Depression in adults: treatment and management (Update) (2018)

Second consultation on draft guideline - Stakeholder comments table
15/05/2018 – 12/06/2018

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NIHR Health Technology Assessment Programme	Addendum H	5	5	The closing search date of June 2016 sounds very out of date for guidance that will emerge in late 2018. As someone who has done lots of systematic reviews, I appreciate the constant dilemma in trading off a later search date versus the amount of work involved, especially for a NMA. I have particular concern as HTA programme director that some key NIHR HTA studies that have been published post June 2016 are now not included – some of which are topics that ironically have been suggested to us by NICE. I suspect members of the public would find such a condition very odd, and those who participated in the HTA trials might rightly feel disappointed that their contribution to an important NICE-generated research question never made into the NICE depression guidelines. But I do appreciate what an enormous and important project this is and that you must be left to make your own decisions independently with the best public interests at heart.	Thank you for your comment. Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Public Health England	Full	General	General	The only appearance of smoking in the guidance relates to advice on sleep hygiene but smoking cessation is associated with improved physical and mental health. A systematic review and meta-analysis found: 'Smoking cessation is associated with reduced depression, anxiety, and stress and improved positive mood and quality of life compared with continuing to smoke. The effect size seems as large for those with	Thank you for your comment. This guideline is about the treatment and management of depression in adults. It is outside the scope to make recommendations on smoking.

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				psychiatric disorders as those without. The effect sizes are equal or larger than those of antidepressant treatment for mood and anxiety disorders.' Source: https://www.bmj.com/content/348/bmj.g1151 This important finding should prompt consideration on the impact of smoking cessation as a treatment for mental health problems, particularly when smoking rates are higher than the general population. We would therefore recommend the inclusion of evidence-based smoking cessation interventions as part of a core and standard treatment offer for depression in mental health services.	
Public Health England	Full	General	General	Public Health England (PHE) notes that there is little mention of drug or alcohol misuse or dependency in the guidance document. PHE would recommend a more substantial inclusion of drug and alcohol misuse or dependency given the significant level of comorbidity and the difficulties experienced by patients who suffer both conditions in accessing effective support. PHE would recommend that the NICE guidance make reference to the following three documents: 1. The newly published PHE guidance document 'Better care for people with co-occurring mental health and alcohol/drug use conditions. A guide for commissioners and service providers' which is available at :	Thank you for your comment. Drug and alcohol misuse is outside the scope of this guideline and

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				https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf 2. The newly published clinical guidance 'Drug misuse and dependence. UK guidelines on clinical management' which has a section devoted to coexisting problems with mental health and substance use (section 7.9), which is available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/628634/clinical_guidelines_2017.pdf 3. In addition, practical advice and guidance for working in Improving Access to Psychological Therapies (IAPT) services with people who use drugs and / or alcohol are available at: http://www.drugwise.org.uk/wp-content/uploads/iapt-drug-and-alcohol-positive-practice-guide.pdf	we are not able to make any recommendations on this issue. We are also not able to cross reference to PHE documents. However, there is existing NICE guidance on these issues which may be useful: • Drug misuse in over 16s: psychosocial interventions (CG51) • Drug misuse in over 16s: opioid detoxification (CG52) • Drug misuse prevention: targeted interventions (NG64) • Alcohol-use disorders: diagnosis and management of physical complications (CG100) • Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (CG115)
University of Nottingham	Full	70-102-		We welcome the qualitative research undertaken although there seems to have been little by way of new qualitative research added to the review. We wish to draw attention to how counselling services, as a matter of course, receive written feedback from clients in regards to their experience of receiving counselling. This evidence could be a great resource for understanding the impact of PCE-CfD. Given there are numerous services with in-house PCE therapists, recovering this data would have been easily	Thank you for your comment. The patient experience section was not included as part of this update (as specified in the guideline scope). Therefore the evidence in this area (including identifying qualitative evidence on the impact of PCE-CfD) has not been reviewed and the text has not been updated.

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				executed and would provide a more rounded qualitative perspective of the impact of PCE-CfD. The qualitative research on ECT indicates no benefit at all from clients, yet ECT is more prominent in the report than counselling, which, as explained above, has so much service user feedback- yet that data is excluded.	
University of Nottingham	Full	678-680-		As referred to in comment12 above, by limiting the paradigm, clients are frequently undermined if they believe there is a 'cure' as is implied by depression being characterised as an illness. It removes the capacity of the individual to recognise the processes they are going through as a natural response and reaction, admittedly often with an overwhelming and distressing impact. Despite the case that for some, perceiving it as an illness may be helpful, for others we consider the illness paradigm prevents engagement through PCE-CfD with a focus on emotions and the resulting opportunity to process their distress.	Thank you for your comment. We do not agree that "an illness paradigm" is something that is commonly adopted by individuals providing treatment for depression. The approach adopted by many professionals, and the one use in this guideline, is one of collaborative assessment and determination of the most appropriate treatment, given the evidence for its effectiveness and an individuals' past experience and hopes for future treatment.
University of Nottingham	Full	General	General	When Lord Layard announced the government investment into psychological therapies for depression, counselling was originally omitted as a psychological approach. As a result of the feedback by BACP, person-centred experiential therapies (PCET) was included and named 'CfD': Counselling for Depression. For clarity we have advised CfD is renamed PCE-CfD so it describes what is being offered. The guidelines, as they stand, do not acknowledge the progress made by PCE-CfD over	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				the last five years. We are very pleased that since 2013 at the University of Nottingham we have qualified over 150 therapists in the East of England - Nottinghamshire, Essex, Norfolk, Suffolk, Lincolnshire and have also accepted delegates from Coventry and Warwickshire and Manchester. We have IAPT therapists still in training with new people qualifying every week. The feedback we receive from the service providers is very positive and their client outcomes are also reported as favourable. We train supervisors who are in place in services supporting the PCE-CfD workforce. The recent IAPT workforce survey showed high levels of stress amongst IAPT therapists. Adopting target driven approaches to employment in a service that is designed to deal with those experiencing stress in their lives is potentially a sad irony. We advocate every service having appropriate supervision and therapists being trusted to manage caseloads as traditionally they have had to. The investment into CBT and PWP training at the beginning of IAPT meant that people with no experience of working with distress were employed and it may explain why a target system was developed. With person-centred therapists they already have gained much experience and that experience and membership of a professional body as well as being accredited or working towards accreditation is essential in order to even get an interview for a post in IAPT. The target driven approaches to working introduces a pressure that is demoralising when dealing with	

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				distressing life experiences such as those who access services tend to bring. We'd ask that NICE considers the pressures employees are put under and recommend that every service that has PCE-CfD counsellors also ensure a number of PCE-CfD supervisors are in place. We have experienced a reluctance by services to put people forward to train as PCE-CfD supervisors , those that have are noticing a boost in staff morale, better outcomes and a reduction in re referrals. By offering clinical supervision that is relatable to the approach staff are properly supported and feel valued.(Nagra and Fryer Healthcare CPJ 2018) There are 4 other institutes who are offering PCE-CfD courses so numbers are increasing every year. Counselling has always been a popular resource in GP services and its place in IAPT has been important so there is still a counselling presence in NHS services. Clients frequently ask for counselling, a non-medical approach, as opposed to pharmacology or cognitive behavioural therapy. Investment in counselling, through IAPT, is relatively new and represents 1% of the entire IAPT budget. We are building up research and appreciate that published papers are the way committees access peer reviewed research and evidence. We are confident that over the next 5 years the research evidence for PCET will have increased. We urge you to recommend PCE-CfD (presently known as CfD) remains as an approach for people struggling with depression . This link takes you to a	

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				meta-analysis conducted in 2008 https://www.pce-world.org/about-pce/articles/102-person-centredexperiential-therapies-are-highly-effective-summary-of-the-2008-meta-analysis.html. Four papers have been published since Sept 2017 and presentations have been made at research conferences , those papers will also be published in due course.We ask you include the real world data provided by the analysis of IAPT MDS scores that showed equivalence between CfD and CBT. The name is updated to be more accurate and cohesive making research much more retrievable- Person-centred experiential counselling for depression.(PCE-CfD) We have the agreement of all the providers of the approach, the agreement of the BACP and the acceptance by the IAPT education lead that this would be a positive step.	
UK Council for Psychotherapy	Full	General	General	Alongside providing professional support for our members, the United Kingdom Council for Psychotherapy (UKCP) 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.	Thank you for your comment and providing this information on the United Kingdom Council for Psychotherapy.

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				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 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 the second consultation on NICE's draft guidelines for depression.	
UK Council for Psychotherapy	Full	General	General	According to the Mental Health Foundation, depression is experienced by at least four out of every ten adults at some point in their lives. The fact that depression is experienced at this scale in England and Wales should necessitate that the Guideline Development Group charged with revising the 2009 guideline adhere to the most robust methodology in the most transparent way. The various methodological concerns UKCP raised in our first response to the draft have not been addressed in the revised version. Accordingly, we maintain our position that this guideline is by its very nature	Thank you for your comment. The decision to have an 'exceptional' consultation was not made because either of the criteria in the technical manual had been met, but because NICE thought it would be useful for stakeholders (who had significant concerns about the content of the first draft of the guideline) to see what had changed and be given another chance to comment, particularly

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				unreliable. Further, if published it will seriously risk the care of millions of people in the UK suffering from depression. Under NICE's own rules, an exceptional second consultation can occur if "information or data that would significantly alter the guideline were omitted from the first draft, or evidence was misinterpreted in the first draft and the amended interpretation significantly alters the draft recommendations"[i]. Both conditions have been met in this case. The UKCP, along with other stakeholders, identified significant methodological flaws in the draft and offered recommendations for addressing them. In spite of NICE acknowledging the omissions and misinterpretations by issuing a second consultation, it is of huge concern to us that fundamental questions have not been adequately addressed in the revised draft guidelines. In short, our response to this second draft is to call for a full and proper revision of the guideline, reflecting acceptable methodological standards and integrity. We contend that the exclusion of large amounts of data, not least data reflecting the service-user and client experience captured in the medium to longer term, leads to an unreliable guideline that seriously threatens patient welfare. 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:	given the complex nature of this guideline and its associated analyses. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document. Please see below for details of what has happened to the other references that you have provided. • Lindhiem 2014 and Swift 2011 could not be included as the guideline did not investigate the comparison of active choice condition relative to no involvement in shared decision making so these studies did not match inclusion criteria. Patient preference, choice and the principles of shared decision making were considered by the committee during the interpretation of evidence and making the recommendations • Cooper 2017 will be considered for inclusion in the guideline as we update the evidence

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				Patient choice of psychotherapy modalities We would like to see the draft NICE guidance endorse the principle of choice of psychotherapeutic approaches for patients, since there is a significant risk that lack of choice will have a large negative impact on clinical practice. While the draft guidance acknowledges the importance of offering patients a choice of treatments (full version, page 43/ line 5; page 248/line 1), the recommendations themselves do not reflect this principle. Instead, the guidance offered throughout regarding all forms of depression (less severe, more severe, chronic and complex depression) proposes Cognitive Behavioural Therapy (CBT) as the first-line treatment, either alone or in combination with medication. The guidance states that lay members of the Guideline Committee regarded patient choice within treatment type, such as psychological interventions, as being of less concern (full version/page 247/line 25). While we acknowledge the importance of lay opinion, it is not clear why the available clinical research evidence concerning the impact of choice of psychological therapy treatment on outcomes was ignored in this instance. 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	• Lin 2005, Wallace 2013 mediator/moderator analyses are outside the protocol of the review • DeRubeis 2014 and Fournier 2009: Secondary analyses of a study (DeRubeis 2005 – was considered for inclusion in the NMA of treatment for a new depressive episode. However it was excluded from this review as mean duration of MDD >2 years which means that this study is ineligible for this review. DeRubeis 2005 could also not be included in the chronic depression review as no minimum duration of MDD was specified as part of the entry criteria for that trial and it is unclear what proportion of participants in the study would meet criteria for chronic depression) • Huibers 2015: Secondary analysis of a study that was already included in the NMA of treatment for a new depressive episode (Lemmens 2015/2016) • Department of Health 2013, NHS England 2016 has not been included in the guideline because it does not meet the study design criteria (not an RCT or systematic review of RCTs)

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				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). These results are also applicable specifically to the treatment of depression, including persistent sub-threshold and mild depression, as well as more severe depression (Lin et al, 2005; Cooper et al, 2017). Patients' choice of treatment is also important in the light of evidence from several randomised controlled trials (RCTs) 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 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 mental health, consistent with the government's parity of esteem agenda (DH, 2013). We conclude from the evidence cited above that a 'one size fits all' approach involving CBT as the default treatment will seriously compromise patient mental health through its application of an exceedingly limited range of	

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				psychological treatments, despite the evidence for the efficacy of a wider range of treatments. In the light of such evidence, we also regard it as unethical that practitioners should be advised to disregard patient choice among psychological treatments. The guidance therefore challenges the ethical practice of clinicians, compromising the principles of good clinical practice, and reducing opportunities for the achievement of optimal mental health outcomes for patients. 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 psychotherapy as if it were a drug for research purposes when a more appropriate metaphor might be therapy as a dialogue • 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	

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				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 being seriously considered for inclusion in its recommendations. Therefore, this excludes patient choice.	
UK Council for Psychotherapy	Full	General	General	Omission of psychotherapeutic modalities The draft guidance omits reference to certain modalities of psychological therapy, an omission that may negatively impact clinical practice. There is evidence for the effectiveness of various forms of Humanistic and Integrative Therapy, such as Transactional Analysis, Gestalt, Integrative Psychotherapy and Person-Centred Counselling (Van Rijn et al, 2011; Van Rijn and Wild, 2013; 2016; Elliott and Freire, 2010), systemic therapy (Stratton 2011; Pinquart, Oslejsek and Teubert (2016) next to evidence for Short Term Psychodynamic Therapy (Steinert et al, 2017). There is also growing evidence for the use of creative and embodied methods in	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				psychotherapy in modalities such as Dance Movement Psychotherapy and Body Psychotherapy; see for example the Cochrane Reviews by Meekums, Karkou and Nelson (2015) and Aalbers, Fusar-Poli, Freeman, et al (2017), meta-analyses by Koch, Kunz, Lykou and Cruz (2014), Ritter and Low (1996), the new multi-centred RCT from Finland (Hyvonen, Pylvainen and Isotalo (2018) and the RCT in the UK by Röhricht et al, (2013) and Röhricht (2015). Furthermore, evidence suggests that both with generalised psychological approaches to mental health as well with more focused approaches, counselling and psychotherapy are not inferior to CBT (Steinert et al, 2017; Pybis, Saxon, Hill, Barkham, 2017; Ward, King, Lloyd, et al, 2000; King, Marston, Bower, 2014; Saxon, Ashley, Bishop-Edwards et al 2017; Bower, Knowles, Coventry, Rowland, 2011; Freire, Williams, Martina-Messow et al 2015;). Given NICE's endorsement of choice, and the evidence we have cited above on the positive impacts on clinical outcomes, we are extremely concerned that the omission of evidence concerning a broader range of modalities will have a negative impact on clinical practice. NICE has responded to reject our references on the grounds that "they do not meet the study design criterion (not an RCT or systematic review of RCTs)." However, it remains apparent that when the study design criteria are met, in the case for example of the Cochrane Systematic	Please see below for details of what has happened to each reference that you have provided: • Röhricht 2013 RCT was included in the chronic depression review as a result of stakeholder comments in the first consultation • Freire 2015 and Ward 2000 are included in the NMA for treatment of a new depressive episode. • King 2014 could not be included as it is a secondary analysis of a study that was already included in the NMA of treatment for a new depressive episode (Ward 2000) • Bower 2011, Meekums 2015, Koch 2014, Ritter 1996, Steinert 2017, SRs have been checked for any additional relevant studies but none of the studies meet our inclusion criteria • Aalbers 2017 could not be included as music therapy was not prioritised for investigation in the review questions for this guideline • Bentall 2004, Engel 1977, Horwitz 2002, MacFarlane 2008, May 2004, Mirowsky 2003, Mirowsky 2017, Pilgrim 2006, Pilgrim 2009, Pybis 2017, Röhricht 2015, Stratton 2011, Van Rijn 2011, Van Rijn 2013, Van Rijn 2016, Zubala 2015, were not included in the guideline

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				Review by Meekums et al (2015) or the Rohricht et al (2013; 2015) study, evidence is either dismissed or misunderstood, excluding a large number of psychotherapy approaches as recommended treatment options. NICE give no basis to the dismissal of key evidence. We find this especially striking given that specifications in NICE's updated guideline procedures allow for data other than RCTs and meta-analyses to be included (NICE, 2014/2017). Alongside many others writing about the social causes of mental distress (Mirowsky and Ross 2003, Horwitz 2002, Bentall 2004), Pilgrim et al (2009) summarise the strong interdisciplinary case for the importance of personal relationships in both the creation and amelioration of mental health problems. This is in line with the call for widespread adoption of a biopsychosocial model for understanding such experience (Engel, 1977) which NICE appear to have ignored in this guideline. Even NICE (2009:628) recognises: "Despite considerable work on the aetiology of depression including neurobiological, genetic and psychological studies, no reliable classificatory system has emerged that links either to the underlying aetiology or has proven strongly predictive of response to treatment" in addition to the fact that "the construction of 'depression' as a clinical condition is contested amongst GPs (Chew-Graham et al 2000; May et al 2004; Pilgrim and Doric, 2006)" (NICE 2009:99-100)	as they do not meet the study design criterion (not an RCT or systematic review of RCTs). • Elliott and Freire 2010 could not be included because it is a systematic review of systematic reviews rather than an RCT or a systematic review of RCTs. • Hyvonen 2018, Karkou (in preparation), Zubala 2018 and Saxon 2017 will be considered for inclusion in the guideline as we update the evidence • Chew-Graham 2000 could not be included as trials that specifically recruit participants with a coexisting physical health condition are excluded from the guideline. • Cottrell 2003 could not be included as it does not meet age criteria, the guideline restricted to adults

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				As Mirowsky and Ross (2017:31) state, "A person is diseased or not. The disease is malaria or not, cholera or not....A language of categories fits some realities better than others. It fits the reality of psychological problems poorly." As categorisation is at the heart of diagnosis, this gives rise to a significant problem - NICE bases all of its guidelines on evidence gathered around patients who have been 'diagnosed' with the relevant 'condition'; mental health is much more complex than this. Even the Guideline Development Group (GDG) for Depression (NICE, 2009:23-4) "considered it important to acknowledge the uncertainty inherent in our current understanding of depression and its classification, and that assuming a false categorical certainty is likely to be unhelpful and, even worse, damaging." We therefore urge NICE to acknowledge and consider the complexity of mental health beyond simplistic and rigid classifications that require complex interventions that look at the person as a whole. We propose that different models of care are properly evaluated. Pertinent examples, among many, are psychotherapies such as Dance Movement and Body Psychotherapy that incorporate creative and embodied means to achieving mental health and depression, and Family and Systemic therapy that acknowledge and intervene within the wider environment within which mental illness may be generated.	

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				We do know that depression affects a large number of people from diverse socio-political, educational and cultural backgrounds. The prevalence of CBT as a first line treatment for people who may find cognitive and language-based interventions challenging remains an issue that needs to be resolved. Creative and embodied psychotherapy approaches such as Dance Movement Psychotherapy and Body Psychotherapy can be attractive treatment options for those who are unable, unwilling or disinterested in cognitive- and language-based approaches to psychotherapy (Zubala and Karkou 2015; Zubala and Karkou 2018; Karkou, Genetti, Zubala et al, in preparation). Such approaches to psychotherapy could therefore, bypass social or cultural barriers and need to be considered as both a first-line as well as more developed treatment options to save the NHS from wasting time, money and effort on treatment options that are not a good fit for the diverse populations whose mental health needs support. Similarly, it is self-evident that depression would impact on families, carers, and the community concerned. Family Therapists understand this, and work with the whole system as is necessary. When working with adults, it is not sufficient to think only of "the couple" particularly if other generations are involved (children, or grandparents). This point does not seem to have been thought through. Furthermore, MacFarlane (2008) argues that there may be	

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				a strong relationship component to many cases of depression, and that marital and family treatment approaches can be effective interventions. Stratton (2011) showed that evidence supports the effectiveness of systemic interventions either alone or as part of multimodal programmes for, inter alia, "depression". Other supporting evidence can be found in the recent meta-analysis by Pinquart et al (2016). Cottrell (2003) notes that although more research is needed before firm conclusions are drawn, there are possibilities of family therapy being an effective intervention with newer methods of working adding further promise to this approach of addressing the mental health of the individual within their wider familial system. We therefore, strongly recommend that the 'one shoe fits all' approach currently adopted by NICE is radically changed to give way to diverse psychological interventions as the first line of treatment drawing from evidence-based, established and/or promising new treatment options.	
UK Council for Psychotherapy	Full	General	General	Over reliance on RCT evidence The guidance also 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 the guidance is based on.	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not

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				The recommended psychological treatments for depression are derived from a narrow consideration of what constitutes appropriate evidence, namely RCTs and meta-analyses. We 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 of populations that clinicians do not typically encounter. As such, the guidelines cannot be regarded as ethically sound, since conclusions drawn from a broader range of evidence involving patients more typically seen in primary and secondary care leads to alternative recommendations for practitioners to implement. The most significant of these conclusions concerns CBT as the first line treatment when there is recent evidence of the efficacy of other psychological approaches such as psychodynamic psychotherapy (Steinert et al, 2017), humanistic and integrative (Van Rijn et al, 2011; Van Rijn and Wild, 2013, 2016), creative and embodied approaches such as dance movement psychotherapy and body psychotherapy (Meekums et al, 2015; Aalbers et al, 2017; Koch et al 2014) and family/systematic therapies (Stratton 2011; Pinquart et al 2016) as argued above. While RCTs have the advantage of controlling for extraneous factors that affect the conclusions that can be drawn concerning the causal effects of psychological	fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document. Please see below for details of what has happened to each reference that you have provided: • Bower 2011, Meekums 2015, Koch 2014, Steinert 2017, SRs have been checked for any additional relevant studies but none of the studies meet our inclusion criteria • Aalbers 2017 could not be included as music therapy was not prioritised for investigation in the review questions for this guideline • Hepgul 2016, Kessler 2003, Lamers 2011, Moffitt 2007, NHS Digital 2017, Pybis 2017, Seligman 1995, Stratton 2011, Van Rijn 2011, Van Rijn 2013, Van Rijn 2016 were not included in the guideline as they do not meet the study design criterion (not an RCT or systematic review of RCTs). • King 2014 could not be included as it is a secondary analysis of a study that was already included in the NMA of treatment for a new depressive episode (Ward 2000) • Saxon 2017 will be considered for inclusion in the guideline as we update the evidence

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				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). For example, Hepgul et al's (2016) study of patients accessing 'Improving Access to Psychological Therapies' (IAPT) services found that as many as 72% met the criteria for two or more diagnostic conditions, with depression and anxiety being the most common co-occurring disorders. Patients seen for depression in primary and secondary care settings are clearly more complex than those that the NICE evidence base draws on. It is questionable therefore, as to how far the findings from the trials used as evidence by NICE can be applied to the clinical populations typically presenting with depression. Evidence from a broader spectrum of studies needs to be taken into account, since results from RCTs may have limited application in real word practice settings. Furthermore, evidence from IAPT, generated in real world practice settings with large samples of patients with and without comorbidities, with the statistical power to control for extraneous variables, leads to different conclusions	

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				regarding the appropriateness of CBT as the first-line treatment. For example, psychodynamic psychotherapy has been shown to have equal efficacy to CBT in actual clinical practice according to metrics used by the NHS. The IAPT dataset shows that both modalities have a recovery rate of 45.9% for depression. However, psychodynamic psychotherapy achieves this result, on average, with slightly fewer sessions (NHS Digital, 2017). Similar results can be seen for other generalised psychological approaches to mental health as well for those with more focused attitude; evidence suggest that counselling and psychotherapy are not inferior to CBT (Steinert et al, 2017; Pybis, Saxon, Hill, Barkham, 2017; Ward et al, 2000; King et al, 2014; Saxon et al, 2017; Bower et al, 2011). It appears that NICE disregards it in order to adhere to a potentially flawed commitment to RCT evidence focussed 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, then other kinds of research evidence need to be reconsidered 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	

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				the hook" (Hill, 1965:108). While NICE recognises that there are problems with RCTs, especially for psychological therapies, it is suggested that Guideline Development Groups (GDGs) 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) which all GDGs rely on: "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." This is not to say that RCTs can never be valid, but it is flawed to assume 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 important though randomisation within 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	

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				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 in teasingly only NICE-approved manualised treatments are available for selection. NICE RCT results cannot be generalisable. Clients typically have 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. While there are broadly two traditions of thought informing vocational practice in the UK – Postivistic-Utilitarian (the one espoused in NICE and IAPT) 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.	

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				It is therefore recommended 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.	
UK Council for Psychotherapy	Full	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 as part of personalised medicine for treatment of physical ill-health is a principle which 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 reviewed here which shows higher completion rates and superior clinical outcomes. We therefore suggest that this principle is applied to mental 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 CBT being the default, and that a wide range of psychological	

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				therapies become an integral part of this choice, given the evidence of their efficacy (see submitted evidence). We believe our suggestions are a better and more cost-effective way of improving access.	
British Association for Counselling & Psychotherapy	Full	General	General	Context of response: BACP have prepared this response to the exceptional 2018 second consultation on the revised *Guideline for Depression in Adults: Treatment and Management*, in our role as a professional body for UK counsellors and psychotherapists. As the largest British professional body for those providing psychological therapies and as laid out in our mission statement (https://www.bacp.co.uk/about_bacp/) we aim to campaign for the highest standards of care for those experiencing 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 depression. This commitment reflects the considerable evidence of broad equivalence between 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 improve treatment outcomes (Lindhiem, Bennett, Trentacosta, & McLear, 2014; Williams et al., 2016).	Thank you for your comment and providing this information about BACP. We have responded to your comments as they occur. Please see below for details of what has happened to the other references that you have provided. • Gyani 2013, Pybis 2017, Stiles 2006, Stiles 2008 have not been included in the guideline because they do not meet the study design criteria (not an RCT or systematic review of RCTs) • Lindhiem 2014 could not be included as the guideline did not investigate the comparison of active choice condition relative to no involvement in shared decision making so these studies did not match inclusion criteria. Patient preference, choice and the principles of shared decision making were considered by the committee during the interpretation of evidence and making the recommendations

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				It is important to note that this means that BACP has a commitment to support choice for all evidence-based therapies and as such welcomes the recommendations in the draft Guideline for the three main modalities practiced in the UK, namely Cognitive Behavioural Therapy (CBT), Psychodynamic Psychotherapy, and what is termed in the Guideline 'Counselling'. This second consultation response however focusses predominantly on counselling.	
British Association for Counselling & Psychotherapy	Full	General	General	Preparation of this response: This document was prepared by members of the BACP Research Department and draws on feedback on the draft Guideline from senior counselling and psychotherapy academic researchers in the UK and beyond. The document also draws on further review by an academic team independent of both NICE and BACP that was specifically commissioned by BACP to review the revised network meta-analysis that informed the revised Guideline.	Thank you for your comment and detailing who was involved in preparing your response.
British Association for Counselling & Psychotherapy	Full	General	General	Length of consultation period: We welcome the provision of an exceptional 2nd consultation period however we wish to state again our view that the time provided for making a response is insufficient to allow a proper scrutiny of the documents given their length (over 800 pages for the main report, over 800 pages for the response to the consultations plus hundreds of further pages in the appendices) and the great complexity of the analyses conducted.	Thank you for your comment. Section 10.3 of Developing NICE guidelines: the manual specifies that when, in exceptional circumstances, a second consultation may be needed "...NICE may consider the need for a further 4 week stakeholder consultation... ' The timeframe for this 'exceptional' consultation was therefore in line with this. Developing NICE guidelines: the manual is regularly updated and consulted upon.

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				We suggest that the limited time for document review undercuts the very purpose of the consultation, which is to allow NICE to benefit from robust stakeholder feedback. We would recommend that the length of a consultation period should not be standardised but flexible to accommodate for documents of great length/analytic complexity as well as in contexts where the outcomes have huge import for the population, as in the case of this guideline on depression.	
British Association for Counselling & Psychotherapy	Full	General	General	Insufficient consideration of potential negative workforce impacts: The issue of appropriate time to respond to NICE consultations is particularly key in contexts where the guideline may have negative impacts on segments of the workforce. BACP maintains in the strongest possible terms that detailed scrutiny of not only the evidence but the methods utilised is critical because historically the NICE Guideline for depression in adults has been significantly influential in shaping service delivery, in particular in England. As described by Clark (2011), the NICE recommendations for depression from 2004 onwards contributed to the development and roll-out of the Improving Access to Psychological Therapies (IAPT) programme, which in England and Wales now provides the bulk of treatment for depression in primary care (Gyani, Pumphrey, Parker, Shafran, & Rose, 2012). Indeed NICE's response to stakeholder feedback includes the statement: "The IAPT programme has been central to the implementation of NICE recommendations on treatment of depression" (p170 of the consultation comments and responses document). As we	Thank you for your comment and for drawing our attention to the Clark (2011) citation. Section 10.3 of Developing NICE guidelines: the manual specifies that when, in exceptional circumstances, a second consultation may be needed "...NICE may consider the need for a further 4 week stakeholder consultation... ' The timeframe for this 'exceptional' consultation was therefore in line with this. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				stated previously, a key impact has been in terms of workforce makeup and numbers overall. In BACP's previous consultation response we pointed out the significant negative impact prior NICE guidelines have had on the counselling workforce as result of counselling being recommended as a second-tier treatment. The response to the point made by NICE was: "As you point out there has been significant expansion in IAPT workforces, and a significant number of counsellors will be employed in that service" (p170, NICE comments and responses document). This response constitutes a wholly dismissive response the concerns that BACP is raising about the potential negative impact of the NICE guideline on one sector of the mental health workforce. These concerns rightfully require that BACP raise concerns over the limited time available to respond; in our view the lack of time to provide a very detailed response means that NICE has failed to facilitate a rigorous response to the consultation and in doing so has not acted in the best interests of the public.	
British Association for Counselling & Psychotherapy	Full	General	General	*Failure to include large standardised routine datasets:* The existing analysis still privileges RCT evidence and fails to consider evidence arising from the IAPT dataset, a routine outcomes dataset which shows how those with depression fare in response to NHS primary care treatment. Note that this is not an argument to abandon RCT/NMA analyses but to consider their results alongside those from relevant	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not

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				routine outcome datasets. As NICE state in their stakeholder responses: "The IAPT programme has been central to the implementation of NICE recommendations on treatment for depression" (p170 of consultation comments and responses document). The aim of the NICE guideline is to improve treatment of depression in NHS primary care and the IAPT database provides the key (and only) evidence of how actual NHS patients with depression have responded to the treatment recommendations of the 2009 NICE depression guideline, in other words how NICE recommendations work in clinical reality. To ignore this hugely pertinent data is thus extraordinary. Further while the key analysis used to derive the recommendations of this guideline, the NMA, consists of a sample of "several thousand" (p117, of consultation comments and responses document) this dataset comprises over half a million per year. The idea that the guideline committee members' understanding of "the 'reality' for people experiencing depression" (p116, of consultation comments and responses document) can substitute for the evidence from millions of actual NHS patients is absurd and, the fact that this is considered justification to ignore this practice-based evidence, illustrates the failure to consider in any serious way this point raised by BACP. Similarly, the justification given to ignore these datasets that: "we cannot be sure that the populations treated with various interventions are the same and to assume so would be potentially misleading" (p117, of consultation	fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document. Please see below for details of what has happened to the other references that you have provided. • Barkham 2017, Gyani 2013, NHS Digital 2014/2015/2016, Pybis 2017 have not been included in the guideline because they do not meet the study design criteria (not an RCT or systematic review of RCTs)

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				comments and responses document) is also unconvincing; it is clearly very important to establish how the populations treated in the NHS respond to NICE recommended treatments and the use in IAPT of the PHQ-9 (one of the instruments in the NMA analyses conducted) provides a useful point of read-across to consider diagnostic equivalence with the populations considered in the NMAs. The IAPT dataset also allows consideration of whether different care pathways do, as claimed in the NICE stakeholder response, provide evidence for the idea that IAPT populations are different: "For example a large proportion of people receiving CBT for depression have been "stepped up" from a low intensity intervention. In contrast a large proportion of people receive counselling as their first line intervention" (p251, of consultation comments and responses document). In contrast to this statement, the most recent IAPT annual report, *Psychological Therapies Annual Report on the Use of IAPT Services, further analyses on 2016-2017,* (NHS Digital, 2018) evidences that there is not a big difference between counselling and CBT in terms of pathway, with 41% of 'Counselling for depression' clients and 36% of CBT clients receiving these respective therapies as their first and last intervention (Table 4c); in other words the most recent publicly available data suggests similar care pathways. Overall the arguments made to ignore this critical source of data on NHS primary care mental health treatment are not convincing. This is troubling since evidence from the	

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				IAPT dataset is that counselling is as effective as CBT as an intervention for depression (Barkham et al, 2017). Existing evidence from IAPT annual reports (NHS Digital, 2014, 2015, 2016) demonstrates that patient recovery rates have been virtually equivalent between CBT and counselling (Barkham et al., 2017). Research on different portions of the IAPT dataset in relation to the treatment of depression have reported comparable outcomes between CBT and counselling (Gyani et al, 2013; Pybis et al, 2017). Given this, it is our view that IAPT data now needs to be considered alongside evidence from trials to form a more complete and accurate assessment of the comparative effectiveness of psychological therapies.	
British Association for Counselling & Psychotherapy	Full	General	General	Approach to consideration of NMA analyses in Revised Guideline: The following sections focus on the issues of concern in the network meta-analyses as this analysis was the key evidence the Guideline Committee used to draw up their recommendations. While not the focus of this stakeholder response, it is acknowledged that the NMAs conducted had many strengths, including: the attempt of limiting clinical heterogeneity by stratifying the population, the careful statistical modelling, the use of multiple outcomes, the conduct of several sensitivity and moderator analyses, and the careful interpretation of the statistical results.	Thank you for your comment and for acknowledging the strengths of the NMAs produced for this guideline.

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British Association for Counselling & Psychotherapy	Full	General	General	Inconsistency BACP's prior consultation response identified concerns with a number of aspects of the homogeneity of the NMA analyses. It is our view that in the revised Guideline, there remain important questions about homogeneity, which is important as another key assumption of network meta-analysis which, if violated, impacts the credibility of the NMA findings. These concerns are further detailed below. *Global inconsistency:* The Revised Guideline authors attempted to limit statistical heterogeneity through defining clinically fairly homogeneous populations, treatments, and treatment classes, as well as through performing sub-analyses, which can be considered an adequate strategy. However, several estimates showed statistical heterogeneity, which limited the possibilities of testing inconsistency. In some cases, inconsistency was detected. It is reported that both heterogeneity and inconsistency were considered by the Guideline Committee in making recommendations but it remains unclear, how this was done exactly. *Local inconsistency* It is stated that "a local assessment of inconsistency was not practical to do for all comparisons due to the size and complexity of the networks" and that "it would produce a very large amount of comparisons to analyse and interpret, leading to a very high risk of finding spurious results". It would definitely be tedious and produce a large amount of information to evaluate.	Thank you for your comment. Please see our related response to your concerns about homogeneity. The committee considered the heterogeneity and evidence for inconsistency across all analyses when interpreting the results and when making recommendations. The impact of heterogeneity and evidence for inconsistency on committee decisions is reported under 'From evidence to recommendations' sections and under 'Quality of evidence' of the second consultation draft. It is not true that assessing for global inconsistency means that we cannot draw conclusions on local inconsistency. The terms "local" and "global" inconsistency refer simply to the methods for testing inconsistency. Both methods rely on relaxing the consistency assumption for one or all loops in the network, so both methods aim to assess the same thing (i.e. the failure of the consistency assumption in a statistical sense). Finding no evidence of global inconsistency is reassuring as it means there is no evidence that the consistency assumption fails to hold across all loops. Local tests could be run in addition, although in networks of this size it is highly likely that spurious results would be found, due to multiple

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				However, ignoring this issue completely means that for all local pairwise comparisons and rankings of treatments, consistency of the evidence is assumed, with very weak empirical support from global and practically almost inevitably underpowered inconsistency tests. *Difficulties in testing inconsistency:* It is apparent in the Revised Guideline that the limitations of comparing pharmacological with psychological treatments and the presence of a pharmacological and a psychological subnetwork were acknowledged. However, the fitting of complex and unusually innovative (or innovatively unusual) statistical models (e.g., classes to connect otherwise unconnected nodes, borrowing evidence or using informative priors when it is necessary), only to ignore, or at least seriously downplay, their results during interpretation is not an easily comprehensible strategy. Keeping the subnetworks separated from the beginning and admitting that they cannot be compared statistically due to diverse populations and treatments might have led to somewhat clearer and more transparent findings.	testing which would then be over-interpreted and unhelpful. Complex statistical models were required to combine the evidence of a complex dataset, comprising 366 trials of 118 interventions in the second consultation draft. Assessing each of the interventions independently was infeasible and interpretation of the results would be very complex. Class models allowed consideration of a neater number of treatment options and, as you note, allowed connection of otherwise unconnected nodes so that no piece of evidence was ignored; moreover, it improved precision of effects by allowing strength to be borrowed across interventions in the class. Use of informative priors was very limited and only where it was needed, and was applied as suggested in the NICE Decision Support Unit technical support document 2. The committee considered the similarities and differences of populations in pharmacological and psychological trials, after categorising by level of symptom severity, and agreed that populations were similar enough to be included in the same network meta-analysis. The results of the NMAs, including indications of heterogeneity, inconsistency or bias due to small study size were transparently reported. The NMA findings were not

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					ignored or seriously downplayed, unless there were serious concerns. Limitations are present in any method of analysis of trial data, so that results need to be interpreted accordingly. The committee considered all characteristics and limitations of the NMAs and their impact on the results, together with other factors, such as the quantity and quality of the evidence base, cost effectiveness, anticipated harms, treatment acceptability and compliance, patient characteristics and preferences when making recommendations.
British Association for Counselling & Psychotherapy	Full	General	General	Transitivity In BACP's prior consultation response, concerns were raised about the third key assumption of network meta-analysis is transitivity (sometimes termed similarity). The role of transitivity is addressed more clearly in the Revised Guideline, particularly in the "Evidence to recommendation" sections (7.4.5, 7.7) however, the issues raised around "Inconsistency" (see above) apply here as well. In particular the presence of two sub-networks of primarily psychological and primarily pharmacological interventions, means that transitivity of the analysed networks can certainly be questioned.	Thank you for your comment. Quantitative appraisal of transitivity of the results was done using inconsistency checks. We agree that assessment of transitivity also needs qualitative appraisal. The committee considered the similarities and differences of populations across trials included in each level of severity and agreed that populations were similar enough to be included in the same network meta-analysis and the same decision problem. If populations in pharmacological, psychological and self-help trials were considered to be systematically different from each other, then it would also be incorrect to consider these interventions as alternative treatment options in the same decision problem and conduct pairwise meta-analysis to inform

					decisions. It is acknowledged that individual treatment preferences may differ across trials (so that a person that accepts to participate in a trial of A vs B may not accept to participate in a trial of A vs C or a trial of C vs D), but this cannot be checked systematically. Preference for a treatment is a potential effect modifier that cannot be easily controlled when synthesising evidence from multiple RCTs and interventions, regardless of the topic area and the method used for evidence synthesis (i.e. NMA or pairwise meta-analysis). Therefore, heterogeneity of the population in this aspect would also be a concern had we conducted pairwise meta-analysis. The NMAs have assumed that service users are willing to accept any of the interventions included in the analyses. The fact that "treatment decisions may be influenced by individual values and goals, and people's preferences for different types of interventions" has been acknowledged during guideline development and was taken into account when making recommendations. The committee noted the presence of two sub-networks of primarily psychological and primarily pharmacological interventions in a number of outcomes in more severe depression in the second consultation draft (response in completers, remission in those randomised, remission in completers). They noted the sparseness of the overall networks and the connection of the two sub-

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					networks by studies comparing psychological with pharmacological interventions which showed very large benefits, resulting in one part of the network (psychological interventions) showing very large effects versus the other part of the network, which consisted of drugs and pill placebo (interestingly, the 'problematic' results in these networks were created by RCTs comparing pharmacological versus psychological interventions). These observations were taken into account by the guideline committee when making recommendations. Notably, following interpretation of these results, the Guideline Committee did not prioritise psychological over pharmacological treatments (or vice versa) for recommendations in adults with more severe depression. Please also refer to our responses to your comments about 'inconsistency' and 'homogeneity of populations'.
British Association for Counselling & Psychotherapy	Full	General	General	Judgements related to rankings of treatments In the Revised Guideline less emphasis was placed on rankings of treatments which BACP raised as a concern in our prior consultation response.	Thank you for your comment and your support.
British Association for	Full	General	General	*Overall concerns about the economic analysis:* Concerns were raised by BACP in the previous consultation response about the validity of the economic analysis. Adding the	Thank you for your comment. We believe that the structure of the economic models on the treatment of new episodes of depression was balanced, so

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Counselling & Psychotherapy				complexity of economic models to the complexity of the underlying network meta-analyses may render virtually any output highly uncertain. Even the authors of the Revised Guideline repeatedly state that the encountered complexities and limitations apply to most network meta-analyses (and economic analyses building upon them), this makes only clear that they are frequent, but does not invalidate the concerns resulting from them. Overall, our conclusion is still that the results are potentially misleading and that the cost effectiveness of counselling as an intervention for depression in adults is not appropriately represented.	as to incorporate events such as treatment discontinuation, response to treatment, remission and relapse, which are major events in the course of depression (and which we considered to be essential components of the model structure), without introducing unnecessary levels of complexity or, conversely, producing a model that was too simplified to adequately represent the course of depression. The probability of each of the modelled events for every intervention was informed by respective guideline NMAs. This was necessary because we were comparing more than two treatment options. NMA allowed simultaneous inference on the relative effectiveness and acceptability of all interventions connected in a single network, which, subsequently, informed the guideline economic analyses. In contrast, a pairwise meta-analysis approach would only allow estimation of the relative effects of pairs of treatment options, which could then inform 'pairwise' economic analyses that would assess the relative cost effectiveness between pairs of interventions, isolated from the range of other interventions that are part of the decision problem. This approach would not be useful when making recommendations. Hence, we believe that the economic analyses were characterised by a reasonable level of complexity (regarding the structure, assumptions and NMAs that informed it)

					that allowed consideration of the treatment course of multiple interventions that were part of the decision problem. The full methods of the economic analysis on treatment of new episodes of depression are clearly described in Chapter 14, including a summary of the limitations of the NMAs that informed the economic analysis, the methods of validation of the economic model, and a detailed discussion of the strengths and limitations of the analysis. We note that a similar approach was also followed for the economic models assessing interventions for relapse prevention [chapter 13]. The strengths and limitations of the NMAs and the economic analyses, including any uncertainty characterising the results, were taken into account by the guideline committee when making recommendations. We note that recommendations were not exclusively based on the results of the NMA and economic analysis (including any secondary/sensitivity analyses); other factors, such as the uncertainty and the limitations characterising the results, the breadth of the evidence base for each intervention, previous history of people with depression, the potential risk of people with less severe depression to develop more severe depression, patient preferences and patient characteristics were also taken into account when making recommendations, and this is reflected both in committee considerations and the recommendations themselves. We are not aware of any issue in the NMAs or the model structure

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					that might potentially bias results against counselling, except your concern regarding the salary scale of practitioners delivering counselling – please refer to our response to your related comment regarding this issue.
British Association for Counselling & Psychotherapy	Full	General	General	Concerns around assumption of grade equivalence for mental health practitioners in the economic analysis: In BACP's prior consultation response we raised concerns about the fact that the economic analysis is based on the assumption that all psychological therapies are delivered by practitioners who are on the same pay scale as a band 7 clinical psychologist. This is not correct, many counsellors and psychotherapists delivering psychological therapies at step 3 within IAPT services and more broadly within the NHS are working at band 6, which makes them considerably more cost effective than this analysis would suggest. The NICE response to this concern was to argue that the assumption was justified as it reflected: "variations in clinical practice, rather standard, optimal practice for the delivery of counselling in the UK, hence the results based on these scenarios were not deemed to reflect the cost effectiveness of counselling across UK routine practice" (NICE consultation comments and responses document, p472). However, we would argue that this issue, as it pertains to counsellors in particular, is not about 'optimal' practice but about the reality of service delivery and the fact that counselling is, in general, not a post-graduate qualification, in contrast to the majority of CBT and psychodynamic qualifications.	Thank you for your comment. As per our response to your previous comments, the committee acknowledged that psychological interventions can be delivered by appropriately trained Band 6 or Band 5 therapists in some settings. However this is not standard practice across interventions and settings. Therefore, delivery of interventions by therapists of a lower salary band was only tested in sensitivity analysis.

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				On this basis, BACP would argue that the hourly costs of counselling are systematically lower than those for other psychological interventions and that as a result the relative cost effectiveness of counselling is underestimated.	
UKPCE	Full	70- 102-		We welcome the qualitative research undertaken although there seems to have been little by way of new qualitative research added to the review. We wish to draw attention to how counselling services, as a matter of course, receive written feedback from clients in regards to their experience of receiving counselling. This evidence could be a great resource for understanding the impact of PCE-CfD. Given there are numerous services with in-house PCE therapists, recovering this data would have been easily executed and would provide a more rounded qualitative perspective of the impact of PCE-CfD. The qualitative research on ECT indicates no benefit at all from clients, yet ECT receives more prominence in the report than counselling. This does not appear just.	Thank you for your comment. The patient experience section was not included as part of this update (as specified in the guideline scope). Therefore the evidence in this area (including identifying qualitative evidence on the impact of PCE-CfD) has not been reviewed and the text has not been updated.
UKPCE	Full	678- 680-		As referred to in comment 5 above, by limiting the paradigm, clients are frequently undermined if they believe there is a 'cure' as is implied by depression being characterised as an illness. It removes the capacity of the individual to recognise the processes they are going through as a natural response and reaction, admittedly often with an overwhelming and distressing impact. Despite the case that for some, perceiving it as an illness	Thank you for your comment. We do not agree that "an illness paradigm" is something that is commonly adopted by individuals providing treatment for depression. The approach adopted by many professionals, and the one use in this guideline, is one of collaborative assessment and determination of the most appropriate treatment, given the evidence for its effectiveness and an

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				may be helpful, for others we consider the illness paradigm prevents engagement through PCE-CfD with a focus on emotions and the resulting opportunity to process their distress.	individuals' past experience and hopes for future treatment.
UKPCE	Full	General	General	When Lord Layard announced the government investment into psychological therapies for depression, counselling was originally omitted as a psychological approach. As a result of the feedback by BACP, person-centred experiential therapy (PCET) was included and named 'CfD': Counselling for Depression. For clarity we have advised CfD is renamed PCE-CfD so it describes what is being offered. The guidelines, as they stand, do not acknowledge the progress made by PCE-CfD over the last five years. Five, high quality, regionally approved providers, at centres of excellence for the approach and quality assured by the professional body BACP, have been providing PCE-CfD practitioner and supervisors training over the last six years. The feedback received from service providers is consistently very positive and client outcomes (as reported through IAPT National MDS data) are also very favourable. PCE-CfD supervisors are trained to ensure the continuing fidelity of the approach. Counselling has always been a popular resource in GP services and its place in IAPT has been important so that a counselling presence in NHS services remains. Clients frequently ask for counselling, a non-medical approach, as opposed to pharmacology or cognitive behavioural therapy. Investment in counselling, through IAPT, is	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				relatively new and represents 1% of the entire IAPT budget. We are building up research and appreciate that published papers are the way committees access peer reviewed research and evidence. We are confident that over the next 5 years the research evidence for PCET will have increased. We urge you to recommend that PCE-CfD (presently known as CfD) remains as a NICE recommended approach for people struggling with depression. This link takes you to a meta-analysis conducted in 2008 https://www.pce-world.org/about-pce/articles/102-person-centredexperiential-therapies-are-highly-effective-summary-of-the-2008-meta-analysis.html We ask you to include the real world UK data provided by the analysis of IAPT MDS scores that showed equivalence between CfD and CBT, and again that the name is updated to be more accurate and cohesive, making research much more retrievable- Person-centred experiential counselling for depression.(PCE-CfD) We have the agreement of all the providers of the approach, the agreement of the BACP and the acceptance by the IAPT education lead that this would be a positive step.	
Parkinson's UK	Full	general	general	For people with Parkinson's with a diagnosis of depression it is important that both their physical and mental health needs are considered together. There are associated effects on cognition, the side effects of medication and ongoing psychological adjustment to living with a long-term condition. (All-Party Parliamentary Group on Parkinson's (2018) – 'Mental health matters too –	Thank you for your comment. This guideline is about the treatment and management of depression in adults. People with depression and a chronic physical health problem, such as Parkinson's, are not within the scope of this guideline. Therefore it is not possible to make

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				Improving mental health services for people with Parkinson's who experience anxiety and depression'). We know that people with Parkinson's not only develop depression as a consequence of adjusting to a long-term condition but also because of integral changes to the production of dopamine and its impact upon other neurotransmitters regulating mood (ibid). We do not feel that the NICE guidance on 'Depression in adults: treatment and management' is sufficient for people with Parkinson's experiencing depression. We recommend the guideline includes more information on adaption of therapies for people with Parkinson's for example for those who experience difficulties with writing or verbal communication, support adjusting to living with a long-term physical condition and information on medication management. This is partially addressed in the NICE guidance on 'Depression in adults with a chronic physical health problem' [CG 91] but does not give adequate guidance around how best to manage mental health alongside Parkinson's.	recommendations for people with Parkinson's in this guideline.
Association for Dance Movement Psychotherapy UK	Full	General	General	The Association of Dance Movement Psychotherapy UK (ADMP UK) has a membership of qualified dance movement psychotherapists who deliver creative and embodied psychotherapy for a wider range of client populations in diverse settings (ADMP UK, 2018; Karkou 2017). One area of work where a number of our practitioners work is depression as we can see in research studies by Zubala and Karkou (2015) and Zubala and	Thank you for your comment and for drawing our attention to the ADMP UK (2018) and Karkou (2017) citations. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence included within the guideline. Consequently all of the analyses within the

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				Karkou (2018). Dance movement psychotherapists are currently registered with UKCP as a creative/embodied form of psychotherapy and is largely recognised as one of the arts psychotherapies, next to music, drama and art psychotherapy. Note: the discipline can also be found as dance movement therapy, dance therapy or movement psychotherapy. Given the relevance of depression as an important area of work for our members, we do welcome the new draft guideline on depression. This second document acknowledges that the first draft guideline needed to be reconsidered. However, we are seriously concerned by the fact that these new revisions remain limited. While the Guideline Development Group (GDG) for this particular NICE guideline appear to adhere to a rigid preference for meta-analysis, systematic reviews and RCTs, at the same time they demonstrate bias and selective application of their own methodology. We therefore, request that: 1. Existing evidence in dance movement psychotherapy is taken into account, translating it to usable recommendations in the treatment of depression on all levels of care. 2. A wide range of studies are considered that respond to both the complexity of the intervention along with patient opinion and preferences. We believe that this guideline, if not substantially revised, will have a direct and devastating impact upon patient care.	guideline will be updated and the wording of recommendations reviewed in light of this updated data. Please see below for details of what has happened to each reference that you have provided: • Zubala 2015, was not included in the guideline as it does not meet the study design criterion (not an RCT or systematic review of RCTs). • Zubala 2018 and Saxon 2017 will be considered for inclusion in the guideline as we update the evidence

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				For this reason, we raise our serious concerns and urge NICE to re-consider existing evidence, open up its methodology to include a wider range of study designs, clinical knowledge and client choice. We are also submitting new evidence for consideration that has emerged since the last consultation. Our main argument here is that dance movement psychotherapy should be recommended as one of a range of different forms of creative, arts-based and embodied psychotherapies at different stages of care. 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 should be at the heart of this NICE guideline and although it should not be as challenging to implement, it will be the one that will have the largest impact on practice. Regarding the second question: Would implementation of any of the draft recommendations have significant cost implications? we argue that:	

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				Continuing to ignore patient choice will have detrimental effect on both their mental and physical health and will have serious cost implications. Rectifying this will be cost effective. Regarding the third question: What would help users overcome any challenges? In the first instance this NICE guideline needs to be changed to allow for diverse psychological options, while appropriate information of the different modalities including dance movement psychotherapy needs to be included on all levels of care including primary care. References: Association of Dance Movement Psychotherapy UK (ADMP UK) What is dance movement psychotherapy. Retrieved 07/06/18 from: https://admp.org.uk/dance-movement-psychotherapy/what-is-dance-movement-psychotherapy/ Karkou, V. (2017). Explainer: What is dance movement psychotherapy? The Conversation. Retrieved December 06, 2017 from https://theconversation.com/explainer-what-is-dancemovement-psychotherapy-79860. Zubala A and Karkou V (2015) Dance movement psychotherapy practice in the UK: Findings from the Arts	

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				Therapies Survey 2011, The Body, Movement and Dancing in Psychotherapy, 1 10, 21-38. Zubala A and Karkou V (2018) Arts Therapies in the Treatment of Depression: International Research in the Treatment of Depression. London: Routledge.	
Association for Dance Movement Psychotherapy UK	Full	general	general	Studies considered by NICE following the previous round of consultation but not taken on board Röhricht F, Papadopoulos N, & Priebe S. (2013). An exploratory randomized controlled trial of body psychotherapy for patients with chronic depression. Journal of Affective Disorders, 151, 85-91. The pilot study by Röhricht et al (2013) pilot RCT has now been included in the chronic depression section of the review. However, no recommendation is made based on this study. (Note: this study involved dance movement psychotherapists in the manualisation process of the intervention and was delivered and supervised by dance movement psychotherapists.) There is no sufficient explanation of why findings from this study have not led to dance movement psychotherapy (and body psychotherapy) being included as a recommended treatment option. 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.	Thank you for your comment. Meekums 2015, Koch 2014 and Ritter 1996 reviews could not be included in their entirety as our inclusion criteria did not match, this is why they are not referenced in the guideline. These reviews were checked for any additional relevant studies but none of the studies met our inclusion criteria. It would not be appropriate to incorporate any sub-analyses from these reviews given that the inclusion criteria of our review is not sufficiently similar. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009895.pub2/epdf. According to NICE, Meekums, Karkou and Nelson (2015) Cochrane Systematic Review has been checked, but, again no recommendations are made based on this review (and no reference is made to this review on the actual guideline). Furthermore, subgroup analysis that has taken place as part of the Cochrane review has not been considered, dismissing the second study by Xiong et al (2009) on the basis that it is not published in English. The NICE authors do not consider the fact that this study was translated in English by the Cochrane review team, which, following a subgroup analysis that combined this study with the study by Rohricht et a (2013), produced some modest but useful results. We are therefore, concerned that both results from Cochrane Reviews, the most rigorous of the systematic reviews available, along with both of the RCTs for adults with depression cited in this review were, essentially, ignored. Koch S, Kunz T, Lykou S and Cruz R (2014) Effects of dance movement therapy and dance on health-related psychological outcomes: A meta-analysis, The Arts in Psychotherapy, 41, 46-64. http://www.sciencedirect.com/science/article/pii/S0197455613001676	

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				The meta-analysis by Koch et al (2014) that looked at the effectiveness of dance movement therapy and dance from 23 primary trials (N = 1078) was equally dismissed. This study, included, apart from other findings, a sub-analysis on depression and anxiety and suggested that dance and dance movement therapy interventions showed moderate effects for depression and anxiety, with an overall moderate pooled effect on interpersonal competence, a skill that can be developed primarily within a non-verbal intervention such as this; poor relationships are often cited as one of the main reasons for depression. Ritter, M. & Low, K. G. (1996). Effects of dance/movement therapy: A meta-analysis. The Arts in Psychotherapy, 23, 249–260. http://www.sciencedirect.com.edgehill.idm.oclc.org/science/article/pii/0197455696000275 Ritter and Low (1996) report on a meta-analysis of 23 studies on dance/movement therapy for a number of different client groups. 781 clients were included in total. An array of benefits from dance/movement therapy were reported in these studies including improvements in motor skills, body awareness, muscle control and balance, special awareness, attention, participation and relaxation, as well as expressivity	
Association for Dance	Full	general	general	New multi-centred RCT	Thank you for your comment. Following feedback from stakeholders, the guideline committee and

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Movement Psychotherapy UK				Hyvonen, K Pylvainen P, Isotalo E and Lappalainen R (2018) Dance therapy in the treatment of depression: Preliminary results, University of Jyvaskyla, Psychology Department: https://www.jyu.fi/psykologia/tanssi-liiketerapia This is a new multi-centred RCT on dance therapy for depression that was conducted in different settings across Finland. The study is based at the University of Jyvaskyla, Department of Psychology, funded by KELA, the Social Insurance Institution of Finland, that provides social security coverage for Finnish residents and operates under the supervision of the Finnish Parliament. The study only recently got completed and for this reason it was not submitted in the previous round of consultation. It adopted a cross over design that involved a total 100 people (50 clients attended group dance movement therapy in the first instance while 50 clients entered the waiting list control group that received the intervention at a later stage). The group size was 6-8 participants. A structured group process was followed for 20 sessions (75 min long each session), meeting twice a week. The facilitators of the groups were all trained dance movement psychotherapists, offering opportunities to participants to deal with issues of depression through movement interaction. Calculations of the results are currently underway. Initial results suggest that on the Beck Depression Inventory, there are statistically significant changes in the	NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				intervention groups with clinical significance favouring this intervention. Statistical differences between the dance movement therapy groups and the control groups on the end mean scores are also reported. Finally, members of the intervention groups scored positively on psychological resources by the end of their participation in dance movement therapy: they were more able to enjoy their regular daily activities, they were more active, presenting a degree of vitality, while reported feeling hopeful for the future.	
Association for Dance Movement Psychotherapy UK	Full	general	general	Omitted studies in Dance Movement Psychotherapy The following studies need to be considered if a less rigid methodology is followed by NICE on this particular guideline (as adopted in other NICE guidelines): Pylvänäinen, P. M., Muotka, J. S., & Lappalainen, R. (2015). A dance movement therapy group for depressed adult patients in a psychiatric outpatient clinic: effects of the treatment. Frontiers in psychology, 6. https://www.frontiersin.org/articles/10.3389/fpsyg.2015.00980/full Pylvänäinen, P. (2018) Embodied treatment of depression: The development of a dance movement therapy model, in A Zubala and V Karkou (eds) Arts Therapies in the Treatment of Depression: International Research in Arts Therapeis. London: Routledge.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data. Please see below for details of what has happened to each reference that you have provided. • Koch 2012, Koch 2013, Papadopoulos 2013, Punkanen 2014, Punkanen 2017, Pylvänäinen 2010, Pylvänäinen 2015, Röhricht 2015, Stewart 1994 were not included in the guideline as they do not meet the study design

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				Pylvänäinen, P. (2010). The dance/movement therapy group in a psychiatric outpatient clinic: explorations in body image and interaction. Body, Movement and Dance in Psychotherapy, 5(3), 219-230. https://www.tandfonline.com/doi/abs/10.1080/17432979.2010.518016?src=recsys&journalCode=tbmd20 Punkanen M, Saarika S and Luck G (2017) Emotions in Motion: Depression in Dance-Movement and Dance-Movement in Treatment of Depression. In V Karkou, S Oliver and S Lycouris (eds) The Oxford Handbook of Dance and Wellbeing. New York: Oxford University Press. Punkanen M, Saarika S and Luck G (2014) Emotions in Motion: Short-term group form Dance/Movement Therapy in the treatment of depression: A pilot Study, The Arts in Psychotherapy, Volume 41, Issue 5, November 2014, Pages 493-497 https://doi.org/10.1016/j.aip.2014.07.001 Papadopoulos N L R & Röhricht F (2013) An investigation into the application and processes of manualised group body psychotherapy for depressive disorder in a clinical trial, Body, Movement and Dance in Psychotherapy, 9:3, 167-180, DOI: 10.1080/17432979.2013.847499 Röhricht F. (2015). Body psychotherapy for the treatment of severe mental disorders–an overview. Body, Movement and Dance in Psychotherapy, 10, 51-67.	criterion (not an RCT or systematic review of RCTs). • Koch 2007 could not be included as the depression outcome measure was not in the list of included outcome measures specified in the review protocol. • Pylvänäinen 2018 is not an RCT or systematic review of RCTs and therefore does not meet inclusion criteria.

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				http://www.frankrohricht.com/media/cc8045b76d77abd0ffff8011ffffe417.pdf Stewart NJ, McMullen LM, Rubin LD. (1994) Movement therapy with depressed inpatients: a randomized multiple single case design. Archives of Psychiatric Nursing, 8(1):22-9. Koch S. C., Morlinghaus M. A. and Fuchs T (2007) The joy dance: Specific effects of a single dance intervention on psychiatric patients with depression, The Arts in Psychotherapy, 34, 4, 340-349. https://doi.org/10.1016/j.aip.2007.07.001 Koch, S. C., Caldwell, C., & Fuchs, T. (2013). On body memory and embodied therapy. Body, Movement and Dance in Psychotherapy , 8(2), 82–94. Doi: 10.1080/17432979.2013.775968. Koch, S. C., Fuchs, T., Summa, M., & Müller, C. (Eds.) (2012). Body, metaphor and movement. Advances in Consciousness Research 84. Amsterdam: John Benjamins Publishing Company.	
Association for Dance Movement Psychotherapy UK	Full	general	General	Studies in Dance Movement Psychotherapy with depression as a comorbid condition	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all

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				Bräuninger I. (2012a) Dance movement therapy group intervention in stress treatment: A randomized controlled trial (RCT). The Arts in Psychotherapy, 39:443-50. Bräuninger I. (2012b) The efficacy of dance movement therapy group on improvement of quality of life: A randomized controlled trial, The Arts in Psychotherapy, 39, 4, 2012, 296-303 Bradt J, Shim M, Goodill SW. (2015) Dance/movement therapy for improving psychological and physical outcomes in cancer patients. Cochrane Database of Systematic Reviews, Issue 1. Art. No.: CD007103. DOI: 10.1002/14651858.CD007103.pub3 Ren J, Xia J. (2013) Dance therapy for schizophrenia. Cochrane Database of Systematic Reviews, Issue 10. Art. No.: CD006868. DOI: 10.1002/14651858.CD006868.pub3	of the analyses will be updated and the wording of recommendations reviewed in light of this updated data. Please see below for details of what has happened to each reference that you have provided. • Bräuninger 2012a and 2012b could not be included as this intervention is targeted at stress in a non-clinical population, rather than symptoms of depression. • Bradt 2015 could not be included as trials that specifically recruit participants with a coexisting physical health condition are excluded from the guideline. • Ren 2013 could not be included as participants had schizophrenia rather than depression
Association for Dance Movement Psychotherapy UK	Full	general	general	Studies from other arts psychotherapies Dance Movement Psychotherapy, as a creative intervention, is closely linked to the other arts therapies. Studies from these affiliate approaches indicate the plethora of evidence on the value of approaching the issue of depression through creative means. Here are some studies from the other arts psychotherapies: Music Therapy	Thank you for your comment. Art, drama and music therapies were not prioritised for investigation in the review questions for this guideline. Consequently the papers that you cite did not meet the inclusion criteria and have not been appraised in the guideline. We are therefore unable to make recommendations on these interventions.

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				Aalbers S, Fusar-Poli L, Freeman RE, Spreen M, Ket JCF, Vink AC, Maratos A, Crawford M, Chen X, Gold C. (2017) Music therapy for depression. Cochrane Database of Systematic Reviews 2017, Issue 11. Art. No.: CD004517. DOI: 10.1002/14651858.CD004517.pub3 Carr, C. (2014). Modelling of intensive group music therapy for acute adult psychiatric inpatients London: Queen Mary University of London. Carr, C., d'Ardenne, P., Sloboda, A., Scott, C., Wang, D., & Priebe, S. (2012). Group music therapy for patients with persistent post-traumatic stress disorder – A pilot randomised controlled trial. Psychology and Psychotherapy: Research and Practice , 85, 179–202. Doi: 10.1111/j.2044–8341.2011.02026.x. Carr, C., Odell-Miller, H., & Priebe, S. (2013). A systematic review of music therapy practice and outcomes with acute adult psychiatric in-patients. PLoS ONE , 8(8), e70252. Doi: 10.1371/journal.pone.0070252. Carr, C., O'Kelly, J., Sandford, S., & Priebe, S. (2017). Feasibility and acceptability of group music therapy vs wait-list control for treatment of patients with long-term depression (the SYNCHRONY trial): Study protocol for a randomised controlled trial. Trials , 18(1), 149. Doi: 10.1186/s13063-017-1893-8. Erkkilä, J., Gold, C., Fachner, J., Ala-Ruona, E., Punkanen, M., & Vanhala, M. (2008). The effect of improvisational music therapy on the treatment of depression: Protocol for	

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				a randomised controlled trial. BMC Psychiatry , 8, 50. Doi: 1471–1244X-8–50 [pii]10.1186/1471–1244X-8–50. Fachner, J., Gold, C., Ala-Ruona, E., Punkanen, M., & Erkkilä, J. (2010). Depression and music therapy treatment – Clinical validity and reliability of EEG alpha asymmetry and frontal midline theta: Three case studies. In S. M. Demorest, S. J. Morrison, & P. S. Campbell (Eds.), Proceedings of the 11th International Conference on Music Perception and Cognition (CD-ROM) (pp. 11–18). Seattle: University of Washington – School of Music. Fachner, J., Gold, C., & Erkkilä, J. (2013). Music therapy modulates fronto-temporal activity in the rest-EEG in depressed clients. Brain Topography , 26(2), 338–354. Doi: 10.1007/s10548–10012–10254-x. Erkkilä, J. (2007). Music Therapy Toolbox (MTTB) – An improvisation analysis tool for clinicians and researchers. In T. Wosch & T. Wigram (Eds.), Microanalysis in music therapy (pp. 134–148). London: Jessica Kingsley. Erkkilä, J., Ala-Ruona, E., Punkanen, M., & Fachner, J. (2011). Perspectives on creativity in improvisational, psychodynamic music therapy. In D. Hargreaves, D. Miell, & R. MacDonald (Eds.), Musical imaginations: Multidisciplinary perspectives on creativity, performance and perception (pp. 414–428). Oxford: Oxford University Press. Gold, C., Fachner, J., & Erkkilä, J. (2013). Validity and reliability of electroencephalographic frontal alpha asymmetry and frontal midline theta as biomarkers for	

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				depression. Scandinavian Journal of Psychology , 54(2), 118–126. Doi: 10.1111/sjop.12022. Punkanen, M., Eerola, T., & Erkkilä, J. (2011). Biased emotional recognition in depression: Perception of emotions in music by depressed patients. Journal of Affective Disorders , 130(1–2), 118–126. Doi: 10.1016/j.jad.2010.10.034. Albornoz, Y. (2011). The effects of group improvisational music therapy on depression in adolescents and adults with substance abuse: a randomized controlled trial. Nordic Journal of Music Therapy , 20(3), 208–224. Doi: 10.1080/08098131.2010.522717. Chen, X., Hannibal, N., & Gold, C. (2015). Randomised trial of group music therapy with Chinese prisoners: impact on anxiety, depression and self-esteem. International Journal of Offender Therapy and Comparative Criminology , 60(9), 1064–1081. Doi: 10.1177/0306624X15572795. Flint, A. J., Black, S. E., Campbell-Taylor, I., Gailey, G. F., & Levinton, C. (1993). Abnormal speech articulation, psychomotor retardation, and subcortical dysfunction in major depression. Journal of Psychiatric Research , 27(3), 309–319. Henriques, J. B., & Davidson, R. J. (1991). Left frontal hypoactivation in depression. Journal of Abnormal Psychology , 100(4), 535–545. Doi: 10.1037/0021–0843X.100.4.535. Maratos, A. S., Gold, C., Wang, X., & Crawford, M. J. (2008). Music therapy for depression (review). The Cochrane Database of Systematic Reviews , (1),	

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				CD004517. Doi: 004510.001002/14651858.CD14004517.pub14651852. Ahessy, B. (2016). The use of music therapy choir to reduce depression and improve quality of life in older adults: A randomised control trial. Music & Medicine , 8(1), 17–28. Borczon, R. M. (2015). Music therapy for survivors of traumatic events. In B. Wheeler (Ed.), Music therapy handbook (pp. 379–389). New York, NY: Guilford Press. Choi, A. N., Lee, M. S., & Lim, J. J. (2008). Effects of group music intervention on depression, anxiety, and relationships in psychiatric patients: A pilot study. Journal of Alternative and Complementary Medicine: Research on Paradigm, Practice, and Policy , 14(5), 567–570. Clift, S., Gilbert, R., & Vella-Burrows, T. (2016). A review of research on the value of singing for older people. A Choir in Every Care Home Working Paper 6 . London: Baring Foundation. Coulton, S., Clift, S., Skingley, A., & Rodriguez, J. (2015). Effectiveness and cost-effectiveness of community singing on mental health-related quality of life of older people: Randomised controlled trial. The British Journal of Psychiatry , 207(3), 250–255. Gold, C., Solli, H. P., Krüger, V., & Lie, S. A. (2009). Dose-response relationship in music therapy for people with serious mental disorders: Systematic review and meta-analysis. Clinical Psychology Review , 29(3), 193–207. Guétin, S., Portet, F., Picot, M. C., Pommié, C., Messaoudi, M., Djabelkir, L., . . . Touchon,	

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				J. (2009). Effect of music therapy on anxiety and depression in patients with Alzheimer's type dementia: Randomised, controlled study. Dementia and Geriatric Cognitive Disorders, 28 (1), 36–46. Hanser, S. B., & Thompson, L. W. (1994). Effects of a music therapy strategy on depressed older adults. Journal of Gerontology , 49(6), 265–269. Schulz, R., McGinnis, K. A., Zhang, S., Martire, L. M., Hebert, R. S., Beach, S. R., Bozena, Z., Czaja, S. J., Belle, S. H. (2008). Dementia patient suffering and caregiver depression. Alzheimer Disease and Associated Disorders , 22(2), 170–176. Cacciafesta, M., & Gueli, N. (2014). Exercise training and music therapy in elderly with depressive syndrome: A pilot study. Complementary Therapies in Medicine , 22(4), 614–620. Werner, J., Wosch, T., & Gold, C. (2017). Effectiveness of group music therapy versus recreational group singing for depressive symptoms of elderly nursing home residents: Pragmatic trial. Aging & Mental Health , 21(2), 147–155. Wickel, H. H., & Hartogh, T. (2015). Musizieren im Alter: Arbeitsfelder und Methoden. Mainz: Schott. Zhao, K., Bai, Z. G., Bo, A., & Chi, I. (2016). A systematic review and meta-analysis of music therapy for the older adults with depression. International Journal of Geriatric Psychiatry, 31(11), 1188–1189. 15032- Dramatherapy	

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				Cassidy, S., Turnbull, S., & Gumley, A. (2014). Exploring core processes facilitating therapeutic change in Dramatherapy: A grounded theory analysis of published case studies. The Arts in Psychotherapy , 41, 353–365. Hardin, K. (2003). Constructing experience in individual interviews, autobiographies and online accounts: A poststructuralist approach. Journal of Advanced Nursing , 41(6), 536–544. Johnson, D. R. (2009). Developmental transformations: Towards the body as presence. In D. R. Johnson & R. Emunah (Eds.), Current approaches in drama therapy (pp. 89–106). Springfield, IL: Charles C. Thomas. Jones, P. (2009). Research into therapists' perceptions of therapeutic change using vignettes and MSN messenger. European Journal of Psychotherapy and Counselling , 11(3), 251–266. Jones, P. (2011). Creativity and destructiveness: A discourse analysis of dramatherapists' accounts of the work. In D. Dokter, P. Holloway & H. Seebohm (Eds.), Dramatherapy and destructiveness: Creating the evidence base, playing with Thanatos . London, UK: Routledge. Landy, R. (1997). Drama Therapy and distancing: Reflections on theory and clinical application. The Arts in Psychotherapy , 23 (5), 367–373. Landy, R. (2009). Role theory and the role method of drama therapy. In D. R. Johnson& R. Emunah (Eds.), Current approaches in drama therapy (pp. 65–88). Springfi eld, IL: Charles C. Thomas.	

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				Pendzik, S. (2006). On dramatic reality and its therapeutic function in drama therapy. The Arts in Psychotherapy , 33(2006), 271–280. Art Psychotherapy Uttley, L. et al. (2015) The clinical and cost effectiveness of group art therapy for people with non-psychotic mental health disorders: A systematic review and cost-effectiveness analysis. BMC Psychiatry, 15: 151 DOI 10.1186/s12888-015-0528-4; Nan, J.K.M., and Ho, R.T.H. (2017) Effects of clay art therapy on adults outpatients with major depressive disorder: A randomized controlled trial. Journal of Affective Disorders, 217, pp. 237-245. DOI 10.1016/j.jad.2017.04.014 Blomdahl, C., Gunnarsson, A. B., Gureg å rd, S., & Bj ö rklund, A. (2013). A realist review of art therapy for clients with depression. Arts in Psychotherapy , 40(3), 322–330. Doi: 10.1016/j.aip.2013.05.009. Gussak, D. (1997a). The ultimate hidden weapon: Art therapy and the compromise option. In D. Gussak & E. Virshup (Eds.), Drawing time: Art therapy in prisons and other correctional settings (pp. 59–74). Chicago, IL: Magnolia Street Publishers. Gussak, D. (1997b). Breaking through barriers: Advantages of art therapy in prison. In D. Gussak & E. Virshup (Eds.), Drawing time: Art therapy in prisons and other correctional	

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				settings (pp. 1–12). Chicago, IL: Magnolia Street Publishers. Gussak, D. (2004). Art therapy with prison inmates: A pilot study. The Arts in Psychotherapy, 31(4), 245–259. Gussak, D. (2006). The effects of art therapy with prison inmates: A follow-up study. The Arts in Psychotherapy , 33, 188–198. Gussak, D. (2007). The effectiveness of art therapy in reducing depression in prison populations. International Journal of Offender Therapy and Comparative Criminology , 5(4), 444–460. Gussak, D. (2009a). Comparing the effectiveness of art therapy on depression and locus of control of male and female inmates. The Arts in Psychotherapy , 36(4), 202–207. Gussak, D. (2009b). The effects of art therapy on male and female inmates: Advancing the research base. The Arts in Psychotherapy , 36(1), 5–12. Gussak, D. E. (2016). Art therapy in the prison milieu. In D. Gussak & M. Rosal (Eds.), The Wiley-Blackwell handbook of art therapy (pp. 478–486). Oxford, UK: Wiley-Blackwell Publishers. Gussak, D., & Cohen-Liebman, M. S. (2001). Investigation vs. intervention: Forensic art therapy and art therapy in forensic settings. The American Journal of Art Therapy , 40(2), 123–135. Gussak, D., & Ploumis-Devick, E. (2004). Creating wellness in forensic populations through the arts: A proposed	

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				interdisciplinary model. Visual Arts Research , 29(1), 35–43. Hall, N. (1997). Creativity and Incarceration: The purpose of art in a prison culture. In D. Gussak & E. Virshup (Eds.), Drawing time: Art therapy in prisons and other correctional settings (pp. 25–41). Chicago, IL: Magnolia Street Publishers. Zubala, A., MacIntyre, D. J., & Karkou, V. (2014b). Art psychotherapy practice with adults suffering from depression in the UK: Qualitative findings from depression-specific questionnaire. The Arts in Psychotherapy , 41(5), 563–569. Czamanski-Cohen, J., & Weihs, K. L. (2016). The bodymind model: A platform for studying the mechanisms of change induced by art therapy. The Arts in Psychotherapy , 51, 63–73. Doi: 10.1016/j.aip.2016.08.006. Argue, J., Bennett, J., & Gussak, D. (2009). Transformation through negotiation: Initiating the inmate mural arts program. The Arts in Psychotherapy , 36(5), 313–319. Doi: 10.1016/j.aip.2009.07.005. Day, E. S., & Onorato, G. T. (1997). Surviving one's sentence: Art therapy with incarcerated trauma survivors. In D. Author & E. Virshup (Eds.), Drawing time: Art therapy in prisons and other correctional settings (pp. 127–152). Chicago, IL: Magnolia Street Publishers. Gilroy, A. (2006). Art therapy, research and evidence-based practice. London: Sage Publications. 15032-1113d-1pass-r03.indd 117 29-03-2018 15:56:41	

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				Kapitan, L. (2012). Does art therapy work? Identifying the active ingredients of art therapy efficacy. Art Therapy , 29(2), 48–49, Doi: 10.1080/07421656.2012.684292. Arts psychotherapies Karkou, V., & Sanderson, P. (2006). Arts therapies: A research-based map of the field. Edinburgh: Elsevier. Zubala A and Karkou V (2018) Arts Therapies in the Treatment of Depression: International Research in Arts Therapies. London: Routledge. Zubala, A., MacIntyre, D. J., Gleeson, N., & Karkou, V. (2013). Description of arts therapies practice with adults suffering from depression in the UK: Quantitative results from the nationwide survey. The Arts in Psychotherapy , 40, 458–464. Doi: 10.1016/j.aip.2013.09.003. Zubala, A. (2013). Description and evaluation of arts therapies practice with depression in the UK (Doctoral thesis). Queen Margaret University. Retrieved from http://etheses.qmu.ac.uk/1775/ . Zubala, A., MacIntyre, D. J., Gleeson, N., & Karkou, V. (2013). Description of arts therapies practice with adults suffering from depression in the UK: Quantitative results from the nationwide survey. The Arts in Psychotherapy , 40(5), 458–464. Doi: 10.1016/j.aip.2013.09.003. Zubala, A., MacIntyre, D. J., Gleeson, N., & Karkou, V. (2014a). Description of arts therapies practice with adults suffering from depression in the UK: Qualitative findings	

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				from the nationwide survey. The Arts in Psychotherapy , 41(5), 535–544. Doi: 10.1016/j.aip.2014.10.005.	
Association for Dance Movement Psychotherapy UK	Full	general	general	Studies from other forms of psychotherapy Dance Movement Psychotherapy is a non-manualised and relational approach, that considers the person as a whole, within a wider environmental context. Studies that address these components are available from other forms of psychotherapies, some of which are listed here. Note that there is evidence that these types of psychotherapy are comparable to CBT. Bower P, Knowles S, Coventry PA, Rowland N. Counselling for mental health and psychosocial problems in primary care. Cochrane Database of Systematic Reviews 2011, Issue 9. Art. No.: CD001025. DOI: 10.1002/14651858.CD001025.pub3. Bower PJ, Rowland N. Effectiveness and cost effectiveness of counselling in primary care. Cochrane Database of Systematic Reviews 2006, Issue 3. Art. No.: CD001025. DOI: 10.1002/14651858.CD001025.pub2. Elliott, R.E., and Freire, E. (2010). The effectiveness of person-centred and experiential therapies: A review of the meta-analyses. In M. Cooper, J.C. Watson and D. Holldampf (eds.), Person-centered and experiential therapies work: A review of the research on counseling, psychotherapy and related practices. Ross-on-Wye: PCCS Books.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data. Please see below for details of what has happened to each reference that you have provided. • Bower 2006, Bower 2011, Shinohara 2013, and Steinert 2017 systematic reviews have been checked for any additional relevant studies but none of the studies met our inclusion criteria. • Elliott 2010, Pybis 2017, Roth 2009, Van Rijn 2011, Van Rijn 2013, and Van Rijn 2016 have not been included in the guideline because

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				Freire, E., Williams, C., Martina-Messow, C., Cooper, M., Elliott, R., McConnachie, A., Walker, A., Heard, D. & Morrison, J. (2015). Counselling versus low-intensity cognitive behavioural therapy for persistent sub-threshold and mild depression (CLICD): a pilot/feasibility randomised controlled trial. BMC Psychiatry. doi:10.1186/s12888-015-0582-y King M, Marston L, Bower P. Comparison of non-directive counselling and cognitive behaviour therapy for patients presenting in general practice with an ICD-10 depressive episode: a randomized control trial. Psychol Med. 2014;44:1835–44. Pinquart M, Oslejsek B & Teubert D (2016) Efficacy of systemic therapy on adults with mental disorders: A meta-analysis, Psychotherapy Research Volume 26, 2, 241-257 Pybis, J., Saxon, D., Hill, A., Barkham, M. (2017) The comparative effectiveness and efficiency of cognitive behaviour therapy and generic counselling in the treatment of depression: evidence from the 2nd UK National Audit of psychological therapies. BMC Psychiatry 17:215 DOI 10.1186/s12888-017-1370-7 Roth, A. D., Hill, A., & Pilling, S. (2009). The competences required to deliver effective Humanistic Psychological Therapies. Centre for Outcomes Research and Effectiveness, University College London. Retrieved from: http://www.ucl.ac.uk/clinicalpsychology/CORE/humanistic_framework.htm Saxon D, Ashley K, Bishop-Edwards L, Connell J, Harrison P, Ohlsen S, et al. A pragmatic randomised controlled trial	they do not meet the study design criteria (not an RCT or systematic review of RCTs) • Saxon 2017 will be considered for inclusion in the guideline as we update the evidence • Freire 2015 and Ward 2000 are already included in the NMA for treatment of a new depressive episode. • King 2014 could not be included as it is a secondary analysis of a study that was already included in the NMA of treatment of a new depressive episode (Ward 2000).

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				assessing the non-inferiority of counselling for depression versus cognitive-behaviour therapy for patients in primary care meeting a diagnosis of moderate or severe depression (PRaCTICED): study protocol for a randomised controlled trial. Trials. 2017;18:93. Shinohara K, Honyashiki M, Imai H, Hunot V, Caldwell DM, Davies P, Moore THM, Furukawa TA, Churchill R. (2013) Behavioural therapies versus other psychological therapies for depression. Cochrane Database of Systematic Reviews, Issue 10. Art. No.: CD008696. DOI: 10.1002/14651858.CD008696.pub2 Steinert, C., Munder, T., Rabung, S., Hoyer, J., and Leichsenring, F. (2017). Psychodynamic therapy: As efficacious as other empirically supported treatments? A meta-analysis testing equivalence of outcomes. https://doi.org/10.1176/appi.ajp.2017.17010057 Van Rijn B, Wild C, & Moran P. (2011). Evaluating the outcomes of transactional analysis and integrative counselling psychology within UK primary care settings. International Journal of Transactional Analysis Research & Practice, 2, 34-43. Van Rijn BV & Wild, C. (2013). Humanistic and integrative therapies for anxiety and depression: Practice-based evaluation of transactional analysis, gestalt, and integrative psychotherapies and person-centred counselling. Transactional Analysis Journal, 43, 150-163. Van Rijn BV, & Wild C. (2016). Comparison of transactional analysis group and individual psychotherapy in the treatment of depression and anxiety: Routine outcomes	

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				evaluation in community clinics. Transactional Analysis Journal, 46, 63-74. Ward E, King M, Lloyd M, Bower P, Sibbald B, Farrelly S, et al Randomised controlled trial of non-directive counselling, cognitive-behaviour therapy, and usual general practitioner care for patients with depression. I: Clinical Effectiveness. Brit Med J. 2000;321:1383–8.	
Association for Dance Movement Psychotherapy UK	Full	general	general	Studies on patient preference Since patient choice needs to be at the heart of this guideline, studies on patient preference and patient characteristics need to be considered. Here are some examples: Blomdahl, C., Gunnarsson, B. A., Gureg å rd, S., Rusner, M., Wijk, H., & Bj ö rklund, A. (2016). Art therapy for patients with depression: Expert opinions on its main aspects for clinical practice. Journal of Mental Health , 25, 6, 527–535, Doi: 10.1080/09638237.2016.1207226. Cooper M, Messow C, McConnachie A, et al. (2017). Patient preference as a predictor of outcomes in a pilot trial of person-centred counselling versus low-intensity cognitive behavioural therapy for persistent sub-threshold and mild depression. http://www.tandfonline.com/doi/abs/10.1080/09515070.2017.1329708 DeRubeis RJ, Cohen ZD, Forand NR, Fournier JC, Gelfand LA, & Lorenzo-Luaces L. (2014). The Personalized	Thank you for your comment. Patient preference, choice and the principles of shared decision making were considered by the committee during the interpretation of evidence and making the recommendations. However, the guideline did not investigate the comparison of active choice condition relative to no involvement in shared decision making and for this reason Lindhiem 2014 and Swift 2011 could not be included. Please see below for details of what has happened to the other references that you have provided. • Blomdahl 2016 and Hepgul 2016 could not be included as they do not meet the study design inclusion criterion (not an RCT or systematic review of RCTs). • Cooper 2017 will be considered for inclusion in the guideline as we update the evidence. • DeRubeis 2014 could not be included as it is a secondary analysis of a study (DeRubeis 2005 – was considered for inclusion in the NMA of

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				Advantage Index: Translating Research on Prediction into Individualized Treatment Recommendations. A Demonstration. PLoS ONE 9 (1): e83875. Hansson, M, Chotai, J, & Bodlund, O. (2010). Patients' beliefs about the cause of their depression, Journal of Affective Disorders, 124, 54–59. Hepgul N et al. (2016). Clinical characteristics of patients assessed within an Improving Access to Psychological Therapies (IAPT) service: results from a naturalistic cohort study (Predicting Outcome Following Psychological Therapy; PROMPT). BMC Psychiatry. Lin P, Campbell DG, Chaney EF, et al. (2005). The influence of patient preference on depression treatment in primary care. Annals of Behavioral Medicine, 30, 167–173. Lindhiem O, Bennett CB, Trentacosta CJ, & McLear C. (2014). Client preferences affect treatment satisfaction, completion, and clinical outcome: A meta-analysis. Clinical Psychology Review, 34, 506–517. Swift JK, Callahan JL, Vollmer BM. (2011). Preferences. Journal of Clinical Psychology, 67, 155-65.	treatment for a new depressive episode. However it was excluded from this review as mean duration of MDD >2 years which means that this study is ineligible for this review. DeRubeis 2005 could also not be included in the chronic depression review as no minimum duration of MDD was specified as part of the entry criteria for that trial and it is unclear what proportion of participants in the study would meet criteria for chronic depression). • Hansson 2010 could not be included as the aetiology of depression is outside the scope of this guideline. Qualitative evidence is also outside the scope of this update as the experience of care section is not being updated • Lin 2005 could not be included as mediator/moderator analyses do not match the review protocol
Association for Family Therapy & Systematic Practice	Full	general	general	The evidence-based medicine paradigm has been shaped by medical science. This requires some adjustment when comparing and contrasting medical treatments with psychological treatments. The overall methodological approach in the guideline inherently favours (a) medical trials over psychological trials; and (b) particular psychological treatments over others. This is not an acceptable scientific stance and creates biases that are based on subjective choices rather than good scientific	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues

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				evidence of treatment effectiveness. The populations sampled for RCTs are not equivalent to clinical populations as they are often recruited through advertising, complex and co-morbid factors are usually screened out, whereas clinical populations are characterised by complexity and co-morbidity. The evidence is considered from a 'brand name' therapies point of view which results in a bias towards those with more published RCTs, and away from those with less prolific research using RCTs. The Common factors approach to effectiveness research points to common effective therapeutic factors across different talking therapies, with variance within and between different approaches being comparable, but superior to no treatment (or treatment as usual which does not include psychotherapy), e.g. Laska, Kevin & S Gurman, Alan & Wampold, Bruce. (2013). Expanding the Lens of Evidence-Based Practice in Psychotherapy: A Common Factors Perspective. Psychotherapy (Chicago, Ill.). 51. 10.1037/a0034332. Bruce E. Wampold, Stephanie L. Budge, Kevin M. Laska, A.C. Del Re, Timothy P. Baardseth, Christoph Flűckiger, Takuya Minami, D. Martin Kivlighan, Wade Gunn,Evidence-based treatments for depression and anxiety versus treatment-as-usual: A meta-analysis of direct comparisons. Clinical Psychology Review,Volume	raised, and a response to these issues, is provided in the table at the end of this document. Psychological interventions were categorised and analysed according to their content rather than what they had been labelled and no psychotherapy was excluded *a priori*. Bruce 2013 and Laska 2013 have been checked for any relevant studies. However, no additional studies were identified that met inclusion criteria.

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				31, Issue 8,2011, Pages 1304-1312,https://doi.org/10.1016/j.cpr.2011.07.012.	
University of Essex	Full	General	General	In our original response, we noted our concern that the GC decision to separate the analyses of Chronic Depression [CD] & Treatment Resistant Depression[TRD] will damage both the clinical treatments provided and future research. We noted strong evidence for the existence of a more loosely defined heterogenous group of long-term, difficult to treat depressive conditions, frequently associated with co-morbid common mental disorders, various personality disorders/traits and serious psycho-social disability. We noted that UK guidance will be out of line with the APA (DSM-V) and the European Psychiatric Association (EPA) guidance (2016) which both recommend a common "persistent" depression category with sub-categories for severity and degree of associated psycho-social disability. We cited scientific evidence supporting the position that TRD and CD are not distinct categories e.g. Ruhe et al (2012). Citing evidence to support a position is a pillar of scientific practice. Full citations to in-text references are listed at the end of this comment, following standard citation practice. The GC response to this concern is entirely inadequate and lacks scientific merit. The CG appear to have mis-understood the purpose of academic citation practices and have interpreted the citations supporting our scientific position as indirect requests for including those studies in	Thank you for your comment and for drawing our attention to the Ruhe 2012 and Jobst 2016 citations. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document.

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				the review. For a body operating under scientific principles it is very strange to find that NICE misunderstands the need for and practice of scientific citation. The GC response to our concern about separating TRD and CD is to claim that the guideline has followed an 'accepted conventional definition of TRD' without citing any scientific support for this definition. It is also claimed that stakeholders took 'their view' because of a 'misunderstanding of the current definition of TRD'. There is no scientific evidence offered to defend this position, in contrast to the approach taken by stakeholders to back-up their comments with scientific evidence. The action taken by the GC in response to this comment was to change the subheading of the TRD category to 'no or limited response' and slightly loosening the term for CD while still maintaining the false distinction between chronic, complex and TRD. This response is inadequate as it fails to address the much more fundamental concerns raised and offers no scientific defence of the position adopted in the guideline. References Jobst A et al. (2016) European Psychiatric Association Guidance on psychotherapy in chronic depression across Europe. European Psychiatry, 33, 18 – 36.	

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				Ruhe HG, van Rooijen G, Spijker J, Peeters FP, Schene AH. (2012) Staging methods for treatment resistant depression. A systematic review. J Affect Disord, 137, 35–45.	
University of Essex	Full	General	General	In our original response we noted the more detailed problems with the way in which TRD has been defined and operationalised in the draft guideline. In particular we noted that the Fonagy et al RCT had been classified as an augmentation strategy for TRD and was analysed alongside other augmentation strategies. All of these other trials had detailed retrospective methods for operationalising a pharmacological interpretation of TRD as a construct. We argued that the Fonagy RCT approached TRD from a broader psychological perspective and was therefore not comparable to the other studies in this category. The study fits the guideline criteria for CD as well (as noted in the guideline appendix) and yet it has been treated as an augmentation strategy as though the TRD category is discrete from and also has priority over the CD category. The GC response to this point was inadequate and lacking in scientific merit. The response simply reiterates the TRD criteria applied by the GC and states that the Fonagy study meets these criteria. The response does not address the more complex point we were making as noted above. There is also no explanation or scientific defence of the idea that if a trial fits both the TRD and the CD category, it should only be considered in the TRD category.	Thank you for your comment. The committee recognise that the Fonagy 2015 study could be categorised in either the 'further-line treatment' or 'chronic depression' review but agreed that it fitted better into the 'further-line treatment' review. An opinion possibly endorsed by the authors of that study given the title 'Pragmatic randomized controlled trial of long-term psychoanalytic psychotherapy for treatment-resistant depression: the Tavistock Adult Depression Study (TADS)'. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document. Thank you for drawing our attention to the Ijaz et al. 2018 systematic review. This has been checked for any additional relevant studies. However, no new

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				In the last few weeks a Cochrane review of psychological treatments for TRD has been published (see Ijaz et al, 2018). We note that this review excluded the Fonagy et al study on the grounds that "No criterion pertained to the dose/duration of treatment in defining a 'failed attempt,' whereas our definition included a minimum of four weeks' treatment at an adequate dose". This Cochrane review is therefore in line with our argument. The broader point we made in the previous point that TRD and CD should not be artificially separated at all is emphasised by this more detailed analysis of problems that arise when attempting to do so. We have noted that the GC is out of step with the European and American Psychiatric Associations and now we also suggest that the GC is out of step with the Cochrane collaboration on a finer point of classifying TRD. By persisting with this muddled approach to chronic forms of depression, the GC is misrepresenting the body of knowledge and generating misleading comparisons which do not serve the purpose of generating guidelines in the best interests of patients. This muddle is further confounded by the inappropriate definition and separation of complex depression from TRD and CD which was also noted in our original response and not addressed adequately by the GC response. Reference Ijaz S, Davies P, Williams CJ, Kessler D, Lewis G, Wiles N. Psychological therapies for treatment-resistant depression in adults. Cochrane Database of Systematic	studies meeting our inclusion criteria were identified. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				Reviews 2018, Issue 5. Art. No.: CD010558. DOI: 10.1002/14651858.CD010558.pub2.	
University of Essex	Full	General	General	In our original response we noted serious problems with the method of dividing trial populations by categorising baseline severity as more or less severe. We noted the lack of transparency and validation of the GC method for determining severity and the arising discrepancy of the Fonagy et al study being classified as 'Less severe' in spite of the HRSD baseline data actually falling into the Severe category on that scale. We requested that the GC demonstrate exactly how the methodology is more valid and reliable than that of the source measure, or failing this to correct the misleading classification of the severity of this Study's patient population. We suggested that partial remission rates and/or a method of determining Reliable and Clinically Significant Change should be employed particularly when trials have studied the treatment of markedly severe populations for whom currently there are few moderately well-evidenced treatments available. We used citations to scientific evidence in our response. The GC response to this concern is entirely inadequate and lacks scientific merit. The CG appear to have misunderstood the purpose of academic citation practices and have interpreted our citations supporting our scientific position as indirect requests for including those studies in the review. For a body operating under scientific principles it is very strange to find that NICE misunderstands the need for and practice of scientific citation.	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document.

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				The specific response from the GC details the method by which they divided all trials into More severe or Less severe. This description is very lengthy but is absent of support for its validity. One study is cited (Fournier et al, 2010) to support an alternative cut-off point on the HRDS based on drug trials; beyond this, the claims that the GC's method is better than the cut-offs provided by scale developers is a generalised un-referenced statement. The GC state that broadly there was good agreement [with published scale cut-offs] (a difference of one or two points in most cases except for the PHQ-9"(p204 full guideline). This statement is inaccurate. The HRSD-17 cut-off for 'Severe' in the GC system (Table 46) is 24. The published scale cut-offs are 8 for Mild, 14 for Moderate, 19 for Severe and 23 for Very Severe. This represents a 5 point difference between the GC 'severe' cut-off and the validated HRSD 'severe' cut-off; to base an entire NMA on this as well as rely on this system for taking into account baseline severity in the outcome comparisons is extremely risky. This risk is in part illustrated in the classification of the Fonagy et al (2015) study which was classified by the GC as Less severe based on a baseline mean HRSD score of 20 – in spite of this trial also having reported a baseline mean BDI-II score of 36.5 which falls well within the More Severe range the GC applied for the BDI-II (>27). Clearly this trial has been misclassified as Less severe, the GC system is seriously flawed and many other trials are likely to have been misclassified given.	

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				The GC acknowledge in their response that severity is often 'defined (mistakenly) simply by symptom count' rather than taking into account 'the duration of symptoms and the degree of social and functional impairment'. In spite of acknowledging this (which was in fact our point elsewhere in our original response), the GC maintain their sole use of symptoms on the grounds that there was no other option and that their approach would provide most utility in general practice. There is no citation or reference to any supporting evidence indicating that this system would be useful in primary care or any indication that this position would be supported by GPs in practice. It is concerning that the response goes on to defend the More/Less Severe classification on the grounds that a dichotomous classification was required in order to perform a Network Meta-Analysis, indicating that the drive to use a novel technique (NMA), itself unvalidated for current purposes nor holding overall support in the scientific community, has driven an arbitrary approach to classification of depression severity. The position maintained by the GC on this issue is unsustainable and is entirely lacking in scientific credibility. The GC also state that it was not possible to take baseline severity into account when comparing treatment efficacy because they could not access trial data (for Reliable and Clinically Significant change analysis) and could not	

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				determine a consistent cut-off point to use for partial recovery. NICE should be recommending that in future all trials must report reliable and clinically significant change analyses and should prioritise these analyses in future reviews. Meanwhile, for the current guideline, given that the GC selected <8 on the HRSD as a standard for full remission, there is no reason they could not, in addition to calculating effect sizes, choose a reasonable cut-off for partial remission which represented a move to 'mild' depression. The GC state that rather than doing this, they used the baseline severity dichotomy More/Less severe to address the need to take baseline severity into account in determining treatment effectiveness. Yet where this is most critical, in the populations which are chronic and complex, the More/Less severe distinction was not used to separate analyses. This leaves the guideline with no way of identifying treatments for complex, chronic and severe depression which might have a clinically useful effect. This is extremely troubling considering the very few treatments which have been found to be useful for this population of extremely distressed and vulnerable people.	
University of Essex	Full	General	General	In our original response we noted the concern about the failure to give proper attention to long-term follow-ups/observation periods and their outcomes. This omission is particularly difficult to understand when dealing with treatments for chronic/TRD/long lasting/ persisting depressions. We cited numerous scientific peer-reviewed	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that

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				studies dating back to 2004 which all emphasised the need for long-term follow-up points in studies of chronic psychological conditions to be included in trials and in reviews. Unfortunately, the GC appear to have misunderstood the purpose of academic citation practices and have interpreted our citations supporting our scientific position as indirect requests for including those studies in the review. For a body operating under scientific principles it is very strange to find that NICE misunderstands the need for and practice of scientific citation. The specific response to this concern is entirely inadequate and lacks scientific merit. The CG state that they did not include follow-up data because "this data was not widely available across different intervention types and thus did not enable meaningful comparison". The solution the GC have applied is to include "research recommendations to specify that these data need to be collected". The problem with this position is that the citations we provided were specifically there to indicate that such research recommendations have been made for over a decade in the scientific literature and if researchers are continuing to ignore this recommendation then it is unlikely a research recommendation from NICE will make any difference. In the meantime, recommendations based on	the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document.

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				short-term outcomes are misleading and would, as we noted, be regarded as entirely unacceptable for a guideline for a chronic physical condition. If there are insufficient studies with long term follow up data then it is inappropriate for the guideline to make any firm recommendations for specific treatments based on (albeit large amounts of) short-term outcome data. Large amounts of poor evidence must not be used in place of small amounts of good evidence. NICE should conduct a proper analysis of 1 and 2-year follow-up data where available and prioritise treatment recommendations made on the basis of this data over and above current recommendations made on the basis of short term outcomes (less than 1 year).	
University of Essex	Full	General	general	In our original response, among other concerns about the use of GRADE, we noted in particular that GRADE scorings should not down-grade studies involving treatments where concealment is not possible, for example, those evaluating psychological forms of therapy. These involve sentient participation by sentient human subjects (therapists, service users, carers, researchers). This practice systematically operates in favour of drug trials. We noted that GRADE is designed to be used flexibly, citing GRADE publications e.g. Dijkers (2013). Unfortunately, the GC appear to have misunderstood the purpose of academic citation practices and have interpreted our citations supporting our scientific position as indirect requests for including those studies in the	Thank you for your comment and for drawing our attention to the Dijkers 2013 citation. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document. Thank you for drawing our attention to the Wampold 2001 and Baldwin & Imel 2013 citations.

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				review. For a body operating under scientific principles it is very strange to find that NICE misunderstands the need for and practice of scientific citation. In spite of the GRADE system being designed to be flexible, the GC response maintains that it must be used inflexibly. The suggestion is that in psychological treatment studies, double blinding "is possible, for instance by isolating the active ingredient and using an attention-placebo (that is similar in other aspects with the exception of the active ingredient)". This position is not supported by any reference or indication of a scientific consensus. Considering that many of the GC are familiar with delivery and/or receipt of psychological treatments, it is very difficult to understand how they could maintain such a seemingly strange idea that the active ingredient in psychotherapy can be isolated. As members of the GC are most likely aware, there are many complex active ingredients in psychotherapy which cannot and should not be isolated. Most of these factors are not taken account of in this guideline review which focuses exclusively on modality or branding to distinguish therapies, ignoring a large body of scientific evidence on therapy process factors. For example, Wampold (2001) found that 'therapeutic alliance' accounted for 7% of therapy effects while therapy modality accounted for 1%; Baldwin and Imel (2013) found that therapist effects account for approximately 5-8% of patient outcomes. It is also a strange position for experts familiar with psychological	The guideline focused on the effectiveness of different interventions to treat depression. Therapist effects were not an area that was prioritised for inclusion in the guideline, therefore the evidence on this has not been reviewed and we are not able to make any recommendations on this issue.

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				therapies to maintain a position that clients can be effectively deceived into not knowing what type of therapy they are receiving or that they can or should be forbidden from revealing aspects of their therapy to assessors asking them personal questions about how things are going for them. Given these complexities are presumably understood by the GC it is at best irresponsible to ignore them under the cover of applying a grading system 'fairly' in full knowledge that doing so advantages a medical form of treatment for which the preferred research design is most suited, rather than grapple intellectually with the known complexity in the field to find a novel and creative solution. The GC also note repeatedly that GRADE cannot not upgrade trials on quality, it only downgrades trials based on certain criteria. This response evades the conceptual basis of our comment and does not preclude our suggestion that the system could be used to 'give more weight' to studies with long-term follow-up data. The Guideline Committee could usefully apply their creative capacities to finding a solution to the problem. For example, trials which have no follow up data of at least 1 year after end of treatment could be 'downgraded', which would be in keeping with the 'downgrading only' system. The GC also note that studies with no effect at treatment end were systematically downgraded and there was no way to give weight to studies where the effect emerged at long term follow-up. Where there is willing to solve a	

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				serious issue there is likely to be a way to do so. A suggested solution might be not to downgrade any study on the basis of the significance of effect. The size/significance of effect is relevant to the meta-analyses when comparing outcomes. If it is also used as an indicator of quality then the implication is that a study showing no effect at any time point is of poor quality; this is conceptually problematic given existing problems of publication bias in scientific literature. A trial showing no treatment effect may be a very good quality trial, providing good quality evidence of an absence of treatment effect. Publications of trials showing no effect should be encouraged and should be included in reviews. It is conceptually at odds with this concept to take the existence of a significant treatment effect as a quality criterion rather than simply a finding. References Baldwin, S.A., Imel, Z.E. (2013). Therapist effects: findings and methods. In M.J. Lambert (Ed), *Bergin and Garfield's handbook of psychotherapy and behavior change (6th ed.)* (pp.258-297). New York: Wiley. Dijkers M (2013) Introducing GRADE: a systematic approach to rating evidence in systematic reviews and to guideline development. KT Update (Vol. 1, No. 5 - August 2013) [http://www.ktdrr.org/products/update/v1n5/]	

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				Wampold BE (2001) *The great psychotherapy debate: models, methods, and findings*. New Jersey: Lawrence Erlbaum Associates.	
University of Essex	Full	General	General	In our original response we noted concern that the GC has considered outcomes based on symptom measures while neglecting measures of quality of life and psychosocial functioning. Service users regularly report these as being of greater importance to them. We noted peer-reviewed scientific evidence indicating that analysis of these outcomes can alter the comparative efficacy of treatments (McPherson, Evans & Richardson, 2009). Indeed this review was based on psychological treatment trials included in the 2004 NICE guideline for depression. This review demonstrated that it is possible and useful to undertake a review of non-symptom outcomes, even though the number of studies reporting this data is limited. Unfortunately, the GC appear to have misunderstood the purpose of academic citation practices and have interpreted our citations supporting our scientific position as indirect requests for including those studies in the review. For a body operating under scientific principles it is very strange to find that NICE misunderstands the need for and practice of scientific citation.	Thank you for your comment and for drawing our attention to the McPherson 2009 citation. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document. McPherson 2009 and Wampold 2017 have not been included as they do not meet the study design inclusion criterion (not an RCT or systematic review of RCTs). Whilst we do understand citation practices, it is standard NICE process that for every reference provided in comments by stakeholders, we respond

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				The specific response to this concern is entirely inadequate and lacks scientific merit. The CG state that they did not review non-symptom outcomes because "these kinds of measures are rarely reported and they are often reported inconsistently across studies. For these reasons these measures were not prioritised for inclusion in the review protocols for this guideline." The GC claim that use of this data "could be potentially misleading about the effectiveness of interventions". On the contrary, it is more likely that focusing exclusively on symptom outcomes is misleading, if we take the position that good social and functioning outcomes are preferable to good symptom outcomes from a service user perspective. Moreover, the complex system devised by the GC to 'read across' diverse symptom measures demonstrates that where there is willing to address diversity of measures and scaling, there is a way. The problem with the GC position is that if there are insufficient studies with non-symptom outcomes then it is inappropriate for the guideline to make any firm recommendations for specific treatments based on (albeit large amounts of) symptom outcome data, if we know that service users would prefer good social and functioning outcomes over symptoms. Large amounts of poor evidence must not be used in place of small amounts of good evidence. The principle of patient-centred care, enshrined in the NHS Constitution and other NHS policies, demands that NICE take account of what service users actually want	to clarify if that reference was included in the guideline and if not, the reasons for this. s

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				from treatment. NICE should run a re-analysis of studies using quality of life and/or functioning outcomes where these are available and prioritise recommendations based on these measures, given that these are the measures of greatest priority to service users. Reference McPherson S, Evans C & Richardson P (2009) The NICE Depression Guidelines and the recovery model: is there an evidence base for IAPT? Journal of Mental Health, 18(5).	
University of Essex	Full	General	General	In our original response we noted our deep concern that the service user experience evidence was not updated. The GC response is that "the proposal not to include the experience of care section in this update was consulted on with registered stakeholders at the time of consultation on the draft scope." This is an entirely inadequate response to this very serious issue. It was suggested by NICE staff in a face-to-face meeting with stakeholders that 'only 1' stakeholder specifically suggesting this section be updated during the scoping consultation stage. This is not the same as numerous stakeholders asking for it not to be updated. It is the responsibility of NICE to undertake appropriate updates to guidelines when there is sufficient new evidence. As we noted in our original response, there is ample new evidence which would make a significant	Thank you for your comment. When updating a guideline, a decision is taken whilst developing the scope as to which sections of the guideline will be updated and which will not. When the scope for this update was developed, the patient experience section was explicitly not included as part of the update. Registered stakeholders would have had the opportunity to comment on this proposal as part of consultation on the draft scope. Subsequent to consultation, the scope was finalised and the patient experience section was excluded from the update. It is not now possible to go back and reverse this decision. However the committee developing the guideline included several service user and carer members who were able to provide their perspectives during discussion of the evidence and

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				impact on the guideline. If 'only 1' stakeholder had actively suggested reviewing RCTs, it is unimaginable that on that basis NICE would decide not to review RCTs. In omitting a significant body of evidence containing the voices of service users and carers, NICE has failed to follow its own stated approach to Patient and Public Involvement (PPI), which "reflects policy initiatives to involve patients, service users, carers and the public across the NHS and social care." In setting out its approach to PPI, NICE refers to policy contained in the Health and Social Care Act 2012; the NHS Constitution; Putting People at the Heart of Care 2009; and Essential Standards of Quality and Safety (Care Quality Commission, 2010). These policies collectively, along with several other legislative and policy documents, enshrine the right of service users to be fully involved in decisions affecting their care. The specific role of NICE within the planning of healthcare is to commission or conduct methodologically robust systematic reviews of evidence and to use findings from such reviews to inform a set of guidelines for the delivery and implementation of care. PPI must reflect this specific role and hence include methodologically rigorous reviews concerning service user experience. The decision not to update this section in the guideline was not justified, given that evidence relating to service user experience has at least equal value to quantitative evidence of clinical outcomes.	who were integral to the development of the recommendations in those areas of the guideline that were being updated. The references that you cite would not meet inclusion criteria as we have not updated the patient experience section.

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				The service user section copied over from the 2009 guideline was itself inadequate. This section was based on a reanalysis of 38 patient accounts from Healthtalkonline; a brief summary of 7 additional accounts elicited by NICE; a summary of one qualitative systematic review of experiences of self-help plus two primary studies; and brief comments from NICE's service user involvement group. The overall approach was methodologically weak, unsystematic and lacking the level of transparency and rigour expected in qualitative synthesis approaches as referred to in the NICE manual such as meta-ethnography. The experience of depression is intertwined with the social and economic context in which people live. The decision of NICE not to update the section in the guideline on service user experience fails to reflect the dynamic context in which people experience depression. There is growing evidence of the impact of austerity on depression and many clients with depression have been significantly affected by reductions in their benefits, loss of work or changes to employment conditions resulting from the economic downturn and political choices. There have been changes which impact on the extent to which stigma features in client experience. Moreover, recent policy changes, such as the Care Act 2014 and benefits changes, mean that carers' experiences are unlikely to be the same as in 2004 or 2009. These changes in context are further justification for ensuring up to date evidence is reviewed.	

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				The 2009 review of primary literature (based on one existing review of patient experience of guided self-help for depression plus two primary studies) was skewed, narrow, unsystematic and failed to employ any formal qualitative synthesis methodology. A scoping search was carried out in March 2018 by Dr Susan McPherson (author of this response) to identify qualitative peer reviewed research published between 2009 and 2018. This scoping found 93 studies in which people with direct experiences of depression were interviewed or took part in focus groups. These studies elicited accounts from adults whose primary presenting problem was depression. The number of participants across these studies was over 2500. These 93 studies comprised 87 primary studies and 6 qualitative systematic reviews which included many more participant voices. In addition, a further qualitative systematic review examines the experiences of relatives and carers of people with depression using formal qualitative synthesis methods (Priestley & McPherson, 2016). This recent literature extends client experience data to many under-represented groups (such as those listed in the scoping document as requiring 'special consideration'); and takes account of changes in socio-economic and cultural circumstances. Given the purpose of a NICE review is to conduct methodologically sound reviews of evidence, a full systematic review of primary studies is required, employing formal methodology for synthesis such as meta-	

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				ethnographic synthesis, meta-synthesis or formal grounded theory as recommended in the NICE manual (NICE, 2014). This would enhance understanding of service user experiences, a position held by several bodies including the American Psychiatric Association, the Cochrane Collaboration (Noyes et al, 2011) and the Health Foundation. Findings from such a review must also be incorporated into the broader approach to quantitative review and treatment recommendations rather than being left as a stand-alone section. At present, none of the issues raised by service users in the existing 2009 service user experience section have been taken account of in forming the approach to the wider guideline and its treatment recommendations. Updating this review and taking account of its findings when forming treatment recommendations would have a significant impact on the recommendations because, for example, service users often voice a preference for more rather than less choice and for longer-term rather than shorter-term therapies, as alluded to in the 2009 service user experience section. References Care Quality Commission (2010) Essential Standards of Quality and Safety NICE (2014). Developing NICE guidelines: the manual, p107. Noyes, J., Popay, J., Pearson, A., Hannes, K. & Booth, A. (2011). Qualitative research and Cochrane Reviews. In J. Higgins & S. Green (Eds.), *Cochrane Handbook for*	

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				Systematic Reviews of Interventions (version 5.1.0) (chapter 20). The Cochrane Collaboration. Priestley, J. & McPherson, S. (2016). Couples Disease: the experience of living with a partner with chronic depression. *Journal of Couple and Relationship Therapy, 17(* 2), 128-145.	
University of Essex	Full	General	General	The document containing responses to stakeholder comments is overall of very poor quality, much like the first draft of the guideline. It reveals a lack of rigour and quality assurance throughout the process. There are stock responses given to stakeholder comments which appear to have been deemed to fall into certain categories revealing that the comments have not been read or understood properly. There is a blanket misunderstanding of citation practices such that all citations given to support stakeholder positions are treated as requests for inclusion of the study in the review. The responses to stakeholder concerns are often given without any scientific rationale with the implication that the GC know best and do not need to support their position with science or follow scientific convention. The quality assurance process in this document and in the overall process appear to fall short of scientific standards and lack scientific integrity. The response document states, in terms of our request for a second consultation, that 'NICE judged these criteria were not met, therefore no second consultation was conducted'. This statement is clearly wrong and the NICE executive	Thank you for your comment. In the revised guideline following first consultation we took into account comments from a broad range of stakeholders and made a wide variety of changes to the guideline. All comments were responded to. We did not always take up the suggestions made by stakeholders but in such instances we have given our reasons for this. The document containing responses to stakeholder comments has been through several rounds of quality assurance, from both the Developer and NICE. Where stakeholders have commented on similar issues, the same response has been repeated to ensure consistency. However each response was read against each comment to ensure the response addressed all of the issues

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				appear to have over-ruled the GC on this matter. We find the new draft has failed to take account of significant flaws noted in the first consultation and would ask that the NICE executive take the necessary step of postponing publication of this guideline until a proper revision can be undertaken which will meet the high scientific standards expected of NICE which is otherwise seen as a world leader in guideline development.	raised and amendments were made where needed. Whilst we do understand citation practices, it is standard NICE process that for every reference provided in comments by stakeholders, we respond to clarify if that reference was included in the guideline and if not, the reasons for this. We apologise for the typo in the statement about the second consultation. NICE ran this exceptional second consultation so that, before final publication, stakeholders could see how their previous comments have been dealt with and to provide an additional opportunity to comment. However it is not the case that the NICE executive over-ruled the committee on this decision.
Tavistock & Portman NHS Foundation Trust	Full	general	general	Conceptual framework of depression In our first stakeholder response, we expressed a widely-held concern that the framework/conceptual structure used in the draft guideline skewed its processes and its recommendations in a way that is actively unhelpful, particularly to the many patients suffering from long-lasting forms of depression. We believe that this mistaken description and categorisation which fails to adequately take account of the patient voice and patients' treatment and outcome preferences (i.e. what outcomes matter to them), fails to put depression on a par with physical long	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document.

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				term conditions, failing to provide these patients with parity of esteem. Specifically, we expressed concern about the decision to distinguish so called "treatment-resistant depression" from chronic depression as well as from complex depression. We argued that by doing so, this guideline will not be consistent with the APA (DSM-5) and the European Psychiatric Association (EPA) guidance (2016), both of which recommend a common "persistent" depression category with sub-categories for severity and degree of associated psycho-social disability. We furthermore raised the concern that by doing so, the guidance will complicate future outcome research, as many participants in trials included in the treatment-resistant depression meta-analysis meet the guideline's definition of chronic depression and/or complex depression. The GC's approach to change the terminology of TRD has not addressed the concern raised. We therefore raise it here once more. The use of what are widely regarded as scientifically invalid distinctions between chronic, so-called "treatment resistant depression", and complex depression, combined with a sequence of treatment stages that is un-evidenced and relies on inappropriate thresholds, lead to the exclusion of valuable evidence about potentially valuable treatments for these patients.	
Tavistock & Portman NHS	Full	general	general	The importance of long-term follow-up data	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June

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Foundation Trust				We maintain our position that the inclusion and analysis of long-term follow-up data is pivotal in a treatment guideline for depression. We appreciate that such data may not be readily available, however, this should not be a reason for the Guideline not considering it when some exceptional studies have collected it. We maintain that this is particularly important for the analyses for chronic depression or those forms that are already known not to respond to available treatments, but also for studies concerned with first episodes of depression given the well-established knowledge of its episodic nature. It is of upmost importance that a guideline on its treatment includes evidence that assesses whether treatment effects are sustained over time. Whilst we welcome the GC's decision to include a call for long-term follow-up data in the research recommendation section, we fear that unless it is strongly framed and truly meant, it will continue to be ignored in future guidelines as it has been in this one. To redress this, the revised version of this draft should consider all the long-term follow-up evidence already available and not find methodological pretexts for ignoring it because it is doesn't fit with arbitrary categories. Thus, we maintain that by ignoring important long-term follow-up data that is available, the Guideline misses important evidence that has direct influence on its treatment recommendations.	2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document.

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				The case in point is the study conducted within our Trust. The Tavistock Adult Depression Study (Fonagy et al., 2015) has provided evidence that a long-term approach (18 months) has been more effective in treating individuals with complex, chronic depression, who have had several treatment attempts before (including antidepressant medication and psychological treatments) compared to TAU (consisting of the various short-term treatment recommended in the 2009 NICE guidelines). The effect emerged during treatment and became statistically significant over the long-term follow-up. Therefore, excluding the data from the 2-year term follow-up and concluding that the long-term psychoanalytic psychotherapy (LTTP) LTPP tested in this study was not effective is misleading and incorrect. The GC points out in their response that even if these findings were included, they would not show clinically significant results given that full remission rates were not achieved. We would like to point out that (a) focusing on complete remission rates based on the HRSD or BDI for a patient group of such severity, complexity and chronicity is clinically unfeasible and (b) that achieving partial-remission rates or indeed a statistically significant reduction in meeting diagnostic criteria for MDD provides clinically relevant evidence of treatment benefit. Indeed the study found that at the end of the 2 year follow-up 40% of those who received LTPP no longer met criteria for MDD compared to only 10% in those who received TAU.	

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				This points to a further methodological flaw in the guideline, namely to focus solely on remission rates (as defined in the guideline) prohibits the detection of clinically significant change. Neither the BDI, nor the HRSD are used in clinical practice, whereas the DSM or ICD diagnostic criteria are. Individuals with a chronic course of depression for over 20 years cannot be expected to reach full remission rates; it's not only unrealistic but moreover creates false and damaging expectations for clinicians and patients of what can and cannot be achieved in treatment. What constitutes effective and meaningful change needs to be determined based on the context and particular group of patients at hand. It seems that the review question for further line treatment, dealing with a very different population of patients with depression, has not taken that into account.	
Tavistock & Portman NHS Foundation Trust	Full	general	general	Problems with the method of dividing trial populations by categorising baseline severity simply as more severe or less severe We appreciate the GC's detailed response to our concern, however, feel its answer to be inadequate. As clinicians we do not share the opinion that a distinction between less severe and more severe depression is clinically adequate or improves the currently internationally accepted classification. We fear that this distinction will lead to even	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues

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				greater confusion about the clinical management of patients. We maintain that the new classification system as well as its method for cut offs developed is based on the un-evidenced assumption that equivalence algorithm that combines different rating scales is valid (McPherson, Rost et al., 2018). Before a novel categorisation system can be used, it needs to undergo the usual rigorous validity and reliability tests. We therefore suggest to revert back to the previously adopted categorisation system until any new measure has been accepted by the wider research and clinical community. As already pointed out in our first response, the eyeballing of the studies included into either category, reveals the flaws with this method. A study population as severe as the one included in the Tavistock Adult Depression Study (Fonagy et al., 2015) would under the current criteria fall under 'less severe depression'. We therefore re-emphasise our concern and ask the GC to revert back to the classification system adopted in the previous guideline.	raised, and a response to these issues, is provided in the table at the end of this document.
Tavistock & Portman NHS Foundation Trust	full	general	General	GRADE We uphold our view that the draft guidance applies GRADE inappropriately. GRADE is designed to be used flexibly as appropriate to the nature of intervention and	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms

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				index problem being assessed. As these include psychological as well as medical trials, we emphasise the need to adapt the system to assess and rate risk of biases accordingly. Once again, we argue that the current GRADE scorings should give increased weight to studies which have collected and reported long-term follow-up data (that is progressively, ≥12 months rather than simply end-of-treatment ratings as they are currently). Furthermore, we uphold the view that GRADE scorings should not down-rate studies involving treatments where concealment is not possible, such as the evaluation of psychological therapies which involve human participants who are in a position to reflect and engage with the study and their position within it. In terms of non-blinding of participants and investigators, this is an unreasonable standard to apply to psychological treatment trials. Thus, all psychological intervention studies should not be downgraded for failing to blind participants or investigators as this is an illogical standard to apply and discredits the GRADE approach. In the TADS study (Fonagy et al, 2015), risk of bias was classed as very serious because of "high risk of bias associated with randomisation method due to significant difference between groups at baseline, non-blind participants and intervention administrator(s)". In terms of a significant difference between groups at baseline, this refers to a significant difference on education levels only. It	raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document. The reason for the rating of very serious risk of bias for Fonagy 2015 is primarily due to the significant difference at baseline. Almost regardless of what this difference is, it suggests that there is a problem with randomisation as randomisation is intended to balance out potentially confounding variables. The non-blinding of participants and intervention administrators also presents a risk of bias, although we accept that this is more of a problem for psychological than pharmacological trials, it does not negate the fact that participant and intervention administrator knowledge of the treatment being received/delivered is likely to introduce some degree of performance bias due to individual's inherent beliefs about that intervention.

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				is unclear how many trials routinely collect this information and test baseline differences. GRADE is designed to be used flexibly as appropriate and it is argued here that differences at baseline that should be taken into account are those already known to be likely to affect intervention performance. The variables most likely to affect performance of the intervention are those used in the minimization protocol: gender, baseline severity and being on or off medication. It is not reasonable to downgrade evidence because of a difference in baseline characteristics which not all trials have measured and which is unproven to lead to significant difference in intervention performance.	
Tavistock & Portman NHS Foundation Trust	full	general	general	Outcomes based on symptom measures neglect measures of quality of life and psychosocial functioning As pointed out in our first response already, service users regularly report quality of life as being of greater importance to them, yet the draft guideline has not taken this into consideration in the revised version of the draft and thus continues to take a narrow view of outcomes assessed in being only symptom based. This sets aside the importance of functional outcomes such as quality of life, improved relationships with others, self-care, problem solving, improvements in social functioning, improvements in being able to attain and sustain employment.	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document.

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				The response by the GC was that there are insufficient numbers of studies with outcomes of functioning indices for its inclusion to be viable. Following a similar line of argument as above, we would like to stress that it ought to be included where it is available, or if it is not, it might – as a consequence – not be appropriate for the guideline to make any firm recommendations for specific treatments based on (albeit large amounts of) symptom outcome data, if we know that service users would prefer functioning outcomes over symptom reduction. The principle of patient-centred care, enshrined in the NHS Constitution and other NHS policies, demands that NICE take account of what service users actually want from treatment. As an NHS Trust, we cannot stress this point more highly. We therefore recommend that all statistical analyses should be carried out with outcomes of functioning in addition to symptoms given that these are the measures of greatest priority to service users. These findings should influence the recommendations made.	
Tavistock & Portman NHS Foundation Trust	Full	general	general	We'd like to point out that there is increasing evidence that long-term psychodynamic psychotherapies also provides decreased risk of relapse following treatment ending. As many of the studies providing such evidence are not included in this guideline due to its chosen inclusion/exclusion criteria, it misses important evidence. Once again, by the exclusion of long-term follow-up data, the phenomenon of the so called sleeper effect, in which	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by

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				symptomatic change is brought about as a consequence of the gradual consolidation of internal changes sometime after treatment ends, is not being acknowledged despite the increasing evidence of its occurrence in studies of psychoanalytic treatments (e.g. Abbass, Town, & Driessen, 2011; Falkenstrom, Grant,Broberg, & Sandell, 2007; Huber et al., 2012; Leichsenring & Rabung, 2011; Leuzinger- Bohleber, Stuhr, Rüger, & Beutel, 2003).	some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document. Please see below for details of what has happened to the other references that you have provided. Abbass 2008 was excluded from the complex depression review because there were no extractable outcomes of interest. Falkenstrom 2007, Huber 2012 and Leuzinger-Bohleber 2003 are not included as they do not meet the study design criteria (not an RCT or systematic review of RCTs). Leichsenring & Rabung, 2011 SR checked for any additional relevant studies, however, no new studies were identified that met inclusion criteria
Tavistock & Portman NHS Foundation Trust	Full	general	general	The document containing responses to stakeholder comments is of poor quality. It often relies on restating the developers' model. It reveals a lack of rigour and quality assurance throughout the process, falling short of scientific standards. We find the new draft has failed to address the various significant concerns we, along with many other stakeholders, have raised in our first consultation. We	Thank you for your comment. In the revised guideline following first consultation we took into account comments from a broad range of stakeholders and made a wide variety of changes to the guideline. All comments were responded to. We did not always take up the suggestions made by stakeholders but in such instances we have given our reasons for this.

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				therefore ask that the necessary steps be taken to address these in a proper revision now to assure that this guideline meets the high scientific standards expected of NICE as a world leader in guideline development when it is published.	The document containing responses to stakeholder comments has been through several rounds of quality assurance, from both the Developer and NICE. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document.
Society for Psychotherapy Research UK	Full	general	general	Categorisation of trial population into less severe or more severe Our concern with the decision to divide trial populations into 'less severe' and 'more severe' based on baseline severity scores still holds. Given that the treatment recommendations rely on these analyses, this will have a significant impact on the resulting recommendations. We considered this points specifically to fulfil the criteria for a second consultation and are concerned that it has not been addressed in this revised version and urge the GC to do so before publication.	Thank you for your comment. The decision to have an 'exceptional' consultation was not made because either of the criteria in the technical manual had been met, but because NICE thought it would be useful for stakeholders (who had significant concerns about the content of the first draft of the guideline) to see what had changed and be given another chance to comment, particularly given the complex nature of this guideline and its associated analyses. Following the exceptional consultation on the Depression (update) guideline between 15 May

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				We maintain that the proposed classification system as well as its proposed method for cut offs are based on the un-evidenced assumption that equivalence algorithm that combines different rating scales is valid (McPherson, Rost et al., 2018). We furthermore would like emphasise that before a new categorisation system can be applied it needs to undergo the usual rigorous validity and reliability tests. As this has not been done in this instance, we suggest to use the previously adopted categorisation system until it has indeed found acceptance by the wider research and clinical community. We stress again, that any treatment recommendations based on methodological choices that have not been validated need to be viewed with caution. References/citation: McPherson, Rost, Town & Abbass (2018). Epistemological flaws in NICE review methodology and its impact on recommendations for psychodynamic psychotherapies for complex and persistent depression. Psychoanalytic Psychotherapy, online	and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document.
Society for Psychotherapy Research UK	Full	general	general	The distinction between treatment-resistant depression (TRD), chronic depression and complex depression In our first response we raised concerns with the proposed distinction between TRD, chronic depression and complex depression. We do not agree with the GC's assumption	Thank you for your comment and for drawing our attention to the APA 2013 and Jobst 2016 citations. The decision to have an 'exceptional' consultation was not made because either of the criteria in the technical manual had been met, but because NICE

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				that our concern was due to a misunderstanding of the provided definition of TRD and point out that changing the definition to 'no or limited response' has not addressed the issue. Therefore, we are re-iterating that there is still no evidence available that warrants such a distinction and that the overlap between individuals falling into these categories is too large. We furthermore raised the concern that by doing so, the guidance will complicate future outcome research, as many participants in trials included in the TRD meta-analysis meet the guideline's definition of chronic depression and/or complex depression. An example is the study by Barnhofer (2009) that was categorised under chronic depression but clearly meets the criteria for 'no or limited response' as well. Another example is Fonagy et al (2015) that falls under 'no or limited response' and clearly meets criteria for chronic depression as well as complex depression. It is out of line with clinical and research guidance provided by both the American Psychiatric Association (2013) and the European Psychiatric Association guidance (Jobst, 2016), which recommend a common "persistent" depression category with sub-categories for severity and degree of associated psycho-social disability. Thus, we uphold our concern and once again urge the GC to either restore the position taken in the previous (2009) version of the NICE guideline, or to adopt the classification system recommended by the American Psychiatric	thought it would be useful for stakeholders (who had significant concerns about the content of the first draft of the guideline) to see what had changed and be given another chance to comment, particularly given the complex nature of this guideline and its associated analyses. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document. Barnhofer 2009 does not meet the criteria for further-line treatment as participants are not receiving any treatment at baseline and are not randomised at the point of non-response. The committee recognise that the Fonagy 2015 study could be categorised in either the 'further-line treatment' or 'chronic depression' review but agreed that it fitted better into the 'further-line treatment' review. An opinion possibly endorsed by the authors of that study given the title 'Pragmatic

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				Association and the European Psychiatric Association, and to re-run the meta-analyses accordingly. Given that the treatment recommendations rely on these analyses, this will have a significant impact on the resulting recommendations. We also considered this points specifically to fulfil the criteria for a second consultation and are concerned that it has not been addressed in this revised version and urge the GC to do so before publication. References/citations: Barnhofer T, Crane C, Hargus E, Amarasinghe M, Winder R, Williams JM. Mindfulness-based cognitive therapy as a treatment for chronic depression: A preliminary study. Behaviour research and therapy. 2009 May 31;47(5):366-73. Fonagy P, Rost F, Carlyle JA, McPherson S, Thomas R, Pasco Fearon RM, Goldberg D, Taylor D. Pragmatic randomized controlled trial of long-term psychoanalytic psychotherapy for treatment-resistant depression: the Tavistock Adult Depression Study (TADS). World Psychiatry. 2015 Oct 1;14(3):312-21. American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: American Psychiatric Association Jobst, A., Brakemeier, E-L., Buchheim, A., Caspar, E., Cuijpers P. et al. (2016) European Psychiatric Association	randomized controlled trial of long-term psychoanalytic psychotherapy for treatment-resistant depression: the Tavistock Adult Depression Study (TADS)'.

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				Guidance on psychotherapy in chronic depression across Europe. European Psychiatry, 33, 18 – 36.	
Society for Psychotherapy Research UK	Full	general	general	Application of the GRADE system As stressed in our response to the first draft, we are concerned about the GRADE system upon which the grading of the quality of evidence as well as the statistical adjustments and penalisation of studies is based. In particular we are concerned that it has not been adapted to studies that investigate psychological treatments. The system follows a medical paradigm that cannot be applied to psychological studies. As a consequence medical trials are from the outset graded higher quality than psychological trials. Currently all studies that do not follow a double-blind approach are downgraded despite the fact that it is impossible to do so in psychological studies. The response provided by the GC states: "although it is more difficult to blind participants and intervention administrators in psychological studies, it is possible, for instance by isolating the active ingredient and using an attention-placebo (that is similar in other aspects with the exception of the active ingredient)". This is a very theoretical assertion with no foundation in practice. Whilst it is indeed possible to blind outcome assessors (and every study ought to be encouraged to do so or try to mitigate by double rating outcome assessments), it is impossible to	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document.

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				blind participants and intervention administrators (i.e. therapists) as to what they receive or provide. It is furthermore impossible to discern and control for *the* active ingredient in psychological treatments for there are usually multiple interacting ingredients. Thus we maintain that the draft guideline applies GRADE inappropriately. The application of the GRADE system needs to be adapted when psychological studies are investigated. Indeed the GRADE system was designed to be used flexibly with regard to the nature of the intervention and index problem being assessed.	
Society for Psychotherapy Research UK	Full	general	general	Therapist effects In our first response, we raised the concern that the quality of assessment currently adopted does not examine whether studies have controlled for variability across therapist participants (i.e., therapist effects). We consider the GC's response insufficient and re-iterate the importance of needing to adapt the criteria when psychological interventions are assessed and reviewed in addition or alongside medical trials. There are several active ingredients in psychotherapy that cannot and should neither be isolated nor forgotten to be taken into account. This guideline review focuses exclusively on therapy modality or brand to distinguish the various psychological treatments and thereby ignores the increasingly growing scientific evidence on therapy process factors and	Thank you for your comment and for drawing our attention to the Wampold 2001, Baldwin & Imel 2013 and Barkham 2017 citations. The guideline focused on the effectiveness of different interventions to treat depression. Therapist effects were not an area that was prioritised for inclusion in the guideline, therefore the evidence on this has not been reviewed and we are not able to make any recommendations on this issue.

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				therapist effects on patient outcome (e.g. Wampold, 2001; Baldwin and Imel, 2013). Failure to control for therapist effects leads to this effect being attributed to the treatment effect and thereby either inflating or deflating it (Barkham et al., 2017). Given its importance, as well as improved research methodology that enables the quantification of therapist effect estimates (Baldwin & Imel, 2013; Barkham et al., 2017), it is insufficient to claim that the "examination of therapist effects specifically is outside the scope of this guideline" as per the GC's response. We therefore reiterate our recommendation to (a) include a quality criterion to identify evidence where therapist effects have been controlled for, (b) to conduct post hoc analysis to control for therapist effects where the data is accessible. References/Citations: Baldwin, S. A., & Imel, Z. E. (2013). Therapist effects: Findings and methods. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed.). Hoboken, NJ: Wiley. Barkham, Lutz, Lambert, & Saxon (2017). Therapist effects, effective therapists, and the law of variability. In L.G. Castonguay & C.E.Hill (Eds.), How and why are some therapists better than others? (pp. 13-36). Washington: American Psychological Association.	

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				Barkham, Moller & Pybis (2017). How should we evaluate research on counselling and the treatment of depression? A case study on how the National Institute for Health and Care Excellence's draft 2018 guideline for depression considered what counts as best evidence. Counselling and Psychotherapy Research, 17(4): 253–268 Wampold BE (2001) The great psychotherapy debate: models, methods, and findings. New Jersey: Lawrence Erlbaum Associates.	
Society for Psychotherapy Research UK	Full	general	general	Long-term Follow-up We welcome the amendment to the research recommendation that stresses the importance for studies to include long-term outcome data. However, we maintain that it is important to include a separate analysis of long-term outcome data for all review questions (not just for the relapse prevention review) in this current draft guideline. As stated in our first response, this is particularly important as depression is often recurring or chronic (e.g. Rush et al, 2006) and given that research has found that many individuals with depression do not respond to the treatments offered (e.g. Pybis et al., 2017) Both points are emphasised throughout this guideline, and as such it appears inconsistent not to report on the evidence that demonstrates whether treatment effects can be sustained over time or indeed only appear after treatment ended over the long-term follow-up (sleeper effect).	Thank you for your comment. The decision to have an 'exceptional' consultation was not made because either of the criteria in the technical manual had been met, but because NICE thought it would be useful for stakeholders (who had significant concerns about the content of the first draft of the guideline) to see what had changed and be given another chance to comment, particularly given the complex nature of this guideline and its associated analyses. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key

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				As we have already pointed out in our first response, post treatment follow-up data needs to be taken into account in particular when assessing outcome evidence for the treatment of chronic and so-called treatment resistant depression. We point out once more that NICE does not treat chronic physical conditions in this way. The guideline for Type 2 diabetes in adults, for instance, includes several measurement points of the outcomes, ranging from 2 – 10 years. The epilepsy guideline and arthritis guideline examined evidence including 1 and 2 years follow up data. Thus, persistent forms of depression need to be viewed as long-term conditions on par with long term physical conditions. Whilst we understand that this data is not always available excluding the data where it is available is untenable. The guideline is not only following a rigid methodological approach by only considering pre and post outcomes, but moreover misses important evidence that could improve what treatments are offered to patients that are currently at a severe disadvantage in terms of their clinical management. We thus enforce our recommendation to amend the draft guidelines by including longer term follow-up data from studies where it is available when making treatment recommendations. Given that the treatment recommendations rely on these analyses, this will have a	issues raised, and a response to these issues, is provided in the table at the end of this document.

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				significant impact on the resulting recommendations. We considered this points specifically to fulfil the criteria for a second consultation and are concerned that it has not been addressed in this revised version and urge the GC to do so. References/citations: Pybis, J., Saxon, D., Hill, A. & Barkham, M.. 2017. The comparative effectiveness and efficiency of cognitive behaviour therapy and generic counselling in the treatment of depression: evidence from the 2(nd) UK National Audit of psychological therapies. BMC Psychiatry 17: 215. Rush, A. J., Trivedi, M. H., Wisniewski, S. R., Stewart, J. W., Nierenberg, A. A., Thase, M. E., 28 ... Luther, J. F. (2006). Bupropion-SR, sertraline, or venlafaxine-XR after failure of SSRIs for 29 depression. New England Journal of Medicine, 354(12), 1231-1242.	
Society for Psychotherapy Research UK	Full	general	general	The sole focus on depression severity as outcome variable We maintain our concern already raised during the first consultation that the outcome focusing primarily on depression symptomatology (be it as a continuous measure or categorical in form of remission and relapse), is too narrow and needs to include other outcomes, in particular functioning. We quoted a sentence from the guidelines' introduction in order to highlight a major inconsistency: On the one hand the guideline stresses the importance that treatments should not only aim to relieve	Thank you for your comment. The decision to have an 'exceptional' consultation was not made because either of the criteria in the technical manual had been met, but because NICE thought it would be useful for stakeholders (who had significant concerns about the content of the first draft of the guideline) to see what had changed and be given another chance to comment, particularly given the complex nature of this guideline and its associated analyses.

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				symptoms but also increase individual's functioning, on the other hand it does not follow this approach through itself by exclusively focusing on depression symptomatology. The response by the GC to our concern was that functioning measures are rarely as well as inconsistently reported. We would like to challenge the former assumption and comment on the latter that the same problem applies to outcomes reported on depression symptomatology, which was dealt with in the current guideline. Eyeballing the majority of the studies included revealed that most studies do in fact include a measure of functioning. Furthermore, as also already pointed out in our first response, McPherson and colleagues (2009) carried out a re-analysis of the studies included in the 2004 NICE review focusing on functioning outcome. They were not only able to do so, which indicates the reporting of a functioning measure by the majority of the studies included, but most importantly, the authors found a different order of comparative efficacy amongst intervention with the consequence of a different derived treatment recommendation. We thus maintain our recommendation to amend the draft guideline by including at least one other outcome measure of functioning alongside depression symptomatology. Given that the treatment recommendations rely on these analyses, this will have a significant impact on the resulting recommendations. We considered this points	Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document.

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				specifically to fulfil the criteria for a second consultation and are concerned that it has not been addressed in this revised version and urge the GC to do so. References/Citations: McPherson, S., Cairns, P., Carlyle, J., Shapiro, D., Richardson, P. and Taylor, D. (2005) The effectiveness of psychological treatments for refractory depression: A systematic review, Acta Psychiatrica Scandinavica, 111, 331-340.	
Society for Psychotherapy Research UK	Full Appendix	general	general	Network Meta-Analysis In line with leading scientists, we strongly maintain that network meta-analysis (NMA) should only be used when certain conditions are met. We have stated the various reasons why we believe that these conditions are not met in this draft guideline, and that, as a consequence, the resulting treatment recommendations have to be viewed with absolute caution and may not even be valid. Despite the attempt to address some of the identified effect modifiers (e.g. age and whether treatment was inpatient or outpatient), many of the others, as highlighted in our first response, have not been addressed adequately and violate the assumptions needed to carry out an NMA. Thus, we are extremely concerned by the choice to use NMA as a primary analysis rather than using it to	Thank you for your comment. Network meta-analysis (NMA) is an established approach that should be considered when multiple competing options are being appraised, as recommended in the NICE guidelines manual (p104). In the second consultation draft, for the treatment of new episodes we identified 366 RCTs comparing 30 classes of 118 pharmacological, psychological and physical interventions alone or in combination, which reported a range of data such as discontinuation, response, remission, and continuous scale scores, all of which were of interest for evidence synthesis. Employing pairwise meta-analysis to analyse these data would entail hundreds of pairwise comparisons that would have to be concurrently taken into account in order to assess the relative effectiveness of treatments.

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				supplement evidence derived from direct comparisons (standard meta analyses), and regret that this has not been changed in this revised version as we requested in our first response. We thus maintain our recommendation to amend the draft guidelines accordingly. Given that the treatment recommendations rely on these analyses, this will have a significant impact on the resulting recommendations. We considered this points specifically to fulfil the criteria for a second consultation and are concerned that it has not been addressed in this revised version and urge the GC to do so before publication of the guideline.	Such a task would require implicit indirect comparisons between interventions and further qualitative inference on the relative effectiveness of the 118 interventions, in order to formulate recommendations. This approach would entail high risks, as it would be impossible for the committee to process and interpret appropriately the fragmented information [hundreds of pairwise comparisons] derived from this approach. Moreover, such an approach would not allow for the relative cost effectiveness of treatments to be assessed, which is a core consideration of NICE guidelines, since, in order to conduct an economic evaluation of multiple treatment options, simultaneous inference on the efficacy of all options is required, and this is impossible to obtain from pairwise meta-analysis. We note that potential heterogeneity in populations or interventions is a problem in both pairwise and network meta-analysis and should be considered prior to conducting the meta-analysis, and also when interpreting the results. If we employed pairwise meta-analysis, according to your suggestion we would need to take into account any heterogeneity across the 366 trials, potentially 'breaking' the analysis into smaller sub-analyses according to potential effect modifiers; this would result in an even larger number of pairwise

					comparisons that would be impossible to process. Moreover, we would be able to assess heterogeneity quantitatively only within each of the pairwise comparisons, and not across studies included in the systematic review, which means that, in order to assess the relative effectiveness of interventions, we would need to add an extra 'layer' of qualitative considerations on the potential heterogeneity and the presence of effect modifiers across the 366 RCTs included in the review, when interpreting the results of the pairwise meta-analysis. Instead, we employed NMA techniques, after assessing carefully the populations and interventions in the trials and controlling for a large part of heterogeneity. The data from the 366 trials were synthesised in 14 analyses that informed the clinical effectiveness analysis and also the economic analysis, which was an essential part of the guideline. We addressed several potential effect modifiers and controlled for a large part of heterogeneity by splitting populations with less and more severe depression; using detailed treatment definitions [including treatment intensity and mode of delivery for psychological interventions] and categorising them using a class random effects model; examining for model fit and checking for inconsistency between direct and indirect evidence. Between-study heterogeneity in the NMA was formally assessed for each network. Other potential

					effect modifiers, such as age and setting (outpatient vs outpatient) were assessed in sub-analyses, using pairwise meta-analysis. Bias attributable to small sample size was addressed by conducting bias-adjusted analyses, controlling for study size. We agree that other parameters, such as sex, number of previous episodes, socio-economic factors, therapist factors, may also be potential treatment effect modifiers that contribute to heterogeneity, in particular in such a large and complex dataset, but, as we argue above, the presence of potential effect modifiers would also be an issue had pairwise meta-analysis of the 366 studies included in the systematic review been conducted, and consideration of heterogeneity when assessing the hundreds 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. The guideline committee considered the NMA results, including the models' goodness of fit and heterogeneity, inconsistency between direct and indirect evidence, sub-analyses of potential effect modifiers, bias-adjusted analyses, the characteristics and homogeneity of populations across trials, the risk of bias of individual studies, and interpreted results accordingly. They also

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					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. We therefore believe that the NMAs undertaken for the NICE Depression guideline were appropriately conducted for the analysis of such a complex dataset, and for the purposes of a NICE guideline that requires both clinical and cost effectiveness to be assessed. The limitations of the data [which are inherent in the data and would be present whether a NMA or a pairwise meta-analysis approach had been employed] and any limitations of the NMAs (e.g. high between-study heterogeneity, inconsistency between direct and indirect evidence) were highlighted and considered by the committee when making recommendations. The role of people's values and goals and their preferences for different types of treatment in treatment decisions were also taken into account in decision-making.
Society for Psychotherapy Research UK	Full	general	general	Qualitative evidence for effectiveness since 2009 We are concerned with the fact that this guideline is not based on observational research such as qualitative studies and case studies. We appreciate the fact that the committee focuses on the relative benefit of the relevant	Thank you for your comment. We did not consider qualitative evidence/case series on which interventions would be effective or appropriate for which patients because we do not consider this to be the best available evidence when differentiating

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				interventions and we understand that RCT data provide the strongest type of evidence to answer that question. We also appreciate the fact that the committee does aim to take into consideration the reality of the experience of patients and the reality of the context in which clinicians are working though the committee discussions. However, we are concerned with the fact that the committee tackles these questions through committee discussions only rather than by consulting the best type of evidence to answer those questions, namely qualitative studies and case reports. There is an important distinction to be made between making general decisions on which psychotherapeutic interventions are the most effective, and making contextually-sensitive decisions on which interventions will be effective (appropriate) for which patients/clients. We don't believe the present version of the guideline adequately addresses these latter considerations, thus not providing sufficient guidance for clinicians about making contextually sensitive referrals. We are concerned that the present evidence base is not being fully utilised and that, as a real consequence of this, inappropriate referrals may be made. A qualitative evidence synthesis approach should provide a degree of latitude to invoke qualitative and case study evidence, not for making general claims about effectiveness per se, but in specifically addressing those	the relative efficacy of different interventions for different subgroups of people. Thank you for providing details of the literature search you conducted for published case series and qualitative evidence. However, as indicated above single case studies or case series do not provide the high quality evidence needed to support decisions on the relative or differential effectiveness of different interventions. Consequently they have not been included in the guideline. Context is taken into account by the committee in making recommendations. Guidelines are explicitly a guide to judgment and not a substitute for it. We expect all users of the guideline to take into account personal factors when applying the recommendations in everyday practice and so take into account heterogeneity. The decision to have an 'exceptional' consultation was not made because either of the criteria in the technical manual had been met, but because NICE thought it would be useful for stakeholders (who had significant concerns about the content of the first draft of the guideline) to see what had changed and be given another chance to comment,

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				relevant contextual factors. We believe that the observational study evidence you are presently excluding could be utilised to better inform these more narrative and consensual aspects of your decision making process. Therefore, our recommendation is that the committee should take a more systematic approach to how contextual factors should be included in the clinical decision process. These factors could be represented through the production of meta-syntheses of case study and qualitative evidence, for example that provide clear guidance for clinicians about which interventions are most appropriate for which patients. It is the responsibility of a NICE guideline to undertake a full systematic review of the existing evidence and to update guidelines when there is sufficient new evidence. Qualitative research evidence was included in the 2009 version of the guideline, and it is not clear why this evidence has not been updated despite the fact that new evidence has been accumulated since 2004/2009. A scoping search carried out by Dr McPherson in March 2018 identified 93 studies that included over 2500 service users voices that were not taken into consideration in this guideline. We thus maintain our recommendation to amend the draft guidelines by updating this section and to incorporate the findings into other aspects of the guideline, including how depression is categorised and into the treatment	particularly given the complex nature of this guideline and its associated analyses. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document.

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				recommendations. We considered this points specifically to fulfil the criteria for a second consultation and are concerned that it has not been addressed in this revised version and urge the GC to do so.	
Council for Evidence-based Psychiatry	Full	General	General	The Council for Evidence Based Psychiatry has a number of general concerns about the evidence review processes that underpin this guideline. There are a set of problems associated with the use of outcome data in the trials used to recommend the use of antidepressant medication. The differences between antidepressants and placebo are very small, and there is little evidence that they are clinically relevant. The only empirical study to attempt to match depression rating scale scores to clinical evaluations found that the level of differences found in placebo controlled trials would not even be detectable in global clinical evaluations, and is well below the level required for a 'mild' degree of difference (Leucht et al, 2014; Moncrieff & Kirsch). Reasons for the perception that antidepressant-placebo differences are more significant than they are have been extensively discussed now and include unblinding due to side effects, publication bias and use of categorical outcomes (see: Leucht S, Fennema H, Engel R, Kaspers-Janssen M, Lepping P, Szegedi A. What does the HAMD mean? J Affect Disord 2013 Jun;148(2-3):243-8 http://www.jad-journal.com/article/S0165-0327(12)00834-8/abstract and Moncrieff, J. & Kirsch, I.	Thank you for your comment and for drawing our attention to Leucht 2014 and Moncrieff & Kirsch citations. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document.

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				(2015). Empirically derived criteria cast doubt on the clinical significance of antidepressant-placebo differences. Contemporary Clinical Trials 43, 60-62). Quality of life outcomes are almost never reported on in journal publications. In making recommendations, NICE should consider a specific analysis of studies using quality of life and/or functioning outcomes where these are available and prioritise recommendations based on these measures, given that these are the measures of greatest priority to service users. Similarly, NICE recommendations are based on very short-term analyses of effect. Consideration should be given to prioritisation of 1 and 2-year follow-up data from trials over and above recommendations which are made on the basis of short term outcomes. Given these considerations, we argue that there is insufficient evidence to conclude that antidepressants do more good than harm, especially in the long-term and when considering patient-relevant global or objective outcomes. We believe that greater consideration should be given to qualitative studies and accounts of patient experience especially as concerns the mental and physical alterations people experience when taking antidepressant drugs. This mirrors the first point above. It is highly likely that	

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				medication has a profound effect on the brain, but whether or not the medication is a wise solution to the presenting problems is a much more subtle judgement, and therefore it is valuable properly to incorporate qualitative as well as quantitative evidence. There is, for example, relatively little data on drug induced subjective alterations, and qualitative data can help. Qualitative accounts can also help us better how problems such as depression are conceptualised, therefore whether medication is an appropriate response, and qualitative data can provide evidence for functional and real world outcomes in the longer term. Finally, when discussing the effects and utility of antidepressants, qualitative data reveals that people say conflicting things, and this complexity should be reflected in clinical guidelines.	
Umbrella organisation comprising: AFT, BACP, BPC, BPS, BPF, MIND, National Survivor User Network, Psychotherapy Foundation, RCPsych,	Full	General	General	Summary of Serious Concerns The various methodological concerns we raised in our first response to the draft have not been addressed in the revised version. Thus, we maintain our position that this guideline is not fit for purpose and if published will seriously impede the care of millions of people in the UK suffering from depression, potentially even causing clinical harm. Under NICE's own rules, a second consultation can occur exceptionally if "information or data that would significantly alter the guideline were omitted from the first draft, or	Thank you for your comment. The decision to have an 'exceptional' consultation was not made because either of the criteria in the technical manual had been met, but because NICE thought it would be useful for stakeholders (who had significant concerns about the content of the first draft of the guideline) to see what had changed and be given another chance to comment, particularly given the complex nature of this guideline and its associated analyses.

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Society for Psychotherapy Research UK, South London & Maudsley NHS FT, Tavistock & Portman NHS FT, Tavistock Relationships, UK Council for Psychotherapy, University of Essex				evidence was misinterpreted in the first draft and the amended interpretation significantly alters the draft recommendations"ii. Both conditions have been met in this case. Stakeholders identified wide ranging and fundamental methodological flaws in the draft and offered recommendations for addressing these. In spite of acknowledging the serious omissions and misinterpretations through issuing a second consultation, these key issues have not been addressed in the new draft. The quality assurance process in the stakeholder response document and in the overall process appear to fall short of acceptable scientific standards and lack scientific integrity. Our position, therefore, is that a full and proper revision of the guideline must take place allowing sufficient time for the guideline group to properly address the concerns listed in this statement. These issues relate both to the omission of large amounts of data as well as the potentially significant material impact on the recommendations that would arise from their inclusion. If these issues are not adequately addressed, the treatment recommendations cannot be relied on. The draft guideline in its current form poses a serious threat to patient choice and will result in patients being offered a limited selection of treatments, which may not be the treatments that have the best chance of relieving their suffering (which in turn will contribute to poor cost	Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data. 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 guideline. The biggest advantage of the NMAs is that they allowed synthesis of evidence from 366 RCTs comparing 30 classes of 118 pharmacological, psychological and physical interventions alone or in combination in 14 separate analyses that informed both clinical

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				effectiveness in the long term). The following amendments must be made before the guideline is published: NICE should conduct a proper analysis of 1 and 2-year follow-up data from trials and prioritise treatment recommendations made on the basis of these data over and above recommendations which are made on the basis of short term outcomes (less than 1 year). A full systematic review of primary studies of service user experience is required, employing formal methodology for qualitative synthesis; AND findings from such a review must be incorporated into the broader approach to quantitative review and treatment recommendations rather than being left as a stand-alone section. Trials where the majority of the population is clinically complex, chronic or treatment resistant need to be grouped together as 'persistent depression' for the purposes of review, following the European Psychiatric Associationiii. The guideline review must look at the amount of clinical effect (e.g. partial recovery) from a severe baseline point and not ignore treatment effects because clients do not fully recover by the end of treatment. Moreover, categorisations of depression severity must be based on validated tools, not un-validated non-transparent functions of them. Findings from indirect or mixed comparisons using Network Meta-Analysis (NMA) should only be used to supplement evidence derived from direct comparisons.	effectiveness and the guideline economic models. If NMA techniques were not available, then we would have to undertake innumerous pairwise meta-analyses on 14 different outcomes, and still make (qualitative) inference on the relative effectiveness of the 118 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. Moreover, the relative cost effectiveness of interventions [which is a core consideration of NICE guidelines] would be impossible to estimate if we used pairwise meta-analyses, as in order to conduct the economic analysis we need simultaneous inference on all treatments, which is possible only with the employment of NMA techniques. Detailed results of inconsistency checks and comparison between mixed (NMA) and direct evidence have been provided in Appendix W of the full guideline draft. The Guideline Committee considered carefully the strengths and limitations of each of the 14 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

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				NICE must reanalyse the data using standard meta-analyses and should NMA be used to supplement the findings a validated and reliable model for doing so should be employed. NICE must run a reanalysis of studies using quality of life and/or functioning outcomes where these are available and prioritise recommendations based on these measures, given that these are the measures of greatest priority to service users. This position statement outlines in detail below the basis for each of these required amendments.	individual studies, the models' goodness of fit and heterogeneity, the possible presence of inconsistency and the results of the bias-adjusted models, 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.
Umbrella organisation comprising: AFT, BACP, BPC, BPS, BPF, MIND, National Survivor User Network, Psychotherapy Foundation, RCPsych, Society for Psychotherapy Research UK, South London & Maudsley	Full	General	General	Methodological focus of concerns This coalition of stakeholders is driven by and comes from a position of psychotherapeutic neutrality and scientific integrity, just as the development of the guideline should be. In other words, whilst some of the organisations involved may have a particular leaning towards one therapeutic approach or another, our concerns are directed towards the methodology adopted by the guideline development group and specifically their (a) selection, (b) grouping, and (c) analysis of the supporting evidence. The evidence-based medicine paradigm has been shaped by medical science. This requires some adjustment when comparing and contrasting medical treatments with psychological treatments. The overall methodological approach in the guideline inherently favours (a) medical	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document.

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NHS FT, Tavistock & Portman NHS FT, Tavistock Relationships, UK Council for Psychotherapy, University of Essex				trials over psychological trials; and (b) particular psychological treatments over others. This is not an acceptable scientific stance and creates biases that are based on subjective choices rather than good scientific evidence of treatment effectiveness. Moreover, we note that the guideline displays an over-reliance on one type of scientific method and fails to take account of the wide variety of good quality evidence available that uses a variety of methodologies and designs. Relying entirely on Randomized Controlled Trials (RCTs) represents a seriously restricted model of science. The various limitations of RCTs specifically in the field of mental health have been pointed out repeatedly by experts from many scientific disciplines and positions irrespective of therapeutic modality. Most psychotherapy trials are not sufficiently powered to detect true differencesiv, and guidelines that ignore important evidence as they occur in clinical practice are concerning. Thus, there is a need to take account of large standardised routine outcome datasets, such as the Improving Access to Psychological Therapies (IAPT) dataset. As the Health Foundation and Cochrane Collaboration have stressedv,vi, creating sound policy requires that we draw on a diverse range of evidence and that cohort studies as well as qualitative and case study research evidence maximizes the value of reviews to policy and practice decision-making. We recognise that some of	

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				these broader methodological matters should and will be addressed in our stakeholder responses to the NICE manual consultation currently ongoing. Nevertheless, serious methodological flaws in the current draft guideline for depression outlined below relate to the Guideline Committee's application of methodological practices set out in the current NICE manual.	
Umbrella organisation comprising: AFT, BACP, BPC, BPS, BPF, MIND, National Survivor User Network, Psychotherapy Foundation, RCPsych, Society for Psychotherapy Research UK, South London & Maudsley NHS FT, Tavistock & Portman NHS FT, Tavistock Relationships,	Full	General	General	The guideline must enable NHS services to deliver 'parity of esteem' 'Parity of esteem' refers to the legal requirement, set out in the Health and Social Care Act (2012), for NHS bodies to give equal priority to mental and physical health. Treatment recommendations set out in the draft guideline for depression will have a direct impact on the future commissioning of mental health care services and workforce planning (including IAPT and secondary care) and thus have an impact on the care of millions of people with depression and their families. Depression often manifests as a long-term condition, or becomes a long-term condition if immediate care is inadequate. Depression can also be highly episodic and there is a high relapse rate. For example 38% of IAPT clients are repeat attendersvii. It is imperative for research to demonstrate that treatment effects are long-lasting, or indeed to note where effects might appear over the long-term follow-up (sleeper effects).	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document.

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UK Council for Psychotherapy, University of Essex				NICE states that "the aim of [an] intervention is to restore health through the relief of symptoms and restoration of function, and in the longer term, to prevent relapse". NICE guidelines for long-term physical conditions such as epilepsy and asthma examine treatment outcome data over 1-10 years. The evaluation of treatments for depression must meet the same standards as guidelines for long term physical conditions. This requires the guideline to base recommendations on evidence concerning the long-term effectiveness of treatments. The current draft recommendations are all made on the basis of very short-term outcomes (often 6-12 weeks) and always less than 1 year. This is inadequate as a basis for recommendations for long-term conditions (whether physical or mental). NICE guidelines for long-term physical conditions would treat this evidence as inadequate, requiring at least 1 or 2 years follow-up data. Follow up data of 1-2 years have been omitted in the draft depression guideline. The Guideline Committee state that there are insufficient studies with long term follow up data to conduct such analyses. If this is the case then it is inappropriate for the guideline to make any firm recommendations for specific treatments based on (albeit large amounts of) short-term outcome data. Large amounts of poor evidence must not be used in place of small amounts of good evidence. NICE should conduct a proper analysis of 1 and 2-year follow-up	

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				data where available and prioritise treatment recommendations made on the basis of this data over and above current recommendations made on the basis of short term outcomes (less than 1 year). This is likely to alter the recommendations significantly, since, for example, where follow-up data is available these tend to be favourable to longer-term therapies over short-term therapies.	
Umbrella organisation comprising: AFT, BACP, BPC, BPS, BPF, MIND, National Survivor User Network, Psychotherapy Foundation, RCPsych, Society for Psychotherapy Research UK, South London & Maudsley NHS FT, Tavistock & Portman NHS FT, Tavistock	Full	General	General	The guideline must review evidence on service user experience Ensuring that the views and experiences of those who use the services are properly taken account of, should be the sine qua non of a publicly funded body tasked with devising clinical guidelines, particularly as these services are fundamentally shaped by the guidance NICE produces. While the guideline committee has consulted service users as part of the guideline development process, it has largely ignored the voices of service users, using out-of-date evidence of service user and carer experiences mostly dating back to before 2004 and has failed even to incorporate this evidence into treatment recommendations. The decision not to update this section is not justified given that evidence relating to service user experience has at least equal value to quantitative evidence of clinical outcomes. In omitting such a significant body of evidence, NICE has failed to follow its own stated approach to	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document.

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Relationships, UK Council for Psychotherapy, University of Essex				Patient and Public Involvement (PPI), which "reflects policy initiatives to involve patients, service users, carers and the public across the NHS and social care." In setting out its approach to PPI, NICE refers to policy contained in the Health and Social Care Act 2012; the NHS Constitution; Putting People at the Heart of Care 2009; and Essential Standards of Quality and Safety. These policies collectively enshrine the right of service users to be fully involved in decisions affecting their care. The specific role of NICE within the planning of healthcare is to commission or conduct methodologically robust systematic reviews of evidence and to use findings from such reviews to inform a set of guidelines for the delivery and implementation of care. PPI must reflect this specific role and hence guidelines must include methodologically rigorous reviews concerning service user experience. By not updating this section, the guideline fails to reflect the dynamic context in which people experience depression which is intertwined with the social and economic context in which people live. There is growing evidence of the impact of austerity on depression and many clients have been significantly affected by reductions in their benefits, loss of work or changes to employment conditions resulting from the economic downturn and political choices. There have been changes which may impact on the extent to which clients encounter stigma. Moreover, recent policy changes, such as the Care Act	

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				2014 and benefits changes, mean that carers' experiences are unlikely to be the same as in 2004 or 2009. These changes in context are further justification for ensuring up to date evidence is reviewed and included in this guideline now. The service user section copied over from the 2009 guideline was itself inadequate. The overall approach was methodologically weak, unsystematic and lacking the level of transparency and rigour expected in qualitative synthesis approaches as referred to in the NICE manual. A scoping search was carried out in March 2018 by Dr Susan McPherson to identify qualitative peer reviewed research published between 2009 and 2018. This scoping found 93 studies that included over 2500 participant voices that were not considered. In addition, a further qualitative systematic review examines the experiences of relatives and carers of people with depression using formal qualitative synthesis methodsviii. This recent literature extends client experience data to many under-represented groups (such as those listed in the scoping document as requiring 'special consideration'); and takes account of changes in socio-economic and cultural circumstances. Given the purpose of a NICE review is to conduct methodologically sound reviews of evidence, a full systematic review of primary studies is required, employing formal methodology for synthesis such as meta-ethnographic synthesis, meta-synthesis or formal	

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				grounded theory as recommended in the NICE manualix. This would enhance understanding of service user experiences, a position held by several bodies including the American Psychiatric Association, the Cochrane Collaborationx and the Health Foundation. Findings from such a review must also be incorporated into the broader approach to quantitative review and treatment recommendations rather than being left as a stand-alone section. Updating this review and taking account of its findings when forming treatment recommendations would have a significant impact on the recommendations because, for example, service users often voice a preference for more rather than less choice and for longer-term rather than shorter-term therapies, as alluded to in the 2009 service user experience section.	
Umbrella organisation comprising: AFT, BACP, BPC, BPS, BPF, MIND, National Survivor User Network, Psychotherapy Foundation, RCPsych, Society for Psychotherapy	Full	General	General	Categorisation of persistent forms of depression must reflect good evidence The current draft guideline is out of step with US and European guideline methodologies, leading to erroneous and unhelpful classification of research studies which do not match clinical or service user experiences. The adopted distinction between treatment resistant and chronic depression (as well as distinguishing both from complex depression) is particularly concerning. There is no evidence that warrants these distinctions and no appropriate sensitivity analyses were carried out. These distinctions cause confounds in treatment research, as many participants in the trials meet the guideline's	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document.

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Research UK, South London & Maudsley NHS FT, Tavistock & Portman NHS FT, Tavistock Relationships, UK Council for Psychotherapy, University of Essex				definition of treatment resistant and chronic depression and in some cases also complex depression. Trials where the majority of the population is clinically complex, chronic or treatment resistant need to be grouped together as 'persistent depression' for the purposes of review, following the European Psychiatric Associationxi. This would have a significant impact on the guideline. In the future NICE also needs to look at whether the overall categorical system of mental disorders really fits with service user experience or whether a more trauma-focused approach would fit service user experience better. In the meantime, the current guideline must at least be in line with the best clinical and research evidence.	
Umbrella organisation comprising: AFT, BACP, BPC, BPS, BPF, MIND, National Survivor User Network, Psychotherapy Foundation, RCPsych, Society for Psychotherapy	Full	General	General	The guideline must use appropriate methods for determining treatment effect The current draft guideline has used inadequate methods for working out whether a trial has found a clinically significant treatment effect. The Guideline Committee devised a method for dichotomising study populations into 'More severe' or 'Less severe' in order to account for baseline severity when determining treatment effect. This approach has no scientific validity and overrides the categorisations of severity used by well-established measures as well as established methods of calculating the clinical significance of treatment effects. This dichotomy is also relied on for the Network Meta Analysis. Indeed the Guideline Committee admit that this	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document.

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Research UK, South London & Maudsley NHS FT, Tavistock & Portman NHS FT, Tavistock Relationships, UK Council for Psychotherapy, University of Essex				dichotomisation was driven by their wish to conduct a Network Meta Analysis, which is an inappropriate form of reverse engineering, particularly as dichotomization inflates effect sizesxii. The Guideline Committee claim that this dichotomization was supported by and will benefit General Practitioners but present no evidence or this claim. This is of critical importance because persistent, severe and complex forms of depression represent a large component of the population of people with depression, yet there are very few treatments which have been found to help. Full remission from a severe baseline is difficult to achieve, whereas a treatment which helps some service users move from severe depression to mild or moderate depression (i.e. 'partial recovery'), for example, would be worth recommending. Service users with persistent depression are already doubly disadvantaged by their long-term mental illness because of the lack of parity of esteem reflected in the decision to omit long-term outcome data. In order to identify clinical practices which can relieve the severe and ongoing suffering within this population, the guideline review must look at the amount of clinical effect from a severe baseline point and not ignore treatment effects simply because clients do not fully recover by the end of treatment. Examining partial recovery is therefore critical in order to identify treatments which can be of some benefit to people with severe and/or complex depression.	

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Umbrella organisation comprising: AFT, BACP, BPC, BPS, BPF, MIND, National Survivor User Network, Psychotherapy Foundation, RCPsych, Society for Psychotherapy Research UK, South London & Maudsley NHS FT, Tavistock & Portman NHS FT, Tavistock Relationships, UK Council for Psychotherapy, University of Essex	Full	General	General	The guideline must not base its primary recommendations on results of Network Meta-Analysis The current draft guideline used statistical analyses (i.e. network meta-analysis, NMA) that are associated with serious and unique risks over and above that of standard meta-analyses that need careful addressing when employing itxiii,xiv,xv. The Guideline Committee disagrees yet offers no scientific basis for their disagreement. 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. 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 formal stakeholder consultation, which has not yet taken place. NICE has over-reached its function in undertaking this experimental technique and making it the basis of a national guideline impacting on millions of people experiencing distress. 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.	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

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				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 modifiersxvi. These include not only severity at baseline, number of previous episodes and quality of study, which the draft guideline tried to address, but also sample size, age, sex, socio-economic factors, therapist factors, as well as treatment dose and administration of treatment, which the draft did not address. The NMA included 351 studies comparing 81 interventions and combinations of interventions, which differed considerably in all these variables, thus violating the transitivity or consistency assumptionxvii. The variable distribution and thus contribution of the different treatments included in the NMA is highly problematic. It is evident that some treatments contributed very few studies (e.g. yoga and any AD contributed only two studies), whilst others (e.g. individual CBT contributed 35 and Amitriptyline contributed 43 studies). Thus, findings might not depict a representative range of treatment, thereby biasing an effect estimate compared with those with more studies12. It is our position, and in line with Canadian Agency for Drugs and Technologies in Healthxviii, that findings from indirect or mixed comparisons (NMA) should only be used	http://www.cochranelibrary.com/app/content/special-collections/article/?doi=10.1002/(ISSN)14651858(CAT)Freeaccesstoreviews(VI)networkmetaanalysis. We believe that the examples 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 guideline. The biggest advantage of the NMAs is that in the second consultation draft they allowed synthesis of evidence from 366 RCTs comparing 30 classes of 118 pharmacological, psychological and physical interventions alone or in combination in 14 separate analyses that informed both clinical effectiveness and the guideline economic models in the second consultation draft. If NMA techniques were not available, then we would have to undertake innumerous pairwise meta-analyses on 14 different outcomes, and still make (qualitative) inference on the relative effectiveness of the 118interventions, by making implicit indirect

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				to supplement evidence derived from direct comparisons (standard meta-analysis). The evidence must be re-analysed accordingly. Given that the recommendations for first episode depression rely on these analyses, this will have a significant impact on the recommendations.	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. Moreover, the relative cost effectiveness of interventions [which is a core consideration of NICE guidelines] would be impossible to estimate if we used pairwise meta-analyses, as in order to conduct the economic analysis we need simultaneous inference on all treatments that are part of the decision problem, which is possible only with the employment of NMA techniques. As we explained following the previous consultation, 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. As you note, we addressed several potential effect modifiers and controlled for a large part of heterogeneity by splitting populations with less and more severe depression; using detailed treatment definitions [including treatment intensity and mode of delivery for psychological interventions] and categorising them using a class random effects model, examining for model fit and checking for inconsistency between direct and indirect evidence.

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					Other potential effect modifiers, such as age and setting (outpatient vs outpatient) were assessed in sub-analyses, using pairwise meta-analysis. Bias attributable to small sample size was addressed by conducting bias-adjusted analyses, controlling for study size. We agree that other parameters, such as sex, number of previous episodes, socio-economic factors, therapist factors, may also be potential treatment effect modifiers that contribute to heterogeneity, in particular in such a large and complex dataset, but the presence of potential effect modifiers would also be an issue had pairwise meta-analysis of the 366 studies included in the systematic review been conducted. Considering heterogeneity when assessing the hundreds 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; results of this assessment were taken into account when interpreting the results of the NMA and making recommendations. 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 Chapter 17 with a summary provided in Chapter 7. Detailed results of inconsistency checks

					and comparison between mixed (NMA) and direct evidence have been provided in Appendix W of the full guideline draft. The Guideline Committee considered carefully the strengths and limitations of each of the 14 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 heterogeneity, the possible presence of inconsistency and the results of the bias-adjusted models, 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. The fact that some treatments may contribute very few studies and some others many studies is a characteristic of the evidence base, not of the method of evidence synthesis. You argue that "findings might not depict a representative range of treatment". This would also be true if we undertook multiple pairwise meta-analyses. The committee took into consideration the evidence base for each treatment, and focused on treatments with a wider evidence base. Treatments tested in very few trials or on a small number of people were not considered for recommendation. The committee also considered the connections across

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					interventions in each network and explored the impact of interventions tested in few trials that created 'thin' connections in the network on the NMA results. 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 guideline. The guideline committee acknowledged the strengths and limitations of the method and took them into account when making recommendations. In particular, we believe that the presence of potential effect modifiers in the data [which is unavoidable and cannot be fully accounted for in any complex dataset regardless of the approach to evidence synthesis] was satisfactorily dealt with where possible, and was considered appropriately when making recommendations.
Umbrella organisation comprising: AFT, BACP, BPC, BPS, BPF, MIND, National Survivor User Network,	Full	General	General	The guideline must take proper account of non-symptom outcomes The current draft guideline has an extremely narrow focus on symptom outcomes and fails to take into account other aspects of service user experience which have long been called for, such as quality of life, relationships and ability to participate in work, education or society. The guideline scope lists adaptive functioning, carer wellbeing and a range of other outcomes among the list of main outcomes	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues

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Psychotherapy Foundation, RCPsych, Society for Psychotherapy Research UK, South London & Maudsley NHS FT, Tavistock & Portman NHS FT, Tavistock Relationships, UK Council for Psychotherapy, University of Essex				to be considered, and yet the guideline takes no account of these outcomes. Analysis of these outcomes would significantly impact the findings of the reviews. This is known because a re-analysis of the 2004 NICE guideline studies focusing on non-symptom outcomes (quality of life and functioning) found that the 'best' treatments were not the same as those deemed 'best' from the analysis of symptom outcomesxix. This re-analysis demonstrates that such a review is both possible and useful. The Guideline Committee state, without foundation, that such an analysis is not possible because of the limited number of studies reporting such outcomes. Large amounts of inadequate evidence should not be used in place of small amounts of good evidence. Service users express a preference for improvements in quality of life over symptom change. The principle of patient-centred care, enshrined in the NHS Constitution and other NHS policies, demands that NICE take account of what service users actually want from treatment. NICE must run a re-analysis of studies using quality of life and/or functioning outcomes where these are available and prioritise recommendations based on these measures, given that these are the measures of greatest priority to service users.	raised, and a response to these issues, is provided in the table at the end of this document.
Umbrella organisation comprising: AFT, BACP,	Full	General	General	Conclusion If these serious methodological flaws are not adequately addressed in the guideline, the treatment recommendations cannot be relied on and will be	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments

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BPC, BPS, BPF, MIND, National Survivor User Network, Psychotherapy Foundation, RCPsych, Society for Psychotherapy Research UK, South London & Maudsley NHS FT, Tavistock & Portman NHS FT, Tavistock Relationships, UK Council for Psychotherapy, University of Essex				misleading, invalid and impair the care of millions of people in the UK, potentially causing clinical harm. During the meeting between this coalition of stakeholders and NICE, NICE representatives suggested that some of these concerns could be addressed in the next revision of the guideline. Whilst we hope that NICE will indeed improve their methodological approach in future guidelines, we maintain that these issues need to be addressed now and not postponed. NICE guidelines have a significant influence on UK policy as well as internationally and therefore, publishing this guideline in its current form would have a very damaging impact on service users, services, the health professional work-force and research practices.	received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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Umbrella organisation comprising: AFT, BACP, BPC, BPS, BPF, MIND, National Survivor User Network, Psychotherapy Foundation, RCPsych, Society for Psychotherapy Research UK, South London & Maudsley NHS FT, Tavistock & Portman NHS FT, Tavistock Relationships, UK Council for Psychotherapy, University of Essex	Full	General	General	Please note references below: References [1] NICE (2014). Developing NICE guidelines: the manual [1] Jobst, A., Brakemeier, E.L., Buchheim, A., Caspar, F., Cuijpers, P., Ebmeier, K.P… Padberg, F. (2016). European Psychiatric Association Guidance on psychotherapy in chronic depression across Europe. *European Psychiatry, 33*, 18–36. [1] Leichsenring, F., Abbass, A., Hilsenroth, M.J., Leweke, F., Luyten, P., Keefe, J.R.… Steinert, C. (2017). Biases in research: risk factors for non-replicability in psychotherapy and pharmacotherapy research. *Psychological Medicine, 47*(6), 1000-1011. [1] Health Foundation (2017). Healthy lives for healthy people. [1] Cochrane Collaboration (2011). [1] Hepgul, N., King, S., Amarasinghe, M., Breen, G., Grant, N., Grey, N… Cleare, A.J. (2016). Clinical characteristics of patients assessed within an Improving Access to Psychological Therapies (IAPT) service: results from a naturalistic cohort study (Predicting Outcome Following Psychological Therapy; PROMPT). *BMC Psychiatry, 16*(1), 52. [1] McPherson & Priestley (2016). Couples Disease: the experience of living with a partner with chronic depression. *Journal of Couple and Relationship Therapy, 17(*2), 128-145.	Thank you for your comment. Please see below for details of what has happened to the references that you have provided. • Cochrane Collaboration 2011: It is not clear what reference this citation refers to so we are unable to comment further. • Jobst 2016, Health Foundation 2017, Hepgul et al. 2016, Hengartner 2017, Leichsenring 2017 and Wells et al. 2009 have not been included in the guideline as they do not meet the study design criteria (not RCT or systematic review of RCTs) • Priestley and McPherson 2016, and Noyes et al. 2011 the experience of care section in the guideline has not been updated and these studies therefore do not meet the inclusion criteria of the review protocols • Keefe 2015, Del Re 2013, Kibret et al. 2014, Cipriani et al. 2013, Baker & Kramer 2002- are concerned with methodological issues associated with NMAs and so have been considered but cannot be included in the review • McPherson et al. 2009: Quality of life outcome which we did not include

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				[1] NICE (2014). Developing NICE guidelines: the manual, p107. [1] Noyes, J., Popay, J., Pearson, A., Hannes, K. & Booth, A. (2011). Qualitative research and Cochrane Reviews. In J. Higgins & S. Green (Eds.), *Cochrane Handbook for Systematic Reviews of Interventions (version 5.1.0)* (chapter 20). The Cochrane Collaboration. [1] Jobst, A., Brakemeier, E.L., Buchheim, A., Caspar, F., Cuijpers, P., Ebmeier, K.P… Padberg, F. (2016). European Psychiatric Association Guidance on psychotherapy in chronic depression across Europe. *European Psychiatry, 33*, 18–36. [1] Hengartner, M. (2017). Methodological flaws, conflicts of interest and scientific fallacies: implications for the evaluation of antidepressants. *Frontiers in Psychiatry*, December 2017. [1] Keefe, R. (2015). Correspondence. Heightened risk of false positives in a network meta-analysis of social anxiety. *British Medical Journal*, *2*(4), 292–293. [1] Del Re, A.C., Spielmans, G.I., Flückiger, C. & Wampold, B.E. (2013). Efficacy of new generation antidepressants: Differences seem illusory. *PLoS ONE, 8*(6), e63509. [1] Kibret, T., Richer, D., and Beyene, J. (2014). Bias in identification of the best treatment in a Bayesian network meta-analysis for binary outcome: a simulation study. *Clinical Epidemiology, 6*, 451–60. [1] Cipriani, A., Higgins, J., Geddes, J.R., and Salanti, G. (2013). Conceptual and technical challenges in network meta-analysis. *Annals of Internal Medicine, 159*, 130-137.	

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				[1] Baker, S.G. and Kramer, B.S. (2002). The transitive fallacy for randomized trials: if A bests B and B bests C in separate trials, is A better than C? *BMC Medical Research Methodology, 2*, 13. [1] Wells, G.A., Sultan, S.A., Chen, L., Khan, M. and Coyle, D. (2009). Indirect Evidence: Indirect Treatment Comparisons in Meta-Analysis. Ottawa: Canadian Agency for Drugs and Technologies in Health. [1] McPherson, S., Evans, C. & Richardson, P. (2009). The NICE Depression Guidelines and the recovery model: is there an evidence base for IAPT*? Journal of Mental Health, 18*(5), 405-414.	
The Royal College of Psychiatrists	Full	general	general	The omission of ketamine from the Guideline is of great concern. There are multiple RCTs (published well before this Guideline) demonstrating its acute antidepressant effects with relatively good tolerability. Given the lack of information regarding its longer term or repeated use a statement from NICE on its evidence based place in therapy would have been of value for clinicians and may have helped restrict its inappropriate widespread use.	Thank you for your comment. Ketamine was not prioritised for investigation by this guideline as it is not a currently available first-line intervention for depression, it is not licensed for use in depression and it is an abused drug. In these circumstance the committee did not think it was appropriate to review it. As a consequence we are not able to make any recommendations about it's use.
Mental Health Foundation	Full	General	General	This NICE guideline, "Depression in adults: treatment and management" is at risk of missing out on a critical dimension of efforts to tackle depression, that is, how depression in adults can be prevented. Issues of preventing depression are almost wholly missing in the document. Whilst there is a section on Relapse Prevention (pages 626-675), there is no wider discussion	Thank you for your comment. Prevention of depression is outside the scope of this guideline and we are not able to make recommendations on this issue. The Centre for Guidelines at NICE will consider your suggestion for a new NICE guideline on prevention of depression.

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				of the interventions and approaches to protecting wellbeing and preventing depression in adults from taking hold. Overall, the guidance is weak in terms of the early stages of depression (step 1 and 2 interventions). A wide evidence base for preventing depression now exists, as detailed in Mental Health Foundation publications such as 'Surviving or Thriving' (2017), 'Poverty and Mental Health' (2016), 'Mental Health and Prevention: Taking Local Action for Better Mental Health' (2016) and 'Better Mental Health for All: A public health approach to mental health improvement (2016). There is now a compelling case for investing in upstream interventions to stem the increasingly intense demands on mental health services, which should be underpinned by robust review of their efficacy. We suggest that there is therefore an opportunity for NICE to develop a separate, additional set of guidelines which set out best practice for preventing depression amongst adults from a public health perspective. This would complement the current guidelines on treatment and management.	
Mental Health Foundation	Full	General	General	We urge NICE to take a more proportionate and pluralistic approach to evidence. Evidence on the efficacy of public health interventions for prevention may need to be drawn from more diverse range of sources than in the treatment and management arena.	Thank you for your comment. Prevention of depression is outside the scope of this guideline and we are not able to make recommendations on this issue.

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				Whilst Randomised Control Trials (RCTs) provide important evidence, in the field of public health it is often possible to reach more robust conclusions by triangulating research from a range of disciplines and through mixed method studies. We recommend that NICE complement the evidence of RCT trials with qualitative, participatory, and other forms of quantitative research. A rigid approach of only accepting RCT evidence is particularly problematic when it doesn't consider the risks and costs associated with non-treatment, and issues of time-lag in the production of evidence. Mindfulness Based Cognitive Therapy (MBCT) has been undervalued by this approach. It is important to balance the evidence-threshold in proportion to the low levels of risk associated with using this treatment; and the higher levels of risk associated with non-treatment (for example because of waiting times; individual resistance to Cognitive Behavioural Therapy (CBT); or resistance to taking medication). Additionally, the constraints of only accepting RCT evidence risks missing opportunities provided by new digital solutions. In the fast-moving field of digital innovation, it is crucial that guidelines on digital solutions are developed to respond to new advances in a valid but timely way. Guidance needs to be contemporaneous with digital technologies, rather than providing recommendations on apps or technology which have	

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				already become obsolete. The rigidity of the RCT evidence model compromises the extent to which NICE guidance can be timely and impactful in a context where the public is increasingly buying commercial products which claim to benefit mental health.	
NHS England (IAPT Team)	Full	general		The guidelines are comprehensive and detailed, however, their emphasis seems to be more relevant to services outside general practice. Whilst it is understood that a number of cases may not be identified by general practitioners but it would be useful to recognise that their role in providing support and treatment to those whom they identify is essential. Practical clinical advice for general practitioners to effectively deliver their role in such cases would be invaluable.	Thank you for your comment. It is clear that GPs and other primary care staff have a central role in the identification, support and treatment of people with mental health problems. As case recognition, assessment, referral and the support that may need to be provided to ensure people with mental health problems can appropriately access treatment are often pandiagnostic, NICE developed a guideline across all disorders (Common mental health problems: identification and pathways to care (CG123)). GC123 makes recommendations on the areas where you have requested further guidance. The Depression guideline cites GC123 in its list of related NICE guidelines
NHS England (IAPT Team)	Full	general		It is not clear if representatives from general practice were part of the group of authors, academic organisations of general practice with track record of championing mental health such as Royal College of General Practitioners do not seem to be represented in the group developing these guidelines	Thank you for your comment. There were 2 GPs on the guideline committee both of whom had substantial academic experience which is documented in Appendix A. The RCGP were an active stakeholder in the consultation.
NHS England (IAPT Team)	Full	general		The document is too lengthy and it would be useful to develop concise sections relevant to clinical services in	Thank you for your comment. In addition to the full version that you commented on, NICE also

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				order to make the recommendations more accessible and implementable	produce a shorter version of the guideline which only contains the recommendations. Hopefully that version of the guideline will fulfil your requirements
University of Exeter	Full	General	General	A number of these now excluded trials represent significant investment of taxpayers' money through NIHR HTA commissioning. One of these trials, representing six year's work, £1.8m in direct research funding plus a further £500k excess treatment costs, was published online in the Lancet 22 days after the NICE cut-off date, through the vagaries of the Lancet's publication deadlines. In total, I estimate that trials being excluded from the new guidelines have cost around £5m of direct funds for HTA trials, plus associated excess treatment and service support costs, likely to be around a further £2m. This waste of taxpayers' money is simply scandalous. Several of these trials were commissioned as a consequence of research recommendations in previous NICE guidelines for depression. The investigator teams and NIHR responded to these research recommendations by designing, implementing and funding trials to address uncertainties identified in previous guidelines. This process has taken significant time and effort and represents a shift change in the size and quality of UK funded non-commercial depression trials. The UK now leads the world in large-scale trials of non-pharmacological treatments for depression, as a direct consequence of NIHR investment. None of this will now be used by NICE to guide depression treatment going forward.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				Although you have suggested a number of justifications for exclusion, including that inclusion would have made no material difference to your recommendations, these justifications are post-hoc, debateable and do not include economic data. One trial, now excluded, demonstrated a 21% direct cost saving to the NHS if an alternative non-pharmacological treatment is made available. Inclusion of this trial would have certainly changed the economic guidance on treatment choice for patients. It seems to me quite incredible that NICE should arbitrarily set search cut off dates without reference to the commissioned HTA trial pipeline, particularly where this pipeline represents exactly those trials recommended by NICE itself. Furthermore, it is now June 2018. NICE will not produce its depression guidelines until late 2018, meaning that around two and a half years will have passed during which a number of significant NIHR HTA funded trials have been published and yet will have no influence on the guidelines. This built in obsolescence will render the guidelines a laughing stock. NIHR and NICE exist to serve the public and clinicians. Guidelines that are produced two and a half years out of date, that ignore UK taxpayer funded investment in science, and do not represent the current clinical and economic data are themselves another, and arguably	

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				extreme, example of research waste. These guidelines are currently already obsolete.	
British Acupuncture Council	Full	General	General	Thank you for the replies to our previous comments. We shall not repeat all of that here (though we believe that most of it stands) but focus on the changes made by the committee in response. First, though, a reiteration of the main general point. There has been a trend recently, in those NICE guidelines where acupuncture is included in the scope, to adopt procedures that disadvantage it in relation to the orthodox treatment options. Other organisations than ours have come to a similar conclusion (see low back pain stakeholder comments). For depression, the key is to be included in one of the NMAs: virtually every sort of treatment that went into an NMA was recommended in some form or another, whereas virtually all of those relegated to pair-wise evaluation did not get recommended. Hence in order to avoid acupuncture endorsement it would be necessary to exclude it from the NMAs – and this is indeed what happened. The given rationale for this looks flimsy – this is discussed below.	Thank you for your comment. As we have stated in the guideline, acupuncture was excluded from the NMA because the participants in acupuncture trials may have been selected populations that would be different from those in the more and less severe networks. In addition the committee needed to ensure there was consistency across populations in terms of the nature of the depressive disorder and the broad context in which people were treated. On this basis, it was decided not to include acupuncture in the NMAs. This decision was not taken to disadvantage acupuncture or any other intervention investigated by pairwise comparisons. The reasons that interventions investigated in pairwise comparisons were not recommended was because the evidence did not support doing so.
British Association for Counselling & Psychotherapy	Full	52-59; 215-218	General	*Selection of studies for inclusion:* In summary BACP is expressing concern about this foundational aspect of the NMAs. Lack of clarity about included studies - As in our prior consultation response, we remain concerned about the fact that it is still very difficult to understand which studies have been included in the various analyses conducted. The	Thank you for your comment. Appendix J3.1 provides a full list of included and excluded studies for the NMA. The studies included in the various analyses for the NMA Is contained within Appendix N3 but we agree that this information could be more accessible and in response to this comment we have added a new tab 'Included studies per outcome' to Appendix J3.1 which provides a list of

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				implication of the lack of clarity about the included studies is that a core process in the NICE analysis is not transparent and not thus amenable to review. Confidence that the review of the literature was systematic and comprehensive – BACP acknowledges inclusion of 15 new RCTs in the NMA analysis as a result of BACP bringing them to the attention of NICE (p2 of consultation comments and responses document). However as stated in our prior consultation response the limited consultation time given the significant length of the documentation (main report plus all appendices) and the great complexity of the analyses run, made it impossible for BACP to do more than a cursory search for additional literature. The fact that even so we were able to locate considerable relevant missing literature does not allow us to feel confident that NICE has engaged in a comprehensive and systematic search of the relevant literature as it pertains to counselling and the treatment of depression. Our confidence is further undermined by the various errors in recording of studies/reference lists as detailed in the NICE response to the BACP consultation responses (p4 of consultation comments and responses document). A lack of confidence in the literature review which identified the relevant research for the NMA and other analyses obviously makes it difficult to have confidence in the findings. Confidence that the included literature is up-to-date – No studies published after June 2016 (p126 of consultation	the studies included for each outcome in each model of the NMA. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				comments and responses document) have been included in the analysis which means that by the time this guideline is published (potentially end of 2018) the literature review will be over two years out of date. This is also problematic.	
British Association for Counselling & Psychotherapy	Full	56-59; 281-284	General	*Insufficient consideration of bias:* BACP notes the various efforts to manage risk of bias but remains unconvinced that these were appropriate. Failure to use GRADE system developed for NMA: We made an important point about this in our last consultation response. No response to this feedback has been given. In our view this is a serious omission that has implications for being able to be confident in the overall analysis. In our last consultation response we noted that the Guideline authors did not use the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system for rating the quality of evidence and we identified systems that were, "because GRADE was not developed with network meta-analysis in mind" (Section 7.4 and 7.5). Although it is true, at least two GRADE-based evaluation systems are available for network-meta-analysis (Salanti et al., 2014; Puhan et al., 2014). It is acknowledged that these systems are recent yet although the Guideline authors address important GRADE-related issues while rating the quality of evidence, the assessment of quality of evidence conducted falls short of what is required by the two referenced systems, particularly with regard to the assessment of direct and indirect evidence (along with their methodological	Thank you for your comment. We apologise for not responding to your feedback about the GRADE system developed for NMA in the previous consultation. In our view, the GRADE system for NMAs described in the papers you cite is not fit for purpose in its current state and its application in guideline development is currently being assessed. Moreover, in the context of the Depression NMAs it would not be feasible to use this system as described in the papers by Salanti et al. and Phan et al., because of the particularly high number of pairwise (direct and indirect) comparisons that we would need to assess in each of the 14 NMAs that informed the review questions on the treatment of new episodes of depression. Instead, we took into account all factors that are assessed in a GRADE profile (i.e. risk of bias, publication bias, imprecision, inconsistency, and indirectness), using an approach that was modified accordingly to be suitable and feasible for the assessment of the quality of the NMAs, which were considered by the committee when making recommendations. The committee did not make recommendations based solely on the results of the NMAs and the economic analysis (including secondary/sensitivity analyses).

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				quality) for each effect estimate as well as regarding ranking treatments. Researcher allegiance: In our last consultation response we raised concerns about the failure to systematically consider this issue. We had previously argued that it is critical to assess researcher allegiance (RA) in psychotherapy research because this form of bias has been found to considerably impact the result of apparently 'neutral' trials (Munder, Brutsch, Leonhart, Gerger & Barth, 2013). Failure to assess RA thus makes it highly likely that the findings of the NMA analyses are inaccurate. RA was not assessed by the Guideline developers because, according to the consultation responses and comments document (p412), RA was not captured by Cochrane risk of bias tool used to assess studies. The importance of RA is then dismissed with the statement: "In head-to-head trials, one might assume, that this bias would balance out as the researchers for 1 study could be committed to 1 type of treatment whereas researchers of another study could show reverse allegiance, and thus across studies the positive and negative sources of bias should balance" (ibid). The idea of researcher allegiance "balancing out" in head-to-head trials is a very strong assumption, without any empirical or theoretical rationale. This might be true if the number/N of studies in each treatment class were equal however this is patently not the case in the studies that are included in the NICE analyses; this means that the impact of RA on the analyses was	They also considered factors such as the uncertainty and the limitations characterising the results, the breadth of the evidence base for each intervention, previous history of people with depression, individual preferences and patient characteristics. Regarding researcher allegiance: thank you for drawing our attention to the Munder et al. (2013), Flacco et al. (2015) and Cuijpers (2016) citations. This is an issue that is inherent in the studies and would also have been an issue had we conducted pairwise meta-analyses. The committee would have had to consider researcher allegiance in the context of hundreds of pairwise meta-analyses and attempt to draw conclusions on the relative effectiveness of all suitable options for the treatment of a new episode of depression and this would be no more (possibly less) achievable than the same task would be in the context of an NMA. Regarding the bias-adjusted analyses, thank you for drawing our attention to the Juni et al. (2001) citation. We would like to note that these were conducted not simply to correct for publication bias, but also to address quality issues, which tend to affect small studies more than large ones. We also note that a more intensive search for studies would not identify studies that are, by definition,

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				likely considerable. This is problematic as shown by the previously cited meta-meta-anlaysis of RA in psychotherapy trials; RA is also problematic outside this domain, as shown by findings suggesting that head-to-head trials are frequently industry sponsored and their findings mostly favour the sponsor (Flacco et al., 2015). There is currently no easily applicable method to deal with this issue on the scale of the network meta-analyses that were performed in the Revised Guideline, but it would have deserved a more intensive discussion, particularly as RA has been both assessed in a number of meta-analytic reviews of depression and found to significantly impact findings (e.g. Cuijpers, 2016). Overall the dismissal of the importance of RA as a source of bias is both unconvincing and worrying. Failure to conduct bias-adjusted analysis: Bias adjustment models were fitted to adjust for small-study bias, considered a proxy for publication bias by the Revised Guideline authors (7.3.6). Although the authors should be acknowledged for these analyses, other methods (e.g., a more intensive search for studies, including unpublished ones) may have limited publication bias even more effectively. Adjusting for methodological quality (risk of bias) domains in individual trials was not considered, although could have been performed rather easily. The justification for not performing a bias-adjusted analysis using domains of the risk of bias assessment (NICE consultation comments and responses document, p412) is thus not convincing. Based on the findings regarding risk	'unpublished'. A search in trial registries would identify registered studies, but the results of them might still be unpublished, so although we would be aware of their existence, we would not be able to assess/quantify the bias associated with unpublished studies identified with this approach. Adjustment for methodological quality (risk of bias) domains of individual trials was not feasible as, although there was considerable spread regarding quality ratings of the single domains (as you note), only few studies were overall rated as of 'low risk of bias', according to the RoB assessments, across comparisons, as, on average, most studies included in the NMA were of moderate quality. However, in order to undertake this type of bias-adjusted analysis, we need a good spread of an adequate number of overall good quality studies [i.e. studies with 'low risk of bias' in most areas] across comparisons, that can serve as an 'anchor' against which lower quality studies can be adjusted. Therefore, although we do acknowledge that this type of bias-adjusted analysis would have been useful in principle [and was considered as an option during guideline development], it was not feasible to undertake for the reason stated above.

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				of bias (7.4.1, 7.4.5), there was considerable spread regarding quality ratings of the single domains. Using these domain ratings (as recommended, instead of using a "global study quality" judgment; Juni, Altman & Egger, 2001)) would have been feasible and would have allowed for a more thorough consideration of risk of bias. Although, as stated, the small study adjustment is likely to have compensated for some of the methodological factors, it is unnecessarily simplistic. In general, risk of bias within and across the primary studies was sub-optimally addressed in the analyses reported in the Revised Guideline. Erroneous conclusions due to risk of bias in the primary studies (crudely addressed through the small study adjustment), researcher allegiance (unaddressed), and publication bias (very crudely accounted for through the small study adjustment but not seriously addressed through intensively searching for unpublished studies, see 3.5) cannot be excluded.	
University of Nottingham	Full	185-189		As identified in this section the research omits diverse perspectives on depression. Understanding different paradigms is important and by limiting the evidence to a medical paradigm the scope of the research is not inclusive. Many clients do not consider their depression to be an illness and conceptualise it in a variety of ways. We recommend the report takes note of the outcome of the	Thank you for your comment. The patient experience section from the 2009 guideline was not included in this update. In line with NICE processes, the 2009 content has been carried across to this updated guideline but we are not able to add new evidence to the existing review. In addition, the PRaCTICE trial has not yet published so we are not able to take account of the results of

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				PRaCTICE trial which compares a medical approach (CBT) to a humanistic approach (PCE-CfD). As a result of dialogue with Islamic counselling group organisers, Sabnum Dharamsi and Stephen Abdullah Maynard, we have been made aware of the DSM-5 supplements regarding the (new) Cultural Formulation Interview (CFI). The CFI assesses both the cultural or ethnic groups that the client belongs to and the ways in which they understand and experience their situations. CFI and its associated conceptual material are not widely used and many diagnoses don't take into account cultural formulation at all. Growth from distress is best facilitated in a relational approach such as that offered by communities who work with their members and in the approach as described in person-centred experiential therapy. Translation facilities vary across the country, and are often inadequate. BAME communities experience complex life events that lead to complex emotional challenges and levels of distress. These can include asylum seeking, previous experience of war, DV and FGM and intergenerational trauma. In PCE-CfD the relationship is central, the client leads the therapy so the potential for trust to develop is higher than in approaches that pathologise diagnose or offer cognitive based approaches that avoid emotions, circumstance and trauma. Person-Centred Experiential approaches are familiar and recorded in the literature internationally as being impactful with traumatized clients. Investment into	this study in the guideline. We will forward this information to the NICE surveillance team for consideration. We note your reference to a proposed new assessment system, but the assessment section of this guideline was not part of the update. They system you mention may be considered by future updates of the guideline. In describing a range of other mental health disorders where this system may be useful, you make reference to a range of traumatic events (e.g. domestic violence). These are likely disorders which would be more appropriately addressed within the remit of the PTSD guideline which is currently being updated.

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				supporting communities to develop their services, access training and increase the workforce is essential.	
British Association for Counselling & Psychotherapy	Full	206-210	General	Classification of interventions *Clinical heterogeneity of interventions:* As BACP noted in our last consultation response, the decision how to define interventions and interventions classes remains immanently subjective (Kriston, 2013). As Linde et al. (2015a) state: "Because psychological treatments are considered complex interventions, grouping them can be performed along several dimensions and remains controversial" [see also Craig et al, 2008]. The fact that the decision on the classification of interventions was informed by expertise and previous work is encouraging. However, this decision is and cannot be a purely scientific one (even if different scientists group the interventions similarly across reviews). The grouping of (more or less complex) interventions in mental health care is rarely unequivocal and is based on some assumptions regarding modes of action and active components that are unlikely to be shared by every recipient. Similarly to the definition of interventions, the definition of classes can also be debated; especially for psychological interventions (particularly self-help and computerized treatments), for which no generally accepted classification exists. It might be considered somewhat confusing that similarity of mechanisms of action was used to justify the definition of treatments and grouping them into classes (7.3.3), but at the same time the Revised Guideline authors	Thank you for your comment and for drawing our attention to the Kriston (2013), Linde et al. (2015) and Craig et al. (2008) citations. The grouping of interventions into classes was necessary as the systematic review of interventions for the treatment of new episodes of depression included 366 trials and 118 distinct interventions in the second consultation draft. It would be unfeasible for the committee to consider all individual intervention effects when making recommendations. As we explained in our responses following the previous consultation, the class model retains the individual intervention effects, whilst borrowing strength from the other elements in the class; relative effects between classes are easier to interpret and more helpful to decision-making when there are many treatment options. We note that although Linde et al. (2015a) state that "grouping [psychological treatments] can be performed along several dimensions and remains controversial", they also grouped psychological interventions in their meta-analysis. Similarly, Barth et al. also classified psychological interventions into 7 different types in their network meta-analysis [PLoS Med 10(5): e1001454]. Both studies further classified interventions according to mode of delivery (individual vs group, face-to-face vs remote

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				recommend further research exactly on these mechanisms of action in psychological treatments (7.8.1). Thus, definition and grouping of psychological treatments should be considered preliminary. Treatment as usual - Section 7.3.3 states that "it was agreed that the treatment effect of an intervention added onto TAU should mainly be attributed to the active intervention, in particular if TAU comprises 'basic' care and support. For this reason, active interventions added onto TAU were treated as variations of the active intervention and formed different interventions within the active intervention's class", which can be considered a reasonable form of dealing with interventions provided with or without TAU. Unfortunately, the results reported in Section 7.4 and 7.5 do not inform on interventions added to TAU (detailed results are to find in the Appendices). As the decision whether an intervention should be added to TAU or replace it may be a clinically important one, addressing this issue in the main document would be desirable. In summary, the NMA utilises categorisation of the included studies into classes but the judgement about class membership is necessarily subjective; it is thus entirely possible that different groupings would have resulted in different findings from the NMA.	contact, as well as according to number of sessions/contact intensity). Lack of classification would make results on individual interventions difficult to interpret and impractical for decision-making. For our classification, the committee used similar principles with these two studies. Our definition of classes and interventions was based on the committee's expert opinion, after considering their similarities and differences in their mode of action, treatment components or approaches, using objective criteria as much as possible. We accept that currently no system of classification of psychological interventions is entirely objective so that some subjective judgement is necessary. The fit of all NMA models to the data was checked and we were satisfied that the data supported the modelling assumptions, including those relating to formation of treatment classes. The research recommendation on mechanisms of action in the second consultation draft focuses on the identification and isolation of the effective components and delivery elements of each intervention that has been found to be effective, so that these can inform the development of new treatments. In contrast, the classification of the interventions in the NMA was informed by similarities across interventions in the overall mode

					of action and treatment components or approaches; these characteristics, for each psychological intervention considered in the NMA, were described in the respective RCTs included in the NMA. Regarding the reporting of results relating to TAU: as you describe, active interventions added onto TAU were treated as variations of the active intervention and formed different interventions within the active intervention's class. Results are reported for classes of interventions, and do not include the results for individual interventions [such as interventions added to TAU]. This is because relative effects between a more limited number of classes were easier to interpret and thus more helpful for the committee when making recommendations. Nevertheless, for the SMD of depressive symptom scores, which was the main efficacy outcome, the forest plots of individual intervention effects versus pill placebo were also provided for information. These figures do not include the results for interventions added to TAU, because these treatments were considered to be variations of the active intervention and not part of the decision problem per se. As we stated, TAU across trials comprised basic care and support; this should be part of the NHS care and thus would not be possible to 'remove' or 'replace' by an active intervention. Moreover, the evidence for some interventions added to TAU was too limited to allow

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					robust conclusions on whether TAU should remain as a component of the intervention or be replaced by the active intervention. In any case, the committee considered primarily the class effects and the effects for individual interventions that were part of the decision problem and did not focus on whether an intervention should be added to TAU or replace it. For this reason, and for completeness in reporting, results of interventions added on TAU are included only in the guideline appendices.
UKPCE	Full	185-189		As identified in this section the research omits diverse perspectives on depression. Understanding different paradigms is important and by limiting the evidence to a medical paradigm the scope of the research is not inclusive. Many clients do not consider their depression to be an illness and conceptualise it in a variety of ways. We recommend the report takes note of the outcome of the PRaCTICED trial which compares a medical approach (CBT) to a humanistic approach (PCE-CfD) Consultations with members of Islamic counselling services highlights that diverse communities are not as yet, well served by IAPT and research carried out by the BACP confirms that poverty and social deprivation impacts on the MDS outcomes, clearly indicating that the need for diverse approaches such as PCE-CfD are invested into alongside collaboration with community based services, that need to access funding in order to attend training provided by our institutes. This would be easily executed and with our	Thank you for your comment. The patient experience section from the 2009 guideline was not included in this update. In line with NICE processes, the 2009 content has been carried across to this updated guideline but we are not able to add new evidence to the existing review. In addition, the PRaCTICE trial has not yet published so we are not able to take account of the results of this study in the guideline. We will forward this information to the NICE surveillance team for consideration.

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				positioning in England could make a significant impact over a broad area in a few years.	
University of Nottingham	Full	586-588		PCE-CfD is not represented. RCT's are limited in regards to the evidence they offer and 'real world data' such as that revealed by the MDS data needs to be valued and included in this context. Clients are reporting recovery as a result of experiencing CfD in equivalent, if not slightly higher instances to CBT and this needs to be reflected in the evidence.	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document.
UKPCE	Full	586-588		PCE-CfD is not represented. RCT's are limited in regards to the evidence they offer and 'real world data' such as that revealed by IAPTs internal, MDS data needs to be valued and included in this context. Clients are reporting recovery as a result of experiencing PCE-CfD in equivalent, if not slightly higher instances to CBT and this needs to be reflected in the evidence.	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document.
University of Nottingham	Full	810-811	All lines	Economic model. The assumption that there is no or negligible mortality in the first 12 weeks after prescription	Thank you for your comment. We note that in no place in the guideline do we claim that "there is no

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				of antidepressants is unsound in relation to NHS clinical practice for which this guidance was produced. In randomised controlled trials (RCTs), patients are carefully selected to have no history or current clinical features indicating suicidality or any significant physical illness so suicides and mortality are extremely rare. Our BMJ paper in 2015 (Coupland et al, 2015) showed increased suicide rates in the first 28 days of the prescription of any antidepressant. However we also showed increased rates of suicide in the first 28 days of stopping an antidepressant (although these are not as great as when starting the antidepressant). If you claim that there is no need to include mortality in your economic models because the RCTs in your network meta-analysis did not report excess mortality, then you must acknowledge the lack of relevance of your economic model to NHS practice. NICE is inconsistent in its approach. In some NICE guidelines using economic modelling, suicide and mortality is allowed for even if there are no reported suicides or deaths in RCTs used to estimate treatment effects in a NMA. The assumption seems especially inappropriate given that 70% of suicides are due to depression and antidepressants may be implicated in suicidality in the early stages of treatment.	or negligible mortality in the first 12 weeks after prescription of antidepressants". In fact, we acknowledge that "the mortality risk in people with depression is higher than that of people in the general population, but also that "suicide (which is the main cause of death in adults with a new episode of depression) is a rare outcome in trials, and there are no substantial differential data on suicide between treatments". Also, we report that "The GC expressed the view that consideration of suicide in the acute part of the model would have no significant impact on the relative cost effectiveness between different treatments". We note that mortality (including suicide) WAS considered in the Markov component of the economic model, which lasted 2 years. We also note that the paper by Coupland et al. focuses on suicide associated with antidepressant treatment, and not with other, non-pharmacological treatments, so the information included in the paper would not be useful in populating all arms of the economic model, as we needed differential mortality data across all pharmacological, psychological and combined treatments included in the model over the first 12 weeks. Another thing to point out is that, although the paper by Coupland et al. reports that the relative risk of suicide is increased with some antidepressants vs others, it also reports that the absolute risk of suicide over

					one year was 0.05% for citalopram and 0.19% for mirtazapine (these were the only drugs included in the economic analysis). These figures would translate into 12-week probabilities of 0.012% and 0.044%, respectively, assuming exponential function. Even if we conservatively assume that these 12-week probabilities are 50% higher (because in the first 28 days the risk of suicide is higher), this would give us a 12-week risk of suicide of 0.02% and 0.07%, for citalopram and mirtazapine, respectively. This means that out of 1000 people in the hypothetical model cohort for each drug, 0.2 and 0.7 would die because of suicide, respectively, in the first 12 weeks of the model. We note that there is suicide risk associated with other non-pharmacological treatments, therefore the differential effect of suicide between drugs and non-pharmacological treatments is lower than 0.2 and 0.7 deaths per 1000 people, respectively. We argue that the impact of this difference in deaths between a drug and a non-pharmacological treatment on the relative cost effectiveness between them would be very small over the time horizon of the analysis [12 weeks + 2 years], and this is the opinion expressed by the committee. Therefore, we believe that omission of death in the first 12-weeks of the model did not have a considerable impact on the results of the analysis and was an appropriate model simplification due to lack of relevant differential mortality data across interventions. In the

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					discussion section of the economic analysis we do acknowledge that lack of consideration of side effects associated with pharmacological treatments "has potentially overestimated the cost effectiveness of drugs or combined interventions with a drug component relative to other interventions" and this was taken into account by the committee when formulating recommendations.
Tavistock & Portman NHS Foundation Trust	Full	360 - 361		Definition of TRD The currently adopted definition of TRD in the guideline (p 360) are exclusive pharmacological and requires the operationalisation of dose and duration monitoring. It is a definition that is not used in clinical settings where individuals are identified and diagnosed descriptively, involving a complex evaluation of psychosocial functioning across several domains.	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document.
The Royal College of Psychiatrists	Full	91-92	general	It is fallacious to quote frequencies of experience reported from the Healthtalk modules. The method of analysis used in creating Healthtalk modules (thematic analysis) is explicitly designed to report the range BUT NOT the distribution of experiences. So, to say that 3 of 4 patients reported negative experiences with ECT is misleading. Clearly there is going to be a huge sampling bias, not to mention a tiny sample. Further, the specific ECT module	Thank you for your comment. The text you refer to is in the section on patient experience which was not included in this update. In line with NICE processes, the 2009 content has been carried across to this updated guideline but we are not able to add new evidence to the existing review.

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				on Healthtalk should be the source of information on ECT, not the Depression module. The ECT Healthtalk module (as opposed to the depression Healthtalk module) includes several accounts by patients and their families of their experience of having to work hard to persuade their psychiatrist to give them ECT, knowing that it is the only thing that helped them. Further information on the point of the general acceptability of ECT in the UK can be found in the paper by Maguire et al (Ulster Med J, 85, 1182-186, 2016) which showed a high compliance with ECTAS standards and that 80% of patients felt they had benefitted from ECT.	
University of Nottingham	Full	50- 51	18-31 1-27	PCE-CfD is again omitted. We receive numerous accounts of how PCE-CfD is frequently the approach offered in services where CBT and CT and pharmacology fail.	Thank you for your comment. The text you refer to is the methods section of the guideline which describes how it was developed. It would therefore not be appropriate to mention a specific intervention at this point.
UKPCE	Full	50- 51	18-31 1-27	PCE-CfD is again omitted. We receive numerous accounts of how PCE-CfD is frequently the approach offered in services where CBT, CT and pharmacology fail.	Thank you for your comment. The text you refer to is the methods section of the guideline which describes how it was developed. It would therefore not be appropriate to mention a specific intervention at this point.
British Association for Counselling & Psychotherapy	Full	50; 70-85	General	*Consideration of service user voice in revised Guideline:* We noted in our last response that the section on the patient user experience in the 2009 Guideline had not been updated which means that by release this section will be over a decade old. While there was some inclusion of service user voices in the process of the guideline development this is not any substitute for seriously	Thank you for your comment. When updating a guideline, a decision is taken whilst developing the scope as to which sections of the guideline will be updated and which will not. When the scope for this update was developed, the patient experience section was explicitly not included as part of the update. Registered stakeholders would have had

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				considering the considerable and growing literature on how those with depression experience treatment for depression. As such we maintain that the current revised guideline has failed to sufficiently consider service user voices, in contradiction with both NICE and NHS mandates in this regard. This remains hugely problematic and significantly undercuts confidence in the recommendations. It is also contrary to both NHS and NICE policies around prioritising the service user voice.	the opportunity to comment on this proposal as part of consultation on the draft scope. Subsequent to consultation, the scope was finalised and the patient experience section was excluded from the update. It is not now possible to go back and reverse this decision. However the committee developing the guideline included several service user and carer members who were able to provide their perspectives during discussion of the evidence and who were integral to the development of the recommendations in those areas of the guideline that were being updated.
Lundbeck	Full	43	2-3	We are pleased that the description of vortioxetine has been revised to align with the description given in NICE TA367. This description better reflects the different multi-modal action of vortioxetine.	Thank you for your comment and your support.
The Royal College of Psychiatrists	Full	44	40-41	"… ECT is usually used for the treatment of severe, high risk depression or following unsuccessful treatment with pharmacotherapy." It is important to note that the positive evidence for ECT extends well beyond these groups and the restriction in its use is a phenomenon related to Guidelines including NICE Guidelines. Left to clinicians' evidence-based judgements, ECT would be far more widely used. (Please see more detailed discussion on this point at comment number 15)	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data. The wording of the background text may also be amended.
The Royal College of Psychiatrists	Full	44	37	"…which is a particular concern for older patients." Why is longer term autobiographical memory loss (which is relatively uncommon) more of a concern for older	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for

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				patients? We would have thought it was more of a concern for patients of working age required to remember things for their job etc. This unreferenced statement is inappropriate	those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data. The wording of the background text may also be amended.
British Association for Counselling & Psychotherapy	Full	15-16; 51	General	*Guideline Committee membership:* In our last response we raised an issue about the checks carried out on the committee members to ensure that as a committee they represented (overall) an unbiased group. Given the reliance in the production of these guidelines on the views of the Guideline Committee this is critical. We previously outlined our concerns about the failure to (apparently) consider or provide information on the specific professional allegiances of the members of the guideline group, such as which therapies and interventions they have been trained in, or which they research, train others in, and currently use/ recommend to patients. We note that some of this information might be inferred from the Declaration of Interests in Appendix B of the Guideline and – from what can be gleaned – the committee membership included a number of members with probable allegiance to CBT, BA and MBCT; potentially two members with allegiance to psychodynamic models and no members with allegiances to counselling. The apparent evidence thus is that the membership of the committee may not have been neutral in this crucial area of allegiance to therapy models. The failure to consider this source of bias	Thank you for your comment and for drawing our attention to the Munder et al. (2013) citation. In selecting people for the committee we are guided by the specification for committee membership set out during the scoping phase of guideline development. In drawing up the scope, which was the subject of public consultation, NICE seeks to recruit a broadly representative group of members. It is not possible to meet your requirement to represent all possible therapeutic orientations in the committee when other criteria such as profession, area of work and clinical and academic expertise are taken into account. We believe that NICE's methods and the consultation processes are important safeguards against individual bias effecting the interpretation of the evidence.

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				in the committee is deeply problematic given the fact that 'researcher allegiance' to therapy models is a known and significant biasing factor in psychotherapy research (Munder, Brutsch, Leonhart, Gerger & Barth, 2013) and potentially in the context of Guideline recommendations.	
University of Nottingham	Full	66	6-28	There is no reference to academic institutes such as ours as stakeholders who offer the education to the NHS counsellors involved in the NHS funded services and who also carry out the research that provides the evidence to NICE	Thank you for your comment. We have included academic institutes in the list of stakeholders.
UKPCE	Full	Pg 66	6-28	There is no reference to academic institutes which make up the membership of UK-PCE As stakeholders we offer the education to the NHS counsellors involved in the NHS funded services and carry out the research that provides the evidence to NICE	Thank you for your comment. We have included academic institutes in the list of stakeholders.
SignHealth	Full	187	13-16	Recognition and assessment 6.8.19 We have no doubt that the intention behind this was probably well meant. But if communication with a Deaf patient is difficult (because the clinician does not use British Sign Language), then they need to remedy that by using a BSL/English interpreter. A Deaf patient may be very willing and able to talk about their depression, but they are 'disabled' by the clinician not understanding them. Trying to go around the barrier, rather than removing it, by asking family members would be wrong. A clinician may well want to get the views of family members, but that is a separate issue and would apply whether the person was Deaf or not. NHS England's Accessible Information	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				Standard provides very clear guidance on issues such as this.	
Tavistock & Portman NHS Foundation Trust	full	190	7.1..12	This sentence is not correct. Psychoanalytic treatment did not emerge in the 1950s 1960s. It was the dominant treatment modality within Western psychiatry until other psychological treatments began to emerge from it in the 1950s and 1960s.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data. The wording of the background text may also be amended.
Tavistock & Portman NHS Foundation Trust	full	196	7.1.2.19	Why is the description of long-term psychodynamic psychotherapy so brief in comparison to all others? Could this section please be amended to do justice to this form of treatment? Also, why does it include the following sentence: "A number of recent trials have examined a longer-term version of psychodynamic psychotherapy with treatment durations of up to three years." This section is intended to describe a modality and not to compare it to others in this way. None of the other description include a sentence to that effect.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data. The wording of the background text may also be amended.
NHS England (IAPT Team)	Full	197	13-26	Many peer roles are paid – so "peer volunteers" should be replaced with "peer workers or volunteers". There is a significant omission of recovery college courses as a widespread example of psychosocial intervention. Suggest therefore changing "These interventions can include	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all

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				befriending and mentoring" to "These interventions can include befriending, mentoring and recovery college courses".	of the analyses will be updated and the wording of recommendations reviewed in light of this updated data. The wording of the background text may also be amended.
The Royal College of Psychiatrists	Full	197	30	"… ECT is perceived by many healthcare professionals to be a safe and effective treatment… " This conflates evidence of perception, with clinical evidence of efficacy. This statement should read "ECT *is* a safe and effective treatment" as there is irrefutable evidence to support this fact.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data. The wording of the background text may also be amended.
The Royal College of Psychiatrists	Full	198	14	The polarisation of views is addressed in a recent paper (Knight et al, Qualitative Research, 27(11):1675-1685, 2017) which suggests that this polarisation relates largely to the environment surrounding inpatient care rather than to the ECT itself, and that high quality practice is associated with better patient experience.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data. The wording of the background text may also be amended.
British Acupuncture Council	Full	201	41-48	Thank you for providing an explanation of why acupuncture was excluded from the NMAs. Unfortunately we find it to be unconvincing and to raise more questions than it answers.	Thank you for your comment. We have responded in detail to your other comments where you raise specific concerns.

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British Acupuncture Council	Full	201	45-48	There are around 3000 acupuncturists on a register that is accredited by the Professional Standards Authority; hence GPs can refer to them (GMC guideline, 2013). These members of the British Acupuncture Council are indeed 'appropriately trained and competent people to deliver acupuncture for the treatment of depression'. Guideline endorsement in respect of acupuncture is not about weighing down the NHS with acupuncture responsibilities: we know from experience in the past with back pain that few commissioners will fund it. This is about the NICE stamp of approval giving GPs more scope in what they suggest to patients, which for acupuncture would be mainly private treatment. NHS England (2017) already recommends acupuncture for depression, in its shared decision making advice, as a possible self-help intervention. The fact that acupuncture actually has positive evidence (however it may be classified or interpreted) would support this use: a tool for self-help that can support the patient as they also explore other interventions. It would be helpful to see NICE move into line with what proves to be valuable to patients and clinicians on the ground.	Thank you for your comment. We accept that GPs can refer to acupuncturists. However we have looked at relevant education materials and standards for acupuncture as set out by the British Acupuncture Council, for example those on diagnosis, and could find no specific reference to mental health conditions. The focus of this guideline is treatment in the NHS and not private treatment, which you identify as the main route into treatment for those who want acupuncture.
British Acupuncture Council	Full	201	41-43	Please explain why you think that the acupuncture trial populations were selected in a way that made them significantly different from those used for all of the other interventions? About half of the total acupuncture participants in the trials reviewed here derived from the NIHR funded UK study (MacPherson 2013), which was	Thank you for your comment. We think that people who would agree to take part in a controlled trial of acupuncture may be different to those who go into trials of more standard treatments (e.g. drug/psychological therapies). We do however accept that the NIHR funded study was as you

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				purposely aligned with normal practice in the UK for each aspect of PICO. Is there any substantive basis to the committee's lack of confidence in this respect or is just supposition?	describe, aligned with normal practice. But this alignment does not fully discount that the population may be somewhat different. We have amended text to make this clearer.
British Acupuncture Council	Full	201	43-45	There were 7 Chinese studies and one each from the UK, US, Australia, Sweden and the Netherlands. The issue of different healthcare systems to the UK presumably relates to the Chinese component, as this is stated explicitly elsewhere in the guideline. What are we meant to make of this? The healthcare setup in the US is also very different from that in the UK, and many of the studies of other interventions are US studies, but the committee were not, apparently, concerned with that. In the responses to our comments on the first draft, though not in the text of the second draft, there was an additional idea put forward, that in a country (like China) where acupuncture use is more common place the expectations of treatment response are likely to be higher. Given that one of the arguments levelled against acupuncture evidence in the past was that patient expectations in Western countries would be higher than for orthodox treatments, because of its exotic nature, this argument is hard to take seriously. There is little evidence to support either of these viewpoints. Further explanation, please, preferably with some hard evidence. If there were a good reason for exclusion of acupuncture on the basis of the Chinese studies then why not just	Thank you for your comment. We do think that the Chinese healthcare system is significantly different from other healthcare systems in high-income, developed countries principally because access to healthcare (particularly primary care) is very different; systems for payment are different and cultural attitudes to acupuncture are different. The systems for the delivery, assessment and broader cultural placement of acupuncture is very different in Chinese society and this was taken into account when making the decision to exclude it from the NMA.

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				remove the latter and enter acupuncture into the NMA with the other 5 trials?	
British Association for Counselling & Psychotherapy	Full	210	General	Outcome variables *Development of a hierarchy of depression scales:* In our prior response we pointed out one example of where there has been insufficient time to allow for proper scrutiny would be section 7.3.4, p210-211 of the draft Guideline, which refers to the development of a "hierarchy of depression scales" "based on GC expert advice"; this hierarchy led to the inclusion in the network meta-analysis of data related to some scales but not others. No information is given in the documentation about either the rationale for the prioritising of some instruments over others or the impact of data 'lost' from the analyses; it is possible that the impact of these decisions on the findings of the analyses was considerable. In the consultation response from NICE this point has not been addressed which means both that no rationale has been provided for the choices made by the GC (Guideline Committee) and it is still entirely unclear what impact the preferential ranking of instruments had on the analysis. *Issues with SMD outcome and response variables may have biased results*: Standardised mean difference of change from baseline scores, response, and remission were used as efficacy outcomes in the network meta-analyses (7.3.4). In our prior consultation response, we argued that there were problems with the decision to focus on change from baseline SMDs as the key outcome	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document. As we argued in our prior response to your comment, the SMD was selected by the committee as the main clinical outcome because it is a measure commonly used in research (the use of 'effect size' as an outcome in a large number of research studies usually refers to SMD) and the committee was familiar with interpretation of findings expressed in the form of SMD. Use of SMD instead of MD was essential, because studies reported change-from-baseline or endpoint scores on a wide range of scales, and these data could only be combined in the form of SMD. As we explained in our previous response, we used change-from-baseline scores and not endpoint values, as the latter may be affected by the

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				variable for the clinical NMA. The authors of the Revised Guideline argue that change-from-baseline scores counteract baseline differences within studies, which is indeed a clear advantage over end-of-treatment scores. However, the majority of the change-from-baseline SMDs could not be directly calculated from reported data and the standard deviations that are needed to calculate them had to be estimated. An assumption behind this estimation was that the correlation between baseline and end-of-treatment scores is .5. However, this assumption was not supported by corresponding analyses (Appendix N1/1.2.7), and it remains unclear, whether and how it influenced the results, which is particularly problematic given that this uncertainty effects the majority of the SMDs used in the analyses. The same applies to response data, which was frequently estimated from the standardized mean differences. Further, as SMDs are extremely sensitive to the standard deviations that are used for calculation, it remains unclear, whether and how the results were influenced by using estimated change-from-baseline rather than observed end-of-treatment data. A corresponding sensitivity analysis could have provided some insight but was not conducted. The Revised Guideline authors themselves do acknowledge that the mixture of methods of imputation of missing continuous data in the primary studies (e.g.,	variation of baseline scores of the study samples in each trial – the advantage of our approach over the use of endpoint values instead is acknowledged in your comment. As you correctly report, the majority of the change-from-baseline SMDs could not be directly calculated from reported data and the standard deviations [SDs] of the change scores (that are needed to calculate them) had to be estimated. To this direction, we attempted to impute the SD using a correlation coefficient following an approach that is consistent with the methods recommended in the Cochrane Handbook (version 6, section 16.1.3.2): a number of studies within and beyond the NMA dataset were first identified that reported data that could be used to estimate a correlation coefficient; however, available data were very sparse and the correlations estimated from these studies varied widely. This variation in correlations was not a systematic, robust finding that could be attributed to specific studies, interventions or scales. Therefore, assuming different correlations for different studies/interventions within the NMA based on this evidence was not possible. Instead, we assumed a correlation between the baseline and end-of-treatment scores of 0.5. The same assumption was applied to continuous scale data that were used to estimate response in those

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				baseline vs. last observation carried forward) may have biased the results; overall important questions still remain about whether the approach taken for the key outcome variables has led to biased findings. Failure to focus on long-term follow-up data: The Revised Guideline authors state that data on follow-up was not extracted because it was not available for many studies. However, data on economic outcomes were also sparse, but they were extracted and used for analyses anyway. Missing results on the long-term outcomes of the investigated treatments is missing a very important piece of clinically highly relevant information that is essential for choosing between treatment options in routine depression care. In summary, it is the view of BACP that there are a number of important concerns about the outcome variables selected for the NMAs which cast doubt on the findings.	randomised or response in completers in trials that did not report dichotomous response data. We note that we tested this assumption in a sensitivity analysis (as recommended in the Cochrane Handbook), using a correlation of 0.3 across all analyses that utilised continuous data (i.e. SMD, response in those randomised and response in completers) and we found that overall the results were similar to the original analyses, although for most outcomes the uncertainty slightly decreased and for a few outcomes the uncertainty slightly increased. The results of this sensitivity analysis indicate that use of an alternative assumption for the correlation between the baseline and end-of-treatment scores would have no substantial impact on the results. Assuming a correlation of 0.5 and testing this assumption in sensitivity analysis is consistent with guidance provided in the NICE Technical Support Document 2 (section 3.4.1). A sensitivity analysis using end-of-treatment data (and a comparison between the results of this analysis and the results of the analyses that utilised change-from-baseline scores) was not considered useful or appropriate, because of the limitations characterising the end-of-treatment data, as

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					described above, and therefore it was not conducted. We have indeed acknowledged that the mixture of methods of imputation of missing continuous data in the primary studies may have biased the results, but this is a problem inherent in the evidence base (i.e. the studies and data that informed our NMA) and not a problem of our method of analysis. The diversity in the methods used to impute missing data in primary studies is a problem present in most meta-analyses.
British Association for Counselling & Psychotherapy	Full	218	General	*Homogeneity of study population:* Combining studies on pharmacotherapy, psychotherapy, and (computerized) self-help interventions can be seen as problematic in terms of assumptions about the homogeneity of the study population. Populations in these studies are likely to be different with regard to characteristics that are not or only weakly correlated with treatment severity, jeopardizing the transitivity assumption behind the performed network meta-analyses. Although the Revised Guideline authors discuss this issue at several points (e.g., 7.4.1), in absence of an empirical investigation of the distribution of possible effect moderators across these trials, their arguments remain somewhat speculative. In summary, the failure to more properly investigate the population homogeneity or to consider running NMAs for psychotherapy versus pharmacotherapy separately casts	Thank you for your comment. Heterogeneity in populations participating in pharmacotherapy, psychotherapy and self-help interventions can be a problem in both pairwise and network meta-analysis. Effects obtained from the NMA are exchangeable across populations if populations are similar enough and there are no underlying effect modifiers that are unequally distributed across trials - the same applies to pairwise meta-analysis. A large part of heterogeneity in populations was controlled by splitting populations with less and more severe depression and conducting separate NMAs for each level of severity. Other potential effect modifiers, such as age and setting (outpatient vs outpatient) were assessed in sub-analyses, using pairwise meta-analysis. The

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				doubt on the findings of the NMAs run since a central assumption of network meta-analysis is that the populations investigated in a network are clinically homogeneous.	committee considered the similarities and differences of populations across trials included in each level of severity and agreed that populations were similar enough to be included in the same network meta-analysis and the same decision problem. If populations in pharmacological, psychological and self-help trials were considered to be systematically different from each other, then it would also be incorrect to consider these interventions as alternative treatment options in the same decision problem and conduct pairwise meta-analysis to inform decisions. It is acknowledged that other parameters, such as sex and socio-economic factors may also contribute to the heterogeneity of study population, but examination of the data did not suggest that these differed systematically across pharmacotherapy, psychotherapy and self-help trials. It is possible that individual treatment preferences differ across trials (so that a person that accepts to participate in a trial of A vs B may not accept to participate in a trial of A vs C or a trial of C vs D), but this cannot be checked systematically. Preference for a treatment is a potential effect modifier that cannot be easily controlled when synthesising evidence from multiple RCTs and interventions, regardless of the topic area and the method used for evidence synthesis (i.e. NMA or pairwise meta-analysis). Therefore, heterogeneity of the population in this

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					aspect would also be a concern had we conducted pairwise meta-analysis. The fact that treatment decisions may be influenced by individual values and goals, and people's preferences for different types of interventions has been acknowledged by the committee during guideline development and in the second consultation draft. Overall, taking into account the potential heterogeneity of populations when assessing the hundreds 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; results of this assessment were taken into account when interpreting the results of the NMA. In addition, the committee considered the inconsistency between direct and indirect comparisons, the potential bias due to small study size, the plausibility of the results, the quantity and quality of the evidence base, as well as other factors such as cost effectiveness, anticipated harms, treatment acceptability and compliance, patient characteristics and preferences when making recommendations in general, and in particular when considering psychological, pharmacological and self-help treatments.
APPG on Prescribed	Full	259	40	The All-Party Parliamentary Group (APPG) for Prescribed Drug Dependence (PDD) believes the current NICE	Thank you for your comment. Following feedback from stakeholders, the guideline committee and

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Drug Dependence				Guidelines on antidepressant (AD) withdrawal are wrong, 14 years out of date, and are adversely affecting patients. We request this to be resolved. The APPG for PDD recently undertook a systematic and comprehensive literature review into antidepressant withdrawal. This review, surveying over 200 articles, and tabulating the results of the most relevant studies in the field of antidepressant withdrawal - around 100 in total – can be found here: http://prescribeddrug.org/wp-content/uploads/2018/06/APPG-PDD-report-on-antidepressant-dependence-and-withdrawal.pdf The review generated three main conclusions: • Approximately half of all people who take antidepressants experience withdrawal when they stop their medication. • Approximately one quarter of people who take antidepressants experience certain withdrawal reactions for at least 3 months. • Approximately one quarter of people who take antidepressants report their withdrawal as severe. Significantly, these conclusions directly contradict what the current NICE Guidelines (2009) say about antidepressant withdrawal, which we quote here:	NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				"[withdrawal] symptoms are usually mild and self-limiting over about 1 week, but can be severe, particularly if the drug is stopped abruptly" (1.9.2.1 in CG90) The above statement is repeated, with slightly different wording, in the 2018 update: "discontinuation symptoms are usually mild and go away after a week but can sometimes be severe, particularly if the antidepressant medication is stopped suddenly" (Line 40, page 249, 2018) Given that the conclusions of the APPG review and NICE significantly differ, we therefore issued a Freedom of Information request to NICE asking for the supporting evidence for its statement on antidepressant withdrawal. NICE responded that the statement was a hangover from one issued in the 2004 NICE guidelines, for a different but related claim about antidepressant withdrawal: "There are no systematic randomised studies in this area. Treatment is pragmatic. If symptoms are mild, reassure the patient that these symptoms are not uncommon after discontinuing an antidepressant and that they will pass in a few days. If symptoms are severe, reintroduce the original antidepressant (or another with a longer half-life from the same class) and taper gradually	

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				while monitoring for symptoms" (4.5.2.48 in CG23, 2004, bold added). NICE then indicated that there were only two pieces of research to support the above claim that antidepressant withdrawal 'will pass in a few days' (or the one-week claim): Haddad, P. (2001) Antidepressant Discontinuation Syndromes Clinical Relevance, Prevention and *Management Drug Safety*; 24 (3): 183-197 Lejoyeux, M., and Adès, J. (1997) Antidepressant Discontinuation: A Review of the Literature. *J Clin Psychiatry,* 1997; 58 (suppl 7) Firstly, both are review articles and neither cites a single source that, in our view, supports the NICE one-week claim. In fact, the evidence cited rather appears to contradict the one-week claim. In short, NICE's current position on antidepressant withdrawal is not only 14 years out of date, was originally advanced on weak evidence, but is disproved by subsequent evidence. The APPG is concerned that doctors are therefore being given wrong information, and that this is affecting how they understand and respond to antidepressant withdrawal. As current guidelines wrongly indicate that antidepressant withdrawal is usually self-	

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				limiting over about 1 week, we are concerned that large numbers of patients will visit their doctor more than 1 week after having stopped their antidepressants, manifesting withdrawal reactions. We believe, based on research we are currently conducting, that many of these patients will simply have their withdrawal misread as relapse, with antidepressants being reinstated as a consequence, and we further believe that this dynamic is contributing to lengthening AD use and the increase in antidepressant prescriptions. We urge that NICE addresses this issue for the good of patients, and to mitigate the evident harms – both economic and human – current NICE Guidelines on antidepressant withdrawal are unwittingly causing. A proposed rewording is as follows: "Explain that there is substantial variation in people's experience of discontinuation symptoms: they are often mild and go away after a few weeks, but can last for much longer (up to several months and sometimes beyond a year) and can be severe. The incidence and severity of withdrawal may also increase if the antidepressant medication is stopped suddenly".	
Council for Evidence-	Full	259	40	The Council for Evidence Based Psychiatry shares the concerns of colleagues reporting to the All Party	Thank you for your comment. Following feedback from stakeholders, the guideline committee and

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based Psychiatry				Parliamentary Group for Prescribed Drug Dependence that the current NICE Guidelines on antidepressant withdrawal are inappropriate. The APPG for PDD recently undertook a systematic and comprehensive literature review into antidepressant withdrawal. That review, surveying over 200 articles, and tabulating the results of the most relevant studies in the field of antidepressant withdrawal - around 100 in total – can be found here: http://prescribeddrug.org/wp-content/uploads/2018/06/APPG-PDD-report-on-antidepressant-dependence-and-withdrawal.pdf and formed part of the APPG submission to this consultation. Given the available data - and the gaps in the evidence – the Council for Evidence Based Psychiatry joins with the APPG in recommending a revision to the relevant clinical guideline: "Explain that there is substantial variation in people's experience of discontinuation symptoms: they are often mild and go away after a few weeks, but can last for much longer (up to several months and sometimes beyond a year) and can be severe. The incidence and severity of withdrawal may also increase if the antidepressant medication is stopped suddenly".	NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Council for Evidence-	Full	259	27 and 29	In using the phrases "not addictive" (29) and "cannot get addicted" (27) these guidelines use a particular and very restrictive definition of 'addiction'. That is, those (including	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for

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based Psychiatry				luminaries of the Royal College of Psychiatrists) who argue that antidepressant medication is not addictive make reference to little evidence of tolerance and in particular of the need for ever increasing doses to achieve effect. However, common-sense and lay uses of the term 'addictive' do not have such a restrictive interpretation. Wikipedia might not be the correct source for academic research, but it is where many millions of people get valuable information, and 'addictive' – in this context – is routinely interpreted as synonymous with 'dependence'. It's worth pointing out (especially remembering that NICE has a 'standing order' to report links to the tobacco industry) that cigarettes would fail this test of 'addictive' – cigarette smokers are clearly 'addicted' to their cigarettes, but typically smoke the same amount of tobacco every day (doing so, primarily, to avoid the withdrawal effects). We could not countenance statements made to the effect that 'cigarettes are not addictive', and there is no reason to say the same about antidepressants. Given that the BMA (and others) and Public Health England are currently undertaking a review of this area, explicitly referring to prescription drugs that can cause dependence, and given that these guidelines refer to 'discontinuation symptoms', it seems unreasonable to conclude that antidepressant medication does not come	those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				with the risks of adverse consequences upon withdrawal. That, specifically, would be interpreted by most people as 'addictive'. More to the point, the phrase 'not addictive' would – and probably is intended – to mean 'there are no negative consequences of discontinuation'. This is clearly not true, belied by the very next clause ("... if they stop taking it..."). The Council for Evidence Based Psychiatry therefore recommends that these to references to 'not addictive' be removed. They are either tautological or misleading. We recommend that the final bullet point of recommendation 39 (lines 27 and 28 of page 259) be deleted. We further recommend that recommendation 40 (line 29 of page 259) be amended to read: "... Advise people taking antidepressant medication that, if they stop taking it, miss doses or do not take a full dose, they may have discontinuation symptoms such as:..."	
University of Nottingham	Full	264	36-38	The review question here (and similar elsewhere in guideline) is to assess "relative benefits and harms" of interventions. As acknowledged in Table 3, page 52 prospective cohorts, registry, and cross-sectional studies are the best study designs for questions around rates and	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that

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				rare side effects. Yet for the review questions around harms of interventions only RCTs are considered. Although they are comparatively rare, important adverse outcomes such as suicide, self-harm, bleeds and fracture should be considered when making recommendations about antidepressants. They need to be assessed using large observational studies based on representative populations rather than small short-term trials in select participants. The response to a comment on the previous consultation that studies of safety "cannot be included in the review as they do not meet the study design criteria (not an RCT or systematic review of RCTs)" seems inadequate. For such widely used drugs with small to moderate effectiveness recommendations should include consideration of safety from careful review of pharmacoepidemiological studies. These types of studies have been used to inform other NICE guidelines.	the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document.
British Association for Counselling & Psychotherapy	Full	264	9	The evidence for the recommendation that any counselling intervention should be one developed specifically for depression (7.4.6): In our prior consultation response, BACP asked why this requirement is only specified for counselling and short-term psychodynamic psychotherapy but not for CBT and IPT. The response from the committee states: *"Thank you for your comment. IPT and CBT were both developed specifically for the treatment of depression. In contrast, there has been less development of models of STPT and counselling that are specifically for treating*	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				depression. The committee thought it important to highlight this." We don't believe that the response adequately addresses our point and we once again request that an evidence-based rationale for what condition's modalities of psychological therapies have been developed to work with is given, rather than one that appears to be based on the personal judgement of the guideline development committee. The impact of these opinions has a significant effect on the composition of the psychological therapies workforce and its ability to deliver choice of evidence based therapies within the NHS.	
British Acupuncture Council	Full	315	5	Why are there now 12 trials and 4 comparisons for acupuncture (rather than 7 and 6 previously)?	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
British Acupuncture Council	Full	340	7-11	There is now more evidence in favour of acupuncture (than in the last draft) but still you maintain that only couples therapy is at all convincing. Acupuncture was found superior, for depressive symptoms, to usual care	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline

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				and to antidepressants (which themselves are recommended); better than medication alone when given together with it, and as good as counselling (which itself gets a recommendation).	update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
British Acupuncture Council	Full	340	13-17	Couples therapy gets recommended despite its very poor evidence and absence of economic data. The contrast with acupuncture is stark	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
British Acupuncture Council	Full	341	1-3	The committee chair said at the scoping meeting that they didn't hold much with placebo/sham controlled trials but looked mainly to comparative effectiveness research. Having locked acupuncture out of the latter sort of evaluation (the NMAs) it is surprising to find that the committee now 'were particularly interested in the data from the comparison between acupuncture and sham acupuncture because they were concerned about a potentially very significant placebo effect with acupuncture'. NICE has form for being particularly interested in sham acupuncture comparisons but why did the committee feel the need to change tack? In recent guidelines, when the data showed acupuncture to be statistically superior to sham then NICE raised the bar by bringing in a bogus clinical significance criterion (OA, back	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				pain). With depression, this is unnecessary, because the two sham trials are so small that statistical significance would be most unlikely (though ironically they are said to be clinically significant). Why are the committee worried about a large placebo effect? Surely that's to be cherished if you want to get an effective intervention? Don't effective psychological interventions also depend on a large placebo effect? And what about exercise? The committee appears to have no concerns on that score for any other treatment. Sham acupuncture is merely a lesser dose of verum acupuncture, not a placebo, so any advantage for the latter is always expected to be low (in some cases it could be inferior, where a particularly minimal intervention is preferable). The problems with sham acupuncture have been well aired and are surely known to NICE, if not to the committee members.	
Tavistock & Portman NHS Foundation Trust	Full	360ff		Selective inclusion of bona fide treatments We noticed that several studies examining psychodynamic treatments were not included for the reason that "data was not available" or publication being in 'book' format. Given the scarcity of such important evidence, this should not be an exclusion criteria and all efforts should be made to get hold of the relevant data for a review of such importance. Based upon the accurate inclusion of only bona fide therapies for treatment resistant depression, for example, we argue that the evidence for STPP as a first-line	Thank you for your comment and for drawing our attention to the Leichsenring et al. (2017) citation. The methods and processes used to develop NICE guidelines are documented in Developing NICE guidelines: the manual. It is not usual process to contact authors or to include books. Fonagy et al 2015 does not report the proportion of people with comorbid personality disorder and complex depression in the guideline was defined as depression with coexisting personality disorder. We were not able to determine if it met the

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				treatment approach is at least comparable to that for Interpersonal Psychotherapy Therapy (IPT). On closer examination of the inclusion criteria of studies included under the category of 'STPP versus treatment as usual or antidepressants', a significant mistake was identified. Data for Brief Supportive Psychotherapy (BSP) from another RCT (Klein et al., 2011; Kocsis et al., 2009) were included as data on STPP. BSP is a recognised treatment approach emphasising common psychotherapy factors but is distinct from other psychoanalytic psychotherapies given its lack of structure and specific interventions. We therefore ask for it to be excluded as it should not be classified as an STPP here and raises serious problems with the integrity of the analysis. The GC concluded that there was no effect of STPP as an augmentation strategy, clearly taking a lead from the Kocsis et al. (2009) trial rather than Town et al. (2017) – the latter a bona fide STPP treatment indicating a clinically important and statistically significant benefit of individual STPP, which has not been included in the review. On examination of the 70 RCTs reviewed for inclusion in the 'complex depression' meta-analysis, the Fonagy et al. (2015) study of LTPP was not considered for inclusion and five RCTs of STPP were considered but excluded. Eighty-five per cent of the Fonagy et al. (2015) study population had one or more Axis II disorder. Participants had high	inclusion criteria for the review on complex depression and consequently it was excluded from that review. The committee recognise that the Fonagy 2015 study could be categorised in either the 'further-line treatment' or 'chronic depression' review but agreed that it fitted better into the 'further-line treatment' review. An opinion possibly endorsed by the authors of that study given the title 'Pragmatic randomized controlled trial of long-term psychoanalytic psychotherapy for treatment-resistant depression: the Tavistock Adult Depression Study (TADS)'. The committee agreed that the artificial distinction of chronic and treatment-resistant depression was not useful and that was the justification for including chronic depression studies in the further-line treatment review where participants were randomised at the point of non-response. The review protocols defined a priori what the inclusion criteria were for each question. If studies did not meet the inclusion criteria, they were excluded. The reasons for any exclusions have been clearly documented in the appendices. Abbass et al. 2008 and Vinnars et al. 2005 do not include a depression scale that is within the

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				levels of childhood adversity (89% – unpublished data available on request); and high comorbidity: 47% had musculoskeletal problems, 25% had gastrointestinal problems; 91% had at least one other comorbid Axis 1 disorder; 54% were unemployed; the mean GAF score was 49.1; 45% had made at least one previous suicide attempt. Clinically this is a very complex population, yet the trial is classed as TRD only – rather than chronic and/or complex, highlighting the systematic ignoring of individual subjectivities which in many cases are likely to be highly predicated on childhood adversity and trauma. Five RCTs of STPP were excluded on the grounds that these studies included (i) 'no extractable outcomes of interest' (Abbass, Sheldon, Gyra, & Kalpin, 2008; Vinnars, Barber, Noren, Gallop, & Weinryb, 2005); (ii) less than 50% of the trial population had comorbid PD (Thyme et al., 2007); and (iii) less than 10 participants per treatment arm (Maina, Forner, & Bogetto, 2005; Svartberg, Stiles, & Seltzer, 2004). However, despite the protocol for the review of interventions for complex depression specifying the inclusion of systematic reviews and disaggregated RCT data for this population, published disaggregated data were overlooked for 79 participants receiving STPP from these 5 RCTs (Abbass, Town, & Driessen, 2011). All participants in this excluded group had confirmed diagnoses of depressive	protocol of this review. Furthermore, although all participants have a personality disorder, less than 80% of participants have coexisting MDD so these studies would also have been excluded on that basis. Thyme et al. 2007 was excluded because the sample do not meet our definition of complex depression, i.e. they do not have coexisting personality disorder. Liberman & Eckman (1981) met criteria for this review as the study authors state that 'Most patients would have been given personality disorder designations (axis 2 of DSM-III), including histrionic, narcissistic, borderline, avoidant, and dependent types.' This was considered sufficient as participants were not required to have a diagnosis of depression either, as all those with clinically important symptoms were eligible. Maina et al. 2005 and Svartberg et al. 2004 were excluded on the basis of small sample size (minimum sample size N = 10 in each arm as specified in the review protocol). The Abbass 2011 systematic review had been identified and searched for relevant references prior to consultation and was the source of two

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				disorder with PD and treatment outcome data on validated depression scales were available. Three RCTs of STPP (Abbass et al., 2008; Thyme et al., 2007; Vinnars et al., 2005) were essentially incorrectly excluded based on rationale i and ii. Furthermore, disaggregated data from two further RCTs of STPP (Maina et al., 2005; Svartberg et al., 2004), which identified a true sample of complex depression, were excluded because of less than 10 participants per treatment arm. In contrast, one of the five RCTs included in this review (Liberman & Eckman, 1981, study of Behaviour Therapy) had failed to administer a formal PD assessment and the precise numbers of those with an unconfirmed PD diagnosis were not provided. The GC conclude that the evidence base for complex depression is limited in volume having only included five small RCTs. If bona fide studies of therapies are selectively excluded from data analytic approaches to examine the effects of a specific treatment in this way, estimates of within- and between-group differences can be expected to be unreliable and ensuing quality statements and recommendations questionable (Leichsenring et al., 2017). Likewise, including non bona fide interventions as noted previously in the inclusion of BSP as an STPP has an equally problematic impact on guideline recommendations.	studies included in the complex depression review (Hellerstein 1998 and Liberman 1981). Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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Tavistock & Portman NHS Foundation Trust	full	364		Miss-classifying of the Tavistock Adult Depression study (Fonagy et al., 2015) The study was classified erroneously as "augmenting the antidepressant with a psychological intervention versus continuing with the antidepressant only". As clearly indicated this study investigated the treatment of long-term psychoanalytic psychotherapy + TAU versus TAU. TAU consistent of a range of short-term treatments (including CBT, counselling, IPT, CMHT, to which the primary care provider referred the patients to. The study did not follow an augmentation strategy. The study used a fundamentally different definition of TRD than proposed in this guideline that uses an exclusively pharmacological definition that requires operationalising of dose and duration monitoring. Furthermore, although the appendices of the guideline indicate that the study meets criteria for both chronic depression as well as treatment-resistant depression, it is placed among the group of TRD rather than chronic depression. This has the consequence that this trial is being compared against drug trials in methodologically inappropriate ways. Therefore, we request that if current definitions are retained, it should be included under the review of studies for chronic depression.	Thank you for your comment. The study is classified as 'augmenting the antidepressant with a psychological intervention versus continuing with the antidepressant only' as 82% of the sample were receiving an antidepressant at baseline (relative to 10% CBT and 14% counselling). Furthermore, Fonagy 2015 cite inclusion criteria as "at least two failed treatment attempts (elicited at interview and verified from medical records), one of which must have included treatment with an antidepressant medication, and the other with either an antidepressant medication or a psychological intervention". This is consistent with how other studies have been classified in the guideline. The committee recognise that the Fonagy 2015 study could be categorised in either the 'further-line treatment' or 'chronic depression' review but agreed that it fitted better into the 'further-line treatment' review. An opinion possibly endorsed by the authors of that study given the title 'Pragmatic randomized controlled trial of long-term psychoanalytic psychotherapy for treatment-resistant depression: the Tavistock Adult Depression Study (TADS)'. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the

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				We request this sentence to be changed in light of the above. It is inaccurate. Furthermore, as stated above we request the analysis of the follow-up data of this study, which clearly shows the clinically important and statistically significant benefit of long-term psychodynamic psychotherapy compared to TAU in reducing depressive symptom (and increases functioning).	comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document.
Tavistock & Portman NHS Foundation Trust	Full Appendix J5	438		Please correct the following: "the study partially funded by the International Psychoanalytic Association (IPA)". This is incorrect. The RCT was funded by the NHS. A qualitative arm was included into the study in 2009 (6 years after it was launched) and it was for this that the study received small grands from the IPA. Taking this into account, the risk criteria for the study will need to be reviewed and adjusted accordingly.	Thank you for your comment. This was taken from the paper that reports "The study was supported by the Tavistock Clinic Charitable Foundation and the Tavistock & Portman NHS Foundation Trust, plus a small grant from the International Psychoanalytic Association". It is important that psychological and pharmacological trials are treated fairly and this study was classified in an equivalent way as a pharmacological trial that had received partial funding from a pharmaceutical company.
The Royal College of Psychiatrists	Full	629	24-25	Psychotic depression. The statement that "The GC noted that there was little evidence on the use of ECT and this was not statistically significant" is puzzling. It is not clear why the decision was made to only look at ECT in the prevention of relapse in psychotic depression rather than its effectiveness in acute treatment of psychotic depression. There is evidence and a vast amount of clinical experience that ECT is particularly effective for psychotic depression (Petrides et al, J ECT, 17,244-253, 2001: Birkenhager et al, Journal of Affective Disorders 74, 191-195, 2003). Furthermore, positive predictors of	Thank you for your comment. ECT as an acute treatment for psychotic depression was not excluded. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				response to ECT include delusions (Spashett et al, J ECT, 30,227-231,2014). In addition to the two papers looked at in the review, data from the PRIDE study show that ECT is protective against relapse (Kellner et al, Am J Psychiat, 173, 1110-1118, 2016).	Petrides et al. 2001, Birkenhager et al. 2003, and Spashett et al. 2014 could not be included as they do not meet study design inclusion criteria for this review (not an RCT or systematic review of RCTs) as pre-specified in the review protocol, and are also concerned with comparing effects in psychotic versus non-psychotic groups (which is outside the scope of this guideline) rather than comparing relative intervention efficacy for those with psychotic depression which is the question that this review addressed. Kellner et al. 2016 will be considered for inclusion in the guideline as we update the evidence
The Mindfulness Initiative	Full	683	19	MAINTENANCE OF IMPACT One issue in assessing the suitability of treatments for long-term prevention of depressive relapse is the degree to which people stop taking their medication or do not take it as advised. Non adherence is seen as a greater issue in mental health conditions than in physical health conditions. A review found that the mean amount of prescribed medication taken is 65% for those prescribed antidepressantsxx. According to one study this can associate SSRIs with an increase in suicidexxi We notice that there is an assumption in one part of the guidance analysis that the preventative effect of MBCT lasts only one year. However there is evidence that the benefits of MBIs like MBCT are retained over periods of at	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				least six years even in the context of low-levels of adherence to formal mindfulness practice xxii A recent study by Farb et alxxiii concludes that MBCT and CT are equally effective at reducing relapse and supports the suggestion that they help participants develop metacognitive skills for the regulation of distressing thoughts and emotions.	
The Royal College of Psychiatrists	Full	687	21-24	This is restrictive. What about situations in which ECT is an appropriate first-line treatment? When it is opted for by the patient or by their family, often because it worked so well before? When other treatments are relatively contraindicated or less preferable (e.g. in pregnancy, during breastfeeding, with co-morbid physical illness e.g. hyponatraemia)? When a rapid action is desired but life is not in danger (e.g. tormented by delusions, or postpartum with a need to feed and bond with baby)? These are all evidence-based indications yet this guidance denies treatment to these vulnerable groups of patients and puts their well-being and that of their families at risk. It is recommended that we must wait until "*multiple* pharmacological *and* psychological treatments" have failed. What does "multiple" mean here? What about a patient who thinks she is dead and believes she is in hell? The guidance may leave her in that pitiful state for many weeks on a ward while treatment after treatment fails to help her? This recommendation also lacks practical utility:	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				engaging a highly agitated patient who can barely string a sentence together in CBT is not practical. We agreed with the recommendations of CG90 which stated "ECT should be considered for severe depression that is life-threatening, or where a rapid response is required or where other treatments have failed. ECT should not be used routinely in moderate depression but should be considered if there has been no response to multiple drug treatments and psychological treatment. If patients have not responded well to ECT in the past, ECT should only be considered again after review of the adequacy of previous treatment, a consideration of other options and after discussion with the patient and their advocates or carers if appropriate." We are confident that no new evidence has emerged in the past 8 years to warrant any change in NICE's position. Indeed there has been a consolidation of data and information driven by some large well conducted RCTs.	
The Royal College of Psychiatrists	Full	688	9-17	These recommendations do not have an evidence base and would be impractical and very difficult to standardise and implement. Considerable problems (e.g. learning effects) would ensue with repeating such tasks at such frequency There are no established measures for assessing "subjective memory impairment". See the following three papers for reviews of this area: - 1.Semkovska, M. & McLoughlin, D. M. (2013). Measuring retrograde autobiographical amnesia following electroconvulsive therapy: historical perspective and current issues. The Journal of ECT 29, 127-133. 2.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				Semkovska, M. & McLoughlin, D. M. (2014). Retrograde autobiographical amnesia after electroconvulsive therapy: on the difficulty of finding the baby and clearing murky bathwater. The Journal of ECT 30, 187-188. 3. Semkovska, M., Noone, M., Carton, M. & McLoughlin, D. M. (2012). Measuring consistency of autobiographical memory recall in depression. Psychiatry Res 197, 41-48.	
The Royal College of Psychiatrists	Full	688	36-38	There should also be a recommendation for continuation ECT as an option to prevent relapse after successful ECT here. There is good RCT data in geriatric depression that additional ECT after remission (in the study operationalized as four continuation ECT treatments followed by further ECT only as needed) was beneficial in sustaining mood improvement for most patients and better than the venlafaxine plus lithium arm (Kellner et al, Am J Psychiat, 173, 1110-1118, 2016). Another RCT showed that continuation ECT combined with antidepressant prolonged survival time in elderly patients with psychotic unipolar depression who had remitted with ECT compared to the antidepressant alone. (Navarro et al, Am J Geriatr Psychiatry 16,498-505,2008)	Thank you for your comment. ECT was included as an intervention in the review questions on treating depression. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data. Navarro et al. 2008 was excluded from the relapse prevention review as participants were not randomised to maintenance therapy. Kellner et al. 2016 will be considered for inclusion in the guideline as we update the evidence
Public Health England	Full	854	Abbreviations	PHE note that there is a reference to the CAGE (a short assessment for alcohol misuse) in the full guideline abbreviations appendix which suggests alcohol was considered by the guideline group. A more relevant tool would be the Alcohol Use Disorders Identification Test (AUDIT).	Thank you for your comment and for pointing out this error in the guideline. As the abbreviation CAGE is not used in the text it should not have been included in the list of abbreviations and has now been removed.

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University of Nottingham	Full	855	5	There remains confusion over the definition of counselling and how it is applied to the context of the delivery of evidence based therapies. There is an evidenced based therapy for depression that has in the title the term 'counselling'. We understand this might be confusing for the guideline reviewers because in fact the evidenced based form of counselling for depression is actually 'person-centred experiential' counselling for depression. It should be noted that this approach does not follow the definition and description given for counselling within the guideline. Where counselling is defined it makes reference to a more surface level and eclectic way of conducting therapy. This is NOT the 'counselling for depression' that IAPT has approved of and therefore the definition of counselling for depression should be amended and clearly marked out as a distinct form of therapy. We notice there is no abbreviation present for CfD (Counselling for Depression) indicating that again it does not have any presence in the revised guideline, despite us raising this in September 2017. CfD was developed by the British association for counselling and psychotherapy (BACP) in collaboration with Improving Access to Psychological Therapies (IAPT) and Skills for Health. The approach is an evidence based therapy that draws on the humanistic competency framework and a group of randomised control trials that test the effectiveness of Person-Centred Experiential Therapies. Counselling for Depression (CfD) needs to be named explicitly in order to	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data. The PRaCTICE trial has not yet published so we are not able to take account of the results of this study in the guideline. We will forward this information to the NICE surveillance team for consideration. Thank you for highlighting the abbreviation PCA to us. We have checked and since this abbreviation is not used in the full guideline we have deleted it from the list of abbreviations.

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				describe precisely what it is i.e.: Person-Centred Experiential Counselling for Depression (PCE-CfD). This is important and will ensure the approach is identified directly, in the same way as IPT and CBT. The recommissioned text book being published by Sage is entitled Person-Centred Experiential Counselling for Depression, and this is the book all the courses in England will be recommending. Presently there is an RCT being conducted into Person-Centred Experiential-CfD (PCE-CfD) called 'PRaCTICED' being led by researchers at the University of Sheffield and is funded by BACP. It is a non-inferiority trial comparing PCE-CfD and CBT. The results are expected to be reported in early 2018. In regards to the abbreviation of the approach, for the purposes of this feedback we will use the abbreviation for Person-Centred Experiential Therapies (PCET) and specifically for PCE-CfD when referring to the approach as it is refined for working with clients diagnosed with depression. The abbreviations in the draft lists PCA - however the acronym PCA for us is person-centred approach, in this report that acronym is for something entirely unrelated. This illustrates how important it is to name things clearly PCE-CfD does not appear as anything else in literature, whereas CfD is identified by Wikipedia as 'computer fluid dynamic' as well as 'contract for difference'- a derivative ' financial product. This is unhelpful and confusing for academics and students carrying out research and publishing papers.	

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UKPCE	Full	855	5	There seems to be some confusion over the definition of counselling and how it is applied to the context of the delivery of evidence based therapies. There is an evidenced based therapy for depression that has in the title the term 'counselling'. We understand this might be confusing for the guideline reviewers because in fact the evidenced based form of counselling for depression is actually 'person-centred experiential' counselling for depression. It should be noted that this approach does not follow the definition and description given for counselling within the guideline. Where counselling is defined it makes reference to a more surface level and eclectic way of conducting therapy. This is NOT the 'counselling for depression' that IAPT has approved of and therefore the definition of counselling for depression should be amended and clearly marked out as a distinct form of therapy. We notice there is no abbreviation present for CfD (Counselling for Depression) indicating that it does not have any presence in the revised guideline. CfD was developed by the BACP in collaboration with IAPT and Skills for Health. The approach is an evidence based therapy that draws on the humanistic competency framework and a group of randomised control trials that test the effectiveness of Person-Centred Experiential Therapies. CfD needs to be named explicitly in order to describe precisely what it is i.e.: Person-Centred Experiential Counselling for Depression (PCE-CfD). This is	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data. The PRaCTICE trial has not yet published so we are not able to take account of the results of this study in the guideline. We will forward this information to the NICE surveillance team for consideration. Thank you for highlighting the abbreviation PCA to us. We have checked and since this abbreviation is not used in the full guideline we have deleted it from the list of abbreviations.

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				important and will ensure the approach is identified directly, in the same way as IPT and CBT. Presently there is an RCT being conducted into person-centred experiential-CfD (PCE-CfD) called PRaCTICED being led by researchers at the University of Sheffield and is funded by BACP. It is a non-inferiority trial comparing PCE-CfD and CBT. The results are expected to be reported in early 2018. In regards to the abbreviation of the approach, for the purposes of this feedback we will use the abbreviation for Person-Centred Experiential Therapies (PCET) and specifically for PCE-CfD when referring to the approach as it is refined for working with clients diagnosed with depression. The abbreviations do list PCA- however the acronym PCA for us is person-centred approach, in this report that acronym is for something entirely unrelated. This illustrates how important it is to name things clearly. PCE-CfD does not appear as anything else in literature, whereas, CfD is 'computer fluid dynamic' as well as 'contract for difference'- a derivative ' financial product. Not naming the approach clearly is unhelpful for the literature. Members of UK-PCE are authoring the second edition of the recommissioned text book being published by Sage, entitled Person-Centred Experiential Counselling for Depression and this is the book the course will be recommending. BACP support the name change and a paper arguing this has been presented to the head of IAPT education.	

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University of Nottingham	Full	520--555	General	This section excludes PCE-CfD resulting in falling short of the IAPT commitment to ensuring client choice. The evidence considered is mostly pharmacological, Cognitive Therapy and Cognitive Behavioural Therapy and IPT. As a training institute of PCE-CfD for IAPT therapists we received evidence from NHS services suggesting they have noticed a positive impact on their services as a result of including PCE-CfD supported by trained PCE-CfD supervisors. This is excellent news considering the relatively low training costs for this approach as all our delegates are already qualified person-centred and humanistic therapists, and as such are an extremely valuable resource for the workforce. IAPT emphasises frequently the importance of 'experts by experience'. Our person-centred counsellors, whilst achieving their qualifications, necessarily reflect on their own experiences of trauma, stress and distress and engage in rigorous and disciplined training in regards to theory, practice and ethical considerations in order to gain their qualification- this is regardless of whether the qualification is at diploma, first degree masters of doctoral level. The IAPT evidence from the 2016-7 Minimum data set (MDS) outcomes shows PCE- CfD has 50.2% success rate compared to CBT which has 47.3 % . This shows equivalence. This data needs to be included in your considerations as MDS was an essential requirement for any service to receive IAPT funding and services, counsellors and clients all adhered to this mandatory request,. The data shows equivalence between CBT and PCE- CfD yet PCE- CfD is	Thank you for your comment. Counselling was included as an intervention in the review protocol for chronic depression. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				excluded completely. High-intensity therapies for depression: CBT (N=20,754) = 47.3% recovery rate; Counselling for Depression (N=13,976) = 50.2% recovery rate. Equivalence.	
UKPCE	Full	520--555	General	This section excludes PCE-CfD resulting in falling short of the IAPT commitment to ensuring client choice. The evidence considered is mostly pharmacological, Cognitive Therapy, Cognitive Behavioural Therapy and IPT . As many of our members are training institutes for PCE-CfD IAPT therapists we received evidence from NHS services suggesting they have noticed a positive impact on their services as a result of including PCE-CfD supported by trained PCE-CfD supervisors. This is excellent news considering the relatively low training costs for this approach. The latest IAPT evidence from the 2016-7 MDS outcomes shows PCE- CfD has 50.2% success rate compared to CBT having 47:3 % showing equivalence, these comparative CBT, PCE-CfD results have remained consistent throughout the time IAPT have been reporting MDS outcomes. We request that this data is included. Use of the MDS is essential for any service to receive IAPT funding and services. Courses at our Institutes involve ensuring that therapists are comfortable with introducing the MDS with new clients. By not including this evidence, a lack of consideration for the efforts made by each service, each counsellor and the input each IAPT client offers about their personal experiences of struggling with difficulties, may be communicated by default. The MDS is	Thank you for your comment. Counselling was included as an intervention in the review protocol for chronic depression. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				the largest UK database of outcomes by far with a very significant sample size, year on year, for both CBT and PCE-CfD. Disregarding this evidence is a concern to us as a group as it is hard not to view this as unrecognised bias by the board, in favour of the aspects of the report which are given high profile such as pharmacology, cognitive therapy and electroconvulsive therapy. Counsellors and clients all adhered to this mandatory request. The data shows equivalence between CBT and PCE- CfD, yet PCE-CfD is excluded completely in this report. The most recent large scale national IAPT evidence showed: High-intensity therapies for depression: CBT (N=20,754) = 47.3% recovery rate; Counselling for Depression (N=13,976) = 50.2% recovery rate. This equals at the very least, equivalence. In addition, results reported from successive meta-analyses carried out by Pim Cuijpers and his associates shows that when risk of bias and researcher allegiance are taken in to account, then any small disadvantage to counselling disappears. This suggests elements of systematic bias in reported trials that works to disadvantage counselling when evaluated in trials but that is not present in data collected in routine settings. A position stating a superiority to CBT in depression will be at odds with the weight of evidence in the research community and will raise questions of inherent bias in the process.	

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Society for Psychotherapy Research UK	Full & short Full Full	General 592 632	General 17-22 3	Recommending a treatment that is currently not a recognised treatment in the UK We are seriously concerned about the recommendation of CBASP for people with chronic depression, as this is not an established treatment model in the UK, and raises questions of availability, training provision, and extra costs to do so. Although the revised draft stressed this point on page 592, we would like to point out that the rationale provided is incorrect. As indeed highlighted on page 632, line 3 of the guideline "Depression is often recurring or chronic. Although approximately half of the people who become depressed will only have a single episode of major depression in their lifetimes, approximately 50% will have multiple episodes or protracted chronic periods of depression". Thus, the guideline clearly acknowledges that it refers to a significantly high proportion of depressed individuals, and as such the extra cost is likely to be high as well. Whether CBASP is a successful treatment in reducing recurrent episodes, or can be said to have lasting effect, has not been established in this guideline as follow-up data of these trials have not been analysed. We therefore request to amend this section accordingly.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Society for Psychotherapy Research UK	Full & Short	general	general	Patient choice and range of evidence-based treatments We emphasise our concern expressed in our first response here once again: We believe that a guideline that endeavours to discern a hierarchy of evidence (and thereby recommends as few treatments as possible),	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that

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				operates in contradiction to the ethos and ambition to offer patient choice. It does not acknowledge the suffering individual, and the fact that a one-size-fits all approach for mental health and psychotherapy research is untenable. There is an inherent challenge in systematic reviews, namely that the outcome depends on the inclusion and exclusion criteria chosen. Thus, it is method dependent and prone to many biases. Whilst we appreciate all efforts made by the GC to address these biases, we believe that some of the methodological decisions made in this review leads from the outset to favour medical trials over psychological trials and particular treatment modalities over others. It does not provide equal opportunities for all treatments, which the scientific community has already identified as having an evidence base, to be assessed fairly in answering the various review questions in this guideline. There is a further inherent problem in the approach adopted; namely the assumption that all individuals falling into the chosen categories (less severe, more severe etc) are essentially the same, experience depression the same and are expected to benefit from treatment in the same way. It is a very restricted conceptualisation, which endangers all real efforts in providing the adequate help for the increasing numbers of suffering individuals.	the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document.

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				The many systematic reviews and meta-systematic reviews that have been carried out to date have provided a strong evidence base that many of the psychological treatments are as effective as each other in treating depression (see Cuijpers, 2017, for an overview). What is needed now is research into differential treatment effects; studies that discerns who benefits most from what intervention at what point in time. We appreciate that more research is needed for guidelines to include such evidence. However, a guideline that endorses a hierarchical and sequential approach based on effectiveness and cost-effectiveness of intervention type does not foster what is needed. Patient informal and formal feedback shows that different modalities of psychotherapy has had different impacts at different periods in their life, and it is thus crucial that we ensure that our health service provides and offers a range of evidence-based treatments all the time. Thus, in response to the GC's response, individuals not only be able to decline offered treatments, but should in a first instance be able to choose what treatment they would like to receive. The research evidence that patient choice and patient preference has a significant impact on treatment outcome cannot be ignored (e.g. Gelhorn et al, 2011; Williams et al., 2016). Likewise, we should not ignore the impact a wrong treatment can have on the individuals' overall experience of care and belief in therapeutic help in general.	

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				References/citations: Cuijpers, P., 2017. Four decades of outcome research on psychotherapies for adult depression: an overview of a series of meta-analyses. Canadian Psychology/Psychologie canadienne, 58(1), 7-19. Gelhorn, H.L., Sexton, C.C., and Classi, P.M. (2011). Patient preference for treatment of major depressive disorder and the impact on health outcomes: a systematic review. Primary Care Companion CNS Disorder, 13(5), PCC.11r01161. Williams, R., Farquharson, L., Palmer, L., Bassett, P., Clarke, J., Clark, D.M., and Crawford, M.J. (2016). Patient preference in psychological treatment and associations with self-reported outcome: national cross-sectional survey in England and Wales. BMC Psychiatry, 16:4	
Society for Psychotherapy Research UK	Full & Short	general	general	The document containing responses to stakeholder comments is overall of very poor quality, much like the first draft of the guideline. We regret that they seem simply to involve restating the developers' approach to many of the concerns raised. The GC appear to have misunderstood our citations provided in support of our arguments when taken from published sources as requests for including those studies in the review! It reveals a lack of rigour and quality assurance throughout the process, falling short of scientific standards. We find the new draft has failed to address the various significant methodological concerns that we, along with	Thank you for your comment. In the revised guideline following first consultation we took into account comments from a broad range of stakeholders and made a wide variety of changes to the guideline. All comments were responded to. We did not always take up the suggestions made by stakeholders but in such instances we have given our reasons for this. Whilst we do understand citation practices, it is standard NICE process that for every reference provided in comments by stakeholders, we respond

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				many other stakeholders, have raised in our first consultation. We therefore ask that the necessary steps be taken to address these in a proper revision to assure that this guideline meets the high scientific standards expected of NICE as a world leader in guideline development when it is published.	to clarify if that reference was included in the guideline and if not, the reasons for this. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document.
Society for Psychotherapy Research UK	Full & short	43 49 209 217 266 363 508	22 8-9	Transparency of measurement points and wording of recommendations In our first response, we pointed out that we were surprised that neither the Methods section, nor the Review Questions in the full version, nor the Methods section in Chapter 17 (now appendix N1) included a straightforward description of the measurement time points chosen and the rationale for choosing it for each of the review questions. Although the GC's response indicated that it was amended in the revised version, we are unable to find these amendments.	Thank you for your comment. The timing of measurement was not specified a priori and this is why it is not included in the review questions, protocol or methods chapter. Instead, the availability of follow-up data was assessed and the committee came to the conclusion that there was insufficient follow-up data available across different intervention types and thus did not enable meaningful comparison. An amendment was made to section 7.3.4 of the full guideline where it is clearly stated that the data on follow-up was not extracted for the NMA as this was very limited for many of the included studies. A section highlighting that follow-up data was not included for further-line treatment is also included in the 'Quality of

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				In light of the concerns stressed above, we view it as important for those who will be using this guideline to be provided with a coherent rationale as to why only pre and post assessments were chosen and the long-term follow-up outcome for all but one review question not assessed. Although, we urge the GC to change as stressed above. We furthermore would like to point out that the current wording of "end of treatment follow-up" is not consistently used throughout the document. The word "follow-up" is used for the end of treatment measurement point as well as for 6 or 12 months after treatment termination. We recommend that this is made clearer in the revised version as "6 or 12 months follow-up" could mean either 6 or 12 months during treatment or after treatment. We would also like to stress that it is equally important to emphasise when making recommendations (especially in the short version) that these are based on the results obtained from the end of treatment measurement points and that no claims can be made as per these treatments' long-term effects on patients. The wording used in this draft guideline can easily lead to a misconception that a recommended treatment is expected to lead to long-lasting effects (as indeed is being highlighted in the guideline's introduction to be an aim of an intervention). We recommend a careful reviewing of the wording in order to avoid creating such misunderstanding.	evidence' subsection (8.7.4) of the 'From evidence to recommendations' section. The committee agreed that it is important that long-term follow up data are collected in future research to enable comparison of this outcome across different interventions and amended the research recommendations to specify that these data need to be collected. We were a little unclear as to where the inconsistent use of the term follow-up applied. If it is in the GRADE evidence profiles, it is a standard output of GRADE to refer to length of follow-up which here essentially means treatment duration.

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Janssen	Full, short and appendices	General	General	We thank NICE for the opportunity to comment on the update of NICE Clinical Guideline (CG) 90: Depression in adults: recognition and management. We welcome NICE taking this opportunity to update the current clinical guideline with the latest evidence published in the disease area. We believe that this review is timely and important given that mental health is a national priority and depression disproportionately impacts people and society. We note that the second draft clinical guideline out for consultation has been revised from the existing version. We welcome the fact that NICE has addressed comments from consultees and adapted the guidelines accordingly. For example, including the SNRIs within the guideline However, we still do not believe that the new evidence identified in the update warrants a complete restructure of the clinical guideline from the existing NICE CG 90. We are still concerned that the new recommendations could lead to confusion amongst health care professionals and commissioners, which may impact on the quality of care that patients receive and would lead to greater variation of service provision and negatively impact patient outcomes. We would strongly urge to maintain existing structure and framework of NICE CG 90 based on the stepped care model to ensure continuity of care and clarity of recommendations throughout the guideline.	Thank you for your comment. We do not agree that the current structure is a complete re-structure of CG90. The underlying principles on which GC90 was constructed remain the same. That is we have made a distinction between more and less and severe depression (which is essentially the same as the distinction made between mild/moderate and moderate/severe in GC90). Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				As Cowan and Anderson state in their publication (*BJPsych Advances (2015), vol. 21, 315–323*), 'Despite the current difficulty in matching individual patients to pharmacological treatment, there is evidence that algorithm-guided approaches are superior to treatment as usual in patients with depression (Bauer 2009)'. We agree with this statement and urge NICE to reconsider the current decision not to structure the guideline based on a stepped care model. We believe that only referring to principles of stepped care approach within the guideline is insufficient and accordingly the guideline fails to provide clarity on an appropriate treatment sequence to reduce variation in service provision and improve patient outcomes. We are disappointed that NICE did not address our comments and have not gone further to improve the structure and recommend the use of a stepped model in comparison to the previous draft version of the guideline. We further note that in its response to our comments on the structure of the previous guideline version, NICE clarifies that '*in the recommendations that commissioners and providers of mental health services should consider using stepped care models for organising the delivery of care and treatment for people with depression.'* This suggests that although NICE acknowledges the value of using a stepped care model, it still feels that it is the responsibility of other, regional and local stakeholders. Janssen strongly believes that relying on other stakeholders will lead to greater	

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				diversity and variation of service provision and consequently impact outcomes. We feel that an opportunity to reduce variation in service provision has been missed here and this will lead to sub-optimal outcomes for depression patients across the UK.	
Tavistock & Portman NHS Foundation Trust	Full/ Section 4	70		Service user voice In our first response to the draft guideline we stressed the importance to update the service user experience section and it is regrettable that this has not been done in this revised version. We therefore recommend once more that this section be updated and its findings integrated into this guideline before publication. It is the responsibility of NICE to undertake a full systematic review of the existing evidence and to update the guidelines when there is sufficient new evidence. As was pointed out by several other stakeholders in their first response, there is new evidence that would make a significant impact on the guideline. A scoping search carried out by Dr McPherson in March 2018, identified 93 studies that included over 2500 service user voices that were ignored in this guideline. Paying attention to the experience of service users should furthermore not be let as a stand-alone section in the guideline, but findings should be sufficiently incorporated into other aspects of the guideline, including how depression is defined and categorised (and as such	Thank you for your comment. When updating a guideline, a decision is taken whilst developing the scope as to which sections of the guideline will be updated and which will not. When the scope for this update was developed, the patient experience section was explicitly not included as part of the update. Registered stakeholders would have had the opportunity to comment on this proposal as part of consultation on the draft scope. Subsequent to consultation, the scope was finalised and the patient experience section was excluded from the update. It is not now possible to go back and reverse this decision. However the committee developing the guideline included several service user and carer members who were able to provide their perspectives during discussion of the evidence and who were integral to the development of the recommendations in those areas of the guideline that were being updated.

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				subsequently analysed), as well as into treatment recommendations.	
The Mindfulness Initiative	Full/Short	General	General	We welcome the opportunity offered by a 2nd consultation on the guideline. Depression is one of the major causes of health related disability and forecast to become the leading cause worldwide within a few years. The Chief Medical Officer's reportxxiv on mental health highlighted the exceptional cost of some £105 billion to the UK economy of mental ill health. Senior figures in Government, Parliament, the medical profession and civil society increasingly make it clear that "business as usual", in which only a minority of people experiencing depression receive effective treatment, is not acceptable. In the absence of effective and efficient delivery of a choice of treatments through NHS routes the public are increasingly drawn to untested "mental health" apps available on the market This second consultation is an opportunity to address this, to ensure guidance is up to date and reflects the urgency of population health needs and to enable a much higher proportion of people to experience effective treatment and to exercise choice in their care. The Chief Medical Officer's report, reinforced by the Five Year Forward View for Mental Health, emphasises the need for prevention and early intervention. The review of the draft guideline offers an opportunity to strengthen this	Thank you for your comment and providing this information.

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				aspect, to which we consider mindfulness can make a valuable contribution.	
Sussex Partnership NHS Foundation Trust	General	general	general	Thank you for the responses to our earlier comments. We are pleased to see them addressed directly and for some suggestions to be directly adopted.	Thank you for your comment.
UK Council for Psychotherapy	General	General	General	In response to question 3: '*What would help users overcome any challenges?'* we offer the following recommendations: Patient choice of psychotherapy modalities Patients should be offered a choice among psychological treatments, and this should be reflected within the guidelines such that CBT is not regarded as the default treatment. 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	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				in couples and in groups, and that clients should be matched to their treatment, instead of CBT being the primary treatment offered.	
UK Council for Psychotherapy	General	General	General	References Aalbers S, Fusar-Poli L, Freeman RE, Spreen M, Ket JCF, Vink AC, Maratos A, Crawford M, Chen X, Gold C. (2017) Music therapy for depression. *Cochrane Database of Systematic Reviews* 2017, Issue 11. Art. No.: CD004517. DOI: 10.1002/14651858.CD004517.pub3 Bentall, R. (2004) *Madness Explained: Psychosis and Human Nature*, England: Penguin. Bifulco A, Kwon J, Jacobs C, Moran PM, Bunn A, & Beer N. (2006). Adult attachment style as mediator between childhood neglect/abuse and adult depression and anxiety. *Social Psychiatry and Psychiatric Epidemiology, 41,* 796-805. 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. Bower P, Knowles S, Coventry PA, Rowland N. (2011). Counselling for mental health and psychosocial problems	Thank you for your comment. Please see below for details of what has happened to the references that you have provided. • Bower 2006, Bower 2011, Koch 2014, Meekums 2015, Ritter 1996 and Steinert 2017 systematic reviews were checked for any additional relevant studies but none of the studies met our inclusion criteria • Aalbers 2017 could not be included as music therapy was not prioritised for investigation in the review questions for this guideline • The Pinquart 2016 systematic review that you drew our attention to includes two additional studies on couples therapy will be included in the analysis when we update the evidence. • Bentall 2004, Bohart 2008, Cruz 1998, Department of Health 2013, Elliott 2010, Engel 1977, Hepgul 2016, Horwitz 2002, Kessler 2003, Lamers 2011, MacFarlane 2008, Mirowsky 2003/2017, Moffitt 2007, NHS Digital 2017, NHS England 2016, Pilgrim 2009, Pybis 2017, RCGP/NSPCC 2014, Röhricht 2015, Roth 2009, Seligman 1995, Stratton 2011, Van Rijn 2011, Van Rijn 2013, Van Rijn 2016, Zubala 2015 and Zubala 2018 have not been

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				in primary care. *Cochrane Database of Systematic Reviews*, Issue 9. Art. No.: CD001025. DOI: 10.1002/14651858.CD001025.pub3. Bower PJ, and Rowland N. (2006). Effectiveness and cost effectiveness of counselling in primary care. *Cochrane Database of Systematic Reviews*, Issue 3. Art. No.: CD001025. DOI: 10.1002/14651858.CD001025.pub2. Bradt J, Shim M, Goodill SW. (2015) Dance/movement therapy for improving psychological and physical outcomes in cancer patients. Cochrane Database of Systematic Reviews, Issue 1. Art. No.: CD007103. DOI: 10.1002/14651858.CD007103.pub3 Bräuninger I. (2012) Dance movement therapy group intervention in stress treatment: A randomized controlled trial (RCT). The Arts in Psychotherapy, 39:443-50. Chew-Graham, CA and May C. (2000). 'Partners in pain'—the game of painmanship revisited. *Family Practice*, 17: 285–287. Cooper, M, Messow, C, McConnachie, A, et al. (2017). Patient preference as a predictor of outcomes in a pilot trial of person-centred counselling versus low-intensity cognitive behavioural therapy for persistent sub-threshold and mild depression.	included in the guideline because they do not meet the study design criteria (not an RCT or systematic review of RCTs) • Bifulco 2006, Lin 2005, and Wallace 2013 mediator/moderator analyses are outside the protocol of the review • Bradt 2015 and Chew-Graham 2000 could not be included as trials that specifically recruit participants with a coexisting physical health condition are excluded from the guideline. • Bräuninger 2012: This intervention is targeted at stress in a non-clinical population, rather than symptoms of depression • Cooper 2017, Hyvonen 2018, Karkou (in preparation) and Saxon 2017 will be considered for inclusion in the guideline as we update the evidence. • Cottrell 2003: Does not meet the inclusions criteria for age - this guideline is restricted to adults • DeRubeis 2014 and Fournier 2009: Secondary analyses of a study (DeRubeis 2005 – was considered for inclusion in the NMA of treatment for a new depressive episode. However it was excluded from this review as mean duration of MDD >2 years which means that this study is ineligible for this review. DeRubeis 2005 could also not be included in the chronic depression review as no minimum

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				http://www.tandfonline.com/doi/abs/10.1080/09515070.2017.1329708 Cottrell, D. (2003). Outcome studies of family therapy in child and adolescent depression. *Journal of Family Therapy*. 25 (4), 406-416. Cruz, R., & Sabers, D. (1998). Dance/movement therapy is more effective than previously reported. The Arts in Psychotherapy, 25(2), 101–104. http://link.springer.com/article/10.1023/A%3A1013041723005 Department for Health. (2013). *Achieving parity of esteem between mental and physical health*, transcript of speech by Rt Hon Norman Lamb MP, retrieved 06/06/2018. Available at: https://www.gov.uk/government/speeches/achieving-parity-of-esteem-between-mental-and-physical-health DeRubeis RJ, Cohen ZD, Forand NR, Fournier JC, Gelfand LA, & Lorenzo-Luaces L. (2014). The Personalized Advantage Index: Translating Research on Prediction into Individualized Treatment Recommendations. A Demonstration. *PLoS ONE 9 (1):* e83875. Elliott, R.E., and Freire, E. (2010). The effectiveness of person-centred and experiential therapies: A review of the	duration of MDD was specified as part of the entry criteria for that trial and it is unclear what proportion of participants in the study would meet criteria for chronic depression) • Freire 2015 and Ward 2000: Included in the NMA for treatment of a new depressive episode • Hansson 2010: The aetiology of depression is outside the scope of this guideline. Qualitative evidence is also outside the scope of this update as the experience of care section is not being updated • Huibers 2015: Secondary analysis of a study that was already included in the NMA of treatment for a new depressive episode (Lemmens 2015/2016) • King 2014: Secondary analysis of a study that was already included in the NMA of treatment for a new depressive episode (Ward 2000) • Lindhiem 2014 and Swift 2011 could not be included as the guideline did not investigate the comparison of active choice condition relative to no involvement in shared decision making so these studies did not match inclusion criteria. Patient preference, choice and the principles of shared decision making were considered by the committee during the interpretation of evidence and making the recommendations

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				meta-analyses. In M. Cooper, J.C. Watson and D. Holldampf (eds.), *Person-centered and experiential therapies work: A review of the research on counseling, psychotherapy and related practices.* Ross-on-Wye: PCCS Books. Engel, G.L. (1977). The need for a new medical model: a challenge for biomedicine, *Family Systems Medicine*, Vol 10(3), Fal, 1992. Special issue: The behavioural scientist in primary care medicine. pp. 317-331 Fournier JC, DeRubeis RJ, Shelton RC, Hollon SD, Amsterdam JD, & Gallop R. (2009). Prediction of Response to Medication and Cognitive Therapy in the Treatment of Moderate to Severe Depression. *Journal of Consulting and Clinical Psychology, 77*, 775–787. Freire, E., Williams, C., Martina-Messow, C., Cooper, M., Elliott, R., McConnachie, A., Walker, A., Heard, D. & Morrison, J. (2015). Counselling versus low-intensity cognitive behavioural therapy for persistent sub-threshold and mild depression (CLICD): a pilot/feasibility randomised controlled trial. BMC Psychiatry. doi:10.1186/s12888-015-0582-y Hansson, M, Chotai, J, & Bodlund, O. (2010). Patients' beliefs about the cause of their depression, *Journal of Affective Disorders*, *124,* 54–59.	• The guideline was developed in accordance with the NICE guidelines manual and all relevant studies from the previous Depression guideline (2009) were included in this guideline • NICE 2014 (psychosis and schizophrenia in adults guideline) and Ren 2013 are not relevant as they are not about depression • Röhricht 2013 RCT was included in the chronic depression review as a result of stakeholder comments in the first consultation

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				Hepgul N et al. (2016). Clinical characteristics of patients assessed within an Improving Access to Psychological Therapies (IAPT) service: results from a naturalistic cohort study (Predicting Outcome Following Psychological Therapy; PROMPT). *BMC Psychiatry,* BMC series – open, inclusive and trusted 16:52. DOI: https://doi.org/10.1186/s12888-016-0736-6 Horwitz, A. (2002). *Creating Mental Illness*, Chicago: University of Chicago Press. Huibers MJH, Cohen ZD, Lemmens LHJM, et al. (2015). Predicting Optimal Outcomes in Cognitive Therapy or Interpersonal Psychotherapy for Depressed Individuals Using the Personalized Advantage Index Approach. *PLoS ONE 10 (11):* e0140771. Hyvonen, K Pylvainen P, Isotalo E and Lappalainen R (2018) Dance therapy in the treatment of depression: Preliminary results, *University of Jyvaskyla, Psychology Department.* Available at: https://www.jyu.fi/psykologia/tanssi-liiketerapia Karkou V, Genetti A, Zubala A, Aithal S, and Meekums B. (in preparation). The Role of Dance Movement Therapy in the Treatment of Depression: From Clinical Practice to Research Evidence and Back, *Frontiers in Psychology.*	

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				Kessler RC, Berglund P, Demler O, et al. (2003). The epidemiology of major depressive disorder: results from the national comorbidity survey replication, *JAMA, 289,* 3095-3105. King M, Marston L, Bower P. (2014) Comparison of non-directive counselling and cognitive behaviour therapy for patients presenting in general practice with an ICD-10 depressive episode: a randomized control trial. Psychological Medicine. 44:1835–44. Koch S, Kunz T, Lykou S and Cruz R. (2014). Effects of dance movement therapy and dance on health-related psychological outcomes: A meta-analysis, *The Arts in Psychotherapy*, 41, 46-64. Lamers F, van Oppen P, Comijs HC, et al. (2011). Comorbidity patterns of anxiety and depressive disorders in a large cohort study: the Netherlands Study of Depression and Anxiety (NESDA). *Journal of Clinical Psychiatry, 72,* 341-8. Lin P, Campbell DG, Chaney EF, et al. (2005). The influence of patient preference on depression treatment in primary care. *Annals of Behavioral Medicine, 30,* 167–173. Lindhiem O, Bennett CB, Trentacosta CJ, & McLear C. (2014). Client preferences affect treatment satisfaction,	

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				completion, and clinical outcome: A meta-analysis. *Clinical Psychology Review*, *34*, 506–517. MacFarlane, M. (2008). Systemic Treatment of Depression, *Journal of Family Psychotherapy*,14:1, 43-61, DOI: 10.1300/J085v14n01_05 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. Mirowsky, J. and Ross, C. (2003). *Social Causes of Psychological Distress.* New York: Aldine de Gruyter. Mirowsky, J. and Ross, C. (2017). *Social Causes of Psychological Distress* (2nd Edition). New York: Routledge. Moffitt TE, Harrington H, Caspi A, et al. (2007). Depression and generalised anxiety disorder: cumulative and sequential comorbidity in a birth cohort followed prospectively to age 32 years. *Archives of General Psychiatry, 64,* 651-660. NHS Digital (2017). *Psychological Therapies: Annual Report on the use of IAPT services, England, 2015-16.* http://www.content.digital.nhs.uk/catalogue/PUB22110/psyc-ther-ann-rep-2015-16_v2.pdf	

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				NHS England (2016). *Improving outcomes through personalised medicine*. https://www.england.nhs.uk/wp-content/uploads/2016/09/improving-outcomes-personalised-medicine.pdf NICE (2009). *Treatment and Management of Depression in Adults (CG90)* Available: http://guidance.nice.org.uk/CG90/Guidance/pdf/English NICE (2014). *Psychosis and schizophrenia in adults: prevention and management* (CG178). Available: https://www.nice.org.uk/guidance/cg178 NICE (2014/updated 2017). *Developing NICE guidelines: the manual: Process and methods* (PMG20). Available: https://www.nice.org.uk/process/pmg20 Pilgrim, D, Rogers, A and Bentall, R. (2009). The centrality of personal relationships in the creation and amelioration of mental health problems: the current interdisciplinary case, *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, Vol 13(2): 235 – 254. Pinquart M, Oslejsek B & Teubert D (2016) Psychotherapy Research Volume 26, 2, 241-257	

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				Pybis, J, Saxon, D, Hill, A, and Barkham, M. (2017) The comparative effectiveness and efficiency of cognitive behaviour therapy and generic counselling in the treatment of depression: evidence from the 2nd UK National Audit of psychological therapies. *BMC Psychiatry* 17:215 DOI 10.1186/s12888-017-1370-7 RCGP/NSPCC (2014). *Adult survivors and disclosures of historical abuse. Safeguarding children toolkit for General Practice.* http://www.rcgp.org.uk/clinical-and-research/toolkits/the-rcgp-nspcc-safeguarding-children-toolkit-for-general-practice.aspx Ren J and Xia J. (2013). Dance therapy for schizophrenia. Cochrane Database of Systematic Reviews, Issue 10. Art. No.: CD006868. DOI: 10.1002/14651858.CD006868.pub3 Ritter, M. & Low, K. G. (1996). Effects of dance/movement therapy: A meta-analysis. The Arts in Psychotherapy, 23, 249–260. Available: http://www.sciencedirect.com.edgehill.idm.oclc.org/science/article/pii/0197455696000275 Röhricht F, Papadopoulos N, & Priebe S. (2013). An exploratory randomized controlled trial of body psychotherapy for patients with chronic depression. *Journal of Affective Disorders, 151,* 85-91.	

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				Röhricht F. (2015). Body psychotherapy for the treatment of severe mental disorders–an overview. *Body, Movement and Dance in Psychotherapy, 10,* 51-67. Roth, A. D., Hill, A., & Pilling, S. (2009). The competences required to deliver effective Humanistic Psychological Therapies. *Centre for Outcomes Research and Effectiveness, University College London*. Retrieved from: http://www.ucl.ac.uk/clinicalpsychology/CORE/humanistic_framework.html Saxon D, Ashley K, Bishop-Edwards L, Connell J, Harrison P, Ohlsen S, et al. (2017). A pragmatic randomised controlled trial assessing the non-inferiority of counselling for depression versus cognitive-behaviour therapy for patients in primary care meeting a diagnosis of moderate or severe depression (PRaCTICED): study protocol for a randomised controlled trial. Trials. 2017;18:93. DOI: https://doi.org/10.1186/s13063-017-1834-6 Seligman, M. (1995). The effectiveness of psychotherapy: The Consumer Reports study. *American Psychologist*, Vol 50(12): 965-974. Steinert, C, Munder, T, Rabung, S, Hoyer, J, and Leichsenring, F. (2017). Psychodynamic therapy: As efficacious as other empirically supported treatments? A	

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				meta-analysis testing equivalence of outcomes. https://doi.org/10.1176/appi.ajp.2017.17010057 Stratton, P. (2011). *The evidence base of systemic family and couples therapies.* Available: http://www.aft.org.uk/SpringboardWebApp/userfiles/aft/file/Research/Final%20evidence%20base.pdf Last accessed 06/06/2018. Swift, JK, Callahan, JL, Vollmer, BM. (2011). Preferences. *Journal of Clinical Psychology, 67,* 155-65. Van Rijn, B, Wild, C and Moran, P. (2011). Evaluating the outcomes of transactional analysis and integrative counselling psychology within UK primary care settings. *International Journal of Transactional Analysis Research & Practice, 2,* 34-43. Van Rijn, BV & Wild, C. (2013). Humanistic and integrative therapies for anxiety and depression: Practice-based evaluation of transactional analysis, gestalt, and integrative psychotherapies and person-centred counselling. *Transactional Analysis Journal,* 43*,* 150-163. Van Rijn, BV and Wild, C. (2016). Comparison of transactional analysis group and individual psychotherapy in the treatment of depression and anxiety: Routine outcomes evaluation in community clinics. *Transactional Analysis Journal, 46*, 63-74.	

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British Association for Counselling & Psychotherapy	General	General	General	Recommendations for research In our prior consultation report we made a number of suggestions for additional focusses for research. One of these was for RCTs which utilise CBT as a comparator; specifically, RCTs on Humanistic Therapies focussed on both mild to moderate and severe depression. The NICE response to this was: "There is a large trial which is	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated

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				nearing completion in this area so we did not prioritise recommending further research" (NICE consultation comments and responses document, p611). The trial is not named but we assume that this might be the PRACTICED trial? If so this trial provides the first RCT on Counselling for Depression, a model of Person-Centred/Experiential counselling developed specifically to work with depression, as recommended/preferred in this revised Guideline. However, one trial is not enough. A big issue in the field is the imbalance of research on interventions, with much more research on some interventions, in particular CBT, than on others. The Revised Guideline discusses the importance of patient choice of psychological interventions (p257); if NICE wishes to honour this commitment to patients in the view of BACP it must advocate RCTs on NICE recommended treatments which have a limited evidence base in comparison with CBT, such as Humanistic counselling.	data. The research recommendations will also be reviewed.
British Association for Counselling & Psychotherapy	General	General	General	References Barth, J., Munder, T., Gerger, H., Nüesch, E., Trelle, S., Znoj, H., ... & Cuijpers, P. (2013). Comparative efficacy of seven psychotherapeutic interventions for patients with depression: a network meta-analysis. *PLoS medicine*, *10*(5), e1001454. Barkham, M., Lutz, W., Lambert, M. J., & Saxon, D. (2017). Therapist effects, effective therapists, and	Thank you for your comment. Please see below for details of what has happened to the references that you have provided. • Barkham 2017a and 2017b, Craig 2008, Flacco 2015, Gyani 2012, Gyani 2013, Kriston 2013, Juni 2001, NHS Digital 2014/2015/2016/2018, Puhan 2014, Pybis 2017, Salanti 2014, Stiles 2006, and Stiles 2008 have not been included in the guideline because they do not meet the study design

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				the law of variability. In L. G. Castonguay and Hill, C. E. (Eds.), *How and why are some therapists better than others?: Understanding therapist effects*. Washington, DC: American Psychological Association Barkham, M.; Moller, N. P. & Pybis, J (2017) How should we evaluate research on counselling and the treatment of depression? A case study on how NICE's draft 2018 guideline considered what counts as best evidence. *Counselling and Psychotherapy Research* Craig P, Dieppe P, Macintyre S, Michie S, Nazareth I, Petticrew M. (2008) Developing and evaluating complex interventions: the new Medical Research Council guidance. BMJ; 337:a1655. Cuijpers, P. (2016) Are all psychotherapies equally effective in the treatment of adult depression? The lack of statistical power of comparative outcome studies. *Evidence Based Mental Health, 19,* 39-42. Flacco ME, Manzoli L, Boccia S, Capasso L, Aleksovska K, Rosso A, et al. Head-to-head randomized trials are mostly industry sponsored and almost always favor the industry sponsor. J Clin Epidemiol 2015;68:811–20. doi:10.1016/j.jclinepi.2014.12.016.	criteria (not an RCT or systematic review of RCTs) • Barth 2013 systematic review was checked as a result of stakeholder comments from the first consultation and an additional 14 RCTs were added. The information from these RCTs was included in the analysis that went out for second consultation • Cuijpers 2016 ('Are all psychotherapies equally effective in the treatment of adult depression? The lack of statistical power of comparative outcome studies') and Munder 2013 do not meet the study design criteria for inclusion in the review because they are systematic reviews of systematic reviews rather than an RCT or a systematic review of RCTs. • Lindhiem 2014 could not be included as the guideline did not investigate the comparison of active choice condition relative to no involvement in shared decision making so these studies did not match inclusion criteria. Patient preference, choice and the principles of shared decision making were considered by the committee during the interpretation of evidence and making the recommendations

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				NHS Digital (2014). Psychological Therapies: Annual report on the use of IAPT services. England, 2013-2014. http://content.digital.nhs.uk/catalogue/PUB14899 NHS Digital (2015). Psychological Therapies: Annual report on the use of IAPT services. England, 2014-2015. http://content.digital.nhs.uk/catalogue/PUB19098 NHS Digital (2016). Psychological Therapies: Annual report on the use of IAPT services. England, 2015-2016 http://content.digital.nhs.uk/pubs/psycther1516 NHS Digital (2018) Psychological Therapies Annual report on the use of IAPT services, further analyses on 2016-17. https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-report-on-the-use-of-iapt-services/psychological-therapies-annual-report-on-the-use-of-iapt-services-england-further-analyses-on-2016-17 Puhan, M., Schunemann, H., Murad, M., Li, T., Brignardello-Petersen, R., Singh, J., Kessels, A. and Guyatt, G (2014) A GRADE Working Group approach for rating the quality of treatment effect estimates from network meta-analysis. Pybis, J., Saxon, D., Hill, A., & Barkham, M. (2017). The comparative effectiveness and efficiency of cognitive behaviour therapy and counselling in the treatment of	

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				depression: Evidence from the 2nd UK national audit of psychological therapies. *BMC Psychiatry, 17,* 215. Salanti G, Giovane CD, Chaimani A, Caldwell DM, Higgins JPT (2014). Evaluating the quality of evidence from a network metaanalysis. PLoS One 2014; 9: e99682. Stiles, W.B., Barkham, M., Twigg, E., Mellor-Clark, J., & Cooper, M. (2006). Effectiveness of cognitivebehavioural, person-centred, and psychodynamic therapies as practiced in UK National Health Service settings. *Psychological Medicine, 36,* 555-566. Stiles, W.B., Barkham, M., Mellor-Clark, J., & Connell, J. (2008). Effectiveness of cognitivebehavioural, person-centred, and psychodynamic therapies in UK primary care routine practice: Replication in a larger sample. *Psychological Medicine, 38,* 677-688.	
UK Mindfulness University Centres	General	General	General	We would like to thank the committee for considering and responding to our comments on the first draft of the revised guideline. We have provided additional comments below on the second draft of the revised guideline and we hope that the committee find these helpful.	Thank you for your comment.
Lundbeck	General	General	General	Lundbeck ("we") originally flagged a number of general concerns about the first consultation drafts of both the short and full clinical guideline. In particular, we were concerned:	Thank you for your comment and support for the changes made to the guideline.

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				• That vortioxetine, an antidepressant (AD) licensed for the treatment of major depressive episodes in adults, had been excluded as an intervention of interest for the decision problem for all review questions considered by the Guideline Committee (GC); • That vortioxetine was not therefore included in the systematic literature review underpinning the guideline; and • That NICE Single Technology Appraisal (TA) Guidance 367 for the use of vortioxetine for the treatment of major depressive episodes (NICE, 2015) had been omitted from the guideline recommendations altogether; and, • That vortioxetine was omitted as a treatment option from the proposed care pathway for adults with depression entirely, despite it being the only pharmacological treatment licensed for the treatment of depression that has current, extant and positive NICE technology appraisal guidance. We are very pleased to note that the GC has acted upon our concerns and that this second guideline draft includes a number of amendments to address these important points. We particularly welcome the acknowledgement that TA367 is a valid and current piece of guidance, the cross-references to that guidance, and the explanation of how published NICE TAs are linked to NICE clinical guidelines.	

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				We believe that the newly-added cross-reference to TA367 on the use of vortioxetine, to highlight its position as an option before changing to a combination of 2 different classes of medication, better reflects the evidence base considered by NICE during that appraisal, ensuring vortioxetine is included in the care pathway for adults with depression in line with this current, extant and positive NICE technology appraisal guidance. These proposed amendments to the guideline now support the mandate for clinical commissioning groups, NHS England and, with respect to their public health functions, local authorities, to comply with the recommendations of TA367, in accordance with Section 7(6) of the National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013. We felt the last short and full drafts left the reader assuming that the implementation of TA367 was no longer relevant. Reference: NICE Technology Appraisal 367: Vortioxetine for treating major depressive episodes (November 2015).	
Lundbeck	General	General	General	We welcome the fact that the GC has revised the ordering of the recommendations on further line treatment to clarify that increasing the dose of an antidepressant (AD), switching medication or changing to a combination of psychological therapy plus medication are all options to consider before combining 2 medications.	Thank you for your comment, for drawing our attention to the Taylor et al. (2018) citation, and your support for the changes made to the guideline.

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				We believe that this revised list of recommendations better reflects the current evidence base for the management of depression and is also in line with similar evidence-based recommendations made in the recently-published Maudsley Prescribing Guidelines in Psychiatry 13th Edition (2018). Reference: Taylor, D, Barnes, T. R. E and Young, A. H (2018) Maudsley Prescribing Guidelines in Psychiatry 13th Edition. Wiley Blackwell.	
Lundbeck	General	General	General	The first consultation draft signalled an important change of direction from that of the original CG90, proposing a shift in the prescribing decision from primary to secondary/specialist care for all but first-line pharmacological options. We support the GC's revised suggestion that these recommendations relate to a more restricted group of people with depression whose symptoms significantly impair their personal and social functioning only.	Thank you for your comment and support for the changes made to the guideline.
The Psychotherapy & Counselling Union	General	General	General	At the level of policy to service delivery, IAPTs own end of treatment outcome data reports an outcome probability to increasing well-being that is equal to chance i.e. around 50%/50% (treatment/no-treatment; NHS England, 2018). IAPT treated 1 million people (2009-2012) with a recovery rate of 45% (Department of Health, 2012). Of more serious concern is that from its own data, IAPT may be reducing levels of well-being. Gyani, Shafran, Layard, & Clark,	Thank you for your comment. The recovery rate in the IAPT programme is currently 53% (DH, 2018) It is misleading to say that recovery is no better than chance when it is well established that the recovery from depression in naturalistic studies and in experimental groups in less than 50%, for example around 30% in placebo controlled trials .

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				2013) reported that 6.6% of patients showed reliable deterioration. Translating this to experiences, 66,000 people experienced IAPT as iatrogenic. IAPT is due to scale-up to treat 1.5 million people annually (Clarke, 2016), which could translate into 99,000 people feeling harmed by attending public sector therapy (Cox, 2018). For socio-economically diverse or marginalised populations, public sector therapy may be the only support available. Therefore, it needs to be fit for purpose. At one-year follow up the outcome data reports a recovery rate of 40% (Gyani et al., 2013) of the 50% i.e. at best 20% of those who began treatment. A fine grained analysis of Pybis, Saxon, Hill, & Barkham's (2017) analysis of IAPT's data suggests that only 7% of those referred to IAPT show improvement. Additionally, alternative approaches to IAPT report outcomes for counselling and CBT in the treatment of depression that are comparable, and that efforts should focus on factors other than therapy type, which may influence outcomes (Pybis et al., 2017). Therefore, and by its own assessment, IAPT is not delivering the claimed social or economic programme to the general population (Timimi, 2018). The Centre for Social Justice's (2012, p. 2) review of the effectiveness of IAPT services found only 15% of people referred to its project were achieving 'recovery' by the time they left. From this finer analysis of IAPT's data, serious philosophical, political and ethical questions emerge regarding the continued support of IAPT.	The deterioration you refer to in the IAPT data set is typical of that reported in clinical trials and similar to that of large cohort studies such as those reported by Prof Mike Lambert's group (e.g. Okiishi et al 2003). Of course the deterioration of any person in treatment is a cause for concern and a number of IAPT clinical networks as well as individual clinicians work in a range of clinical services The analysis from Pybis et al you report of people entering treatment is misleading as the paper reports rates of recovery varying from 22% to 62%. We note your concerns regarding the extension of IAPT into Job Centres but as you state this is outside the scope of the guideline. NICE is committed to promoting equality of access to treatment and to equality of outcomes and we have addressed these issues in the recommendations. NHSE and IAPT has a similar approach but it is outside of the scope of the guideline to focus on such issues for particular services such as IAPT.

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				The Psychotherapy and Counselling Union's submission suggests that diverse and marginalised patient populations are particularly vulnerable to their health being affected in the negative direction. Since alternatives to treat adult depression that are comparable or greater than IAPT are effective (Pybis et al, 2017), there is reason to question whether IAPT in its current form is suited to meet the needs of adults experiencing depression. Members of the Psychotherapy and Counselling Union (PCU) who are both providers and receivers of NHS well-being care, report that such issues are particularly pertinent for their clients from diverse and marginalised backgrounds. Although beyond the remit of the consultation, we ask that consideration be given to a key concern strongly registered by our members; the extension of IAPT into Jobcentres, also known as psycho-compulsion (Friedli & Steam, 2015). The Psychotherapy and Counselling Union appreciates that many submissions will provide concerning Evidence-based practice, critiques of the quantitative research data supporting IAPT. This is because marginalised groups are particularly impacted by IAPT's narrow data perspective and its narrow focus omits consideration of alternative ways to work with adult depression, to meet the needs of those connected with IAPT, or the impact of political, economic and social factors. The PCU represents members who work in a range of settings. Similar to IAPT	

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				staff, our members report increasing dissatisfaction with their roles, measured by increasing works days lost to sickness, low staff morale and the low retention rate of staff relative to similar services. As these issues are well-documented in NHS and IAPT reports we will not reiterate them here (Rao et al., 2016; Westwood, Morison, Allt, & Holmes, 2017). The PCU's submission will focus on equality, diversity and marginalisation. For instance, the LGBT+ communities experience poorer outcomes of NHS therapy (King et al, 2008: Semlyen, King, Varney, & Hagger-Johnson, 2016). Also, ethnic minorities consistently report receiving poorer access to, and levels of, therapy (Ade-Serrano & Nkansa-Dwamena, 2016). Due to space restrictions, the PCU's will focus on one diverse group, which reflects the issues experienced by all diverse groups. The Union's rationale is that we are particularly concerned about diverse groups who remain hidden within the perspective of the draft consultation. The 2010 Equalities Act (Legislation.gov.uk, 2010) is required to also address faith. Generally, IAPT does not. The lack of cultural awareness in specific relation to adult depression means that ethnic identifications are often conflated with religious identifications. This is particularly serious given the current social climate of islamophobia, where many patients from Muslim backgrounds are subject to increasing levels of antagonisation and poor	

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				practice in regard to IAPT provision. Muslims represent approximately 5% of the population. Approaching a faith community primarily with a secular model to address their psychological well-being may be at worst damaging, and at best lead to low levels of engagement. The 2016 IAPT report shows that recovery rates are highest amongst Jain, Christian and Jewish patients, and lowest amongst Pagan and Muslim patients (NHS England, 2018). There is a strong correlation between relative deprivation and mental ill health with nearly half (46%) of the Muslim population residing in the bottom 10% of the most deprived local Authority Districts in England, and are therefore more likely to be impacted by poor mental health (Bhui et al., 2005). IAPT has identified its poorest outcomes are in socio-economically deprived areas (House of Commons, 2018). Within this frame, diverse and marginalised communities are expected to be able to move to recovery within 6 sessions. This is also assuming that the assessment has developed a shared understanding between patient and practitioner of the presenting problem and the underlying cause - the levels of somatisation in communities where English is not the first language indicates the degree to which this is not possible. This has not been addressed through widespread use of PHQ 15 testing, or any other strategy. Black and minority ethnic (BAME) communities also experience complex life events that lead to complex mental ill health presentations. These can include asylum	

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				seeking, previous experience of war, Domestic Violence, Female Genital Mutilation and intergenerational trauma. To expect that such complex experiences can be unpacked and addressed in short standardised interventions risks introducing iatrogenic practices into a process intended to enhance well-being. The Cultural Formulation Interview (CFI: APA, 2013), assesses both the cultural or ethnic groups that the patient belongs to, and the ways in which those groups understand a problem such as depression, and how this affects a person's experience of DEPRESSION. Many diagnoses don't take into account cultural formulation at all. The significance of this in relation to assessment compounds the invisibility of BAME experience of mental illness and related outcomes. This needs to be highlighted within the guidelines and pathways identified specifically with regard to mental health inequalities. With regard to hyper-diverse communities, IAPTS provision is not available in many of the languages patients use to make sense of their social world. Translation facilities within the NHS are also often inadequate with interpreters ill equipped to work with mental health or counselling. In addition, translations of IAPT assessments GAD7 and PHQ9 are not available in the variety of languages. The PCU suggests that, "What is being suggested here is that racism and other environmental stress factors can cause psychic collapse	

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				and ... Therapists who will be challenged to work with this particular form of 'mental health' presentation should take into consideration ... Eurocentric notion[s, ideologically-driven motivations to control resources, patriarchal- and colonial-based power relations and cisgendered views] of disease and mental illness" (Allyene, 2009, p. 166). When revising the guidelines, the PCU recommends: within the UK's pluralistic society, consideration be given to how the above points impact notions and treatment of adult depression; that IAPT investigates the factors which lead to lower recovery rates in socio-economically deprived areas; that a greater consideration of diversity be given to all minority communities; that the strategic revision of IAPT monitors the lack of impact in the Muslim community and addresses the underlying mental health inequalities experienced; and the Cultural Formulation Interview (CFI) be applied where appropriate. Examples of good practice be consulted such as the Lateef Project's community led Islamic counselling service (Birmingham) and Adapted behavioural activation (Leeds: Mir et al., 2015). References Ade-Serrano, Y., & Nkansa-Dwamena, O. (2016). Voicing the uncomfortable: How can we talk about race? Special Edition: 'Race' and Counselling Psychology. Counselling Psychology Review, 31(2), 5-9. Alleyne, A. (2009). Working therapeutically with hidden dimensions of racism. In S. Fernando & F. Keating. (Eds). Mental health in a multi-ethnic society: A multidisciplinary	

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				(accessed 11 June 18) https://digital.nhs.uk/data-and-information/ publications/statistical/psychological-therapies-report-on-the-use-of-iapt-services/ psychological-therapies-annual-report-on-the-use-of-iapt-services-england-2016-17. NHS England. (2018). 70 years of the NHS 1948-2018. (accessed 11 June 2018) www. england.nhs.uk/mental-health/adults/iapt/service-standards/. Pybis, J., Saxon, D., Hill, & Barkham, M. (2017). The comparative effectiveness and efficiency of cognitive behaviour therapy and generic counselling in the treatment of depression: evidence from the 2nd UK National Audit of psychological therapies. BMC Psychiatry, 17:215, 1-13. (accessed 11 June 2018) doi: 10.1186/s12888-017-1370-7. Rao, A., Clarke, J., Bhutani, G., Dosanjh, N., Cohen-Tovée, E., Hacker-Hughes, J. & Neal, A. (2016). Workforce Wellbeing Survey 2014 – 2016. British Psychological Society, Division of Clinical Psychology & New Savoy Conference. (accessed 11 June 2018) www.Newsavoypartnership.org/2017presentations/dosanjh-g-bhutani.pdf. Semlyen, J., King, M., Varney, J., & Hagger-Johnson, G. (2016). Sexual orientation and symptoms of common mental disorders or low wellbeing: combined meta-analysis of 12 UK population health surveys. BMC Psychiatry, 16(67), 1-9. doi: 10.1186/s12888016-0767-z.	

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The British Psychological Society	General	General	General	Under NICE's own rules, a second consultation can occur exceptionally if "information or data that would significantly alter the guideline were omitted from the first draft, or evidence was misinterpreted in the first draft and the amended interpretation significantly alters the draft recommendations". Both conditions have been met in this case. Stakeholders identified wide ranging and fundamental methodological flaws in the draft and offered recommendations for addressing these. In spite of acknowledging the serious omissions and misinterpretations through issuing a second consultation, these key issues have not been addressed in the new draft. Therefore, The Society strongly welcomes the issuing of a second consultation on the guideline and urge the	Thank you for your comment. The decision to have an 'exceptional' consultation was not made because either of the criteria in the technical manual had been met, but because NICE thought it would be useful for stakeholders (who had significant concerns about the content of the first draft of the guideline) to see what had changed and be given another chance to comment, particularly given the complex nature of this guideline and its associated analyses. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee

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				guideline group to consider data which was omitted from the first version. If these issues are not adequately addressed, the treatment recommendations cannot be relied on. The draft guideline in its current form poses a serious threat to patient choice and will result in patients being offered a limited selection of treatments, which may not be the treatments that have the best chance of relieving their suffering (which in turn will contribute to poor cost effectiveness in the long term).	agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document.
The British Psychological Society	General	General	General	The Practice-Based Evidence from the second round of the National Audit of Psychological Therapies (NAPT) in addition to the evidence from randomised controlled trials (RCTs) and Meta-Analyses of RCTs should be considered. The current version of the draft NICE Guidelines for Depression appears to neglect the Practiced-Based Evidence into the efficacy of counselling and CBT. Pybis et al (2017) looked at the outcomes of 33,243-patients across 103 Improving Access to Psychological Therapy (IAPT) Services, who were treated for depression with either CBT or counselling. The analysis showed that the outcomes of counselling and CBT in the treatment of depression were comparable. The data also indicated that counselling is more efficient than CBT for patients who required less than 8-sessions of therapy.	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document. We would like to clarify that pill placebo data were not selected to serve as a 'control' for psychotherapy studies. For presentational purposes, we decided to select a 'reference treatment' and report the relative effects of all

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				Moreover, there are serious concerns arising from the network meta-analysis to compare effectiveness across interventions for depression, including both psychological and pharmacological. A particular issue is the assumption that pill placebo data can serve as an adequate control for psychotherapy studies. A more adequate and valid control would be the provision of no therapy and a measure of expectation (based on the general public), rather than a pharmacologically-relevant one. The inappropriate use of a pill placebo will almost certainly result in psychotherapies looking considerably worse than they should compared to pharmacological treatments. The NICE analysis needs to be re-run using appropriate control comparisons for the psychotherapies.	classes and interventions considered in the network (i.e. psychological, pharmacological, physical or combined) against this reference. This was essential because the NMAs included a very large number of classes and interventions, leading to hundreds of pairwise comparisons that were unfeasible to report [although these have been reported in NMA-related appendices]. Please note that NMA combines direct with indirect evidence and allows estimation of relative effects between all pairs of all classes/interventions that have been considered in the NMA, whether these have been directly compared in head-to-head trials or not. Pill placebo was selected as a reasonable 'reference treatment' due to the high pill placebo response in populations with depression and because it is a more reliable and consistently described comparator in the trials than either waitlist or TAU, the definition of which may vary across studies. The use of pill placebo as the reference treatment had absolutely no impact on the relative effects between classes/interventions or their relative rankings. The relative effects between classes/interventions and their rankings are not affected by the intervention that serves as the reference treatment and would be exactly the same had we used waitlist, TAU, a different inactive control, or, indeed, any active intervention as reference treatment. However, as the pill placebo

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					has a larger absolute effect compared with waitlist and TAU, interventions that appear to be effective compared with waitlist or TAU [with a potentially large relative effect] may not appear to be as effective compared with pill placebo [i.e. their relative effect in this case may be smaller, as the relative effect between an intervention and its control is the difference between the absolute effect of the intervention and the absolute effect of the control]. This explains why the relative effects of psychological interventions versus pill placebo that were reported in the draft Depression guideline were lower than the relative effects of psychological interventions versus TAU or waitlist, as reported in other published meta-analyses. Nevertheless, we note that the relative effects of psychological interventions versus TAU on the SMD outcome, which were also presented in the guideline draft, were similar to those observed in published reviews [please note the identical ranking of pharmacological and pharmacological interventions following use of either pill placebo or TAU as reference treatment]. We note that use of different reference treatment for different interventions considered in the same NMA (e.g. use of waitlist as a reference for psychological interventions and use of pill placebo as a reference for pharmacological interventions)

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					would be inappropriate and misleading as it would introduce bias in the analysis and the resulting conclusions (it would mean not comparing like with like and would lead to invalid conclusions on the relative effectiveness between psychological and pharmacological interventions). It is true that because of the higher absolute effect of pill placebo compared with TAU and waitlist, an intervention with a superior effect to TAU or waitlist may not show a superior effect to pill placebo. However, the committee expressed the view that it would not make sense to recommend a psychological intervention that appears to have a similar effect to pill placebo (the same way as they would probably not recommend a drug with a similar effect to pill placebo). It is also true that because of the higher absolute effect of pill placebo compared with TAU and waitlist, an intervention that is significantly better than TAU or waitlist, may show a benefit versus pill placebo that does not reach the level of statistical significance. However, such a situation would not affect recommendations, as the committee did not make recommendations based on the statistical significance of the class and intervention effects; rather, they considered the magnitude of the effects, the uncertainty around them, the size and

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					quality of the evidence base, and other factors including cost effectiveness, patient characteristics and choice.
The British Psychological Society	General	General	General	There are various methodological concerns raised in relation to the first draft which have not been addressed in the revised version. As a result, the guideline is not fit for purpose and if published will seriously impede the care of millions of people in the UK suffering from depression, potentially even causing clinical harm.	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document.
The British Psychological Society	General	General	General	The Matrix (2015) A Guide to Delivering Evidence-Based Psychological Therapies in Scotland is a document which provides information on the delivery of psychological therapy. Although this is specific to Scotland, the document also includes the evidence-base for various psychological interventions for different groups (such as older people, children and young people etc.)	Thank you for your comment and for providing this information.
The British Psychological Society	General	General	General	<u>References</u> Beck A.T., Rush A.J., Shaw B.F. & Emery, G. (1979) Cognitive Therapy of Depression. New York: Guilford Press	Thank you for your comment. Please see below for details of what has happened to the references that you have provided. • Beck 1979, Hepgul 2016, Hengartner 2017, Pybis 2017, and Mental Health in Scotland 2015 have not been included in the guideline

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				Hepgul, N., King, S., Amarasinghe, M., Breen, G., Grant, N., Grey, N… Cleare, A.J. (2016). Clinical characteristics of patients assessed within an Improving Access to Psychological Therapies (IAPT) service: results from a naturalistic cohort study (Predicting Outcome Following Psychological Therapy; PROMPT). BMC Psychiatry, 16(1), 52. Hengartner, M. (2017). Methodological flaws, conflicts of interest and scientific fallacies: implications for the evaluation of antidepressants. Frontiers in Psychiatry. Pybis, J., Saxon, D., Hill, A., & Barkham, M. (2017). The comparative effectiveness and efficiency of cognitive behaviour therapy and counselling in the treatment of depression: Evidence from the 2nd UK national audit of psychological therapies. BMC Psychiatry, 17, 215. Mental Health in Scotland: The CAMHS Matrix (2015) A guide to delivering evidence-based Psychological Therapies in Scotland. / Schwannauer, Matthias; Taylor, Emily. Education Scotland (NES), 88 p.	because they do not meet the study design criteria (not an RCT or systematic review of RCTs)
Psychotherapy Foundation	General	General	General	Major Flaws in the Process, Method and Outcome of Guideline Development The development of this guideline contains errors and potential errors at four significant layers in process and development of this guideline which affect outcome and recommendations:	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that

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				1. Terms and definitions are not used with sufficient precision and accuracy 2. Assumptions made in in the process of analysis lack precision and accuracy 3. Selection of studies for analysis, particularly network analysis, therefore also lacks sufficient precision and accuracy 4. Consequently, the process of decisions regarding the arrangement and inputs for network analysis are flawed We know that the process and analytic method used in the development of these draft guidelines started its evolution four years ago. There are new and highly novel, perhaps even innovative, aspects to the methods used in this development. However the development has happened behind closed doors, and has not been exposed to broad peer review and the wider scientific community. It will take considerable time and work to replicate and examine what has been developed, the analytic methods used, and their solutions. This means that the guideline is fundamentally flawed.	the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document.
Psychotherapy Foundation	General	General	General	Misuse of Terms and Definitions A misuse of terms and definitions has led to flawed process, method, outcome and recommendations. As an example, previous response to consultation drew attention	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline

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				to a use of the cover term 'cognitive behavioural therapy (CBT)' which the documents present this uncritically throughout. It seems to us that there is little doubt that, within the domain announced by this cover term, there are many specific cognitive and behavioural treatments. Some of these specific treatments have an evidence base, usually restricted by setting and/or diagnosis, and some have little or no evidence base. As is discernible from the research referenced in the draft guidelines only a very small number of treatment approaches within the domain 'cognitive behavioural therapy' are evidence based for the treatment of depression. The response from the guideline development team in the first consultation was: *Thank you for your comment. We consider that cognitive behavioural therapy is a widely used term that will be understood by readers of the guideline Therefore we have kept this term in the guideline.* This response, in our view, is complacent and fails in rigour, precision and accuracy which are requirements in the development of a guideline of this importance. The continued use of the cover term 'cognitive behavioural therapy' is misleading and obscures treatment development and research direction. It is misleading for patients and users, clinicians, educators, researchers, providers, commissioners, and the public as a whole.	update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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Psychotherapy Foundation	General	General	General	Major Flaws in Assumptions Guiding Selection of Studies and Network Analysis A misuse of conceptual and theoretical frameworks informing assumptions has led to flawed process, method, outcome and recommendations. Assumptions about diagnosis, severity, complexity, treatment failure/resistance, chronicity, and comorbidity and poorly elaborated and justified. They have not taken account of the wider scientific community and published research. A dominance of comorbidity as a mediator within these assumptions is detrimentally ignored. There is a failure to utilise a proper approach to differential diagnosis, and although mention is given to 'Depression with comorbidities', failing to recognise that dominant, evidence based models of psychological treatment require concurrent management of anxiety through treatment of the depressive disorder, and perhaps a more important diagnosis of comorbid depression and personality disorder is not properly addressed. Similarly sections on remission, recovery, treatment failure and treatment success rates are not properly described or differentiated. Treatment failure and data is obscured within remission. A failure to properly integrate evidence about assessment and diagnostics, including comorbidities, with data about remission, recovery, treatment failure and treatment success is a major weakness of the draft guidelines.	Thank you for your comment. The guideline adopted the commonly used diagnostic systems for depression and related concepts such as severity, chronicity and complexity as they were important concepts identified in the scoping process. Some adjustments were made to these concepts, for example the combining of treatment resistant depression and limited response to treatment after a consideration of the evidence. The reasons for this are set out in the methods section. It is not within the scope of the guideline to review the underlying rationale of current diagnostic systems or scales for the rating of symptom severity. However in developing the recommendations the guideline committee did take into account information on diagnosis, comorbidities (e.g. complex depression), chronicity, remission and recovery as well a range of contextual factors. These terms are well established and generally well defined and the committee did not see any purpose in an extensive review of them

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				There are assumptions asserted with authority but with inadequate review and analysis, or referenced evidence, eg chronicity. Other research evidence referenced in this document, and relied on in detail, in our view is overvalued and given greater hierarchical status than might be considered appropriate. Assumptions, particularly regarding diagnosis, severity, complexity, treatment failure/resistance, chronicity, and comorbidity, lack precision and accuracy and fail to properly address baseline critiques from within the scientific community. The foundations and manipulations of these assumptions in the guideline development process have not been properly and appropriately exposed to peer review and the wider scientific and research communities.	
Psychotherapy Foundation	General	General	General	Major Flaws in Study Selection, Network Arrangement and Network Analysis The misuse of terms, definitions, and assumptions made in selecting studies for inclusion, and in the composition of networks for analysis, has led to a flawed process. Additionally there are few properly replicated studies, and few which are replicable given that the specification of patients, therapists, therapies and study methods is generally not of a high standard and often unreliable. These weaknesses are workable in reviewing individual studies for progression of understanding, but contribute to	Thank you for your comment. The inclusion criteria for all review questions including the network meta-analyses, were pre-specified and agreed by the committee. Heterogeneity was considered in all analyses and the committee factored this into their interpretation of the evidence. The review protocol for the network meta-analysis has been registered on PROSPERO and as such is accessible to the wider scientific community.

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				heterogeneity which is highly corrosive of reliable results in meta-analysis, and thoroughly undermining in more complex methods such as network meta-analysis. The document, although complex and detailed, lacks sophistication and accuracy in translating research evidence into usable practice guidelines. In the four years of development of this guideline the complex and controversial methodology and method has not been exposed for broad peer review and into the wider scientific community. It will take considerable time and work to replicate and examine what has been developed, the analytic methods used, and their solutions. This is a significant and major flaw.	Moreover, NICE have now conducted a large number of network meta-analyses in published guidelines, including in mental health for instance in social anxiety, bipolar disorder, and eating disorders. In the NICE guidelines manual this is now the recommended approach when multiple treatment options are being appraised.
Nottinghamshire Healthcare Foundation Trust	General	General	General	NICE stakeholder response from the Let's Talk Wellbeing Counselling Cohort The Key Summary of this submission is that within Nottingham Healthcare NHS Foundation Trust Let's Talk Wellbeing IAPT Service Counselling modality has proved to be an effective psychological therapy for the treatment of depression, with very positive patient recovery rates and experience feedback. The Counselling cohort has reviewed the draft guidelines and enclosed is their considered opinions.	Thank you for your comment and for drawing our attention to the Barkham (2018), Metanoia (2012), Bower & Gilbody (2005), Ward et al. (2000), Therapy Today (July 2011; Feb, 2012; Oct. 2015), Rowland et al. (2001), Glover et al. (2010), Pybis et al. (2017), and Kuyken et al. (2016) citations. Counselling was included as an intervention in the review questions. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be

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				The following summary will articulate the effectiveness of Counselling for Depression (CfD) for patients with a diagnosis of F32.0 Major depressive disorder, single episode, mild. F32.1 Major depressive disorder, single episode, moderate followed by patient experience feedback that the Counselling clinicians have received from their patients, and concluded by Practitioner feedback regarding the draft NICE guidelines for depression. All data within the report is anonymized, and conforms to NHS Information Governance expectations. Background: The service employs 14 counsellors who support the delivering an effective IAPT service for patients experiencing depression, achieving annual recovery rate of 52%, the same recovery rate CBT in the service. Over the last year Counselling has received 1138 referrals, with 987 completing therapy and 94 clients (9.5%) moving off benefits and back into work. The average sessions across all modalities in the service is 8. Many of this cohort are part of a long standing experienced workforce. This workforce works with predominantly mild to moderately depressed patients. Current situation – The Let's Talk Wellbeing Service operates under an Any Qualified Provider contractual model with a PBr tariff based payment structure. Research & literature reviewed to form responses	updated and the wording of recommendations reviewed in light of this updated data.

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				Counselling holds a historical standing across the broad spectrum of health service provision. It seems vital to uphold that option as a standard psychological treatment for varying levels of mental health issues (Metanoia, 2012). While there are differing approaches under the umbrella term of Counselling, it has long been available in NHS primary care and provided consistent and extensive therapeutic intervention to a wide range of patients (Metanoia, 2012). Counselling is a recognised and established form of psychological therapy. There is a vast amount of research to show that it is evidence-based and practice-based evidence therapy (Bower and Gilbody, 2005; Ward et al, 2000; Therapy Today Feb, 2012). IAPT was designed to make psychological therapies more widely available (Therapy Today, Dec, 2010). The inclusion of counselling in the NICE guidelines supports the importance of having a range of choices available to suitably meet the diverse needs of the local population (Therapy Today, July, 2011). Therefore, it is highly disappointing to see where counselling is being placed in the latest draft of the NICE depression Guideline. Counselling is being severely downgraded in the ranks of recommended psychological therapies for the most common mental health problems. This formal response makes particular reference to the following points:	

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				1.5.11 Consider counselling if a person with less severe depression would 5 like help for significant psychosocial, relationship or employment 6 problems and: 7 • has had self-help with support, exercise, antidepressant 8 medication, individual CBT or BA or IPT for a previous 9 episode of depression, but this did not work well for them, 10 or 11 • does not want self-help with support, exercise, 12 antidepressant medication, individual CBT or BA or IPT. 13 [new 2018] 1.5.12 Deliver counselling for people with less severe depression that: 15 • is based on a model developed specifically for depression 16 • consists of up to 16 individual sessions each lasting up to 17 an hour 18 • takes place over 16 weeks. [new 2018] After considerable drive, effort and investment to cement a position for counselling in IAPT services; it is deeply concerning that it's value is being seen as 'less than'. This is despite the outcomes of counselling as a treatment proving to be extremely effective in terms of cost, quota of sessions obtained and it's lasting impact on clients (Rowland et al, 2001; Glover, Webb & Evison, 2010). NICE seems to be framing counselling as a treatment option when every other IAPT treatment has been unsuccessful or declined. Counselling is a high intensity treatment. It is important to remember that the IAPT model	

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				for improving access to CBT will not meet all the psychological therapy needs of those affected by mental health difficulties (Therapy Today, Feb, 2012). Person-Centred Experiential - Counselling For Depression (PCE –CfD) as a currently recognised NICE-approved mode of counselling is being widely offered. This is to extend what is available in primary care and to improve the quality of life for those who present with depression and low mood (Therapy Today, Oct, 2015). National outcome data 2016/2017 shows CBT to have 47% of the almost 21,000 cases achieve recovery. PCE-CfD had 50 % of almost 14,000 cases reach recovery (Barkham, 2018). Counselling also achieves comparable outcomes in fewer sessions than CBT. Therefore, it seems misplaced to give one model of superiority over the other (Pybis, Saxon, Hill et al, 2017). This indicates the need for NICE guidance to reflect real world data (Barkham, 2018). Counsellors are aware of recent evidence submitted to NICE for consideration by the BACP (British association for counselling and psychotherapy). This included questioning the use of randomised control trials alone as the basis of this evidence. for NICE to consider. This looked at the efficacy of counselling and included questioning the use of randomised control trials (RCT) alone as the basis of this evidence. The counselling	

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				profession is doing the best it can with limited resources. Professor Michael Barkham is leading an RCT trial: "PRaCTICED: Pragmatic, Randomised Controlled Trial assessing the non-Inferiority of Counselling and its Effectiveness for Depression" information at: https://www.sheffield.ac.uk/scharr/sections/hsr/mhru/mhresearch/practiced/info Other notable academics such as Scott D. Miller, Ph.D. Director, International Center for Clinical Excellence also contribute to the development of 'evidence based' psychotherapies. This powerfully challenges the assumption that it is the modality of therapy that makes the difference (Pybis, Saxon, Hill et al, 2017). There are many variables to consider in the quest to aid recovery. For person-centred experiential (PCE) therapists, it has been much welcomed to have a humanistic approach being specifically designed and endorsed for delivery in the context of IAPT (BACP, 2011). While CfD has developed a prominent role in IAPT services it is important to note that the vast counselling workforce are still qualified counsellors who are highly skilled and experience practitioners with core professional competencies and who are not yet trained in CfD (Therapy Today, Oct, 2015). PCE-CfD accredited counsellors welcome NICE recommendation that the counselling offered is	

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				'specifically for depression'. However, it was assumed that this would lead the way for other modes of counselling to be highlighted and devised for the treatment of various psycho-social difficulties. Counselling has been found to be the most common approach in treating reactions to loss and has often been offered just as much as CBT for generalised anxiety disorder episodes. Those referred by GP's are also more likely to receive counselling (Therapy Today, Dec, 2010). Therefore, there must continue to be room for CfD to grow and for the counselling profession as a whole to be sustained and elevate the counselling provision in the NHS (Therapy Today, Oct, 2015). There would seem to be more ground for NICE to strongly recommend this approach to commissioners. Distinctions within generic counselling are not usually specified by NICE. As a result the profession of counselling suffers from an underappreciation of the skills, values and commitment of staff. Counsellors welcome NICE recommendation that counselling for depression be offered for up to sixteen weeks. However, the latest draft has omitted the named model of PCE-CFD. Generally counsellors are expected to help patients achieve significant improvement and or recovery in fewer sessions than CBT and IPT. All modalities strive for this where possible, not least because	

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				it's the only way for services to survive financially. Hopefully government will support services to provide extended treatment, when necessary. Examples Taken from the Counselling Cohorts PEQ Treat The counsellor pushed me at the right times gave encouragement and made me realise deep rooted thing I have been holding. Great Counsellor, great service! These sessions have helped me for more than any other counselling I have previously received. Let`s Talk has been incredibly helpful; enabling me to identify and discuss options to help with my problems. Great balance of freedom to talk, encouragement and challenging responses. Only improvement would be if sessions are 1.5 hours duration. The therapist was extremely professional caring and I found the session very helpful. I found the meetings helpful and reassuring. The understanding and some of the issues were very useful. I was reluctant to go at first because of a previous experiences of counselling but I am glad I persisted.	

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				There was no embarrassment or awkwardness. He was very kind and helped me to see myself in a more positive way. The counselling has helped me to move forward and no longer feel `stuck`. I have made progress during the weeks. The counsellor was a pleasure to speak to and made me f She has helped me a lot and I am very grateful for her hel The counsellor helped me understand I can get through a once the initial step has been taken to opt for counselling i Absolutely fantastic service that was very helpful in helping me understand how I`m feeling. It helped me overcome my issues. Thank you. I would recommend this service to family and friends. The counsellor was a remarkable person and made me believe in myself again. I feel more in control of my life thanks to her. <u>In summary</u> Counsellors wish to see NICE take more account of the many years of outcome data showing it's equivalence with	

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				CBT. In this way, counselling can be reclassified as a recommended first line of psychological treatment for depression. It is important to remember that the IAPT model for improving access to CBT will not meet all the psychological therapy needs of those affected by mental health difficulties (Therapy Today, Feb, 2012). We ask that the current draft of the NICE depression guideline is reviewed, taking into account how vital counselling is as a step 3 Hi Intensity treatment within the stepped-care model of IAPT. We ask that careful consideration is given to the quality and diverse skills available within the counselling workforce. This is backed by successful data gained from key research in the last few years and should be reflected in recommendations outlined by NICE. We ask that PCE-CfD retains its status and approval as an effective treatment for depression. It is also crucial that the wider spectrum of counselling provision has a platform to receive more funding for research and training in order to be offered in more dynamic ways within the context of IAPT. Due to time pressure, we haven't been able provide a full academic response. However, we hope this statement will go some way to register our initial impression and concerns about the current NICE Draft. We sincerely hope this feedback will be taken on board, as well as all	

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				other stake holders. (Academic References available upon request).	
UK Mindfulness University Centres	General	27-28	12	Thank you for your detailed response to our comments following the first consultation on caveats introduced when recommending MBCT as a relapse prevention intervention for depression. This second version of the draft guideline has the following caveats which were not included in the 2004 or 2009 version of the guideline and also represent some slight changes from the first version of the draft guideline. MBCT is recommended only for people (our emphasis): • who have recovered from *more severe depression when treated with medication* (alone or in combination with a psychological therapy), but are assessed as having a higher risk of relapse or *who want to stop taking antidepressant medication* (short version 1.8.4). • who have recovered with initial psychological therapy but are assessed as having a higher risk of relapse *but only if the initial psychological therapy doesn't have an explicit relapse prevention component* (short version 1.8.5). In our response to the first version of the draft guideline we highlighted the most comprehensive individual patient	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				meta-analysis of RCTs of MBCT for relapse prevention to date, published in JAMA Psychiatry (Kuyken et al., 2016). We stated that their analysis showed significantly reduced between-group risk of depressive relapse within 60 weeks (hazard ratio, 0.69; 95%CI, 0.58-0.82). Moreover, there was a significantly reduced between-group risk of depressive relapse within 60 weeks when comparing MBCT to anti-depressant medication (hazard ratio, 0.77; 95%CI, 0.60-0.98). In relation to the caveats noted above, it is important to highlight that the trials included in the Kuyken et al. (2016) meta-analysis were: • *not* limited to people who had recovered from more severe depression - people with histories of less severe and more severe depression were included. In your response to our previous comment on this matter you noted that the majority of people in the Kuyken et al. (2016) meta-analysis had severe depression and quote the following from the paper: 'our analyses suggest that the treatment effect of MBCT on the risk of depressive relapse/recurrence is larger in participants with higher levels of depression symptoms at baseline compared with non-MBCT treatments, suggesting that MBCT may be particularly helpful to those who still have significant depressive symptoms.' However, is an understandable misinterpretation of this statement (we agree that this statement is easy to misinterpret). Baseline levels of depression were in the residual symptom range in the included trials (i.e. non-	

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				clinical range) as currently being in recovery from depression was an inclusion criterion for the MBCT relapse prevention trials. The analysis referred to in the statement applies to participants with relatively higher residual symptoms at baseline, not severe symptoms of depression. We therefore suggest that our original point stands – that limiting the offer of MBCT to people who have recovered from more severe depression is not based on the evidence from MBCT relapse prevention trials, and that the evidence for MBCT for relapse prevention applies to people who have recovered both from less severe and more severe depression. • *not* limited to people who had recovered following treatment with medication or psychological therapy - people were included who had received no previous treatment. We appreciate your comment that people were included in the MBCT trials who had recovered following medication or psychological therapy. We are not aware however of meta-analytic findings that suggest that the effectiveness of MBCT is moderated by receipt of previous treatment (medication or psychological therapy) and we suggest that such an analysis would be needed if limiting the recommendation of MBCT in this way. We therefore respectfully suggest that the caveat that MBCT is limited to people who have recovered following	

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				treatment with medication or psychological therapy is removed. • *not* limited to people who recovered with medication but wanted to stop taking it. We suggest that the evidence to date for MBCT for depressive relapse prevention does not warrant this caveat and that people included in the MBCT relapse prevention trials included people who had never taken medication, were currently taking medication, and who had discontinued medication. We suggest that a meta-analysis exploring the moderating effects of medication continuation or discontinuation on MBCT relapse prevention outcomes would be of interest, but to our knowledge this has not informed this particular caveat. We therefore ask that the caveat that MBCT is limited to people who want to stop taking medication is removed. We suggest that the caveat (short version 1.8.5) that MBCT should only be offered if the initial psychological therapy does not have a relapse prevention component limits patient choice. We are not aware of evidence that other psychological therapies with relapse prevention components (you suggest CBT and BA as examples) are more effective at preventing relapse than MBCT. We also suggest that the cost of offering 8 sessions of group MBCT would not be greater than offering 4 more sessions of the initial psychological therapy on an individual basis (see	

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				short version 1.8.5). We respectfully ask that this caveat is removed. In summary, based on our review of the evidence to date for relapse prevention, MBCT should be offered as a choice to people who have recovered from less severe and more severe depression and who are assessed as having a higher risk of relapse and that this should be irrespective of severity of previous episodes and whether or not previous treatment has been received.	
UK Mindfulness University Centres	General	Short Version Section 1.5 (First-line treatment for less severe depression) Short Version Section 1.6 (First-	General	Since we submitted our comments on the first draft of the revised guideline in September 2017, a ground breaking systematic review and meta-analysis has been published in Clinical Psychology Review of mindfulness-based interventions for psychiatric disorders, including depression (Goldberg et al., 2018). This review and meta-analysis consolidates outcomes from randomised controlled trials of mindfulness-based interventions for people with a diagnosed psychiatric disorder and we would urge the committee to consider the implications of findings for the revised NICE guideline for depression. We summarise findings and implications of the Goldberg et al. (2018) study below. Goldberg et al. (2018) reviewed 142 randomised controlled trials (RCTs) of mindfulness-based interventions for people with a diagnosed psychiatric disorder, with a total of 12,005 participants. For the 30 RCTs comparing	Thank you for your comment and for drawing our attention to the Halliwell (2010) citation. The Goldberg et al. (2018) systematic review has been checked for any additional studies and no new studies that met inclusion criteria were identified. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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		line treatment for more severe depression		mindfulness-based interventions to inactive control groups specifically for people with a diagnosis of depression there was a medium-large post-intervention between-group effect size on depression outcomes (d=0.56; 95% CI: 0.49-0.73). This effect was maintained at follow-up for the 12 RCTs with follow-up data (d=0.55; 95% CI: 0.25-0.84). When compared to evidence-based treatments (defined as treatments recommended for depression by APA Division 12 or other relevant organisations), findings strongly suggest equivalence. In the 10 included trials the post-intervention effect size on depression outcomes between mindfulness-based interventions and evidence-based treatments for people diagnosed with depression was almost zero (d=-0.01; 95% CI: -0.19-0.16) and this remained true for the seven studies with data at follow-up time points (d=0.04; 95% CI: -0.13-0.20). We suggest that findings from Goldberg et al. (2018) add considerable weight to our comment during the previous consultation that mindfulness-based cognitive therapy (MBCT), the mindfulness-based intervention for depression with the largest and most robust evidence-base (Goldberg et al., 2018; Kuyken et al., 2016), should be offered as a first line treatment for less severe and more severe depression (short version sections 1.5 and 1.6). The Goldberg et al. (2018) study suggests equivalence with evidence-based treatments at post-intervention and follow-up.	

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				There is also a compelling economic case for recommending MBCT as a first line intervention alongside other evidence-based treatments. MBCT is a group intervention with a low per participant cost of £112 (Kuyken et al., 2015). This is not significantly more expensive in a robust health economic evaluation than maintenance antidepressants over a two-year period (Kuyken et al., 2015). We therefore respectfully suggest that MBCT should be offered alongside other evidence-based treatments as a first line intervention to provide patients with choice, particularly given the interest that patients and GPs have in accessing MBCT in the NHS (Halliwell, 2010).	
UK Mindfulness University Centres	General	Short Version Section 1.9 (No or limited response to initial treatment)	General	In the first draft of the revised guideline published in July 2017 MBCT was recommended as a second line intervention for people with limited response and treatment-resistant depression. This was in line with recent evidence from RCTs of MBCT for treatment-resistant depression (Chiesa et al., 2015; Eisendrath et al., 2016). We were therefore surprised to see that this recommendation has been removed in the second draft of the revised guideline. The committee responded to our comment by stating: "Following a further review of the evidence for MBCT in further line treatment we have removed it from the recommendations as the evidence for the effectiveness of other interventions was stronger." It is	Thank you for your comment and for drawing our attention to the Halliwell 2010 citation. Both Chiesa 2015 and Eisendrath 2016 are included. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				unclear to which evidence this statement refers to, but this is an area where researchers and funders (see recent NIHR calls) agree that more research is urgently needed. At the current stage, existence of a definitive randomized-controlled trial with positive results (as outlined above) represents a significant piece of evidence in this domain. This would also increase patient choice amongst evidence-based treatments for people not responding to initial treatment and would be in line with the interest from patients and GPs in accessing MBCT in the NHS (Halliwell, 2010).	
Lundbeck	General	Short 30 Full 504	Short 15 Full 29-31	Lundbeck particularly welcomes the addition of section 1.9.6 to the short version of the guideline and the very explicit acknowledgement that vortioxetine is a recommended treatment option for people who have had no response, or a limited response, to treatment after 2 lines of treatment and who want to continue with antidepressant medication. We also welcome the cross-reference to TA367 and hyperlink to the relevant guidance page. This addition to the short version of the guideline is particularly important as it is likely to be the primary point of reference for most individual prescribers/commissioners and NHS organisations. The revised draft guideline now provides clear and current guidance for NHS organisations updating their clinical pathways and supports the mandate for clinical commissioning groups, NHS England and, with	Thank you for your comment and support for the changes made to the guideline.

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				respect to their public health functions, local authorities to implement TA367, if they have not already done so. Reference: NICE Technology Appraisal 367: Vortioxetine for treating major depressive episodes. November 2015.	
Health Assured	Short	General	General	Introduction In our role as an Employee Assistance Professionals Association (EAPA), Employee Assistance European Forum (EAEF) and British Association for Counselling and Psychotherapy (BACP) accredited specialist Employee Assistance Programme and wellbeing provider, Health Assured have prepared this response to the 2017 NICE consultation on the revised Guidelines for Depression in Adults: Treatment and Management. We pride ourselves on delivering holistic short-term solution focused workplace wellbeing services, built upon robust clinical processes and aligned with key touchpoints, boundaries and responsibilities with other wellbeing providers and specialist care providers. Our Clinical Governance Model ensures the right interventions are delivered and there is no ambiguity around the clinical appropriateness of support delivered by Health Assured and with clear onward referral criteria to primary care and long-term support services. Reflective of this, as well as working to the guidelines provided by the Employee Assistance Professionals Association, our service model is also shaped by influences from the National Institute for	Thank you for your comment and providing this information about Health Assured.

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				Health and Care Excellence, the NHS Stepped Care Model, the Health & Safety Executive, Robertson Cooper, the Chartered Institute for Personnel and Development, the British Association for Counselling and Psychotherapy and the World Health Organisation. We continue to grow and develop our services to meet the requirements of client's and their employees, in line with the changing landscape of wellbeing and best practice. Through the development of more proactive service interventions, we are ideally placed to support an organisation's duty of care to its employees, adding value not only to employers and employees, but society as a whole. Reflective of this, given the increased prevalence of depression as a presenting issue, this means we have a commitment offer support, where clinically appropriate within the operating model of an Employee Assistance Programme.	
British Psychoanalytic Council	Short	General	General	The key concerns of the BPC were contained within our original response to the first consultation. Those concerns broadly remain, and we reiterate some of those here. In addition, the BPC is a signatory to the joint stakeholder position statement and our responses here reinforce the concerns raised in that joint statement. Our view is that the revised draft has not considered the significant flaws noted by us and many other stakeholders in the first consultation. We believe postponing publication of the guidelines until a proper revision can be undertaken would be the best course of action.	Thank you for your comment. We have responded to your other comments where you raise specific concerns.

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British Association of Art Therapists	Short	General		We wonder why consideration of arts therapies has been ruled out, bearing in mind that many other therapies that are recommended have little or poor evidence and there is some new evidence for art therapy for depression. This includes the following studies. Among these, Uttley et al. (2015) is a review of art therapy for non-psychotic conditions, which includes studies that assessed depression, and Gabel and Robb (2017) sheds light on possible common mechanisms of group art therapy for a wide range of conditions: ----Blomdahl, C., Gunnarsson, A. B., Gureg å rd, S., & Bj ö rklund, A. (2013). A realist review of art therapy for clients with depression. *Arts in Psychotherapy* , 40(3), 322–330. Doi: 10.1016/j.aip.2013.05.009. ----Blomdahl, C., Gunnarsson, B. A., Gureg å rd, S., Rusner, M., Wijk, H., & Bj ö rklund, A. (2016). Art therapy for patients with depression: Expert opinions on its main aspects for clinical practice. *Journal of Mental Health* , 25, 6, 527–535, Doi: 10.1080/09638237.2016.1207226. ----Czamanski-Cohen, J., & Weihs, K. L. (2016). The bodymind model: A platform for studying the mechanisms of change induced by art therapy. *The Arts in Psychotherapy* , 51, 63–73. Doi: 10.1016/j.aip.2016.08.006. ----Gabel, A. and Robb, M. (2017). (Re)considering psychological constructs: a thematic synthesis defining five	Thank you for your comment. Art therapy was not prioritised for investigation in the review questions for this guideline. Consequently the papers that you cite did not meet the inclusion criteria and have not been appraised in the guideline. We are therefore not able to make recommendations about this intervention.

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				therapeutic factors in group art therapy. *The Arts in Psychotherapy*, 55, 126-35, doi: 10.1016/j.aip.2017.05.005. ---- Gussak, D. (2009). The effects of art therapy on male and female inmates: Advancing the research base. *The Arts in Psychotherapy* , 36(1), 5–12. http://dx.doi.org/10.1016/j.aip.2008.10.002 ---- Kapitan, L. (2012). Does art therapy work? Identifying the active ingredients of art therapy efficacy. *Art Therapy*, 29(2), 48–49, Doi: 10.1080/07421656.2012.684292. ----Nan, J.K.M., and Ho, R.T.H. (2017) Effects of clay art therapy on adults outpatients with major depressive disorder: A randomized controlled trial. *Journal of Affective Disorders,* 217, pp. 237-245. DOI 10.1016/j.jad.2017.04.014 ----Uttley, L. et al. (2015) The clinical and cost effectiveness of group art therapy for people with non-psychotic mental health disorders: A systematic review and cost-effectiveness analysis. *BMC Psychiatry*, 15: 151 DOI 10.1186/s12888-015-0528-4; ----Zubala, A., MacIntyre, D. J., & Karkou, V. (2014). Art psychotherapy practice with adults suffering from depression in the UK: Qualitative fi ndings from depression-specific questionnaire. *The Arts in Psychotherapy* , 41(5), 563–569. http://dx.doi.org/doi:10.1016/j.aip.2014.10.007	
British Association of Art Therapists	Short	General		We also wonder why there appears to be only minimal recognition of the role that community and social factors	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for

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				have in causing and maintaining depression – see comments above relating to page 30, lines 19-23.	those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Health Assured	Short	General	General	Cost Implications Within the scope of an Employee Assistance Programme, we work to a short term solution focussed model, this is typically providing access to up to 6 or 8 sessions. However, we do provide access to a range of therapies where higher intensity, lower term psychological interventions are required, this is typically to be provided on an ad hoc basis given the functionality of the usual pricing models utilised within in the industry. In falling outside of the realm of a short term model this would significantly impact the commercial viability for our clients and our organisation.	Thank you for your comment. In line with NICE processes, we have recommended those interventions where there is evidence of their clinical and cost effectiveness
Health Assured	Short	General	General	Helping users overcome any challenges? There are benefits that cannot be denied in regards to the services that Employee Assistance Programmes can provide in alleviating waiting times and improving access to support, where clinically appropriate and we have demonstrable and tangible outcomes to support this. NHS England detail the IAPT service standard waiting times as 75% of people referred to IAPT services should start	Thank you for your comment and providing details of how you would implement the recommendations for self-help or CBT and how you deal with complex cases. In line with NICE processes, we have recommended those interventions where there is evidence of their clinical and cost effectiveness. However it is not within our remit to specify who should provide these interventions and

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				treatment within 6 weeks of referral, and 95% should start treatment within 18 weeks of referral in which we would be working to much stringent service level agreements. However, in effectively supporting service users and individuals requiring treatment for depression, there needs to be a clear guidance to provide understanding that Employee Assistance Providers are skilled at offering support where clinically appropriate however we are not and are in no way a provision that should be clinically offering or providing end to end support such as that provided by primary care/IAPT programmes. Referral Process to Primary Care If an individual requires support beyond individual self-help or cCBT (low-intensity psychological intervention for less severe depression) or up to 16 sessions of individual CBT (higher intensity psychological intervention for less severe depression), we would look to bridge the individual to longer-term, primary care support. We provide specialist care planning by ensuring that individuals are referred to specialist mental health primary care services to ensure coordinated multidisciplinary care if they are presenting with more severe depression with multiple complex problems or significant coexisting conditions as per the draft guidelines. Complex Cases We ensure all individuals contacting and utilising our service are aware of the potential limitations in regard to	so we are not able to comment on Employee Assistance Providers and how they work.

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				the support we offer. We manage expectations clearly from the outset, and explain that the short-term/low intensity interventions we provide will not be enough to move them through into recovery alone. In these cases, we still offer support, counselling or individual self-help if required to help bridge the individual into longer term interventions and to deal with some of the surface issues that the conditions are creating. If an individual with complex mental health issues wants to access the service for an immediate life event, such as bereavement, we are able to offer support for the immediate issues while offering bridging support should the individual want to address the other issues. We would never turn someone away from the service. Our aim is to make people aware of what can and cannot be achieved in a short-term setting and not to cause psychological harm by attempting to deal with complex cases in a short-term period, which could result in someone being left in a more vulnerable state then when they commenced support. Our support enables the individual to be able to function on a daily basis, rather than looking at the core of the complex issue(s). We believe that if the both the potential benefits and limitations are recognised by both service users and other care channels then this would elevate potential challenges in relation to access to care and a joined-up, collaborative provision. There is a requirement for both the governing	

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				bodies that Employee Assistance Programme providers adhere to as well as NICE to provide guidance going forward as to where our services will fit within the treatment and management of depression.	
Assurex Health	Short	General	General	We are concerned that the exclusion of a discussion on pharmacogenomic (PGx) testing to guide medication treatment decisions is a disservice to providers and patients. Multiple studies provide evidence for the clinical validity, clinical utility, and economic utility of utilizing PGx testing when making treatment decisions for patients with depression Question 1: PGx testing would improve outcomes for patients with depression by guiding medication decisions and as a shared decision making tool. PGx implementation is currently challenging due to lack of clinical practice guidelines, education, and reimbursement. Inclusion of PGx testing in guidelines would help providers understand the benefits and limitations of testing as well as how and when testing may be beneficial for a specific patient. Therefore, PGx testing in guidelines would increase provider knowledge and improve access for patients. Question 2: PGx testing has been shown to save ~$1000-6000 in healthcare and medication costs per patient, per year in primary care and psychiatric specialty settings. According to the Department of Health and Social Care 2011 policy statement, the greatest disability burden in the UK is due to mental illness and costs £105.2 billion each	Thank you for your comment. PGx testing was not an area that was prioritised for investigation in the guideline. As such the evidence in this area has not been appraised and we are not able to make any recommendations on this issue.

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				year. Further, patients who have failed multiple medications and become treatment resistant, contribute disproportionately to the cost of the disease with treatment-resistant depression incur healthcare costs of £22,124 per member per year. Therefore, utilizing PGx testing earlier in treatment reduces direct and indirect healthcare and medication costs for patients with MDD. PGx testing can reduce healthcare and medication costs by improving patient outcomes and reducing the population of patients who become treatment-resistant by avoiding genetically discordant medications. Question 3: Guidelines would provide helpful information to providers on how to evaluate available PGx tests, how to identify patients who many benefit from testing, and how to implement the testing in conjunction with clinical treatment. Education on PGx and PGx testing is imperative for medical and pharmacy education as well as continuing education.	
Assurex Health	Short	General	General	We propose that PGx testing may be warranted once a patient has failed one adequate medication trial due to non-response or side effects in the current episode. Depression treatment with medications is often trial-and-error. PGx testing can shed light on the biological underpinnings of response and side effects leading to shortened time to remission and wellness. Improving patient outcomes earlier, may also reduce the prevalence of treatment-resistance among patients with depression.	Thank you for your comment. PGx testing was not an area that was prioritised for investigation in the guideline. As such the evidence in this area has not been appraised and we are not able to make any recommendations on this issue.
Assurex Health	Short	General	General	Expanded response with citations:	Thank you for your comment and for drawing our attention to the Bousman and Hopwood (2016)

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				The use of PGx testing in psychiatry is on the rise and dozens of commercial companies offer testing panels including psychotropic medications (Bousman and Hopwood 2016). While the evidence supporting "widespread use" of PGx testing in psychiatry is lacking, there exists a large amount of evidence on the clinical validity and utility of utilizing PGx testing to guide treatment for patients with depression. PGx testing can take many forms, from single genes and panels with multiple genes, to combinatorial algorithms. Combinatorial PGx testing utilizes algorithms that incorporate specific information from a patient (i.e. genotype and phenotype) and the weighted effect of the gene(s) on a specific medication to guide treatment decisions. These treatment decisions may be related to medication dosing, risk of reduced response, and side effect burdens. Combinatorial algorithms take into account the effect of multiple genes/variants on a medication rather than the effect of each gene individually. PGx testing is not meant to be a standalone replacement for medication management. However, it is a tool to be incorporated into practice that can shed light on biological factors that may explain and predict patient outcomes with specific medications. PGx testing can not only guide medication decisions by stratifying medications based on severity of gene-drug interactions, but also provide specific gene-drug interactions that may affect treatment. Although a medication has a significant gene-drug interaction for a specific patient, it may still be beneficial at a higher or	citation. PGx testing was not an area that was prioritised for investigation in the guideline. As such the evidence in this area has not been appraised and we are not able to make any recommendations on this issue.

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				lower dose depending on the information provided by the testing platform. PGx tests are currently available commercially and many providers already order them for patients. As patients become more engaged in their own healthcare, in many cases they are arriving to offices requesting PGx testing or with reports from elsewhere wanting the information to be incorporated into their care. Based on the evidence supporting clinical utility of PGx testing in patients with depression, patients should have the option to include testing as an intervention within their treatment plan if discussed with their provider. Many providers have a limited understanding of what information PGx tests provide and how to use them appropriately in clinical practice. It's imperative that providers understand how to evaluate, interpret, and utilize a test effectively in order to optimize care for patients. The potential benefits of PGx testing are eliminated if providers do not have the background to understand PGx testing. Incorporation of PGx testing recommendations into guidelines is critical for providers who wish to understand the who, what, where, when, why, and how of utilizing PGx testing in practice. Providers want to know how to identify who may benefit from PGx testing, what information the test may provide, in what treatment setting testing may be appropriate (where), when in the course of treatment testing may be beneficial, why could the test be beneficial in the situation, and how to evaluate the tests available along with how to interpret and implement testing with	

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				individual patients. Guidelines can answer these questions with incorporation of evidence ratings and recommendations. There have been multiple clinical studies utilizing PGx testing to guide treatment in patients with depression, including both open label and double-blind randomized controlled trials. Patient symptom improvement, response, and remission was greater than treatment as usual in all studies but the outcomes were not always significant. Studies have also shown that the combinatorial algorithm approach to PGx testing can predict outcomes better than utilizing a panel with multiple single genes. Finally, multiple retrospective, prospective, and modelling studies have shown the economic benefits of PGx testing in patients with depression and other diagnoses. Open-label Hall-Flavin et al. (2012) *Transl Psychiatry* Hall-Flavin et al. (2013) *Pharmacogenet Genomics* Brennan et al. (2015) *Companion CNS Disord* Bousman et al. (2017) *Pharmacogenomics and Genomics* Elliott et al. (2017) *PLos One* RCT Winner et al. (2013) *Discovery Med* Singh (2015) *Clin Psychopharmacol Neurosci* Perez et al. (2017) *BMC Psychiatry* Bradley et al. (2018) *J Psychiatr Res* Olson et al. (2017) *Prim Care Companion CNS Disord*	

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				Economics Winner et al. (2013) *Transl Psychiatry* Winner et al. (2015) *Curr Med Res Opin* Hornberger et al. (2015) *Am J Manag Care* Brown et al. (2017) *Clin Ther* Brixner et al. (2016) *J Med Econ* Maciel et al. (2018) *Neuropsychiatr Dis Treat* Najafzadeh et al. (2017) *Pharmacoeconomics* Perlis et al. (2018) *Depression and Anxiety* Fagerness et. al. (2014) *American Journal of Managed Care*	
Parkinson's UK	Short	General	General	We also agree with the All-Party Parliamentary Group on Parkinson's latest report on mental health that the NICE guidance on 'Depression in adults with a chronic physical health problem' [CG 91] as referenced in the NICE guidance on 'Parkinsons disease in adults' [NG 71] does not adequately address the needs of people with Parkinson's experiencing depression. For example, in line 1.1.4.4. there is a suggestion that if a person has mobility issues as many people with Parkinson's do, that therapy could be conducted by telephone, however a person with Parkinson's may also experience difficulties with speech as well as, and thus excluded from treatment on this basis. We endorse the All Party Parliamentary Group on Parkinson's recommendation that the "NICE guidance on Parkinsons' should be updated to reflect effective evidence-based interventions for the treatment of	Thank you for your comment. This consultation only relates to the guideline about the treatment and management of depression in adults. As such we are not able to change recommendations in other guidelines.

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				depression and anxiety in people with Parkinsons". We recommend the guidance is improved so it addresses the specific needs of people with Parkinson's in respect to adaptions to cognitive behavioural therapy techniques, medication management, liaising with physical healthcare professionals within Parkinson's multi-disciplinary teams, and identification of more complex mental health needs linked to Parkinson's medication such as impulsive control disorders and associated referral pathways to specialist services.	
British Association for Psychopharmacology	Short	General	General	This second draft does appear to be an improvement on the previous one. However, from a psychopharmacological perspective there remain at least three major concerns: 1) The threshold for referral to specialist mental health care is substantially lower than that in current practice. If these guidelines are followed precisely then secondary care will be completely over-whelmed. 2) The level of guidance regarding the pharmacological management of patients who do not achieve full remission following first or second line monotherapy (section 1.9) is so rudimentary to be of no practical value. Vague statements are made about a 'combination of 2 different classes of medication'. What such combinations might be is described in 1.9.9 but it remains extremely vague. At face value it encourages use of combinations of mediation for which there is NO evidence of effectiveness.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				3) Section 1.10 on chronic depression continues to cause concern. In the guideline the category "Chronic depression" conflates mild sub-syndromal depression (aka 'dysthymia') with full syndromal depression, including that which is severe, into one group simply on the basis that symptoms have been present for at least 2 years. The pharmacological guidance that has been made is based almost entirely on evidence regarding dysthymia. Recommendation such as monotherapy amisulpride (1.10.4) would be viewed by experts in the field as ineffective and potentially dangerous for patients with chronic severe depression. Aside from these major concerns, we would make the same comments regarding psych-social interventions as we made on the first draft. The very substantial increase in reference to psycho-social interventions is to be welcomed. In all 13 different interventions are described (CBT (individual and group), BA, IPT, STPT, BCT, MBCT, CBASP, self-help with support, physical activity programmes and rehabilitation programmes). The concern with such a broad range of therapies included in the recommendations for routine care is a) the lack of awareness of the range of treatments and the difference between them (e.g. between BA and physical activity programmes, CBASP vs CBT and MBCT); b) the lack of availability of such a range across the country and c) the degree of fidelity to each of the specific model 'in the field'.	

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College of Mental Health Pharmacy	Short	General		We still feel that this guideline is psychological-intervention focused. We are concerned about how readily these psychological interventions will be available, both in primary and secondary care in view of the already long waiting list times.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Association for Family Therapy & Systematic Practice	Short	general	general	Within the draft, room is made for CBT, IPT, short term psychodynamic therapy and behavioural couples therapy. If NICE would broaden these recommendations to Cognitive and Behavioural approaches, Interpersonal approaches, short term Psychodynamic approaches and Systemic approaches (which can be used with individuals as well as with couples and families), then the emphasis is on broader therapies with an evidence base, which can then be combined with personal choice and session-by-session monitoring to tailor towards the best outcome, according to that person's experience in therapy. The IPT website describes IPT thus: 'The treatment attends to difficulties arising in the daily experience of maintaining relationships and resolving difficulties while suffering an episode of major depression. The fundamental clinical task of IPT is to help patients to learn to link mood with interpersonal contacts, and to	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data. Please see below for details of what has happened to the references that you have provided. • The Pinquart 2016 systematic review that you drew our attention to includes two additional studies on couples therapy that will be included in the analysis when we update the evidence. • Lopes 2014, Barcons 2016 and Kuhn 2011 could not be included as they do not meet study design criterion (not an RCT or

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				recognise that by appropriately addressing interpersonal situations they may simultaneously improve both their relationships and depressive state'. (IPT website) Systemic therapy addresses the above, and additionally. • Unlike IPT, which is an individual / group approach, family therapy allows for addressing interpersonal situations in the presence of significant others and with the help of the systemic therapist both the person suffering with depression and the significant members of their family social network can begin to notice the effects of relationships and interactions on the person's mental health symptoms and the mental health symptoms on the relationships and interactions. Tracking these patterns can assist the individual and those around them to make significant changes in relationships and in the management of symptoms of depression. • Systemic therapy allows the person and significant members of their family and social network to jointly explore and understand the effects of psychosocial, economic, cultural factors on the person's wellbeing. • Furthermore it assists family members to discuss jointly with the person who suffers from depression how episodes of low mood and risk can be managed by all involved and to develop plans for preventing such episodes from re-occurring.	systematic review of RCTs) as pre-specified in the review protocol

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				These are crucial since people of all ages rely on their family and social network for maintaining wellness and coping in crisis. Systemic therapy is effective in mood disorders, including depression, (more effective than control, comparable efficacy to other therapies, and in combination with medication more effective than medication alone). And we think it should be included as a first line option, in a similar way that IPT and STPT are considered where there are relational issues (we would differentiate by saying issues in relationships or because of social judgement, stigma or discrimination against the person concerned). Efficacy of systemic therapy on adults with mental disorders: A meta-analysis. Martin Pinquart, Barbara Oslejsek & Daniela Teubert *Psychotherapy Research* Volume 26, 2016 - Issue 2 pp. 241-257. Effectiveness of Brief Systemic Therapy versus Cognitive Behavioral Therapy in routine clinical practice Carles Barcons, Oriol Cunillera, Vanesa Miquel, Irene Ardèvol and Mark Beyebach. *Psicothema* 2016, Vol. 28, No. 3, 298-303 doi: 10.7334/psicothema2015.309 Narrative therapy (one of the therapies within the group of systemic therapies), assists people in the presence of their significant family and social network, to build on wellness, by beginning to notice how the episodes of depression	

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				affect them and those around them and evaluating how these episodes fit in with their preferred identity, and what is important to them. Narrative therapy is useful with those suffering from depression to identify exceptions to the patterns of depression which might be in line with the person's preferred identity and values. Once these exceptions are identified narrative therapy has been very helpful in the amplification of these episodes and in considering how these can be extended into the future to enable individuals to manage the effects of depression in their lives. Narrative therapy has been shown to have similar outcomes to CBT for depression. Narrative Therapy vs. Cognitive-Behavioral Therapy for moderate depression: Empirical evidence from a controlled clinical trial. Rodrigo T. Lopes, Miguel M. Gonçalves, Paulo P.P. Machado, Dana Sinai, Tiago Bento & João Salgado Psychotherapy Research (2014) DOI: 10.1080/10503307.2013.874052 In Children and Young people's IAPT services, systemic therapy is one of the approaches IAPT practitioners can be trained in. This seems lacking in the adult guidance. As I said previously systemic therapy is about a relational view - it may work with several people in relationship (family, couple, etc.) or it may work with an individual in a relational way. Since a very common issue in depression	

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				is social isolation, a relational approach will be key for many people, not just for those in a couple whose relationship is deemed to be either contributing towards depression, or that depression is having an effect on the relationship. Relations go much wider than this. Newnham pilot systemic IAPT service had similar results to CBT IAPT service Kuhn, P. (2011), Improving access to psychological therapies: systemic therapy in the Newham pilot site. Journal of Family Therapy, 33: 400-414. doi:10.1111/j.1467-6427.2011.00545.x	
British Psychoanalytic Council	Short	General	General	Patient Choice We remain concerned that the revised guidelines still do not do not support meaningful patient choice despite increasing evidence that patients have improved treatment outcomes and completion rates if they can access a preferred choice of therapy. Cognitive Behavioural Therapy (CBT) remains the first treatment for patients, alone or with medication before other treatments can be considered. Given this growing evidence for the efficacy of providing a range of treatments - appropriate treatments for all patients – we consider that limiting choice not only goes against the growing evidence but is also unethical and cost-ineffective. Limiting choice undermines parity of esteem between physical and mental health, where it is common practice and considered cost-effective within	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data. Please see below for details of what has happened to the references that you have provided. • Lindhiem 2014 could not be included as the guideline did not investigate the comparison of active choice condition relative to no involvement in shared decision making so

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				treatment for physical health for example, to match patients to the most appropriate treatment for them individually (as recognised by NHS England in 2016). Evidence which could usefully have been considered includes: Lindhiem, O., Bennett, CB., Trentacosta, CJ., & McLear, C. (2014). Client Preferences Affect Treatment Satisfaction, Completion, and Clinical Outcome: A Meta-Analysis. *Clinical Psychology Review*, *34*(6): 506–517. Lin, P., Campbell, DG., Chaney, EF., Lie, C., Heagerty, P., Felker, BL., Hendrick, SC. (2005) The influence of patient preference on depression treatment in primary care. *Annals of Behavioral Medicine*, 30(2):167–173.	these studies did not match inclusion criteria. Patient preference, choice and the principles of shared decision making were considered by the committee during the interpretation of evidence and making the recommendations. • Lin 2005 mediator/moderator analyses are outside the protocol of the review
British Psychoanalytic Council	Short	General	General	<u>Narrow consideration of what constitutes evidence:</u> The recommendations continue to derive from a narrow consideration of what constitutes appropriate evidence: RCTs and meta-analyses. Although RCTs and meta-analyses lend themselves well to scientific study, RCTs also use populations that are not representative of clinical experience. This is a significant problem, where treatment recommendations are then made for clinical populations,	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues

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				including choice of treatments, based on evidence that is not particularly clinically representative. This can only lead to recommendations which are not necessarily in the best interests of patients, based on a privileging of treatments which lend themselves to RCTs (CBT for example) but which have limited clinical utility. The inclusion of long-term follow-up data is crucial in a treatment guideline for depression, particularly for the analyses for chronic depression. Ignoring important long-term follow-up data results in guidance following a rigid methodological approach and missing important evidence that has direct influence on its treatment recommendations. The Tavistock Adult Depression study (Fonagy et al., 2015) provides evidence that a long-term approach (18 months) has been more effective in treating individuals with complex, chronic depression, who have had several treatment attempts before (including antidepressant medication and psychological treatments) compared to TAU.	raised, and a response to these issues, is provided in the table at the end of this document.
British Psychoanalytic Council	Short	General	General	Short-Term Psychodynamic Psychotherapy (STPT) Short-Term Psychodynamic Psychotherapy (STPT) remains recommended only after other interventions (group CBT, physical activity programme, facilitated self-help, pharmacological interventions, individual CBT or BA) had not worked well in a previous episode of depression. We remain concerned that, in practice, this will deplete the	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				availability of STPT nationally. Little information is currently given to patients on therapy types recommended by NICE (as opposed to information provided to patients about the types of therapy available at their local IAPT). This is also problematical because it goes against evidence that shows only 6.6% of patients identify developmental difficulties as the cause of their depression, where 68.6% of patients identify existing life stressors as the key reason for their depression. Evidence also shows that patients with depression caused largely by developmental difficulties are more likely to have difficulties in their current relationships, suggesting that many persons who would benefit from STPT will not do so, largely down to focusing overwhelmingly on their current relationship difficulties in the first instance.	
British Psychoanalytic Council	Short	General	General	<u>Patient/service user experience:</u> We are concerned that the draft guidelines remain based on dated patient/service user experience research. This concern us greatly particularly given the NICE Charter talks of ensuing the NICE "*reflects the needs and priorities of those who will be affected"*. It seems in this guidance the most recent patient/user experiences are not considered. There are several studies that the guidelines have not considered because of the cut off date for the patient/service user experience research. These include.	Thank you for your comment. When updating a guideline, a decision is taken whilst developing the scope as to which sections of the guideline will be updated and which will not. When the scope for this update was developed, the patient experience section was explicitly not included as part of the update. Registered stakeholders would have had the opportunity to comment on this proposal as part of consultation on the draft scope. Subsequent to consultation, the scope was finalised and the patient experience section was excluded from the update. It is not now possible to go back and

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				Alderson, SL., Foy, R., Glidewell, L., House, AO. (2014). Patients understanding of depression associated with chronic physical illness: a qualitative study, *BMC Family Practice,* 20,15:37. Brenne, E., Loge, JH., Kaasa, S., Heitzer, E., Knudsen, AK., Wasteson, E. (2013). European Palliative Care Research Collaborative. Depressed patients with incurable cancer: which depressive symptoms do they experience? *Palliative Support Care*, 11(6):491-501. Clarke, DM., Cook, KE., Coleman, KJ., Smith, GC. (2006). A qualitative examination of the experience of 'depression' in hospitalized medically ill patients, *Psychopathology*, 39(6):303-12 Corcoran, J., Brown, E., Davis, M., Pineda, M., Kadolph, J., Bell, H. (2013). Depression in older adults: a meta-synthesis, *Journal of Gerontological Social Work*, 56(6):509-34. doi: 10.1080/01634372.2013.811144 Dekker RL(1), Peden AR, Lennie TA, Schooler MP, Moser DK. 2009 Living with depressive symptoms: patients with heart failure.Am J Crit Care.;18(4):310-8. doi: 10.4037/ajcc2009672. Feely M(1), Long A. 2009 Depression: a psychiatric nursing theory of connectivity.J Psychiatr Ment Health	reverse this decision. However the committee developing the guideline included several service user and carer members who were able to provide their perspectives during discussion of the evidence and who were integral to the development of the recommendations in those areas of the guideline that were being updated. The references that you cite would not meet inclusion criteria as we have not updated the patient experience section.

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				Nurs.;16(8):725-37. doi:10.1111/j.1365-2850.2009.01452.x. Kokanovic R(1), Bendelow G, Philip B. 2012 Depression: the ambivalence of diagnosis.Sociol Health Illn. Aug 16. doi: 10.1111/j.1467-9566.2012.01486.x. Oliffe JL(1), Ogrodniczuk JS, Bottorff JL, Johnson JL, Hoyak K. 2012 "You feel like you can't live anymore": suicide from the perspectives of Canadian men who experience depression Soc Sci Med.;74(4):506-14. doi: 10.1016/j.socscimed.2010.03.057 Scroggs N(1), Shattell M, Cowling WR 2010 "An existential place of pain": the essence of despair in women.Issues Ment Health Nurs.;31(7):477-82. doi: 10.3109/01612841003602679 Smith JA, Rhodes JE. 2014 Being depleted and being shaken: An interpretative phenomenological analysis of the experiential features of a first episode of depression. Psychol Psychother. doi: 10.1111/papt.12034 van Grieken RA(1), Beune EJ(2), Kirkenier AC(3), Koeter MW(3), van Zwieten MC(4), Schene AH(5). 2014 Patients' perspectives on how treatment can impede their recovery from	

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				depression.J Affect Disord. 2014 Oct;167:153-9. doi: 10.1016/j.jad.2014.05.065	
Hyperparathyroid UK Action 4 Change	Short	general	general	With an initial diagnosis of depression and anxiety, blood tests for hyperparathyroidism could prevent years of needless suffering as depression and anxiety are often the first symptoms	Thank you for your comment and for providing this information. This guideline is about the treatment and management of depression in adults. Therefore it is outside the scope of this guideline to make recommendations on the diagnosis or management of hyperparathyroidism or the management of depression associated with hyperparathyroidism.
Hyperparathyroid UK Action 4 Change	Short	general	general	I took an overdose of antidepressants and other medications in 1989. This remains on my medical records, so when I was again treated for depression in 2000, my doctors just thought I have a tendency for depression despite no reoccurrence for 11 years. I was finally diagnosed with hyperparathyroidism that obliterated my quality of life, they now dismiss low mood, likely because I am still standing and suggest I refer myself for talking therapies.	Thank you for your comment and for providing this information. This guideline is about the treatment and management of depression in adults. Therefore it is outside the scope of this guideline to make recommendations on the diagnosis or management of hyperparathyroidism or the management of depression associated with hyperparathyroidism.
Hyperparathyroid UK Action 4 Change	Short	general	general	Medication doses need to be tailored to the patient for general treatment of depression. Most doses are for around a 80kg person.	Thank you for your comment. We agree that dose of medication needs to be tailored to the individual which is why we have not been prescriptive in the recommendations about what the dose should be.
Dorset Healthcare	Short	57-58 (1.5.11)		The comments about counselling, together, imply that all counsellors have to be trained in a model that specifically	Thank you for your comment. Following feedback from stakeholders, the guideline committee and

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University NHS Foundation Trust				treats depression e.g. Counselling for Depression and that the Generic Counselling that we offer (in accordance with the previous Guideline) is no longer recommended. I am referring to the statements that start - 'Consider counselling' (p57) and 'deliver counselling' (p58). The combined implication of these statements is that all counsellors are to be trained in Counselling for Depression. If we have understood this correctly then this would be a challenge to deliver in practice for the following reason. We have many counsellors Trust-wide who are trained in a variety of modalities, delivering effective counselling that treats depression (evidenced by using PHQ9). A number of them have not been trained an IAPT approved modality. There would be significant cost implications to achieve this. Our trust has had experience of implementing Generic Counselling and collating data in one locality and would be willing to submit its experiences to the NICE shared learning database. Contact Liz Doyle	NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
The Royal College of Psychiatrists	Short	General	General	This second draft improves the previous version but there are remaining problems : 1. The threshold for referral to secondary care mental health services is too low: if these guidelines are	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of

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				followed secondary care services will be unable to cope with the referral tsunami. 2. The guidance regarding further pharmacological management of patients who do not achieve full remission following first or second line monotherapy (section 1.9) is essentially valueless. Vague statements are made about a 'combination of 2 different classes of medication'. Very limited guidance is provided on drug treatment combinations and there is a risk that doctors will be lead into prescribing combinations for which there is minimal evidence of benefit. 3. The section (1.10) on chronic depression is still poor. Use of the term 'chronic depression' merges together mild sub-syndromal depression (previously called 'dysthymia') with full syndromal depression, including severe depression, simply on the basis of symptoms lasting two years or more. The guidance would be associated with hyperprolactinaemia in a substantial minority of patients. The increase in attention to psycho-social interventions is a positive aspect. A very broad range of interventions is named but this is potentially problematic in routine clinical care as most health professionals will not be aware of same of the interventions and in many areas they are not available. Furthermore many of the interventions require	recommendations reviewed in light of this updated data.

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				strict adherence to a protocol for treatments and supervision and the degree of adherence to this protocol is known to often be poor in routine practice.	
Action on Hearing Loss	Short	General	General	Action on Hearing Loss, formerly RNID, is the UK's largest charity working for people with deafness, hearing loss and tinnitus. Our vision is of a world where deafness, hearing loss and tinnitus do not limit or label people and where people value and look after their hearing. We help people confronting deafness, tinnitus and hearing loss to live the life they choose, enabling them to take control of their lives and removing the barriers in their way. We give people support and care; develop technology and treatments and campaign for equality. Throughout this response we use the terms 'people with hearing loss' to refer to people with all levels of hearing loss and 'people who are deaf' to refer to people who are profoundly deaf who use British Sign Language (BSL) as their first or preferred language. Action on Hearing Loss welcomes the opportunity to comment on NICE's Depression in Adults: Treatment and Management Guideline. We support the aims of this Guideline to improve the diagnosis and management of depression in adults. At present, we believe the Guideline does not take full account of the relationship between hearing loss and depression and the importance of good	Thank you for your comment and providing this information on Action on Hearing Loss. We have to your comments where you raise specific concerns.

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				communication. In our response, we have provided feedback on the Guideline's recommendations and suggested additional recommendations, supported by evidence, that are crucial for the improving the quality of mental health care for people with depression. For ease of reference, the key points from our response are summarised below: • **Health and social care practitioners carrying out depression assessments should be aware of the relationship between hearing loss, depression and other mental health problems (see comment 2).** • **Practitioners should consider hearing loss when diagnosing and managing depression in people with dementia (see comment 3).** • **Practitioners should be alert to the early signs of hearing loss, the benefits of hearing aids, and the role of the GP in referring people for a hearing assessment (see comment 4).** • **The Guideline should reference NHS England's Accessible Information Standard (see comments 5 and 6).**	
Brighter Tomorrow Ltd	Short	General	General	There are many reason for depression and provided there is no physical evidence that sexual abuse occurred several years ago then the focus on the treatment must be on the symptoms not the abuse	Thank you for your comment.

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Brighter Tomorrow Ltd	Short	General	General	Freud's theories are not supported by scientific evidence and in many cases, the therapy can be doing more harm than good. It is imperative, that NICE protects patients. NICE needs to endure patients have a unambiguous understanding of their treatment, outcomes, and how to complain if they are not in agreement.	Thank you for your comment. We agree and think these issues are adequately covered by the recommendations in the General Principles section.
Brighter Tomorrow Ltd	Short	General	General	After reading through this I am mortified nothing has been mentioned in the beginning about informing the patient and their family or carer how to complain if they disagree with the treating professional. NHS Values are patient centred making the patient, not the treating professional, the centre of care. This document is horribly not patient centred. More improvements needs to be done to put the patient in control.	Thank you for your comment. There is an established complaints procedure throughout the NHS in which a patient or family member can formally complain about their treatment. In addition the various professional accreditation bodies (such as the GMC, NMC, HCPC) all have established complaints procedures. These are important mechanisms for ensuring high quality care is provided but they are outside the remit of this guideline. We do not think it is correct that the guideline is not patient centres. We have taken care to ensure that patients understanding of their difficulties and the nature of treatment options available are carefully discussed before decisions are made about treatment.
Brighter Tomorrow Ltd	Short	General	General	With cuts being made to the NHS more needs to be done to ensure patients are getting the right care the first time and those providing the care have the correct training. This means, establishing an independent review organisation that looks at cost, outcomes, and treatment being used in order to protect patients from unnecessary therapy along with protecting the taxpayer from patients being diagnosed more severely than needed.	Thank you for your comment. It is not within our remit to establish an independent review organisation or to make recommendations that this should happen

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Brighter Tomorrow Ltd	Short	General	General	NICE needs to ensure patients are fully informed about treatment, outcomes, timings, and how to complain. This cannot be done verbally and needs to be done in writing to document the patient was notified.	Thank you for your comment. We agree and think these issues are adequately covered by the recommendations in the General Principles section.
Central & North West London NHS Foundation Trust	Short	General	General	We are concerned that, despite their inclusion in the search terms, the GDG do not seem to have considered the evidence base for the arts therapies. Arts therapists see many of our patients with a range of mental illnesses and have extremely high patient satisfaction ratings as well as good outcomes locally. We believe it is important that there is parity with more traditional therapies as patient choice is correlated with outcome.	Thank you for your comment. Art therapy was not prioritised for investigation in the review questions for this guideline. Consequently it was not included in the search terms (see Appendix H) and papers on this intervention would not have met the inclusion criteria to be appraised. As the evidence on art therapy has not been appraised we have not made any recommendations on the use of this intervention.
Central & North West London NHS Foundation Trust	Short	General	General	From a pragmatic perspective, arts therapists are also a reliable resource who are more easily recruited and retained in some areas where other psychological therapy posts are difficult to fill.	Thank you for your comment. Art therapy was not prioritised for investigation in the review questions for this guideline. Consequently it was not included in the search terms (see Appendix H) and papers on this intervention would not have met the inclusion criteria to be appraised. As the evidence on art therapy has not been appraised we have not made any recommendations on the use of this intervention.
Central & North West London NHS Foundation Trust	Short	General	General	The GDG has not reviewed the music therapy trial literature on depression, and we would ask the GDG to take this into account this time, particularly the latest update of the Cochrane review: Aalbers S, Fusar-Poli L, Freeman RE, Spreen M, Ket JCF, Vink AC, Maratos A, Crawford M, Chen X, Gold C. (2017)	Thank you for your comment. Aalbers 2017 could not be included as music therapy was not prioritised for investigation in the review questions for this guideline

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				Music therapy for depression. Cochrane Database of Systematic Reviews 2017, Issue 11. Art. No.: CD004517. DOI: 10.1002/14651858.CD004517.pub3 This updated Cochrane review of music therapy for depression includes 9 studies with 421 participants. The studies looked at active music therapy (where clients sing or play music) and receptive music therapy (where clients listen to music with a therapist). The authors found that music therapy is more effective than treatment as usual. Music therapy seems to reduce depressive symptoms and anxiety and helps to improve functioning, e.g. maintaining the involvement in job, activities and relationships. No differences were found between music therapy and other psychological therapies, neither between receptive and active music therapy. For more detail on the studies involved in the trial please see the submission by ADMP UK – the association of Dance Movement Psychotherapists.	
Central & North West London NHS Foundation Trust	Short	General	General	We would recommend that the GDG analyse trial data from the arts psychotherapies as a whole group as was done with the Schizophrenia guideline. Whilst the actual creative medium may differ between modalities, all four arts therapies (Dance Movement Psychotherapy, Body Psychotherapy, Art Psychotherapy, Music Therapy and Dramatherapy) use the co-creation and/or appreciation of	Thank you for your comment. Art, drama and music therapies were not prioritised for investigation in the review questions for this guideline. We are therefore unable to make recommendations on these interventions.

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				one or more of the creative arts as the basis a psychotherapeutic relationship.	
Central & North West London NHS Foundation Trust	Short	General	General	**Lorentzen, S., Ruud, T., Fjeldstad, A., & Høglend, P. (2013). Comparison of short- and long-term dynamic group psychotherapy: Randomised clinical trial. The British Journal of Psychiatry, 203, 280–287. doi:10.1192/bjp.bp.112.113688** We are glad of this opportunity to flag up this trial of group dynamic psychotherapy with 167 participants which we believe constitutes a robust emerging evidence base. It has been shown to be of high enough quality to be published in the BJPsych. It is also one of very few trials of a longer-term therapy: this is important as NICE recommendations are often necessarily based on evidence of shorter term treatments, partly due to funding restrictions on trials of longer length therapies. Group analysis has a high engagement rate and high user satisfaction locally. We recognise that the lack of homogenous treatment groups in the study sample may be a stumbling block for NICE. There is a tension here between the needs of the research community, and keeping the integrity of the work. Dynamic group therapy in practice seems to work best with heterogenous groups, but all group members will likely have a depression either as a primary or a secondary symptom. Symptom change, including depressive symptoms, is a primary outcome of this trial	Thank you for your comment and drawing this study to our attention. Lorentizen 2013 was identified but was excluded on the basis of the design, namely that there is no clear endpoint so assessments made at different time points and participants varied in those who had or had not completed at time points, so the final assessment at 104 weeks includes endpoint and follow-up data.

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				and it is a main outcome in usual dynamic group therapy practice. We would therefore ask that the outcomes are looked at by the GDG, rather than dismissing the RCT due to mixed study population or lack of homogenous primary diagnosis. We are glad that NICE seem to be thinking about the evidence base in a more human and flexible way through this second consultation and hope this will support more real evidence production by the professions. If not, there is a risk that the professions will need to change practice to fit in with the guideline needs, with poorer outcomes for patients, and obviously with poorer outcome for NICE which is trying to ensure best practice for the UK population.	
British Association for Psychopharmacology	Short	29-32		Section 1.9 ECT is an additional option for patients not responding to other treatments. Why is it not mentioned in section 1.9?	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
The Royal College of Psychiatrists	Short	29-32		Section 1.9. ECT is an established additional option for patients who do not respond to other treatments, but is not mentioned, which is perplexing.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all

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					of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
UK Council for Psychotherapy	Short	32-34	Selected lines	Chronic depressive symptoms and chronic depression Diverse forms of psychotherapy are not included in these two sections, ie 1.10 "treating chronic depressive symptoms" as well as 1.11 "treating complex depression". Given that these two sections deal with the time when pharmacological treatment and CBT do not work, it is strange that other psychological interventions are not considered. Furthermore, the GDG go to a great length to ignore relevant evidence from family therapy, humanistic and integrative forms of psychotherapy, dance movement psychotherapy and body psychotherapy, listed before. Some of the existing evidence clearly refer to chronic and complex depression, while evidence from studies that look at comorbid conditions are being considered in other NICE guidelines – see, for example, the NICE guideline for schizophrenia that refers to the arts therapies as recommended form of psychological treatment (NICE, 2009, 25-6). Similarly, although psychodynamic psychotherapy is mentioned in previous sections, in sections 1.10 and 1.11 references to this form of psychotherapy are dropped. Given that these are areas (ie 1.10 and 1.11) where medication and CBT have failed as interventions (as far as	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				we understand), psychotherapy approaches that are more relational, systemic and creative/embodied deserve particular mention and recommendation in those sections.	
Association for Dance Movement Psychotherapy UK	Short	32-34	Selected lines	Dance Movement psychotherapy for chronic depressive symptoms and chronic depression Given that these two sections deal with the time when pharmacological treatment and CBT do not work, it is strange that other psychological interventions are not considered. Furthermore, the GDG go to a great length to ignore relevant evidence from dance movement psychotherapy and body psychotherapy, listed before. Some of the existing evidence clearly refer to chronic and complex depression, while evidence from studies that look at comorbid conditions are being considered in other NICE guidelines (see for example the NICE guideline for schizophrenia that refers to the arts therapies as recommended form of psychological treatment). Given that these are areas (ie 1.10 and 1.11) where medication and CBT have failed as interventions, psychotherapy approaches that are more relational, creative and embodied deserve particular mention and recommendation in those sections.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
College of Mental Health Pharmacy	Short	14-16	22 to 13 respectively	To devote 52 lines to discontinuation symptoms of antidepressant is completely out of proportion and portrays antidepressants "in a bad light". To be fair, the reader	Thank you for your comment. As you will be aware discontinuation symptoms refers specifically to those stopping antidepressants. This relates to the

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				needs a balanced view regarding discontinuation of psychological interventions. Are there any studies on the discontinuation symptoms of psychological therapy programmes? If not then perhaps it should be added to the section "Recommendations for research" on pages 48-51?	underlying pharmacology of the drugs. There is no equivalent for psychological treatments. It would therefore not be appropriate to make a research recommendation in this area.
British Association for Psychopharmacology	Short	32-33		Section 1.10 This section has not been changed from the first draft. Our concerns remain, namely: The biggest concern we have with regards to this section is the recommendations for medication options if an SSRI fails to lead to remission. Given the overlap of chronic depression with TRD and the definition of chronic depression used in the guidelines, it is unclear why the medication options recommended in section 1.9 are not included here. Indeed many of the patients included in the studies used to support the use of combinations of medications have an episode duration of over 2 years. The medication options recommended are somewhat perplexing. A switch to a TCA or moclobemide is recommended, despite the statements in section 1.9 that there is little value in switching antidepressants. The rationale for the recommendation for TCAs is not clear. We assume the rationale for the recommendation of moclobemide or amisulpride is on the basis of the network meta-analysis of Kriston et al. 2014 (Depress Anxiety 31: 621–630). This suggested an advantage of moclodemide and amisulpride over fluoxetine in patients with persistent depression as defined by DSM-5. There are at least two	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				concerns about the extrapolation of these findings to the recommendations made for 'chronic depression' as defined in the NICE guideline. Firstly, the studies included in this network analysis were predominantly of patients with dysthymia rather than patients with chronic MDD. Of the studies including amisupride, Amore 2001 was of patients with dysthymia +/- MDD, Smeraldi 1998 was of patients with dysthymia or MDD in partial remission, while the studies of Leon 1994, Boyer 1996, Belino 1997, Bogetto 1997, Ravizza 1999 and Rocca 2002 entirely consisted of patients with dysthymia. The second issue we have with regards to the extrapolation from this study to recommend moclobemide or amisulpride for Chronic MDD is that these two drugs were only superior to fluoxetine. They were not superior to paroxetine, sertraline or imipramine. As for non-chronic depression, the second line treatments (after a single trial of an SSRI) are recommended for use in specialist care or with specialist advice. As we have argued above, such a recommendation will lead to a dramatic increase in demand on specialist services and it is unclear that there are not more cost-effective approaches that could be employed at a primary care level.	
The Royal College of Psychiatrists	Short	32-33		Section 1.10. This section seems unchanged. But there are persistent problems. 1. It seems strange that the various options described in section 1.9 are not included.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all

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				2. A switch to a TCA or moclobemide is recommended, despite statements in section 1.9 that there is little to be gained from switching between antidepressants. 3. The rationale for the recommendation for TCAs is not clear. The rationale for recommending moclobemide or amisulpride may come from the network meta-analysis of Kriston et al. (2014), which suggested an advantage for these medicines over fluoxetine in patients with persistent depression: but it is precarious logic to attempt to use these findings to inform recommendations regarding the broader category of 'chronic depression'. The studies included in this analysis were predominantly conducted in patients with 'dysthymia' rather than chronic MDD. Furthermore these two drugs were found to be superior to only fluoxetine, and not superior to paroxetine, sertraline or imipramine.	of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Association for Family Therapy & Systematic Practice	Short	25-26	27-30 (25) and 1-7 (26)	The wording 'for a person with less or more severe depression' is confusing – if it is referring also to less severe depression then this advice should be replicated in the preceding section (1.6 – pages 20-24). Behavioural couples therapy is not the only form of couples therapy which is likely to be effective with depression – many other systemic approaches, models and techniques can be effectively used and we would ask you to consider amending the wording to provide less limited therapy options for couples.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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College of Mental Health Pharmacy	Short	49-50	17- 31 and 1-9 respectively	We feel that the section about "Recommendations for research" is imbalanced in favour of researching psychological interventions.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data. The research recommendations will also be reviewed.
Lundbeck	Short	30-31	15-28; 1-2	We welcome the revised ordering of the recommendations on further line treatment. We believe the evidence base is better reflected with the proposed recommendation that increasing the dose, switching medication or changing to a combination of psychological therapy plus medication are options to consider before combining 2 medications. This is also supported by similar evidence-based recommendations in the recently published Maudsley Prescribing Guidelines in Psychiatry 13th Edition (2018). Reference: Taylor, D, Barnes, T. R. E and Young, A. H (2018) Maudsley Prescribing Guidelines in Psychiatry 13th Edition. Wiley Blackwell.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Association for Family Therapy & Systematic Practice	Short	12-13	22, 8-9	The proposed routine measurement of outcome, session by session, should be helpful in shaping a positive therapeutic encounter, but viewing therapy in the same way as medication is not appropriate. They are different things.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all

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					of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
College of Mental Health Pharmacy	Short	32-33	28, 1-2 respectively	We did not find any mention for agomelatine in this guideline. Surely it should be mentioned, in view of numerous double-blind placebo controlled RCTs, as an option when other antidepressants have failed. Furthermore, after the recent Cipriani *et al* review (Cipriani *et al*, 2018), it was in the top 6-7 antidepressants for efficacy and tolerability and has a different mechanism of action. Reference: Cipriani *et al* 2018. Comparative efficacy and acceptability of 21 antidepressant drugs for the acute treatment of adults with major depressive disorder: a systematic review and network meta-analysis, The Lancet. 2018;391:1357-1366	Thank you for your comment and for drawing our attention to the Cipriani et al. (2018) citation. Agomelatine was not prioritised for investigation as an intervention in the guideline because of additional monitoring requirements and possible liver toxicity. Therefore the evidence for this has not been appraised and we are not able to make any recommendations on its use.
The British Psychological Society	Short	51/76	13 – 29	The use of specialist teams who are trained to provide support to older people and are focused on increasing their access to psychological therapies by increasing awareness, as well as the increasing provision of low intensity PTs using a stepped care model, can increase access to psychological therapies for this underrepresented group.	Thank you for your comment and providing this information.
British Association for Psychopharmacology	Short	30/31	26-28, 1-2	Section 1.9.8 This section states that patients should be warned of the increased side effect burden of taking two different drugs – including risk of serotonin syndrome. This is a risk with	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline

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				some combinations, but NOT all. Why does a patient need to be warned of this particular side effect if the combination they are going on to does not pose this risk?	update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
The Royal College of Psychiatrists	Short	30/31	26-28, 1-2	Section 1.9.8. The risk of serotonin syndrome is mentioned when patients are taking two antidepressants, but this is not a relevant risk for many drug-drug combinations. Why raise unnecessary concern?	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Sussex Partnership NHS Foundation Trust	Short	Section 1.5 (First-line treatment for less severe depression) and Section 1.6 (First-line treatment for more	General	Since we submitted our comments on the first draft of the revised guideline in September 2017, an important review and meta-analysis has been published in Clinical Psychology Review of mindfulness-based interventions for psychiatric disorders, including depression (Goldberg et al., 2018). Goldberg et al. (2018) adds weight to the offer of mindfulness-based cognitive therapy (MBCT) as a first line treatment for less severe and more severe depression. We suggest that MBCT should be offered alongside other evidence-based treatments as a first line intervention to provide patients with choice.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data. The Goldberg et al. (2018) systematic review has been checked for any additional studies and no new studies that met inclusion criteria were identified.

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		severe depression			
Sussex Partnership NHS Foundation Trust	Short	Section 1.8 (Relapse Prevention)	Page 27 line 12 to page 28 line 2	This second version of the draft guideline has the following caveats which were not included in the 2004 or 2009 version of the guideline and also represent some slight changes from the first version of the draft guideline. MBCT is recommended only for people (our emphasis): • who have recovered from *more severe depression when treated with medication* (alone or in combination with a psychological therapy), but are assessed as having a higher risk of relapse or *who want to stop taking antidepressant medication* (short version 1.8.4). • who have recovered with initial psychological therapy but are assessed as having a higher risk of relapse *but only if the initial psychological therapy doesn't have an explicit relapse prevention component* (short version 1.8.5). Our trust believes that the Kuyken et al. (2016) meta-analysis provides evidence contrary to these caveats and that MBCT should be offered as a choice to people who have recovered from less severe and more severe depression and who are assessed as having a higher risk of relapse and that this should be irrespective of severity of previous episodes and whether or not previous treatment has been received.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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Sussex Partnership NHS Foundation Trust	Short	Section 1.9 (No or limited response to initial treatment)	General	In the first draft MBCT was recommended as a second line intervention for people with limited response and treatment-resistant depression. This recommendation has been removed in the second draft of the revised guideline. We suggest that the positive evidence from the trials by Chiesa et al. (2015) and Eisendrath et al. (2016) is sufficiently strong to warrant recommending MBCT as a second-line treatment, particularly given that this would increase patient choice amongst evidence-based treatments for people not responding to initial treatment.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Action on Hearing Loss	Short	5	12-19	**Recommendation 1.2.5. should be reworded to include "sensory loss" in the list of conditions in brackets that require special attention.** The Department of Health and NHS England's *Action Plan on Hearing Loss*[1] states that hearing loss is responsible for enormous "personal, social and economic impact throughout life". The *Action Plan* highlights hearing loss in older people is "major challenge" that should be should be "considered within national and local strategies and plans" aimed at tackling other long-term conditions.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

[1] Department of Health and NHS England, 2015. *The Action Plan on Hearing Loss*. Available at: https://www.england.nhs.uk/wp-content/uploads/2015/03/act-plan-hearing-loss-upd.pdf

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				Hearing loss and its associated health problems are risk factors for depression that health and social care practitioners need to be aware of. The communication barriers caused by hearing loss may lead to people withdrawing from social situations and becoming isolated.[2] For example, one study found that people with hearing loss are more likely to experience emotional distress and withdraw from social situations.[3] Partners of people with hearing loss also often experience frustration, loneliness, and reduced quality of life.[4] Unaddressed hearing loss has been linked with depression, anxiety and other mental health problems.[5] For example, research shows that hearing loss **doubles the risk of developing depression.**[6]	

[2] Arlinger, 2003. Negative consequences of uncorrected hearing loss – a review. *International Journal of Audiology*, 42 (2), 17-20; Gopinath et al, 2012. Hearing-impaired adults are at increased risk of experiencing emotional distress and social engagement restrictions five years later. *Age and Ageing*, 41 (5), 618-62. Hétu et al, 1993. The impact of acquired hearing loss on intimate relationships: implications for rehabilitation. *Audiology*, 32 (3), 363-81; Monzani et al, 2008. Psychological profile and social behaviour of working adults with mild or moderate hearing loss. *Acta Otorhinolaryngologica Italica*, 28 (2), 61-6.
[3] Gopinath et al, 2012. Hearing-impaired adults are at increased risk of experiencing emotional distress and social engagement restrictions five years later. *Age and Ageing*, 41 (5), 618-62.
[4] Echalier, 2011. *In it together: the impact of hearing loss on personal relationships*. London: RNID; Wallhagen et al, 2004. Impact of self-assessed hearing loss on a spouse: a longitudinal analysis of couples. *Journals of Gerontology: Series B,* 59 (3), S190-S196.
[5] Eastwood et al, 1985. Acquired hearing loss and psychiatric illness: an estimate of prevalence and co-morbidity in a geriatric setting. British Journal of Psychiatry, 147: 552–556; Garnefski & Kraai, 2012. Cognitive coping and goal adjustment are associated with symptoms of depression and anxiety in people with acquired hearing loss. *International Journal of Audiology*, 51: 545–550; Mulrow et al, 1990. Quality-of-life changes and hearing impairment. A randomized trial- Ann Intern Med. 1;113(3):188-94; National Council on Aging, 2000. The consequences of untreated hearing loss in older persons. *Head and Neck Nursing*, 18(1), 12-6;
[6] Saito et al, 2010. Hearing handicap predicts the development of depressive symptoms after three years in older community-dwelling Japanese

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Brighter Tomorrow Ltd	Short	5	10	On page 5 After line 24 add another line: Carer or family member should be informed of treatment, outcomes, and if treatment is experimental. If patient has capacity to consent then patient should be informed of any experimental treatment.	Thank you for your comment. The patient experience section from the 2009 guideline was not included in this update. In line with NICE processes, the 2009 content has been carried across to this updated guideline but the evidence on patient experience has not been reviewed. As the evidence in these areas has not been reviewed, we are not able to make the changes you suggest to the recommendations.
Brighter Tomorrow Ltd	Short	5	10	After above insert, Carer or family member to advised if there is better treatment that offers faster outcome and to be advised of alternative treatments that have been validated through the scientific method of research.	Thank you for your comment. The patient experience section from the 2009 guideline was not included in this update. In line with NICE processes, the 2009 content has been carried across to this updated guideline but the evidence on patient experience has not been reviewed. As the evidence in these areas has not been reviewed, we are not able to make the changes you suggest to the recommendations.
Brighter Tomorrow Ltd	Short	5	23	In section 1.2.2 after, "… to an appropriate individual who can.." Insert, "unless there is collaborating physical evidence to suggest sexual abuse, an appropriate referral excludes any professional is known to use regression therapy or therapy like to create false memories of abuse." This is supported by Freud's redaction of his sexual seduction theory in 1897. Furthermore, by referring a patient to a therapist who is known to practice regression or false memory therapy can ultimately cost the NHS more thereby driving up the cost of care. NICE has a responsibility to the taxpayer to ensure tax money is used	Thank you for your comment. The patient experience section from the 2009 guideline was not included in this update. In line with NICE processes, the 2009 content has been carried across to this updated guideline but the evidence on patient experience has not been reviewed. As the evidence in these areas has not been reviewed, we are not able to make the changes you suggest to the recommendations.

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				appropriately and to ensure patients get the treatment most suited for them.	
Public Health England	Short	6	15 - 27	Given the extent of co-morbid alcohol problems among people with depressive disorders, PHE recommend that there should be a specific reference to it in this section. Suggest adding the following bullet to sentence: • "any history of depression and coexisting mental health and physical disorders including substance misuse"	Thank you for your comment. The section on recognition, assessment and initial management was not included in this update and therefore the content from the 2009 guideline has been reproduced in line with NICE processes. As the evidence in this area has not been reviewed it is not possible for us to make any changes to the recommendations. In addition, drug and alcohol misuse is outside the scope of this guideline and so we are not able to make any recommendations on this issue.
Brighter Tomorrow Ltd	Short	6	1	Change the word "Consider," to the word "Unless testing is not possible because of a limitation then to arrive at the diagnosis testing must be done," It is negligent to make assumptions and proper diagnosis must be done. This includes using the MMPI and other properly validated psychometric tests. It makes patients vulnerable to false memory therapy, regression therapy, and it puts the patient at risk. NICE has a duty of care to the patient to protect them from harm and to the taxpayer to ensure tax money is used appropriately.	Thank you for your comment. The section on recognition, assessment and initial management was not included in this update and therefore the content from the 2009 guideline has been reproduced in line with NICE processes. As the evidence in this area has not been reviewed it is not possible for us to make any changes to the recommendations.
Public Health England	Short	7	20 - 27	Given the association between suicide and alcohol intoxication, PHE recommend that alcohol and other substance use be mentioned as a specific risk factor.	Thank you for your comment. The section on recognition, assessment and initial management was not included in this update and therefore the content from the 2009 guideline has been reproduced in line with NICE processes. As the evidence in this area has not been reviewed it is

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					not possible for us to make any changes to the recommendations. In addition, drug and alcohol misuse is outside the scope of this guideline and so we are not able to make any recommendations on this issue.
Action on Hearing Loss	Short	7	7-13	**"consider other forms of support that could improve the effectiveness of depression interventions (e.g. the provision of hearing aids)" should be added as a bullet point to Recommendation 1.2.9.** Diagnosing and managing hearing loss is essential for improving effectiveness of depression interventions. There's gold-standard evidence that hearing aids are a cost effective[7] form of treatment that improve quality of life and the listening ability of people with hearing loss.[8] Hearing aids have been shown to have a positive impact	Thank you for your comment. The section on recognition, assessment and initial management was not included in this update and therefore the content from the 2009 guideline has been reproduced in line with NICE processes. As the evidence in this area has not been reviewed it is not possible for us to make any changes to the recommendations.

[7] Davis et al, 2007. Acceptability, benefit and costs of early screening for hearing disability: A study of potential screening tests and models. *Health Technology Assessment* 11: 1–294; Chao & Chen, 2008. Cost-effectiveness of hearing aids in the hearing-impaired elderly: a probabilistic approach. *Otology and Neurotology* 29(6): 776-83; Ferguson et al, 2017. Hearing aids for mild to moderate hearing loss in adults. Cochrane Database of Systematic Reviews 2017, Issue 9. Art. No.: CD012023. DOI: 10.1002/14651858.CD012023.pub2

[8] Chisholm et al, 2007. A systematic review of health-related quality of life and hearing aids: Final report of the American Academy of Audiology task force on the health-related quality of life benefits of amplification in adults. *Journal of American Academy of Audiology*, 18, 151-183; Ciorba et al, 2012. The impact of hearing loss on quality of life of elderly adults. *Clinical interventions in aging*, 7,159-63; Jerger et al, 1996. Comparison of conventional amplification and an assistive listening device in elderly persons. *Ear and Hearing*, 17 (6), 490-504; Mulrow et al, 1990. Quality-of-life changes and hearing impairment, a randomized trial. *Annals of Internal Medicine,* 113 (3), 188-194; Yueh et al, 2001. Randomized trial of amplification strategies. *Archives of Otolaryngology - Head and Neck Surgery* 127 (10), 1197-204

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				on overall health.[9] Research shows that hearing aids reduce the risk of loneliness and depression[10] and early evidence suggests that they may even reduce the risk of dementia.[11] Despite the benefits of hearing loss, research shows that only two-fifths of people who need hearing aids have them.[12] Evidence suggests that people wait ten years on average before seeking help for their hearing loss and the average age for referral is in the mid-70s.[13] The longer people wait before seeking help, the less likely they are to benefit from hearing aids.[13]	

[9] Dawes et al, 2015. Hearing aid use and long-term health outcomes. Hearing-aid use and long-term health outcomes: Hearing handicap, mental health, social engagement, cognitive function, physical health, and mortality. *International journal of audiology*, 54 (11), 838-844.
[10] Acar et al, 2011. Effects of hearing aids on cognitive functions and depressive signs in elderly people. *Archives of Gerontology and Geriatrics*, 52 (3): 250-2; Pronk et al, 2011.Prospective effects of hearing status on loneliness and depression in older persons: identification of subgroups. *International Journal of Audiology*, 50 (12), 887-96; Dawes et al, 2015. Hearing Loss and Cognition: The Role of Hearing Aids, Social Isolation and Depression. *PLoS ONE,* 10 (3): e0119616; National Council on the Aging, 2000. The consequences of untreated hearing loss in older persons. *Head and Neck Nursing*, 18 (1), 12-16.
[11] Amieva et al, 2015. Self-Reported Hearing Loss, Hearing Aids, and Cognitive Decline in Elderly Adults: A 25-Year Study. *Journal of the American Geriatrics Society*, 63 (10), 2099-2104; Dawes et al, 2015. Hearing Loss and Cognition: The Role of Hearing Aids, Social Isolation and Depression. *PLoS ONE,* 10 (3): e0119616; Deal et al, 2015. Hearing impairment and cognitive decline: A pilot study conducted within the atherosclerosis risk in communities neurocognitive study. *American Journal of Epidemiology*, 181(9), 680-90.
[12] NHS England, 2016. *Commissioning services for people with hearing loss; a framework for Clinical Commissioning Groups (CCGs)*. Available from: https://www.england.nhs.uk/wp-content/uploads/2016/07/HLCF.pdf
[13] Davis et al, 2007. Acceptability, benefit and costs of early screening for hearing disability: a study of potential screening tests and models. *Health Technology Assessment*, 2 (42).

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				Negative stereotypes about hearing loss and hearing aids as well as fear of stigma itself can be a significant barrier stopping people from seeking help[14]. Older people may view hearing loss as an inevitable part of the ageing process[15] and may find it difficult to access support for their hearing loss due to communication or memory problems caused by dementia or other long-term conditions.[16] Health and social care practitioners have an important role play in supporting people to seek help for their hearing loss, especially those who may otherwise find it difficult to access support, such as older people living in care and people with other long-term conditions., It estimated that over 80% of older people living in care homes will require support for their hearing loss to maximise their independence and wellbeing.[17] NICE's *Mental Wellbeing of Older People in Care Homes Quality Standard*[18] *states* that sensory needs should be included in care plans. The Quality Standard also states that care staff should be alert	

[14] Doggett et al, 1998. Hearing aid effect in older females. *Journal of the American Academy of Audiology*, 9 (5), 361-66; Southall et al, 2010. Stigma: a negative and positive influence on help-seeking for adults with acquired hearing loss. *International Journal of Audiology*, 49 (11), 804-814.
[15] Echalier, 2012. *A World of Silence*. Available from: http://www.actiononhearingloss.org.uk/-/media/ahl/documents/research-and-policy/reports/care-home-report.pdf
[16] Action on Hearing Loss, 2013. *Joining Up*. Available from: https://www.actiononhearingloss.org.uk/how-we-help/information-and-resources/publications/research-reports/joining-up-report/
[17] NHS England, 2016. *Commissioning services for people with hearing loss; a framework for Clinical Commissioning Groups (CCGs)*. Available from: https://www.england.nhs.uk/wp-content/uploads/2016/07/HLCF.pdf
[18] NICE Quality Standards, 2013. *Mental wellbeing of older people in care homes*. Available from https://www.nice.org.uk/guidance/qs50

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				to the early signs of hearing loss and the role of the GP in referring people for a hearing assessment to ensure prompt access to treatment.	
Association for Family Therapy & Systematic Practice	Short	7	14-19	Advice to treat depression first if there are comorbid anxiety symptoms, but consider treating anxiety first if there is an anxiety disorder, comes across as confusing and does not centre the person's experience or priorities, and also does not permit that an effective therapeutic approach, within a collaborative therapeutic relationship would be supporting the person to create positive change in whatever she / he / they find troubling, regardless of how many or how few categorical labels can be applied.	Thank you for your comment. The section on recognition, assessment and initial management was not included in this update and therefore the content from the 2009 guideline has been reproduced in line with NICE processes. As the evidence in this area has not been reviewed it is not possible for us to make any changes to the recommendations.
Action on Hearing Loss	Short	7	2-6	**"be aware of sensory loss and communication difficulties" should be added as a bullet point to Recommendation 1.2.8.** Aside from relationship between hearing loss, depression and other mental health problems (see comment 2), research shows that there is an association between hearing loss, cognitive decline and dementia, [19] with the risk of developing dementia increasing in line with the	Thank you for your comment. The section on recognition, assessment and initial management was not included in this update and therefore the content from the 2009 guideline has been reproduced in line with NICE processes. As the evidence in this area has not been reviewed it is not possible for us to make any changes to the recommendations.

[19] Lin FR et al, 2011. Hearing loss and incident dementia. *Archives of Neurology*, 68 (2), 214-220; Lin, et al, 2013. Hearing loss and cognitive decline in older adults. *Internal medicine*, 173 (4), 293-299; Gurgel et al, 2014. Relationship of Hearing Loss and Dementia: A Prospective, Population-Based Study. *Otology & Neurotology*. 35 (5), 775-781; Albers et al, 2015. At the interface of sensory and motor dysfunctions and Alzheimer's disease. *Alzheimers and Dementia Journal*, 11 (1), 70–98. Deal, et al, 2017. Hearing impairment and incident dementia and cognitive decline in older adults: the health ABC study. *The Journals of Gerontology*, 72 (5), 703-709.

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				severity of hearing loss.[20] A recent study identified hearing loss as the **largest modifiable risk factor for dementia**.[21] If removed, the study states that 9% of dementia cases could be prevented. Undiagnosed hearing loss can also exacerbate communication difficulties experienced by people with dementia and this needs to be taken into account during mental health assessments. Research shows that hearing loss can complicate the symptoms of dementia by making communication more difficult. [22] In some cases hearing loss can even be misdiagnosed as dementia due to the appearance of similar symptoms.[22] The draft NICE *Hearing Loss in Adults Guideline* states that unaddressed hearing loss in people with dementia will "significantly affect understanding and will exacerbate underlying cognitive difficulties".[23]	

[20] Lin FR et al, 2011. Hearing loss and incident dementia. *Archives of Neurology*, 68 (2), 214-220; Lin, et al, 2013. Hearing loss and cognitive decline in older adults. *Internal medicine*, 173 (4), 293-299.
[21] Livingston et al, 2017, Dementia prevention, intervention, and care. The Lancet Commission. http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31363-6/fulltext
[22] Van Boxtel et al, 2000. Mild hearing impairment can reduce verbal memory performance in a healthy adult population, *Journal of Clinical and Experimental Neuropsychology*, 22 (1), 147-54; Burkhalter et al, 2009. Examining the effectiveness of traditional audiological assessments for nursing home residents with dementia-related behaviors, *Journal of American Academic Audiology*, 20 (9), 529-38.
[23] NICE, 2017. *Hearing loss; Hearing loss in adults: assessment and management*. Draft guideline

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Action on Hearing Loss	Short	9	5-15	**", in line with NHS England's Accessible Information Standard" should be added to the end of the first bullet point in Recommendation 1.3.1.** People who are deaf or have hearing loss may struggle to access GPs and other NHS services when they need to due to the lack of accessible alternatives to the telephone, poor deaf awareness or the lack of communication support. Our *Good Practice*?[24] report shows many people who are deaf or have hearing loss cannot contact their GP surgery in the preferred way. For example, one-quarter (26%) of survey respondents said that they ask a family member, friend or support worker to call their GP surgery on their behalf, but a much small proportion, less than one in 12 (7%), said they wanted other people to book GP appointments for them. More than two-fifths (43%) of survey respondents said that staff at their GP surgery let them know when it's their turn to be seen, by the doctor or nurse, by calling their name out. Our previous research shows that that one in seven (14%) people with hearing loss had missed an appointment because they didn't hear their name being called in the waiting room. After seeing the GP, nearly two-thirds (64%) of survey respondents said they feel unclear about the information they have been given at their GP	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

[24] Action on Hearing Loss, 2018. *Good practice? Why people who are deaf or have hearing loss are still not getting accessible information from their GP*. Available at: www.actiononhearingloss.org.uk/goodpractice

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				appointments, at least some of the time. When asked why they felt unclear, more than half (52%) of survey respondents with hearing loss said doctors or nurses spoke too quickly – or didn't check whether they had been understood. Poor communication in waiting areas causes considerable stress and anxiety for people who are deaf or have hearing loss. This may put people off visiting their GP surgeries altogether: forcing them to delay seeking help until their health gets worse and they can't wait any longer. NHS England also estimates that the cost of people with hearing loss missing appointments – because they didn't hear their name being called in the waiting room – could be as high as £15m every year.[25] The Ear Foundation estimates that, because of communication difficulties, people with hearing loss cost the NHS £76m in extra GP visits every year.[26] Our *Good Practice?* report found that more than half (57%) of survey respondents who are deaf said they felt unclear about their health advice because a sign language interpreter was unavailable for their appointment. More than one in eight (13%) also said that the quality of sign	

[25] NHS England, 2017.*Accessible Information Standard: Specification*. Available at: www.england.nhs.uk/accessibleinfo
[26] The Ear Foundation, 2014.*The Real Cost of Adult Hearing Loss: Reducing its impact by increasing access to the latest hearing technologies*. Available at: earfoundation.org.uk/ research/adult-strategy-reports/the-real-cost-of-adult-hearing-loss-2014

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				language interpretation wasn't good enough. Research by *SignHealth*[27] shows that more than one-third (34%) of people who are deaf were unaware they had high or very high blood pressure and more than half (55%) of those who said they had cardiovascular disease were not receiving appropriate treatment – suggesting problems with communication and access. Without access to a well-qualified communication professional, people who are deaf, in particular, are at risk of worse care and poor health. *SignHealth* estimates that the missed diagnosis and poor treatment of people who are deaf costs the NHS £30m every year.[27] Evidence suggests Poor awareness of BSL and Deaf culture may also lead to misdiagnosis or under-diagnosis of mental health problems in people who are deaf.[28] NHS England's *Accessible Information Standard*[29] provides clear guidance on improving the accessibility of health and social care services for people with disabilities and sensory loss. The Standard sets out a clear five step process to make sure people with disabilities and sensory loss get the support they need to communicate well and understand information when accessing health and social	

[27] SignHealth, 2014.*Sick of It*.Available at: signhealth.org.uk/sickofit/
[28] Department of Health, 2002.*A Sign of the Times*.London: The Department of Health; Department of Health, 2005.*Mental Health and Deafness: Towards equity and access*.London: The Department of Health.
[29] NHS England, 2017.*Accessible Information Standard*. DCB 1605 Available at: www.england.nhs.uk/accessibleinfo

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				care. The Standard is mandatory for providers of NHS care and publicly funded adult social care. The Standard sets out a consistent approach for improving the accessibility of mental health services for people with disabilities and sensory loss and is therefore highly relevant for ensuring successful implementation of Recommendation 1.3.1.	
Action on Hearing Loss	Short	9	16-19	**", in line with NHS England's Accessible Information Standard" should be added to the end of Recommendation 1.3.2.** The Accessible Information Standard provides clear guidance on improving the accessibility of health and social care services for people with disabilities and sensory and is therefore essential for the successful implementation of this recommendation (see comment 5).	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Public Health England	Short	9	4	There is a risk that the current system of healthcare commissioning in England may have led to barriers to delivering integrated care for people with co-occuring substance misuse and depressive disorders. PHE recommend suggest that local authority commissioned drug and alcohol services are mentioned as a key partner in delivering integrated care.	Thank you for your comment. Drug and alcohol misuse is outside the scope of this guideline and so we are not able to make any recommendations on this issue.
Lundbeck	Short	9	5 et seq.	In our response to the first consultation draft, we expressed concern that the draft guideline appeared to signal a change of direction, preferring a collaborative care model over the stepped care model introduced in the previous version of CG90. We were particularly concerned	Thank you for your comment and support for the changes made to the guideline.

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				that the collaborative care model put forward in this guideline update marginalises the role primary care plays in identifying and managing depression and promotes an over-reliance on specialist services. We therefore welcome the additional recommendations contained in section 1.3 of the second consultation draft to ensure that structures are in place to promote greater integration between primary and secondary care, as we believe there is a service gap for patients diagnosed with depression in care clusters 1-4, who could be better managed if this recommendation is fully embraced and implemented by service providers. Reference: NHS England (2016). Mental Health Clustering Booklet v5.0. NHS England Publications Gateway. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499475/Annex_B4_Mental_health_clustering_booklet.pdf [accessed 6/6/18]	
Multiple System Atrophy Trust	Short	9	20	There should be pathways to support people diagnosed with terminal progressive conditions such as Multiple System Atrophy, and including carers.	Thank you for your comment. This guideline is about the treatment and management of depression in adults. It is therefore outside the scope to make recommendations for people with terminal progressive conditions.
The British Psychological Society	Short	9	29	While routine collection of data on access to, uptake of, and outcomes of the interventions in the pathway is helpful, it is important that evaluation is considered in the context of the complex cases seen. For example, cases seen by psychologists in secondary care often have	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all

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				several co-morbidities and enduring personality difficulties and so outcomes expected are often small and not always captured by evaluation measures. Also, the recommendation of collecting routine outcome data is too general. The pathway could be more explicit and highlight that this should be done within an infrastructure that allows for using the data in a more meaningful way. NICE should conduct a proper analysis of 1 and 2-year follow-up data from trials and prioritise treatment recommendations made on the basis of these data over and above recommendations which are made on the basis of short term outcomes (less than 1 year)	of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Hyperparathyroid UK Action 4 Change	Short	10	10-12	I know that I am extremely depressed and so many doctors want to make this out to be my problem but my depression is from being so sick for so many years without being helped! I have primary hyperparathyroidism.	Thank you for your comment and for providing this information. This guideline is about the treatment and management of depression in adults. Therefore it is outside the scope of this guideline to make recommendations on the diagnosis or management of hyperparathyroidism or the management of depression associated with hyperparathyroidism
British Association for Psychopharmacology	Short	10	11-12	Section 1.3.4 A bullet point in this section refers to: "delivery of pharmacological, psychological and social interventions". This should be adjusted to include neurostimulatory treatment such as ECT and TMS.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all

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				We are unclear why there is no mention of TMS anywhere in the guideline despite recommendations in NICE IPG542	of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Hyperparathyroid UK Action 4 Change	Short	10	19-20	There is no support from general practioners, just a repeat prescription for anti-depressants, then all following symptoms are blamed on depression. There seems to be no investigation for cause at all. Tests for primary hyperparathyroidism could reveal a cause that can be treated and cured.	Thank you for your comment and for providing this information. This guideline is about the treatment and management of depression in adults. Therefore it is outside the scope of this guideline to make recommendations on the diagnosis or management of hyperparathyroidism or the management of depression associated with hyperparathyroidism. The guideline already recommends that people with no or limited response should be assessed to establish if there is an underlying physical illness that could explain their symptoms.
The Royal College of Psychiatrists	Short	10	11-12	Section 1.3.4. The bullet point which refers to: "delivery of pharmacological, psychological and social interventions" should should be adjusted to include neurostimulatory treatments such as ECT and TMS. It seems odd that TMS is not mentioned in the guideline despite being recommended in NICE IPG542.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Hyperparathyroid UK Action 4 Change	Short	10	8	I was diagnosed with mild depression with anxiety and low vitamin D, and not with hyperparathyroidism for another 6 or 7 years.	Thank you for your comment and for providing this information. This guideline is about the treatment and management of depression in adults.

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					Therefore it is outside the scope of this guideline to make recommendations on the diagnosis or management of hyperparathyroidism or the management of depression associated with hyperparathyroidism.
Gorlin Syndrome Group	Short	10	13	In our experience, it is hard to access mental health services from specialist services for physical illness. How will '' care coordination including care provided by physical health services'' work. For example, for physical health services practitioners managing patients with chronic diseases, will they know who and how to refer to for mental health services?	Thank you for your comment. Deciding how the care coordination will work will be a matter for local implementation
NHS England (IAPT Team)	Short	10	28	Section 1.3.6: Self-referral directly into an IAPT service is a key service characteristic. Perhaps this could be mentioned in the section?	Thank you for your comment. Self-referral into an IAPT service may be one of the ways this recommendation is implemented, however we are not able to make recommendations about this.
NHS England (IAPT Team)	Short	11	15-24	Could People with physical or sensory disability be included on the list of groups that we need to pay special attention to in relation to access as they seem to have been missed.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Public Health England	Short	11	15	People with drug and alcohol problems often feel excluded from mainstream mental health services and therefore PHE suggest that the guideline includes a reference to	Thank you for your comment. Drug and alcohol misuse is outside the scope of this guideline and so we are not able to make any recommendations on this issue.

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				ensuring people with drug and alcohol problems are able to access services (or not excluded).	
Multiple System Atrophy Trust	Short	11	15	The list should also include people who have conditions which compromise their ability to communicate, such as people in the advanced stages of Multiple System Atrophy.	Thank you for your comment. This guideline is about the treatment and management of depression in adults. It is therefore outside the scope to make recommendations for people with terminal progressive conditions.
British Association of Art Therapists	Short	12	24-25	Restriction to use of treatment manuals may reduce choice of treatment because some potentially effective treatments have not yet been manualised. Perhaps other forms of evidence should also be taken into account, e.g. from (a) trials without a manual but with detailed description of treatment, and (b) systematic and rigorous qualitative, and mixed-methods and case studies that have enabled clear links to be made between treatment/intervention elements and service users' self-reported outcome.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Hyperparathyroid UK Action 4 Change	Short	12	19-20	'regular liaison between healthcare professionals in specialist and non-specialist settings' - When I told a rheumatology nurse that medication I had been taking had worsened my depression and I had been contemplating suicide, she responded with 'Oh, you are an intelligent woman who has run her own business'; implying that intelligent people don't consider suicide. Sometimes seeking help is dismissed by healthcare professionals and can be very damaging and lead to worsened isolation and feelings of helplessness. This attitude must be addressed	Thank you for your comment and providing this information. This guideline is about the treatment and management of depression in adults. Therefore it is outside the scope of this guideline to make recommendations on the diagnosis or management of hyperparathyroidism or the management of depression associated with hyperparathyroidism.

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Hyperparathyroid UK Action 4 Change	Short	12	19-20	I think liaison between healthcare professionals is in specialist and non-specialist settings is deficient and there is much room for improvement	Thank you for your comment. We hope that the recommendations made in this guideline will facilitate improvements in this area.
Brighter Tomorrow Ltd	Short	12	2	At the end of line 2 on page 12 add, "This must be done in writing, becoming a part of the patient's permanent record, disclosed if the patient decides to litigate and signature from patient obtained. If the patient is not able to consent their authorised legal representative. Information must be at a level to allow all patients to provide informed consent." Regarding therapists who practice false memory and regression therapy a further statement needs to be included, "the therapy is controversial because it can create memories of events that never occurred and it can lead to a destruction of ties with friends and family. Furthermore, there is no guarantee the therapy will help and it might make you worse."	No evidence was identified about false memory and regression therapy. Therefore we are unable to comment on this in the guideline.
NHS England (IAPT Team)	Short	12	4	It would be helpful if a broader range of delivery formats could be specified – for example face-to-face and over the telephone, or book and digitally).	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Brighter Tomorrow Ltd	Short	12	9	At the end add, As a part of the written record of what was discussed regarding patient treatment disclosure, see above, at the end add of line 9 on page 12, An estimate of length of treatment and number of sessions before patient	Thank you for your comment. This concerns the routine practice and implementation of the recommendations and would be a matter for local determination.

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				will see progress. Also, in regards to the above when disclosing other options (see page 12 line) length of time and number of session. Along with providing names of treatment providers if the individual is not able to complete themselves.	
Brighter Tomorrow Ltd	Short	12	11	Strike on line 11 page 12, ".. the likelihood of developing more severe depression…" This creates an expectation depression is more likely to become severe. In my opinion, this is an example of the expectancy effect. Whereby the user only hears the words more severe and depression may become worse because of the expectation created. Again I point out, NICE has a duty to people seeking mental health care to ensure they get the best possible treatment in the shortest amount of time. Furthermore, again I highlight NICE's need to be guardian of the public purse string by not causing patients unnecessary treatment because they are under the expectation they will get worse. This will lead to increase needs that can be completely avoided by having the right conversations at the right time	Thank you for yourr comment. In producing this guideline we focus on clinical and cost-effectiveness to ensure that public funds are used appropriately.
College of Mental Health Pharmacy	Short	12	22	We suggest adding 'appropriate' validated measures. This is because some measures may be validated for research but not appropriate for routine clinical practice	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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College of Mental Health Pharmacy	Short	12	23	We suggest adding another point: taking account of any previous treatments and/or interventions offered or received	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Brighter Tomorrow Ltd	Short	12	23	After line 23 on page 12 add, Contingency planning must be a part of any invention planning including listing other services and providers if treatment is not working. Along with contingency planning identifying SMART (Specific Measurable Achievable Realistic and Time) criteria to measure progress and if progress is not being made then activating the appropriate contingency plan.	Thank you for your comment. We advocate outcome monitoring to ensure that progress in treatment can be effectively monitored.
Association for Family Therapy & Systematic Practice	Short	12	24	We understand that some of the advice to use manuals may be to guide less experienced and trained IAPT practitioners, and a manual can be a resource to support a therapist develop therapeutic skills, however this fits more with some approaches (CBT and IPT for example) than others (certainly many systemic approaches, particularly those which emphasise client as expert, working collaboratively, prioritising client goals over symptomatology and which develop according to the specific skills, social and relational resources which the person brings with them to therapy). Delivery is not standardised, even with manualised CBT approaches, (and some would argue that if it were completely	Thank you for your comment. The committee was of the view that taking a manual as a guide to best practice was one way in which to support the delivery of effective evidence based interventions. The committee are unconvinced by the argument that there is a differential approach to the use of manuals across different therapeutic approaches. In particular we think it is inaccurate to suggest that CBT or IPT do not work collaboratively with a client and do not build on skills, knowledge and understanding that the person brings to treatment. It is the case that in any treatment, a manual acts as an overall guide to delivery of care and

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				standardised and invariable then it is not therapy, but a lecture).	appropriate adjustments will be made in response to an individual's needs.
College of Mental Health Pharmacy	Short	12	25	We suggest adding the word "psychological" after the words "length of"	Thank you for your comment. We do not think that this change is needed as it is clear from the start of the recommendation that it relates to psychological treatments.
NHS England (IAPT Team)	Short	12	26	The recommendation states "Consider using competence frameworks developed from treatment manuals for psychological and psychosocial interventions to support effective training, delivery and supervision of interventions". We feel this is not strong enough, as it leaves the use of competence frameworks at the discretion of trainers and employers. This introduces a significant risk of the dilution of the competences and training required to deliver the interventions as delivered in the trials. The following change would safeguard against this: "Use competence frameworks developed from treatment manuals for psychological and psychosocial interventions to support effective training using recognised training curricula based on these frameworks, as well as effective delivery and supervision of interventions"	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
British Association of Art Therapists	Short	13	13-15	Competence monitoring and evaluation are important, but routinely using video and audio-recordings for all practitioners seems impractical. We suggest that service users and those referring them should ensure that therapists are qualified and HCPC registered and have regular supervision from an appropriately qualified person. Routine outcome measures are also important, along with	Thank you for your comment. Video and audio recordings are cited in the recommendation only as examples of how competence can be evaluated and monitored. Other formats could also be used - they key factor is that competence is evaluated and monitored.

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				additional scales such as PSYCHLOPS (http://www.psychlops.org.uk/), a self-report scale that allows patients to decide their own outcome goals and rate them, and which has good psychometric properties.	
Hyperparathyroid UK Action 4 Change	Short	13	10-12	'Healthcare professionals delivering interventions for people with depression should: • receive regular high-quality supervision' This supervision is not happening realistically. Many of our members are left on medication for years only to later find they have hyperparathyroidism which was a cause of their depression	Thank you for your comment. Supervision of healthcare professionals delivering interventions for people with depression will be a matter for local implementation of the guideline. It is also outside the scope of this guideline to make recommendations on the diagnosis or management of hyperparathyroidism.
College of Mental Health Pharmacy	Short	13	26-27	We welcome the correction to the onset of action in the first version, but we are not sure where the 3 weeks comes from and how the term "typically" is justified. As per our previous response, there is much data showing 50% improvement compared with placebo non responders at 2 weeks.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Brighter Tomorrow Ltd	Short	13	14	Page 13 line 14 after "..video…" add "review of notes"	Thank you for your comment. Video and audio recordings are cited in the recommendation only as examples of how competence can be evaluated and monitored. Other formats could also be used - they key factor is that competence is evaluated and monitored.
Brighter Tomorrow Ltd	Short	13	15	Page 13 line 15 add the end, "Sample of work to be independently reviewed to ensure compliance and quality of treatment. Any defects to be corrected and if not	Thank you for your comment. This will be a matter for local implementation.

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				correctable then appropriate disciplinary action should be taken."	
Brighter Tomorrow Ltd	Short	13	11 – 12	Page 13 lines 11 – 12 this wording is greatly concerning and more clarification must be provided. Reviewing for pharmacological and psychological harm cannot be done by clinician. It **must** be done by an independent review body to ensure no unnecessary experimentation with Pharmaceuticals has been done (see the story of Maxine Berry) it happened in the US, I can be confident it in my assumption it is happening in the UK too), and no harm is occurring. This is the only way to safeguard patients and protect the NHS from fraudulent diagnosis.	Thank you for your comment. It is the responsibility of all clinicians to monitor for harms associated with any interventions. What you propose would not be practical and may lead to a number of harms going undetected.
British Association of Art Therapists	Short	14	20-21	Whilst we appreciate the addition of guidelines on discussing patients' worries about stopping antidepressant medication, we still believe that there is no justification for advising professionals to tell people "the fact that they cannot get addicted to antidepressant medication". We note that you acknowledge the need to discuss "discontinuation effects". However, telling people they cannot get addicted will be heard to mean "it probably won't be difficult to stop the medication". This is factually inaccurate since a great many people find it difficult to stop. To have a guideline with this message presents the following challenges: More people taking antidepressants (many of whom may do better without), more people having "discontinuation effects" and therefore having to stay on them longer, costing money for more medication or the cost of treatment required due to stopping or support for slowly reducing. It also makes antidepressants	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				appear to be a more benign option than they really are, perhaps reducing the incentive for services to make alternative approaches available (especially psychological therapies), or for service users to consider alternatives. It may also disempower service users, making them believe there is something wrong with their brain that medication can continue to fix, rather than focusing on their own strengths and capacities and social resources. It may also promote the belief in those close to them that social support and belonging are less important than medication, when in fact the opposite may be true but it is less well researched.	
College of Mental Health Pharmacy	Short	14	20-21	We welcome this point	Thank you for your comment.
Health Assured	Short	16	23-28	Challenging to Implement As above we could provide access to group-based CBT therapy where clinically appropriate in a corporate-funded setting, however there would be potential delays of current service level agreements and imposed restrictions in regards to accessing support. For example, for Group CBT to go ahead, this would require a number of individuals in the same organisation to have similar presenting issues and request support within a short timeframe. Using this example, Health Assured believe Group CBT would be more applicable for those receiving care via primary care services and if required would function as a service outside Employee Assistance models and therefore	Thank you for your comment. It will be a matter for local implementation to agree how the recommendations in the guideline are put into practice.

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				guidance would only be adopted where the treatment is feasible and appropriate for delivery.	
Health Assured	Short	16	9-12	Impact on Practice Health Assured would discourage both our existing and future clients as well as other Employee Assistance providers from digressing away from the traditional model of offering telephone, online and face-to-face support options on a short term, solution-focused all-inclusive model as this is proven effective in supporting a range of presenting work/life issues. However, when the guidelines are issued, for the management and treatment of depression specifically, we believe that as an Employee Assistance Programme provider will be required to provide alternative therapeutic interventions and these will need to be considered as a separate ad-hoc services for those requiring support outside the typical short term model interventions. As always, we would advise caution around an Employee Assistance Programmes being perceived as stepping in place of other services, such as the NHS or Private Medical Insurance especially given Improving Access to Psychological Therapies (IAPT) programme(s), in England and Wales provide the majority of treatment for depression in primary care (Gyani, Pumphrey, Parker, Shafran, & Rose, 2012). However, do believe that there is value in Employee Assistance Programmes being able to support	Thank you for your comment and for drawing our attention to the Gyani et al. (2012) citation. In line with NICE processes, we have recommended those interventions where there is evidence of their clinical and cost effectiveness. However it is not within our remit to specify who should provide these interventions and so we are not able to comment on Employee Assistance Providers and how they work.

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				depression where clinically appropriate (within defined remit and scope) acknowledging that the recommendation of counselling as a secondary treatment and the introduction of group CBT is not applicable across all service providers with the predominant focus of the revised guidance being primary care and IAPT services. For example: We currently provide individual self-help utilising CBT techniques (such as behavioural activation and applied problem solving techniques) on a 6-8 session model, or alternatively, via computerised CBT on an 8 module model, supported by up to six support calls with a trained practitioner, operating on a 9 to 12-week duration (as opposed to a six-week duration). However, for group-based CBT as a first line treatment would cause detriment to our standard service levels, delaying individuals in accessing support given the national spread and varying requirements of those individuals utilising our service. This support has increased feasibility when via primary care services given the nature of numerous referrals solely for depression.	
British Association for Psychopharmacology	Short	17	18-21	Section 1.4.20 This refers to the therapeutic level of lithium being between 0.4 and 1.0 mmol/l. We wonder how NICE determined this range. There is very little evidence to guide what the therapeutic range should be in unipolar depression. However, the analysis of Bauer et al. 2013 (J Affect Disord. 2013 Oct;151(1):209-19) suggests	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of

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				significantly worse outcomes for patients when levels are below 0.6 mmol/l. We would recommend this as the normal lower limit UNLESS there is a clinical reason to use lower levels (e.g. due to significant adverse effects even at 0.6 mmol/l).	recommendations reviewed in light of this updated data.
College of Mental Health Pharmacy	Short	17	1-4	We feel that you need to explain here that there may be a greater risk of death from venlafaxine because it was used in people with more severe depression and at higher doses.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
The Royal College of Psychiatrists	Short	17	18-21	Section 1.4.20. The therapeutic level of lithium is described as being between 0.4 and 1.0 mmol/l. but an analysis (Bauer et al. J Affect Disord. 2013; 151: 209-219) suggests clinical outcomes are noticeably worse when lithium levels are below 0.6 mmol/l.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
College of Mental Health Pharmacy	Short	17	15-17	We welcome this	Thank you for your comment.
Hyperparathyroid UK Action 4 Change	Short	17	11	I was on Lithium for 18 months post parathyroidectomy. It was 2015 when I finally came off all psych meds and 3 months later hyperparathyroid symptoms returned. I	Thank you for your comment and for providing this information. This guideline is about the treatment and management of depression in adults.

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				believe now the meds I was on were masking the hyperparathyroid symptoms.	Therefore it is outside the scope of this guideline to make recommendations on the diagnosis or management of hyperparathyroidism or the management of depression associated with hyperparathyroidism
Hyperparathyroid UK Action 4 Change	Short	17	11	Calcium should not only be monitored for people taking lithium, but all those diagnosed with depression. I recently found out that blood tests in 2009 showed calcium at the top end, and in 2011 calcium had risen over the top. In 2012 I saw the same GP about quite heavy depression and was offered very little support. If the GP had borne in mind the blood tests, it could all have been resolved years ago. I've battled depression on and off over the past 7 years, and only got diagnosed with HPT last October.	Thank you for your comment and for providing this information. This guideline is about the treatment and management of depression in adults. Therefore it is outside the scope of this guideline to make recommendations on the diagnosis or management of hyperparathyroidism or the management of depression associated with hyperparathyroidism.
Hyperparathyroid UK Action 4 Change	Short	17	11	Early 2009, presented to GP with depression, SSRI 6 months & CBT. Then blood test for thyroid, and basic panel done and renal issue flagged up, off to hospital. Just found first consultant report, high calcium and high PHT mentioned 9 years ago, no follow up until last year, was on anti-depressants until 2014. I agree PHPT should be tested for when presenting with depression, not just when prescribed lithium.	Thank you for your comment and for providing this information. This guideline is about the treatment and management of depression in adults. Therefore it is outside the scope of this guideline to make recommendations on the diagnosis or management of hyperparathyroidism or the management of depression associated with hyperparathyroidism.
UK Council for Psychotherapy	Short	19	13	Less severe depression 1. Overly restrictive criteria for recommending Short-Term Psychodynamic Therapy (STPT) 2. Absence of recommending other forms of psychotherapy such as Humanistic, Integrative, creative and embodied approaches to	Thank you for your comment and for drawing our attention to the RCGP/NSPCC (2014), Brauninger (2012), Bradt et al. (2015), and Ren & Xia (2013) citations.

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				psychotherapy such as Dance Movement Psychotherapy and Body Psychotherapy, and Family/Systemic Therapies. The guideline proposal is based on an uncertain methodology that raises grave concerns for the UKCP about the validity of its recommendations, not least in regard to public risk. For example, advice to treat depression first if there are comorbid anxiety symptoms, but consider treating anxiety first if there is an anxiety disorder, comes across as confusing and does not centre the person's experience or priorities, and also does not permit that an effective therapeutic approach, within a collaborative therapeutic relationship would be supporting the person to create positive change in whatever she / he / they find troubling, regardless of how many or how few categorical labels can be applied (see also arguments above of the flaws of strict categorisation in a situation that presents high levels of co-morbidity and remains largely complex). We are also seriously concerned about the fact that other forms of psychotherapy are not mentioned despite evidence to suggest that a wider range of psychotherapies are as effective as CBT, while when particular psychological approaches are mentioned, the recommendation is highly restrictive.	Couple interventions were considered in the pairwise meta-analysis. The Pinquart 2016 systematic review that you drew our attention to includes two additional studies on couples therapy will be included in the analysis when we update the evidence. Please see below for details of what has happened to the other references that you have provided. • Bower 2011, Koch 2014, Meekums 2015, Ritter 1996 and Steinert 2017 systematic reviews have been checked for any additional relevant studies but no new studies that met our inclusion criteria were identified • The aetiology of depression was outside the scope of this guideline (Hansson et al. 2010; Bifluco et al. 2006) • Pybis 2017, Röhricht 2015, Zubala 2015 and 2018 have not been included in the guideline because they do not meet the study design criteria (not an RCT or systematic review of RCTs) • Ward 2000 is already included in the NMA for treatment of a new depressive episode • King 2014 could not be included as it is a secondary analysis of a study that was already included in the NMA of treatment of a new depressive episode (Ward 2000)

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				For example, the guidance indicates that in cases of less severe depression, short-term psychodynamic psychotherapy (STPT) can be offered only in cases where CBT, exercise or facilitated self-help, or medication did not work for an earlier episode of depression or are not wanted. While the draft guidance includes Short-Term Psychodynamic Psychotherapy (STPT) as a recommended treatment for depression, we are concerned that it is only recommended in unjustifiability limited circumstances. The guidance indicates that STPT can only be offered where CBT, exercise or facilitated self-help, or medication did not work for an earlier episode of depression or are not wanted, *and* a person requests help with emotional and developmental difficulties in relationships. The requirement that a person asks for help with '*emotional and developmental difficulties in relationships'* is problematic on a number of grounds. Firstly, the experimental evidence does not justify this requirement. For example, a recent meta-analysis comparing STPT to CBT showed comparable effects for *all* cases of depression (Steinert et al, 2017). Secondly, even if client's depression has a developmental origin, it may be manifesting in a different way at the time	• Saxon 2017, Hyvonen 2018 and Karkou et al. (in preparation) will be considered for inclusion in the guideline as we update the evidence • Aalbers 2017 could not be included as music therapy was not prioritised for investigation in the review questions for this guideline Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				they present for treatment. Clients may not make the conscious link between their past experiences and their current difficulties. Evidence indicates that as few as 6.6% of patients identify developmental, childhood difficulties as the cause of their depression when they present in primary care compared with 68.6% who identify current life stressors as the precipitating factor in their depression (Hansson et al, 2010). While developmental difficulties do indeed contribute to the cause of depression, patients with such factors are also more likely to experience difficulties in their *current relationships* (Bifluco et al, 2006) and it is current life stressors that they are far more likely to present with at assessment (Hansson et al, 2010). The guidance makes assumptions about the sophistication of patients' understanding of complex, developmental aetiological models of depression when the evidence suggests that this is not likely to be the case. Such patients with childhood difficulties may benefit from different forms of psychotherapy that address childhood difficulties but would miss the opportunity to receive this psychological intervention given their more likely presentation of current stressors rather than developmental issues. Thirdly, the guidance further assumes that patients are always willing to disclose highly sensitive information	

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				about their historic experience during initial assessment, including childhood abuse and neglect. This is not the case, as guidance from the Royal College of General Practitioners and the National Society for the Prevention of Child Cruelty suggests: '*Knowing and understanding a patient's history is key to providing appropriate support and management but many patients find it hard to disclose a history of abuse and GPs may become frustrated by a seeming inability to help a patient attending frequently with apparently inexplicable symptoms or unsolvable problems'* (RCGP/NSPCC, 2014, p.108). As a result, practitioners would have little opportunity to recommend STPT for patients' depression, and even less opportunity to recommend any other forms of psychotherapy, despite growing evidence of the value of such approaches to dealing with *all* forms of depression and the fact that such approaches may represent the choice of the patient. While we welcome the acknowledgement of emotional and developmental causes of depression within the guidance, the guidance is problematic for patients who: (i) are not likely to receive STPT (ii) are offered no other choice from the wide range of psychotherapy approaches available. Turning to this second point, humanistic and integrative approaches to psychotherapy that are not restricted to counselling for depression are clearly missing, despite, as we have argued above, relevant evidence to suggest that humanistic and integrative counselling and psychotherapy are comparable to other approaches to CBT	

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				psychotherapy (Pybis et al, 2017; Ward et al, 2000; King et al, 2014; Saxon et al, 2017; Bower et al 2011). Thus, these interventions need to be considered for their usefulness for less severe depression and before symptoms of depression deteriorate further. Similarly, creative approaches to psychotherapy with a psychodynamic, humanistic or integrative ethos such Dance Movement Psychotherapy and Body Psychotherapy are not mentioned, omitting existing (and growing) evidence in this area (Meekums et al, 2015; Aalbers et al, 2017; Koch et al, 2014; Ritter and Low; 1996; Hyvonen et al, 2018; Röhricht et al, 2013; Röhricht, 2015). The literature suggests that these might be appropriate types of treatment for people who do not find medication or verbal interaction as their preferred way of engaging with treatment (Zubala and Karkou 2015; 2018; Karkou et al in preparation). The absence of such psychological treatment options in primary care for people with less severe depression contradicts evidence from patients who tend to favour such approaches over other forms of treatment, ignores available evidence of the value of such interventions for all forms of depression and depression as a co-morbid condition with anxiety for example (Brauninger 2012), in cancer care (Bradt, Shim and Goodill 2015) or schizophrenia (Ren and Xia 2013). It is also important to consider why, when exercise and CBT are strongly recommended as first line treatment options for people with less severe depression, approaches to	

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				psychotherapy that combine physical with psychological components are not also considered as (i) first line treatment options and (ii) after other approaches have not worked. Systemic/family therapy is also missing, contradicting existing clinical judgement and current practice. In Children and Young people's IAPT services for example, systemic therapy is one of the approaches IAPT practitioners can be trained in. This seems lacking in the adult guidance. Systemic therapy is about a relational view - it may work with several people in relationship (family, couple, etc.) or it may work with an individual in a relational way. Since a very common issue in depression is social isolation, a relational approach will be key for many people, not just for those in a couple whose relationship is deemed to be either contributing towards depression, or that depression is having an effect on the relationship. Relations go much wider than this. Again, evidence is missing for systemic therapy that shows effectiveness in mood disorders, including depression, (more effective than control, comparable efficacy to other therapies, and in combination with medication more effective than medication alone). Efficacy of systemic therapy on adults with mental disorders by Pinquart et al (2016). And we think it should be included as a first line option, where there are issues in	

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				relationships or because of social judgement, stigma or discrimination against them. Within the draft, room is made for CBT, IPT, short term psychodynamic therapy and behavioural couples therapy. If the GDG were to broaden this to a range of approaches, embracing interpersonal approaches, short term psychodynamic approaches, systemic approaches (individuals as well as with couples and families), Jungian, psychoanalytic, humanistic and integrative approaches including person-centred, Gestalt, transactional analysis, transpersonal, and creative/embodied psychotherapies such as dance movement psychotherapy and body psychotherapy next to psychodrama and arts psychotherapies, then the emphasis will be on broader range of therapies with an evidence base. This can then be combined with personal choice and session-by-session monitoring to tailor towards the best outcome, according to that person's experience.	
Association for Dance Movement Psychotherapy UK	Short	19	13	Dance Movement Psychotherapy as a first line of treatment for less severe depression Creative, arts-based and embodied approaches to psychotherapy such as Dance Movement Psychotherapy are not recommended here, omitting existing (and growing) evidence in this area as we see above. Further research literature suggests that these might be appropriate types of treatment for people who do not find	Thank you for your comment and for drawing our attention to the Brauninger (2012), Bradt et al. (2015), and Ren & Xia (2013) citations. Please see below for details of what has happened to the other references that you have provided. • Zubala 2015 and 2018 have not been included in the guideline because they do not meet the

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				medication or verbal interaction as their preferred way of engaging with treatment (Zubala and Karkou 2015; 2018; Karkou et al in preparation). The absence of such psychological treatment options in primary care for people with less severe depression contradicts evidence from patients who tend to favour such approaches over other forms of treatment, ignores available evidence of the value of such interventions for all forms of depression and depression as a co-morbid condition with anxiety for example (Brauninger 2012), in cancer care (Bradt, Shim and Goodill 2015) or schizophrenia (Ren and Xia 2013) as indicated above. It is also important to consider why, when exercise and CBT are strongly recommended as first line treatment options for people with less severe depression, approaches to psychotherapy that combine physical with psychological components are not also considered as (i) first line treatment options *and* (ii) after other approaches have not worked.	study design criteria (not an RCT or systematic review of RCTs) • Karkou et al. (in preparation) will be considered for inclusion in the guideline as we update the evidence Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Brighter Tomorrow Ltd	Short	20	8	I raise a general concern regarding 1.5.4 on line 8. The question I ask is what is limit of the group exercise? If it is done by someone who has physical education background without training as mental health profession and the group is strictly limited to exercise then no issue. However the group allow discussion of depression or sexual abuse issue then the group can lead to worsening of someone's condition. Also, it can lead to creation of false memories. Should the latter is true then there need to be monitoring	Thank you for your comment. What constitutes a physical activity programme is defined in the recommendations - aerobic exercise of moderate intensity. We have not looked at the evidence on social media and so are not able to make recommendations on this.

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				and regulation to protect participants from harm. Finally what limits on social media and other contacts are in these groups? Again there can be harm being done.	
UK Council for Psychotherapy	Short	20	10	Severe depression 1. Overly restrictive criteria for recommending STPT for severe depression. 2. Absence of recommending other forms of psychotherapy such as Humanistic, Integrative, creative and embodied approaches to psychotherapy such as Dance Movement Psychotherapy and Body Psychotherapy, and Family/Systemic Therapies. Consistent with our comments above regarding less severe depression, for the treatment of severe depression we think that it not is appropriate for STPT to be offered only in cases where CBT, exercise or facilitated self-help, or medication did not work for an earlier episode of depression or are not wanted, *and* patients have identified for themselves aetiological developmental factors and are willing to disclose their emotional and developmental relationship difficulties at assessment. We also urge NICE to include in this guideline other forms of psychotherapy such as humanistic, integrative and creative approaches to psychotherapy such as dance	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				movement psychotherapy and body psychotherapy next to systemic and family therapy approaches. Some of the advice to use manuals may be to guide less experienced and trained IAPT practitioners, and a manual can be a resource to support a therapist develop therapeutic skills, however this fits more with some approaches (CBT and IPT for example) than others (certainly most forms of psychotherapy, particularly those which emphasise client as expert, working collaboratively, prioritising client goals over symptomatology and which develop according to the specific skills, social and relational resources which the person brings with them to therapy).	
	Short	20	10	Dance Movement Psychotherapy as a first line of treatment for severe depression As above, we also urge NICE to include in this guideline creative, arts-based and embodied approaches to psychotherapy such as dance movement psychotherapy, considering existing evidence that follows both its current methodology and an expanded version of this methodology that takes into account professional expertise and patient choice. The need to create a good fit between the needs of patients and existing therapies is imperative. With severe depression in particular, creative, arts-based and embodied approaches to psychotherapy that do not rely on verbalisation such as dance movement	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				psychotherapy are particularly relevant, especially given the limited verbal interaction that can be achieved when someone is seriously depressed.	
The British Psychological Society	Short	20	19	The Guideline Committee devised a method for dichotomising study populations into 'More severe' or 'Less severe' in order to account for baseline severity when determining treatment effect. This approach has no scientific validity and overrides the categorisations of severity used by well-established measures as well as established methods of calculating the clinical significance of treatment effects. This dichotomy is also relied on for the Network Meta-Analysis. Indeed the Guideline Committee admit that this dichotomisation was driven by their wish to conduct a Network Meta-Analysis, which is an inappropriate form of reverse engineering, particularly as dichotomization inflates effect sizes (Hengartner, M, 2017). The Guideline Committee claim that this dichotomization was supported by and will benefit General Practitioners but there is no present evidence of this claim. With respect to the specific recommendations, the recommendation of offering individual self help (with a CBT focus) as an initial treatment for people with less severe depression, presents a challenge to the current service delivery model. Firstly, offering self-help to every patient with less severe depression has significant cost implications. Secondly, there is the lack of trained CBT practitioners to deliver this.	Thank you for your comment. Following the exceptional consultation on the Depression (update) guideline between 15 May and 12 June 2018, the committee discussed the comments received. Regarding the methodological criticisms raised by stakeholders, the committee agreed that the methods used in the guideline were not fundamentally flawed as had been suggested by some stakeholders. More detail on the key issues raised, and a response to these issues, is provided in the table at the end of this document. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				A potential way of tackling these challenges is to offer a group based intervention (using a CBT model) and where necessary to provide individual treatment for those for whom assessment dictates that group treatment is not suitable. This is one example of what is currently done, and is more in keeping with a stepped care, cost effective approach. Significant funding and resourcing would need to be added to the system to implement the new recommendation of offering individual self-help (with a CBT focus) as an initial treatment for people with less severe depression.	
NHS England (IAPT Team)	Short	20	19	Section 1.5.1 the first reference here [1.5.1] is to 'self-help with support' under a heading 'Low Intensity Psychological Interventions' and it is not until [1.5.2] that CBT is mentioned. The recommended low intensity interventions are all CBT based. We think it would be helpful if this could be reflected in the "self-help with support term" throughout. Consider something like "self-help based on CBT principles with support" or "CBT self-help with support".	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
South West London & St George Mental Health NHS Foundation Trust	Short	20	19	The recommendation that first-line low intensity interventions for depression are to be limited to guided self-help, and the associated removal of low intensity groups as a first line intervention for depression, is disappointing and will be challenging to implement. This recommendation will significantly increase the treatment	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of

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				capacity required to treat the large numbers of patients that enter our IAPT services with a primary diagnosis of depression and will have significant cost implications as well as implications for waiting times for patients. It is also disappointing as our trust IAPT services has tended to see better outcomes from our low intensity groups compared to guided self-help interventions. We would be willing to submit our experiences of running low intensity CBT groups for depression to the NICE shared learning database. Contact Dr Yvonne Hemmings: yvonne.hemmings@swlstg.nhs.uk	recommendations reviewed in light of this updated data.
Brighter Tomorrow Ltd	Short	20	23	I challenge line 23 on page 20. What is written material? For example, 'Courage to Heal,' is highly litigated that some claim destroys families and creates false memories of abuse. Is such a book suitable when no someone has no history of abuse and comes in with a complaint of feeling "down?" I believe, it is not since it is not appropriate use taxpayers' money and it unnecessarily puts the patient as risk. Not to mention their family and ultimately hurts society.	Thank you for your comment. This refers to the use of written self-help material
NHS England (IAPT Team)	Short	20	25	"have support from a trained practitioner" leaves too much scope for variation in the training that is recognised, e.g. a one-day in house training. This is a particular risk as the delivery of low intensity interventions is not regulated by a registering body. It would be safer to say "Have support from a trained psychological wellbeing practitioner or other qualified mental health professional".	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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Brighter Tomorrow Ltd	Short	20	25	I question the use of the word,"… trained practitioner…" what is a trained practitioner? What qualification do they require? How are they monitored?	Thank you for your comment. Ensuring that staff are appropriately trained and qualified will be a matter for local implementation.
NHS England (IAPT Team)	Short	21	1	"Typically consist of up to 10 sessions" - only defining an upper limit risks services offering sub-therapeutic 'doses'. See our general comment. We would appreciate an amendment which makes it clear that the average dose should also be in line with the practice in RCTs that generated the guidance.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
NHS England (IAPT Team)	Short	21	16	Is there scope to determine what is meant by a High Intensity BA based intervention? We are concerned that lack of specification will lead to confusion as a form of BA is also used as a low intensity intervention by PWPs.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
NHS England (IAPT Team)	Short	21	19	Earlier in the short guide reference was made to physical activity as a treatment for depression, but the language here and in some other places refers to 'exercise'. Our understanding is that the evidence is for physical activity more generally rather than just formal exercise programmes. If the panel agrees, perhaps the term physical activity could be used throughout the guideline. Alternatively, if the panel thinks the evidence base is more	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				restricted to formal exercise programmes, perhaps the term exercise could be used throughout the guides. Either way consistency would be appreciated.	
Interpersonal Psychotherapy UK	Short	22		We welcome the recommendation for 3-4 maintenance sessions over 3-6 months for less severe depression and rewording of the rationale but would request clarity of the distinction between follow up sessions, which might be characterised as 'check ins' and maintenance sessions, which are formulation and goal based and carefully contracted.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Interpersonal Psychotherapy UK	Short	22	1-9	The committee has maintained the recommendation that IPT is *considered* as an intervention for less severe depression, on the basis of combined clinical and economic analyses. The committee recommends that IPT is considered if the person, "would like help for interpersonal difficulties that focus on role transition or disputes or grief". The committee has speculated that IPT will be more effective and cost effective for this sub population than the "general" population with less severe depression. It is of concern that this recommendation is based on opinion and not evidence, most if not all trials to date did not include this specification. This recommendation is incompatible with understanding of the functional and social impairment, which form core diagnostic features of depression, and are highlighted elsewhere in this document (Full Guideline	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				2.3). We accept that not every patient will choose to pursue a interpersonally formulated treatment and welcome careful consideration of patients' wishes in selecting an evidence-based intervention. However, the formulation of key factors that will serve as the focus of treatment is the result of careful and collaborative assessment and may not be readily identified by an individual prior to this assessment when the care pathway is being chosen. Identifying a focus prior to assessment is explicitly warned against in IPT practitioner training. In addition, the committee explicitly recommends, "emphasising the importance of decisions about treatment and risk of severity, being made in discussion with the person", (Full guideline 7.4.5.2, lines 25-34), yet the recommendations are inconsistent in applying this principle, with prior positive experience of a treatment only being included for CBT and BA (Short 1.5.5, line 21) and not being extended to patients with prior positive response to IPT. No evidence is provided to support this inconsistency, which risks disregarding the opinions of client with prior experience of IPT. Further, the committee does not provide an explanation of why only three of the four focal areas in IPT are specified in this recommendation. The fourth focal area, originally described as interpersonal deficits and now more	

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				commonly referred to as interpersonal sensitivities, addresses difficulties in establishing and maintaining meaningful and satisfying relationships. This focal area has been very extensively used in the UK and is frequently reported to be one of the most commonly selected focal areas when IPT is delivered in IAPT services. All trial based evidence available for IPT for depression has included aplications of all four focus areas and does not allow for effective differentiation between them in terms of acceptailty or effectiveness. When this question has been addressed empirically, no differences were found (Levenson et al, 2010). The committee offers no explanation for the exclusion of this theme, raising concerns about the breadth of understanding of the model and the implications of removing this care pathway. The committee should reword this recommendation to represent the full clinical application of IPT, include past response to IPT as a consideration in selecting treatment and highlight the importance of enquiring about the relevance of a range of interpersonal triggers and contextual factors that may have contributed to the onset of depression during pre-treatment screening.	
Interpersonal Psychotherapy UK	Short	22	10-11	It is of considerable concern that the current draft guideline has reworded the recommendation on duration of treatment to, "up to 16 sessions". This is considerably weaker than the previous recommendation, which explicitly required 16 sessions, ensuring consistency with published manuals. It is also inconsistent with the	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of

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				guidelines expressed guiding principles, which include, "use [of] appropriate manuals" (Full guideline,7.4.5.2 lines 42-48, 1-4). Suggesting a maximum rather than a minimum number of sessions introduces considerable scope for interpretation, making provision of 1 and 16 session interventions equally consistent with the recommendation and is not in line with the exisint evidence base. It is well evidenced that many services have delivered recommended interventions in far fewer session than the published evidence recommends. This guideline must provide a robust defence of minimally acceptable standards, including circumstances in which delivery over fewer sessions would be acceptable and consistent with available evidence, to guide these service level decisions. The duration and format of treatment must be linked to published treatment manuals.	recommendations reviewed in light of this updated data.
Interpersonal Psychotherapy UK	Short	22	14-15	The guideline suggests that, "When giving individual CBT, BA or IPT, also consider providing: 2 sessions per week for the first 2–3 weeks of treatment for people with less severe depression" The rationale behind this recommendation for a population with less severe depression is unclear, as is the omission of this recommendation for more severe depression, when it may be assumed that the person may experience	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				greater obstacles to engaging gin therapy and may be less motivated to initiate change.	
South West London & St George Mental Health NHS Foundation Trust	Short	22	1	The description of when IPT might be considered for less severe depression is arbitrary in identifying only three of the four focal areas for this model (grief, disputes and transitions). In clinical practice we see the fourth focal area (difficulties forming and maintaining relationships, known as "sensitivities") accounts for a significant proportion of casework using IPT in IAPT. There is no theoretical or evidence based rationale for removing the fourth focal area, and the absence of the fourth focal area is also inconsistent with the recommendation for more severe depression, where no such thematic constraint is applied. The description of when IPT can be useful should be expanded to include recurring difficulty in either forming or maintaining satisfying relationships.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
NHS England (IAPT Team)	Short	22	10	"Provide individual CBT, BA or IPT to treat less severe depression in up to 16 sessions, each lasting 50–60 minutes, over 3–4 months". By only specifying the upper limit to session numbers there is a risk that services will offer a sub-therapeutic 'dose'. See our general comment. We would appreciate an amendment which makes it clear that the average dose should also be in line with the practice in RCTs that generated the guidance.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
NHS England (IAPT Team)	Short	22	20	It is good to see group-based CBT relegated for consideration until after other interventions are tried first or	Thank you for your comment. Following feedback from stakeholders, the guideline committee and

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				patient explicitly states a preference. Is further specification following the evidence regarding groups possible, even if only in the full guidance? Groups commonly employed can vary, especially from group based 'psychoeducation' (based on models such as Jim White's 'Stresspac', to supporting CBT self-help interventions in groups. Whilst specification as to group size and duration is given, no specificity is given as to type of group and this may present challenges in the event the evidence supports certain group type.	NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Mental Health Foundation	Short	22	25	The guidance places unnecessary limits on the applications of Mindfulness Based Cognitive Therapy (MBCT). Within these guidelines, the role of MBCT is restricted to those at high-risk of relapse (those who have had three or more previous episodes), and who have already received pharmaceutical/psychological interventions. We would advocate that MBCT and indeed Mindfulness Based Stress Reduction (MBSR) are effective as preventative and protective measures. A systematic review and meta-analysis conducted by Gu et al in 2015 evaluated mechanisms of action underlying both MBCT and MBSR. Inclusion criteria meant that studies were included if their outcome variables assessed mental health and well-being, rather than specifically for Major Depressive Disorder. In addition, studies were included even if they used adapted versions of MBCT or	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				MBSR. For inclusion, studies must also have included MBCT or MBSR in a mediation analysis. These two mindfulness-based approaches were collapsed into one intervention category. A total of 20 studies were included in this review, and of these only nine included depressive symptoms as an outcome variable. Other outcomes included anxiety, stress, mood state, quality of life, and anger expression. The results of the narrative review showed strong and consistent evidence for cognitive and emotional reactivity, moderate and consistent evidence for mindfulness and repetitive negative thought, and preliminary but insufficient evidence for self-compassion and psychological flexibility as mechanisms of change within mindfulness-based interventions for clinical and nonclinical outcomes. The results of the two modelling analyses showed that both mindfulness and repetitive negative thought were significant mediators of the effect of MBCT/MBSR on mental health outcomes, including anxiety, depressive symptoms, general psychopathology, stress, and negative affect. These findings provide evidence that mindfulness is likely an influential factor in the effectiveness of MBCT for psychopathology. Indeed, the stipulation that MBCT can only be offered after other interventions runs contrary to the stated NHS goals of enabling patients to have more options in their treatment. This has been at the forefront of the patient	

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				choice agenda set out by the Secretary of State and the Department of Health, and is particularly pertinent where patients have strong aversions to other forms of psychological therapy or medication. Patients, of course, can only choose from what is available. It is crucial to broaden professional skillsets of staff so that MBCT can be offered more widely. Currently, the guidance offers MBCT on a par with CBT and the proposed change bears a risk that NHS Trusts will limit their offering to the latter because this is the modality where they have existing services. MBCT is a popular specialism for health professionals, and allowing staff to train to extend their portfolio of expertise could help tackle challenges around recruitment and retention.	
College of Mental Health Pharmacy	Short	11 and 12	26-29 and 1-9 respectively	This section assumes that "all interventions" are entirely psychological therapies. This is in conflict with the remit of the document and that other therapies are included	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
NHS England (IAPT Team)	Short	23	3	"typically consists of up to 12 weekly sessions of up to 2 hours each, for up to 6–8 participants". By only specifying the upper limit to session numbers there is a risk that	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for

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				services will offer a sub-therapeutic 'dose'. See our general comment. We would appreciate an amendment which makes it clear that the average dose should also be in line with the practice in RCTs that generated the guidance.	those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Mental Health Foundation	Short	23	11	The guidelines refer to Mindfulness Based Cognitive Therapy (MBCT) as being delivered in a group setting of up to 15 participants. This neglects the fact that this modality can be highly effective when applied as an online training module. There is growing evidence (Stjernswärd 2016, Krusche et al 2013, Morledge et al 2013, Monshat 2012, Gluck et al 2011, Wolever et al 2012) for well-structured online mindfulness courses being as effective as other face-to-face interventions and online courses for stress, even without a therapeutic alliance. Studies are finding that online mindfulness courses can be beneficial for depression in samples with IBS and epilepsy and anxiety symptoms in a non-clinical sample comparing a 3-week mindfulness course with positive psychology interventions and treatment as usual. Online courses are not restricted by access issues in the same way as face-to-face approaches, and can be a preferred option for those who do not find face-to-face therapy appealing.	Thank you for your comment. In terms of categorising interventions, computerised MBCT would be classified as self-help (with or without support depending on the level of guidance involved). Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data. Please see below for details of what has happened to the references that you have provided. • Gluck 2011 could not be included as the depression scale is not within the protocol for this review (added to excluded list) • Morledge 2013 and Wolever 2012 could not be included as the interventions were targeted at stress not depression

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				We recommend that NICE amending the guidelines to reflect the availability of online MBCT training, in addition to face-to-face options.	• Krusche 2013 and Monshat 2012 could not be included as they do not meet the study design inclusion criterion (not an RCT or systematic review of RCTs) • Stjernswärd 2016 will be considered for inclusion in the guideline as we update the evidence
NHS England (IAPT Team)	Short	23	16	Recommendation is that counselling "is based on a model developed specifically for depression". We feel this is not strong enough as it could be interpreted as supporting any form of counselling that the developer feels is appropriate for depression, even if that particular form of counselling has not been tested in positive randomised controlled trials. To safeguard against this we suggest an amendment along the following lines: "is based on an empirically validated protocol developed specifically for depression and supported by an evidence-based competence framework for practitioners".	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
NHS England (IAPT Team)	Short	23	17	"consists of up to 16 individual sessions each lasting up to an hour • takes place over 16 weeks". By only specifying the upper limit to session numbers there is a risk that services will offer a sub-therapeutic 'dose'. See our general comment. We would appreciate an amendment which makes it clear that the average dose should also be in line with the practice in RCTs that generated the guidance.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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South West London & St George Mental Health NHS Foundation Trust	Short	24	19-28	We welcome the re-inclusion of IPT as a first-line intervention for more severe depression, and consider the new guidelines around combination treatment will be much easier to implement than that in the previous draft.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
College of Mental Health Pharmacy	Short	24	14-17	We welcome this bullet point	Thank you for your comment.
NHS England (IAPT Team)	Short	24	2	Recommendation is that STPT "is based on a model developed specifically for depression". We feel this is not strong enough as it could be interpreted as supporting any form of psychodynamic treatment that the developer feels is appropriate for depression, even if that particular form of psychodynamic treatment has not been tested in positive randomised controlled trials. To safeguard against this we suggest an amendment along the following lines: "is based on an empirically validated protocol developed specifically for depression and supported by an evidence-based competence framework for practitioners".	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
NHS England (IAPT Team)	Short	24	3	"consists of up to 16 individual sessions each lasting up to an hour • takes place over 16 weeks." By only specifying the upper limit to session numbers there is a risk that services will offer a sub-therapeutic	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all

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				'dose'. See our general comment. We would appreciate an amendment which makes it clear that the average dose should also be in line with the practice in RCTs that generated the guidance.	of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Interpersonal Psychotherapy UK	Short	24	23	We welcome and support the return of IPT as a first line intervention for more severe depression in this draft of the guidelines, representing a more accurate representation of the published and practice-based evidence currently available. We appreciate the considerable work that has gone into developing a second draft guideline and giving due consideration to stakeholders responses to the first consultation.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Lundbeck	Short	25	9-15	We previously expressed concern - as did other stakeholders - that mirtazapine is recommended as a first line pharmacological intervention treatment option for a person with "less severe" depression. We are pleased to note that the GC has acted on these concerns, considered revised analyses of the clinically and cost-effective treatments for a new depressive episode and amended the recommendations to remove mirtazapine as a first-line option for the treatment of less severe depression. However, in light of stakeholder feedback about the limited nature of the data on mirtazapine and the lack of SMD data, we are surprised that mirtazapine is still recommended as an option for first-line treatment of more severe depression alongside SSRIs.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				Mirtazapine has a very different side effect profile to SSRIs. The mirtazapine Summary of Product Characteristics (SPC) lists a number of potential drug-to-drug interactions with mirtazapine, including a large number of widely-prescribed drugs including diabetes treatments. The SPC advises mirtazapine can affect alertness and driving, no alcohol should be consumed while on mirtazapine treatment, and the treatment effects of increase in appetite and weight gain affect more than 1 in 10 people treated with mirtazapine (MSD, 2017). As such, in clinical practice, mirtazapine is generally used where sedation may be required, and this is also noted in the recently updated Maudsley Prescribing Guidelines in Psychiatry 13th Edition. Given this profile, we are still concerned that mirtazapine may not a suitable or appropriate pharmacological option for the vast majority of people even with more severe depression and should certainly not be positioned as "on a par" with the SSRIs as a class. As such, we feel that mirtazapine should be described merely as an option "to be considered" for the treatment of more severe depression, and that this recommendation should be accompanied by a full and clear summary of the risks associated with mirtazapine treatment compared to SSRIs. Reference:	

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				Taylor, D, Barnes, T. R. E and Young, A. H (2018) Maudsley Prescribing Guidelines in Psychiatry 13th Edition. Wiley Blackwell. Zispin SolTab Orodispersible Tablets (mirtazapine) SmPC (2017) Merck Sharp & Dohme Limited. https://www.medicines.org.uk/emc/product/6505/smpc.	
Lundbeck	Short	25	9-15	We feel that some more explanation of, and addition of clear statements about, the potential risks and burden associated with "considering" older ADs (TCAs such as lofepramine or nortriptyline) and those with a high side-effect burden (e.g. mirtazapine and weight gain/sedation) is still required. This would put the older ADs on a similar footing to some of the other ADs recommended in the draft guideline, where this information is provided. For example, "paroxetine and venlafaxine are more likely to be associated with discontinuation symptoms, so particular care is needed with them".	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
British Association for Psychopharmacology	Short	25	13-15	Section 1.6.3 There is a recommendation that for people with a history of poor response to an SSRI or mirtazapine that a TCA should be considered. Only lofepramine and nortriptyline are named. What is the rationale for this? The recent Ciprinai meta-analysis (Lancet. 2018 Apr 7;391(10128):1357-1366) found Amitriptyline to have the largest effect size. Additionally, why just a TCA? Why not an SNRI or vortioxetine? We do not understand what evidence is driving this recommendation.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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The Royal College of Psychiatrists	Short	25	13-15	Section 1.6.3. It seems odd to recommend that only a TCA should be considered when patients have not responded to an SSRI or mirtazapine: what about an SNRI (venlafaxine, duloxetine) or vortioxetine?	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Central & North West London NHS Foundation Trust	Short	25	1.6.3	No mention of venlafaxine which is often prescribed as an alternative option to SSRIs and mirtazapine which for some patients can work very well – has this deliberately been excluded based of trial evidence?	Thank you for your comment. Venlafaxine was not included in the NMA analysis for the acute treatment of depression due to concerns about discontinuation symptoms.
Brighter Tomorrow Ltd	Short	25	1.6.4	Completely strike 1.6.4. Psychodymic theory developed by Freud has been discredited including Freud's sexual seduction, which Freud redacted in 1897. Granted psychodynamic comes in many different 'flavours' like Alder and Horney. However these theories lack any scientific validation. Furthermore, psychodynamic is at the core of dangerous therapies like regression and the creation of false memories. I would encourage you to look at the work of Christopher Barden in the US or author Mark Pendagrast. There is no basis that psychodynamic therapy works. I can send you list of books, research, and information to back my point. Instead of causing your email to crash, I will state if you need more information I can do what I can with my contacts to get the information you require. To make the best use of taxpayers' money	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				and protect patients from psychodynamic theory is not an option.	
University of Nottingham	Short	25	9	Recommendation 1.6.3 recommends mirtazapine or SSRI as a first line antidepressant for people with more severe depression. Mirtazapine should not be recommended for severe depression on the grounds of safety and lack of efficacy. We provided evidence to NICE that mirtazapine was associated with an increased rate of mortality, suicide and self-harm, not acknowledged in the revised documentation even in the reference list except Coupland et al (2011). The 2018 guideline revised from the 2017 guideline no longer recommends mirtazapine or SSRI for less severe depression. However the same evidence points to similar problems of increased mortality, suicide and self-harm in people with either less severe or more severe depression. In our large scale primary care database studies using QResearch, mirtazapine is associated with significant absolute increases in rates of suicide, self-harm and mortality in people aged 20-64 years at one year and five years (compared to citalopram, SSRI and no antidepressants (Coupland et al, 2015; Coupland et al, 2018). We accounted for severity of depression and this made no difference to our overall results. The absolute rate increases in mortality are not trivial. We estimate that in people aged 20 to 64 the use of mirtazapine results in an additional 23 deaths per 10,000 people per year in contrast with citalopram and a 3.7 fold increased risk of	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				suicide (an additional 14 suicides per 10,000 people treated per year). These aren't small increases given the number of prescriptions for these drugs (7,526,200 prescriptions for mirtazapine in England in 2016). We previously showed that in people over the age of 65 years, the relative risks of self-harm and all-cause mortality for mirtazapine compared to citalopram were also increased (Coupland et al, 2011). Unlike all other antidepressants the excess in absolute or relative rates of suicide and mortality are robust using sensitivity analyses and over 1 and 5 years. Furthermore, our findings are consistent with a study of FDA Summary Basis of Approval Reports combining mortality rates across short or medium term randomised controlled trials of antidepressants in people with established psychiatric illness (Khan et al, 2013). Most of this mortality is due to suicide. This report by Khan which is not susceptible to residual confounding or indication bias as it is based on randomised trials shows increased risks of mortality and suicide for a group of antidepressants comprising mirtazapine, amitriptyline, imipramine and maprotiline compared with placebo but no increase in suicide with SSRIs. Furthermore, the guideline itself provides no robust evidence that mirtazapine is effective versus pill placebo in severe depression because in the full guideline figures 14 and 16 and Tables 55, 57 and 59, the 95% confidence intervals include no difference in outcome (for remission or	

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				continuous depression symptoms) unlike SSRIs, TCAs or even named SSRIs such as citalopram, escitalopram, fluoxetine or TCAs such as lofepramine. Also the recommendation for mirtazapine as first line treatment in severe depression seems to be based on a total of only 272 patients, from trials several showing unclear/high aspects of bias and mainly short term (6-8 weeks). This hardly seems sufficient evidence to recommend longer term prescribing to potentially hundreds of thousands of people with the most severe type of depression. References. Coupland C, Dhiman P, Morriss R, Arthur A, Barton G, Hippisley-Cox J. Antidepressant use and risk of adverse outcomes in older people: population based cohort study. BMJ. 2011 Aug 2;343:d4551. Coupland C, Hill T, Morriss R, Arthur A, Moore M, Hippisley-Cox J. Antidepressant use and risk of suicide and attempted suicide or self harm in people aged 20 to 64: cohort study using a primary care database. BMJ. 2015 Feb 18;350:h517. Coupland C, Hill T, Morriss R, Moore M, Arthur A, Hippisley-Cox J. Antidepressant use and risk of cardiovascular outcomes in people aged 20 to 64: cohort study using primary care database. BMJ. 2016 Mar 22;352:i1350.	

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				Coupland C, Hill T, Morriss R, Moore M, Arthur A, Hippisley-Cox J. Antidepressant use and risk of adverse outcomes in people aged 20-64 years: cohort study using a primary care database. BMC Med. 2018 Mar 8;16(1):36. Hill T, Coupland C, Morriss R, Arthur A, Moore M, Hippisley-Cox J. Antidepressant use and risk of epilepsy and seizures in people aged 20 to 64 years: cohort study using a primary care database. BMC Psychiatry. 2015 Dec 17;15:315. Khan A, Faucett J, Morrison S, Brown WA. Comparative mortality risk in adult patients with schizophrenia, depression, bipolar disorder, anxiety disorders, and attention-deficit/hyperactivity disorder participating in psychopharmacology clinical trials. JAMA Psychiat. 2013;70:1091–9.	
College of Mental Health Pharmacy	Short	25	13	What is the rationale for including nortriptyline here? It is toxic in overdose and rarely used.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
NHS England (IAPT Team)	Short	26	6	"follows the behavioural principles for couples therapy" is rather loose, as it allows for a wide range of different approaches to be implemented. To safeguard against this suggest this is amended to: "follows the behavioural	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline

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				principles for couples therapy, supported by an evidence-based competence framework for practitioners"	update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
College of Mental Health Pharmacy	Short	27	2-23	We welcome this	Thank you for your comment.
South West London & St George Mental Health NHS Foundation Trust	Short	27	9-11 and 24-28	The guidance in these two sections appears contradictory, first suggesting that relapse prevention should follow CBT principles and later allowing space for the suggestion that 4 sessions of the treatment already received by the patient could be added for the purposes of maintenance, if a relapse prevention component exists for the treatment already received by the patient. It is not clear why having had a combination treatment instead of psychological therapy alone would mean that you should have CBT maintenance instead of maintenance work following the theoretical model already received. The switch of model for maintenance work from, e.g., IPT to CBT would be logically inconsistent to patients, and would be difficult to implement in practice, as this could require a change of therapist as well as therapy. Socialising patients to CBT quickly enough to effectively implement a CBT based relapse prevention intervention would be challenging for therapists working with patients who have never engaged in CBT before. We would like to see the suggestion that maintenance work could continue in the model received applied to those who have received combination therapy	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				as well as those who have received psychological therapy alone.	
South West London & St George Mental Health NHS Foundation Trust	Short	27	27-28	We would welcome clarification that the suggestion that relapse prevention might be offered in the form of "4 more sessions of the same treatment if it has an explicit relapse component", is indeed making way for the use of IPT-M (IPT maintenance sessions) for those who have received IPT as a first line intervention for more severe recurrent depression.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
The Mindfulness Initiative	Short	27	12	PATIENT CHOICE According to the Adult Psychiatric Morbidity Survey (APMS)xxv, the majority of adults in England with conditions such as anxiety or depression do not receive treatment (61% in 2014) An increase in treatment (up from 24% since 2007) was mainly driven by a steep rise in the use of psychotropic medication ("One in five adults with [Common Mental Disorder] symptoms reported psychotropic medication use in 2000 (19.3%) and 2007 (19.6%), compared with one in three in 2014 (34.5%)"). Although, treatment rates were highest in those with depression (61.3%), it is unacceptable that 4/10 of those surveyed who require support still did not access treatment and this is a sign that NHS should be widening choice. Research by Sansone et alxxvi suggests that approximately half of psychiatric and primary care patients	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				prematurely discontinue antidepressant therapy. Trivedi et alxxvii indicate that only 25 to 50 percent of patients with major depression adhere to treatment. Therefore there are a substantial proportion of people experiencing depression who are not receiving treatment, at a cost to their health, employment and financial status, education and family life. In other countries more emphasis is placed on the choice offered to people experiencing common mental health disorders, with a resulting increase in adherence to the treatment undertaken and an increase in self reported recovery. Mindfulness-Based Cognitive Therapy (MBCT) is unique amongst interventions for depression in that it has wide, mainstream appeal and is non-stigmatising. One reason for this is that mindfulness practice is popular amongst healthy individuals wishing to flourish and those who consider their mental health is under pressure as well as those who experience depressive episodes at diagnosable levels (with or without formal diagnosis). This means that the transition to structured and evidence based MBCT is straightforward. Due to the increasing success of mindfulness apps, podcasts and books, many patients will already have tried mindfulness practice in some form, making them more open to taking a clinical course and seeing it through its full 8-12 weeks. Mindfulness-Based Interventions (MBIs),	

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				like MBCT, are consistently found to be 'highly acceptable' to participants in research looking at a wide range of contexts from clinical health applications to schools and workplaces. Halliwellxxviii (2010) found interest from patients and GPs in accessing mindfulness within the NHS. In 2015 the Mental Health Foundation's call for GPs to be able to prescribe mindfulness (MBCT and MBSR) received backing from leading primary care figures, following a national survey showing public interest in the practice to reduce stress. Mindfulness could assist in ensuring greater equality of treatment. The present NHS treatment offers for CMD do not reach all ethnic groups in the UK equally. Equalities legislation would suggest that there should be reasonable adjustment to ensure that there is a wider range of offers and choices, ensuring a more diverse take up of treatment. The APMS found that Black/Black British people with CMD had "particularly low treatment rates". This is likely to be, at least in part, attributable to concerns around stigma that MBCT could resolve for some. Choice over mental health treatments is also most limited for those in lower income brackets. The APMS 2014 (page 23) found that while 1 in 10 adults with severe CMD symptoms asked for treatment and did not receive it (about half of whom were receiving no treatment at all),	

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				those on low income were particularly likely not to be receiving the treatment they had requested. Patient surveysxxix show that medication is half as popular with patients as psychological treatment but only a minority of people are offered this. Due to a lack of treatment choice through the NHS, many people pay for public mindfulness courses to help them manage their CMD. However, this only serves to increase the striking health inequalities in mental disorders, as those in lower socio-economic groups will be less likely to know about MBCT or be able to afford to take a course. It also leaves those with conditions at clinical levels seeking treatment in non-clinical settings without GP supervision. One reason for the popularity of mindfulness courses is that people have experienced and rejected the side-effects of anti-depressant medication. Any side-effects of MBCT are yet to be demonstrated. Structured online MBI offerings are also likely to bring greater accessibility and acceptance and should be considered by NICE using new methodologies for assessing digital innovations. It has recently been reported that US FDA approval is being sought for Headspace's development of a new online mindfulness app for CMD and the NHS Healthy Workforce Programme has partnered with Headspace in 12 pilot sites to maintain NHS staff wellbeingxxx. In the UK online mindfulness has been available for some 8 years, is	

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				included in the NHS Apps Library, used by some NHS IAPT services and used by more than 12,000 people reporting good resultsxxxi. In line with the evidencexxxii and in line with the draft guidance submitted in the first consultation, MBCT should be offered as treatment for current depression to increase patient choice.	
The Mindfulness Initiative	Short	27	12	ARBITRARY DISTINCTIONS BETWEEN RECOVERY AND RELAPSE PHASE There is evidence that MBCT is effective both as a first-line treatment for depression (Goldberg, Note vii) and as a preventative treatment for those at risk of depressive relapse. However, in reality depression is often a long-term and cyclical disorder. People experience the symptoms at different intensities at different times. An MBCT course teaches participants how to manage the symptoms of depression, reducing its severity, as well as how to stay well once they have recovered. There is evidence for both outcomes and the guidance should avoid making an arbitrary distinction about the state of the individual at a particular time and support their ongoing commitment to improving and sustaining their mental health. The distinction does not reflect the fluctuating reality of the condition, but it makes the guideline more difficult for GPs	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data. The Goldberg et al. (2018) systematic review has been checked for any additional studies and no new studies that met inclusion criteria were identified.

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				to use to enable their patients to contribute to their own sustained recovery and reduced chances of relapse.	
The Mindfulness Initiative	Short	27	12	PREVENTION The 2016 Five Year Forward Viewxxxiii from the Mental Health Taskforce placed significant emphasis on prevention following this emerging as a top priority in the public consultation of 20,000 people. " In future, new models of care will support people's mental health alongside their other needs ... and will have a greater emphasis on prevention, self-management, choice, peer support, and partnership with other sectors. (p 39) ". We would hope that NICE will consider providing explicit guidance on prevention in mental health in the near future. Thriving at Work: The Farmer Stevenson Reviewxxxiv, stresses the importance of identifying people at work who are at higher risk and cites good practice examples to support staff wellbeing, including employers who provide mindfulness toolkits. Structured MBCT and MBSR programmes enable people who have sub clinical levels of stress, anxiety and depression to take active steps to reduce their risk and to understand how to manage their mental health more successfully. However, as it is a relatively recent innovation, most NHS Trusts still do not offer it. However 72% of UK GPs consider their patients can derive health benefits from mindfulness and two thirds would support campaigns to promote these benefitsxxxv. A national	Thank you for your comment. Prevention of depression is outside the scope of this guideline and we are not able to make recommendations on this issue.

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				survey of GPs found that 52% consider MBCT to be effectivexxxvi. GPs need a NICE Guideline that enables them to offer this choice to their patients who they judge would benefit from this approach to managing their mental health. The current proposed guideline is overly complex in relation to MBCT. This is likely to dissuade NHS Trusts from developing a range of effective preventative options for local patients, with the unfortunate result that patients with depressive symptoms unnecessarily spend long waiting times for treatment when this can result in their conditioning worsening. This misses the opportunity to shift investment into prevention as recommended by the Five Year Forward View and recent Prevention Concordat for Better Mental Healthxxxvii.	
College of Mental Health Pharmacy	Short	29	2-5	We welcome the correction to the onset of action in the first version, but we are not sure where the 3 weeks comes from and how the term "typically" is justified. As per our previous response, there is much data showing 50% improvement compared with placebo non responders at 2 weeks.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
British Association of Art Therapists	Short	29	27-28	Given that the long version of the guideline acknowledges that there is no evidence of benefit from increasing the medication dose, and given that increased dose also increases "side effects", why is this recommendation	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline

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				included? Indeed, the need to increase the dose could be seen as a sign of tolerance and the beginning of addiction, alongside "discontinuation effects". The potential negative consequences of increasing medication dose are similar to those stated above of encouraging people to take medication by persuading them that they are not addictive.	update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Hyperparathyroid UK Action 4 Change	Short	29	6-7	'Health conditions that might explain why the treatment isn't working'. About 5 months post op my 'mood' started to drop again. Now I was still being treated by the Mental health Drs rather than being referred back to the specialist physician or endocrine surgeon.....so hence the SNRI antidepressant I was still on was augmented with Lithium to help maintain my mental health state. I was not followed up post op by the endocrine surgeon, specialist physician or GP because one surgery was supposed to fix hyperparathyroid in their view. I am now being investigated for recurrent primary hyperparathyroidism that I have had to chase this 2nd diagnosis myself.	Thank you for your comment and for providing this information. This guideline is about the treatment and management of depression in adults. Therefore it is outside the scope of this guideline to make recommendations on the diagnosis or management of hyperparathyroidism or the management of depression associated with hyperparathyroidism.
Hyperparathyroid UK Action 4 Change	Short	29	6-7	I was treated with seroxat for depression for 4 years then again diagnosed with depression on and off for the next 10 years and offered CBT therapy and Prozac, only to find I'd had hypercalcemia for most of those 14 years, recorded as high as 2.91 which was ignored by my doctors and hospital.	Thank you for your comment and for providing this information. This guideline is about the treatment and management of depression in adults. Therefore it is outside the scope of this guideline to make recommendations on the diagnosis or management of hyperparathyroidism or the management of depression associated with hyperparathyroidism.
Hyperparathyroid UK Action 4 Change	short	29	6-7	Comprehensive blood tests to exclude any medical reason for the depressive illness should be added. In my case in 2009 my GP did no basic blood tests let alone specific	Thank you for you comment. We think that undertaking blood tests would be encompassed by the current recommendation to assess whether

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				ones. That GP sent me to be admitted to the Mental health unit. The Mental health unit only did basic blood tests and did not even pick up the severe anaemia I had then let alone primary hyperparathyroidism. I was not tested for Parathyroid disease till my 2nd admission to the same Mental health unit in 2012, and then the obvious high calcium and parathyroid hormone levels were not considered enough to cause my major depression. I was incorrectly treated with SNRI antidepressants and became suicidal which is a recognized side effect in some people. Because I tried to harm myself, I was further subjected to mood stabilizers and later, (despite parathyroid surgery being scheduled) forced against my will, electric shock treatments x6. Thankfully that was then deemed enough or these would have continued.	there are any physical health conditions that could explain why the treatment isn't working
Hyperparathyroid UK Action 4 Change	Short	29	6-7	Hyperparathyroidism and low vitamin D needs to be flagged in the Depression Guidelines.	Thank you for your comment and for providing this information. This guideline is about the treatment and management of depression in adults. Therefore it is outside the scope of this guideline to make recommendations on the diagnosis or management of hyperparathyroidism or the management of depression associated with hyperparathyroidism.
Hyperparathyroid UK Action 4 Change	Short	29	6-7	The depression caused by the horrific illness primary hyperparathyroidism is so real! Truth is I'm so down that I'm surviving hour by hour! I just can't wrap my mind around the fact that this is 2018 and the doctors have everything they need right at their fingertips to be able to correctly diagnose us and they don't!	Thank you for your comment and for providing this information. This guideline is about the treatment and management of depression in adults. Therefore it is outside the scope of this guideline to make recommendations on the diagnosis or management of hyperparathyroidism or the

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					management of depression associated with hyperparathyroidism.
Hyperparathyroid UK Action 4 Change	Short	29	6-7	I was on antidepressants 3 times in the 7 years before I was diagnosed with primary hyperparathyroidism.. I had begun to believe that I was simply a grumpy, lazy bitch and I sat and cried with relief when I found out that I had just been sick for all that time.	Thank you for your comment and for providing this information. This guideline is about the treatment and management of depression in adults. Therefore it is outside the scope of this guideline to make recommendations on the diagnosis or management of hyperparathyroidism or the management of depression associated with hyperparathyroidism.
Hyperparathyroid UK Action 4 Change	Short	29	6-7	I believe this section is very important to emphasise with our doctors. There is generally no thought of a cause such as primary hyperparathyroidism by general practioners. Depression is a symptom of PHPT experienced by a high percentage of people.	Thank you for your comment and your support.
Hyperparathyroid UK Action 4 Change	Short	29	6-7	I believe I have had hyperparathyroidism for at least 15 years. I went through a very traumatic divorce 12 years ago, my reaction to it was incredibly bad, abnormally bad, and completely out of character. I had a nervous breakdown, including a suicide attempt, and began a cycle of both physical and mental illness that lasted at least 7 or 8 years. I've battled never ending depression and anxiety ever since my divorce, and I assumed I just became a broken person because of it. I've been doing a lot of thinking since my diagnosis of primary hyperparathyroidism, and what role this disease has played in all of this. I devolved into an entirely different person that the woman I was 15 years ago, would never recognise today. I cannot help but wonder how differently	Thank you for your comment and providing this information.

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				things could have been if I had known about this sooner, and didn't just beat myself up for a decade for not being able to lift myself up out of it.	
Hyperparathyroid UK Action 4 Change	Short	29	6-7	There are MANY physical illnesses that can cause depression and the fact that nobody is testing for them before starting treatment for depression (some of which are harmful and most come with their own side effects). Whilst I appreciate the need to start treatment to preserve potential loss of life, I feel it is very important to run a thorough blood panel for potential physical causes of depression when a person first presents.	Thank you for your comment. This guideline is about the treatment and management of depression in adults. As such it is outside the scope to make recommenations about testing to diagnose other physical illnesses.
Hyperparathyroid UK Action 4 Change	Short	29	6-7	A full range of blood tests are absolutely essential to rule out hypercalcaemia/hyperparathyroidism. This must be top of the list when patients present with anxiety/depression. I suffered for years until a random health check revealed hyperparathyroidism. GPs hopeless and completely disinterested. Told me to exercise and meditate. V difficult to be calm & meditate when you're frantic with anxiety.	Thank you for your comment. This guideline is about the treatment and management of depression in adults. As such it is outside the scope to make recommenations about testing to diagnose other physical illnesses.
Central & North West London NHS Foundation Trust	Short	29	1.9	The Tavistock Depression Study (an RCT) demonstrated a significant treatment effect of eighteen months of weekly psychoanalytic therapy for patients with resistant depression which was demonstrated at four year follow-up. This study is close to our model in K&C psychotherapy and the patient group is of similar severe pathology.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				The NICE guidelines shortened version 1.9 (No or limited response to initial treatment) should include a reference to this study and include this treatment model in service provision particularly as it shows lasting and increasing treatment effects years after the therapy has ended, as opposed to rapid relapse as seen in short term interventions. The Depression Conference UCL March 2018 presented the data on why this study was excluded (only looking at short term outcome) and the arguments for including it. Fonagy, P., Rost, F. Carlyle, J. McPherson, S., Thomas, R., Fearon, P., Goldberg, D, Taylor, D. *Pragmatic randomized controlled trial of long-term psychoanalytic psychotherapy for treatment-resistant depression: the Tavistock Adult Depression Study (TADS)* **World Psychiatry** 2015; 14:312–321	
Assurex Health	Short	29	10	We believe this description of no/limited response should include a comment regarding pharmacokinetics (slow or fast metabolizer) based on reactions to treatment history or pharmacogenetics testing results. Clues to a pharmacokinetic effect may be side effects at very low doses or nonresponse without side effects at high doses.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of

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					recommendations reviewed in light of this updated data.
Brighter Tomorrow Ltd	Short	29	10	At the end of line 10 on page 29, I will ask a new line is added. "if the focus on therapy is on sexual abuse then consider abuse did not occur as a possibility and try treating the symptoms not an underlying cause that may not exist."	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
The British Psychological Society	Short	29	13	The recommendation to provide more support by increasing the number and length of appointments for patients not responding to treatment may not necessarily meet the patients' needs. It is important to have an understanding about the specific reasons as to why the patient is not responding to treatment. Offering more and longer appointment may not address the issue and indeed could make the situation worse. Psychological formulations can be helpful to identify blocks to treatment which may be hindering patient progress.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
British Association of Art Therapists	Short	30	19-23	It is unclear why there is a recommendation to place people who have not responded to initial treatments on more than one type of medication in combination, given (a) the likely increase in side effects, (b) the poor quality	Thank you for your comment and for drawing our attention to the Barr et al. (2012, 2015) and Daly & Delaney (0213) citations. Following feedback from stakeholders, the guideline committee and NICE

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				evidence to support it, as detailed in the long version of the guideline, and (c) the acknowledgement that "treatment resistant depression" tends to be associated with "living alone; lower income; unemployment; male gender; lower education; higher complexity through associated physical or psychiatric disorder" (Long version, p. 361, lines 4-5). Social deprivation should surely be a contra-indication for increased drug treatment since it will not address the powerlessness, lack of hope and loss of meaningful social identity that often go with worklessness, poverty and low educational opportunity and attainment . Relevant research: Barr, B., Taylor-Robinson, D., Scott-Samuel, A., McKee, M., Stuckler, D. (2012). Suicides associated with the 2008-2010 recession in the UK: a time-trend analysis. *BMJ* 345, e5142. http://dx.doi.org/10.1136/bmj.e5142. Barr, B., Kinderman, K., & Whitehead, M. (2015) Trends in mental health inequalities in England during a period of recession, austerity and welfare reform 2004 to 2013. *Social Science & Medicine*, 147, 324e331. http://dx.doi.org/10.1016/j.socscimed.2015.11.009. Daly, M., and Delaney, L. (2013). The scarring effect of unemployment throughout adulthood on psychological distress at age 50: Estimates controlling for early adulthood distress and childhood psychological factors. *Social Science and Medicine,* 80, 19-23. http://dx.doi.org/10.1016/j.socscimed.2012.12.008.	have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
British Association for	Short	30	11-14	Section 1.9.5	Thank you for your comment. Following feedback from stakeholders, the guideline committee and

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Psychopharmacology				If this guideline is followed then a patient who has failed to respond fully to an SSRI after 4-6 weeks (1.9.1) and then a second antidepressant for 2-4 weeks (section 1.9.5) they would be referred into secondary care. This is a MUCH lower threshold for referral that is occurring in practice in much of the UK. This recommendation will have a profound impact on services with secondary care mental health services in particular being put under extreme pressure.	NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
College of Mental Health Pharmacy	Short	30	15-18	We welcome the inclusion of this reference to another NICE publication	Thank you for your comment.
The Royal College of Psychiatrists	Short	30	11-14	Section 1.9.5. This is especially troublesome. If this guidance is applied, a patient who has not responded to an SSRI after 4-6 weeks' treatment (1.9.1) then a second antidepressant after 2-4 weeks' treatment (section 1.9.5) would be referred to secondary care mental health services. This is completely impracticable and would considerable tensions at the primary-secondary care interface.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Assurex Health	Short	30	1	We believe that if a patient wishes to continue with antidepressant treatment after non-response and/or side effects to first line treatment, that the provider and patient consider the benefits and limitations of utilizing PGx testing to guide the next step of medication treatment.	Thank you for your comment. PGx testing was not an area that was prioritised for investigation in the guideline. As such the evidence in this area has not been appraised and we are not able to make any recommendations on this issue.
Assurex Health	Short	30	1	We are concerned that the recommendation of multiple classes including multiple medications is too broad to	Thank you for your comment. PGx testing was not an area that was prioritised for investigation in the

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				effectively guide medication treatment options. We propose that utilizing PGx testing may illuminate what medications may be less genetically optimal for the patient. PGx testing thus utilizes biological information to more precisely determine second-line treatment.	guideline. As such the evidence in this area has not been appraised and we are not able to make any recommendations on this issue.
College of Mental Health Pharmacy	Short	30	2	We feel that it would not be appropriate to use an MAOI at this early stage	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Assurex Health	Short	30	19	We are concerned that without the inclusion of PGx testing as second line treatment guidance, that patients may initiate a long road of polypharmacy by continuing to combine medications that can lead to drug-drug interactions, drug-gene-drug interactions, and an increased risk for side effects.	Thank you for your comment. PGx testing was not an area that was prioritised for investigation in the guideline. As such the evidence in this area has not been appraised and we are not able to make any recommendations on this issue.
British Association for Psychopharmacology	Short	31	3-16	Section 1.9.9 This section causes us great concern, primarily because of the lack of guidance that it actually offers to clinicians. It starts off recommending a combination of antidepressants and then gives just one example (an SSRI + mirtazapine). The second bullet point then correctly states that some combinations of antidepressants are dangerous and then gives the example of an SSRI, SNRI or TCA + an MAOI. However, no other guidance is given.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				We are unclear why. A range of different combinations of antidepressants (e.g. SSRI + SNRI; SSRI + TCA) have little if any evidence to support their effectiveness AND these can also be associated with significant harms. The guidance then goes onto suggest consideration of lithium or an antipsychotic added to an antidepressant. However, again no guidance is given with regards to which antipsychotic. Only a very limited number actually have any evidence of efficacy in this situation (see Cleare et al. J Psychopharmacol. 2015 May;29(5):459-525). Antipsychotics are associated with significant harms. We do not understand why NICE is recommending them as a class when we do not know whether or not they are all associated with benefit. It is a major concern that no other options have been described beyond second line treatment. Unfortunately a significant minority of patients fail to respond to first and second line treatments. NHS clinicians are in need of advice with regards to what treatment options such be considered in such circumstances. There is an evidence base for a number of options including thyroid hormone (Aronson et al. Arch Gen Psychiatry 1996 53: 842–848) and modafinil (Goss et al. J Clin Psychiatry 2013 74:1101–1107. These and other options are included in other guidelines (Cleare et al. J Psychopharmacol. 2015 May;29(5):459-525; Bauer et al. World J Biol Psychiatry. 2013 Jul;14(5):334-85) and are conspicuous by their absence in these NICE guidelines. There is also growing	Please see below for what has happened to the references that you provided. • Cleare et al. 2015 and Bauer 2013 et al. cannot be included as they do not meet the study design criterion for inclusion (not an RCT or systematic review of RCTs) • Aronson et al. 1996 systematic review has been checked for any additional relevant studies and no new studies that met inclusion criteria were identified • Goss 2013 could not be included as the intervention is outside the review protocol (modafinil) • Han 2016 will be considered for inclusion in the guideline as we update the evidence)

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				evidence for the use of ketamine for MDD with published meta-analyses (e.g. Han et al. Neuropsychiatr Dis Treat. 2016 Nov 3;12:2859-2867) and, indeed, a growing number of centres in the UK providing this. We are unclear why NICE has chosen not to mention this at all in the guideline.	
The Royal College of Psychiatrists	Short	31	3-16	Section 1.9.9. This section is far too vague. 1. Combination antidepressant treatment is recommended but only one example is provided. 2. No guidance is offered on which specific combinations might be hazardous. 3. The combination of lithium or an antipsychotic with an antidepressant is mentioned but guidance on which antipsychotic to use is poor. 4. No other options have been described beyond second line treatment: why is this so? There is evidence for a range of options including thyroid hormone and modafinil and ketamine, but guidance relating to these interventions (summarised in other guidelines such as the BAP guidelines of 2015) is missing.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
British Association of Art Therapists	Short	31	3-9	The suggestion to consider adding another antidepressant in consultation with a "specialist" means this approach is not only potentially detrimental to the person's well-being through increased side effects and potential later "discontinuation effects", but involves the added expense of specialist care that is mainly needed for medication monitoring and will not address the root causes of the	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of

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				depression. People may not want psychological therapy for a number of reasons and these need to be addressed. Regarding men finding it difficult to talk about distress, a recent overview of programmes for suicide prevention in men in Quebec province in Canada suggests that it may be beneficial to enable men to see talking about their distress as strong, not weak, and to help service personnel to see past the stereotype of men not seeking help or talking about distress: Roy, P., Tremblay, G., and Duplessis-Brochu, E. (2017). Problematizing men's suicide, mental health and well-being: 20 years of social work innovation in the province of Quebec, Canada. *Crisis,* 39, 137-143. DOI:10.1027/0227-5910/a000477.	recommendations reviewed in light of this updated data.
British Association of Art Therapists	Short	31	13-16	The suggestion of adding an antipsychotic alongside an antidepressant presents additional risk of both psychological and physical harm, and should not be recommended. The reasons why some people do not respond to usual treatments need more attention. One study suggested that a specialist psychosocial treatment could not only reduce depression but also led to increased employment and reduced use of medication at one year follow-up compared to treatment as usual: Stålsett, G., Gude, T., Helge Rønnestad, M., & Monsen, J.T. (2012) Existential dynamic therapy ("VITA") for treatment-resistant depression with Cluster C disorder: Matched comparison to treatment as usual, *Psychotherapy Research*, 22:5, 579-591, https://doi.org/10.1080/10503307.2012.692214	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data. Please see below for what happened to the references that you provided. • Stålsett et al. 2012 could not be included as it does not meet the study design inclusion criteria for the review (not an RCT or systematic review of RCTs)

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				Also see Fonagy, P., Rost, F., Carlyle J., McPherson, S., Thomas, R., Fearon, R.M.P, Goldberg, D., & Taylor, D. (2015). Pragmatic randomized controlled trial of long-term psychoanalytic psychotherapy for treatment-resistant depression: the Tavistock Adult Depression Study (TADS). World Psychiatry, 14:312–321. DOI 10.1002/wps.20267	• Fonagy 2015 is already included in the further-line treatment review. However, it is the only study included for long-term psychodynamic psychotherapy and the committee did not think that a recommendation based on this study was justified given the non-significant effects observed on remission and depression symptomatology
College of Mental Health Pharmacy	Short	31	10-12	We would suggest that you add a statement here making it clear that such combinations should be limited to specialist mental health service recommendation, not primary care.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
British Association for Psychopharmacology	Short	31	17-18	Section 1.9.9 This bullet point specifically refers to the issue of QTc prolongation with citalopram and escitalopram. Why is it in this section? It is of relevance if combining one of these antidepressants with an antipsychotic that may increase QTc. However, the issues are NOT confined only to the addition of other psychotropics. There is a potential concern about citalopram or escitalopram being combined with physical health medicines that also prolong QTc. This statement (final bullet point in section 1.9.9) would therefore be more appropriate in sections 1.4.8 onwards.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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University of Nottingham	Short	31	3	For similar reasons of lack of safety and little robust evidence of effectiveness, mirtazapine should not be used as an example of a combination of medications. Our data showed that combinations of antidepressants are also associated twice the rate of self-harm, 60% increases in all cause mortality with increases in absolute rates of cardiac arrhythmia, gastrointestinal bleeds, adverse drug reactions and seizures over one to 5 years. There is one trial underway at present exploring the efficacy of mirtazapine plus SSRI versus SSRI plus placebo (the MIR trial) but this study has not published its results yet so it is premature to even suggest this combination of antidepressants. Table 115 found 2 RCTs of very low quality of 86 patients of SSRI augmentation with mirtazapine versus sertraline versus placebo.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Assurex Health	Short	31	3	We are concerned that without the inclusion of PGx testing as second line treatment guidance, that patients may initiate a long road of polypharmacy by continuing to combine medications that can lead to drug-drug interactions, drug-gene-drug interactions, and an increased risk for side effects.	Thank you for your comment. PGx testing was not an area that was prioritised for investigation in the guideline. As such the evidence in this area has not been appraised and we are not able to make any recommendations on this issue.
Assurex Health	Short	31	17	We are concerned that this recommendation may imply that escitalopram and citalopram should be used less frequently than other SSRIs. We believe this explanation could be expanded to include a statement with further guidance to reduce the potential of QTc prolongation with these medications. Inclusion of wording that indicates to reference dosing recommendations based on age, CYP2C19 metabolizer status, and concomitant	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				medications is suggested (MHRA 2011; Kumar et al. 2014).	
University of Nottingham	Short	31	19	For the same reasons of safety and lack of robust evidence of effectiveness, mirtazapine should not be recommended for those who have not responded to other treatments for depression. No evidence is given for the effectiveness of mirtazapine when there is no response to other treatments for depression.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
British Association of Art Therapists	Short	32	24-29	Why are only drug therapies recommended here? When people have impaired social functioning and find it difficult to talk in therapy, sometimes an arts-based therapy can be helpful. One-to-one therapy initially can enable someone to begin to interact non-verbally, for example by making marks, and this can establish trust. Later, group art therapy may enable more social interaction and confidence-building. Nan and Ho (2015) reported evidence of improvement in depression and emotional expression following clay art therapy compared to non-directive art control group (Nan, J.K.M., and Ho, R.T.H. (2017) Effects of clay art therapy on adults outpatients with major depressive disorder: A randomized controlled trial. *Journal of Affective Disorders,* 217, pp. 237-245. DOI 10.1016/j.jad.2017.04.014)	Thank you for your comment. Art therapy was not prioritised for investigation in the review questions for this guideline. Consequently the papers that you cite did not meet the inclusion criteria and have not been appraised in the guideline. We are therefore not able to make recommendations about this intervention.
College of Mental Health Pharmacy	Short	32	29	It should be noted that tricyclic antidepressants (including lofepramine) have an anticholinergic burden and are probably not suited for someone likely to have cognitive impairment due to chronic depression.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline

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					update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
British Association of Art Therapists	Short	33	6-12	It is good to see befriending and rehabilitation recommended.	Thank you for yourcomment.
NHS England (IAPT Team)	Short	33	16-17	Either drop the 'a' or amend 'services' to 'service'.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
College of Mental Health Pharmacy	Short	33	2	We feel that there is very little credible evidence for amisupiride. A Cochrane review (Komossa, K *et al*, Second-generation antipsychotics for major depressive disorder and dysthymia, Cochrane library 2010, available at http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD008121.pub2/full/) found evidence that amisulpiride might lead to symptom reduction in dysthymia while no important differences were seen for major depression.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data. The Komossa et al. (2010) systematic review has been checked for any additional relevant studies. However, no new studies that met inclusion criteria were identified.

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NHS England (IAPT Team)	Short	33	33	Provision of 'befriending' in primary care settings would be difficult due to lack of availability of such opportunities and difficulties of implementing appropriate safeguarding structures in such situations.	Thank you for your comment. How befriending services are provided will be a matter for local implementation of the guideline s
The British Psychological Society	Short	34	17	This recommendation may not be appropriate and meet all individual patient's needs. Patients with complex depression, including personality disorders, often require more than one year of treatment. It would be more helpful to decide upon treatment length on an individual basis, in collaboration with the patient, rather than be prescriptive. Depression often manifests as a long-term condition, or becomes a long-term condition if immediate care is inadequate. Depression can also be highly episodic and there is a high relapse rate. For example 38% of IAPT clients are repeat attenders (Hepgul et al, 2016). It is imperative for research to demonstrate that treatment effects are long-lasting, or indeed to note where effects might appear over the long-term follow-up (sleeper effects).	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Hyperparathyroid UK Action 4 Change	Short	34	27	ECT: The mental health Drs felt the SNRI anti-depressant I was on, was not acting quickly enough and I had become suicidal (a known side effect in some people) and tried to harm myself. Because the Drs did not feel that my high calcium and Pth hormone levels would be enough to cause my major depression they despite my protests ordered ECT treatment.	Thank you for your comment and providing this information.

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British Association for Psychopharmacology	Short	18 & 19	7-9 on page 18; 10-12 on page 19	Section 1.4.21 vs 1.4.25 We are unclear why there is a recommendation for antipsychotic use to be monitored in specialist care for 12 months before transfer to share care arrangements, but not for lithium.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
The Royal College of Psychiatrists	Short	18 & 19	7-9 on page 18; 10-12 on page 19	Section 1.4.21 vs 1.4.25. It seems curious to recommend that antipsychotic drug use should be monitored in specialist care services for 12 months before being transferred to share care arrangements, but not to make this recommendation for treatment with lithium, which is rather more complex.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Gorlin Syndrome Group	Short	38	11	How will the following work: 'Refer people with more severe depression or chronic depressive……to specialist mental health services for coordinated multidisciplinary care if……have significant coexisting mental and physical health conditions.'' We agree access to mental health services is an unmet need for people with chronic physical disease, but will practitioners know who and how to refer to for mental health services? Who will arrange and support MDTs?	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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The British Psychological Society	Short	40	9	It is the case that for some community services they do not have a mechanism for expediting cases that started psychological therapy in hospital. If the therapy has been group-based, inpatient psychological treatments encourage people to attend as an outpatient, in order to complete the therapy. However, if the treatment has been individual, inpatient psychology often arrange 1-2 further outpatient appointments in order to wind down and prepare to end the therapy. There is no clear mechanism for transferring to CMHT colleagues other than a referral and placement on waiting list as usual. This does not sound consistent with the proposed NICE guidance and would present an organisational challenge though may represent a better model of care.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
NHS England (IAPT Team)	Short	43	28	"Factors that favour urgent referral to specialist mental health services" This header is misleading as an IAPT service is also specialist at what it does. Suggest rewording to "Factors that favour referral to crisis care / urgent and emergency mental health services".	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
NHS England (IAPT Team)	Short	43	15 & 21	"Factors that favour more active treatment in primary care" & "Factors that favour referral to mental health professionals". These headings and the criteria stated within them are misleading as they suggest that only those with quite severe or recurrent difficulties would be referred	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all

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				to IAPT services (i.e. 'mental health professionals'). To correct this, suggest emending the headers to "Factors that favour more active treatment in primary care, including primary care mental health services" & "Factors that favour referral to secondary mental health services".	of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
University of Nottingham	Short	48	10	In light of weak evidence of effectiveness of mirtazapine and concerns raised by our studies and others about increased risks of suicides/self-harm/mortality for mirtazapine we consider it would be important to have a research question around assessing safety including looking at specific causes of death for mirtazapine before recommending it as a first line treatment in more severe depression.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Central & North West London NHS Foundation Trust	Short	24 and 25	1.5.15 and 1.6.3	In some areas the choice of antidepressant needs to be emphasised which would be dependent on patient preference, physical health and existing co-morbidities	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
NHS England (IAPT Team)	Short	49	30	'Remoralization' should be changed to 'Remoralisation' to reflect UK not US English used throughout the rest of the document.	Thank you for your comment. Following feedback from stakeholders, further work will be done on the content of the guideline. We will check for spelling errors at that point.

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British Association of Art Therapists	Short	30 & 31	26-28 & 1-2	We support the advice that if a person does not want psychological therapy and wants to try a combination of medications, they should be advised of the possibility of increased side effects.	Thank you for your comment.
Association for Family Therapy & Systematic Practice	Short	22, 23,27,28	20-28 (22) 1-4 (23) 12-23 (27) and 3-5 (28)	Group therapy for depression can be very powerful since it automatically includes a social and relational context. A CBT approach is not the only one which can be beneficial, here. Systemic approaches (particularly Narrative therapy) are also used as group approaches.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.
Tavistock & Portman NHS Foundation Trust	Short & Full Full	General 592	General 17-22	CBAPS We have serious concern about the recommendation of CBAPS for people with chronic depression, as this is not an established treatment model in the UK, and raises questions of availability, training provision, and the extra costs to do so. The response to this concern raised the Royal College of Psychiatrist in the first review states: "In light of this we have removed CBASP from this recommendation". However, this does not seem to be the case as it is still recommended. Such a statement can only be made with confidence if long-term data proving the lasting effect of CBAPS. So far, there is no evidence that CBAPS is an effective treatment of chronic depression in the long-term.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				Furthermore, this sentence contradicts what has been stressed in many places throughout the document, including on page 632, line 3: "Depression is often recurring or chronic. Although approximately half of the people who become depressed will only have a single episode of major depression in their lifetimes, approximately 50% will have multiple episodes or protracted chronic periods of depression". This is not a small proportion of individuals and as such the additional cost is likely to be significant.	
Society for Psychotherapy Research UK	Short & Full	general	general	The nature of depression In our first response we raised concerns with respect to how depression has been defined in the draft guideline. We thank the GC for their detailed response, however, would like to re-state our concern as we feel it has not been adequately addressed in the revised version. The definition of depression is descriptive and symptom based, rather than explanatory. In this, it is disorder focused. It uses a practical severity classification of mild through moderate to severe which determines the step on which the person is placed at entry into the care system. Essentially, the classification runs from internal distress to distress discernible by people in that person's relationship circle and, finally, obvious and profound loss of ability to function.	Thank you for your comment. In developing the recommendations the guideline committee took into a range of factors such as diagnosis, comorbidities (e.g. complex depression), chronicity, and recovery. These terms are well established and generally well defined. As in all guidelines, the recommendations developed are a guide to judgement and not a substitute for it. This may include taking into account possible precipitants and maintaining factors. We believe this is reflected in the guideline recommendations and is also covered in the introduction in the full guideline.

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				Having a severity-based system approach helps health-care professionals make expedient judgements about where to place someone in the system and provides guidance on best practice in various scenarios. As the guideline acknowledges, the document is a management system and is not a substitute for clinical judgement. All praise for making that distinction. However it is still an external system which has little to say about causes, pathological mechanisms and rationale for remedies. In describing depression, the guideline focusses primarily on non-complex depression i.e. depression that is not complicated by co-morbidity, personality disorder or physical illness. The guideline only deals with it in a sub-section but it is debatable that such pure disorders commonly exist. Depression is embedded in person, time and place. While the system is not aetiological, it does point to a spectrum where biological processes are increasingly important as severity increases, both in mechanism and treatment. At the less severe end, treatments with different supposed modes of action may be deployed (e.g. pharmacological and two types of psychological). Simplifying, pharmaceutical treatment predicates the therapy on correcting malfunctioning biochemical processes, CBT on challenging false and unhelpful cognitions and counselling on feeling states and relationships. The last two often approach problems with a	

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				different timeline perspective: present and future and past and present. The fine details of a patient's depression can point the way to which therapy or combination or sequence of therapy are likely to be most apt. This clinical process is not addressed in the guidelines. Safeguarding issues are addressed and rightly so. Symptom based definitions of depression are a practical way of categorising disorder with benefits in communication, research and service provision. However, symptoms may have meaning and can be signposts to what is wrong in a person's life and might be open to change. Depression is not just an imposed disorder but frequently is part of that person's life narrative: the relationship with genetic and cultural inheritance, the interaction with their growing up and life, the challenges and in particular the losses they may face, the quality and supportiveness of personal relationships, their ability to work and love and the opportunities open to them to have either or both, and the meaning they take and impose on their world. Thus, as stressed below, updating the service user experience evidence is paramount to that effect. Thus, we recommend that the document needs a preamble describing the complex and varied nature of depression and giving guidance on how the patient may be assessed and the different parameters that may be important e.g. stress factors, personal and social circumstance, personality, family history support networks	

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				and, crucially, how the individual perceives and understands their symptoms. Being understood is therapeutic in itself and the more the assessor understands the person the better the potential match between person and type of therapy.	
The British Psychological Society	Short and Full	49/76	21-31	Although this is an interesting topic for research, it is likely that the "most effective components" of individual psychological treatments for depression will vary from patient to patient. The most crucial component, alongside a strong therapeutic relationship, is the development of a formulation which informs a personalised approach to therapeutic intervention.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data. The research recommendations will also be reviewed.
NHS England (IAPT Team)	Short and Full	General	General	The IAPT national team is grateful to NICE for its careful consideration of our comments on the first draft of the guideline. We were particularly concerned that promoting group CBT to the first line psychological intervention was inappropriate as it was based on an economic analysis which used the wrong values for the relevant therapist salaries. We are delighted to see that this point has been acknowledged and the recommendation for group CBT has been changed accordingly. We were also concerned that some trials of IPT had not been considered and that the removal of a recommendation for IPT in moderate to severe depression may therefore not be warranted. We are pleased that further consideration was given to this matter and that the recommendation for IPT has returned	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

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				to supporting its use in both mild to moderate and moderate to severe depression. Psychological therapies are more difficult to deliver than medication. They only achieve the outcomes observed in the RCTs that underpin NICE guidance if they are delivered in an adequate dose by properly trained and supervised therapists, who use the right delivery methods. Our comments on the present draft particularly focus on how one might ensure that this happens. Our major concern relates to the dose of therapy. In previous guidelines, NICE has addressed this issue by recommending that particular psychological therapies are given up to X sessions where X is the maximum number of sessions that might have been deployed in the RCTs that underpin the guidance. Unfortunately, this way of specifying dose has not worked. It is stated that CBT for depression should be offered up to 20 sessions. Although this does happen in IAPT services, it is clear that some services are still clinging to outmoded practices that were common in primary care counselling before the advent of IAPT. That is to say, offering a small fixed number of sessions (say 6). We now have evidence that this practice leads to poorer outcomes (Gyani et al, 2013, *Behaviour Research and Therapy,* 51, 597-606: Clark et al, 2018, *Lancet,* 391:679-686). We would therefore be grateful if the panel could reconsider how it specifies that therapists should deliver the right dose of treatment. We recommend	

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				that in addition to a maximum recommended number of sessions, the panel also specifies the normal range or the average number of sessions that might be expected. In the *Lancet* article the regression analyses indicate that the optimal average number of sessions for an IAPT service is 9 to 10, rather than the national average of 6.5. Specifying an average of 9 sessions with a maximum of up to 20 for CBT for depression (for example) would be one way to go. An alternative would be to look at the RCTs that generated the evidence base for the recommendation of each therapy and to specify the average number of sessions that would be offered in those RCTs. Either way, the extended guidance is likely to be helpful as it would lead to a recommendation which is more than the small and arbitrary fixed number of sessions that some services still seem to employ. It would also be in line with the recently published IAPT manual https://www.england.nhs.uk/publication/the-improving-access-to-psychological-therapies-manual/. Another consideration about dose might be linking it to the recommendations elsewhere in the guideline about ensuring that relapse prevention work is included in a treatment protocol prior to discharge. In other words, if a patient is showing some reasonable response to treatment, it should continue with enough sessions to allow the person the possibility to recovering and putting in place relapse prevention work.	

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University of Nottingham	Short/full	general	general	There is inconsistent reference to relevant NICE Technology Appraisals in depression. This is contrast to other NICE Guidelines where relevant NICE Technology Appraisals are reported. Mention is given to the Technology Appraisal for the drug vortioxetine. However the guideline recommendations do not acknowledge that Transcranial Magnetic Stimulation has been recommended as a clinically and cost effective treatment of depression and treatment resistant depression (TRD) in particular by NICE. NICE (IPG 542, December 2015) appraised the evidence for rTMS in TRD and found it to be safe and effective in reducing depressive symptoms compared to sham TMS and requiring neither hospital admission nor anaesthesia. It was therefore recommended for the treatment of depression, including TRD. This should be highlighted in both the short and full guidelines.	Thank you for your comment. Following feedback from stakeholders, the guideline committee and NICE have decided to update the evidence for those questions that form part of this guideline update (as defined in the scope). Consequently all of the analyses will be updated and the wording of recommendations reviewed in light of this updated data.

Depression (update) – summary response to methodological issues raised during 2nd consultation

Key issues raised by stakeholders	**Response**
Limiting evidence to RCTs only	The committee concluded that restricting the evidence base for questions about treatment efficacy to only RCTs was appropriate (because RCT data is the best type of evidence to determine the relative efficacy of different interventions compared against each other) and that this should not be changed.

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	Many patients included in trials of treatments for depression also have comorbid disorders. For example in Hollon et al (2005), 80% of participants had more than one disorder (69.2% had an Axis I disorder and 49% had an Axis II disorder). Therefore the committee do not agree that typically participants in the RCTs are less 'complex' than those seen in clinical practice. Therapist effects were not an area that was prioritised for inclusion in the guideline, therefore the evidence on this has not been reviewed and we are not able to make any recommendations on this issue. In developing recommendations the committee did not rely solely on the outcome of RCTs but took into account a range of different information, including health economic evidence and contextual information. It should be noted that there is RCT evidence supporting the use of a range of psychological therapies including counselling, CBT, BA, IPT and STPT. There is also RCT evidence supporting the effectiveness of different pharmacological treatments. The guideline has therefore made recommendations for a range of pharmacological and psychological treatments, the evidence for which varies in strength. The committee have not attempted to draw conclusions from the IAPT database as they did not consider routine datasets to be better or equivalent to RCT data as one cannot be sure that the populations treated with the different interventions are the same, and using RCT data is the standard approach for NICE CfG review questions regarding effectiveness (where RCT data are available). For example, examination of IAPT data sets shows that those who received CBT were more likely to have received a previous intervention (typically guided self-help) than those who received other psychological interventions.
Use of GRADE methodology	GRADE ratings are performed at a summary level on the outcomes of interest, rather than on individual studies. They are a measure of our confidence in a number of parameters, including the effect estimate and thus it is not possible to perform GRADE independently of the effect estimate.

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	The committee appreciate the difficulties in blinding associated with psychological trials. However, that does not change the fact that awareness of the intervention may affect participant's behaviour in a trial and responses on subjective outcome measures and it is important that this is reflected in the GRADE ratings as any bias affects our confidence in the estimate of effect. However, as the GRADE system allows for strong recommendations on the basis of weak evidence (and vice versa) as decisions are based not only on the quality of evidence but also on the balance between desirable and undesirable consequences, variability in values and preferences, and resource use. Therefore the committee do not agree that it is the case that psychological interventions are unfairly treated. In fact, it is worth noting that in a number of cases the guideline recommends psychological interventions over pharmacological interventions. Incorporating follow-up data from different time points in the same GRADE profile would not be in line with the processes set out in Developing NICE guidelines: the manual and would also be inconsistent with the fact that long-term follow-up data is not included in the analyses of this guideline (except for relapse prevention). It is also worth pointing out that the process for using GRADE is guided by NICE and not the committee.
Not including long-term follow up data	The committee regard long-term follow up data as important in informing decisions about the comparative effectiveness of psychological interventions. Unfortunately, there is limited available data on long-term follow up and as a result the committee agreed prior to the examination of any evidence that this could not be the primary outcome for comparing treatment efficacy. But we used long term data where possible. Several stakeholders have suggested that interventions should not be recommended unless they report long-term follow up data. It is worth noting that if the committee had not made recommendations for interventions which only report short-term data, there would have been very few recommendations in the guideline, which would have severely limited its clinical utility.
Definitions of chronic/treatment resistant depression	The committee considered that it was not meaningful to separate further line treatment of chronic depression from further line treatment following an inadequate response to first-line treatment or for treatment-resistant depression. Therefore, a single category was formed 'further-line treatment' which combined all these groups where participants

	are randomised at the point of non-response (this excluded chronic depression studies where entry to the study did not require lack of response to immediate previous treatment) and treatment strategies include increasing dose, augmenting or switching. The text of the guideline will be amended to clarify how the data have been analysed so that this is clearer to the reader. The committee also agreed that the term chronic depression should continue to be used in the guideline as this is in line with current ICD-10 terminology. Persistent depressive disorder is a term used in DSM-V and broader than the definition given by stakeholders so the committee agreed it should not be adopted in the guideline. The committee were aware of the population in the Fonagy 2015 study. Entry criteria for the trial, as indicated by the title of the published paper ('Pragmatic randomized controlled trial of long-term psychoanalytic psychotherapy for treatment-resistant depression: the Tavistock Adult Depression Study (TADS)') focused on people who were treatment resistant as a primary entry criteria. Further-line treatment of chronic depression and treatment-resistant depression were analysed in a single category so this distinction is not meaningful in terms of the analysis.
Use of baseline data to categorise studies into more/less severe groups	This approach is entirely consistent with the approach taken in the 2004 and 2009 guidelines. In adopting the terms 'more' and 'less' severe depression, the populations described by this were the same as the populations previously described as 'mild to moderate' and 'moderate to severe' depression. This change was made on the basis of advice from committee members that the previous terminology was confusing to practitioners (especially those in primary care), particularly because moderate was present in both groups. By adopting this classification we established two populations for two separate NMAs which therefore were likely to be more homogeneous. It should be noted that it was not a desire to undertake an NMA per se that drove this categorisation. Having reviewed stakeholder feedback, the committee concluded that the terminology used in this guideline (more/less severe depression) remained preferable to the terminology used in CG90. However, it was agreed that the rationale for changing the terminology would be made clearer in the guideline text. The committee also agreed that baseline data was an appropriate metric to use to categorise people into the 'more' /'less' severe groups whilst recognizing that there is some uncertainty and potential for measurement error involved

	in comparing across different measures. The original Hamilton manual does report a cut off of 19 for 'more severe' depression but this was viewed as too low a rating by the committee. The scale has been subject to considerable criticism focused largely on its psychometric properties (e.g. Bagby et la, 2004, Licht et al, 2005). A number of subsequent, large scale studies have suggested the original cut-offs are not appropriate. Drawing on independent ratings of severity such as that of Zimmerman et al 2013 (which recommended a cut-off for severe depression of >= 24) and Fournier et al (2010) which identified 25 as the point on the Hamilton at which there was meaningful difference between active drugs and placebo in an individual patient data analysis the committee decided to increase the threshold for severe depression. An examination of included trials indicated participants had mean baseline scores ranging from 14 to 23 with a mean for these baseline scores of 20. Participants in these trials were variously described as having moderate to severe depression, major depression, moderate depression or as being dysthymic and depressed. It is interesting to note that despite a mean score of 20, none of these studies were described as trials of severe depression. This data supported the committee in drawing a distinction between more and less severe depression at 23 on the HRSD. The problems identified with the HRSD are not confined to that measure, a number of measures we used gave a rating for severity that required adjustment. For example, the PHQ-9 has a cut off for caseness of 10 but classifies a score of 5-9 as mild depression with consequences for the rating of severity for the measure. We developed an algorithm to allow for read across between different scales and to support the correct allocation of studies but this did not lead to any changes in the threshold for caseness. It is worth noting that whilst baseline data were used to separate studies into two populations to facilitate the analysis and the development of recommendations, a range of contextual factors were also taken into account and it would be incorrect to assume that recommendations were made purely on symptom score.
Additional functional outcomes such as quality of life should be measured	In our reviews of the effectiveness of interventions we considered a range of outcomes. The committee agreed that critical outcomes were remission, response, relapse (for relevant questions), depression symptomatology and discontinuation (for any reason and due to adverse events). Details of the review protocols are provided in Appendix F. For the question on treatment of a new depressive episode, depression symptomatology outcomes were prioritised for interpreting the results of the NMA. This was based on the advice of the committee because there was the most data and the most connected network. This decision is documented in the 'evidence to recommendations' section in the full guideline.

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	We agree that measures of functioning and quality of life measures are important. However, these measures are relatively rarely reported. For this reason these measures were not prioritised for inclusion in the review protocols for this guideline. However, when making recommendations, the committee interpreted the evidence in light of their knowledge of the clinical context so that the 'reality' for people experiencing depression is taken into consideration and recommendations can be made that are relevant to the populations that clinicians typically encounter. The committees' discussions on this are documented in the evidence to recommendations sections of the full guideline.
Patient choice not reflected in the guideline and patient experience section not being updated	The stepped care framework has built in a number of factors which do not assume that all individuals are the same. For example, previous experience of treatment, response to current treatments, co-morbidities (principally personality disorder), severity and chronicity are all taken into account when determining the initial treatment people are offered. Discussing with people these factors and the evidence about their relation to treatment outcomes is a good basis on which to help a person in making an evidence based choice of treatments. Based on feedback from stakeholders, we are expanding the scope of the work to include the issue of patient choice. This work will be used to inform the committee's thinking about the choice of treatments recommended in the guideline. However we will not be reviewing the evidence about the impact of patient preference on treatment outcomes. In terms of the concerns raised about not updating the patient experience section of the guideline, we believe that a combination of the work above and referring to relevant NICE guidance published since CG90 will be the most efficient way to deal with the concerns that have been raised.

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