. There was only one study meeting the inclusion criteria for this review (Jeong 2005). We have checked the references you mention in your comment. Please see below for our response to each reference: - Cornish (2013) was a literature review but not a systematic review - McLachlan (2015) was an evaluation study without an RCT design - Taylor Buck (2013) was a survey and we only included RCTs - Hall (2008) is a book and the search strategy for reviews of the effectiveness of interventions does not include databases of books.

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				parents and families (Taylor Buck, Dent-Brown & Parry 2013) and a large number of them who work psychodynamically. References: Cornish, S. (2013). Is There a Need to Define the Role of Art Therapy in Specialist CAMHS in England? Waving not Drowning. A Systematic Literature Review. Art Therapy Online, 4(1). McLachlan N & Laletin L (2015) An evaluation of a mindfulness group in CAMHS using dramatherapy practice, Dramatherapy, 37:2-3, 78-88. Taylor Buck, E, Dent-Brown K & Parry G (2013) Exploring a dyadic approach to art psychotherapy with children and young people: A survey of British art psychotherapists, International Journal of Art Therapy, 18:1, 20-28, DOI: 10.1080/17454832.2012.749293. Hall, P. (2008). Painting together: An art therapy approach to mother-infant relationships. In C. Case & T. Dalley (Eds.), Art therapy with children: From infancy to adolescence (pp. 20-35). New York, NY, US: Routledge/Taylor & Francis Group.	

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Association for Dance Movement Psychotherapy UK	Guideline	11	Table 1	**Depression unresponsive to treatment/recurrent depression/psychotic depression:** Although intensive psychological therapy is proposed in tier 3 and 4, in the types of psychological therapies that are made available for children and adolescents, arts therapies are not mentioned. This needs to be changed, explicitly referring to different types of possible interventions.	Thank you for your comment. The sections "Depression unresponsive to combined treatment" and "The treatment of psychotic depression" were not within the scope of this update and therefore we are unable to make changes to these areas.
Association for Family Therapy & Systematic Practice UK	General	General	General	The conceptualisation of depression (even more so for children) is flawed. For children, who by definition are dependent, signs of distress must be considered in the contexts of families, carers, peer group, school, etc., rather than "treated" as if it were an individualised "disease" or "illness". Although the guidance includes some (unchanged) advice on supporting children with single undesirable life events, there is not much mention of the context of events, situations, relationships and social and cultural expectations in which the child or young person's experience is embedded.	Thank you for your comment. The committee agreed that it was important to look at the child or young person in the context of their past and current circumstances and medical/social/personal history to take factors like the family/ carers into account. They made a recommendation to reflect this as part of the choice of psychological treatment of mild or moderate to severe depression. The underlying factors that lead to depression, including the academic stresses that children are subject to, and the prevention of depression are not within the scope of the guideline and we are therefore unable to make recommendations on these topics.

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				By turning distress into illness people are distanced from any sense of agency they and their families/friends might have in their own lives. They become dependent on the wisdom of some expert at the cost of their own expertise and resources. This view also obscures the very real effects of social inequalities, educational and other governmental policies and wider social, cultural and media on the distress of children and young people. "Treating" a child for "depression" does not facilitate the understanding of contextual factors which may often need to be addressed in order to create positive change in the child's experience. Taking a wider approach of understanding the uniqueness of each child's experience, the contributing factors and the meanings attached to them means that although one child may have symptoms which are labelled as 'depression', another 'anxiety', another 'conduct disorder' or another 'low self-esteem', 'treating these each individually risks further problematising the child (which can contribute further to distress)	

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				and missing the opportunity to adopt interventions than can have cross-diagnostic impact, for example undercover anti-bullying teams (Winslade, Williams, Barba, Knox, Uppal, Williams & Hedtke (2015) Undercover anti-bullying teams. Interpersona Vol 9 (1), 1-99. doi: 10.5964/ijpr.v9i1.181). Other wider interventions could be inviting schools to develop robust 'Restorative Practice' initiatives would contribute significantly to young people's well-being in the school arena. This could be supported by having appropriate legislation (where possible) for social media (which has become a very 21st-century means of bullying and abuse) and closer working between Social Services Departments and CAMHS to support families (rather than to 'cure' children). It is also important to understand that children are subject to multiple pressures to achieve academically and this (together with other constraints on their free time) often leaves children with	

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				reduced opportunities for free and creative play, including with other children. For children play is a primary means by which they understand and master new or challenging situations and make sense out of distress and trauma, and facing greater pressures together with reduced opportunities to use their natural resources of play and relationships, are likely to be an important aspect which is de-emphasised by the focus on an individualised disease model.	
Association for Family Therapy & Systematic Practice UK	Guideline	17	18	The recommendation for digital CBT for 5-11 year olds based on evidence relating to 12-18 year olds may not be valid. In our opinion, the relational context is even more important when children are young, and more dependent on adults, so efficacy may not be directly inferred from another group.	Thank you for your comment. The committee agreed that 5-11 year olds are very different to 12-18 year olds in terms of maturity and developmental level. This point was already reflected in the recommendation for a full needs assessment to underlie the choice of therapy, which included consideration of maturity and developmental level. The evidence base for this age group was very limited. This is reflected in the committee discussions of the evidence under "quality of the evidence" and "benefits and harms". We have extended these sections based on committee discussions of stakeholder comments. The committee noted that there was a very limited evidence base for 5-11 year olds with mild depression and that group CBT was not better than control at reducing depression symptoms. However, they agreed that it was important to offer these children treatment. Taking consultation comments into account, they decided to include

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					a new recommendation specifically for 5-11 year olds with mild depression to follow the treatments for 12-18 year olds, but with use of developmental adaptation where needed. The consideration of developmental level and maturity is also included as part of the full assessment of needs recommendation. There was more evidence for 5 to 11 year olds with moderate to severe depression, but the evidence of effectiveness for individual therapies was weak. In this case, the committee used their clinical expertise and the limited evidence to make a new recommendation for 5-11 year olds with moderate to severe depression. This included the interventions that were most effective in the trials that recruited the 5-11 years olds and individual CBT because this was the most effective intervention for 12-18 year olds. This recommendation also included the use of developmental adaptation where needed. In addition, based on stakeholder comments, the committee agreed to expand the scope of the research recommendation to cover children aged 5 to 11 years with mild or moderate to severe depression. The new research recommendation does not specify a particular psychological therapy.
Association for Family Therapy & Systematic Practice UK	Guideline	17	19-20	Groups provide a context for therapy whereby participants are exposed to and benefit from more than just the theoretical model used (as in individual therapy, but arguably with greater additional benefits because of the inclusion of peers). Limiting the theoretical models to only CBT, IPT or mindfulness places the emphasis on the	Thank you for your comment. We have not specifically excluded group therapies based on other treatment modalities however we did not find any RCTs that matched our review protocol for these therapies. We have checked the study by Javanmiri (2013) but were unable to include it in the evidence review because it was not possible for us to allocate it to mild or moderate to severe depression based on the description of the inclusion criteria in the paper and our categorisation of these groups. In this update, studies were included in the mild depression category if they

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				theory, rather than the process of learning and change in a group setting, and how this relates to factors in the lives of children and young people, outside of the group. Groups based on other theoretical models (e.g. systemic family therapy models such as narrative therapy or solution-focused brief therapy) can also be effective. Systemically-informed groups also would be focused on how children and young people can utilise supportive relationships and make a difference in their lives outside of the group (not just focusing on 'treating symptoms'). Javanmiri, Kimiaee & Abadi The Study of Solution-Focused Group Counseling in Decreasing Depression among Teenage Girls. International Journal of Psychological Studies; Vol. 5, No. 1; 2013	contained participants who were recruited on the basis of depression symptoms, while the moderate to severe depression category required study participants to have a diagnosis of depression. Javanmiri (2013) had one of the inclusion criteria as "meeting a clinical interview based on DSM-IV-2". However, they did not specify what diagnoses were identified with the clinical interview. Javanmiri (2013) also reported the baseline means of depression using the Beck depression inventory (BDI) for both intervention and control groups. However, the committee highlighted that these means and their standard deviations covered mild to moderate depression.
Association for Family Therapy & Systematic Practice UK	Guideline	17	25	We welcome the inclusion of Family Therapy, however we would encourage the use of 'Family and Systemic therapy' since Family and Systemic therapists do not only work with families, but also consider the influence of and how to work with and influence other important	Thank you for your comment. The committee agreed that family therapy can include different subtypes of therapy such as attachment-based and systemic family therapy and we have now included this point in the discussion section of the evidence review. They also noted that specific types of family therapy were shown to be effective for mild or moderate to severe depression for each age

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				social contexts and relationships around children and young people.	group. Therefore, the committee agreed to specify the type of family therapy in the recommended psychological therapies.
Association for Family Therapy & Systematic Practice UK	Guideline	18 19	21 5	There is a recommendation to base choice on individual and carer needs, preferences and values, however the recommendations represent only a limited choice of therapies, missing out significant interventions available such as play therapy, art therapy, occupational therapy input. The possibility of group interventions is also not included for those whose symptoms reach the moderate to severe threshold, when groups could be an option, here.	Thank you for your comment. The recommendations in the current update were made following the process outlined in the NICE guidelines manual. The protocol for the systematic review of evidence that underlies these recommendations in summarised in Table 1 of the evidence review and included arts/creative psychotherapies (such as art therapy, psychodrama, music therapy, dance therapy, play therapy). However, no RCTs were identified that met the review protocol for art therapy and the included play therapy study (Bolton 2007) only reported data in an extractable format for discontinuation. We were therefore unable to include these therapies in the recommendations. The moderate to severe depression evidence base included group CBT and group IPT, but they were not recommended because they were not better than waiting list/ no treatment for depression symptoms or functional status post treatment in the NMAs. Reference: Bolton P, Bass J, Betancourt T et al. (2007) Interventions for depression symptoms among adolescent survivors of war and displacement in northern Uganda: a randomized controlled trial. JAMA 298: 519-27.
Association for Family Therapy & Systematic Practice UK	Guideline	19	13	'brief psychosocial intervention' is recommended, which appears to allude to a specific intervention from the IMPACT trial (which appears similar to behavioural activation for adults). The term 'brief psychosocial intervention'7is a term which could be interpreted widely	Thank you for your comment. The committee recognised that brief psychosocial intervention was recommended based on the IMPACT trial. Therefore, they agreed to include a description for brief psychosocial intervention as delivered in the IMPACT trial. This description has been added to the section of 'Terms used in this guideline'.

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				to include any brief intervention which relates to psychological and social factors, and if NICE is recommending something more specific, more description should be included. However in our view, the narrowing of recommendations for interventions is placing undue emphasis on the content or theory, rather than the process, context, relationship and extra-therapeutic factors which are likely to contribute more to outcomes (see Lambert's four-factor model, below): Lambert, M. J. (1992). Psychotherapy outcome research: Implications for integrative and eclectic therapists. In J. C. Norcross & M. R. Goldfried (Eds.), Handbook of psychotherapy integration (pp. 94–129) New York: Basic Books In addition the IMPACT trial showed that all children continued to improve beyond the end of therapy (52 weeks and 86 weeks) with differences between treatments becoming less pronounced. This could be interpreted as fitting with the idea that factors other than therapy are important in improvement, and	

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				therapies which aim to understand and influence these extra-therapeutic factors (such as systemic family therapy) are likely to be helpful.	
Association for Family Therapy & Systematic Practice UK	Guideline	35	20-24	You say "There was some evidence for psychotherapies for children aged 5-11 years with moderate to severe depression, but this included very few interventions. In the analysis of the evidence, none of the therapies were more effective than waiting list / no treatment for reducing depressive symptoms at the end of treatment." On the basis of the lack of any compelling evidence we are concerned that recommendations limit the creativity and expertise of experienced clinicians to collaborate with children, young people and their families to make positive differences.	Thank you for your comment. As you note, the evidence base for children 5 to 11 years old was very limited. This is reflected in the committee discussions of the evidence under "quality of the evidence" and "benefits and harms". We have extended these sections based on committee discussions of stakeholder comments. The evidence of effectiveness for individual therapies was weak for 5 to 11 year olds with moderate to severe depression. In this case, the committee used their clinical expertise and the limited evidence to make a new recommendation for 5-11 year olds with moderate to severe depression. This included the interventions that were most effective in the trials that recruited the 5-11 year olds and individual CBT because this was the most effective intervention for 12-18 year olds. This recommendation also included the use of developmental adaptation where needed. In addition, based on stakeholder comments, the committee agreed to expand the scope of the research recommendation to cover children aged 5 to 11 years with mild or moderate to severe depression. The new research recommendation does not specify a particular psychological therapy.
Association of Child Psychotherapists	Guideline and Evidence Review	General	General	TERMINOLOGY: there is an interchangeable use of terms in the draft guidance - 'psychodynamic' 'child psychodynamic' 'child psychotherapy'. In the Evidence Review the intervention	Thank you for your comment. The committee discussed the interchangeable use of terms in the draft guideline. They agreed to use the term psychodynamic psychotherapy and to add a paragraph to the discussion of the benefits and harms section in the evidence review to clarify this issue.

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				list has 'child psychodynamic' and 'child psychoanalytic'. This is understandable as different terms have been used in US and European studies but as a result the guideline appears to be unclear about what form of psychodynamic or psychoanalytic psychotherapy and individual child psychotherapy is being recommended, based on which studies, and who should be providing it. This is critical for future service and workforce planning as both recommendation 1.6.5 and 1.6.12 are dependent on access to a workforce of Child and Adolescent Psychoanalytic Psychotherapists (currently lacking in many parts of the UK). A way of clarifying this would be helpful. For information, the IMPACT study was a study of 'Short Term Psychoanalytic Psychotherapy' which was conducted by Child and Adolescent Psychoanalytic Psychotherapists (members of the Association of Child Psychotherapists) who also wrote the manual for the study, whilst Trowell et al. used the term 'Focused Individual Psychodynamic Psychotherapy'. However, both studies	The committee noted that there were variations in the treatment protocols within individual psychological interventions between trials. They chose to group common intervention categories, such as psychodynamic psychotherapy, together within the pairwise and network meta-analyses, believing that the mechanism of action is sufficiently similar that this assumption was appropriate. They felt that all psychological interventions should only be delivered by properly trained professionals but did not feel that being prescriptive about this would be helpful to the system as a range of professionals might have undertaken the proper training to deliver individual psychological treatments. For psychodynamic psychotherapy, they expected this would largely but not exclusively be delivered by appropriately qualified clinical psychologists. They felt that recommending protocols from individual trials would be unhelpfully prescriptive, given the heterogeneity in the patient population.

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				were fundamentally evaluating the same type of therapy, i.e. a 28-30 session model of psychoanalytic psychotherapy with children and adolescents, as practiced by psychoanalytically-trained child psychotherapists in the UK and Europe.	
Association of Child Psychotherapists	Guideline	19	6	The revised guideline contains a downgrading of the recommendation to offer psychodynamic psychotherapy compared to the current iteration of the guideline. Whereas the current recommendation is: *1.6.1.2 Offer children and young people with moderate to severe depression a specific psychological therapy (individual CBT, interpersonal therapy, family therapy, or psychodynamic psychotherapy) that runs for at least 3 months. [new 2015]* The revised recommendation, in 1.6.4, is individual CBT or family therapy as the first line offer, with psychodynamic psychotherapy only to be 'considered' if 'the options in recommendation 1.6.4 would not meet the child or young person's clinical needs or are unsuitable for their circumstances'.	Thank you for your comment. The committee discussed the evidence for psychodynamic psychotherapy, but the lack of effect compared to a control for depression symptoms and small number of trials led to committee to make it a 2nd line treatment. Individual CBT was better at reducing depression symptoms and improving functional status, quality of life and suicidal ideas compared to waiting list/ no treatment or usual care, and at increasing remission compared to attention control and other therapies (such as family therapy) at the end of treatment. Based on this information and the magnitude of the effects, the committee agreed to recommend individual CBT as the first line treatment for young people with moderate to severe depression. However, the committee recognised that individual CBT might not be suitable or meet the needs of all young people with moderate to severe depression and so they agreed that additional options should be available such as psychodynamic psychotherapy.

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				This upgrading of CBT and family therapy for 2019 and downgrading of psychodynamic psychotherapy would appear to indicate that the guideline committee has reviewed evidence indicating this change is justified. However, the committee recognises (p.37 line 6) that "*The analysis of the evidence showed that psychodynamic psychotherapy increased remission at the end of treatment compared with attention control or family therapy and relaxation. In addition, it was as effective as individual CBT across a range of outcomes and follow-up times*." It would therefore appear to be inconsistent to amend the guideline in the way that has been done. It appears the justification for this is that 'only 1 study included psychodynamic psychotherapy', however this is incorrect – see comment 3 below. The major additional study considered by the committee as part of this review is the IMPACT study (Goodyer et al, 2017) which demonstrated equivalence with CBT as a first-stage treatment for moderate to severe depression. This would suggest psychodynamic	

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				psychotherapy should be upgraded to be one option as a first-stage treatment, but in fact the opposite has happened and CBT and family therapy have been prioritised. Is the committee clear that the review of evidence justifies this change? It is likely to have a significant impact on how services invest in and prioritise therapies (see comment 2 below) and must be based on clear and robust evidence of significantly greater first line effectiveness for CBT and family therapy to justify a change to the existing guidance. Is the committee satisfied that this is the case? The rationale indicates otherwise.	
Association of Child Psychotherapists	Guideline	30	7	Key recommendations for research. Given the relative paucity of evidence in relation to moderate to severe depression, as recognised in the rationale for the guideline (p.35), and the fact that quantity and quality of studies decreases as severity increases, and allied to recent prevalence data showing an increase in severity, it is surprising that the committee has prioritised further research into group CBT for children aged 5 to 11 years with moderate to severe depression and brief	Thank you for your comment. The committee agreed to amend the research recommendation on group CBT in children aged 5 to 11 years with moderate to severe depression. The new research recommendation does not specify a particular psychological therapy and has been expanded to include children aged 5 to 11 with mild or moderate to severe depression. The committee decided to remove the research recommendation on sequencing of psychological interventions because they agreed that research investment would be better focused on obtaining additional evidence of effectiveness for psychological interventions such as the brief psychosocial intervention (BPI), psychodynamic psychotherapy and IPT-A (IPT for adolescents) for moderate to severe depression.

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				psychosocial interventions. Surely the priority research gap relates to building on the existing, but limited, evidence of effectiveness in relation to moderate to severe (or perhaps severe and complex) depression. Perhaps this is covered by Recommendation 3. Sequences of psychological interventions, but it would be helpful if this was explicit otherwise there is a danger that this could lead to investment in further studies of treatment of mild depression which are more straightforward to fund and conduct. Treatment of, and research into, mild to moderate depression is clearly necessary but NICE needs to consider whether its recommendation may further distort the overall body of evidence which currently favours brief interventions and more mild presentations.	
Association of Child Psychotherapists	Guideline	37	9	It is stated that 'However, only 1 study included psychodynamic psychotherapy'. This is incorrect as both the IMPACT study and that by Trowell et al (2007) should be included. Trowell et al is cited in the Evidence Review pg. 543.	Thank you for your comment. The committee discussed the study by Trowell (2007) and they agreed to add a paragraph to the discussion of the "benefits and harms" section in the evidence review to clarify this issue. Trowell (2007) also tested psychodynamic psychotherapy intervention in 9-15 year olds, but was included in the analysis of the 5-11 age group. This trial showed that psychodynamic psychotherapy could not be differentiated from family therapy for

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					functional status post treatment and at 6 months, while depression symptoms were reduced by family therapy compared to psychodynamic psychotherapy post treatment, but could not be differentiated at 6 months follow up. These findings provide extra support for the inclusion of psychodynamic psychotherapy in the recommendations for 12-18 year olds with moderate to severe depression.
Association of Child Psychotherapists	Guideline	38	6	Further to comment 1, in the section 'How the recommendations might affect practice' it states that: 'The recommendations are likely to result in an increased use of individual CBT and family therapy and a decrease in other individual therapies.' This is concerning and emphasises why recommendation 1.6.4 needs to be carefully considered. It is unclear why the updated evidence should lead to recommendations that lead to a decrease in the use of psychodynamic psychotherapy, especially given there is now greater evidence of effectiveness, via the IMPACT study, than was available to the previous guideline review. This comment must be assumed to be based on the change to guidance in section 1.6.4 and 1.6.5. relating to first line treatment for mild to moderate depression. However, the guideline also	Thank you for your comment. The committee agreed to amend the section "How the recommendations might affect practice". They recognised that recommendations for moderate to severe depression are unlikely to change resource use, apart from the brief psychosocial intervention which is not commonly delivered in current practice but it is expected to be a lower intensity intervention than other individual therapies. Recommendation 1.6.12 is out of scope of this update and as a result, we are unable to change it. We are not refreshing out of scope recommendations as part of this update. The recommendation about using a full assessment of needs and patient and carer preferences and values is aimed at ensuring the most appropriate therapy is selected for the individual. This includes a clinical assessment of their depression severity. If the healthcare professional, together with the child or young person (CYP) with depression and their family members, agree that a psychological therapy (either from first or second-line options) is the most appropriate choice of therapy to meet the CYPs needs then the hierarchy of the recommendations should not be a barrier to their receiving the chosen psychological therapy. To ensure this is the case the committee specifically noted the role of individual

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				contains an unchanged recommendation at 1.6.12 for 'individual child psychotherapy (approximately 30 weekly sessions).[2005]' in the case of 'Depression unresponsive to combined treatment'. If it was the case that the severity of illness being seen by NHS CAMHS was increasing (and there is anecdotal evidence that it is and that many services are raising thresholds as a result, and there is also evidence of increased severity in the recent prevalence data from NHS Digital) then it might be the case that more children would not be able to benefit from the first line treatment and would be referred on to second line treatments such as individual psychotherapy. Has the committee assessed the level of need and severity of depression now presenting in services and is it satisfied that the guidance is appropriately calibrated to meet those needs? If not, the suggestion that 'the recommendations are likely to result in an increased use of individual CBT and family therapy and a decrease in other individual therapies' would seem to be inappropriate and potentially unhelpful.	preferences for the CYP and their family members in the choice of therapy and stated that if the first line options would not meet the CYP's clinical needs or are unsuitable for their circumstances, to consider one of the following options.

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				The danger is that service commissioners and providers will take this comment about practice implications as a NICE supported recommendation to increase or decrease therapies accordingly, *whether or not* that is the intention of the committee.	
British Association for Behavioural & Cognitive Psychotherapies	Guideline	General	General	Consideration of the use of systemic CBT throughout the guidance for all levels of depression – or at least to broaden the scope of the problem list to include important social relationships- that support or undermine so these are always considered in therapy.	Thank you for your comment. The committee made a recommendation about the full assessment of needs to base the choice of psychological therapy that highlights important considerations for the shared decision-making process including the circumstances of the child or young person and their family members or carer(s) and their personal/social history and presentation.
British Association for Behavioural & Cognitive Psychotherapies	Guideline	General	General	It is important to consider the differential diagnosis of symptoms representative of low mood, such as Body dysmorphic disorder, attachment and trauma. This is not highlighted significantly throughout the guidelines and is a frequent misdiagnosis/ misunderstanding when assessing symptomology.	Thank you for your comment. The section " Detection, risk profiling and referral" was not within the scope of this update and therefore we are unable to make changes to this area. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
British Association for Behavioural & Cognitive Psychotherapies	Guideline	11	2	Within the stepped care model table, we are concerned that this recommendation is based on a medical model. It is important to include biopsychosocial aspects such as regular exercise and engaging social activity to help relieve symptoms of low mood. This should be	Thank you for your comment. As you note, the stepped care model presented in Table 1 focuses on the use of psychological therapies and medication. However, the section "Treatment and considerations in all settings" includes recommendations on the benefits of exercise and a balanced diet.

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				considered for all presentations and incidents of reference to mild depression throughout the guidance. NICE should be endorsing physical and social activity to help maintain mental health and manage all levels of mental health difficulties. Also, severity alone doesn't predict what level/step in care should be offered – but instead complexity and crucially preference- how they want to learn and work on their difficulties. Who offers support for varied self-help interventions also should take into account preference.	The stepped care model in its entirety was not part of this update, but was updated in part to reflect the new recommendations on psychological therapies.
British Association for Behavioural & Cognitive Psychotherapies	Guideline	17	4	Understanding the options of therapy can only be fully realised in conjunction with sufficient psycho education is given to the patient from a physiological perspective. The theory of the therapies, mapped on to the physiological understanding is demonstratable in practice. The common overlap of low mood and irritability in young people and often confusing range of symptoms faced can really benefit from a CBT formulation that helps make sense of what is happening and what needs to change.	Thank you for your comment. The recommendation you refer to already includes a discussion on how the chosen psychological therapies could meet children and young people's individual needs which might involve the discussion of symptoms.

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British Association for Psychopharmacology	General	General	General	No distinctions made between prepubertal and postpubertal depression despite evidence they seem different.	Thank you for your comment. The committee agreed with the importance of maturity and developmental level when treating depression in children and young people. Therefore, the new recommendations on treating mild or moderate to severe depression in 5 to 11 year olds include consideration of the children's developmental level as part of the process of adapting the chosen psychological therapy.
British Association for Psychopharmacology	General	General	General	Training opportunities should be made available to improve the accuracy 10 of CAMHS professionals in diagnosing depressive conditions. The 11 existing interviewer-based instruments (such as Kiddie-Sads [K-SADS] 12 and Child and Adolescent Psychiatric Assessment [CAPA]) could be used 13 for this purpose but will require modification for regular use in busy routine 14 CAMHS settings. [2005] This is not realistic really. Also not evidence-based –depression behaves as a dimension in any case. So accuracy as such is spurious. Suggest an alternative that is going to be feasible in practice. DAWBA is at least digital but even then quite hard to get families to complete. Again-it will mean clinicians will ignore the guidance. Maybe focus more closely	Thank you for your comment. The section "Referral criteria" that contains this recommendation on training was not within the scope of this update and therefore we are unable to make changes to this area. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.

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				on quick easy methods to assess in primary care (questionnaires first) and how quickly to gauge severity e.g. mild, moderate etc.	
British Association for Psychopharmacology	Guideline	Table 1	General	Treatment guidance seems to be heavily guided by one trial-the IMPACT trial. This should be made explicit and the specifics of the treatments stated especially for psychodynamic psychotherapy that can be delivered in many different ways. To me, the main RCT findings at present seem to highlight non superiority of a single type of psychotherapy. It would be helpful to have more general recommendations –ie. More moderate-severe depression -give psychotherapy (the following have been trialled). Table 1 is confusing and I think most clinicians will ignore it and may fail to get the key message. Again access to treatment to any therapy at present is a problem-these guidelines assume it is not a problem. Would be good to have much more for primary care and Tier 1. Very heavily geared towards psychiatry /clinical psychology in s-CAMHS at present.	Thank you for your comment. The recommendation about the full assessment of needs is not intended to be prescriptive, but rather to highlight some important considerations for the shared decision-making process. If the healthcare professional, together with the child or young person (CYP) with depression and their family members, agree that a psychological therapy (either from first or second-line options) is the most appropriate choice of therapy to meet the CYPs needs then the hierarchy of the recommendations should not be a barrier to their receiving the chosen psychological therapy. To ensure this is the case the committee specifically noted the role of individual preferences for the CYP and their family members in the choice of therapy and stated that if the first line options would not meet the CYP's clinical needs or are unsuitable for their circumstances, to consider one of the following options including the chosen psychological therapy. Although as you point out the IMPACT trial did not show superiority of one therapy over another, analysis of a larger body of evidence for 12-18 year olds with moderate to severe depression, individual CBT was better at reducing depression symptoms and improving functional status, quality of life and suicidal ideas compared to waiting list/ no treatment or usual care, and at increasing remission compared to attention control and other therapies (such as family therapy) at the end of treatment. Based on this information and the magnitude of the effects, the committee agreed to recommend

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				s-CAMHS can be much more straightforward guidance-psychotherapy (list and explicitly state nature of which ones) plus or minus fluoxetine.	individual CBT as the first line treatment for young people with moderate to severe depression. However, the committee recognised that individual CBT might not be suitable or meet the needs of all young people with moderate to severe depression and so they agreed that additional options should be available. They chose to include IPT-A (IPT for adolescents), family therapy, brief psychosocial intervention and psychodynamic psychotherapy as second line options that were evidence based but where effectiveness was less certain.
British Association for Psychopharmacology	Guideline	Table 1	General	Family therapy-doesn't the evidence base relate to children and is weak for adolescents? Again, not very clear because the evidence here comes from very specific manualised treatments when practice-based therapies could mean something very very different.	Thank you for your comment. The committee agreed that family therapy can include a range of different types of therapies including attachment-based and systemic subgroups. They also noted that specific types of family therapy were shown to be effective for mild or moderate to severe depression for each age group. Therefore, the committee agreed to specify the type of family therapy in the recommended psychological therapies for each age group. Family therapy was considered a second line option because evidence on effectiveness was less certain for both mild and moderate to severe depression.
British Association for Psychopharmacology	Guideline	1.1.11 1.1.5	4	I am concerned that neurodevelopmental disorders such as ADHD and ASD may get omitted in assessment of comorbidities and is relevant to treatment. Self-help - also include digital/web-based-DVD-based psychoeducation-not just leaflets	Thank you for your comment. The committee recognised that children and young people with depression and with neurodevelopmental disorders may require directing towards different therapies and, based on stakeholder comments, the committee included consideration of comorbidities, neurodevelopmental disorders, communication needs (language, sensory impairment) and learning disabilities in the full assessment of needs recommendation to reflect this. The committee also included neurodevelopmental disorders as a subgroup in their research recommendations because they

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		General	32 10	Big literature (and clinical experience) that difficult to access s-CAMHS and highly trained therapists. Wait lists will remain a problem with this guidance. How about more on what to do in Tier 1 especially with planned moves now to do more in primary mental health teams and in schools. Given literature gaps still on more severe depression, can still give guidance on some things that might work (or not work) e.g. BAT in low and middle income countries, enhancing resilience, self-care, dealing with stressors and relationships.	recognised that there was a shortage of evidence of effective treatments for this group.
British Association for Psychopharmacology	Guideline	19	6	The recommended first-line treatment for moderate to severe depression in adolescents is CBT or family therapy (1.6.4). This is despite the evidence summary demonstrating that neither therapy is significantly superior to any active comparators (eg placebo, monitoring, NDST, supportive therapy, p. 375, table 23); they are simply better than being on a waiting-list with no treatment. As with previous versions of the guideline, fluoxetine is not recommended as a first-line treatment. While a lot of effort has been made to	Thank you for your comment. Antidepressant treatments were not within the scope of this update and therefore we are unable to make changes to this area. The recommendation about the full assessment of needs is not intended to be prescriptive, but rather to highlight some important considerations for the shared decision-making process. If the healthcare professional, together with the child or young person (CYP) with depression and their family members, agree that a psychological therapy (either from first or second-line options) is the most appropriate choice of therapy to meet the CYPs needs then the hierarchy of the recommendations should not be a barrier to their receiving the chosen psychological therapy. To ensure this is the case the committee specifically noted the role of individual preferences for the CYP and their family members in the choice of

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				compare psychological therapies, it seems wrong that fluoxetine (and indeed other antidepressants) are not included in the network meta-analysis. This would be possible as placebo is one of the nodes of NMA. This deliberate omission of one potential treatment seems especially remiss when recent meta-analyses have demonstrated fluoxetine (unlike psychological therapies) to be significantly superior to placebo (Cipriani et al., 2016)(Locher et al., 2017); and the only comparative study demonstrated fluoxetine to be significantly superior to CBT by end of treatment (March et al., 2004); notably that March RCT was much larger than most studies included in the NMA used to create these guidelines (more than 100 per group) and was not industry-funded. We think it appropriate to include all potential treatments in a network meta-analysis used to make treatment recommendations. We predict that this would demonstrate fluoxetine to be superior to placebo (unlike CBT and FT); and may demonstrate fluoxetine to be superior to FT and CBT. We accept that one reason for suggesting CBT and	therapy and stated that if the first line options would not meet the CYP's clinical needs or are unsuitable for their circumstances, to consider one of the following options including the chosen psychological therapy. In an analysis of a large body of evidence for 12-18 year olds with moderate to severe depression, individual CBT was better at reducing depression symptoms and improving functional status, quality of life and suicidal ideas compared to waiting list/ no treatment or usual care, and at increasing remission compared to attention control and other therapies (such as family therapy) at the end of treatment. Based on this information and the magnitude of the effects, the committee agreed to recommend individual CBT as the first line treatment for young people with moderate to severe depression. However, the committee recognised that individual CBT might not be suitable or meet the needs of all young people with moderate to severe depression and so they agreed that additional options should be available. They chose to include IPT-A (IPT for adolescents), family therapy, brief psychosocial intervention and psychodynamic psychotherapy as second line options that were evidence based but where effectiveness was less certain.

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				FT as first-line may be (as stated in the original 2005 CG28) because the benefit:risk balance is favourable for psychological therapies. The caveat here being that as yet psychological therapies have not developed treatment sensitive side effects measures and we do not know how tolerable and safe therapies are in this age range. Therefore in the absence of safety data this is a non-robust conclusion to draw when most psychological therapy studies have not measured side-effects, or have focused solely on the side-effects more common in antidepressants but not psychological therapy (Nutt & Sharpe, 2008) (Goodyer and Wilkinson 2018). Even if the evidence were robust for side-effects to be less in psychological therapy, the evidence of efficacy is stronger for antidepressants than psychological therapy. Thus antidepressants could be said to have more benefits but more side-effects – making a decision on which treatment to use first line to be non-straightforward. It therefore seems inappropriate for NICE to decide on behalf of individual patients and their families which type of	

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				treatment has a greater benefit:risk ratio. Instead we believe it would be more appropriate for patients and their families to be presented with the evidence for benefits and harms of psychological therapy and fluoxetine, and to make the informed choice themselves weighing up the potential benefits and harms for themselves (Goodyer and Wilkinson 2018). To make this more real world at a time when there is such a shortage of trained psychological therapists, it may be even more appropriate that families should weigh up the benefits, harms and waiting-lists for antidepressants and talking therapies. In conclusion, we think that fluoxetine should be added as a potential first-line treatment for moderate-severe depression in adolescents (alongside, but not superior nor inferior to, psychological therapies). Finally the suggestion that FT should be a first line treatment disregards that the newer forms of this treatment are not those currently practised in the UK. To recommend FT without specifying that the Diamond et al model currently under investigation is specifically about	

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				attachment based FT: not what most FT in NHS practice will be using. There is a risk of overgeneralisation not consistent with the preliminary data by Diamond and colleagues. We do not see sufficient evidence or change in benefit:risk ratio to uprate FT to 1st line treatment. Cipriani, A., Zhou, X., Del Giovane, C., Hetrick, S. E., Qin, B., Whittington, C., … Xie, P. (2016). Comparative efficacy and tolerability of antidepressants for major depressive disorder in children and adolescents: a network meta-analysis. *Lancet*. https://doi.org/10.1016/S0140-6736(16)30385-3 Goodyer IM, Wilkinson PO.(2018) Practitioner Review: Therapeutics of unipolar major depressions in adolescents. J Child Psychol Psychiatry. doi: 10.1111/jcpp.12940. [Epub ahead of print]. Locher, C., Koechlin, H., Zion, S. R., Werner, C., Pine, D. S., Kirsch, I., … Kossowsky, J. (2017). Efficacy and Safety of Selective Serotonin	

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				Reuptake Inhibitors, Serotonin-Norepinephrine Reuptake Inhibitors, and Placebo for Common Psychiatric Disorders Among Children and Adolescents: A Systematic Review and Meta-analysis. *JAMA Psychiatry*, *74*(10), 1011–1020. https://doi.org/10.1001/jamapsychiatry.2017.2432 March, J., Silva, S., Petrycki, S., Curry, J., Wells, K., Fairbank, J., … Severe, J. (2004). Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression: Treatment for Adolescents With Depression Study (TADS) randomized controlled trial. *Journal of the American Medical Association*, *292*(7), 807–820. Retrieved from http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=15315995 Nutt, D. J., & Sharpe, M. (2008). Uncritical positive regard? Issues in the efficacy and safety of psychotherapy. *J*	

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				Psychopharmacol, *22*(1), 3–6. https://doi.org/10.1177/0269881107086283	
British Association for Psychopharmacology	Guideline	19	6	IPT-A has been changed to a second-line treatment after previously being a first-line treatment in the 2005 and 2015 guidelines (1.6.4). This is despite there being no new evidence since then that IPT is not effective (nor no large new studies showing CBT/FT to be effective). This seems to be because the new draft guidelines only use self-rated symptoms and not both self and observer-rated symptoms. The latter were used in the previous guidelines and the recent NMA that found IPT and CBT (but not family therapy) to be effective for adolescent depression; and IPT to have significantly higher acceptability than CBT (Zhou et al., 2015). This is important as the two main studies comparing IPT to active control treatments use the observer-rated HAM-D as the primary outcome measure, and in both studies, IPT led to a statistically-significant reduction in HAM-D (the primary outcome measure) compared with placebo (Mufson et al., 2004; Mufson, Weissman, Moreau, & Garfinkel, 1999). It is normal good	Thank you for your comment. The recommendation about using a full assessment of needs and patient and carer preferences and values is aimed at ensuring the most appropriate therapy is selected for the individual. If the healthcare professional, together with the child or young person (CYP) with depression and their family members, agree that a psychological therapy (either from first or second-line options) is the most appropriate choice of therapy to meet the CYPs needs then the hierarchy of the recommendations should not be a barrier to their receiving the chosen psychological therapy. To ensure this is the case the committee specifically noted the role of individual preferences for the CYP and their family members in the choice of therapy and stated that if the first line options would not meet the CYP's clinical needs or are unsuitable for their circumstances, to consider one of the following options including IPT-A (IPT for adolescents). Based on the NMAs for 12-18 year olds with moderate to severe depression, IPT-A was effective at reducing depression symptoms and increasing functional status post-treatment compared to waiting list/no treatment or usual care. However, IPT-A was recommended as a second line option, because there was no data for remission, suicide ideation or quality of life, or for later time points for functional status and IPT-A was no better or worse than other interventions or controls at 6 months for depression symptoms In contrast, there was a larger body of evidence for individual CBT and it was better at reducing depression symptoms and improving functional status, quality of life and suicidal ideas compared to

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				practice for treatment studies (and hence meta-analyses) to use both observer and self-rated symptoms (Uher et al., 2012) and no justification is given for dropping observer-rated measures in this guideline. Given that none of the psychological therapies was significantly better than active control treatments, it would seem appropriate to use a wide variety of outcome measures to make conclusions from such a set of therapies, all with only a small amount of evidence demonstrating efficacy. It is also notable that even when self-rating depressive symptom scores were used: IPT was rated as equivalent to FT (ie 50% chance that each one is superior over the other) (p423, table 36); and that if meta-analysis of direct comparisons is used, IPT is superior to waiting-list while family therapy is not tested against waiting-list (p. 375, table 23); both good reasons for IPT not to be below family therapy. Further support for IPT is given by the fact that the NMA demonstrated it to be better than usual care in reducing functional impairment; and that the largest effect size for improvement in functional impairment was found for IPT.	waiting list/ no treatment or usual care, and at increasing remission compared to attention control and other therapies (such as family therapy) at the end of treatment. Based on this information and the magnitude of the effects, the committee agreed to recommend individual CBT as the first line treatment for young people with moderate to severe depression. The committee recognised that additional research on IPT-A that provided evidence on more outcomes and longer time points would be useful in determining the relative effectiveness of this intervention in comparison to individual CBT and other psychological therapies and they made a research recommendation to address this issue At the stage of data extraction, we identified the most commonly used tools for reporting functional status and other outcomes such as depression symptoms. Most studies reported depression symptoms using more than 1 rating scale, with the Child depression rating scale-revised and Child depression Inventory being the most common with 16 and 14 studies respectively. In comparison, the Hamilton rating scale for depression was only reported by 9 studies. The committee agreed to allow prioritisation of certain scales for data extraction for each outcome based on the most frequently used scales in the included studies, a hierarchy of depression symptom severity measurement scales reported by a Cochrane review of newer generation antidepressants for depressive disorders in children and adolescents (Hetrick 2012) and their own experience. The committee agreed that self-report scales would give the opportunity to children and young people to report their own experience.

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				We think it wrong that IPT is wrongly excluded from the NMA for 6-18 months, when again the previously-published NMA showed IPT to be significantly superior to control treatments at long-term follow-up (Zhou et al., 2015). Mufson, L., Weissman, M. M., Moreau, D., & Garfinkel, R. (1999). Efficacy of interpersonal psychotherapy for depressed adolescents. *Archives of General Psychiatry*, *56*(6), 573–579. Mufson, L., Dorta, K. P., Wickramaratne, P., Nomura, Y., Olfson, M., & Weissman, M. M. (2004). A randomized effectiveness trial of interpersonal psychotherapy for depressed adolescents. *Arch Gen Psychiatry*, *61*(6), 577–584. Uher, R., Ph, D., Perlis, R. H., Placentino, A., Psy, D., Dernovšek, Z., … Farmer, A. (2012). Self-report and clinician-rated measures of depression severity: can one replace the other? *Depress Anxiety*, *29*(12), 1043–1049. https://doi.org/10.1002/da.21993 Zhou, X., Hetrick, S. E., Cuijpers, P.,	The evidence on IPT-A for functional status at 6 to 18 months was not connected to the rest of the treatments, and therefore, it was not included to the NMA. We are aware of the Zhou (2015) NMA and include it in our evidence base as a published NMA. However, we have not used it to make recommendations because the authors grouped therapies based on their approach (IPT, CBT etc.) but did not separate them out by method of delivery (group, individual etc.).

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				Qin, B., Barth, J., Whittington, C. J., … Xie, P. (2015). Comparative efficacy and acceptability of psychotherapies for depression in children and adolescents: A systematic review and network meta-analysis. *World Psychiatry*, *14*(2), 207–222. https://doi.org/10.1002/wps.20217	
British Association for Psychopharmacology	Guideline	19	6	'Family therapy' has been recommended as a first-line treatment. Family therapy is a very broad range of related therapies, that focus primarily on working at the family, rather than the individual level. The main therapies that suggested effectiveness (although themselves not showing significant benefits vs control) for moderate-severe depression in adolescents were actually of attachment-based family therapy (Diamond 2002, Israel 2013, Poole 2018), which is rather different to standard family therapy. Hence delivering standard FT (as suggested by the guidelines) would not lead to similar results, and should not be recommended. Indeed the main study of standard FT (Brent 1997) suggested family therapy to be inferior to non-	Thank you for your comment. The committee agreed that multiple forms of family therapy exist, including family-focused treatment for childhood depression, attachment based and systemic family therapy, but agreed that they were sufficiently similar that they could be analysed under the grouping of family therapy. They also agreed to reclassify the study by Dietz (2015) as family based IPT. The NMAs were reanalysed and family based IPT showed to be effective for the treatment of moderate to severe depression in children aged 5 to 11 years. The committee agreed to add a separate recommendation for this group including family based IPT as one of the recommended psychological therapies. The committee also specified the types of family therapy in the recommendation based on the forms used by the studies included in the evidence.

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				directive supportive therapy. Dietz 2015 is included as a family therapy study when the intervention is actually family-based interpersonal psychotherapy (FB-IPT), not family therapy. The difference is important – FB-IPT is mainly focused on the individual adolescent and their relationships (with family and peers), with parental support. This is different to family therapy which works with the whole family and all the relationships in that family. And so this study should be included under IPT, not FT.	
British Association for Psychopharmacology	Guideline Guideline	19 36-37	15 22-5	IPT plus parent sessions is recommended as being better than individual IPT (1.6.5). This seems to be based entirely on a single pilot feasibility study of 15 patients (Gunlicks-Stoessel & Mufson, 2016). Furthermore, that study had a tight inclusion criterion of high levels of family conflict, hence it is not right to extrapolate it to the full population of depressed adolescents. From speaking to an IPT-A expert, the IPT-A control group in that study does not resemble normal IPT-A as practised and taught in the UK (and indeed in other parts of the world, including in the main RCTs of IPT): this has much	Thank you for your comment. The committee agreed that the RCT by Gunlicks-Stoessel (2016) artificially manipulated the involvement of parents in both arms of the study. Therefore, this RCT was not connected to the network meta-analyses anymore and it was removed from the NMAs. Gunlicks-Stoessel (2016) was only reported in the pairwise analysis. IPT-A (IPT for adolescents) was kept in the recommendations for moderate to severe depression but without any specific involvement of parents. The committee also recognised that IPT-A is designed to include parents on a flexible basis.

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				greater parental involvement. Hence UK IPT-A seems to lie somewhere between the IPT-AP and the IPT-A in this study, and cannot be seen as inferior to IPT-AP.	
British Association for Psychopharmacology	Guideline	31	7	Studies of all psychological therapies have sadly been mostly small and of poor quality. IPT is significantly better than active control treatments on observer-rated, but not self-rated, depression symptoms, but these studies were small and inadequately powered, which may explain why the difference on self-rated depression scales was non-significant. IPT has been shown to be equivalent to CBT for adult depression, based on more and larger studies (Barth et al., 2013). We therefore think it important to evaluate this treatment properly in depressed adolescents in a robust, adequately powered RCT. Ideally this would be against CBT and an active control. In fact, a large study could test moderators of treatment so we can tell what works for whom. We think this should be added to the research recommendations. Barth, J., Munder, T., Gerger, H.,	Thank you for your comment. The committee agreed to add a research recommendation to obtain additional evidence of effectiveness for psychological interventions such as IPT-A (IPT for adolescents), brief psychosocial intervention (BPI) and psychodynamic psychotherapy compared to each other and to individual CBT in young people aged 12 to 18 years with moderate to severe depression.

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				Nuesch, E., Trelle, S., Znoj, H., … Cuijpers, P. (2013). Comparative Efficacy of Seven Psychotherapeutic Interventions for Patients with Depression : A Network. *PLoS Med*, *10*(5), e1001454. https://doi.org/10.1371/journal.pmed.1001454	
British Association of Counselling and Psychotherapy	Guideline	General	1.5.8	We strongly support this recommendation and recognise that support offered outside of CAMHS may meet the needs of different client groups. Specifically, research has found that counselling provided in voluntary and community sector services may be more accessible for those from marginalised groups, such as those from Black, Asian and Minority Ethnic (BAME) backgrounds (Duncan, Rayment, Kenrick & Cooper, 2018)[CD1] . [CD1]Duncan, C., Rayment, B., Kenrick, J., & Cooper, M. (2018). Counselling for young people and young adults in the voluntary and community sector: An overview of the demographic profile of clients and outcomes. *Psychology and*	Thank you for your comment and support of this recommendation.

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				Psychotherapy: Theory, Research and Practice.	
British Association of Counselling and Psychotherapy	Guideline	17	1.5.4	**Context of response:** BACP have prepared this response to the updated draft guidelines in our role as a professional body for UK counsellors and psychotherapists. As the largest British professional body for those providing psychological therapies we aim to campaign for the highest standards of care for children and young people who experience anxiety and depression. Moreover, our responsibility to both our members and the British public means that we campaign for a range of treatments to be available through the NHS for those with mild to moderate depression. This commitment reflects the considerable evidence of broad equivalence between (adult) therapies for depression (Gyani, Shafran, Layard & Clark, 2013; Pybis, Saxon, Hill, & Barkham, 2017; Stiles, Barkham, Twigg, Mellor- Clark, & Cooper, 2006; Stiles, Barkham, Mellor-Clark, & Connell, 2008) but also the evidence that it is important to give clients choice about treatment options because doing so improves treatment	Thank you for your comment. We do not include studies on adults as evidence for this update as the guideline is focused on identifying and managing depression in children and young people between the ages of 5-18 years. Counselling was included in the protocol for this update (see Table 1 in the evidence review), but we did not identify any relevant RCTs that met the protocol. We did not include Javanmiri 2013, because it was not possible for us to allocate it to mild or moderate to severe depression based on the description of the inclusion criteria in the paper and our categorisation of these groups. In this review, studies were included in the mild depression category if they contained participants who were recruited on the basis of depression symptoms, while the moderate to severe depression category required study participants to have a diagnosis of depression. Javanmiri (2013) had one of the inclusion criteria as "meeting a clinical interview based on DSM-IV-2". However, they did not specify what diagnoses were identified with the clinical interview. Javanmiri (2013) also reported the baseline means of depression using the Beck depression inventory (BDI) for both intervention and control groups. However, the committee highlighted that these means and their standard deviations covered mild to moderate depression. The committee agreed that it was important to match the choice of psychological therapy with individual and family needs, preferences and values. The hierarchy of the recommendations should not preclude the tailoring of the choice of therapy to individual needs as

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				outcomes (Lindhiem, Bennett, Trentacosta, & McLear, 2014; Williams et al., 2016). BACP welcome the opportunity to respond to these draft guidelines and has concerns regarding elements of the document, we note the introduction of digital CBT for low level depression as an option, acknowledging that online platforms are **one** of young people's personal preferences regarding choice and treatments and can work well for those in isolated areas or where there are a lack of therapists, we feel, however, the choice offered is limited. We strongly advocate for a full range of therapeutic options, including the offer of both online and face-to-face humanistic counselling to meet individual needs for both mild to moderate depression. **Humanistic counselling involves an** individual processing and articulating their thoughts and feelings, the emphasis being on self-development, leading to greater understanding and consequently change rather than on problematic behaviour or responding to	the recommendations list an additional choice of options should the first line treatments prove unsuitable. As you note, recommendation 1.5.2.1 was removed. Therefore, the committee agreed to recommend that health care professionals explain the evidence for each age group (including the limited evidence for 5- to 11-year-olds) within the recommendation on the discussion of the choice of psychological therapies for both mild and moderate to severe depression. The committee agreed to base recommendations for psychological therapies on effectiveness data on a number of outcomes and on cost as well as data from the NMAs showing clinical effectiveness across a range of outcomes, average costs estimated for digital CBT and group therapy (CBT, IPT and NDST) were lower than those for individual CBT and family therapy. Taking the estimated cost, the size of the evidence base and the magnitude of effect into account, the committee agreed that a choice of digital CBT, group IPT, group NDST or group CBT should be offered first. Additional reasons for individual CBT not being included as a first line option were that the magnitude of effect on depression symptoms was smaller than the first line therapies and, even though there was a meaningful effect on functional status, this outcome was only reported in a study that recruited young people with depression and a comorbidity. Family therapy showed meaningful effects on depression symptoms, but these results were based on a single study. A full discussion can be found in the Evidence Review document. Regarding the ongoing ETHOS trial (Stafford 2018), we will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.

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				a set number of predetermined questions. Research supports that different types of clients require different treatments and relationships (Norcross & Wampold, 2019), again advocating for more choice to meet individual and family needs, preferences and values, something which is emphasised in the new draft guidelines although the choice offered is hierarchical with first-line options extremely limited. We are concerned that the new guidelines omit the statement from the 2015 update that 'there is no good-quality evidence that one type of psychological therapy is better than the others''. The present document contradicts this thinking with the introduction of a rigid stepped referral pathway (excluding a full range of psychological therapies) whilst at the same time, advocating more choice to meet individual needs. Such choice should include school-based humanistic counselling (SBHC)	Reference: Javanmiri et al., (2013). The Study of Solution-Focused Group Counselling in Decreasing Depression among Teenage Girls. International Journal of Psychological Studies; Vol. 5, No. 1; p105.

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				which is a manualised, evidence-based approach, rooted in humanistic competencies for working with young people. Pilot research suggests SBHC is associated with medium to large reductions in psychological distress, compared to pastoral care as usual at 12 weeks (Stafford, et al., 2018). There is currently a fully-powered clinical and cost-effectiveness randomised control trial (RCT) being undertaken in London (ETHOS trial). Data are being collected on psychological distress, anxiety, depression, self-esteem, well-being and personal goals at baseline, 6 week, 12 week and 24 week follow up (Stafford et al., 2018). Results are expected in 2019. Guideline developers should be aware of this research and BACP recommends that the present guidelines are reviewed once the ETHOS results become publicly available.	
British Association of Counselling and Psychotherapy	Guideline	17	1.5.6	BACP notes the limitations of this offer due to lack of therapeutic choice and would welcome more options, including humanistic counselling as an early intervention when working with psychological distress caused by low	Thank you for your comment. Counselling was included in the protocol for this update (see Table 1 PICO table in the evidence review), but we did not identify any relevant RCTs that met the protocol. We did not include Javanmiri 2013, because it was not possible for us to allocate it to mild or moderate to severe depression based on the description of the

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				level anxiety and depression. Evidence from our school-based counselling evaluation in Wales found that average scores on YP-CORE (a standardised measure of psychological distress) reduced from 18 to 10.5 across an average period of 4-6 sessions. Over the same period, scores on the Strengths and Difficulties Questionnaire (a standardised emotional and behavioural screening tool) fell from 18 to 12. We recommend that up to 16 to 20 sessions are available for mild to moderate depression, as this would allow for flexibility should there be a clinical need to extend treatment (as well as limiting the number of professionals a child or young person sees, as recommended in 'Future in Mind'). Added to this, the cost effectiveness of IPT provision needs to be considered, as well as the available workforce, humanistic counselling could be offered as a cheaper alternative, with a trained, competent workforce ready to go, with similar results. Humanistic counsellors are already working at levels of recognised competencies and have	inclusion criteria in the paper and our categorisation of these groups. In this review, studies were included in the mild depression category if they contained participants who were recruited on the basis of depression symptoms, while the moderate to severe depression category required study participants to have a diagnosis of depression. Javanmiri (2013) had one of the inclusion criteria as "meeting a clinical interview based on DSM-IV-2". However, they did not specify what diagnoses were identified with the clinical interview. Javanmiri (2013) also reported the baseline means of depression using the Beck depression inventory (BDI) for both intervention and control groups. However, the committee highlighted that these means and their standard deviations covered mild to moderate depression. The committee recognised that the evidence on digital CBT was from a variety of programmes which had different components and were delivered in a variety of settings. Therefore, the committee agreed to provide a list of these programmes and their common components as part of the terms used in the guideline. Some of these programmes also include support and regular monitoring. The committee have now included a research recommendation looking at the relative effectiveness of supported and unsupported digital CBT, which also aims to determine which key components are responsible for the effectiveness of the intervention. The recommendation about the full assessment of needs is not intended to be prescriptive, but rather to highlight some important considerations for the shared decision-making process. If the healthcare professional, together with the child or young person (CYP) with depression and their family members, agree that a

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				been contributing to the CYPT IAPT provision. We would query whether the digital CBT offered was through a therapist available online or whether the courses were self-help programmes that children and young people simply work through, the former being favourable as it would provide therapeutic contact, we would still query how much therapeutic contact this involved. Whilst discussing mental health, the government continuously refer to Future in Mind, The Five Year Forward View for Mental Health and the recently published NHS Long-Term Plan (HC Deb 12 February 2019), all documents emphasizing the importance of patient choice. Future in Mind stresses the importance of having 'the opportunity to shape the services you receive" (Future in Mind, 11). The Five Year Forward View talks about the importance of a choice of **psychological therapies:** "every person with a mental health problem	psychological therapy (either from first or second-line options) is the most appropriate choice of therapy to meet the CYPs needs then the hierarchy of the recommendations should not be a barrier to their receiving the chosen psychological therapy. To ensure this is the case the committee specifically noted the role of individual preferences for the CYP and their family members in the choice of therapy and stated that if the first line options would not meet the CYP's clinical needs or are unsuitable for their circumstances, to consider one of the following options including the chosen psychological therapy. As there were no data on counselling included in the clinical review, the committee could not assess its cost-effectiveness versus the recommended therapies. They noted that IPT-A (IPT for adolescents) was shown to be effective for some outcomes in the clinical review and was not significantly different in costs to other recommended psychological therapies. They therefore concluded that it is likely to represent a cost-effective use of resources within this patient group. Reference: Javanmiri et al., (2013). The Study of Solution-Focused Group Counseling in Decreasing Depression among Teenage Girls. International Journal of Psychological Studies; Vol. 5, No. 1; p105.

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				should be able to say: I have rapid access, within a guaranteed time, to effective, personalised care. I have a choice of talking therapy so that I can find one appropriate to me", adding that "people also value having a choice of support, tailored to their specific needs, including access to a full range of psychological therapies." The guideline contradicts these flagship documents around patient choice in relationship to psychological therapies and needs to reflect other leading policies.	
British Association of Counselling and Psychotherapy	Guideline	17	1.5.7	BACP are concerned that non-directive support therapy has been removed and highlight that non-CBT therapies do not receive equal funding, resulting in less research being available. Lack of research demonstrating effectiveness is not the same as it being ineffective. Added to this, CBT studies have been criticised for being of low quality and at risk of being influenced by researcher bias, therefore, a more pluralistic approach to treatment and research is needed (Leichsenring, & Steinert, 2017). BACP question whether CBT should be gold standard for psychotherapy,	Thank you for your comment. The committee agreed not to recommend non-directive supportive therapy (NDST) because: - NDST was not more effective at reducing depression symptoms at the end of treatment or 6 months follow-up than control and there was no evidence for functional status or remission. However, the network meta-analyses were reanalysed after removing evidence including comorbidities. The committee discussed that evidence from RCTs including young people with depression and with comorbidities may show a differential effect compared to RCTs including young people with depression and without comorbidities. Therefore, the committee agreed to remove this evidence from the network meta-analyses. The new evidence showed that group NDST was more effective than waiting list/no treatment at reducing depression symptoms at 6 months and up to 18 months post-treatment. Based on these findings, the committee agreed to add group NDST together with

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				stressing the need for plurality in treatment and research. Whilst supporting the offer of family therapy, BACP note there is a risk factor when offering this treatment as **one** of **only** two options, most notably, around undisclosed domestic abuse, which impacts on low to moderate depression, with children's services estimating that in 2017 they only worked with 50% of children and young people who are affected by domestic abuse. The risk factor being around fear and control as an under-current within the family therapy room and either remaining hidden or resulting in disclosure. Again, this links to lack of choice, a theme throughout the document.	digital CBT, group CBT, and group IPT for the treatment of mild depression in 12-18 year olds. The recommendation about the full assessment of needs is not intended to be prescriptive, but rather to highlight some important considerations for the shared decision-making process. If the healthcare professional, together with the child or young person (CYP) with depression and their family members, agree that family therapy is not the most appropriate choice of therapy to meet the CYPs needs then the hierarchy of the recommendations should not be a barrier to their receiving the chosen psychological therapy. To ensure this is the case the committee specifically noted the role of individual preferences for the CYP and their family members in the choice of therapy.
British Association of Counselling and Psychotherapy	Guideline	17	1.5.9	BACP support this recommendation though do note that humanistic counsellors are highly trained and competent professionals when working within mental health, as well as competent when working with children and young people, with BACP members working to accredited professional standards in both counselling and psychotherapy.	Thank you for your comment and this information.

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British Association of Counselling and Psychotherapy	Guideline	18	1.5.10	BACP recommend that humanistic counselling should be offered alongside other earlier therapeutic options prior to the need to refer to tier 2 or 3 services thus narrowing the gap between primary care and CAMHS. Many GP's refer to CAMHS knowing children and young people will be rejected but acknowledging they still need more support, as many as one in four young people do not meet CAMHS thresholds. BACP strongly advocate for a professional school- based counsellor in every school secondary school in England (providing parity with NI, Wales and more recently Scotland), calling for a national joined up strategic approach for those young people who would benefit from counselling at the point of referral. This would relieve huge pressure on CAMHS and in the interim period could include referral pathways to counselling agencies and individual practitioners who are already working with young people. This workforce is already working to high standards with this age group with evidence-based outcomes.	Thank you for your comment. Counselling was included in the protocol for this update (see Table 1 in the evidence review), but we did not identify any relevant RCTs that met this protocol and are therefore unable to recommend counselling. We did not include Javanmiri (2013), because it was not possible for us to allocate it to mild or moderate to severe depression based on the description of the inclusion criteria in the paper and our method of categorisation. In this review, studies were included in the mild depression category if they contained participants who were recruited based on depression symptoms, while the moderate to severe depression category required study participants to have a diagnosis of depression. Javanmiri (2013) had one of the inclusion criteria as "meeting a clinical interview based on DSM-IV-2". However, they did not specify what diagnoses were identified with the clinical interview. Javanmiri (2013) also reported the baseline means of depression using the Beck depression inventory (BDI) for both intervention and control groups. However, the committee highlighted that these means and their standard deviations covered mild to moderate depression. This guideline update focused on psychological therapies for treatment of mild and moderate to severe depression. The stepped care model, as described in Table 1 in the guideline, was only within the scope of this update as far as the choice of therapy. We are therefore unable to make recommendations concerning the optimal provision of child and young person mental health services. The recommendation to refer the child or young person to the next stage in the stepped care pathway if they have not responded to psychological therapy after 3 months reflects the existing system.

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				In addition, this would allow for extended sessions to be offered where a relationship is already established, counterbalancing damage that inappropriate endings may cause as well as working with individuals to resolve presenting difficulties. 'Future in Mind', talks of limiting the amount of times a young person tells their story, the current recommendations contradict this with the stepped care approach, resulting in concerns regarding how many professionals' children and young people may have seen before entering a higher tiered provision.	Reference: Javanmiri (2013). The Study of Solution-Focused Group Counseling in Decreasing Depression among Teenage Girls. International Journal of Psychological Studies; Vol. 5, No. 1; p105.
British Association of Counselling and Psychotherapy	Guideline	18	1.6.1	Many CCG's in England currently commission counselling as an alternative to services offered by CAMHS for low and moderate levels of anxiety and depression which not only cuts waiting times for those who meet higher thresholds but also provides more timely support for those lower level issues that can all too easily escalate.	Thank you for your comment. Counselling was included in the protocol for this update (see Table 1 in the evidence review), but we did not identify any relevant RCTs that met this protocol and are therefore unable to recommend counselling. We did not include Javanmiri (2013), because it was not possible for us to allocate it to mild or moderate to severe depression based on the description of the inclusion criteria in the paper and our method of categorisation. In this review, studies were included in the mild depression category if they contained participants who were recruited based on depression symptoms, while the moderate to severe depression category required study participants to have a diagnosis of depression. Javanmiri (2013) had one of the inclusion criteria as "meeting a clinical interview based on DSM-IV-2". However, they did not

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					specify what diagnoses were identified with the clinical interview. Javanmiri (2013) also reported the baseline means of depression using the Beck depression inventory (BDI) for both intervention and control groups. However, the committee highlighted that these means and their standard deviations covered mild to moderate depression. Reference: Javanmiri et al., (2013). The Study of Solution-Focused Group Counseling in Decreasing Depression among Teenage Girls. International Journal of Psychological Studies; Vol. 5, No. 1; p105
British Association of Counselling and Psychotherapy	Guideline	19	1.6.4	Following on from the findings of the IMPACT trial, we would query why CBT is recommended as a first line treatment when there was no significant difference in outcomes between CBT, psychodynamic psychotherapy and brief psychological intervention. All were found equally effective therefore it would follow that all should be equally offered. In addition, psychosocial intervention showed significantly fewer sessions required than other interventions compared to 9 sessions of CBT and 11 sessions of psychodynamic therapy, we might therefore assume that it is a more cost-effective treatment.	Thank you for your comment. The recommendation about the full assessment of needs is not intended to be prescriptive, but rather to highlight some important considerations for the shared decision-making process. If the healthcare professional, together with the child or young person (CYP) with depression and their family members, agree that a psychological therapy (either from first or second-line options) is the most appropriate choice of therapy to meet the CYPs needs then the hierarchy of the recommendations should not be a barrier to their receiving the chosen psychological therapy. To ensure this is the case the committee specifically noted the role of individual preferences for the CYP and their family members in the choice of therapy and stated that if the first line options would not meet the CYP's clinical needs or are unsuitable for their circumstances, to consider one of the following options including the chosen psychological therapy. In an analysis of a large body of evidence for 12-18 year olds with moderate to severe depression, individual CBT was better at reducing depression symptoms and improving functional status, quality of life and suicidal ideas compared to waiting list/ no treatment or usual care, and at increasing remission compared to

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					attention control and other therapies (such as family therapy) at the end of treatment. Based on this information and the magnitude of the effects, the committee agreed to recommend individual CBT as the first line treatment for young people with moderate to severe depression. However, the committee recognised that individual CBT might not be suitable or meet the needs of all young people with moderate to severe depression and so they agreed that additional options should be available. They chose to include IPT-A (IPT for adolescents), family therapy, brief psychosocial intervention and psychodynamic psychotherapy as second line options that were evidence based but where effectiveness was less certain.
British Association of Counselling and Psychotherapy	Guideline	19	1.6.5	As above.	Thank you for your comment. The recommendation about the full assessment of needs is not intended to be prescriptive, but rather to highlight some important considerations for the shared decision-making process. If the healthcare professional, together with the child or young person (CYP) with depression and their family members, agree that a psychological therapy (either from first or second-line options) is the most appropriate choice of therapy to meet the CYPs needs then the hierarchy of the recommendations should not be a barrier to their receiving the chosen psychological therapy. To ensure this is the case the committee specifically noted the role of individual preferences for the CYP and their family members in the choice of therapy and stated that if the first line options would not meet the CYP's clinical needs or are unsuitable for their circumstances, to consider one of the following options including the chosen psychological therapy. In an analysis of a large body of evidence for 12-18 year olds with moderate to severe depression, individual CBT was better at

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					reducing depression symptoms and improving functional status, quality of life and suicidal ideas compared to waiting list/ no treatment or usual care, and at increasing remission compared to attention control and other therapies (such as family therapy) at the end of treatment. Based on this information and the magnitude of the effects, the committee agreed to recommend individual CBT as the first line treatment for young people with moderate to severe depression. However, the committee recognised that individual CBT might not be suitable or meet the needs of all young people with moderate to severe depression and so they agreed that additional options should be available. They chose to include IPT-A (IPT for adolescents), family therapy, brief psychosocial intervention and psychodynamic psychotherapy as second line options that were evidence based but where effectiveness was less certain.
Central and North West London NHS Foundation Trust	General	General	General	**References** Cipriani A, Zhou X, Del Giovane C, et al. (2016) Comparative efficacy and tolerability of antidepressants for major depressive disorder in children and adolescents: a network meta-analysis. *Lancet* 388: 881-890. Goodyer IM, Reynolds S, Barrett B, et al. (2017) Cognitive behavioural therapy and short-term psychoanalytical psychotherapy versus a brief psychosocial intervention in adolescents with	Thank you for your comment. We have addressed your comments related to these references. Please see ID 130, 151 and 161.

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				unipolar major depressive disorder (IMPACT): a multicentre, pragmatic, observer-blind, randomised controlled superiority trial. *Lancet Psychiatry* 4: 109-119. March J, Silva S, Petrycki S, et al. (2004) Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression: Treatment for Adolescents With Depression Study (TADS) randomized controlled trial. *Jama* 292: 807-820. Weisz JR, Kuppens S, Ng MY, et al. (2017) What five decades of research tells us about the effects of youth psychological therapy: A multilevel meta-analysis and implications for science and practice. *Am Psychol* 72: 79-117. Zhou X, Hetrick SE, Cuijpers P, et al. (2015) Comparative efficacy and acceptability of psychotherapies for depression in children and adolescents: A systematic review and network meta-	

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				analysis. *World Psychiatry* 14: 207-222.	
Central and North West London NHS Foundation Trust	Guideline	7	8	'1.1.18 When the clinical progress of children and young people with depression 8 is being monitored in secondary care, the self-report Mood and Feelings 9 Questionnaire (MFQ) should be considered as an adjunct to clinical 10 judgement. **[2005]'** This is very sensible. Unfortunately the NICE guideline doesn't comment so the fact that CAMHS services in the UK are using the RCADS (mandated by CYP-IAPT) and this is a much weaker instrument for depression. The problem is that patients and their families and services are burdened with using many instruments that are weak and add to the staff administrative load. However I realise this aspect could be outside of the remit of the NICE Guidance.	Thank you for your comment. The section "Assessment and coordination of care" was not within the scope of this update and therefore we are unable to make changes to this area. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
Central and North West London NHS Foundation Trust	Guideline	10	4	'1.1.33 A child or young person with depression should be offered advice on the benefits of regular exercise and encouraged to consider following a 5 structured and supervised exercise programme of typically up to three 6 sessions per week of moderate duration	Thank you for your comment. We are glad you agree with these existing recommendations and that they should be offered whatever the level of severity of the depression, at the appropriate time, supporting their location in the section "Treatment and considerations in all settings".

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				(45 minutes to 1 hour) for 7 between 10 and 12 weeks. **[2005]** 1.1.34 A child or young person with depression should be offered advice about 9 sleep hygiene and anxiety management. **[2005]** 1.1.35 A child or young person with depression should be offered advice about nutrition and the benefits of a balanced diet. **[2005]'** These are all sensible aspects of management and should be offered whatever the level of severity of the depression, at the appropriate time.	
Central and North West London NHS Foundation Trust	Guideline	17	21	'1.5.7 If the options in recommendation 1.5.6 would not meet the child or young person's clinical needs, are unsuitable for their circumstances or are not available, offer the following: □ individual CBT, **or** □ family therapy. **[2019]'** The main problem with this recommendation is that it looks as if it places CBT and family therapy on the same level in terms of the strength of	Thank you for your comment. The committee recognised that individual CBT might not be suitable or meet the needs of all young people with mild depression and so they agreed that additional options should be available, such as family therapy that showed meaningful effects on depression symptoms. Both individual CBT and family therapy are now recommended as second line options after the evidence was reanalysed. Although there was more evidence for individual CBT as you mention, individual CBT and family therapy were among the most expensive options. Individual CBT had a smaller effect on depression symptoms than the first line options: digital CBT or group therapy (CBT, IPT or NDST).

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				the evidence base, which is not at all the case. As the Guidance indicate many CBT trials have been carried out, only a small number of family therapy trials which ave small sample sizes and mainly of low quality. The network meta-analysis carried out in 2015 did not find that family therapy was effective (Zhou et al., 2015). For individual cases the formulation may suggest family therapy is preferable, but overall the evidence based doesn't point to this.	We are aware of the Zhou (2015) NMA and include it in our evidence base as a published NMA. However, we have not used it to make recommendations because the authors grouped therapies based on their approach (IPT, CBT etc.) but did not separate them out by method of delivery (group, individual etc.).
Central and North West London NHS Foundation Trust	Guideline	19	6	'1.6.4 For children and young people with moderate to severe depression, offer a choice of the following psychological therapies for at least 3 months: □ individual CBT, **or** □ family therapy. **[2019]'** The Guideline is structured to suggest that for moderate to severe depression, after the assessment, psychological treatments should be the first intervention. The evidence base that we have doesn't point to this. A major limitation of the Guideline is that	Thank you for your comment. Antidepressant treatments were not within the scope of this update and therefore we are unable to make changes to this area. The recommendation about the full assessment of needs is not intended to be prescriptive, but rather to highlight some important considerations for the shared decision-making process. If the healthcare professional, together with the child or young person (CYP) with depression and their family members, agree that a psychological therapy (either from first or second-line options) is the most appropriate choice of therapy to meet the CYPs needs then the hierarchy of the recommendations should not be a barrier to their receiving the chosen psychological therapy. To ensure this is the case the committee specifically noted the role of individual preferences for the CYP and their family members in the choice of therapy and stated that if the first line options would not meet the CYP's clinical needs or are unsuitable for their circumstances, to

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				it hasn't included a review of drug treatments alongside psychological treatments. It is known that overall psychological treatments for child and adolescent depression are not very effective. The largest review of this topic found an effect size of 0.22 for psychological treatments at the end of treatment [mainly CBT] (Weisz et al., 2017). By contrast, the effect size for drug treatment for depression – mainly based on studies of adolescents – is 0.51 (Cipriani et al., 2016). This is not a surprise as it has been known for a long time that CBT and psychological treatments are less effective for more severe depression. One landmark study (TADS) found that CBT was no better than placebo (March et al., 2004). In addition, suggesting that CBT or family therapy could be offered , as if there is the same evidence base is not appropriate (as indicated above).	consider one of the following options including the chosen psychological therapy. In an analysis of a large body of evidence for 12-18 year olds with moderate to severe depression, individual CBT was better at reducing depression symptoms and improving functional status, quality of life and suicidal ideas compared to waiting list/ no treatment or usual care, and at increasing remission compared to attention control and other therapies (such as family therapy) at the end of treatment. Based on this information and the magnitude of the effects, the committee agreed to recommend individual CBT as the first line treatment for young people with moderate to severe depression. However, the committee recognised that individual CBT might not be suitable or meet the needs of all young people with moderate to severe depression and so they agreed that additional options should be available. They chose to include IPT-A (IPT for adolescents), family therapy, brief psychosocial intervention and psychodynamic psychotherapy as second line options that were evidence based but where effectiveness was less certain.
Central and North West London NHS Foundation Trust	Guideline	19	10	'1.6.5 If the options in recommendation 1.6.4 would not meet the child or young 10 person's clinical needs or are unsuitable for their circumstances,	Thank you for your comment. The committee discussed the evidence on psychodynamic psychotherapy and agreed that effectiveness was less certain for this therapy but it was effective at increasing remission. Based on this evidence, the committee

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				consider 11 one of the following options: 12 □ brief psychosocial intervention, **or** 13 □ psychodynamic psychotherapy, **or** 14 □ IPT plus parent sessions. **[2019]'** Psychodynamic psychotherapy doesn't seem to have an evidence base (Zhou et al., 2015). The IMPACT trial (Goodyer et al., 2017) that is mentioned doesn't help because: 1. It really is a multimodal intervention as at the start of the trial 20 % of patients were on SSRI's and this rose to 40 % by the end , so improvement couldn't be attributed to the psychological treatment. 2. In addition to the individual psychotherapy al l were offered family/parent sessions. 3. The study aim was to investigate treatment outcomes one year after treatment by which time any difference between treatments is attenuated; although it did in fact report outcomes at 36 weeks .[ie it did not to look at outcomes at after the usual 12 -16 weeks of treatment].	agreed to recommend psychodynamic psychotherapy as a second line therapy. The committee noted that antidepressants were used in the IMPACT trial and that there was a similar proportion of antidepressants use in the 3 arms of the trial (individual CBT, short term psychoanalytical psychotherapy [STPP], and brief psychosocial intervention [BPI]). Therefore, any effects of antidepressants on improvements were expected to be equivalent between the 3 arms. The committee also agreed that any effects of family/parent sessions on improvements were expected to be equivalent because these sessions were offered to participants in the 3 arms. They agreed to add a paragraph to the discussion of the benefits and harms section in the evidence review to clarify that parental involvement was an explicit element in some of the psychological therapies included in the analyses of this update such as BPI, psychodynamic psychotherapy and CBT. The IMPACT trial reported outcomes at 6, 12, 36, 52, and 86 weeks. However, the interventions were delivered for more than 20 weeks. Therefore, the assessment at 36 weeks would have happened after the interventions were delivered at 6 weeks for BPI and at 16 weeks for individual CBT and STPP.

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Central and North West London NHS Foundation Trust	Guideline	21	4	'1.6.12 Following multidisciplinary review, the following should be considered: an alternative psychological therapy which has not been tried 5 previously (individual CBT, interpersonal therapy or shorter-term family 6 therapy, of at least 3 months' duration), or 7 systemic family therapy (at least 15 fortnightly sessions), or individual child psychotherapy (approximately 30 weekly sessions). **[2005]'** Studies have not been published to my knowledge , and none are referenced the Guideline evidence review, of research that investigates children and adolescents who show no response to one psychological treatment and are then entered into a treatment study of another psychological treatment. So the recommendation 1.6.12 is not based on any evidence at all.	Thank you for your comment. The section "Depression unresponsive to combined treatment" was not within the scope of this update and therefore we did not identify or review any evidence on this topic in the evidence review.
Diabetes UK	Guideline	General	General	Diabetes UK recommends that this guideline makes explicit reference to the	Thank you for your comment. The committee were unable to make separate recommendations for the treatment of depression in

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				connection between long-term physical health conditions, like diabetes, and depression. This connection has been well established and is referenced in the introduction to NICE guideline CG91. We recommend that guideline NG18 on *Diabetes (type 1 and type 2) in children and young people: diagnosis and management*, is referenced in this guideline, in particular sections 1.2.98, 1.2.100, 1.2.101, 1.2.106, 1.2.109, 1.3.37, 1.3.39, 1.3.41, 1.3.42 and 1.5.1. https://www.nice.org.uk/guidance/ng18	children with comorbidities as this was not within the scope of the guideline. However, there is an existing recommendation about assessing and managing comorbid diagnoses and developmental, social and educational problems in the section of the guideline on "Treatment and considerations in all settings". We have added a cross reference to NG18 at the start of the section of the guideline on detection and risk profiling. This refers to the sections on psychological and social issues in children and young people with type 1 or type 2 diabetes. The NICE Pathway will be able to link directly to the individual recommendations. After reviewing the comments about comorbidities, the committee decided to add an additional line to the recommendation describing the full assessment of needs. This now includes consideration of comorbidities, neurodevelopmental disorders, communication needs (language, sensory impairment) and learning disabilities.
Diabetes UK	Guideline	2	23	Treatment and considerations in all settings 1.1.31 Diabetes UK welcomes the reference to comorbidities here but would recommend a stronger reference to children and young people with long-term physical health conditions and to how such conditions can impact on mental health. We would also suggest a reference to the importance of healthcare professionals treating the long-term physical health condition and the depression having a clear	Thank you for your comment. The section "Care of all children and young people with depression" was not within the scope of this update and therefore we are unable to make changes to this area. The committee were unable to make separate recommendations for the treatment of depression in children with comorbidities as this was not within the scope of the guideline. However, there is an existing recommendation about assessing and managing comorbid diagnoses and developmental, social and educational problems in the section of the guideline on "Treatment and considerations in all settings". We have added a cross reference to NG18 at the start of the section of the guideline on detection and risk profiling. This refers to the sections on psychological and social issues in children and young people with type 1 or type 2 diabetes. (We are unable to link

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				understanding of and access to information about the respective conditions and the connections between them. Diabetes UK recommends that key guidance from guideline CG91 on *Depression in adults with a chronic physical health problem: recognition and management* is used to inform the development of similar guidance for the identification and management of children with depression and long-term physical health conditions. https://www.nice.org.uk/guidance/cg91	directly to individual recommendations due to the move away from PDFs to web-based documents.) After reviewing the comments about comorbidities, the committee decided to add an additional line to the recommendation describing the full assessment of needs. This now includes consideration of comorbidities, neurodevelopmental disorders, communication needs (language, sensory impairment) and learning disabilities.
Greater Manchester Mental Health NHS Foundation Trust	Guideline	35	19	Your guidelines acknowledge the limited evidence for psychological treatments for younger children (12 and under) with depression. The guidance takes a pragmatic approach and recommends that treatment should still be offered to this age group. I agree. I would add that Family Based IPT, an adaptation of the IPT model for younger children, should be considered as a recommendation.	Thank you for your comment. The committee agreed that family therapy can include different interventions. Therefore, based on stakeholder comments, they agreed to reclassify the study by Dietz (2015) as family based IPT. The NMAs were reanalysed and provided some evidence that family based IPT could be effective for the treatment of moderate to severe depression in children aged 5 to 11 years. The committee agreed to add a separate recommendation for this group including family based IPT as one of the recommended psychological therapies.

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				FB IPT has a small evidence base, consisting, as far as I am aware, of one open trial in 2008, and one RCT in 2015 (Dietz et al. – Journal of American Academy of Child and Adolescent Psychiatry). This RCT demonstrated a higher rate of remission, reduced depression symptoms and reduced anxiety symptoms by the end of treatment, compared to a control therapy condition. Unlike typical IPT-A, FB-IPT requires parent involvement in every session and focusses specifically on the sources of inter-family stress/miscommunication that may be maintaining depression symptoms. The therapy is therefore developmentally appropriate for this age group. Given the evidence base for IPT-A with older children, a pragmatic approach of extrapolation of these findings should be considered in the recommendations for this younger age group. I.e. the persuasive evidence base for teenagers receiving IPT-A, should encourage recommendation of FB-IPT for younger	

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				children, even whilst the evidence base is still in its early stages.	
Greater Manchester Mental Health NHS Foundation Trust	Guideline	36	22 - onwards	I note the comments about IPT plus parent sessions and the lack of symptomatic change through this intervention. I note that based on this, IPT is essentially downgraded from a first line to second line treatment for mod to severe depression in young people (YP). I fear that this is based on a misunderstanding of the evidence base and a failure to consider recent high quality meta analyses on this matter. Furthermore, IPT, when adapted for adolescents (IPT-A) routinely involves carers in some treatment sessions, so I am not sure that the distinction between IPT with Vs IPT without parent sessions is a distinction that holds in clinical practice. Regarding the evidence base, Pu et al (2017) Psychiatry Research (253) is a meta analysis comparing IPT-A to various control conditions and placebo groups, and finds that IPT is superior in symptom reduction, functioning and retention.	Thank you for your comment. The committee agreed that the RCT by Gunlicks-Stoessel (2016) artificially manipulated the involvement of parents in the study. For this reason, the RCT was removed from the NMAs and it was only reported in the pairwise analysis. IPT-A (IPT for adolescents) was kept in the recommendations for moderate to severe depression but without a specific involvement of parents. The committee also recognised that IPT-A is designed to include parents on a flexible basis. Based on the NMAs for 12-18 year olds with moderate to severe depression, IPT-A was effective at reducing depression symptoms and increasing functional status post-treatment compared to waiting list/no treatment or usual care. However, IPT-A was recommended as a second line option, because there was no data for remission, suicide ideation or quality of life, or for later time points for functional status and IPT-A was no better or worse than other interventions or controls at 6 months for depression symptoms In contrast, there was a larger body of evidence for individual CBT and it was CBT was better at reducing depression symptoms and improving functional status, quality of life and suicidal ideas compared to waiting list/ no treatment or usual care, and at increasing remission compared to attention control and other therapies (such as family therapy) at the end of treatment. Based on this information and the magnitude of the effects, the committee agreed to recommend individual CBT as the first line treatment for young people with moderate to severe depression. The committee recognised that additional research on IPT-A (IPT for adolescents) that provided evidence on more outcomes and

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				Zhou et al. (2015) World Psychiatry (14) conduct a systematic review and network meta analysis comparing IPT-A to many other treatment modalities for depression in young people. 52 studies are reviewed, with a total of 3805 participants. 9 treatment modalities and 4 control groups are compared. The findings indicate that only IPT and CBT have symptomatic benefit at 6 months post treatment, and only IPT maintains these gains at 12 months post treatment. IPT also has the lowest drop rate, indicating a promising degree of 'acceptability' for participants. Not only does IPT-A have an evidence base that justifies its inclusion as a first line treatment for depression in YP, it has strong 'face validity', in that is attempts to address the link between symptoms of depression and adverse relationship experiences. As such, it is developmentally appropriate for adolescents, for whom peer relationships and family discord/change are psychosocial factors that are so closely entwined with their mental health struggles.	longer time points would be useful in determining the relative effectiveness of this intervention in comparison to individual CBT and other psychological therapies and they made a research recommendation to address this issue. The recommendation about using a full assessment of needs and patient and carer preferences and values is aimed at ensuring the most appropriate therapy is selected for the individual. If the healthcare professional, together with the child or young person (CYP) with depression and their family members, agree that a psychological therapy (either from first or second-line options) is the most appropriate choice of therapy to meet the CYPs needs then the hierarchy of the recommendations should not be a barrier to their receiving the chosen psychological therapy. To ensure this is the case the committee specifically noted the role of individual preferences for the CYP and their family members in the choice of therapy and stated that if the first line options would not meet the CYP's clinical needs or are unsuitable for their circumstances, to consider one of the following options including IPT-A (IPT for adolescents). Pu (2017) was used as reference for individual RCTs but it was not included as evidence. We are aware of the Zhou (2015) NMA and include it in our evidence base as a published NMA. However, we have not used it to make recommendations because the authors grouped therapies based on their approach (IPT, CBT etc.) but did not separate them out by method of delivery (group, individual etc.).

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				Finally, training in IPT-A as an evidence based treatment is currently on offer to the existing CAMHS workforce via the national CYP-IAPT program. Existing and newly recruited staff in CAMHS are being trained to Post Graduate Certificate or Diploma level, and to a standard that meets eligibility for IPT-UK accreditation. Centres in Manchester (GMMH Trust), London (Anna Freud) and Reading currently offer training programs, and the IPT-A trained workforce has increased considerably over the past five years. This means that the therapy is not only evidence based and developmentally appropriate, but is also an accessible and realistic treatment option.	
International Society of Interpersonal Psychotherapy	Evidence Review	9	23-27	Your evidence review (page 9, lines 23-27) relies on a single outcome measure where multiple important outcomes exist; and it values self-reports over more conservative observer-rated findings as the basis for judgments. This leads to results that contradict findings in meta-analyses and the first line ranking of IPT-A in previous guidelines.	Thank you for your comment. At the stage of data extraction, we identified the most commonly used tools for reporting functional status and other outcomes such as depression symptoms. Most studies reported depression symptoms using more than 1 rating scale, with the Child depression rating scale-revised and Child depression Inventory being the most common with 16 and 14 studies respectively. In comparison, the Hamilton rating scale for depression was only reported by 9 studies. The committee agreed to prioritise certain scales for data extraction for each outcome based on the most frequently used scales in the included studies, a hierarchy of depression symptom severity measurement scales

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					reported by a Cochrane review of newer generation antidepressants for depressive disorders in children and adolescents (Hetrick 2012) and their own experience. The committee agreed that self-report scales would give the opportunity to children and young people to report their own experience.
International Society of Interpersonal Psychotherapy	Guideline	General	General	The International Society of Interpersonal Psychotherapy, an organization of hundreds of researchers and clinicians that includes a strong UK chapter (https://www.iptuk.net), wishes to express concern about these proposed treatment guidelines for depressed children and adolescents. The draft guidelines do not reflect the strong track record Interpersonal Psychotherapy for depressed adolescents (IPT-A) and its adaptations have achieved; the guideline's recommendations downgrade IPT-A from its former, proper status as a first line treatment. Several of the researchers who have conducted the actual research (Drs. Mufson, Young, Gunlicks-Stoessel, and Dietz) will testify that your use of their data has been slipshod and inaccurate, leading to false impressions about the nature of IPT-A and its reported outcomes.	Thank you for your comment. The recommendation about using a full assessment of needs and patient and carer preferences and values is aimed at ensuring the most appropriate therapy is selected for the individual. If the healthcare professional, together with the child or young person (CYP) with depression and their family members, agree that a psychological therapy (either from first or second-line options) is the most appropriate choice of therapy to meet the CYPs needs then the hierarchy of the recommendations should not be a barrier to their receiving the chosen psychological therapy. To ensure this is the case the committee specifically noted the role of individual preferences for the CYP and their family members in the choice of therapy and stated that if the first line options would not meet the CYP's clinical needs or are unsuitable for their circumstances, to consider one of the following options including IPT-A (IPT for adolescents). Based on the network meta-analyses for 12-18 year olds with moderate to severe depression, IPT-A was effective at reducing depression symptoms and increasing functional status post-treatment compared to waiting list/no treatment or usual care. However, IPT-A was recommended as a second line option, because there were no data for remission, suicide ideation or quality of life, or for later time points for functional status and IPT-A was no better or worse than other interventions or controls at 6 months for depression symptoms

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					In contrast, there was a larger body of evidence for individual CBT and it was better at reducing depression symptoms and improving functional status, quality of life and suicidal ideas compared to waiting list/ no treatment or usual care, and at increasing remission compared to attention control and other therapies (such as family therapy) at the end of treatment. Based on this information and the magnitude of the effects, the committee agreed to recommend individual CBT as the first line treatment for young people with moderate to severe depression. The committee recognised that additional research on IPT-A that provided evidence on more outcomes and longer time points would be useful in determining the relative effectiveness of this intervention in comparison to individual CBT and other psychological therapies and they made a research recommendation to address this issue.
International Society of Interpersonal Psychotherapy	Guideline	General	General	The list of errata is considerably longer, but these examples indicate sufficient reasons for concern. As the NICE treatment guidelines have huge public health impact, they should reflect the highest level of critical scientific review and objectivity. The current draft shows neither. The research review appears haphazard and uninformed, and the downgrading of IPT-A combined with high recommendations for CBT (the latter often based on very small samples) raises the question of reviewer bias (cf.	Thank you for your comment. Committee recruitment is achieved through open competition and the committee members are appointed for their quality of experience and expertise. A broad range of experience is sought. We are grateful to the committee for their enthusiasm, hard work and expertise and are confident of their ability to make recommendations. The committee's professional roles, affiliated organisations and declarations of interest are available along with the rest of the guideline documents on the NICE website. The recommendation about using a full assessment of needs and patient and carer preferences and values is aimed at ensuring the most appropriate therapy is selected for the individual. If the healthcare professional, together with the child or young person (CYP) with depression and their family members, agree that a

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				Falkenstrom et al., *Journal of Clinical Psychiatry,* 2013;74:482-491). Have you assessed the therapeutic allegiance of your review panel to ensure its balance? Might it contain a preponderance of CBT-allegiant reviewers? Ideology should not determine treatment guidelines that affect the United Kingdom and the world at large.	psychological therapy (either from first or second-line options) is the most appropriate choice of therapy to meet the CYPs needs then the hierarchy of the recommendations should not be a barrier to their receiving the chosen psychological therapy. To ensure this is the case the committee specifically noted the role of individual preferences for the CYP and their family members in the choice of therapy and stated that if the first line options would not meet the CYP's clinical needs or are unsuitable for their circumstances, to consider one of the following options including IPT-A (IPT for adolescents). Based on the NMAs for 12-18 year olds with moderate to severe depression, IPT-A was effective at reducing depression symptoms and increasing functional status post-treatment compared to waiting list/no treatment or usual care. However, IPT-A was recommended as a second line option, because there was no data for remission, suicide ideation or quality of life, or for later time points for functional status and IPT-A was no better or worse than other interventions or controls at 6 months for depression symptoms In contrast, there was a larger body of evidence for individual CBT and it was better at reducing depression symptoms and improving functional status, quality of life and suicidal ideas compared to waiting list/ no treatment or usual care, and at increasing remission compared to attention control and other therapies (such as family therapy) at the end of treatment. Based on this information and the magnitude of the effects, the committee agreed to recommend individual CBT as the first line treatment for young people with moderate to severe depression. The committee recognised that additional research on IPT-A that provided evidence on more outcomes and longer time points would

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					be useful in determining the relative effectiveness of this intervention in comparison to individual CBT and other psychological therapies and they made a research recommendation to address this issue.
International Society of Interpersonal Psychotherapy	Guideline	19	10-15	For example (page 19, lines 10-15), the proposed guidelines give the misleading impression that standard IPT-A does not include a family therapy component. This errant conclusion appears to have been based on a misreading or lack of reading of treatment outcome research and of the Mufson et al. IPT-A manual (*Interpersonal Psychotherapy for Depressed Adolescents,* 2nd edition, Guilford Press, 2011).	Thank you for your comment. The committee agreed that IPT-A (IPT for adolescents) is designed to include parents on a flexible basis. Therefore, IPT-A is recommended for moderate to severe depression without specifying the level of parental involvement.
International Society of Interpersonal Psychotherapy	Guideline	35	22	On page 35, circa line 22, you appear to have conflated two different studies, leading to dilution of outcome results.	Thank you for your comment. This sentence refers to the results of the NMA for depression symptoms at post-treatment in children 5 to 11 years old with moderate to severe depression. This NMA was reanalysed because the committee agreed that family therapy can include different interventions and Dietz (2015) was reclassified as family based IPT. This NMA includes 4 psychological therapies family therapy, NDST, family based IPT and psychodynamic psychotherapy. This NMA provided some evidence that family based IPT could be effective for the treatment of moderate to severe depression in children aged 5 to 11 years. The committee agreed to add a separate recommendation for this group including family based IPT as one of the recommended psychological therapies.

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Interpersonal Psychotherapy UK Network	Evidence Review	7	Table 1	It is unclear why in the list of psychological therapies that were reviewed CBT is described as individual CBT, Group CBT, CBT with separate parent sessions and IPT is only described as IPT, despite there being evidence of the efficacy of IPT-A in each of the formats described for CBT.	Thank you for your comment. We have amended Table 1 listing the different formats for IPT.
Interpersonal Psychotherapy UK Network	Evidence Review	General	Page 20 Table7	We note several examples of the IPT-A model being misrepresented and evidence being inconsistently or inaccurately reported in these guidelines: A. Inconsistent and inaccurate reporting on the use of measure of functioning (CGAS) in the IPT-A literature e.g. Dietz et al 2015, Mufson et al 1999, 2004 each included a measure of functioning not reported in Table 7. B. Young 2010 study compared group IPT to non-directive supportive therapy. It incorrectly described as individual IPT in Table 7.	Thank you for your comment. We have amended Table 7 regarding Mufson (2004); Young (2010); and Vostanis (1996a). This error was only done on table 7. Therefore, the analyses were correct, and the results did not change after amending table 7. However, we checked the full texts of the studies highlighted in your comment and we found that: - Dietz (2015) does not report functional status at all. - Mufson (1999) only reports that 'There were no significant group differences between treatment conditions on the C-GAS at week 12' but did not provide any data to be included in our analyses. Regarding the excluded studies that you mention in your comment. Please see below for the reasons for the exclusion of these studies: - Mufson (2018) was excluded because participants in the intervention group could have received maintenance treatment after IPT-A or combined IPT-A plus medication. However, data was not reported separately for participants who received or did not received medication - Rossello (2008) compared individual and group CBT with individual and group IPT but we excluded this study because results were not reported separately (results were only reported as

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				C. Vostanis et al (1996a) compared CBT not IPT to NDST, as reported in Table 7 D. Four key omissions from the review process and would like clarification on their exclusion from the review. These include: 1. Mufson, L., Rynn, M., Yanes-Lukin, P., Choo, T. H., Soren, K., Stewart, E., & Wall, M. (2018). Stepped Care Interpersonal Psychotherapy Treatment for Depressed Adolescents: A Pilot Study in Pediatric Clinics. *Administration and Policy in Mental Health and Mental Health Services Research, 45*(3), 417-431. 2. Rossello, J., Bernal, G., & Rivera-Medina, C. (2008). Individual and group CBT and IPT for Puerto Rican adolescents with depressive symptoms. *Cultural Diversity & Ethnic Minority Psychology, 14*(3), 234-245.	combined individual and group CBT and combined individual and group IPT) - Tang (2009) was excluded because participants were not required to have symptoms of depression at recruitment Regarding Bolton (2007), we have now included this study, but only for the outcome of discontinuation because depression symptoms and functional status were not measured using validated tools. During the study identification stage of the evidence review, we checked the studies that had been excluded in the 2015 update on psychological therapies and excluded at title and abstract stage all of the 2015 excluded studies that still had valid reasons for exclusion based on our review protocol. This might account for the absence of potentially relevant references from the excluded studies table. We have now included a modified version of the 2015 excluded studies table to make the reasons for exclusion of these studies clear.

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				3. Tang, T. C., Jou, S. H., Ko, C. H., Huang, S. Y., & Yen, C. F. (2009). Randomized study of school-based intensive interpersonal psychotherapy for depressed adolescents with suicidal risk and parasuicide behaviors. *Psychiatry & Clinical Neurosciences, 63*(4), 463-470. 4. Bolton, P., Bass, J., Betancourt, T., Speelman, L., Onyango, G., Clougherty, K. F., . . . Verdeli, H. (2007). Interventions for depression symptoms among adolescent survivors of war and displacement in northern Uganda - A randomized controlled trial. *Jama-Journal of the American Medical Association, 298*(5), 519-527. doi:10.1001/jama.298.5.519	

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				Multiple descriptive errors and unexplained omissions of relevant studies raise doubts over the reliability of the review process and subsequent conclusions.	
Interpersonal Psychotherapy UK Network	Evidence Review	7	15-16	The psychological therapies recommended in the 2015 guidance are described as falling, "into different groups based on CBT, psychodynamic or systemic principles." This summary highlights the failure to accurately represent the biopsychosocial model, which is the basis of IPT-A, and may explain the inappropriate use of evidence to suggest support for categories which do not accurately reflect the nature of the intervention.	Thank you for your comment. The committee agreed that the biopsychosocial model was not accurately represented in the sentence you refer to. Therefore, the sentence has been removed.
Interpersonal Psychotherapy UK Network	Evidence review	20 465	Table 7	The guidelines have incorrectly included the study Dietz et al, 2015 as a family therapy study(7). This is not a study of family therapy. It is a study of family-based interpersonal psychotherapy. Family therapy works primarily with the family and primarily looks at interactions and relationships within the family. FB-IPT, in contrast, is a dyadic adaptation of IPT-A (an individual therapy) with developmental modifications that address risk factors for depression in	Thank you for your comment. The committee agreed that multiple forms of family therapy exist, including family-focused treatment for childhood depression, attachment based and systemic family therapy, but agreed that they were sufficiently similar that they could be analysed under the grouping of family therapy. They also agreed to reclassify the study by Dietz (2015) as family based IPT. The pairwise and NMAs were reanalysed and provided some evidence that family based IPT and family therapy (including family-focused treatment for childhood depression and systems integrative family therapy) could be effective for the treatment of moderate to severe depression in children aged 5 to 11 years. The committee agreed to add a separate recommendation for this group including

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				children aged 7-12. Increased parental involvement aims to support the child in the work of therapy and tasks between sessions. As such, a parent is often engaged in a role more accurately characterised as co-therapist and in many cases the parent's relationship with the child will not be the central focus of therapy. This is of course highly developmentally-appropriate, given it can be challenging for children of this age to manage therapy on their own. Crucially, the focus of FB-IPT is on the individual child, and the link between their relationships and depressive symptoms. FB-IPT continues to employ the four interpersonal focal areas used in IPT-A, which include scope for addressing difficulties managing normative and forced role transitions, conflict with peers, bereavement and social exclusion. It helps children to improve the way they act in relationships, be they peer and/or family relationships. Half of each session is with the child alone, half is with the child and parent. This latter part is focused on the parent being guided by the child on how to help with the tasks of	family based IPT and family therapy as some of the recommended psychological therapies.

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				individual therapy and is not necessarily targeting change on difficulties within the parent child relationship. We therefore request that this study is re-evaluated in terms of the support it was explicitly intended to provide for IPT based approaches. We question the accuracy and transparency of using "Family Therapy" to describe a broad range of approaches reflecting several distinct theoretical orientations, not all of which have family functioning as the primary target and only some of which have evidence of efficacy, as the basis for the revised recommendation. Pooling these data to create an evidence base for "Family Therapy" results in misleading conclusions that cannot not be readily mapped onto clear evidence-based practice with young people and their families, which is a core function of the guidance. This questionable clustering of evidence leads to an inaccurate representation of the FB-IPT evidence. FB-IPT was combined in the analysis with Family	

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				Focused Therapy for Childhood Depression (FFT-CD). Neither of these dyadic treatments offer a systemic intervention, characteristic of Family Therapy, and they do not share a common treatment orientation (FB-IPT is based on IPT-A and FFT-CD is based on CBT). There is evidence that FB-IPT (7) was more effective than the active control condition (NDST) at reducing post-treatment symptoms in depressed children, in addition to being more effective at improving functional status at post-treatment and increasing remission rates at post-treatment. Tompson et l (2017) was not more effective than the active control condition (NDST) at reducing post-treatment symptoms in depressed children and combining these approaches dilutes the stronger results for FB-IPT.	
Interpersonal Psychotherapy UK Network	Guideline	19	6	IPT-A has been downgraded from a first-line treatment to a second-line treatment in the current draft guideline (1.6.4; please see 1 above for why we think there is no evidence for the specific recommendation that this should be IPT-AP and not IPT-A). This is a major change from the 2005 and 2015	Thank you for your comment. The recommendation about using a full assessment of needs and patient and carer preferences and values is aimed at ensuring the most appropriate therapy is selected for the individual. If the healthcare professional, together with the child or young person (CYP) with depression and their family members, agree that a psychological therapy (either from first or second-line options) is the most appropriate choice of therapy to meet the CYPs needs then the hierarchy of the

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				versions of CG28, despite there being no new evidence on IPT-A to suggest it is no longer as effective as previously concluded; and no evidence since then suggesting CBT and family therapy are more effective than previously thought. It also contrasts with the recent large and respected network meta-analysis which concludes that IPT-A and CBT (and not family therapy) are the only effective treatments compared to active controls at short-term follow-up for adolescent depression; that IPT is significantly more effective than CBT at long-term follow-up; and that IPT-A leads to significantly fewer discontinuations than CBT(4). We think it incorrect to conclude that IPT-A is inferior to CBT; and highly incorrect to conclude that IPT-A is inferior to family therapy based on the available evidence. We have studied the evidence underlying the draft guidelines and some of the primary studies and believe that the following evidence supports our conclusions:	recommendations should not be a barrier to their receiving the chosen psychological therapy. To ensure this is the case the committee specifically noted the role of individual preferences for the CYP and their family members in the choice of therapy and stated that if the first line options would not meet the CYP's clinical needs or are unsuitable for their circumstances, to consider one of the following options including IPT-A (IPT for adolescents). Based on the NMAs for 12-18 year olds with moderate to severe depression, IPT-A was effective at reducing depression symptoms and increasing functional status post-treatment compared to waiting list/no treatment or usual care. However, IPT-A was recommended as a second line option, because there was no data for remission, suicide ideation or quality of life, or for later time points for functional status and IPT-A was no better or worse than other interventions or controls at 6 months for depression symptoms In contrast, there was a larger body of evidence for individual CBT and it was better at reducing depression symptoms and improving functional status, quality of life and suicidal ideas compared to waiting list/ no treatment or usual care, and at increasing remission compared to attention control and other therapies (such as family therapy) at the end of treatment. Based on this information and the magnitude of the effects, the committee agreed to recommend individual CBT as the first line treatment for young people with moderate to severe depression. The committee recognised that additional research on IPT-A that provided evidence on more outcomes and longer time points would be useful in determining the relative effectiveness of this intervention in comparison to individual CBT and other
		424	Table 36		

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				a) Table 36, p 424 (evidence document) summarises the NMA for effectiveness. It concludes that there is a 50% probability IPT-A is better than family therapy; and a 50% probability that family therapy is more effective than IPT-A. There is an 84% chance that IPT-A plus parent sessions is more effective than family therapy. It therefore is inappropriate to rank family therapy above IPT-A. b) There are multiple methods of measuring outcome in a treatment study, including severity of depressive symptoms. Severity of depressive symptoms may be measured by both self-rated and observer-rated questionnaires. Both have advantages and disadvantages, and ideally both should be used(5). It is common practice in meta-analyses to present results from both observer and self-rated questionnaires (eg Cochrane reviews; GG28 2005 and 2015 versions). The readers can then make informed conclusions about differences between	psychological therapies and they made a research recommendation to address this issue. Table 36 has been updated because the RCT by Gunlicks-Stoessel (2016) was removed from the NMAs. The committee agreed that Gunlicks-Stoessel (2016) artificially manipulated the involvement of parents in the study which is different to the way IPT-A was used in the rest of included studies. The probability remained similar between IPT-A and family therapy after the changes in the NMA. At the stage of data extraction, we identified the most commonly used tools for reporting functional status and other outcomes such as depression symptoms. Most studies reported depression symptoms using more than 1 rating scale, with the Child depression rating scale-revised and Child depression Inventory being the most common with 16 and 14 studies respectively. In comparison, the Hamilton rating scale for depression was only reported by 9 studies. The committee agreed to allow prioritisation of certain scales for data extraction for each outcome based on the most frequently used scales in the included studies, a hierarchy of depression symptom severity measurement scales reported by a Cochrane review of newer generation antidepressants for depressive disorders in children and adolescents (Hetrick 2012) and their own experience. The committee agreed that self-report scales would give the opportunity to children and young people to report their own experience.

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				treatments. Alternatively, meta-analyses sometimes choose the primary outcome scale (eg the previously-mentioned NMA of psychological therapy for adolescent depression(4)). If such a process were used, the conclusions about IPT-A would be different. The two IPT-A studies which compared IPT-A against an active therapy(3,6) used the observer-rated HAM-D as the primary outcome scale (as utilised in the Zhou et al NMA(4)). In both studies, IPT-A was significantly better than active control, and this is the reason why this NMA concluded IPT-A was significantly better than active control. Of note, family therapy has never been shown to be better than active control in any study of adolescent depression, as shown in the summary of studies in the evidence document pp484/5. We do accept that IPT-A not being significantly better than control treatments on all outcomes weakens any conclusions that it is effective.	

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				However, given that CBT and family therapy were not significantly more effective than usual care, pill placebo nor NDST on self-rated symptoms (evidence document p375, table 23) it would be wrong to say that there is good evidence that they are effective themselves. We therefore believe that if both self- and observer-rated depressive symptoms were used, the reader could make a more-informed conclusion; and that a reader would no longer think there is a strong case for saying CBT and family therapy are better than IPT-A. Crucially, that was the decision-making process in the 2005/2015 CG28 guidelines, wherein NICE concluded that IPT-A should be a first-line therapy. Reversing this recommendation on the basis of a narrow analysis, without a clear rationale and justification, raises significant doubts about the credibility of the conclusions in these guidelines.	

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Interpersonal Psychotherapy UK Network	Guideline	19 36-37	15 22 - 5	IPT plus parent sessions is recommended over individual IPT (1.6.5 in the current draft guideline. We think that this conclusion is inappropriate and misinformed for several reasons: a) This recommendation is based on a single study of 15 young people, 9 randomized to IPT-A with parent involvement and 6 randomized to IPT-A with no parent involvement, which, according to the paper itself, was designed to test the 'feasibility and acceptability of the treatment and refining the treatment manual' and 'testing the efficacy of IPT-AP was not a study goal' (p226)(1). It therefore seems highly inappropriate to draw a major conclusion based on a very small study that was expressly not designed to compare efficacy of treatments. b) IPT-AP was expressly designed to treat adolescents with depression who were 'also experiencing problems in their relationships with their parents' (p225)(1). Therefore, the inclusion criteria included Conflict Behavior Questionnaire T-	Thank you for your comment. The committee agreed that the RCT by Gunlicks-Stoessel (2016) artificially manipulated the involvement of parents in both arms of the study. Therefore, this RCT was not connected to the network meta-analyses anymore and it was removed from the NMAs. Gunlicks-Stoessel (2016) was only reported in the pairwise analysis. IPT-A (IPT for adolescents) was kept in the recommendations for moderate to severe depression but without any specific involvement of parents. The committee also recognised that IPT-A is designed to include parents on a flexible basis.

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				Score ≥ 65 i.e. less than 10% of the population. This aspect of the study design is logical as it intended to recruit a specific subset of depressed adolescents who also reported high levels of problems in family relationships. The primary aim of that study was to examine the specific impact of parent involvement in IPT-A for this subgroup of depressed adolescents. Consequently, this makes it inappropriate to generalise the results to all adolescents with depression (which is what CG28 is about). There is no evidence to suggest that IPT-AP is better than IPT-A for adolescents in the lower 90% for parent-adolescent conflict or for the significant majority of adolescents who receive IPT-A with a focus that is not framed around parent-adolescent conflict. c) The individual IPT-A delivered in this study was artificially constrained to not include parents and is NOT representative of how individual IPT-A has been	

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				conducted in other clinical trials or how IPT-A is generally delivered in clinical practice. A routine part of IPT-A is working with parents, and sometimes having specific sessions for parent(s) and a young person or parents alone (eg see p77 of the treatment manual(2)). The amount and nature of parent involvement depends on factors such as the interpersonal problems area that has been agreed, the adolescent's willingness to have a parent involved and the parent's willingness to be involved. This is different to the IPT-A as delivered in the IPT-AP study where, to serve the explicit objectives of the study, parental involvement was kept deliberately brief and confined to the first and last sessions (p 226)(1). Conclusions about the efficacy or effectiveness of individual IPT-A cannot legitimately be based on the IPT-A delivered in this study. The need for parent involvement well understood in the individual IPT-A model and is a core competency covered in detail	

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				in the national curriculum for IPT-A training courses e.g. CYP IAPT Therapist PGDip. In the main 2004 IPT-A effectiveness study, several young people had additional parent/family sessions, despite the therapy being delivered in a school setting(3). Most IPT-A in the UK is delivered in a clinic/community setting, where parent involvement is much easier to co-ordinate and hence is near-universal. It is important for this to be flexible and delivered as appropriate to the case formulation and wishes of the family (i.e. some cases will require parent-only sessions, some will not). Hence 'individual' IPT-A includes parent involvement that is at a much greater level than the IPT-A control group in the IPT-AP study; hence it is not appropriate to conclude that IPT-AP is more effective than standard UK IPT-A. d) We welcome the committee's positive acknowledgement of the relational focus of IPT-A for this population and the value of this core component of the model but	

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				firmly believe that it is invalid and would be clinically confusing to base a recommendation on two experimental manipulations of the model, neither or which reflect the majority of the published evidence or competency-based practice. It would be a highly undesirable outcome if the guidelines reduced the autonomy and choice available to young people during a crucial developmental period, characterised by key tasks of individuation and renegotiating familial and peer relationships, by recommending only a therapy with no routine parent involvement or mandatory parent involvement. We believe that the potential to tailor parental involvement with the aim of enhancing outcomes based on formulation of clinical need is more accurately understood as additional evidence of the value of the IPT-A approach and not a valid basis to make IPT-A compete with its own evidence base.	

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Interpersonal Psychotherapy UK Network	Guideline	31	7	We agree that a lot more research does need to be done on psychological therapies for depression. It is notable that no psychological therapies have been shown to be better than active controls across all depression severity/functional outcomes. Part of this may be down to small sample size for a lot of the therapies, making the meta-analysis not powered enough to find significant differences. We accept this is a problem for IPT-A, where there have been only two, relatively small, studies comparing IPT-A against active controls(3,6). Given these have both demonstrated IPT-A to be more effective than active controls for adolescent depression, and given that several meta-analyses have found IPT to be better than active controls and equivalent to CBT in adult depression(8,9), we do believe that a large, adequately powered study comparing IPT-A against active control and/or CBT in depressed adolescents is needed. The draft guidelines quite rightly recommend this for behavioural activation, which, like IPT-A, shows promise. We think the	Thank you for your comment. The committee agreed to add a research recommendation to obtain additional evidence of effectiveness for psychological interventions such as IPT-A (IPT for adolescents), brief psychosocial intervention (BPI) and psychodynamic psychotherapy compared to each other and to individual CBT in young people aged 12 to 18 years with moderate to severe depression.

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				guidelines should also recommend this for IPT-A.	
Interpersonal Psychotherapy UK Network	Guideline	96	8-22	We are very concerned that the guidelines have based recommendations for 5-11year olds on research conducted with 12-18year olds. As noted in the guidance, there are significant developmental differences between the two groups, and we regard it as an invalid and unsafe assumption that therapy that has demonstrated efficacy with adolescents will be accessible and similarly effective for young children, who lack the emotional, cognitive and social maturity of the young people with whom the research was conducted. We are similarly concerned and confused by the committee's decision to focus on and invest in further evaluating group CBT as the most promising intervention for moderate to severe depression in children ages 5-11 despite null findings for reducing depressive symptoms as compared to waiting list/ no treatment from a single paper published almost three decades ago. This recommendation inexplicably	Thank you for your comment. The committee agreed that 5-11 year olds are very different to 12-18 year olds in terms of maturity and developmental level. This point was already reflected in the recommendation for a full needs assessment to underlie the choice of therapy, which included consideration of maturity and developmental level. As you note, the evidence base for this age group was very limited. This is reflected in the committee discussions of the evidence under "quality of the evidence" and "benefits and harms". We have extended these sections based on committee discussions of stakeholder comments. The committee noted that there was a very limited evidence base for 5-11 year olds with mild depression and that group CBT was not better than control at reducing depression symptoms. However, rather than make no recommendation, they agreed that it was important to offer these children treatment. Taking consultation comments into account, they decided to include a new recommendation specifically for 5-11 year olds with mild depression to follow the treatments for 12-18 year olds, but with use of developmental adaptation where needed. The consideration of developmental level and maturity is also included as part of the full assessment of needs recommendation. There was more evidence for 5 to 11 year olds with moderate to severe depression, but the evidence of effectiveness for individual therapies was weak. In this case, the committee used their clinical expertise and the limited evidence to make a new recommendation for 5-11 year olds with moderate to severe depression. This

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				overlooks existing family-based interventions, such as FB-IPT, that have been appropriately modified to reflect developmental context and produced efficacy data when conducted with clinical samples providing more compelling data for future study and dissemination.	included the interventions that were most effective in the trials that recruited the 5-11 years olds and individual CBT because this was the most effective intervention for 12-18 year olds. This recommendation also included the use of developmental adaptation where needed. In addition, based on stakeholder comments, the committee agreed to expand the scope of the research recommendation to cover children aged 5 to 11 years with mild or moderate to severe depression. The new research recommendation does not specify a particular psychological therapy.
Interpersonal Psychotherapy UK Network	References for our comments			1. Gunlicks-Stoessel M, Mufson L. Innovations in Practice : a pilot study of interpersonal psychotherapy for depressed adolescents and their parents. 2016;(4):225–30. 2. Mufson L, Dorta KP, Moreau D, Weissman MM. Interpersonal Psychotherapy for Depressed Adolescents. 2nd ed. New York: Guilford Press; 2004. 3. Mufson L, Dorta KP, Wickramaratne P, Nomura Y, Olfson M, Weissman MM. A randomized effectiveness trial of interpersonal psychotherapy for depressed adolescents. Arch Gen Psychiatry [Internet]. 2004;61(6):577–84. Available from: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMe	Thank you for your comment. We have addressed your comments related to these references. Please see ID 155, 166, 194, 236, and 250.

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				d&dopt=Citation&list_uids=15184237 4. Zhou X, Hetrick SE, Cuijpers P, Qin B, Barth J, Whittington CJ, et al. Comparative efficacy and acceptability of psychotherapies for depression in children and adolescents: A systematic review and network meta-analysis. World Psychiatry [Internet]. 2015;14(2):207–22. Available from: http://www.ncbi.nlm.nih.gov/pubmed/26043339 5. Uher R, Ph D, Perlis RH, Placentino A, Psy D, Dernovšek Z, et al. Self-report and clinician-rated measures of depression severity: can one replace the other? Depress Anxiety. 2012;29(12):1043–9. 6. Mufson L, Weissman MM, Moreau D, Garfinkel R. Efficacy of interpersonal psychotherapy for depressed adolescents. Arch Gen Psychiatry. 1999;56(6):573–9. 7. Dietz LJ, Weinberg RJ, Brent DA, Mufson L. Family-based interpersonal psychotherapy for depressed preadolescents: examining efficacy and potential treatment mechanisms. J Am Acad	

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				Child Adolesc Psychiatry [Internet]. 2015;54(3):191–9. Available from: https://www.ncbi.nlm.nih.gov/pubmed/25721184 8. Barth J, Munder T, Gerger H, Nuesch E, Trelle S, Znoj H, et al. Comparative Efficacy of Seven Psychotherapeutic Interventions for Patients with Depression : A Network. PLoS Med. 2013;10(5):e1001454. 9. Cuijpers P, Donker T, Weissman MM, Ravitz P, Cristea IA. Interpersonal Psychotherapy for Mental Health Problems: A Comprehensive Meta-Analysis. Am J Psychiatry. 2016;173(7):680–7.	
Lactation Consultants of Great Britain	Guideline	General	General	**We would like to see a thorough nutritional assessment of the children/young people and an individualised nutritional and lifestyle support programme introduced, working with the family.** Nutritional deficits, low nutrient intake and other avoidable risk factors may be contributing to mental health issues within the entire family. **In addition, natural daylight, time in nature, exercise, socialising,**	Thank you for your comment. Nutrition and other lifestyle factors were not within the scope of this update and therefore we are unable to make recommendations in this area. However, the section on "Treatment and considerations in all settings" already contains a recommendation on nutrition and the benefits of a balanced diet (recommendation 1.1.36).

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				meaningful activity and meditation are all interventions that are low/no cost but are evidenced to be highly beneficial at both reversing depression and keeping it from returning. Many of these activities are inexpensive to the NHS; do not require direct intervention and maintenance by support staff or could be administered in group sessions. These lifestyle interventions are likely to be highly cost effective and considerably safer for children and young people, as they address several of the key root causes of depression without using drugs. This connection between mental health, nutrition and lifestyle/life stresses is not yet well understood or taught within the mainstream medical profession, yet the weight of biochemical and clinically researched evidence is unequivocal.	

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				See references and additional detail in the following sections for some of the evidence base.	
Lactation Consultants of Great Britain	Guideline	General	General	**Nutrition, including fatty acids and vitamins:** Adams PB, Lawson S, Sanigorski, A, et al. Arachidonic acid to eicosapentaenoic acid ratio in blood correlates positively with clinical symptoms of depression. Lipids. 1996;31 Suppl: S157-61. Eldeen, O.N. Eldayem, S.M.A. Shatla, R.H. *et al*. (2012). 'Homocysteine, folic acid and vitamin B12 levels in serum of epileptic children'. *Egyptian Journal of Medical Human Genetics*, 13 (3), pp. 275-280 Ben Forsyth, A. Deane F.P. Williams, P. (2015). 'A lifestyle intervention for primary care patients with depression and anxiety: A randomised controlled trial', *Psychiatry Research,* 230 (2), pp. 537 –544. Jacka EN, Pasco JA, Henry MJ, et al. Dietary omega-3 fatty acids and depression in a community sample. Nutr Neurosci. 2004;7(2):101-06	Thank you for your comment. Nutrition and other lifestyle factors were not within the scope of this update and therefore we are unable to make recommendations in this area. However, the section on "Treatment and considerations in all settings" already contains a recommendation on nutrition and the benefits of a balanced diet (recommendation 1.1.36).

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				Jacka, F. N. O'Neil, A. Opie, R. *et al*. (2017). 'A randomised controlled trial of dietary improvement for adults with major depression (the "SMILES" trial)', *BMC Medicine*, *15*, 23. Kaner, G. Soylu, M. Yüksel, N. *et al.* (2015). 'Evaluation of Nutritional Status of Patients with Depression', *BioMed Research International*, *2015;*521481 Nguyen, P.H. Grajeda, R. Melgar, P. *et al*. (2009). 'Micronutrient supplementation may reduce symptoms of depression in Guatemalan women', *Arch Latinoam Nutr.* 59(3), pp. 278-286. Opie, R.S. O'Neil, A. Jacka, F.N. *et al.* (2017). 'A Modified Mediterranean dietary intervention for adults with major depression: Dietary protocol and feasibility data from the SMILES trial', *Nutritional Neuroscience,* 19*,* pp. 11-15 Roca, M. Kohls, E. Gili, M. *et al*. (2016). 'Prevention of depression through nutritional strategies in high-risk persons: rationale and design of the MooDFOOD prevention trial', *BMC Psychiatry*, 16, 192	

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				Sánchez-Villegas, A. Martínez-González, M. A. Estruch, R. *et al*. (2013). 'Mediterranean dietary pattern and depression: the PREDIMED randomized trial', *BMC Medicine*, 11, 208. Sánchez-Villegas, A. Ruíz-Canela, M. De la Fuente-Arrillaga, C. *et al*. (2015). 'Dietary inflammatory index, cardiometabolic conditions and depression in the Seguimiento Universidad de Navarra cohort study', *British Journal of Nutrition,*114(9), pp. 1471-1479. Sapolsky, R. (2004) *Why Zebra's don't get ulcers.* New York: Holt Paperbacks. Sarris, J. Murphy, J. Mischoulon, D. *et al.* (2016) 'Adjunctive Nutraceuticals for Depression: A Systematic Review and Meta-Analyses', *The American Journal of Psychiatry,* 173*(*6), pp. 575-587). Sepehrmanesh, Z. Kolahdooz, F. Abedi, F. *et al. (*2017). 'Vitamin D Supplementation Affects the Beck Depression Inventory, Insulin Resistance, and Biomarkers of Oxidative Stress in Patients with Major Depressive	

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				Disorder: A Randomized, Controlled Clinical Trial', *Journal of Nutrition*, 146 (2), pp. 243-248. Shaffer, J. A. Edmondson, D. Wasson, L. T. *et al*. (2014). 'Vitamin D Supplementation for Depressive Symptoms: A Systematic Review and Meta-analysis of Randomized Controlled Trials' *Psychosomatic Medicine*, 76(3), pp.190–196. Maes M, Christophe A, Delanghe J, et al. Lowered omega 3 polyunsaturated fatty acids in serum phospholipids and cholesteryl esters of depressed patients. Psychiatry Res. 1999;85(3):275-91. Miller, A.L. (2008). 'The methylation, neurotransmitter and antioxidant connections between folate and depression', *Alternative Medicine Reviews,* 13(2), pp. 216-226. Mocking, R. J. T. Harmsen, I. Assies, J. *et al*. (2016). 'Meta-analysis and meta-regression of omega-3 polyunsaturated fatty acid supplementation for major depressive disorder', *Translational Psychiatry*, 6 (3), e756	

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				Peet M, Murphy B, Shay J, et al. Depletion of omega-3 fatty acid levels in red blood cell membranes of depressive patients. Biol Psychiatry. 1998;43(5):315-19. Ritsner, M.S. Miodownik, C. Ratner, Y. *et al*. (2011).'L-theanine relieves positive, activation, and anxiety symptoms in patients with schizophrenia and schizoaffective disorder: an 8-week, randomized, double-blind, placebo-controlled, 2-center study', *J Clin Psychiatry,*72 (1), pp. 34-42. Stoll AL, Locke CA, Marangell LB, Severus WE. Omega-3 fatty acids and bipolar disorder: a review. Prostaglandins Leukot Essent Fatty Acids. 1999;60:329-37. Sublette, M.E. Ellis, S.P. Geant, A.L. & Mann, J.J. (2011). 'Meta-analysis of the effects of eicosapentaenoic acid (EPA) in clinical trials in depression', *J Clin Psychiatry*. Vesco, A., Young, A., Arnold, L. and Fristad, M. (2017). Omega-3 supplementation associated with	

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				improved parent-rated executive function in youth with mood disorders: secondary analyses of the omega 3 and therapy (OATS) trials. Journal of Child Psychology and Psychiatry, 59(6), pp.628-636.	
Lactation Consultants of Great Britain	Guideline	General	General	**Disturbances in endocrine, neurotransmitter and metabolic function:** **Background:** An example from an abstract is provided below: This review summarises the evidence that chronic low grade inflammation plays an important role in the pathology of depression. Evidence is provided that pro-inflammatory cytokines, together with dysfunctional endocrine and neurotransmitter systems, provide a network of changes that underlie depression and may ultimately contribute to the neurodegenerative changes that characterise depression. Leonard, B. (2014). Impact of inflammation on neurotransmitter changes in major depression: An insight into the action of antidepressants. *Progress in Neuro-*	Thank you for your comment. Disturbances in endocrine, neurotransmitter and metabolic function were not within the scope of this update and therefore we are unable to make recommendations on this topic.

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				Psychopharmacology and Biological Psychiatry, 48, pp.261-267. Gillespie. CF. & Nemeroff, CB. (2005). 'Hypercortisolemia and depression', *Psychosom Med*. 67 (1):S26-8. Gross, J. A. Fiori, L. M. Labonté, *et al*. (2013). 'Effects of promoter methylation on increased expression of polyamine biosynthetic genes in suicide', *Journal of Psychiatric Research*, *47* (4), pp.513–519. Krishnan, V. & Nestler, E.J.(2008). 'The molecular neurobiology of depression', *Nature*, 455 (7215), pp. 894–902 Lugo-Huitrón, R., Ugalde Muñiz, P., Pineda, B., *et al*. (2013). 'Quinolinic Acid: An Endogenous Neurotoxin with Multiple Targets'.*Oxidative medicine and cellular longevity*, 2013, 104024. Maes M. Major depression and activation of the inflammatory response system. In Cytokines, Stress and Depression, edited by Danzer et al. Kluwer Academic/Plenum Publishers. New York. 1999, pp 25-46.	

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				Maruyama, W. Ota, A. Takahashi, A. *et al*. (1994). 'Food-derived hetero-cyclic amines, 3-amino-1,4-dimethyl-5H-pyrido[4,3-b] indole and related amines, as inhibitors of monoamine metabolism', *Journal of Journal of Neural Transmission*, 41, pp. 327-333. Mawe, G.M. & Hoffman, J.M. (2013). 'Serotonin signalling in the gut—functions, dysfunctions and therapeutic targets', *Nature Reviews Gastroenterology and Hepatology.* 10,pp. 473-486 Van Dam, N. T. Rando, K. Potenza, M. N. *et al.* (2014). 'Childhood Maltreatment, Altered Limbic Neurobiology, and Substance Use Relapse Severity via Trauma-Specific Reductions in Limbic Gray Matter Volume', *JAMA Psychiatry*, 71(8), pp. 917–925. Wong ML, Kling MA, Munson PJ, et al. Pronounced and sustained central hypernoradrenergic function in major depression with melancholic features: relation to hypercortisolism and	

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				corticotropin-releasing hormone. Proc Natl Acad Sci USA. 2000;97(1):325-30. Young, S. (2007). 'How to raise serotonin without drugs'*, Journal of Psychiatry and Neuroscience,* 32 (6)	
Lactation Consultants of Great Britain	Guideline	General	General	**Time in nature:** In addition to a nutrition programme, spending time outdoors in nature has been found to relieve depression for multiple reasons. These include but are not limited to exposure to natural daylight, endogenous Vitamin D production and re-setting to normal circadian, metabolic rhythms. Berman, M. G. Kross, E. Krpan, K. M. *et al*. (2012). 'Interacting with Nature Improves Cognition and Affect for Individuals with Depression', *Journal of Affective Disorders*, *140* (3), 300–305. Cox, D. T. C. & Gaston, K. J. (2016). 'Urban Bird Feeding: Connecting People with Nature', *PLoS ONE*, *11*(7), e0158717. Cox, D. T. C. Shanahan, D. F. Hudson, H. L. *et al*. (2017). 'Doses of Nearby Nature Simultaneously Associated with	Thank you for your comment. Time outdoors in nature was not within the scope of this update and therefore we are unable to make recommendations on this topic.

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				Multiple Health Benefits', *International Journal of Environmental Research and Public Health*, *14*(2), 172.	
Lactation Consultants of Great Britain	Guideline	General	General	**Herbal treatments for depression** Studies have revealed beneficial effects of medical herbs and phytochemicals on depression and their central nervous system mechanism. Although conventional antidepressant therapy can help relieve symptoms of depression and prevent relapse of the illness, complementary therapies are required due to disadvantage of the current therapy such as adverse effects. Use of phytomedicine may be an alternative option for the treatment of depression in case conventional drugs are not applicable due to their side effects, low effectiveness, or inaccessibility. 110 medicinal plants and their phytochemical constituents have been shown to possess anti-depressant activity. This review also highlights the various mechanisms of anti-depressant action of some of these plant phytochemical compounds showing anti-depressant activity such flavanoids,	Thank you for your comment. Herbal treatments were not within the scope of this update and therefore we are unable to make recommendations on this topic.

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				steroids, saponins, sugars, lectins and alkaloids. Martins, J. and S, B. (2018). Phytochemistry and pharmacology of anti-depressant medicinal plants: A review. *Biomedicine & Pharmacotherapy*, 104, pp.343-365. Hausenblas, H. A. Saha, D. Dubyak, P. J. & Anton, S. D. (2013). 'Saffron (*Crocus sativus*L.) and major depressive disorder: a meta-analysis of randomized clinical trials', *Journal of Integrative Medicine*, *11* (6), pp.377–383. Hosseinzadeh, H. & Nassiri-Asl, M. (2013) 'Avicenna's (Ibn Sina) the Canon of Medicine and Saffron (Crocus sativus): A Review',*Phytother. Res*. 27, pp. 475–483. Lee, G. and Bae, H. (2017). Therapeutic Effects of Phytochemicals and Medicinal Herbs on Depression. BioMed Research International, 2017, pp.1-11. (On Carvacrol; Curcumin; Ferulic acid; L-Theanine; Proanthocyanidin; Quercetin; Resveratrol)	

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				Lillehei, A., Halcón, L., Savik, K. and Reis, R. (2015). Effect of Inhaled Lavender and Sleep Hygiene on Self-Reported Sleep Issues: A Randomized Controlled Trial. The Journal of Alternative and Complementary Medicine, 21(7), pp.430-438. Linde, K. Berner, M.M. & Kriston L. (2008). 'St John's wort for major depression', *Cochrane Database of Systematic Reviews*, 4. Art. No.: CD000448. Ng, Q.X. Venkatanarayan, N. & Ho, C.Y. (2017) 'Clinical use of *Hypericum perforatum*(St John's wort) in depression: A meta-analysis'. *Journal of Affective Disorders*, 210(), pp. 211 –221. Osiecki, H. Meeke, F. & Smith, H. (2004) *The Encyclopaedia of Clinical Nutrition-Volume 1, The Nervous System.* Queensland: Bioconcepts publishing. Pizzorno, J.E. & Murray, M.T. (2009). *Textbook of Natural Medicine.* St. Louis: Elsevier/Churchill Livingstone.	

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				Russo, E. Scicchitano, F. Whalley, B.J. *et al.* (2013). 'Hypericum perforatum: pharmacokinetic, mechanism of action, tolerability, and clinical drug–drug interactions',*Phytotherapy Research*. 28 (5), pp. 643-655.	
Lactation Consultants of Great Britain	Guideline	General	General	**Herbs as anti-inflammatories** Common antiinflammatory herbal plants are Curcuma longa, Zingiber officinale, Rosmarinus officinalis, Borago officinalis, Urtica dioica, Uncaria tomentosa, Vaccinium myrtillus, Olea europaea and much more. They are believed to be without side effects unlike the chemical counterparts or synthetic anti-inflammatory agents e.g. steroids, nonsteroid anti-inflammatory drugs, and immunosuppresants used for controlling and suppressing inflammatory crisis. A proper phytochemical, pharmacological and physiological evaluation will enable their safe and effective use in inflammatory conditions. Many of these anti-inflammatory drugs and herbal preparations have been patented with some under consideration.	Thank you for your comment. Herbal treatments as anti-inflammatories were not within the scope of this update and therefore we are unable to make recommendations on this topic.

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				CONCLUSION: Natural herbs are safe, effective and better options as anti-inflammatory agents than synthetic ones. The phytoconstituents are as effective with the comparable mechanism of action as synthetic molecules. Yatoo, M., Gopalakrishnan, A., Saxena, A., Parray, O., Tufani, N., Chakraborty, S., Tiwari, R., Dhama, K. and Iqbal, H. (2018). Anti-Inflammatory Drugs and Herbs with Special Emphasis on Herbal Medicines for Countering Inflammatory Diseases and Disorders - A Review. *Recent Patents on Inflammation & Allergy Drug Discovery*, 12(1), pp.39-58. de Sousa, D., Silva, R., Silva, E. and Gavioli, E. (2017). Essential Oils and Their Constituents: An Alternative Source for Novel Antidepressants. Molecules, 22(8), p.1290.	
Lactation Consultants of Great Britain	Guideline	General	General	**Meditation and yoga techniques** A randomized, waitlist-controlled pilot study evaluated feasibility, efficacy, and tolerability of Sudarshan Kriya yoga (SKY) as an	Thank you for your comment. Meditation and yoga were not within the scope of this update and therefore we are unable to make recommendations on this topic. This update was on psychological therapies only.

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				adjunctive intervention in patients with major depressive disorder (MDD) with inadequate response to antidepressant treatment. Results suggested the feasibility and promise of an adjunctive SKY-based intervention for patients with MDD who have not responded to antidepressants. McKennon, S., Levitt, S. and Bulaj, G. (2017). Commentary: A Breathing-Based Meditation Intervention for Patients with Major Depressive Disorder Following Inadequate Response to Antidepressants: A Randomized Pilot Study. *Frontiers in Medicine*, 4. Prathikanti, S. Rivera, R. Cochran, A. *et al*. (2017). 'Treating major depression with yoga: A prospective, randomized, controlled pilot trial', *PLoS ONE*, 12(3), e0173869. Sharma, A. Barrett, M. S. Cucchiara, A. J. *et al*. (2017). 'A Breathing-based Meditation Intervention for Patients with Major Depressive Disorder Following Inadequate Response to Antidepressants: A Randomized Pilot	

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				Study', *The Journal of Clinical Psychiatry*, *78* (1), e59–e63. Streeter, C. C. Gerbarg, P. L. Whitfield, T. H. *et al*. (2017). 'Treatment of Major Depressive Disorder with Iyengar Yoga and Coherent Breathing: A Randomized Controlled Dosing Study', *Journal of Alternative and Complementary Medicine*, *23*(3), 2pp. 01–207.	
Lactation Consultants of Great Britain	Guideline	General	General	**Meditation CDs or downloads to aid sleep, relaxation and calm** Meditation CDs or downloads can be very effective at calming the sympathetic nervous system. **These are another non-pharmaceutical aid to relaxation – counteracting the anxiety that so often accompanies depression.** There are also CDs that are designed specifically for children and young people. **These are not mentioned as treatment or management options in the guidelines, yet they can be very effective**, particularly those using Hemi-Synch technology, for example: https://www.monroeinstitute.org/node/2216)	Thank you for your comment. Meditation was not within the scope of this update and therefore we are unable to make recommendations on these topics. However, the section on "Treatment and considerations in all settings" already contains a recommendation (1.1.35) about offering the child or young person with depression advice about sleep hygiene and anxiety management. This update was on psychological therapies only.

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				How they work: Audible signals act together to create a resonance that is reflected in unique brain wave forms characteristic of specific states of consciousness. The result is a focused, whole-brain state known as hemispheric synchronization, or Hemi-Sync®, where the left and right hemispheres are working together in a state of coherence. Different Hemi-Sync® signals are used to facilitate deep relaxation, focused attention or other desired states. As an analogy, lasers produce focused, coherent light. Hemi-Sync® produces a focused, coherent mind, which is an optimal condition for improving human performance. Naturally, Hemi-Sync® sleep products incorporate predominately Delta frequencies; learning products predominantly Beta, and so forth. Users remain in total control as these recordings do not contain subliminal messages. Hemispheric synchronization does occur naturally in daily life, but typically only for random, brief periods of time. Hemi-Sync® can assist individuals in achieving and sustaining this highly productive, coherent, brain wave state.	

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				Children and young people find this audio experience very engaging and relaxing. It has been used for specific applications such as focused attention, stress management, meditation, sleep enhancement, and pain management. F. Holmes Atwater, BA. Binaural Beats and the Regulation of Arousal Levels. *Hemi-Sync Journal*, Vol. I, Nos. 1 & 2, Winter-Spring 2009	
Lactation Consultants of Great Britain	Guideline	General	General	**The bigger picture** **Poverty, life chances and depression in young people from disadvantaged backgrounds – cultural, social structural barriers need to change to decrease depression** It is well understood that poverty and a lack of life chances can predispose human beings of any age and in any culture to depression. Particularly illuminating in the study below, was the finding that: *Contrary to the dominant cultural stereotype about African Americans being lazy, the study results show that the participants had highly similar career goals to the majority population yet faced many, significant structural*	Thank you for your comment. The committee agreed that it was important to take the individual's background and circumstances into account when choosing a psychological therapy. This is reflected in the recommendations aimed at helping the medical professional take a comprehensive history of the individual prior to choosing a therapy that matches both their clinical needs and circumstances. Their discussions regarding equalities and disadvantaged groups, including those growing up in poverty, are detailed in the 'other factors the committee took into account' section of the discussion in the evidence review and in the Equalities Impact Assessment document.

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				barriers that interfered with their progress and thus sapped their motivation in achieving their life plans. Participants' life challenges diminished the antidepressant effect of exercise and were linked to depression and excessive screen use. ***Policy change is needed to reduce social structural barriers and racial systems of oppression in order to decrease poverty and depression.*** Kosma, M. and Buchanan, D. (2019). Aspects of Depression Among Socioeconomically Disadvantaged African American Young Adults. *International Quarterly of Community Health Education*, pp.0272684X1982961.	
Lactation Consultants of Great Britain	Guideline	General	General	In terms of 1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. During the research searches, we came across the following abstract on Management of Treatment-Resistant Depression in Children and Adolescents, which seems relevant, given the tone of the current guidelines. The abstract is copied in full below:	Thank you for your comment. The current update was focused on psychological therapies for depression. Antidepressants are not recommended for the initial treatment of children and young people with mild depression and the focus in the guideline is on using psychological therapies at this stage. For moderate to severe depression, psychological therapies are also recommended with/without drug treatment. Nutrition and other lifestyle factors were not within the scope of this update and therefore we are unable to make recommendations in this area. However, the section on "Treatment and considerations in all settings" contains a recommendation on offering advice about

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				Depression is a relatively common diagnosis in children and adolescents, and is associated with significant morbidity and suicidality in this population. Evidence-based treatment of the acute illness is imperative to try to prevent the development of treatment-resistant depression or other complications. In situations where response to acute treatment is inadequate, clinicians should first consider factors that may influence outcome, such as psychiatric or medical comorbidities, psychosocial stressors, and treatment noncompliance. Selective serotonin reuptake inhibitors (SSRIs) are the first-line treatment for depression in children and adolescents. For treatment-resistant depression, a switch to an alternate SSRI is recommended before trials of other antidepressants. Psychotherapy, such as cognitive behavioral therapy or interpersonal therapy, may improve treatment response. More research is needed examining medication augmentation strategies for treatment-resistant depression in children and adolescents.	nutrition and the benefits of a balanced diet and another recommendation on sleep hygiene.

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				DeFilippis, M. and Wagner, K. (2014). Management of Treatment-Resistant Depression in Children and Adolescents. *Pediatric Drugs*, 16(5), pp.353-361. This abstract is depressing in itself. The emphasis is on more medication augmentation strategies, with a passing reference to other treatment modalities such as psychiatric or medical comorbidities, psychosocial stressors, and treatment noncompliance. The research we have provided in the sections above list at least five different areas that need to be taken into account above and beyond medication augmentation, as the references provided attest. **Where these other significant areas are NOT taken into account, it is hardly surprising that depression is "treatment-resistant" – because the many other contributing root causes have not been addressed.** If these additional insights are addressed, many of these cases may turn out instead to be only "current"	

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				treatment resistant - until the factors addressing poor nutrition, high inflammation, lack of daylight, poor sleep and little exercise have been applied to the person's care. **There is hope. We have now highlighted the other areas that can be included, to address what would otherwise appear to be "treatment-resistant depression".** **We may appear to have provided exhaustive detail, but in doing so, we identify and emphasise important research areas that have already demonstrated results at least as effective as drug treatments, (often more so); a better return on NHS investment in terms of quality of life and effectiveness, socially acceptable, socially inclusive treatments, suitable for use in children and young people and that are almost completely side-effect free.** We hope sincerely that by providing the weight of this clinical evidence where	

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				effective alternatives or complements to drug treatment exist - that these will be used in future in NICE guidelines.	
Lactation Consultants of Great Britain	Guideline	General	General	**The biggest challenges** are unfamiliarity with the methods available, such as nutrition and the attitude of "a pill for an ill" within medical treatment of mental disorders, even for children and young people. As stated earlier, nutrition and the effects of lifestyle choices are not taught within the mainstream Western medical profession, so medical professionals might consider that if they are not taught these subjects, they are not important to them or their patients. Much of the funding provided to medical schools is provided by pharmaceutical manufacturers, who cannot take out patents on food or herbs. They are unlikely to encourage the inclusion of a curriculum on nutrition or herbal products within their field of influence – it would be against their profits and their duty to their shareholders. Therefore, a conflict of interest exists between funding, teaching, drug prescribing and effective non-pharmaceutical methods of addressing	Thank you for your comment. Nutrition and other lifestyle factors were not within the scope of this update and therefore we are unable to make recommendations in this area. However, the section on "Treatment and considerations in all settings" contains a recommendation about offering advice about nutrition and the benefits of a balanced diet.

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				depression and other mental illnesses within the NHS. LCGB would assert that it is part of the responsibility of NICE to step beyond these conflicts of interest and act in the best interests of the population, especially those of children and young people. **This inclusion of other treatment modalities ties in well with the aims of the NHS Long Term Plan, which now advocates investing in preventive and integrated strategies to gain both cost savings and improved treatment effectiveness.** **Coincidentally, as depression has such a long term, negative impact on society, the wider economy and NHS resources, these more effective nutrition and lifestyle treatments are also likely to save the NHS and the country - considerable sums of money.** **See the economic evaluation of the SMILES trial below:**	

				RESULTS: Compared with the social support condition, average total health sector costs were $856 lower (95% CI -1247 to - 160) and average societal costs were $2591 lower (95% CI -3591 to - 198) for those receiving dietary support. These differences were driven by lower costs arising from fewer allied and other health professional visits and lower costs of unpaid productivity. Significant differences in mean QALYs were not found between groups. However, 68 and 69% of bootstrap iterations showed the dietary support intervention was dominant (additional QALYs at less cost) from the health sector and societal perspectives. **CONCLUSIONS:** **This novel dietary support intervention was found to be likely cost-effective as an adjunctive treatment for depression from both health sector and societal perspectives.** Chatterton, M., Mihalopoulos, C., O'Neil, A., Itsiopoulos, C., Opie, R., Castle, D., Dash, S., Brazionis, L., Berk, M. and Jacka, F. (2018). Economic evaluation of a dietary intervention for adults with	

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				major depression (the "SMILES" trial). *BMC Public Health*, 18(1).	
Lactation Consultants of Great Britain	Guideline	General	General	**In Summary:** **While the judicious use of medication and psychological techniques are still advocated, due to the complexity of human illness/wellbeing, the emerging evidence encourages a more integrative approach for depression, and an acknowledgment that lifestyle modification should be a routine part of treatment and preventative efforts.** Sarris, J., O'Neil, A., Coulson, C., Schweitzer, I. and Berk, M. (2014). Lifestyle medicine for depression. *BMC Psychiatry*, 14(1).	Thank you for your comment. Lifestyle factors were not within the scope of this update and therefore we are unable to make recommendations on this topic.
Lactation Consultants of Great Britain	Guideline	33	4, 5, 6, 7	**Exercise:** *A child or young person with depression should be offered advice on the benefits of regular exercise and encouraged to consider following a structured and supervised exercise programme of typically up to three sessions per week of moderate duration (45 minutes to 1 hour) for between 10 and 12 weeks. [2005]*	Thank you for your comment. Exercise was not within the scope of this update and therefore we are unable to make recommendations on this topic. Please refer to the section "Treatment and considerations in all settings" for a recommendation covering the benefits of exercise.

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				This is very sensible advice and we welcome it. What is less clear is whether these programmes of exercise are available in all circumstances. What support is the young person is given to enable them to take part in these activities if they are in the adverse circumstances so common in depression? How and where do staff access this support for their patients, at least initially? Are there ringfenced funds to enable young people with depression to take part in local structured exercise classes, for example yoga and meditation, or karate or circuit training? Socialisation is also encouraged by exercise around other people, without forcing contact. This can be beneficial to many shy young people with depression. **Obese adolescents are more likely to be depressed, and less likely to exercise, so an intervention that includes exercise is likely to produce multiple health benefits.** See abstract below:	

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				Depression often has its first onset during adolescence and is associated with obesity. Furthermore, inflammatory processes have been implicated in both depression and obesity, although research amongst adolescents is limited. This review explores associations between depression and obesity, depression and inflammation, and obesity and inflammation from a developmental perspective. The temporal relations between these factors are examined to explore whether obesity and elevated inflammation act as either risk factors for, or outcomes of, adolescent-onset depression. Sex differences in these processes are also summarized. We propose a model whereby increases in sex hormones during puberty increase risk for depression for females, which can lead to obesity, which in turn increases levels of inflammation. Importantly, this model suggests that inflammation and obesity are outcomes of adolescent depression, rather than initial contributing causes. This study recommends further research on biological and psychosocial effects of	

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				sex hormones particularly in children and adolescents. **Meanwhile it would be prudent to use what we already know, to limit inflammation by providing nutritional support using anti-inflammatory foods and by increasing exercise.** Byrne, M., O'Brien-Simpson, N., Mitchell, S. and Allen, N. (2015). Adolescent-Onset Depression: Are Obesity and Inflammation Developmental Mechanisms or Outcomes?. *Child Psychiatry & Human Development*, 46(6), pp.839-850. Kvam, S., Kleppe, C., Nordhus, I. and Hovland, A. (2016). Exercise as a treatment for depression: A meta-analysis. *Journal of Affective Disorders*, 202, pp.67-86. Quek, Y., Tam, W., Zhang, M. and Ho, R. (2017). Exploring the association between childhood and adolescent obesity and depression: a meta-analysis. *Obesity Reviews*, 18(7), pp.742-754.	

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				For those already with a chronic illness: Béland, M., Lavoie, K., Briand, S., White, U., Gemme, C. and Bacon, S. (2019). Aerobic exercise alleviates depressive symptoms in patients with a major non-communicable chronic disease: a systematic review and meta-analysis. *British Journal of Sports Medicine*, pp.bjsports-2018-099360.	
Lactation Consultants of Great Britain	Guideline	34	10	**Sleep** *A child or young person with depression should be offered advice about sleep hygiene and anxiety management. [2005]* Again, this is very sensible advice and we welcome it. What we would like to see is the understanding of the ways that nutrition and natural products such as herbs can support normal, natural, restful sleep. See study conclusions below: These results are the first to document reciprocal effects for major depression and sleep deprivation among adolescents using prospective data. The data suggest reduced quantity of sleep increases risk for major depression,	Thank you for your comment. Sleep hygiene and anxiety management were not within the scope of this update and therefore we are unable to make recommendations on these topics. Please refer to the section "Treatment and considerations in all settings" for an existing recommendation on sleep hygiene and anxiety management.

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				which in turn increases risk for decreased sleep. Roberts, R. and Duong, H. (2014). The Prospective Association between Sleep Deprivation and Depression among Adolescents. *Sleep*, 37(2), pp.239-244. See also: High levels of depressive symptoms at baseline were associated with lower physical activity and higher sleep disturbance after two years but not vice versa in adolescent girls. Raudsepp, L. and Vink, K. (2019). Brief report: Longitudinal associations between physical activity, sleep disturbance and depressive symptoms in adolescent girls. *Journal of Adolescence*, 72, pp.37-41.	
Lactation Consultants of Great Britain	Guideline	35	12	***A child or young person with depression should be offered advice about nutrition and the benefits of a balanced diet. [2005]*** This element was identified in 2005 and is very sensible. **However, we can see no evidence of what any specifics of that advice on nutrition might be, nor what evidence the researchers recommend as to what constitutes a**	Thank you for your comment. Nutrition and benefits of a balanced diet were not within the scope of this update and therefore we are unable to make changes to this area. Please refer to the section "Treatment and considerations in all settings" for an existing recommendation on providing nutritional advice and the benefits of a balanced diet.

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				"balanced" diet. It is not mentioned in any of the research programmes being considered. This guideline provides no links or references to any structured protocol on supporting children and young people (or their families or support staff, if receiving care in an institution/hospital) on healthy eating to reduce depression risk. **Nor can we see any evidence of considering metabolic or endocrine disorders, or metabolic consequences of poor nutrition. This is a serious omission, considering the research that has been available for at least the last forty years on the links between depression, other mental illnesses and inadequate nutrition.** **To help answer the question on would implementation of any of the draft recommendations have significant cost implications, a nutrition intervention is likely to be**	

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				highly cost effective, for several reasons: • Nutrition intervention addresses several of the key physiological root causes of depression, one of which is an underlying inflammatory process • Addressing nutrition often relieves or prevents other common chronic non-communicable, inflammatory diseases • By addressing nutrition, the immune system works better, preventing infection with common acute, inflammatory communicable diseases • Addressing nutrition does not use pharmaceutical drugs o This avoids the side effects, addictions and disturbed ideations, including suicide risk, that are so common with drug use in depression treatment ▪ This is especially the case in young people where correct dosing for	

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				age and size may be more difficult to achieve ▪ More mature mental processes are not yet developed ▪ and drug metabolism may be more difficult to predict **Please see the following research articles that back up this recommendation on nutritional intervention.**	
Mindfulness Foundation	Guideline	29	23	**Recommendations for research** The application of Artificial intelligence (AI) to digital CBT for children. This Research request is based on the 23 January 2019 launch by Google at Davos of the report on "Artificial intelligence (AI) as a tool to accelerate transition" and the IBM's 2016 technology Patent 'With AI, our words will be a window into our mental health.' **Google** Artificial intelligence (AI) can play an important role in enabling this systemic shift. AI is a subset of the technologies	Thank you for your comment. The committee agreed to add a research recommendation on digital CBT to compare supported and unsupported digital CBT as well as to identify the key components of digital CBT that influence effectiveness.

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				enabling the emergent 'Fourth Industrial Revolution' era and deals with models and systems which perform functions generally associated with human intelligence, such as reasoning and learning. https://www.ellenmacarthurfoundation.org/publications/artificial-intelligence-and-the-circular-economy Another key aspect is the 2018 Google $25m Impact Challenge, an open call to organisations around the world to submit their ideas for how they could use AI to help address societal challenges. https://ai.google/social-good/impact-challenge **IBM** In 2016 IBM secured a Mental Health AI Patent 'With AI, our words will be a window into our mental health.' By 2021 what we say and write will be used as indicators of our mental health and physical wellbeing. Patterns in our speech and writing	

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				analyzed by new cognitive systems will provide tell-tale signs of early-stage developmental disorders, mental illness and degenerative neurological diseases that can help doctors and patients better predict, monitor and track these conditions. https://www.research.ibm.com/5-in-5/mental-health/	
NHS England	Evidence Review	28	22	"Important limitations of this study are the low participant adherence to the interventions" - We are unsure where this information comes from. Adherence was high. Early terminations have been analysed at least in a qualitative study of a subsample and the most common reason for termination was rapid improvement. O'Keeffe, S., Martin, P., Goodyer, I. M., Wilkinson, P., Consortium, I., & Midgley, N. (2018). Predicting dropout in adolescents receiving therapy for depression. Psychother Res, 28(5), 708-721. doi: 10.1080/10503307.2017.1393576	Thank you for your comment. We have changed the paragraph to say "Important limitations affecting the generalisability of the cost-effectiveness estimates in this study are the uncertainty about how levels of attendance at planned sessions reflect current clinical practice and the volume of missing data related to resource consumption. This is particularly relevant given the analysis' sensitivity to the cost of interventions and the marginal difference in QALYs gained between comparators."
NHS England	Guideline and	Gener al	General	The NICE recommendations for iCBT does not make a distinction between	Thank you for your comment. The committee agreed that they could not recommend a specific digital CBT programme because

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	Evidence Review			supported and unsupported iCBT. (Uptake and engagement with programmes like MoodGym have been poor in clinical practice). There is wide range of products available at great difference in financial investment. Without specific recommendation of particular products with cost effectiveness data it is hard to understand why NICE has broadly endorsed 'iCBT' as a class– leaving it vague which specific software should be prescribed by services.	the evidence came from a variety of programmes which had different components and were delivered in a variety of settings. Therefore, the committee agreed to provide a list of the programmes used in the studies and their common components as part of the terms used in the guideline. They recognised the uncertainty surrounding the effectiveness of supported or unsupported digital CBT in the UK and made a research recommendation to try to identify which form was most effective in the UK and which key components were associated with this effectiveness. The committee envisaged that the choice of digital CBT programme would be made at a local or national level in a similar manner to the process used to choose digital CBT programmes for adults with depression. We have added some detail relating to these issues to the benefits and harms section of the discussion in the evidence review. While the committee were mindful that there are no detailed cost-effectiveness data, they considered the cost estimates for digital CBT and noted that, while they understood these were imprecise, digital CBT was among the cheapest of the interventions that were shown to be effective for mild depression in the clinical review. They therefore concluded that it is likely to be a cost-effective option.
NHS England	Guideline	General	General	Although this additional community option is only recently developed for CYP, is relevant to comment on the potential role of intensive community support (home treatment)?	Thank you for your comment. We are unclear about which community option you are referring to. This update was confined to psychological therapies for treatment of depression, but there is a recommendation that lists potential settings where these therapies could be delivered. This includes several community settings such as schools and colleges. In addition, the section on "Detection and risk profiling" includes

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					recommendations which talk about healthcare professionals and the settings in which they operate, and they also mention community settings. The role of intensive community support was not within the scope of this update and therefore we are unable to make more specific recommendations on this topic.
NHS England	Guideline	General	General	Is there a place to consider some special or vulnerable populations (eg Looked After Children)	Thank you for your comment. The committee agreed that it was important to consider special and vulnerable populations and as a result, they made a recommendation to base the choice of psychological therapy on a number of factors including the circumstances of the child or young person and their carer(s), their clinical and personal/social history and the context in which treatment is to be provided. The committee specifically worded this recommendation to acknowledge situations where the child or young person is being cared for by people other than their parents (i.e. looked after children) and where the context in which treatment is to be provided is particularly important (for example, for children or young people in young offenders institutes). Their discussions concerning vulnerable populations are covered in detail in the 'other factors the committee took into account' section of the discussion in the main evidence review and the Equality Impact Assessment document.
NHS England	Guideline	5	1.1.6 etc	We recommend a more general statement about training to work with interpreters and the role of family members in this and that meeting the needs of deaf children and parents should be included. May also be appropriate to note the importance of	Thank you for your comment. The section "Language and black, Asian and minority ethnic groups" was not within the scope of this update and therefore we are unable to make changes to this area. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date. However, after reviewing the comments about comorbidities, the committee decided to add an additional line to the recommendation

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				understanding the full context for the CYP including other protected characteristics – for example the new prevalence data demonstrated high level of MH disorder in children and young people reporting as LGBTQ	describing the full assessment of needs in the section that we have updated. This now includes consideration of comorbidities, neurodevelopmental disorders, communication needs (language, sensory impairment) and learning disabilities. We hope that this helps ensure that children and young people who are deaf have their communication needs met appropriately. The "other factors the committee took into account" section of the discussion in the evidence review includes a discussion of groups of children and young people who may be disadvantaged and this already included LGBT people. We have expanded this to LGBTQ based on your comment.
NHS England	Guideline	6	1.1.13	Self-harm: The advent of specialist, dedicated CYPMH urgent and emergency care teams since the 2004 and 2005 guidelines has created a new context for crisis presentations including self-harm and immediate support. Self-harm is a complex, non-dichotomous presentation and specialist mental health assessment and immediate support will effectively mitigate risk for many and avoid potentially increased risk for some who would otherwise be admitted overnight. The statement regarding self-harm is appropriate in itself, but would benefit from brief nuancing or clarification - possibly clarifying '… presents acutely …'	Thank you for your comment. The section "Care of all children and young people with depression" was not within the scope of this update and therefore we are unable to make changes to this area. Recommendation 1.1.13 has a link to NICE's guideline on self-harm which specifically covers the first 48 hours after an episode of self-harm.

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NHS England	Guideline	7	General	Organisation of services: this needs to be updated – specifically to move beyond 'tiers' and using plain English including the acknowledgement of alternative models such as Thrive and 0-25 services and acknowledge the introduction of Mental Health Support Teams. Acknowledgement in the language adopted of other providers who contribute to NHS funded CYPMH who are not NHS employers and the active role of wider children's services and education staff.	Thank you for your comment. As requested, we have updated the terminology for the tiers based on a discussion with your organisation.
NHS England	Guideline	7	1.1.18 Line 10	Many CYP MH services use RCADS (Revised Children's Anxiety and Depression Scale) as its validated, approved for use to report outcome measures on MHSDS (Mental Health Services Data Set) and clinically helpful to consider co-morbidity with anxiety symptoms.	Thank you for your comment. The section "Assessment and coordination of care" was not within the scope of this update and therefore we are unable to make changes to this area. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
NHS England	Guideline	7	1.1.19	Consider whether mental capacity act needs adding as may become applicable for 16-17-year olds	Thank you for your comment. We have added this to the recommendation as suggested.
NHS England	Guideline	7	1.1.20	This paragraph is not clear. We would anticipate local CYPMHS to have skills relevant to the treatment of depression as a matter of course	Thank you for your comment. The section "The organisation and planning of services" was not within the scope of this update and therefore we are unable to make changes to this area.

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NHS England	Guideline	7	Footnote	Footnote – this should be amended - rather than 'Future in Mind policy' please amend to 'Future in Mind' and the NHS Long Term Plan and new models of describing and organising services – such as Thrive, stepped care etc. But is this footnote needed? It isn't really very clear what is being recommended at 1.1.20 and why, what risk is being addressed. Would it be more helpful to put the concern and support / mitigation/s into plain English?	Thank you for your comment. We have amended "Future in Mind policy" to "Future in Mind". We also added a paragraph about the NHS Long Term Plan to the section of "context" in the guideline. Recommendation 1.1.20 was not within the scope of this update and therefore we are unable to make changes to this recommendation. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
NHS England	Guideline	8	1.1.21 & General	This reference is out of date and does not take into account the CYPMH Green Paper and its implementation, nor the schools single point of contact work : MHSTs should be referenced or anticipated instead etc. Latter are also directed to FE colleges which should be explicitly included - they account for more than half our 16+ CYP. But should this 'organisational' solution be stated in preference to the benefits or timing (what are they?) of school and college-based intervention (what are they?) There is more scope to identify the benefits of early intervention, the role of	Thank you for your comment. The section "The organisation and planning of services" was not within the scope of this update and therefore we are unable to make changes to this area. However, colleges have been added to the list of potential settings for psychological treatment in the "Treatments for mild depression" section of the guideline. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.

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				the wider CYPMHS staff and non-health staff.	
NHS England	Guideline	8	1.1.22 & General	Replace 'tiers' throughout with plain English as per earlier footnote. The majority of CYPMHS do not use tiers terminology and actively disavow this. The terminology does not map onto most services and is confusing. It is unintelligible to CYP, the layperson and non-CYPMH professionals – to whom this is also directed.	Thank you for your comment. As requested, we have updated the terminology for the tiers based on a discussion with your organisation.
NHS England	Guideline	8	1.1.23	Access rates might also be compared with those expected from the 2018 ONS survey	Thank you for your comment. The section "The organisation and planning of services" was not within the scope of this update and therefore we are unable to make changes to this area.
NHS England	Guideline	8	1.1.24	Reference CYP-IAPT principles here and CORC (Child Outcomes Research Consortium) / MHSDS (Mental Health Services Data Set) outcome measures. HoNOSCA is very little used whilst (RCADS) Revised Children's Anxiety and Depression Scale is much more widely used and focussed whilst GBO uses a very different clinical approach. The treatment of outcomes has not acknowledged the enormous progress since 2005. The benefit of using session by session outcome measures in care is key in improving both effectiveness and efficiency and should be referenced.	Thank you for your comment. The section "The organisation and planning of services" was not within the scope of this update and therefore we are unable to make changes to this area.

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NHS England	Guideline	9	1.1.26	We recommend again referencing the principles embedded in the CYP-IAPT programme: The formulation (and treatment plan) should be co-produced and shared with the young person and their parent/carers as appropriate in terms of their development, understanding and consent.	Thank you for your comment. "Treatment and considerations in all settings" was not within the scope of this update and therefore we are unable to make changes to this area.
NHS England	Guideline	9	1.1.28	" … who are also trained and experienced in … "	Thank you for your comment. The section "Treatment and considerations in all settings" was not within the scope of this update and therefore we are unable to make changes to this area.
NHS England	Guideline	9-10	1.1.32	Depression is one hugely significant parental influence but other parental factors – including eg general well-being, substance misuse and domestic violence - should be referenced here and taken into account and appropriate intervention sought.	Thank you for your comment. The section "Care of all children and young people with depression" was not within the scope of this update and therefore we are unable to make changes to this area. However, the committee agreed that it was important to take into account the circumstances and history (personal, social as well as clinical) of the child or young person with depression and they made a recommendation to reflect this as part of the section on psychological therapies. This recommendation is aimed at supporting the healthcare professional to take a wider view of the child or young person with depression, that includes consideration of their family life, prior to making the choice of the most appropriate therapy for them. In their discussions (detailed in the "other factors the committee took into account" section of the discussion in the evidence review) the committee included a paragraph reflecting on some of the adverse effects associated with chaotic home lives (for example, due to alcohol and drug abuse by family members).

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NHS England	Guideline	11	Table 1 - general	Replace tiers with plain English.	Thank you for your comment. As requested, we have updated the terminology for the tiers based on a discussion with your organisation.
NHS England	Guideline	12 - 15	1.3 chapter	It would be helpful to comment on the watchful waiting and support that universal services, primary healthcare and schools and colleges staff and parents/carers might offer. Difficult to know if appropriate to comment on the 'normal' process and trajectory of distress following upsetting life events.	Thank you for your comment. The section on "Watchful waiting" was not within the scope of this update and therefore we are unable to make changes to this area or comment on the support that universal services, primary healthcare and schools and colleges staff and parents/carers might offer at this time.
NHS England	Guideline	12	1.3.1 & general	'… schools and colleges'. Colleges account for the majority of 16+ education. Noted that this para and following are helpfully in plain English and sidestep 'tiers'.	Thank you for your comment. The section "Detection and risk profiling" was not within the scope of this update and therefore we are unable to make changes to this area. However, we have added colleges to the recommendation on potential settings for treatments in the section "Treatments for mild depression" to reflect this issue.
NHS England	Guideline	13	1.3.5 etc	Update to reflect CYPMH Green Paper and MHSTs, (Mental Health Support Team) role also of 'education staff'	Thank you for your comment. The section "Detection and risk profiling" was not within the scope of this update and therefore we are unable to make changes to this area. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
NHS England	Guideline	13	1.3.5 etc & general	Check 'CAMHS' language vs wider system acknowledgement of Children and Young People's Mental Health Services (CYPMHS) as per the request of CYP themselves and adopted in Future in mind. Check and reference	Thank you for your comment. As requested, we have updated the terminology for the tiers based on a discussion with your organisation.

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				language adopted by CQC (Care and Quality Commission).	
NHS England	Guideline	13	1.3.6	What about school nurses, educational psychologists and the many counsellors in schools and colleges. Are some of these the target of para 1.1.20	Thank you for your comment. The section on "detection and risk profiling" was not within the scope of this update and the committee did not make any recommendations on this topic.
NHS England	Guideline	13-14	1.3.7 & 1.3.8	This is completely unrealistic as written and does not address the role of non-healthcare staff.	Thank you for your comment. The section on "Detection, and risk profiling" was not within the scope of this update and therefore we are unable to make changes to this area.
NHS England	Guideline	16	1.5 & 1.5.1	'diagnosis' of mild depression: would it be helpful to refer instead to 'identification of mild depression' to empower a wider range of staff who might otherwise expect eg a psychiatrist or clinical psychologist to 'diagnose' ?	Thank you for your comment. The section "Watchful waiting" was not within the scope of this update and therefore we are unable to make changes to this area.
NHS England	Guideline	17	18	What is 'digital CBT'? is this sufficiently clear?	Thank you for your comment. The committee agreed that they could not recommend a specific digital CBT programme because the evidence came from a variety of programmes which had different components and were delivered in a variety of settings. They recognised the uncertainty surrounding the effectiveness of supported or unsupported digital CBT in the UK and made a new research recommendation to try to identify which form was most effective in the UK and which key components were associated with this effectiveness. The committee envisaged that the choice of digital CBT programme would be made at a local or national level in a similar manner to the process used to choose digital CBT programmes for adults with depression. We have added some detail relating to the committee's discussion of these issues to the benefits and harms

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					section of the discussion in the evidence review and a definition of digital CBT is included in the guideline now.
NHS England	Guideline	17	20	NHS England questions the strength of evidence for group mindfulness to be used in mild depression	Thank you for your comment. Group mindfulness was recommended along with other group interventions in the draft version for consultation. However, the committee noted that the data for this intervention came from a single, small US based study with 33 female participants who were at risk of type 2 diabetes due to being overweight or obese. The committee therefore agreed that the evidence behind the results for group mindfulness were insufficiently robust to change UK practice and decided that this intervention should not be recommended. The committee also agreed that a research recommendation was appropriate to obtain additional evidence of effectiveness for group mindfulness compared with other psychological therapies in young people aged 12 to 18 years with mild depression.
NHS England	Guideline	17	25	NHS England questions the health economic evidence to recommend family therapy for mild depression. Interventions for mild depression should be offered within a primary care or community setting- following the CYPMH green paper ideally within schools. This would be not feasible for family therapy without significant growth in workforce Impact trial data – brief psychosocial intervention can be manualised and delivered by mental health support teams within education setting	Thank you for your comment. No economic evaluations were available to assess the relative cost-effectiveness of family therapy and other psychological interventions included in the review. The committee recommended group and digital interventions 1st line on the basis of clinical effectiveness and lower cost. If these interventions would not meet the needs of the individual patient, the committee agreed it would be important to include other options. They therefore made a weaker "consider" recommendation in favour of individual CBT and attachment-based family therapy as other options with favourable effectiveness data in the NMAs. The cost estimates for family therapy and individual CBT were similar to each other. The committee made a recommendation about settings where interventions could be delivered, which included schools and

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					colleges, primary care, social services and the voluntary sector, or in tier 2 child and adolescent mental health services. They saw no evidence that supported recommendations any more specific than this. The recommendation about the full assessment of needs is not intended to be prescriptive, but rather to highlight some important considerations for the shared decision-making process. If the healthcare professional, together with the child or young person (CYP) with depression and their family members, agree that a psychological therapy (either from first or second-line options) is the most appropriate choice of therapy to meet the CYPs needs then the hierarchy of the recommendations should not be a barrier to their receiving the chosen psychological therapy. To ensure this is the case the committee specifically noted the role of individual preferences for the CYP and their family members in the choice of therapy and stated that if the first line options would not meet the CYP's clinical needs or are unsuitable for their circumstances, to consider one of the following options including the chosen psychological therapy. The committee agreed that brief psychosocial intervention could be considered as an alternative treatment to individual CBT for 12-18 year olds with moderate to severe depression. But they acknowledged that further research would be helpful to determine the effectiveness of brief psychosocial intervention when delivered by practitioners other than psychiatrists and in other settings such as primary care. The results of such a trial could provide evidence to support the wider use of BPI.

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NHS England	Guideline	18	1.5.10	This illustrates the problem with referring to Tiers - the text is confusing in reference to 'tier 2 and tier 3'. Who is currently working with the CYP?	Thank you for your comment. As requested, we have updated the terminology for the tiers based on a discussion with your organisation.
NHS England	Guideline	19	6	Neither of the first-line treatments recommended for moderate to severe depression in adolescents is significantly superior to any active comparators. This is wrong in the light of the omission of fluoxetine from this list which has been compared to placebo and is consistently superior to it. The March study also shows superiority to CBT. The Family Therapy (FT) version backed by most evidence is attachment-based FT as developed by Diamond and colleagues. March, J., Silva, S., Petrycki, S., Curry, J., Wells, K., Fairbank, J., … Severe, J. (2004). Fluoxetine, cognitive-behavioural therapy, and their combination for adolescents with depression: Treatment for Adolescents With Depression Study (TADS) randomized controlled trial. Journal of the American Medical Association, 292(7), 807–820. Retrieved from http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=15315995	Thank you for your comment. Antidepressant treatments were not within the scope of this update and therefore we were unable to include antidepressants as active comparators in our analyses.

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NHS England	Guideline	19	6 -15	There is confusion about why IPT-A is no longer a first-line treatment in the 2005 and 2015 guidelines (1.6.4). A recent NMA that reported that IPT and CBT were equally effective for adolescent depression with IPR showing higher acceptability than CBT. We believe that the confusion arises because the Hamilton observer ratings and these measures are dropped in this guideline despite being the gold-standard in most trials. This is odd as the largest ES for functional impairment was found for IPT. We note that not all RCTs of IPT for this group are part of the review and have not been listed under excluded studies either (Bolton et al., 2007; Roselló. et al., 2008; Tang et al., 2009). Further, a study by Dietz 2015 is listed as FT it is a Family Based-IPT mainly individually focused on the relationships of the Young Person (with family and peers) and if the study is included it should be supporting IPT and not FT. The classification of IPT-A seems to reflect insufficient attention to the detail of the treatment by the GDG. It is also incompatible with the current guides for CYP IAPT protocols which	Thank you for your comment. The recommendation about using a full assessment of needs and patient and carer preferences and values is aimed at ensuring the most appropriate therapy is selected for the individual. If the healthcare professional, together with the child or young person (CYP) with depression and their family members, agree that a psychological therapy (either from first or second-line options) is the most appropriate choice of therapy to meet the CYPs needs then the hierarchy of the recommendations should not be a barrier to their receiving the chosen psychological therapy. To ensure this is the case the committee specifically noted the role of individual preferences for the CYP and their family members in the choice of therapy and stated that if the first line options would not meet the CYP's clinical needs or are unsuitable for their circumstances, to consider one of the following options including IPT-A (IPT for adolescents). Based on the NMAs for 12-18 year olds with moderate to severe depression, IPT-A was effective at reducing depression symptoms and increasing functional status post-treatment compared to waiting list/no treatment or usual care. However, IPT-A was recommended as a second line option, because there was no data for remission, suicide ideation or quality of life, or for later time points for functional status and IPT-A was no better or worse than other interventions or controls at 6 months for depression symptoms In contrast, there was a larger body of evidence for individual CBT and it was better at reducing depression symptoms and improving functional status, quality of life and suicidal ideas compared to waiting list/ no treatment or usual care, and at increasing remission compared to attention control and other therapies (such as family therapy) at the end of treatment. Based on this information and the

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				include IPT-A among the therapies recommended for training. Bolton, P. et al (2007). Interventions for depression symptoms among adolescent survivors of war and displacement in Northern Uganda. JAMA 298(5): 519-527. Roselló, J. et al (2008). Individual and group CBT and IPT for Puerto Rican adolescents with depressive symptoms. Cultur Divers Ethnic Minor Psychol, 14(3):234-45. Tang, T.Z., et al (2009). Randomized study of school-based interpersonal psychotherapy for depressed adolescents with suicidal risk and parasuicidal behaviors. Psychiatry and Clinical Neurosciences, 63: 463-470. Zhou, X., Hetrick, S. E., Cuijpers, P., Qin, B., Barth, J., Whittington, C. J., … Xie, P. (2015). Comparative efficacy and acceptability of psychotherapies for depression in children and adolescents: A systematic review and network meta-analysis. World Psychiatry, 14(2), 207–222. https://doi.org/10.1002/wps.20217	magnitude of the effects, the committee agreed to recommend individual CBT as the first line treatment for young people with moderate to severe depression. The committee recognised that additional research on IPT-A that provided evidence on more outcomes and longer time points would be useful in determining the relative effectiveness of this intervention in comparison to individual CBT and other psychological therapies and they made a research recommendation to address this issue We are aware of the Zhou (2015) NMA and include it in our evidence base as a published NMA. However, we have not used it to make recommendations because the authors grouped therapies based on their approach (IPT, CBT etc.) but did not separate them out by method of delivery (group, individual etc.). At the stage of data extraction, we identified the most commonly used tools for reporting functional status and other outcomes such as depression symptoms. Most studies reported depression symptoms using more than 1 rating scale, with the Child depression rating scale-revised and Child depression Inventory being the most common with 16 and 14 studies respectively. In comparison, the Hamilton rating scale for depression was only reported by 9 studies. The committee agreed to allow prioritisation of certain scales for data extraction for each outcome based on the most frequently used scales in the included studies, a hierarchy of depression symptom severity measurement scales reported by a Cochrane review of newer generation antidepressants for depressive disorders in children and adolescents (Hetrick 2012) and their own experience. The committee agreed that self-report scales would

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					give the opportunity to children and young people to report their own experience. We have checked the references you mention in your comment. Please see below for our response to each reference: - Bolton (2007) we have included this study only for discontinuation because depression symptoms and functional status were not measured using validated tools. - Rosselló (2008) compared individual and group CBT with individual and group IPT but we excluded this study because results were not reported separately (results were only reported as combined individual and group CBT and combined individual and group IPT) - Tang (2009) was excluded because participants were not required to have symptoms of depression at recruitment We have reclassified Dietz 2015 under Family Based-IPT based on your comment. Reference: Hetrick SE, McKenzie JE, Cox GR, Simmons MB, Merry SN (2012) Newer generation 7 antidepressants for depressive disorders in children and adolescents. Cochrane Database of 8 Systematic Reviews 2012, Issue 11: CD004851.
NHS England	Guideline	19	1.6.4	NHS England questions whether evidence base and cost-effectiveness would recommend family therapy as 1st line treatment alongside CBT for those with moderate –severe depression, which we regard as more appropriate as second line	Thank you for your comment. The evidence was revised because the network meta-analyses were reanalysed after removing evidence including comorbidities and the artificial manipulation of parents' involvement by Gunlicks-Stoessel (2016) in both arms of the study. The committee discussed that evidence from RCTs including young people with depression and with comorbidities may show a differential effect compared to RCTs including young people with depression and

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				The evidence from the Impact trial suggests that brief psychosocial interventions could deliver equivalent outcomes to CBT – this could be delivered via mental health support teams in schools and therefore would suggest adding to 1st line alongside CBT	without comorbidities. Therefore, the committee agreed to remove this evidence from the network meta-analyses. Based on this revision of evidence, the committee agreed that family therapy should not be recommended as a first line treatment because although it had similar magnitude of effects for functional status and depression symptoms compared to individual CBT, there was no data on suicide ideation and quality of life and the evidence base for family therapy was much smaller (4 studies versus 10 for individual CBT).
NHS England	Guideline	20	1.6.11	Consider adding neurodevelopmental disorder such as ADHD or ASD to co-morbid diagnosis and need to consider whether 1st line treatments such as CBT need to be adapted	Thank you for your comment. The section "Depression unresponsive to combined treatment" was not within the scope of this update and therefore we are unable to make changes to this area. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
NHS England	Guideline	21	1.6.14	It is not stated that prescription of medication should be by a C&A psychiatrist. Is this expected? Consider clarifying eg non-medical prescriber, general practitioner roles Is it also helpful to clarify who might monitor medication within the first 4 weeks or what competencies are required – although this is better clarified at 1.6.17	Thank you for your comment. The section " How to use antidepressants in children and young people" was not within the scope of this update and therefore we are unable to make changes to this area.
NHS England	Guideline	22	1.6.19	Consider adding commonly used outcome measures such as RCADS (Revised Children's Anxiety and Depression Scale) for monitoring response to treatment	Thank you for your comment. The section "How to use antidepressants in children and young people" was not within the scope of this update and therefore we are unable to make changes to this area. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.

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NHS England	Guideline	26	1.6.36 & 1.6.37	Strategic Health Authorities no longer exist. Caution that existing national commissioning arrangements may change through NCM, ICS arrangements	Thank you for your comment. We have removed any references to strategic health authorities from the guideline.
NHS England	Guideline	25	1.6.42 and 1.6.43	Guidance should reference the Mental Health Act, role of SOAD and IMHA	Thank you for your comment. The section "Electroconvulsive therapy" was not within the scope of this update and therefore we are unable to make changes to this area. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
NHS England	Guideline	29	1.7 - chapter	Can this be strengthened in relation to AMHS and for those discharged from specialist services to be prepared for (re-)accessing adult services including IAPT.	Thank you for your comment. The section "Transfer to adult services" was not within the scope of this update and therefore we are unable to make changes to this area. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
NHS England	Guideline	29	1.7.2	Transition guidelines should be referenced here	Thank you for your comment. We have added the requested reference to the start of this section.
North East London NHS Foundation Trust	Guideline Guideline	19 36	6-9 22 - 27	We are concerned that this recommendation does not include IPT-A as a first line treatment. IPT-A here is indented as 12-16 individual sessions with the young person with additional 3-4 parents' sessions. 1. There is evidence around the impact of interpersonal events (especially bullying, peer conflict, parent-child conflict among other) on child and adolescent's depression; these are	Thank you for your comment and the information about the benefits of IPT-A (IPT for adolescents). The recommendation about the full assessment of needs is not intended to be prescriptive, but rather to highlight some important considerations for the shared decision-making process. If the healthcare professional, together with the child or young person (CYP) with depression and their family members, agree that IPT-A is the most appropriate choice of therapy to meet the CYPs needs then the hierarchy of the recommendations should not be a barrier to their receiving IPT-A. To ensure this is the case the committee specifically noted the role of individual preferences for the CYP and their family members in the choice of therapy and stated that if the

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				directly targeted by IPT-A. (Evidence list on request, please contact Dr A.Pirillo). 2. Full assessment of needs (pg 19, lines 1-4) should also include interpersonal functioning and interpersonal effectiveness. We are concerned that the young person's needs in regard to their interpersonal context may be overlooked if therapy is not aiming to target these directly alongside symptoms of depression, as IPT-A can only be offered as a second line treatment if CBT of FT are not suitable. 3. Drawing from our clinical experience with young people, their depression is often linked to their interpersonal world (an area of heightened importance in adolescence) and they find the collaboration, responsive nature of the model accessible. 4. Our clinical experience of applying the IPT-A model demonstrated that both functional status and depressive symptomatology significantly	first line options would not meet the CYP's clinical needs or are unsuitable for their circumstances, to consider one of the following options including IPT-A. The committee agreed that the evidence from the included RCTs supported the inclusion of IPT-A in the recommendations for moderate to severe depression. Thank you for the additional information about your clinical experience of applying IPT-A. We are aware of the Zhou (2015) NMA and include it in our evidence base as a published NMA. However, we have not used it to make recommendations because the authors grouped therapies based on their approach (IPT, CBT etc.) but did not separate them out by method of delivery (group, individual etc.). The committee agreed to reclassify the study by Dietz (2015) as family based IPT. The NMAs were reanalysed and provided some evidence that family based IPT could be effective for the treatment of moderate to severe depression in children aged 5 to 11 years. The committee agreed to add a separate recommendation for this group including family based IPT as one of the recommended psychological therapies.

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				improved at end of treatment, with 84.6% (small sample of 17 patients) of patients not meeting criteria for Depression at end of treatment. The other 15.4% reported a reduction in symptoms of depression but were still scoring around clinical cut-off at 12 sessions. In addition to that, we also noticed a significant reduction in symptoms of Anxiety (when this was a comorbidity) although not directly targeted, and all our patients did not report self-harming behaviours and/or suicidal ideation at end of treatment (compared pre-treatment). 5. A meta-analysis of treatment efficacy for child and adolescent depression found that IPT and CBT had similar effect on reducing symptoms of depression at the end of treatment, while IPT also had better outcomes at long-term follow-up. Please see: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4471978/	

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				6. Having a first line alternative to CBT and FT (that some adolescents really don't want due to the heavy emphasis on family involvement) is really important. It offers them a genuine choice. 7. Feedback from young people and parents about IPT-A, as well as their engagement with therapy, has been excellent. The level of collaboration supported by the model is high, which again helps young people remain engaged throughout. Interestingly, our patients often had experience of counselling, FT or CBT, and reported a preference for IPT-A. 8. Parents reported a preference for IPT-A compared to FT. this was down to the fact that despite the strong focus on parental engagement and participation, IPT-A still remained an individual therapy. 9. We are also concerned that Family-Based IPT (FB-IPT) is not represented in the guidelines. In Kent CAMHS we're seeing increasing	

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				numbers of referrals for younger children, and FB-IPT, under its rightful umbrella of IPT, has an emerging evidence base to treat depression in pre-adolescents to potentially meet this need. 10. Finally and of crucial importance, this recommendation will challenge our practice because as CYPMHS services in Kent we were about to organise and arrange IPT-A clinics, possibly group interventions (for moderate to severe depression - group IPT is recommended for mild depression only) as part of the range of interventions offered. The downgrade will impact on our ability as clinicians to make recommendations to patients/families and offer the most suitable treatment according to their needs as well as our ability to provide a rational for setting up these clinics, although we acknowledge the clinical need for having them. If IPT-A is downgraded to second line treatment, we will have to offer CBT or FT unless these are unsuitable - despite the main focus	

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				being interpersonal, for example. We are concerned that this will not constitute a genuine choice for young people and their family and we will not be able to meet their needs.	
Royal College of General Practitioners	Guideline	General	General	The committee should consider making a recommendation to ensure that GPs can directly refer to CAMHS. In some local areas, CAMHS will only accept referrals made by schools through CAMHS link workers. However, schools (both primary and secondary) seem unwilling to involve the CAMHS link workers, which often leaves patients with no specialist input.	Thank you for your comment. Referral was not within the scope of this update and therefore we are unable to make changes to this area. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
Royal College of General Practitioners	Guideline	General	General	The committee should consider adding a recommendation to consider seeing older children and young people by themselves to assess their wishes and obtain their consent. It is important to hear their story.	Thank you for your comment. "Good information, informed consent and support" was not within the scope of this update and therefore we are unable to make changes to this area.
Royal College of General Practitioners	Guideline	General	General	The committee should consider adding a recommendation that safety netting (e.g. identifying a safe person that they can go to if suicidal thoughts become intrusive) should be discussed with people with suicidal ideation and history of or active self-harming.	Thank you for your comment. "Assessment and coordination of care " was not within the scope of this update and therefore we are unable to make changes to this area.

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Royal College of General Practitioners	Guideline	General	General	The committee should consider making a recommendation that people should ideally be reviewed by the same clinician during treatment.	Thank you for your comment. "Treatment and considerations in all settings" and specifically the question of continuity of care was not within the scope of this update and therefore we are unable to make changes to this area.
Royal College of General Practitioners	Guideline	General	General	The committee should consider making a recommendation on the need to identify and follow up 'did not attend's (DNAs) and for those who default from prescribed therapies	Thank you for your comment. There is already a recommendation on DNAs. Recommendation 1.5.2 Healthcare professionals should make contact with children and young people with depression who do not attend follow up appointments.
Royal College of General Practitioners	Guideline	General	General	The committee should consider making a recommendation around CAMHS communicating with GPs the comprehensive assessment and management plan, and any updates	Thank you for your comment. "Organisation and planning of services" was not within the scope of this update and therefore we are unable to make changes to this area.
Royal College of General Practitioners	Guideline	17	18	The committee should consider specifying which digital CBT sites can be used.	Thank you for your comment. The committee agreed that they could not recommend a specific digital CBT programme because the evidence came from a variety of programmes which had different components and were delivered in a variety of settings. They recognised the uncertainty surrounding the effectiveness of supported or unsupported digital CBT in the UK and made a new research recommendation to try to identify which form was most effective in the UK and which key components were associated with this effectiveness. The committee envisaged that the choice of digital CBT programme would be made at a local or national level in a similar manner to the process used to choose digital CBT programmes for adults with depression. We have added some detail relating to the

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					committee's discussion of these issues to the benefits and harms section of the discussion in the evidence review. The committee have now included a research recommendation looking at the relative effectiveness of supported and unsupported digital CBT, which also aims to determine which key components are responsible for the effectiveness of the intervention.
Royal College of General Practitioners	Guideline	18	16	The committee may want to specify a date for when people should be reviewed by	Thank you for your comment. The committee recognised the importance of reviewing children and young people presenting with moderate to severe depression by CAMHS. However, they were not able to set a definite date or time for this review because we did not look for evidence on the optimal time for review and in practice, this is likely to be determined by clinician discretion.
Royal College of General Practitioners	Guideline	39	4	'However it is not clear whether a single symptom count' should be replaced by 'It is very unlikely that'. A child or young person often needs to be seen on more than one occasion with parents/carers and without if appropriate in order to gain trust. Psychosomatic symptoms are often the initial presentation.	Thank you for your comment. The committee agreed to amend this paragraph as you suggested.
Royal College of General Practitioners	Guideline	39	9	It is important to specifically mention that maltreatment of older children and young people may be by family member or other.	Thank you for your comment. The section of the guideline on safeguarding children was not part of this update and as a result, has not been changed.
Royal College of Nursing	General	General	General	The Royal College of Nursing (RCN) welcomes the draft guidance on Depression in children and young people: identification and management.	Thank you for your response.

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				The RCN invited members who care for and have knowledge of the care of children and young people with depression to review the draft documents on its behalf. The comments below reflect the views of our reviewers.	
Royal College of Nursing	General	General	General	Our members have highlighted the need to be cautious about supporting specific psychological therapies on children and young people with this condition as there is limited evidence of efficacy, especially in moderate to severe depression. As indicated in the draft document, most of the trials reviewed by NICE for this guideline development are of low quality and the guideline reviewers themselves have stated that some of the studies may have potential bias. Additionally, most of the reviewed studies have been conducted outside of the United Kingdom and have small sample sizes. In other similar NICE guidelines there has been a push towards adopting a person centred/child centred approach (for example NICE 2011 Self-harm guidance - longer term treatment). In a Cochrane Randomised Controlled Trial (RCT) review of physical exercise on	Thank you for your comment. The committee discussions, detailed in the discussion section of the evidence review, make clear the limitations of the evidence base for psychological treatments that you have noted. By basing the choice of psychological therapy on a full assessment of needs, including the circumstances of the child or young person and their carer(s), their clinical and personal/social history and presentation, their maturity and developmental level and the context in which treatment is to be provided and patient and carer preferences and values (as appropriate), the committee aimed to ensure that a person centred/child centred approach was taken. The effects of exercise on depression was not within the scope of this update and therefore we are unable to review evidence or make recommendations on this topic. However, the section "Treatment and considerations in all settings" contains a recommendation highlighting the benefits of exercise.

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				anxiety and depression in young people (Larun et al 2006), there is evidence of positive effects. Our members indicate this work could also have been considered in the review of evidence.	
Royal College of Nursing	General	General	General	Peer group plays a pivotal role in adolescence, so group approaches are undoubtedly needed. So, as opposed to having a Cognitive Behavioural Therapy (CBT) for specific groups there could for example be other options included in the Guidelines such as "person centred" therapeutic approaches to the groups.	Thank you for your comment and support of the group therapy recommendations. These were recommended based on evidence from RCTs. We did not identify any studies of 'person centred therapy' and were unable to make any recommendations concerning it as a result.
Royal College of Nursing	General	General	General	Our members have noticed that public statements have been made by NICE about digital CBT, in advance of this NICE guideline being finalised and published.	Thank you for your comment. It is standard NICE process to release public statements at consultation because this is the first time the new recommendations are released, and the media team needs to work with journalists to ensure that coverage represents the guidance. At the bottom of the press release there is a statement that makes it clear that this a draft recommendation and refers readers to the consultation document. Further publicity may also occur at publication, but this is decided on a case by case basis.
Royal College of Nursing	General	General	General	Additionally, our members consider that the guideline should ensure, as part of the risk assessment, that all professionals ascertain a young person's Internet usage and motivation for accessing specific internet sites,	Thank you for your comment. Risk assessment was not within the scope of this update and therefore we are unable to make recommendations on this topic. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.

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				which can have positive or negative effect on their depressive symptomatology. Peer group dynamics also need to be assessed. There is nothing about these aspects in the current guideline.	
Royal College of Nursing	General	General	General	In terms of recommendations for future research - "therapeutic alliance" such as engagement with therapeutic process seems to be paramount and at least relevant to a young person's recovery. Again this needs to be considered. An investigation of the curative factors, skills and techniques needed to promote "alliance" could for example be examined.	Thank you for your comment. Therapeutic alliance was not within the scope of this update and therefore we are unable to make research recommendations in this area.
Royal College of Nursing	General	General	General	As much of the current research is focussed on potential risk factors, could some research recommendation be directed to examining resilient factors to mitigate the emphasis on risk? It is well known that conducting RCTs on psychological interventions can be difficult due the extent of confounding factors etc. So there is a need to be more creative about how to collate robust evidence.	Thank you for your comment. This guideline is aimed at the identification and management of depression in children and young people. Prevention of depression, including mitigation of the risk of depression using resilience factors, is not within the scope of this guideline and therefore we are unable to make research recommendations in this area.

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Royal College of Paediatrics and Child Health	General	General	General	This guideline on depression is very comprehensive	Thank you for your response.
Royal College of Paediatrics and Child Health	Guideline	General	General	Overall, this guideline is very good and very helpful.	Thank you for your comment and support.
Royal College of Paediatrics and Child Health	Guideline	1.6.18	20	Although no RCTs have used higher doses of fluoxetine than 40 mg, clinical practice and expert opinion suggest that some young people who do not respond to fluoxetine 20mg may respond to higher doses, up to the maximum of 60 mg. Unless there are significant persisting side-effects, it therefore seems reasonable to follow a 6-week trial of fluoxetine 20 mg with an upwards dosage titration whose details can be negotiated with the young person and family	Thank you for your comment. The section "How to use antidepressants in children and young people" was not within the scope of this update and therefore we are unable to make changes to this area.
Royal College of Paediatrics and Child Health	Guideline	24	6	Why is a written consent form necessary, verbal consent should also be fine and perhaps this should be updated	Thank you for your comment. The section "How to use antidepressants in children and young people" was not within the scope of this update and therefore we are unable to make changes to this area.
Royal College of Paediatrics and Child Health	Guideline	24	27	The half-life of fluoxetine is about 72 hours, so it withdraws gradually, over 6-8 weeks, even if stopped suddenly. Therefore, this sort of downwards	Thank you for your comment. The section "How to use antidepressants in children and young people" was not within the scope of this update and therefore we are unable to make changes to this area.

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				titration is unnecessary for fluoxetine, although it IS necessary for citalopram and sertraline	
Royal College of Paediatrics and Child Health	Guideline	25	13	It would be unwise, and contrary to the best interests of the patient, to stop St John's Wort if both the young person and parents say that it is working without side-effects. Lack of evidence does not mean lack of efficacy	Thank you for your comment. The section "How to use antidepressants in children and young people" was not within the scope of this update and therefore we are unable to make changes to this area.
Royal College of Paediatrics and Child Health	Guideline	26	22	'Family support' should read 'Family Therapy' --- or Family Therapy should be added to this list	Thank you for your comment. The section "Inpatient care" was not within the scope of this update and therefore we are unable to make changes to this area.
Royal College of Psychiatrists	Evidence Review	General	General	We do not understand why the clinical findings and implications of this large UK pragmatic RCT were excluded from the NICE committee's analysis? We would like to know why? The findings led on to the refinement of BPI first used in none manualised format in ADAPT and had important findings regarding relative effectiveness of CBT, medication and BPI-TAU in ADAPT. It was also like the IMPACT RCT a very large multi risk complex typical NHS specialist service sample and not a	Thank you for your comment. The ADAPT trial was excluded from this update because individual CBT was combined with antidepressants (selective serotonin reuptake inhibitors) in one arm compared to only antidepressants in the other arm. Antidepressants were out of scope of this update. The ADAPT trial was included in the 2015 update of this guideline that reviewed antidepressant therapy as part of the evidence for combined therapy (Byford 2007; Goodyer 2008).

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				highly selected and lower risk subsample as is the case in many other depression studies, so it has important message for routine NHS care. It has not been included in any of the previous NICE guidelines because of dates this is not now appropriate given the range of dates of studies and papers included in this evidence review for the current 2019 guideline. Leaving ADAPT out risks the data being skewed.	
Royal College of Psychiatrists	Evidence Review	28	22	*"Important limitations of this study are the low participant adherence to the interventions"* This is incorrect there was no a priori treatment dose defined as optimal or sub optimal. The committee has assumed the protocol prescription indexes the optimal therapy doses for each treatment as the maximum n of sessions. This is untrue, as there was no dose response curve for any of the treatments available to the IMPACT RCT team. Whatever accounts for treatment response/ non-response in IMPACT it is not due to a failure of a	Thank you for your comment. We have changed the paragraph to say "Important limitations affecting the generalisability of the cost-effectiveness estimates in this study are the uncertainty about how levels of attendance at planned sessions reflect current clinical practice and the volume of missing data related to resource consumption. This is particularly relevant given the analysis' sensitivity to the cost of interventions and the marginal difference in QALYs gained between comparators." The costing exercise used the number of programmed sessions and average number of attended sessions reported in the clinical trials in order to express the opportunity cost associated with each intervention. The limitations of this approach are discussed in Appendix L of the evidence report.

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				known treatment dose, and it is wrong for Nice to imply as such.	
Royal College of Psychiatrists	Evidence Review	64	35-41	It remains unclear why BPI was not suggested as a first line intervention: we think the reasoning needs to be more explicit here and in the main Guideline.	Thank you for your comment. The committee agreed that brief psychosocial intervention (BPI) could be considered as an alternative treatment to individual CBT for 12-18 year olds with moderate to severe depression. They chose to include BPI as one of the second line options that were evidence based but where effectiveness was less certain. In an analysis of a large body of evidence for 12-18 year olds with moderate to severe depression, individual CBT was better at reducing depression symptoms and improving functional status, quality of life and suicidal ideas compared to waiting list/ no treatment or usual care, and at increasing remission compared to attention control and other therapies (such as family therapy) at the end of treatment. BPI was effective at increasing remission at post-treatment compared to attention control and compared to family therapy and relaxation. Based on this information and the magnitude of the effects, the committee agreed to recommend individual CBT as the first line treatment for young people with moderate to severe depression. They also recognised that individual CBT might not be suitable or meet the needs of all young people with moderate to severe depression and so they agreed that additional options should be available such as BPI.
Royal College of Psychiatrists	Evidence Review	78	30-42	1. The evidence review says the evidence for BPI is weaker than for CBT and FT on the basis of table 39 in the annexe	Thank you for your comment. We have extended this section and made changes in the evidence review based on committee discussions of stakeholder comments. Table 39 (now Table 38) refers to the likely lower cost of BPI compared to psychodynamic psychotherapy. The sentence has been reworded to make this clear. The committee decided to

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			37	2. Presumably this refers to the absence of data of BPI v wait list controls data? 3. If so, please can NICE carefully reconsider this decision: we do not consider it ethical to place high risk often self-harming and suicidal youth on no treatment wait list control conditions and that is why there was no such condition in the IMPACT RCT. Please remember it was a real life, few exclusions, NHS routine clinic -based study not a highly selected low risk sample. 4. Many USA studies of depression excluded such risky cases (check this carefully as its hidden in exclusion criteria or only hinted at instead of clearly stated) at the outset because of the litigation risks, neither IMPACT nor ADAPT excluded anyone on the basis of high risk. 5. BPI is explicit in recommendation of parent and carer involvement, on a collaborative and agreed as	recommend BPI because it was not found to be less effective than psychodynamic psychotherapy or individual CBT across a range of outcomes and time points in the pairwise analyses. In the NMAs, BPI was also effective at increasing remission at post-treatment compared to attention control and compared to family therapy and relaxation. The committee agreed to add a paragraph to the discussion of the benefits and harms section in the evidence review to clarify that parental involvement was an explicit element in some of the psychological therapies included in the analyses of this update such as BPI, psychodynamic psychotherapy and CBT.

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				necessary basis: it is incorrect to say BPI does not.	
Royal College of Psychiatrists	Evidence Review	78 500	49 6-7	This is incorrect and a misquote from the Lancet Paper reporting IMPACT: 63 therapists delivered BPI of whom 53 were psychiatrists (84%), 16% were non-psychiatrists. Of the 84% who were Psychiatrists there was a broad mixture of grades, from trainees in Child Psychiatry to Staff and associate specialists through to Consultants, they were not all Consultants. Of the 16% who were non-psychiatrists they were mostly Mental Health Nurses and Psychologists. In addition, we do not see a breakdown of the grades or seniority of staff delivering CBT, FT, STPP or other therapies RCTs assessed in this NICE guideline. That seems inconsistent. For example, many of the Child Psychotherapists delivering STPP in the IMPACT RCT were senior and of Consultant level and so forth…… If seniority is indeed a factor in efficacy of therapies, then surely it should be factored in to NICE's assessment across all treatments across the board.	Thank you for your comment. The committee agreed that not all psychiatrists delivering BPI in the IMPACT trial were consultants and this has been removed from the evidence review and the guideline. The committee also agreed that it was unclear whether the results obtained by these staff would be generalisable to current practice in the NHS. Therefore, they acknowledged that further research would be helpful to determine the effectiveness of brief psychosocial intervention when delivered by practitioners other than psychiatrists and in other settings such as primary care. The results of such a trial could provide evidence to support the wider use of BPI. The committee agreed that BPI could be considered as an alternative treatment to individual CBT for 12-18 year olds with moderate to severe depression. They chose to include BPI as one of the second line options that were evidence based but where effectiveness was less certain. In an analysis of a large body of evidence for 12-18 year olds with moderate to severe depression, individual CBT was better at reducing depression symptoms and improving functional status, quality of life and suicidal ideas compared to waiting list/ no treatment or usual care, and at increasing remission compared to attention control and other therapies (such as family therapy) at the end of treatment. BPI was effective at increasing remission at post-treatment compared to attention control and compared to family therapy and relaxation. Based on this information and the magnitude of the effects, the committee agreed to recommend individual CBT as the first line treatment for young people with

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	Guideline			Given the size, specificity and pragmatic clinical trial nature of the IMPACT RCT and pressing need for scalable available interventions with evidence we see this downgrading of BPI to a second line intervention as missed opportunity, for CYP and services alike.	moderate to severe depression. They also recognised that individual CBT might not be suitable or meet the needs of all young people with moderate to severe depression and so they agreed that additional options should be available such as BPI.
Royal College of Psychiatrists	Evidence Review	532	1-30	We support the recommendation of testing BPI in other settings with other practitioners such as primary care and school settings; however, we recommend an alternative approach to research methodology recommendations: we believe we need to better identify which components of therapies are essential to achieving incremental improvements in effectiveness. All the evidence to date points to common shared components across the main therapies, what is unclear is what non-shared components should be added to achieve incremental effectiveness gain.	Thank you for your comment. The committee decided to remove the research recommendation on sequencing of psychological interventions because they agreed that research investment would be better focused on obtaining additional evidence of effectiveness for psychological interventions such as the brief psychosocial intervention (BPI), psychodynamic psychotherapy and IPT-A (IPT for adolescents) for moderate to severe depression. Mufson (2018) was excluded because participants in the intervention group could have received maintenance treatment after IPT-A or combined IPT-A plus medication. However, data was not reported separately for participants who received or did not receive medication.
	Guideline	30	17-25	We think that we will not establish identification of these components by treatment A v Treatment B models, we recommend instead an adaptive sequential design moving patients through a sequence of treatments if they	

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				respond they stop. If they do not respond they move to the next treatment and go again and this is repeated using predefined stop:go rules and predetermined treatments and response. (Goodyer, I. M. and Wilkinson, P. O. (2018), Practitioner Review: Therapeutics of unipolar major depressions in adolescents. J Child Psychol Psychiatr. doi:10.1111/jcpp.12940). This review suggested an example sequential design with BPI as 1st treatment, SSRI as the last and CBT in the middle. There is an example of one sequential design pilot study in the literature, which had IPT as first-line treatment, with SSRI added if there was no significant improvement after 8 weeks. This showed the stepped care model to be both acceptable and more effective than enhanced treatment as usual. We think this study should not have been omitted from the NICE guideline evidence review without a clear reason. (Mufson et al, Adm Policy Ment Health 2018, 45:417).	
Royal College of Psychiatrists	Guideline and	General	General	The NICE recommendations for iCBT apply only to mild depression –and the studies will have excluded most	Thank you for your comment. As you note in your comment the recommendation for digital CBT only applies to mild depression. and the participants in these trials are likely to have been screened

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	Evidence Review			common risk factors such as suicidality – so generalisability/ ecological validity is always an issue. Distinguishing mild from moderate depression can also be tricky and depression severity fluctuates – so monitoring and follow-up is really important to ensure CYP are not excluded from more intensive interventions if symptoms/ impairment worsens. We understand that an important issue for engagement and effectiveness of iCBT is human support (i.e. guided iCBT). NICE doesn't make this distinction – and the Topooco trial (attached) is probably the only one which includes this. Uptake and engagement with programmes like MoodGym is very poor – unless you recruit a highly motivated group into a study and provide a lot of follow-up (not reflective of clinical practice). NICE has broadly endorsed 'iCBT' as a class– but not individual programmes – which makes it difficult for clinicians to know what to use in practice. Excellent programmes like	for suicidality and additional issue such as comorbidities so the generalisability of this recommendation may be limited. The committee reflected this limitation by specifically stating that the young people should be without significant comorbid problems or active suicidal ideas or plans. The committee agreed that they could not recommend a specific digital CBT programme because the evidence came from a variety of programmes which had different components and were delivered in a variety of settings. They recognised the uncertainty surrounding the effectiveness of supported or unsupported digital CBT in the UK and made a new research recommendation to try to identify which form was most effective in the UK and which key components were associated with this effectiveness. The committee envisaged that the choice of digital CBT programme would be made at a local or national level in a similar manner to the process used to choose digital CBT programmes for adults with depression. We have added some detail relating to the committee's discussion of these issues to the benefits and harms section of the discussion in the evidence review.

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				Sally Merry's (New Zealand) SPARX CBT programme is highly culturally specific (images targeting Maori youth) and would need adaptation for the UK. Overall, we would agree that the evidence is promising for iCBT for milder depression – but the real challenge is implementation and gathering more evidence from real-world populations in the UK. It's unclear what current programmes could be prescribed (with any confidence) that are currently available within the NHS? Digital IAPT for adults has decided only to endorse guided iCBT programmes within IAPT. A similar digital IAPT model is needed for CYP. While we would agree that self-direct CBT programmes should be made available – it should be presented as a choice for young people (generally to augment F2F therapy) and not as an alternative to human contact/ support.	
Royal College of Psychiatrists	General	General	General	The evidence base for mindfulness is limited in CYP (single low quality small RCT), so it is unclear why this has been recommended. There is a large schools	Thank you for your comment. Group mindfulness was recommended along with other group interventions in the draft version for consultation. However, the committee noted that the data for this intervention came from a single, small US based study

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				RCT underway (Kuyken) and surely NICE should await the results of this trial, including any potential adverse effects, before making this recommendation.	with 33 female participants who were at risk of type 2 diabetes due to being overweight or obese. The committee therefore agreed that the evidence behind the results for group mindfulness were insufficiently robust to change UK practice and decided that this intervention should not be recommended. The committee also agreed that a research recommendation was appropriate to obtain additional evidence of effectiveness for group mindfulness compared with other psychological therapies in young people aged 12 to 18 years with mild depression. Regarding the ongoing MYRIAD trial (Kuyken 2017), we will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
Royal College of Psychiatrists	Guideline	General	General	There should be more consideration of depression in CYP with neurodevelopmental disorders	Thank you for your comment. The committee recognised that children and young people with depression and with neurodevelopmental disorders may require directing towards different therapies and, based on stakeholder comments, the committee included consideration of comorbidities, neurodevelopmental disorders, communication needs (language, sensory impairment) and learning disabilities in the full assessment of needs recommendation to reflect this. The committee also included neurodevelopmental disorders as a subgroup in their research recommendations because they recognised that there was a shortage of evidence of effective treatments for this group.
Royal College of Psychiatrists	Guideline	4-10		The positioning and role of BPI as a formalised, manual supported, quantifiable, structured, auditable form of good quality collaborative ordinary 'care' for depression… as highlighted	Thank you for your comment. The committee agreed that brief psychosocial intervention could be considered as an alternative treatment to individual CBT for 12-18 year olds with moderate to severe depression. But they acknowledged that further research would be helpful to determine the effectiveness of brief

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		12-28		throughout the NICE depression Guidelines: BPI is derived from the formalisation of what constitutes 'care or treatment as usual'. BPI was developed based on (i) accepted good practice amongst experts and (ii) principles of good assessment and care laid out in NICE guidelines. It was not possible to explain this detail in the limited word count available for the main RCT report paper, and the absence of members of the BPI development team on the NICE committee means the committee cannot have been fully aware of this. However, we wish to draw the NICE committee's attention to the following important point: taking NICE recommendations for good quality structured clinical care for depression, for all cases of depression, BPI provides those as the 8 defined components of BPI (BPI HTA Report). For example, effective engagement listening skills, parent and carer involvement, psychoeducation, liaison with key agencies and individuals including schools, careful collaborative full formulation including risk	psychosocial intervention when delivered by practitioners other than psychiatrists and in other settings such as primary care. The results of such a trial could provide evidence to support the wider use of BPI. The committee also recognised that brief psychosocial intervention was recommended based on the IMPACT trial. Therefore, they agreed to include a description for brief psychosocial intervention as delivered in the IMPACT trial. This description has been added to the section of 'Terms used in this guideline'.

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				assessment and aetiological risk and protective factor review, understanding of how the altered mental state of depression and its common comorbidities impact on the child their life and relationships, problem solving, advice on health life habits and lifestyles including sleep, diet, exercise and digital lives and general activation and positive stance. On testing in the RCT, BPI turns out to also be an effective intervention in its own right. But this obscures the notion that BPI can, and we recommend should, be delivered to every child and young person as good quality baseline care, including alongside medication management (for which there is a protocol within BPI). Even those for whom other specialised therapies like CBT or IPT or FT or STPP are deemed appropriate. Then for some CYP, BPI is enough, on its own, but for all, they get the comprehensive package of care for	

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				depression that NICE envisages throughout the NICE Guidelines.	
Royal College of Psychiatrists	Guideline	8-10	General	Good care should include routine enquiry into and understanding of each CYP digital life, and its various consequences, beneficial, risky and or harmful, on a routine basis. This appears to be missing from the Guideline as a whole; it is part of the BPI package of care, under lifestyle enquiry and advice.	Thank you for your comment. The section "Care of all children and young people with depression" was not within the scope of this update and therefore we are unable to make changes to this area. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
Royal College of Psychiatrists	Guideline	19	6	The recommended first-line treatment for moderate to severe depression in adolescents is CBT or family therapy (1.6.4). This is despite the evidence summary demonstrating that neither therapy is significantly superior to any active comparators (eg placebo, monitoring, NDST, supportive therapy, p. 375, table 23); they are simply better than being on a waiting-list with no treatment. As with previous versions of the guideline, fluoxetine is not recommended as a first-line treatment. While a lot of effort has been made to compare psychological therapies, it seems wrong that fluoxetine (and indeed other antidepressants) are not included in the network meta-analysis. This	Thank you for your comment. The recommendation about the full assessment of needs is not intended to be prescriptive, but rather to highlight some important considerations for the shared decision-making process. If the healthcare professional, together with the child or young person (CYP) with depression and their family members, agree that a psychological therapy (either from first or second-line options) is the most appropriate choice of therapy to meet the CYPs needs then the hierarchy of the recommendations should not be a barrier to their receiving the chosen psychological therapy. To ensure this is the case the committee specifically noted the role of individual preferences for the CYP and their family members in the choice of therapy and stated that if the first line options would not meet the CYP's clinical needs or are unsuitable for their circumstances, to consider one of the following options including the chosen psychological therapy. In an analysis of a large body of evidence for 12-18 year olds with moderate to severe depression, individual CBT was better at reducing depression symptoms and improving functional status,

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				would be possible as placebo is one of the nodes of NMA. This deliberate omission of one potential treatment seems especially remiss when recent meta-analyses have demonstrated fluoxetine (unlike psychological therapies) to be significantly superior to placebo (Cipriani et al., 2016)(Locher et al., 2017); and the only comparative study demonstrated fluoxetine to be significantly superior to CBT by end of treatment (March et al., 2004); notably that March RCT was much larger than most studies included in the NMA used to create these guidelines (more than 100 per group) and was not industry-funded. We think it appropriate to include all potential treatments in a network meta-analysis used to make treatment recommendations. We predict that this would demonstrate fluoxetine to be superior to placebo (unlike CBT and FT); and may demonstrate fluoxetine to be superior to FT and CBT. We accept that one reason for suggesting CBT and FT as first-line may be (as stated in the original 2005 CG28) because the benefit:risk balance is favourable for psychological therapies. The caveat	quality of life and suicidal ideas compared to waiting list/ no treatment or usual care, and at increasing remission compared to attention control and other therapies (such as family therapy) at the end of treatment. Based on this information and the magnitude of the effects, the committee agreed to recommend individual CBT as the first line treatment for young people with moderate to severe depression. However, the committee recognised that individual CBT might not be suitable or meet the needs of all young people with moderate to severe depression and so they agreed that additional options should be available. They chose to include IPT-A (IPT for adolescents), family therapy, brief psychosocial intervention and psychodynamic psychotherapy as second line options that were evidence based but where effectiveness was less certain. Antidepressant treatments were not within the scope of this update and therefore we are unable to make changes to this area.

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				here being that as yet psychological therapies have not developed treatment sensitive side effects measures and we do not know how tolerable and safe therapies are in this age range. Therefore in the absence of safety data this is a non-robust conclusion to draw when most psychological therapy studies have not measured side-effects, or have focused solely on the side-effects more common in antidepressants but not psychological therapy (Nutt & Sharpe, 2008) (Goodyer and Wilkinson 2018) (Wolpert, M., et al. (2015) . Even if the evidence were robust for side-effects to be less in psychological therapy, the evidence of efficacy is stronger for antidepressants than psychological therapy. Thus antidepressants could be said to have more benefits but more side-effects – making a decision on which treatment to use first line to be non-straightforward. It therefore seems inappropriate for NICE to decide on behalf of individual patients and their families which type of treatment has a greater benefit:risk ratio. Instead we believe it would be more appropriate for patients and their	

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				families to be presented with the evidence for benefits and harms of psychological therapy and fluoxetine, and to make the informed choice themselves weighing up the potential benefits and harms for themselves (Goodyer and Wilkinson 2018). To make this more real world at a time when there is such a shortage of trained psychological therapists, it may be even more appropriate that families should weigh up the benefits, harms and waiting-lists for antidepressants and talking therapies. In conclusion, we think that fluoxetine should be added as a potential first-line treatment for moderate-severe depression in adolescents (alongside, but not superior nor inferior to, psychological therapies). Finally the suggestion that FT should be a first line treatment disregards that the newer forms of this treatment are not those currently practised in the UK. To recommend FT without specifying that the Diamond et al model currently under investigation is specifically about attachment based FT: not what most FT in NHS practice will be using. There is a risk of overgeneralisation not consistent	

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				with the preliminary data by Diamond and colleagues. We do not see sufficient evidence or change in benefit:risk ratio to uprate FT to 1st line treatment. Cipriani, A., Zhou, X., Del Giovane, C., Hetrick, S. E., Qin, B., Whittington, C., … Xie, P. (2016). Comparative efficacy and tolerability of antidepressants for major depressive disorder in children and adolescents: a network meta-analysis. *Lancet*. https://doi.org/10.1016/S0140-6736(16)30385-3 Goodyer IM, Wilkinson PO.(2018) Practitioner Review: Therapeutics of unipolar major depressions in adolescents. J Child Psychol Psychiatry. doi: 10.1111/jcpp.12940. [Epub ahead of print]. Locher, C., Koechlin, H., Zion, S. R., Werner, C., Pine, D. S., Kirsch, I., … Kossowsky, J. (2017). Efficacy and Safety of Selective Serotonin Reuptake Inhibitors, Serotonin-Norepinephrine Reuptake Inhibitors, and Placebo for	

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				Common Psychiatric Disorders Among Children and Adolescents: A Systematic Review and Meta-analysis. *JAMA Psychiatry*, *74*(10), 1011–1020. https://doi.org/10.1001/jamapsychiatry.2017.2432 March, J., Silva, S., Petrycki, S., Curry, J., Wells, K., Fairbank, J., … Severe, J. (2004). Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression: Treatment for Adolescents With Depression Study (TADS) randomized controlled trial. *Journal of the American Medical Association*, *292*(7), 807–820. Retrieved from http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=15315995 Nutt, D. J., & Sharpe, M. (2008). Uncritical positive regard? Issues in the efficacy and safety of psychotherapy. *J Psychopharmacol*, *22*(1), 3–6. https://doi.org/10.1177/0269881107086283	

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				Wolpert, M., et al. (2015). "Considering harm and safety in youth mental health: A call for attention and action." Administration and Policy in Mental Health and Mental Health Services Research **42**(1): 6-9.	
Royal College of Psychiatrists	Guideline	19	6	IPT-A has been changed to a second-line treatment after previously being a first-line treatment in the 2005 and 2015 guidelines(1.6.4). This is despite there being no new evidence since then that IPT is not effective (nor no large new studies showing CBT/FT to be effective). This seems to be because the new draft guidelines only use self-rated symptoms and not both self and observer-rated symptoms. The latter were used in the previous guidelines and the recent NMA that found IPT and CBT (but not family therapy) to be effective for adolescent depression; and IPT to have significantly higher acceptability than CBT (Zhou et al., 2015). This is important as the two main studies comparing IPT to active control treatments use the observer-rated HAM-D as the primary outcome measure, and in both studies, IPT led to a statistically-significant reduction in HAM-D (the primary outcome measure)	Thank you for your comment. The committee revised the evidence and agreed to include IPT-A (IPT for adolescents) as a psychological therapy for moderate to severe depression in young people aged 12 to 18 years. The evidence was revised because the network meta-analyses were reanalysed after removing evidence including comorbidities and the artificial manipulation of parents' involvement (Gunlicks-Stoessel 2016) in both arms of the study. The committee discussed that evidence from RCTs including young people with depression and with comorbidities may show a differential effect compared to RCTs including young people with depression and without comorbidities. Therefore, the committee agreed to remove this evidence from the network meta-analyses. The new evidence for 12-18 year olds with moderate to severe depression showed that IPT-A was effective at reducing depression symptoms and increasing functional status post-treatment compared to waiting list/no treatment or usual care. However, IPT-A was recommended as a second line option, because there was no data for remission, suicide ideation or quality of life, or for later time points for functional status and IPT-A was no better or worse than other interventions or controls at 6 months for depression symptoms.

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				compared with placebo (Mufson et al., 2004; Mufson, Weissman, Moreau, & Garfinkel, 1999). It is normal good practice for treatment studies (and hence meta-analyses) to use both observer and self-rated symptoms (Uher et al., 2012) and no justification is given for dropping observer-rated measures in this guideline. Given that none of the psychological therapies was significantly better than active control treatments, it would seem appropriate to use a wide variety of outcome measures to make conclusions from such a set of therapies, all with only a small amount of evidence demonstrating efficacy. It is also notable that even when self-rating depressive symptom scores were used: IPT was rated as equivalent to FT (ie 50% chance that each one is superior over the other) (p423, table 36); and that if meta-analysis of direct comparisons is used, IPT is superior to waiting-list while family therapy is not tested against waiting-list (p. 375, table 23); both good reasons for IPT not to be below family therapy. Further support for IPT is given by the fact that the NMA demonstrated it to be better than usual care in reducing	The evidence on IPT-A for functional status at 6 to 18 months was not connected to the rest of the treatments, and therefore, it was not included to the NMA. At the stage of data extraction, we identified the most commonly used tools for reporting functional status and other outcomes such as depression symptoms. Most studies reported depression symptoms using more than 1 rating scale, with the Child depression rating scale-revised and Child depression Inventory being the most common with 16 and 14 studies respectively. In comparison, the Hamilton rating scale for depression was only reported by 9 studies. The committee agreed to allow prioritisation of certain scales for data extraction for each outcome based on the most frequently used scales in the included studies, a hierarchy of depression symptom severity measurement scales reported by a Cochrane review of newer generation antidepressants for depressive disorders in children and adolescents (Hetrick 2012) and their own experience. The committee agreed that self-report scales would give the opportunity to children and young people to report their own experience. We are aware of the Zhou (2015) NMA and include it in our evidence base as a published NMA. However, we have not used it to make recommendations because the authors grouped therapies based on their approach (IPT, CBT etc.) but did not separate them out by method of delivery (group, individual etc.). We have checked the references you mention in your comment. Please below our response to each reference: - Bolton (2007) we have included this study only for the outcome of discontinuation because depression symptoms and functional status were not measured using validated tools

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				functional impairment; and that the largest effect size for improvement in functional impairment was found for IPT. We think it wrong that IPT is wrongly excluded from the NMA for 6-18 months, when again the previously-published NMA showed IPT to be significantly superior to control treatments at long-term follow-up (Zhou et al., 2015). In addition, several RCTs of IPT for depressed adolescents have been excluded from the review, and have not been listed under excluded studies (Bolton et al., 2007; Roselló. et al., 2008; Tang et al., 2009). Given these studies are likely to be in scope for this review (RCT with appropriate PICO), then they should have been considered then included or reasons for exclusions explained. Of especial note, the Tang et al RCT demonstrated IPT to be significantly better than TAU for depressed adolescents; there were slightly restrictive inclusion criteria (suicidal thoughts/attempts), but this would have led to fewer exclusions than the Gunlicks-Stoessel RCT of IPT-AP which only included adolescents with	- Rosselló (2008) compared individual and group CBT with individual and group IPT but we excluded this study because results were not reported separately (results were only reported as combined individual and group CBT and combined individual and group IPT) - Tang (2009) was excluded because participants were not required to have symptoms of depression at recruitment.

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				very high levels of family conflict, which has been included in this NMA. Bolton, P. et al (2007). Interventions for depression symptoms among adolescent survivors of war and displacement in Northern Uganda. *JAMA 298*(5): 519-527. Mufson, L., Weissman, M. M., Moreau, D., & Garfinkel, R. (1999). Efficacy of interpersonal psychotherapy for depressed adolescents. *Archives of General Psychiatry*, *56*(6), 573–579. Mufson, L., Dorta, K. P., Wickramaratne, P., Nomura, Y., Olfson, M., & Weissman, M. M. (2004). A randomized effectiveness trial of interpersonal psychotherapy for depressed adolescents. *Arch Gen Psychiatry*, *61*(6), 577–584. Roselló, J. et al (2008). Individual and group CBT and IPT for Puerto Rican adolescents with depressive symptoms. *Cultur Divers Ethnic Minor Psychol, 14*(3):234-45. Tang, T.Z., et al (2009). Randomized study of school-based interpersonal psychotherapy for	

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				depressed adolescents with suicidal risk and parasuicidal behaviors. *Psychiatry and Clinical Neurosciences, 63*: 463-470. Uher, R., Ph, D., Perlis, R. H., Placentino, A., Psy, D., Dernovšek, Z., … Farmer, A. (2012). Self-report and clinician-rated measures of depression severity: can one replace the other? *Depress Anxiety*, *29*(12), 1043–1049. https://doi.org/10.1002/da.21993 Zhou, X., Hetrick, S. E., Cuijpers, P., Qin, B., Barth, J., Whittington, C. J., … Xie, P. (2015). Comparative efficacy and acceptability of psychotherapies for depression in children and adolescents: A systematic review and network meta-analysis. *World Psychiatry*, *14*(2), 207–222. https://doi.org/10.1002/wps.20217	
Royal College of Psychiatrists	Guideline	19	6	'Family therapy' has been recommended as a first-line treatment. Family therapy is a very broad range of related therapies, that focus primarily on working at the family, rather than the individual level. The main therapies that suggested effectiveness (although	Thank you for your comment. The evidence was revised because the network meta-analyses were reanalysed after removing evidence including comorbidities and the artificial manipulation of parents' involvement (Gunlicks-Stoessel 2016) in both arms of the study. The committee discussed that evidence from RCTs including young people with depression and with comorbidities may show a differential effect compared to RCTs including young people with

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				themselves not showing significant benefits vs control) for moderate-severe depression in adolescents were actually of attachment-based family therapy (Diamond 2002, Israel 2013, Poole 2018), which is rather different to standard family therapy. Hence delivering standard FT (as suggested by the guidelines) would not lead to similar results, and should not be recommended. Indeed the main study of standard FT (Brent 1997) suggested family therapy to be inferior to non-directive supportive therapy. Dietz 2015 is included as a family therapy study when the intervention is actually family-based interpersonal psychotherapy (FB-IPT), not family therapy. The difference is important – FB-IPT is mainly focused on the individual adolescent and their relationships (with family and peers), with parental support. This is different to family therapy which works with the whole family and all the relationships in that family. And so this study should be included under IPT, not FT.	depression and without comorbidities. Therefore, the committee agreed to remove this evidence from the network meta-analyses. Based on this revision of evidence, the committee agreed that family therapy should not be recommended as a first line treatment because although it had similar magnitude of effects for functional status and depression symptoms compared to individual CBT, there was no data on suicide ideation and quality of life and the evidence base for family therapy was much smaller (4 studies versus 10 for individual CBT). The committee agreed that multiple forms of family therapy exist, including family-focused treatment for childhood depression, attachment based and systemic family therapy, but agreed that they were sufficiently similar that they could be analysed under the grouping of family therapy. They also agreed to reclassify the study by Dietz (2015) as family based IPT. The NMAs were reanalysed and family based IPT showed to be effective for the treatment of moderate to severe depression in children aged 5 to 11 years. The committee agreed to add a separate recommendation for this group including family based IPT as one of the recommended psychological therapies. The committee also specified the types of family therapy in the recommendations based on the forms used by the studies included in the evidence.
Royal College of Psychiatrists	Guideline	19	15	IPT plus parent sessions is recommended as being better than individual IPT (1.6.5). This seems to be	Thank you for your comment. The committee agreed that the RCT by Gunlicks-Stoessel (2016) artificially manipulated the involvement of parents in both arms of the study. Therefore, this RCT was not

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	Guideline	36 -37	22 - 5	based entirely on a single pilot feasibility study of 15 patients (Gunlicks-Stoessel & Mufson, 2016). Furthermore, that study had a tight inclusion criterion of high levels of family conflict, hence it is not right to extrapolate it to the full population of depressed adolescents. From speaking to an IPT-A expert, the IPT-A control group in that study does not resemble normal IPT-A as practised and taught in the UK (and indeed in other parts of the world, including in the main RCTs of IPT): this has much greater parental involvement. Hence UK IPT-A seems to lie somewhere between the IPT-AP and the IPT-A in this study, and cannot be seen as inferior to IPT-AP.	connected to the network meta-analyses anymore and it was removed from the NMAs. Gunlicks-Stoessel (2016) was only reported in the pairwise analysis. IPT-A (IPT for adolescents) was kept in the recommendations for moderate to severe depression but without any specific involvement of parents. The committee also recognised that IPT-A is designed to include parents on a flexible basis.
Royal College of Psychiatrists	Guideline	31	7	Studies of all psychological therapies have sadly been mostly small and of poor quality. IPT is significantly better than active control treatments on observer-rated, but not self-rated, depression symptoms, but these studies were small and inadequately powered, which may explain why the difference on self-rated depression scales was non-significant. IPT has been shown to be equivalent to CBT for adult depression,	Thank you for your comment. The committee agreed to add a research recommendation to obtain additional evidence of effectiveness for psychological interventions such as IPT-A (IPT for adolescents), brief psychosocial intervention (BPI) and psychodynamic psychotherapy compared to each other and to individual CBT in young people aged 12 to 18 years with moderate to severe depression.

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				based on more and larger studies (Barth et al., 2013). We therefore think it important to evaluate this treatment properly in depressed adolescents in a robust, adequately powered RCT. Ideally this would be against CBT and an active control. In fact, a large study could test moderators of treatment so we can tell what works for whom. We think this should be added to the research recommendations. Barth, J., Munder, T., Gerger, H., Nuesch, E., Trelle, S., Znoj, H., … Cuijpers, P. (2013). Comparative Efficacy of Seven Psychotherapeutic Interventions for Patients with Depression : A Network. *PLoS Med*, *10*(5), e1001454. https://doi.org/10.1371/journal.pmed.1001454	
Royal College of Speech and Language Therapists	Guideline	4	10	RCSLT would encourage 'Developmentally appropriate' to be used rather than 'age appropriate' to consider those with depression who may have language or learning difficulties.	Thank you for your comment. The section "Good information, informed consent and support" was not within the scope of this update and therefore we are unable to make changes to this area. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.

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Royal College of Speech and Language Therapists	Guideline	7	13	We would recommend special attention also be paid to the child's communication abilities.	Thank you for your comment. The section "Assessment and coordination of care" was not within the scope of this update and therefore we are unable to make changes to this area. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date. However, after reviewing the comments about comorbidities, the committee decided to add an additional line to the recommendation describing the full assessment of needs in the section that we have updated. This now includes consideration of comorbidities, neurodevelopmental disorders, communication needs (language, sensory impairment) and learning disabilities. We hope that this helps ensure that children and young people have their communication needs met appropriately.
Royal College of Speech and Language Therapists	Guideline	7	20	We recommend also taking into account the presence of language and learning difficulties that may affect communication. There is a need to involve language screening for children presenting with emotional disorders as unidentified language difficulties in this population are common (Hollo, Wehby & Oliver 2014).	Thank you for your comment. The section "Assessment and coordination of care" was not within the scope of this update and therefore we are unable to make changes to this area. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date. However, after reviewing the comments about comorbidities, the committee decided to add an additional line to the recommendation describing the full assessment of needs in the section that we have updated. This now includes consideration of comorbidities, neurodevelopmental disorders, communication needs (language, sensory impairment) and learning disabilities. We hope that this helps ensure that children and young people have their communication needs met appropriately.
Royal College of Speech and	Guideline	9	23-25	We are pleased to see that assessment of developmental problems is encouraged however we would like to	Thank you for your comment. The section "Treatment and considerations in all settings" was not within the scope of this update and therefore we are unable to make changes to this area.

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Language Therapists				see 'communication difficulties' highlighted too. We would like to add to end of sentence 'including the presence of communication difficulties which may require the depression treatment to be modified to a level that the service user can access'. A systematic review (Law et al. 2011) supports that interventions for speech, language and communication needs can also lead to positive outcomes for emotional and behavioural difficulties.	We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date. However, after reviewing the comments about comorbidities, the committee decided to add an additional line to the recommendation describing the full assessment of needs in the section that we have updated. This now includes consideration of comorbidities, neurodevelopmental disorders, communication needs (language, sensory impairment) and learning disabilities. We hope that this helps ensure that children and young people have their communication needs met appropriately.
Royal College of Speech and Language Therapists	Guideline	9	27	The RCSLT would like to see 'other healthcare professionals including allied health professions' in this recommendation, as well as education and social care networks.	Thank you for your comment. The section "Treatment and considerations in all settings" was not within the scope of this update and therefore we are unable to make changes to this area.
Royal College of Speech and Language Therapists	Guideline	12	24	We feel it is unclear what is meant by 'conversational technique'. RCSLT feels it would be beneficial to add in additional techniques e.g. breaking down verbal information, extra processing time, making information visual.	Thank you for your comment. The section "Detection and risk profiling" was not within the scope of this update and therefore we are unable to make changes to this area. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
Royal College of Speech and Language Therapists	Guideline	13	11	Add 'developmentally appropriate'	Thank you for your comment. The section "Detection and risk profiling" was not within the scope of this update and therefore we are unable to make changes to this area. However, the new recommendations on treating mild or moderate to severe depression do include consideration of the individual's maturity and

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					developmental level as part of the process of choosing a psychological therapy. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
Royal College of Speech and Language Therapists	Guideline	20	8	The multi-disciplinary review should also consider potential presence of communication disorders/difficulties meaning that talking therapies are not as effective, and subsequently be referred to a speech and language therapist for further assessment.	Thank you for your comment. The section "Combined treatments for moderate to severe depression" was not within the scope of this update and therefore we are unable to make changes to this area. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
Royal College of Speech and Language Therapists	Guideline	26	3	The RCSLT would encourage NICE to include a paragraph here recommending that every child admitted has SLT assessment to ensure psychiatric support can be delivered at a level they can access.	Thank you for your comment. The section "Inpatient care" was not within the scope of this update and therefore we are unable to make changes to this area. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
The National Deaf Children's Society	Guideline	General	General	The guidance does not make any reference to disability with regard to the assessment and treatment to support children and young people experiencing depression. We do understand that there is a paucity of robust evidence regarding deaf and disabled children and depression. However there is research which shows deaf children are at greater risks of experiencing mental health difficulties (Health Service Delivery and Research	Thank you for your comment. The committee agreed that children and young people with depression and comorbidities may benefit from different therapies and they have now included consideration of comorbidities, neurodevelopmental disorders, communication needs (language, sensory impairment) and learning disabilities in the full assessment of needs recommendation. Thank you for pointing this omission out. There is an existing recommendation in the section on treatment considerations in all settings about assessing and managing comorbid diagnoses and developmental, social and educational problems.

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				Vol 3(2) February 2015) and the additional complexities regarding diagnosis and treatment have been recognised by the NHS in the establishment in 2009 of the National Deaf CAMHS service for deaf children and young people. Government guidance 'Safeguarding Disabled Children' (2009) and recent analysis of available research by the NSPCC (2014) recognises that deaf and disabled children are likely to be at greater risk of experiencing abuse and neglect. It would therefore seem necessary that within this guidance that there should be some acknowledgement of disability as a factor which needs to be carefully considered within any assessment and treatment for depression.	The committee were unable to make separate recommendations for specific therapies for children and young people with comorbidities as this is not within the scope of the guideline.
The National Deaf Children's Society	Guideline	General	General	We would hope that the current NHSE service specification for National Deaf CAMHS has been considered within this draft guidance.	Thank you for your comment. The section covering "The organisation and planning of services" was not within the scope of this update and therefore we did not review any evidence relating specifically to this section. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
The National Deaf	Guideline	5	5-6	Here the guidance identifies that material should be provided either in written or audiotaped form. However	Thank you for your comment. The section "Language and black, Asian and minority ethnic groups" was not within the scope of this update and therefore we are unable to make changes to this area.

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Children's Society				there is no mention of this being provided in a visually accessible format which would be necessary for deaf children and young people whose first language is British Sign Language, which is a visual-spatial language. Whilst there is the recognition of using professional interpreters (which would allow for a British Sign Language interpreter), this implies this is for only face-to-face communication with patients. However this must not be seen as replacement for the requirement to provide written or audiotaped information which allows a child/young person or family to take this away and give them additional time to remind them of what has been discussed etc. This would not provide an equality of access for a deaf child or young person whose first language is British Sign Language unless the information was also provided in video format in BSL for them to properly consider outside of any meeting. In our opinion the guidance would be clearer if it stated clearly that information	We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date. However, after reviewing the comments about comorbidities, the committee decided to add an additional line to the recommendation describing the full assessment of needs in the section that we have updated. This now includes consideration of comorbidities, neurodevelopmental disorders, communication needs (language, sensory impairment) and learning disabilities. We hope that this helps ensure that children and young people whose first language is British Sign Language have their communication needs met appropriately. The committee discussions regarding equalities and disadvantaged groups, including those whose first language is British Sign Language, are detailed in the 'other factors the committee took into account' section of the discussion in the evidence review and in the Equalities Impact Assessment document.

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				should be provided in written, audio or videotaped format to ensure it meets the communication needs of the child/young person.	
The National Deaf Children's Society	Guideline	5	14-	The local CAMHS service will lack the specialist expertise to understand the cultural needs of some deaf children and young people who may need to be considered as part of the Deaf community. Therefore local CAMHS services will not be able to provide this training to local health care professionals as suggested here. This should be provided with input by specialist National Deaf CAMHS.	Thank you for your comment. The section "Language and black, Asian and minority ethnic groups" was not within the scope of this update and therefore we are unable to make changes to this area. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
The National Deaf Children's Society	Guideline	7	20	In this paragraph the guidance mentions ethnic and cultural variations in communication. In our view there is the potential concern that practitioners may not additionally consider the cultural and accompanying linguistic needs of a deaf child, whose first language may be British Sign Language and whose should be considered therefore as culturally deaf.	Thank you for your comment. The section "Assessment and coordination of care" was not within the scope of this update and therefore we are unable to make changes to this area. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date. However, after reviewing the comments about comorbidities, the committee decided to add an additional line to the recommendation describing the full assessment of needs in the section that we have updated. This now includes consideration of comorbidities, neurodevelopmental disorders, communication needs (language, sensory impairment) and learning disabilities. We hope that this helps ensure that children and young people whose first language is British Sign Language have their communication needs met appropriately. The committee discussions regarding equalities and

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					disadvantaged groups, including those whose first language is British Sign Language, are detailed in the 'other factors the committee took into account' section of the discussion in the evidence review and in the Equalities Impact Assessment document.
The National Deaf Children's Society	Guideline	7	24	We would recommend that the above should be amended to state; *"local CAMHS or equivalent e.g. National Deaf CAMHS…".* This is to recognise that National Deaf CAMHS are commissioned where appropriate, to provide specialist advice to local CAMHS on the specific metal health needs of deaf children and young people, as this expertise in not available within local CAMHS' services.	Thank you for your comment. The section "The organisation and planning of services" was not within the scope of this update and therefore we are unable to make changes to this area. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
The National Deaf Children's Society	Guideline	13	1-3	Seeking advice from specialist Deaf CAMHS is also relevant to healthcare practitioners here.	Thank you for your comment. The section "Detection and risk profiling" was not within the scope of this update and therefore we are unable to make changes to this area. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
The National Deaf Children's Society	Guideline	13	8	The local CAMHS service will lack the specialist expertise to understand the cultural needs of some deaf children and young people who may need to be considered as part of the Deaf community. Therefore local CAMHS services will not be able to provide this training to local health care	Thank you for your comment. The section "Detection and risk profiling" was not within the scope of this update and therefore we are unable to make changes to this area. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.

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				professionals as suggested here. This should be provided with input by specialist National Deaf CAMHS	
The Pituitary Foundation	Guideline	6	2	When assessing a child or young person with depression, healthcare professionals should routinely consider, and record in the patient's notes if the child or young person has a **Pituitary condition,** as this will affect social, educational and family context for the patient and family members. It will potentially affect the quality of interpersonal relationships, both between the patient and other family members and with their friends and peers.	Thank you for your comment. The section "Assessment and coordination of care" was not within the scope of this update and therefore we are unable to make changes to this area.
The Pituitary Foundation	Guideline	10	11	A child or young person with depression should be offered advice about nutrition and the benefits of a balanced diet- this is fundamental if the child /young person has a pituitary condition to maximise wellbeing. Whilst replacement pituitary hormones are prescribed by their Endocrinologists, good nutrition and a balanced diet work in conjunction to help support natural development and growth.	Thank you for your comment and support of the existing recommendation that children or young people with depression should be offered advice about nutrition and the benefits of a balanced diet.
The Pituitary Foundation	Guideline	13	19	When a child or young person is exposed to a single recent undesirable	Thank you for your comment. The section "Detection and risk profiling" was not within the scope of this update and therefore we

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				life event i.e. **diagnosis of chronic pituitary condition,** healthcare professionals in primary care, schools and other relevant community settings should undertake an assessment of the risks of depression associated with the event and make contact with their parent(s) or carer(s) to help integrate parental/carer and professional responses.	are unable to make changes to this area. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
The Pituitary Foundation	Guideline	25	1	As with all other medications, consideration should be given to possible drug interactions when prescribing medication for depression in children and young people. Children with **chronic pituitary conditions** rely on replacement hormone medication to live, grow and mature.	Thank you for your comment. The section "How to use antidepressants in children and young people" was not within the scope of this update and therefore we are unable to make changes to this area.
The Pituitary Foundation	Guideline	26	3	Inpatient treatment- it is essential that replacement hormone medication for children or young people are continued and taken regularly in an inpatient setting to avoid ill health/ collapse/ loss of life.	Thank you for your comment. The section "Inpatient care" was not within the scope of this update and therefore we are unable to make changes to this area. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
The Pituitary Foundation	Guideline	29	1	Transfer to adult services- children or young person will also experience transfer to adult endocrinology services aged 18. This may cause anxiety, fear, and uncertainty for the future for the	Thank you for your comment. The section "Transfer to adult services" was not within the scope of this update and therefore we are unable to make changes to this area. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.

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				child/young person, which may increase risk of depression.	
UK Council on Psychotherapy	Guideline	General	General	**UKCP** Alongside providing professional support for our members, the United Kingdom Council for Psychotherapy is the leading research, innovation, educational and regulatory body working to advance psychotherapies for the benefit of all. We exist to promote and maintain the highest standards of practice of psychotherapy and psychotherapeutic counselling for the benefit of the public. We want a world in which emotional and mental wellness is a human right, in accordance with the World Health Organisation constitution. Our purpose is to transform lives by unlocking potential. Our membership includes more than 9,000 individual therapists and more than 70 training and accrediting organisations. Our individual members work for the NHS, privately, and in third sector organisations offering a wide variety of psychotherapeutic approaches. Our support for the	Thank you for your comment. We welcome your input.

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				psychological therapies is research-based and recognises the diversity of modalities that can deliver better mental health outcomes for all. We hold the national register of psychotherapists and psychotherapeutic counsellors, which only includes practitioners who meet our exacting standards and training requirements and who agree to abide by our stringent ethical standards. We welcome the opportunity to respond to this Consultation and offer our perspective on the Guideline for Depression in Children.	
UK Council on Psychotherapy	Guideline	General	General	Our views concerning the question of '***Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why***' are as follows: **Patient choice of psychotherapy modalities** We would like to see this guideline endorse the principle of choice of psychotherapeutic approaches for patients, since there is a significant risk	Thank you for your comment. The recommendation about the full assessment of needs is not intended to be prescriptive, but rather to highlight some important considerations for the shared decision-making process. If the healthcare professional, together with the child or young person (CYP) with depression and their family members, agree that psychodynamic psychotherapy is the most appropriate choice of therapy to meet the CYPs needs then the hierarchy of the recommendations should not be a barrier to their receiving psychodynamic psychotherapy. To ensure this is the case the committee specifically noted the role of individual preferences for the CYP and their family members in the choice of therapy and stated that if the first line options would not meet the CYP's clinical

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				that lack of choice will have a large negative impact on clinical practice. We are therefore extremely concerned that the Guideline committee state that implementation of the draft set of recommendations would result in "a decrease in individual therapies [other than individual CBT and family therapy]" (Guideline, 38/5). While the draft guidance acknowledges the importance of offering patients a choice of treatments (Guideline, 17/13; 19/5; 33/20), the recommendations clearly do not reflect this principle. Instead, the guidance offered regarding all forms of depression (mild, moderate to severe, treatment resistant) illustrates a hierarchy of therapies in which first-line options are extremely limited. In addressing questions related to children's mental health policy, the Government's points of reference are Future in Mind, The Five Year Forward View for Mental Health and the recently published NHS Long-Term Plan (HC Deb 12 February 2019 216246W). All	needs or are unsuitable for their circumstances, to consider one of the following options including psychodynamic psychotherapy. In an analysis of a large body of evidence for 12-18 year olds with moderate to severe depression, individual CBT was better at reducing depression symptoms and improving functional status, quality of life and suicidal ideas compared to waiting list/ no treatment or usual care, and at increasing remission compared to attention control and other therapies (such as family therapy) at the end of treatment. Based on this information and the magnitude of the effects, the committee agreed to recommend individual CBT as the first line treatment for young people with moderate to severe depression. However, the committee recognised that individual CBT might not be suitable or meet the needs of all young people with moderate to severe depression and so they agreed that additional options should be available. They chose to include IPT-A (IPT for adolescents), family therapy, brief psychosocial intervention and psychodynamic psychotherapy as second line options that were evidence based but where effectiveness was less certain.

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				three of these documents make clear the importance of patient choice. In Future in Mind's "vision" statement, it highlights that you should "have the opportunity to shape the services you receive" (Future in Mind, 11). The Five Year Forward View is even clearer about the importance of a choice of psychological therapies stating that: "every person with a mental health problem should be able to say: I have rapid access, within a guaranteed time, to effective, personalised care. I have a choice of talking therapy so that I can find one appropriate to me" and adding that "people also value having a choice of support, tailored to their specific needs, including access to a full range of psychological therapies." If this Guideline is to match up to the expectations of these flagship documents, patient choice – specifically in relation to psychological therapies – must be given greater precedent. It states in the Guideline that psychodynamic therapy was shown to be as effective as CBT "across a range	

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				of outcomes and follow-up times" (37/8). If there is a genuine commitment to choice amongst the guideline committee then they should reconsider recommending psychodynamic psychotherapy as a possible first-line treatment. This would enhance the choice not only of patients but also of clinicians, who should be adept at identifying patients to whom psychodynamic psychotherapy would be of particular benefit. In Future in Mind, it states that a principle aim of children's mental health policy should be to avoid scenarios in which children have to repeat their story (Future in Mind, 11). The failure to include psychodynamic psychotherapy as a first-line recommendation will not only deny thousands of children the opportunity to have that therapy (through commissioning decisions influenced by this guideline) but also result in other children, who are offered psychodynamic psychotherapy as a second-line treatment, having to repeat their story in what is known to be a painful process.	

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				If the evidence base for psychodynamic psychotherapy is deemed too small – on the basis of the rigid criteria for inclusion of evidence that this committee is following, which we address below – then this should be far better reflected in the research recommendations. Psychodynamic psychotherapy has been shown in at least one trial considered acceptable by this committee to be *as* effective as CBT, which the committee readily acknowledge this Guideline's recommendations will yield more of. It therefore follows that, in keeping with the widely stated commitment to patient choice from the Government and the NHS, the effects of psychodynamic psychotherapy on children with depression must be studied to better support the recommendations held in this Guideline. We urge the committee to reflect this need in their research recommendations. The development and evaluation of responses to depression of different degrees of severity requires different approaches with integration and inter-disciplinary collaboration (Hollis et al.,	

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				2017), and there is strong evidence to support the benefits of patient choice. Recent meta-analyses have shown that patients matched to their preferred therapy are less likely to drop out prematurely and also achieve greater improvement in treatment outcomes (Swift et al, 2011). Meta-analyses also indicate that when clients with psychological disorders are involved in either shared decision-making, choice of treatment condition, or otherwise receive their preferred treatment, they report higher levels of satisfaction, better completion rates, and superior clinical outcomes (Lindhiem et al, 2014). Patients' choice of treatment is also important in the light of evidence from several randomised controlled trials that demonstrate differential responses to treatment types based on patient characteristics (Fournier et al, 2009; Wallace et al, 2013; DeRubeis et al, 2014; Huibers et al, 2015). The need to optimise outcomes by matching individual patients to the most appropriate treatment for them personally is a principle that is endorsed	

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				as part of personalised medicine for treatment of physical ill-health, and is cost effective (NHS England, 2016). We therefore suggest that this principle is applied to children's mental health, consistent with the government's parity of esteem agenda (DHSC, 2013).	
UK Council on Psychotherapy	Guideline	General	General	**Over reliance on RCT evidence** The guidance challenges the ethical practice of clinicians and reduces opportunities for the achievement of optimal mental health outcomes for patients due to the highly selective nature of the evidence that it is based on. The recommended psychological treatments for depression in children are derived from a narrow consideration of what constitutes appropriate evidence, namely RCTs and meta-analyses. We certainly recognise the importance of RCTs as a source of evidence, but would suggest that there is also a significant body of robust data from non-RCTs that also needs to be taken into account. The validity of findings from RCTs is compromised by the selection	Thank you for your comment. This update has addressed a question about the effectiveness of psychological interventions for the treatment of depression. The protocol for this review was developed based on methods outlined in the NICE guidelines manual. From the manual: a review question about the effectiveness of an intervention is usually best answered by a randomised controlled trial (RCT), because a well-conducted RCT is most likely to give an unbiased estimate of effects. As a result, our protocol restricted study design to RCTs only and no observational studies were considered in the evidence base. NICE methods include non-RCT evidence, but where good quality RCTs exist, other study designs are not considered. In this case, we had god quality RCTs so other designs were not considered. RCTs have been used to develop other mental health guidelines by NICE (for example, NICE guidance on social anxiety disorder, bipolar disorder, psychosis and schizophrenia) and other international developers like the World Health Organisation (for example, guidance on brief structured psychological treatment, behavioural activation). NICE also offers advice on depression within guidelines for other conditions including physical health conditions (for example,

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				of populations that clinicians do not typically encounter. While RCTs have the advantage of controlling for extraneous factors that affect the conclusions that can be drawn concerning the causal effects of psychological intervention on outcomes, their often strict criteria for selection of participants compromises their application to real practice settings. RCTs within the NICE evidence base were predominantly based on selection of patients with the sole diagnosis of depression. However, evidence from epidemiological studies demonstrates that depression and anxiety are frequently comorbid (Kessler et al, 2003; Moffitt et al, 2007). Evidence from studies of clinical populations also shows high rates of comorbidity (Lamers et al, 2011; Hepgul et al, 2016). It is questionable therefore, as to how far the findings from the trials used as evidence by NICE can be applied to children typically presenting with depression. Evidence from a broader spectrum of studies needs to be taken into account, since results from RCTs may have	guidance on social anxiety disorder, diabetes (type 1 and type 2) in children and young people). However, NICE guidelines are not intended to replace clinical judgement and it is not expected that guidelines will cover every scenario in clinical practice.

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				limited application in real word practice settings. Indeed, the Guideline committee acknowledge in the evidence review that the majority of RCTs they considered did not include quality of life outcome data (Evidence Review, 69, 34), which the committee highlighted as an outcome measure of primary importance. It appears that NICE aims to adhere to a potentially flawed commitment to RCT evidence focused on particular 'diagnoses' above all other. If it is accepted that psychotherapy's positive effects are the result of a combination of specific therapeutic actions and/or the quality of the therapeutic relationship (Tasca et al, 2018), then other kinds of research evidence need to be considered when forming guidelines – with the probable impact of widening patient choice. The architect of the RCT said that "any belief that the controlled trial is the only way would mean not that the pendulum had swung too far but that it had come right off the hook" (Hill, 1965:108). While	

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				NICE recognises that there are problems with RCTs, especially for psychological therapies, we suggest that Guideline Development Groups have acted as if they are the only way when it comes to making their recommendations for treatment. This has had, and is still having, serious consequences for the range of therapies available to patients both within and increasingly outside the NHS, as training institutions gear up to produce therapists who can deliver 'NICE-approved' treatments. According to NICE's current Guidelines Manual (NICE, 2009a:39-46): "Although there are a number of difficulties with the use of RCTs in the evaluation of interventions in mental health, the RCT remains the most important method for establishing treatment efficacy." We take issue with the assumption that the "treatment"' can be standardised in order to attempt to eliminate the impact of the therapist. In contrast, the need to develop a working alliance is a core requirement for therapy to begin. A good fit with the therapist is dismissed as unimportant though randomisation within	

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				RCTs. Similarly, group therapists pay considerable attention to referral to and setting up of the membership of new groups; in RCTs, randomisation, yet again, dismisses the role that group members and, as a result, group relationships play in therapeutic change. Furthermore, therapy by its nature is inherently unpredictable (Bohart and House, 2008, 195). Therapists must apply a significant level of professional judgement to determine the best way to respond to the needs of each individual client. While NICE (2014) fully recognises the role of practitioner judgement for GPs, it is argued that by treating therapy as a drug rather than a dialogical practice, NICE does not afford the same recognition to psychotherapists. In fact, NICE is effectively removing the option of GPs and patients to exercise their judgement in choosing from amongst a range of 'treatments' as only NICE-approved manualised treatments are available for selection. NICE RCT results cannot be generalisable. Clients typically have	

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				multiple problems, and issues of 'co-morbidity' (Seligman, 1995). There remains a live debate in terms of how significant this latter issue is. It is contended that while NICE has recognised there are problems, it is not taking any corrective action for them with potentially fundamental consequences for the future of provision. With specific reference to systemic family therapy, we know that evidence should include case studies and qualitative research, which can provide rich and detailed stories from service users. Qualitative research has a better fit with systemic theory, with its emphasis on patterns, processes and wider socio-political and cultural contexts. One could assume, for example, that depression is manifested differently by children and young people in different cultures and global contexts. Such cultural differences in the expression and manifestation of depression could be more accurately explored through qualitative research rather than through RCTS and quantitative methods.	

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				While there are broadly two traditions of thought informing vocational practice in the UK – Positivistic-Utilitarian and Phenomenological-Ontological (the alternative tradition upon which much of psychoanalysis and most of humanistic-integrative approaches are based) – we are concerned that only the first of these is reflected in NICE's approach. We therefore recommend that NICE should act on its own stated doubts over the appropriateness and reliability of its method, and open up its process to a more pluralistic approach to what constitutes evidence – in the same way that the APA has done in the USA. We maintain overall that NICE's methodology has been inappropriately applied to psychotherapy in that: • It adheres to an overly medicalised perspective on emotional distress • There is a lack of triangulation • It treats complex psychotherapies as though they are drugs	

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				• It uses an inflexible hierarchy of evidence We question the relevance of the assumptions which underpin NICE's preference for randomised control trials (RCTs) as the research methodology for all psychological therapies. We also question the biased application of this methodology. The case is made here for NICE to adopt a pluralist approach to research methodologies, in order that research using methodologies better suited to psychotherapy (which do not normally operate from the standpoint of manualisation and rigid RCTs designs) can be admitted for consideration in creating guidelines. Furthermore, where meta-analyses, systematic reviews and RCTs do exist, evidence needs to be considered and to be taken into serious consideration in combination with a wider range of research options and clinical experience. NICE is effectively excluding the majority of existing psychological therapies from	

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				being seriously considered for inclusion in its recommendations. This hugely damages patient choice.	
UK Council on Psychotherapy	Guideline	General	General	**Use of Network Meta-Analysis** The current draft guideline used network meta-analysis, which is associated with serious and unique risks over and above that of standard meta-analyses that need careful addressing when employing it. NMA is an experimental technique with no formal expert consensus yet established on its appropriateness for this type of review. It relies on particular conditions, which, if not met, render the outcome unreliable. As we and others stated in response to the consultation on the Depression in Adults Guideline, it is not the role of NICE to provide an experimental platform for methodological technicians. This type of methodology must first be subject to critical discussion and consensus forming within the scientific field through peer-reviewed publications and debate. Use of the methodology in national guidelines should also be subject to	Thank you for your comment. We do not agree with your view that network meta-analysis (NMA) is 'an experimental technique'. It is an established approach that is widely used in international health research, including WHO guidelines [see http://www.who.int/bulletin/volumes/94/10/16-174326/en/] and NICE guidelines, for some years now (for example, see the following NICE mental health guidelines: Schizophrenia CG 178, Generalised anxiety disorder CG 113, Social anxiety disorder CG159, Bipolar disorder CG 185, Eating disorders NG69). The NICE guidelines manual states "When multiple options are being appraised, a network meta-analysis should be considered" (p104). The acceptability of NMA as a valid technique in mental health research is also indicated by the publication of NMAs by high impact peer-reviewed journals, see for example NMAs that compare pharmacological and psychological interventions for the management of social anxiety in adults [Lancet Psychiatry 2014; 1(5): 368–376, work undertaken to inform a NICE guideline]; for the management of OCD in adults [Lancet Psychiatry 2016; 3(8), p730–739]; for the management of bulimia nervosa in adults [Psychol Med 2018, doi: 10.1017/S0033291718001071, work undertaken to inform a NICE guideline]. Furthermore, for a list of Cochrane Reviews that employ NMA techniques see http://www.cochranelibrary.com/app/content/special-collections/article/?doi=10.1002/(ISSN)14651858(CAT)Freeaccesstoreviews(VI)networkmetaanalysis. We believe that the examples

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				formal stakeholder consultation, which has not yet taken place. This approach represents a serious deviation from accepted methodologies, is not supported by several experts in the field, has not been subject to a proper stakeholder consultation and should not be used. The main assumption underpinning the validity of NMA is that the indirect and mixed comparisons are only valid when the studies included in the synthesis are similar in their distribution of effect modifiers. These include severity at baseline, number of previous episodes, quality of study, sample size, sex, socio-economic factors, therapist factors, as well as treatment dose and administration of treatment – these were not addressed in full by the committee. We are therefore concerned about the prominence given to this evidence.	above confirm that NMA is an established rather than an experimental technique. It is the role of NICE to lead on and/or adopt international methodological standards in guideline development. We do not agree that NMA is characterised by serious and unique risks. Every meta-analysis (whether it is a conventional pairwise meta-analysis or a NMA) has its own strengths and limitations, and the same applies to the NMAs conducted to inform the NICE Depression in Children guideline. The biggest advantage of the NMAs is that they allowed synthesis of evidence from a large number of interventions and RCTs into a single analysis for consideration by the committee. If NMA techniques were not available, then we would have to undertake a very large number of pairwise meta-analyses on multiple different outcomes, and still make (qualitative) inference on the relative effectiveness of the interventions, by making implicit indirect comparisons between interventions, in order to formulate recommendations. This approach would entail higher risks, since it would be impossible to process and interpret appropriately the fragmented information derived from this approach. Heterogeneity in populations or interventions can be a problem in both pairwise and network meta-analysis and should be considered prior to conducting the meta-analysis, and when interpreting the results. We have controlled for a large part of heterogeneity by splitting populations with less and more severe depression, using detailed treatment definitions, using random effects models where appropriate, examining for model fit and checking for inconsistency between direct and indirect evidence.

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					We agree that other parameters, such as baseline severity, sex, number of previous episodes, socio-economic factors, therapist factors, may also be potential treatment effect modifiers that contribute to heterogeneity, in particular in a large and complex dataset such as this, but the presence of potential effect modifiers would also be an issue had pairwise meta-analysis of the studies included in the systematic review been conducted. Considering heterogeneity when assessing a very large number of pairwise, independent comparisons of this dataset would make interpretation of the findings and conclusions as to which interventions are the best options highly problematic. Between-study heterogeneity in the NMA was formally assessed for each network. The full methods and results of the NMA, including examination of model fit, heterogeneity, and inconsistency checks, as well as limitations of the NMA, have been reported in detail in the relevant chapter appendix. The Guideline Committee considered carefully the strengths and limitations of each of the NMAs that informed the guideline, including the characteristics and homogeneity of populations across trials, the results of the NMAs and all pairwise sub-analyses, the risk of bias of individual studies, the models' goodness of fit and the possible presence of inconsistency, and interpreted the results accordingly. They also considered the fact that treatment decisions may be influenced by individual values and goals, and people's preferences for different types of interventions. All these factors were taken into account when formulating recommendations. In summary, we strongly believe that NMA is an internationally established technique that was appropriate to use for the analysis of a complex dataset, such as the one in the Depression in Children

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					guideline. The guideline committee acknowledged the strengths and limitations of the method and took them into account when making recommendations.
UK Council on Psychotherapy	Guideline	General	General	Our response to question 2: **'Would implementation of any of the draft recommendations have significant cost implications?'** is as follows: **Patient choice of psychotherapy modalities** The principle of optimising outcomes by matching individual patients to the most appropriate treatment for them personally as endorsed for treatment of physical ill-health should be adopted in relation to mental health. The cost effectiveness of this personalised approach to treatment of physical ill-health is recognised by NHS England (2016). Offering patient choice and tailoring psychological interventions to individual patients will also likely be cost effective for depression, given the evidence cited above (Swift et al, 2011; Lindhiem et al, 2014) which shows higher completion rates and superior clinical outcomes. We therefore suggest that this principle is applied to mental	Thank you for your comment. The recommendation about the full assessment of needs is not intended to be prescriptive, but rather to highlight some important considerations for the shared decision-making process. If the healthcare professional, together with the child or young person (CYP) with depression and their family members, agree that a psychological therapy (either from first or second-line options) is the most appropriate choice of therapy to meet the CYPs needs then the hierarchy of the recommendations should not be a barrier to their receiving the chosen psychological therapy. To ensure this is the case the committee specifically noted the role of individual preferences for the CYP and their family members in the choice of therapy and stated that if the first line options would not meet the CYP's clinical needs or are unsuitable for their circumstances, to consider one of the following options including the chosen psychological therapy. The committee agreed to include a research recommendation for the psychological therapies with less evidence including psychodynamic psychotherapy. The research recommendation asks for evidence at post treatment and at longer-term follow-up. The studies you refer to (Muratori 2013; Shedler 2009; Shedler 2015) would have been excluded from this review for the following reasons: - Muratori (2013) recruited children with depression and/or anxiety but children with depression could not be separated to be included in the update of this guideline.

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				health, consistent with the government's parity of esteem agenda (DH, 2013). We specifically recommend that patients are given a choice of psychological therapy treatments rather than the limited first-line options suggested in the draft guideline, and that a wide range of psychological therapies become an integral part of this choice, in keeping with the stated aims of the Government and NHS (Future in Mind, FYFVMH, LTP) around patient choice. With specific reference to psychodynamic psychotherapy, its effects in children have sometimes been found to have increased in follow-up compared to immediate post-treatment, suggesting a tendency toward increased gains after the end of treatment, called the "sleeper effect", (Muratori et al, 2003). The "sleeper effect' is very powerful as it suggests that the changes created with psychodynamic or psychoanalytic psychotherapy are persistent and that certain blocks to personal and psychological development are positively affected through interventions. Shedler (2009) in his	- Shedler (2009) and Shedler (2015) were literature reviews without anything specific on children and young people with depression. We did not find evidence that psychodynamic psychotherapy is more effective than waiting list/control at longer term follow up.

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				review of meta-analyses also noted that the benefits of psychodynamic psychotherapy not only endure but increase with time. In contrast, the benefits of other (non-psychodynamic) empirically supported therapies may decay over time. In many cases, the gains in therapy with non-psychodynamic therapies begin to be lost immediately after the completion of psychotherapy (Shedler 2015). The long-term cost effectiveness of investing in the enduring effects of psychodynamic psychotherapy – which would be felt by children's services, adult services and in numerous cross-sectoral ways – was not sufficiently covered by the evidence considered in the development of this draft Guideline. We strongly suggest that research into the far longer term financial (and other) benefits of psychodynamic psychotherapy is included in the research recommendations for this guideline.	
UK Council on Psychotherapy	Guideline	General	General	In response to question 3**: '*What would help users overcome any challenges?'*** we offer the following recommendations:	Thank you for your comment. The recommendation about the full assessment of needs is not intended to be prescriptive, but rather to highlight some important considerations for the shared decision-making process. If the healthcare professional, together with the

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				Patient choice of psychotherapy modalities Patients should be offered a choice among psychological treatments, and this should be reflected within the guidelines such that there is greater flexibility between first-line treatments. Given the evidence for improved completion rates, superior clinical outcomes and higher patient satisfaction linked to patient choice of treatment, as well as the evidence for differential responses to treatment based on patient characteristics, we recommend that the principle of patient choice and matching should be endorsed throughout the guidance in relation to all forms of depression. We recommend that patients must be offered a choice of treatments for which there is evidence of clinical benefit, including a diverse range of modalities offered individually and in groups, and that patients should be matched to their treatment, rather than having a hierarchy of therapies imposed on them.	child or young person (CYP) with depression and their family members, agree that a therapy (either from first or second-line options) is the most appropriate choice of therapy to meet the CYPs needs then the hierarchy of the recommendations should not be a barrier to their receiving the chosen therapy (either from first or second-line options). To ensure this is the case the committee specifically noted the role of individual preferences for the CYP and their family members in the choice of therapy and stated that if the first line options would not meet the CYP's clinical needs or are unsuitable for their circumstances, to consider one of the following options. The committee recognised that children and young people with depression from a minority ethnic group may require a different approach. Minority ethnic groups were not mentioned specifically in the recommendations, but were expected to be taken into account when personal/social history is taken as part of the process of choosing a psychological therapy. This is reflected in the recommendations to base the choice of therapy on a list of factors, including the full assessment of needs.

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				Moreover, given that the guideline takes into account the role of cultural competence when assessing and treating depression in children and young people from BAME backgrounds, it is important to note that systemic family therapy – with its emphasis on the wider cultural contexts in which families are located (Falicov, 1995) and research on working with interpreters (Raval and Tribe, 2002) may be the most appropriate treatment when working with children and young people of BAME background and their families.	
UK Council on Psychotherapy	Guideline	General	General	**Exclusion of creative therapies** The draft guideline excludes from its recommendations and, indeed, largely from its evidence review, creative psychotherapy interventions such as dance movement psychotherapy, music, drama, play or art psychotherapy. The absence of creative psychological interventions with children with depression overlooks the benefits these types of therapy can have with hard to reach children and adolescents, particularly those with developmental challenges.	Thank you for your comment. Creative therapies were included in the protocol for this update (see Table 1 for the PICO in the evidence review) under the heading of 'arts/creative psychotherapies'. We therefore included arts/creative psychotherapies in the search for this update. There was only one study meeting the inclusion criteria for this review reporting on dance therapy (Jeong 2005). We included Jeong (2005) in the pairwise data and the NMA for depression symptoms at post-treatment in young people aged 12 to 18 years with mild depression. However, the committee was uncertain about the evidence for dance therapy because this was from a small study with low quality and with an effect below the minimal important difference (MID) to be considered clinically meaningful.

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				Published studies in the field (including Karkou et al 2010; Jeong et al 2005; Gold et al 2017; McArdle et al 2002; Rosal 1993) indicate that the arts therapies can be particularly effective in the treatment of mild depression and preventatively with children at risk of developing depression. In overlooking these therapies, the recommendations ignore the common practice in CAMHS teams to use creative methods and arts therapies as a way of supporting children and young people who find it difficult to engage through verbal and/or cognitive means (McLachlan & Laletin 2015; Cornish 2013). The guideline also fails to acknowledge the large number of arts therapists who work with parents and families (Taylor Buck, Dent-Brown & Parry 2013) and those who work psychodynamically. This omission further highlights the limitations of the evidence considered by the committee. The adopted methodology fails to capture evidence that is sufficiently robust around the creative therapies, meaning a range of developmentally	Regarding the other studies that you mention in your comment, these did not meet the inclusion criteria for this review for the following reasons: - Karkou (2010) is a book and the search strategy for reviews of the effectiveness of interventions does not include databases of books - Gold (2017) recruited students at risk of developing mental health problems and self-reporting unhealthy music use, but without depression - McArdle (2002) recruited children at risk for behavioural or emotional problems, but without depression - Rosal (1993) recruited children with behavior disorders, but without depression - McLachlan (2015) was an evaluation study without an RCT design - Cornish (2013) was a literature review, but not a systematic review - Taylor Buck (2013) was a survey and we only included RCTs in this review. We did not seek to overlook the importance of creative therapies in treating depression, but the lack of good quality evidence that met our review protocol meant that the committee felt unable to make any recommendations about their use.

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				appropriate and relevant interventions for children and adolescents are excluded from the recommendations. The result of this is the further limitation of patient choice, particularly for those who experience other disadvantages relating to their development or protected characteristics.	
UK Council on Psychotherapy	Guideline	General	General	**References** Beck, A.T., 1970. Cognitive therapy: Nature and relation to behavior therapy. *Behavior therapy*, *1*(2), pp.184-200. Bohart, A. and House, R. (2008) Empirically Supported/Validated Treatments as Modernist Ideology, I and II: Dodo, Manualisation and the Paradigm Question, in R. House and D. Loewenthal (eds) *Against and For CBT*. Ross-on-Wye: PCCS Books. Cuijpers, P., Berking, M., Andersson, G., Quigley, L., Kleiboer, A., & Dobson, K. S. (2013). A meta-analysis of cognitive-behavioural therapy for adult depression, alone and in comparison with other treatments. Canadian Journal of Psychiatry, 58, 376–385.	Thank you for your comment. We have addressed your comments related to these references. Please see ID 27-28, 30-32, 197, 217.

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UK Council on Psychotherapy	Guideline	33	22	**Recommendations for 5-11 year olds** Given the substantial variation in cognitive development between, for example, 5 year olds and 12 year olds, we have serious concerns about the appropriateness of applying	Thank you for your comment. As you note, the evidence base for children 5 to 11 years old was very limited. This is reflected in the committee discussions of the evidence under "quality of the evidence" and "benefits and harms". We have extended these sections based on committee discussions of stakeholder comments. The committee noted that there was a very limited evidence base for 5-11 year olds with mild depression and that group CBT was not

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				recommendations for 12-18 year olds to the 5-11 age group. Given that CBT requires an individual to be aware of their cognitive distortions and that they must be able to understand the relationship between cognitions, affect and behaviours, these higher level cognitive approaches may be beyond the reasoning abilities of young children. There is enough empirical evidence to indicate that children under 8 maintain only rudimentary higher order reasoning skills (Grave and Blissett, 2004). For examples, in Beck's cognitive therapy for depression (Beck, 1970), it is assumed that the individual has the capacity to distinguish rational from irrational thoughts once they are identified in session. Young children may not understand this distinction, and distorted thinking is in fact both a hallmark of early childhood and a product of normal development (Shirk, 1988). Care must also be taken to avoid the 'development uniformity myth' (Kendall and Choudhury, 2003) where children at different ages exhibiting	better than control at reducing depression symptoms. However, they agreed that it was important to offer these children treatment. Taking consultation comments into account, they decided to include a new recommendation specifically for 5-11 year olds with mild depression to follow the treatments for 12-18 year olds, but with use of developmental adaptation where needed. The consideration of developmental level and maturity is also included as part of the full assessment of needs recommendation. There was more evidence for 5 to 11 year olds with moderate to severe depression, but the evidence of effectiveness for individual therapies was weak. In this case, the committee used their clinical expertise and the limited evidence to make a new recommendation for 5-11 year olds with moderate to severe depression. This included the interventions that were most effective in the trials that recruited the 5-11 year olds and individual CBT because this was the most effective intervention for 12-18 year olds. This recommendation also included the use of developmental adaptation where needed. In addition, based on stakeholder comments, the committee agreed to expand the scope of the research recommendation to cover children aged 5 to 11 years with mild or moderate to severe depression. The new research recommendation does not specify a particular psychological therapy.

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				similar behaviours are assumed to be alike. Cognitive, social and affective variables all contribute to a child's self-perceptions and their views of others. Although CBT may be affective as a first-line treatment for one child, language development, memory skills and behaviour skills vary widely from child to child (Braswell and Kendall, 2001). We certainly support the inclusion of the 5-11 age group within the research recommendations (Guideline, 30/8) given the obvious shortfall in evidence that was acceptable to the committee. Nevertheless, we are concerned that the principle recommendation is measuring the effectiveness of group CBT, with no other therapies mentioned within that recommendation. The need for further research is clearly greater than indicated by this recommendation. In line with our concerns about the appropriateness of CBT for this age group, and appropriateness of treating the two age groups the same way, we highlight the recommendations made for	

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				5-11 year olds as another problematic by-product of the extremely limited first-line treatment recommendations initially made for 12-18 year olds.	
UK Council on Psychotherapy	Guideline	42	1	**Removal of 2015 recommendation 1.5.2.1** We are extremely concerned about the removal of recommendation 1.5.2.1, added to this Guideline during the 2015 update process and applicable to cases of both mild and moderate to severe depression, which states that clinicians should explain that "there is no good quality evidence that one type of psychological therapy is better than the others". The evidence considered by the committee outlined in the evidence review does not disprove this claim, and it is strongly supported by leading psychotherapy researchers (see, for example, Cuijpers et al, 2008, Cuijpers et al 2013, Tasca et al 2018). Even within the limited confines of the recommendations of this draft guideline, we feel strongly that including	Thank you for your comment. As you note, recommendation 1.5.2.1 was removed. Therefore, the committee agreed to recommend that health care professionals explain the evidence for each age group (including the limited evidence for 5- to 11-year-olds) within the recommendation on the discussion of the choice of psychological therapies for both mild and moderate to severe depression.

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				recommendation 1.5.2.1 would be an important step underlying the possibility of patient choice. Its removal, in conjunction with the limited first-line recommendations, unjustly reinforce the notion of a hierarchy of therapies – not supported by literature – which will further the limit the choice of therapies made available to children with depression.	
UK Council on Psychotherapy	Guideline	43	1	**Removal of 2015 recommendation 1.6.1.2** We have serious concerns about the removal of recommendation 1.6.1.2, added to this Guideline during the 2015 update, which states that children with moderate to severe depression should be offered "a specific psychological therapy (individual CBT, interpersonal therapy, family therapy, or psychodynamic psychotherapy) that runs for at least 3 months"; which has now been replaced by recommendations 1.6.2 to 1.6.5. The effect of replacing this recommendation – which leaves the choice of therapy fully at the discretion	Thank you for your comment. As you note, recommendation 1.6.1.2 was removed. Therefore, the committee agreed to recommend that health care professionals explain the evidence for each age group (including the limited evidence for 5- to 11-year-olds) within the recommendation on the discussion of the choice of psychological therapies for moderate to severe depression. The recommendation about the full assessment of needs is not intended to be prescriptive, but rather to highlight some important considerations for the shared decision-making process. If the healthcare professional, together with the child or young person (CYP) with depression and their family members, agree that psychodynamic psychotherapy (either from first or second-line options) is the most appropriate choice of therapy to meet the CYPs needs then the hierarchy of the recommendations should not be a barrier to their receiving the chosen therapy. To ensure this is the case the committee specifically noted the role of individual preferences for the CYP and their family members in the choice of therapy and stated that if the first line options would not meet the CYP's clinical needs or are unsuitable for their circumstances, to

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				of the clinician and patient, subject to availability – with a recommendation that implies there is a hierarchy of therapies could have significant ramifications on commissioning decisions. It is likely therefore that the imposition of this hierarchy will serve to reduce the choice of treatments available to many children with moderate to severe depression. This change would be understandable if the evidence review suggested clearly that CBT and family therapy are more effective than psychodynamic psychotherapy. However, as we have already pointed out, the committee included evidence which shows psychodynamic psychotherapy is at least as effective as CBT (Guideline, 37/10). The relative number of RCT studies should not dictate the guideline being altered in such a way that could reduce choice of therapies available to children and young people with moderate to severe depression. We have major concerns about the implications of this newly imposed hierarchy of treatments, both in terms of	consider one of the following options including psychodynamic psychotherapy. In an analysis of a large body of evidence for 12-18 year olds with moderate to severe depression, individual CBT was better at reducing depression symptoms and improving functional status, quality of life and suicidal ideas compared to waiting list/ no treatment or usual care, and at increasing remission compared to attention control and other therapies (such as family therapy) at the end of treatment. Based on this information and the magnitude of the effects, the committee agreed to recommend individual CBT as the first line treatment for young people with moderate to severe depression. However, the committee recognised that individual CBT might not be suitable or meet the needs of all young people with moderate to severe depression and so they agreed that additional evidence-based options should be available. They chose to include IPT-A (IPT for adolescents), family therapy, brief psychosocial intervention and psychodynamic psychotherapy as second line options because the evidence supporting their clinical and cost-effectiveness was less strong.

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				patient choice and in terms of therapeutic outcomes.	
University of Cardiff	Guideline	General		There is very strong evidence that the majority of children and adolescents meeting diagnostic criteria for Major Depressive Disorder go unrecognised, undetected and untreated. Thus, there is a significant "treatment gap" for child and adolescent depression. The current guidelines recommend a number of psychological therapies, which require significant training and skill to deliver in areas where there is a current significant lack of capacity particularly in primary care settings including schools. Literature and clinical experience indicate that it is difficult to access specialist CAMHS and highly trained therapists. This may have the inadvertent effect of perpetuating the current treatment gap for depression in children and young people and waiting lists will remain a problem with this guidance. This is in spite of evidence suggesting that early treatment impacts on longer term outcomes (e.g. Patton et al., 2014).	Thank you for your comment. The update of this guideline is aimed at identifying the most effective psychological therapies for treating depression in children and young people. The feasibility of implementation of these recommendations is not within NICE's remit, and instead implementation is controlled by local service providers. However, the committee recognised that there is a gap in the availability of some of these interventions and included this in a recommendation for treatment for mild depression to ensure that some form of suitable treatment could be accessed: "If the options in recommendation 1.5.6 would not meet the child or young person's clinical needs, are unsuitable for their circumstances or are not available, offer the following...."
University of Cardiff	Guideline	General	General	It is recognised that there is a more limited evidence base for childhood (5-	Thank you for your comment. The committee agreed that 5-11 year olds are very different to 12-18 year olds in terms of maturity and

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				11 years) than adolescent (12-18 years) depression. However, no distinction is made between suggested treatments for child and adolescent depression in spite of substantial evidence they seem different (in terms of natural history, genetic aetiology, long-term outcome) and so on. Developmental differences are not alluded to. For example, the research recommendation for CBT in 5-11 year olds with severe depression does not consider developmental issues – which are likely to be important for CBT, in particular in depressed young people with comorbidities such as ADHD and ASD where depression onset is likely to be very early (e.g. Rice et al., 2018 JAMA Psychiatry). Alternative approaches to CBT, for treating very early depression (e.g. Luby et al., 2018 AJP doi: 10.1176/appi.ajp.2018.18030321.) have been published and show early promise.	developmental level. This point was already reflected in the recommendation for a full needs assessment to underlie the choice of therapy, which included consideration of maturity and developmental level. As you note, the evidence base for this age group was very limited. This is reflected in the committee discussions of the evidence under "quality of the evidence" and "benefits and harms". We have extended these sections based on committee discussions of stakeholder comments. The committee noted that there was a very limited evidence base for 5-11 year olds with mild depression and that group CBT was not better than control at reducing depression symptoms. However, they agreed that it was important to offer these children treatment. Taking consultation comments into account, they decided to include a new recommendation specifically for 5-11 year olds with mild depression to follow the treatments for 12-18 year olds, but with use of developmental adaptation where needed. The consideration of developmental level and maturity is also included as part of the full assessment of needs recommendation. There was more evidence for 5 to 11 year olds with moderate to severe depression, but the evidence of effectiveness for individual therapies was weak. In this case, the committee used their clinical expertise and the limited evidence to make a new recommendation for 5-11 year olds with moderate to severe depression. This included the interventions that were most effective in the trials that recruited the 5-11 year olds and individual CBT because this was the most effective intervention for 12-18 year olds. This recommendation also included the use of developmental adaptation where needed.

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					In addition, based on stakeholder comments, the committee agreed to expand the scope of the research recommendation to cover children aged 5 to 11 years with mild or moderate to severe depression. The new research recommendation does not specify a particular psychological therapy. We checked the study reported by Luby (2018) and discussed it with the committee. However, this could not be included because a high proportion of participants were children under 5 years old with depression and data was not reported separately for the 5 years and older group. The scope of this guideline is for children and young people aged 5 to 18 years.
University of Cardiff	Guideline	General	General	Parent mental health and the wider social context is important. This is acknowledged in the earlier sections (1.1). However, there could be more emphasis on this in the management section of the guidelines. The only mention of parents in the management section of the guidelines is to specifically recommend IPT plus parent psychological therapy. A wider appreciation and integration of the importance of parental mental health into the recommendations would be very helpful and evidence based. For instance, there is good evidence that treating parental depression effectively to remission with antidepressants has positive effects on child mental health	Thank you for your comment. Parent mental health was not within the scope of this update and therefore we are unable to make recommendations on this topic. However, the importance of addressing parent mental health issues is stressed in recommendation 1.1.33 within the section on "Treatment and considerations in all settings". NICE also offers guidance on recognition and management of depression in adults. The committee recognised the importance of parents/carers in child mental health and recommended therapies such as IPT-A (IPT for adolescents) and family therapy that involve parent/ carer involvement.

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				(e.g. STAR*D study); that parental depression modifies the effectiveness of CBT in those at high risk or with symptoms (e.g. Garber et al., 2009 JAMA); and that the quality of the parental relationship and co-parent relationship is an important source of support with implications for resilient outcomes in those at high familial risk (e.g. Collishaw et al., 2016 Lancet Psychiatry).	
University of Cardiff	Guideline	General	General	There is very little mention of comorbidity in the management guidelines (though it is referenced in section 1.1). Depression in young people is commonly comorbid (~70% of individuals have another disorder). While this is often anxiety, it is also often antisocial behaviour, ADHD and ASD. Young people with neurodevelopmental disorders and depression may require a different approach and comorbidities may make particular treatments more or less likely to be effective.	Thank you for your comment. The committee agreed that children and young people with depression and comorbidities may benefit from different therapies and they have now included consideration of comorbidities, neurodevelopmental disorders, communication needs (language, sensory impairment) and learning disabilities in the full assessment of needs recommendation. Thank you for pointing this omission out. There is an existing recommendation in the section on treatment considerations in all settings about assessing and managing comorbid diagnoses and developmental, social and educational problems. In addition, the research recommendations include neurodevelopmental disorders as a subgroup analysis because the committee recognised that there was a shortage of evidence for this group. The committee were unable to make separate recommendations for specific therapies for children and young people with comorbidities as this is not within the scope of the guideline. However, we have now included a cross reference to the recommendations on

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					psychological interventions in the NICE guideline on mental health problems in people with learning disabilities and to the recommendations on psychological and social issues in children and young people with type 1 or type 2 diabetes in the NICE guideline on diabetes (type 1 and type 2) in children and young people.
University of Cardiff	Guideline	General	General	On what basis is mindfulness recommended as an intervention for mild depression? The adult literature where mindfulness based cognitive therapy is much more established is only effective in a sub-group of individuals (exposed to trauma) (Williams et al., 2014 J Consult Clin Psychology) and we are aware of at least one study reporting adverse effects of mindfulness on depressive symptoms in adolescents (Rice et al., 2015 J Affective Disorders).	Thank you for your comment. Group mindfulness was recommended along with other group interventions in the draft version for consultation. However, the committee noted that the data for this intervention came from a single, small US based study with 33 female participants who were at risk of type 2 diabetes due to being overweight or obese. The committee therefore agreed that the evidence behind the results for group mindfulness were insufficiently robust to change UK practice and decided that this intervention should not be recommended. The committee also agreed that a research recommendation was appropriate to obtain additional evidence of effectiveness for group mindfulness compared with other psychological therapies in young people aged 12 to 18 years with mild depression. We have checked the study by Rice (2015), but we cannot include this study in the evidence review because it was not an RCT and therefore does not meet our review protocol.
University of Cardiff	Guideline	General	General	There is very little on electronic health interventions with the exception of computerised or digital CBT. Proper evaluation of E-health interventions would be very useful given problems with accessing specialist services, with the time limitations on appointments in	Thank you for your comment. We searched for apps targeting depression (separately from computer- based CBT) as a modality of guided self-help as part of the review process. This covered e-health interventions relevant to children and young people with depression. There was only 1 RCT comparing online guided self-help to waiting list (Ricki 2015). However, guided self-help was not better than the

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				general practice and school settings and is especially relevant for this age group.	recommended psychological therapies at decreasing depression symptoms at post-treatment.
University of Cardiff	Guideline	General Table 1 Page 11	General	Much more emphasis on what low intensity interventions could be offered in Tier 1 is required in the guidelines, in particular interventions that will need to be delivered by non-specialists (as opposed to interventions delivered by highly skilled specialists for which waiting lists are currently problematic which is the current focus of the guidelines). More guidance on what to do in Tier 1 is additionally warranted given planned moves for more interventions in primary mental health teams and in schools. The current guidelines are very heavily geared towards psychiatry /clinical psychology in specialist CAMHS - access to treatment to any therapy at present is a problem and these guidelines do not recognise this. Many CAMHS therapists are mental health nurses/social workers, sometimes with minimal specialists psychological (e.g. CBT) training. Also, in many areas, even when children and young people reach CAMHS, the choice of treatment is limited and will depend on what is available locally. The current	Thank you for your comment. The current update was focused on determining which psychological therapies are effective for treating mild or moderate to severe depression. This review did not look at service provision or consider the intensity of the interventions and as a result, the committee were unable to make any recommendations on this topic. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date. However, the committee did include a recommendation for further research on the brief psychosocial intervention that was trialled in the IMPACT trial (Goodyer, 2017). This was aimed at testing the intervention in other settings including primary care with delivery by less senior medical professionals. The committee recognised that this intervention was less intensive than other interventions examined and could probably be administered by non-psychiatrists, potentially increasing access. Goodyer IM, Reynolds S, Barrett B, et al. (2017) Cognitive-behavioural therapy and short-term psychoanalytic psychotherapy versus brief psychosocial intervention in adolescents with unipolar major depression (IMPACT): a multicentre, pragmatic, observer-blind, randomised controlled trial. Health technology assessment 21(12), 1-94.

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				focus will serve to perpetuate the treatment gap for affected young people and their families.	
University of Cardiff	Guideline	General Table 1 and later	General	Detailed recommendations are made about the specific type of psychological therapies that should be given as first line treatments (CBT, family therapy, IPT plus parent). The IMPACT trial clearly showed that no one psychological therapy was superior to another (CBT, supportive intervention, brief psychodynamic). That finding is also consistent with the Weisz et al (2017) meta-analysis showing only modest and heterogenous effects of CBT on child and adolescent depression (i.e. CBT is not a "one size fits all" intervention). Table 1 is confusing and clinicians may fail to get the key message. Instead, describing the types of psychological interventions for which there is some evidence of effectiveness or efficacy and allowing the clinician, young person and their family/carers to come to a joint decision on which to use/try depending on local availability, waiting lists, preferences, suitability etc would be consistent with the evidence	Thank you for your comment. The recommendation about the full assessment of needs is not intended to be prescriptive, but rather to highlight some important considerations for the shared decision-making process. If the healthcare professional, together with the child or young person (CYP) with depression and their family members, agree that a psychological therapy (either from first or second-line options) is the most appropriate choice of therapy to meet the CYPs needs then the hierarchy of the recommendations should not be a barrier to their receiving the chosen psychological therapy. To ensure this is the case the committee specifically noted the role of individual preferences for the CYP and their family members in the choice of therapy and stated that if the first line options would not meet the CYP's clinical needs or are unsuitable for their circumstances, to consider one of the following options including the chosen psychological therapy. Although as you point out the IMPACT trial did not show superiority of one therapy over another, analysis of a larger body of evidence for 12-18 year olds with moderate to severe depression, individual CBT was better at reducing depression symptoms and improving functional status, quality of life and suicidal ideas compared to waiting list/ no treatment or usual care, and at increasing remission compared to attention control and other therapies (such as family therapy) at the end of treatment. Based on this information and the magnitude of the effects, the committee agreed to recommend individual CBT as the first line treatment for young people with moderate to severe depression.

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				base. Thus, it would be helpful to have more general recommendations e.g. for moderate to severe depression, give psychotherapy (the following have been trialled). Family therapy - doesn't the evidence base relate to children and is weak for adolescents? Again, this recommendation is not very clear because the evidence comes from very specific manualised treatments when practice-based therapies could mean something very different. s-CAMHS recommendation can give much more straightforward guidance - psychotherapy (list and state which ones) plus or minus fluoxetine.	However, the committee recognised that individual CBT might not be suitable or meet the needs of all young people with moderate to severe depression and so they agreed that additional options should be available. They chose to include IPT-A (IPT for adolescents), family therapy, brief psychosocial intervention and psychodynamic psychotherapy as second line options that were evidence based but where effectiveness was less certain. The committee agreed that family therapy can include different interventions. They also noted that specific types of family therapy showed to be effective for mild or moderate to severe depression for each age group. Therefore, the committee agreed to specify the type of family therapy in the recommended psychological therapies.
University of Cardiff	Key recommendations for research	30-31	30-31	Key recommendations for future research. The ordering of these should be altered to reflect the observations that current evidence shows: a) no single psychological intervention is superior to another and b) the likelihood that the psychological intervention can be delivered in primary care settings by individuals who do not need to be a highly trained therapist. To that end,	Thank you for your comment. The prioritised research recommendations are all from the current update of the guideline, but within the top 5 selected there is no further prioritisation. The committee agreed to amend the research recommendation on group CBT in children aged 5 to 11 years with moderate to severe depression. The new research recommendation does not specify a particular psychological therapy and has been expanded to include children aged 5 to 11 with mild or moderate to severe depression. The committee decided to remove the research recommendation on sequencing of psychological interventions because they agreed

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				brief psychosocial intervention = 1; Behavioural activation = 2. We would suggest that the first recommendation (CBT for children aged 5-11 with moderate to severe depression) should be revised so that a particular psychological intervention is not specified to reflect the fact that alternative, developmentally tailored interventions with preliminary evidence of effectiveness are available (e.g. Luby et al., 2018). We would also suggest revising recommendation 3 (sequencing of psychological interventions) to specify a more general recommendation of evaluating which intervention is likely to work for particular individuals. Finally, an investigation of the impact of neurodevelopmental comorbidities would also be an important priority for future research. E-mental health is also particularly relevant for this age group and can help with difficulties of accessibility to treatment as well as potentially helping with treatment flexibility and cost-effectiveness so should be included as a key recommendation for research.	that research investment would be better focused on obtaining additional evidence of effectiveness for psychological interventions such as the brief psychosocial intervention (BPI), psychodynamic psychotherapy and IPT-A (IPT for adolescents) for moderate to severe depression. The research recommendation for BPI is aimed at examining the effectiveness of this intervention when carried out in settings such as primary care by less senior medical staff. The research recommendations have a number of specified subgroup analyses and these already include neurodevelopmental disorders. The committee have now included a research recommendation looking at the relative effectiveness of supported and unsupported digital CBT, which also aims to determine which key components are responsible for the effectiveness of the intervention. There was 1 RCT comparing online guided self-help to waiting list (Ricki 2015). However, guided self-help was not better than the recommended psychological therapies at decreasing depression symptoms at post-treatment.

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University of Cardiff	Guideline	34–35	16	Non-directive supportive therapy and guided self-help are no longer recommended. Guided self-help is not recommended even though it reduced symptoms at follow-up. Instead, a range of psychological therapies are recommended as first line treatments even for mild depression. This is likely to result in greater waiting lists, more unmet need and greater resource use to treat a smaller number of individuals. Guided self-help could be digital. Moreover, some of the therapies recommended in these guidelines did not show benefits that persisted or those data were not always available – the decision to no longer recommend guided self-help seems non pragmatic and somewhat premature. Non-directive supportive therapy was as effective as CBT and brief psychodynamic therapy in the IMPACT trial and it also meets the pragmatic requirement that it can be delivered by non-specialists. The brief psychosocial intervention could be better defined in the guidelines.	Thank you for your comment. The committee agreed that there was a shortage of evidence of long term effectiveness for some interventions and that others lacked information about effects on key outcomes, but they agreed that, despite these limitations, it was still appropriate to recommend the most effective interventions based on the NMA and pairwise analyses. The strength of the evidence is reflected in the wording of the recommendation and the evidence base is now included in the recommendation as part of the discussion between the healthcare professional and individual with depression. In addition, the committee included long term follow up and the full range of outcomes of interest in their research recommendations. The committee agreed not to recommend non-directive supportive therapy (NDST) or guided self-help because: - NDST was not more effective at reducing depression symptoms at the end of treatment or 6 months follow-up than control and there was no evidence for functional status or remission. - Although guided self-help reduced depression symptoms at the end of treatment compared with waiting list control/no treatment, this was not sustained at later time points. In addition, guided self-help was no more effective at reducing depression symptoms at the end of treatment, and less effective at 6 months follow-up, than the recommended group therapies (group CBT, group IPT, group NDST), digital CBT, individual CBT or family therapy and other therapies such as group CBT + computer CBT. We did not find any evidence for digital guided self-help and as a result, are unable to include it in any recommendations. The committee has included a definition of the brief psychosocial intervention as requested.

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University of Edinburgh	Guideline	30-31	7	Our research and those of others in environment-health research suggest that engagement with the natural environment and activities that involve being outdoors and in the natural environment can be very positive experiences and have the potential to be part of therapeutic interventions for treatment of depression. The experience of nature in childhood seems to be particularly important in this respect. It is disappointing, therefore, not to see any mention of such approaches in the guideline, especially in recommendations for future research, whether or not associated with Behavioural Activation. Some relevant references on evidence and calls for more research in this area: Tillmann S, Tobin D, Avison W*, et al* Mental health benefits of interactions with nature in children and teenagers: a systematic review *J Epidemiol Community Health* 2018;**72:**958-966. Dadvand, P.; Hariri, S.; Abbasi, B.; Heshmat, R.; Qorbani, M.; Motlagh, M.E.; Basagaña, X.; Kelishadi, R. Use of green spaces, self-satisfaction and	Thank for your comment. Engagement with the natural environment was not within the scope of this update and therefore we are unable to make changes to this area.

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				social contacts in adolescents: A population-based CASPIAN-V study. Environ. Res. 2019, 168 , 171–177 Natural England 2010 *Wild Adventure Space its role in teenagers' lives*. Natural England Commissioned Report NECR025, First published 20 May 2010, available at URL http://publications.naturalengland.org.uk/publication/41009 Wells, N and Evans, G. 2003. Nearby nature: a buffer of life stress among rural children. *Environ Behav*, 35: 311–330 Abbott-Chapman, Joan. Time Out in 'Green Retreats' & Adolescent Wellbeing [online]. Youth Studies Australia, Vol. 25, No. 4, Dec 2006: 9-16.	

**None of the stakeholders who comments on this clinical guideline have declared any links to the tobacco industry.*