Depression in adults: treatment and management
Consultation on draft guideline - Stakeholder comments table

23 November 2021 - 12 January 2022

ID	Stakeholder	Document	Page No	Line No	**Comments** Please insert each new comment in a new row	**Developer's response** Please respond to each comment
1.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)				This response has been prepared by BABCP – the British Association of Behavioural and Cognitive Psychotherapies. BABCP is the lead organisation for CBT in the UK and Ireland. BABCP promotes, improves, and upholds standards of CBT practice, supervision and training. We are a professional organisation operating a highly respected voluntary register for accredited cognitive behavioural psychotherapists. We also operate a voluntary register for Psychological Well-being Practitioners (PWPs) and other low intensity clinicians. ****BABCP accredits CBT training programmes in the UK and Ireland and publishes Minimum Training Standards (i.e. a national curriculum) for training CBT therapists. BABCP members were invited to contribute to this response. Their comments and observations are quoted verbatim appear at places throughout the document to illustrate and highlight specific points.	Thank you for sharing this information about your organisation.

2.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)				BABCP would like to highlight grave concern about the implied necessity of dropping the stepped care model for treatment of depression that was previously recommended by NICE in 2004 and 2008. The majority of people with depression in England are referred to NHS IAPT services. NHS IAPT (psychological therapy) services are based on a stepped care model and deliver NICE recommended psychological interventions in England. In 2020-2021 IAPT services had 1.45 million referrals and 90% of referrals were seen (virtually in most cases) within 6 weeks. More than 50% of referrals moved to recovery and around 63% of interventions were low intensity interventions, delivered by PWPs. However, the key recommendations made by the committee and illustrated in the Visual Guidance for 'less severe' and 'more severe' depression are not compatible with the stepped care model of service delivery. The draft recommendations state that people with a new episode of depression should normally be offered high intensity psychological therapy in preference to low intensity psychological	Thank you for your comment. In response to stakeholder comments, in particular around implementation issues in the context of IAPT, some changes have been made to the tables of interventions for the treatment of a new episode of depression guided by the principles of offering the least intrusive intervention first, reflecting clinical and cost effectiveness, and reinforcing patient choice. When making recommendations, the committee interpreted the RCT evidence in light of their knowledge of the clinical context (including drawing on their knowledge of the IAPT dataset) so that the 'reality' for people experiencing depression

					interventions. Thus, if implemented, the recommendations would massively increase the demand for high intensity psychological interventions and this demand could not be met. Many thousands of extra staff would need to be trained and recruited, with knock on consequences for funding required from Health Education England for HEIs. In contrast there would be a marked reduction in demand for low intensity interventions and thus many PWPs would need to be retrained, redeployed, or made redundant. Implementation of the draft recommendations would therefore have very negative consequences for NHS mental health services and require massive service redesign and re-organisation that would be complex, costly and disruptive. Waiting times would increase and the number of patients treated would reduce. Very significant additional resources would be required.BABCP suggest that the type of evidence that was reviewed in developing the guidelines (predominantly RCTs of treatment efficacy and effectiveness) is not appropriate as a guide to how	was taken into consideration. The committee were also aware of pragmatic RCTs that were excluded from the NMA typically because the samples in the trials were <80% first-line treatment or <80% non-chronic depression. These were stipulations of the review protocol in order to create a homogenous data set, but the committee used their knowledge of these studies in the round when interpreting the evidence from the systematic review and making recommendations. By way of illustration some of these studies were listed in Evidence report B, however, in response to stakeholder comments the committee agree that it would be more consistent to name all UK-

					services should be organised and delivered. Economic modelling and cost-effectiveness analysis was limited and did not consider the costs of changing systems of delivery or of implementing the Draft Guidance. It is of particular concern that the extensive data collected from IAPT services and freely available in the NHS Digital Annual Report each year (including 2020/2021) has not been used to inform recommendations about how treatments should be delivered and organised.BABCP is also concerned that no distinction was made between efficacy and effectiveness studies. Whilst RCT evidence is highly relevant to assessments of treatment effectiveness and cost-effectiveness many RCTs reviewed were under-powered and not easily generalisable to the NHS in 2022 (and beyond). BABCP also identified concerns with the transparency of Evidence Review B, with the exclusion of relevant studies and with the informal use of committee members' knowledge of studies that had been excluded from the review. BABCP suggests that this process may have introduced bias to the interpretation of results. BABCP also	based studies which were excluded on this basis but which the committee were aware of when making recommendations. In January 2020 NICE published a statement of intent signalling the ambition for the future use of wider sources of data and analytic methods (including sources commonly referred to as real-world data and evidence). To make decisions about the relative effectiveness of interventions, RCTs will continue to be prioritised in line with the NICE guidelines manual, in order to ensure that the populations treated with various interventions are equivalent. However it is possible that in the future, high-quality real-

					identified concerns with the PICO used to guide Evidence Review A and Evidence Review B. The range of interventions reviewed in Evidence Review B did not reflect the full range of interventions currently offered in the NHS and this was particularly problematic for low intensity interventions delivered by PWPs in IAPT services.BABCP therefore suggests that the Evidence Reviews on which the draft Guidance is based include a number of fundamental flaws. We also suggest that to implement the Draft Guidance would have a disastrous impact on NHS mental health services and would result in significantly longer waiting times, significantly more costs and inefficiencies, and reduced access to assessment and treatment for people with depression.	world datasets such as the IAPT dataset, could inform questions about access and engagement.

3.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review A – Service delivery	30	34 Table 1'Population'	BABCP are concerned that the PICO table includes as 'population', participants for whom depression is assessed by DSM or ICD, and those for whom depression is assessed by 'validated scales', and that these are treated equally. These methods of recruitment to trials are not equivalent. BABCP suggests that diagnostic interviews based on DSM or ICD (or similar) are of higher quality than validated self-report scales. Therefore we suggest that studies that assess depression diagnosis at baseline (before treatment), and treatment outcome at the end of treatment and follow up should be given greater weight than studies that use only self-report measures of depression.	Thank you for your comment. As pre-specified in the review protocols, the population included adults with clinically important symptoms of depression (as defined by a diagnosis of depression according to DSM, ICD or similar criteria, or depressive symptoms as indicated by baseline depression scores on validated scales). Studies using depression symptom scales were included (in addition to studies that limited inclusion to those with a diagnosis of depression) on the basis that such scales are widely used in RCT research and clinical practice and are validated in the diagnosis of depression and the assessment of depression symptom severity. The

						committee were concerned that excluding studies that did not use diagnostic interviews would result in the exclusion of a large number of studies, would have a disproportionate impact on the evidence base for some interventions for example for self-help studies, and would not allow examination of those with subthreshold symptoms of depression which were included in the review question and protocol.

4.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review A	31	'Outcomes'	BABCP note that 'critical' outcomes are limited to metrics (scores, response, remission, relapse) related to the symptoms of depression, all of which are based on self-report scores. We suggest that 'critical' outcomes should also reflect functioning and/or quality of life reported by participants.BABCP also suggest that critical outcomes based on structured diagnostic interviews should be weighted more heavily than critical outcomes (e.g. endpoint score) based on responses to a 'validated scale'	Thank you for your comment. As pre-specified in the review protocol, critical outcomes included depression symptomatology, remission (that could include loss of diagnosis but was more commonly defined as scoring below a cut off on a depression scale) and response (usually defined as at least 50% improvement from the baseline score on a depression scale). Studies reporting depression symptomatology outcomes were included on the basis that such scales are widely used in RCT research and clinical practice and are validated in the diagnosis of depression and the assessment of depression symptom severity. The

						committee were concerned that excluding studies that did not use diagnostic interview outcomes would result in the exclusion of a large number of studies, would have a disproportionate impact on the evidence base for some interventions for example for self-help studies, and would not allow examination of those with subthreshold symptoms of depression which were included in the review question and protocol. In addition to the critical, depression-specific, outcomes the committee prioritised 2 important outcomes – these were quality of life and personal, social and occupational functioning. These were selected to determine if treatments

						for depression led to improved quality of life, and helped overcome difficulties in sleep, participation in employment, and carrying out activities of daily living. These were selected as important and not critical outcomes as the committee were aware that there was likely to be less evidence for these outcomes. The committee recognised that although these outcomes were very important to people with depression, as they would not be available for all interventions they would be less useful to the committee to make recommendations.

5.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review A	33	04-May	BABCP note that only 5 RCTs of stepped care were included in the evidence review. BABCP understands the rationale for selecting studies that follow an RCT design. However, in research on service delivery and implementation the use of RCT designs has important limitations and BABCP suggest that other research designs should be included so that the review is includes the most relevant and most extensive data available e.g.: Lobb, R., & Colditz, G. A. (2013). Implementation science and its application to population health. Annual review of public health, 34, 235-251.NHS psychological therapy services in England (i.e. IAPT) follows stepped care principles and provides data on 98% of patients who are referred. This data is freely available and there have been many independent analyses of treatment delivery and outcomes e.g.Radhakrishnan, et al. (2013). Cost of Improving Access to Psychological Therapies (IAPT) programme: An analysis of cost of session, treatment and recovery in selected Primary Care Trusts in the East of England region. Behaviour research and therapy, 51(1), 37-	Thank you for your comment. The committee drew on their knowledge of the IAPT dataset to inform recommendations and to re-structure treatment recommendations in response to stakeholder comments. To make decisions about the relative effectiveness of service delivery models, RCTs have been prioritised in line with the NICE guidelines manual. For this reason, Lobb & Colditz (2013) and Wakefield et al. (2021) were not considered by the committee as they do not meet study design eligibility criteria. Radhakrishnan et al. (2013) also does not meet inclusion criteria for the review, as it is a non-comparative study

					45.Wakefield, S., et al, (2021). Improving Access to Psychological Therapies (IAPT) in the United Kingdom: A systematic review and meta-analysis of 10-years of practice-based evidence. British Journal of Clinical Psychology, 60(1), 1-37.BABCP is very concerned that the freely available data collected by IAPT on the country wide implementation of a stepped care model has not been included in this evidence review. In the view of BABCP this leads to a distorted reflection of the evidence which has important implications for the way in which this guidance has been developed.	reporting costs associated with IAPT services without comparison to an alternative model of delivery. In January 2020 NICE published a statement of intent signalling the ambition for the future use of wider sources of data and analytic methods (including sources commonly referred to as real-world data and evidence). To make decisions about the relative effectiveness of interventions, RCTs will continue to be prioritised in line with the NICE guidelines manual, in order to ensure that the populations treated with various interventions are equivalent. However it is possible that in the future, high-quality real-world datasets such as

						the IAPT dataset, could inform questions about access and engagement.

6.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review A	73	21-27	'The outcomes that matter most' – BABCP note with interest the committee's view that depression symptoms, response, remission, and relapse are the critical outcomes. BABCP suggest that outcomes that matter 'most' would be better identified in collaboration with people who have depression and their carers. Whilst symptoms, relapse etc are important outcomes BABCP hears from many service users who argue that functioning and quality of life are at least as important as symptoms, and may be more important.	Thank you for your comment. In addition to the critical, depression-specific, outcomes the committee prioritised 2 important outcomes – these were quality of life and personal, social and occupational functioning. These were selected to determine if treatments for depression led to improved quality of life, and helped overcome difficulties in sleep, participation in employment, and carrying out activities of daily living. These were selected as important and not critical outcomes as the committee were aware that there was likely to be less evidence for these outcomes. The committee recognised that although these outcomes were very important to people with

						depression, as they would not be available for all interventions they would be less useful to the committee to make recommendations.

7.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review A	73	36-37	BABCP note that most research on service delivery was graded as low or very low quality. BABCP suggests that evaluating research on implementation may require a different set of quality criteria than research focused on treatment effectiveness and cost-effectiveness.	Thank you for your comment. As pre-specified in the review protocol, the committee considered it appropriate to assess risk of bias at the study level (using the Cochrane risk of bias tool) and at the outcome level (using GRADE) in an equivalent manner for RCTs examining models for the coordination and delivery of services as RCTs examining pharmacological or psychological interventions, particularly as many of the latter include complex interventions that share some similarities with service delivery models. In assessing risk of bias using GRADE, the non-blinding of participants and intervention administrators presents a

						risk of bias, although this is more of a problem for service delivery models and psychological trials than for pharmacological trials, it does not negate the fact that participant and intervention administrator knowledge of the treatment being received/delivered or the service delivery model coordinating that care is likely to introduce some degree of performance bias due to an individual's inherent beliefs about that intervention or service delivery model. However, in assessing risk of bias, blinding of outcome assessors is also taken into account. The GRADE system 'quality' rating is not a value judgement on the quality of an individual study but rather an

						estimate of confidence that an estimate of the effect is correct and is unlikely to change with further research. It is also important to note that the GRADE rating of the evidence is just one factor that the guideline committee took into account when making recommendations. They also considered cost-effectiveness and interpreted all evidence in light of their clinical judgement.

8.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review A	74	41-44	Separate recommendation for stepped care: the committee considered this but rejected it. This decision is hard to understand given that the current model for delivery of psychological therapies in England is stepped care. The stepped care model is therefore of particular interest and importance to commissioners and NHS providers.BABCP is concerned that the most relevant data relating to the implementation of a stepped care model (i.e. the IAPT dataset and publications based on these data) was not included in this evidence review.	Thank you for your comment. The section mentioned in your comment refers to Evidence review A where models of care were reviewed. Based on that evidence review, the committee considered the key principles of stepped care, or more accurately matched care, were covered by existing recommendations and were integrated into a care pathway that emphasises patient choice. In response to stakeholder comments, in particular around implementation issues in the context of IAPT, some changes have been made to the tables of interventions for the treatment of a new episode of depression

						guided by the principles of offering the least intrusive intervention first, reflecting clinical and cost effectiveness, and reinforcing patient choice. The stepped care recommendations have also been updated to include the use of matched care. When making recommendations, the committee interpreted the RCT evidence in light of their knowledge of the clinical context (including drawing on their knowledge of the IAPT dataset) so that the 'reality' for people experiencing depression was taken into consideration. In January 2020 NICE published a statement of intent signalling the ambition for the future use of wider

						sources of data and analytic methods (including sources commonly referred to as real-world data and evidence). To make decisions about the relative effectiveness of interventions, RCTs will continue to be prioritised in line with the NICE guidelines manual, in order to ensure that the populations treated with various interventions are equivalent. However it is possible that in the future, high-quality real-world datasets such as the IAPT dataset, could inform questions about access and engagement.

9.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review A	75	48-51	BABCP note with concern the recommendation that a collaborative care model is used to organise the delivery of care and treatment for people with depression. This recommendation is based on economic analysis of a range of RCT studies, many of which were not conducted in the UK and which therefore relate to very different health care systems. Only 3 of the reviewed studies were conducted in the UK and these had important limitations (as noted in lines 39-44).The economic analysis also did not consider any costs of de-commissioning existing stepped care services such as IAPT, or any of the costs of developing new services, adapting existing services and re-building the systems of care. BABCP therefore suggest that the economic analysis presented here is, at best, incomplete and at worst completely misleading. BABCP suggest that a full economic analysis needs to calculate and include the true costs of service re-organisation, re-deployment and redundancy of 1000s of NHS staff, re-training of IAPT staff, recruitment and timing of new NHS staff to deliver interventions that have been	Thank you for your comment. No primary economic analysis was conducted for this question, as other areas in the guideline were considered as higher priorities for de-novo economic modelling. Cost-effectiveness of models of care for co-ordination and delivery of services was informed by a systematic review of existing (published) economic evidence. For each examined model of care, UK economic studies were prioritised for inclusion in the review. If limited/no UK evidence was identified, then non-UK evidence was considered, based on prioritisation criteria (regarding study origin) available in Supplement 1 (Methods). Based on the availability of evidence

					recommended and for which appropriately trained staff are not currently employed. ****In addition the personal, social and economic costs of increased waiting times and reduced access to treatments should be included in the economic model. The far reaching systemic and economic implications of this recommendation are not discussed in this document. BABCP do not believe that this recommendation is well founded, that it is based on a comprehensive assessment of costs, or that it would be feasible.	and those criteria, 12 studies (of which 5 UK) were included in this systematic economic evidence review: 3 UK studies on simple collaborative care plus 1 US study on simple collaborative care in relapse prevention; 1 UK, 1 Dutch and 1 German studies on complex collaborative care; 1 UK, 2 Dutch and 1 Canadian studies on stepped care; 1 Spanish study on medication management; and 1 US study on shared care. Regarding simple collaborative care, this was the only model of care for which sufficient UK evidence was identified, with 1 study having minor and 2 studies having potentially serious limitations. As no primary economic analysis was conducted

						for this model of care, it was not possible or relevant to quantitatively consider costs of re-organising services, unless these were considered in the studies included in the review. According to the related recommendation, collaborative care should be considered, particularly for older people with depression, those with significant physical health problems or social isolation, or those with more chronic depression not responding to usual specialist care. Thus collaborative care is not recommended as the standard model of care for the entire population with depression receiving care. Nevertheless, it is acknowledged that there may be some

						implementation costs associated with this recommendation, especially for the sub-groups of people included in the recommendation. Implementation issues are usually dealt with by NICE where relevant support activity is being planned. The draft guideline recommendations that support the stepped care model and have now been amended to reflect more clearly the key principles of stepped care, which is the prevailing model of care in IAPT.

10.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence Review BTreatment of a new episode	8	Table 1	PICO table: Population BABCP note that studies were included if participants received a diagnosis of depression (DSM or ICD, or similar) or reported symptoms on a 'validated' scale. BABCP suggests that studies which selected participants on the basis of a diagnostic interview are of higher quality (i.e. more valid) and thus should be given greater weight in a meta-analysis. Likewise, studies that selected participants on the basis of 'validated' self-report scales are of lower quality and should be given less weight in a meta-analysis.	Thank you for your comment. As pre-specified in the review protocols, the population included adults with clinically important symptoms of depression (as defined by a diagnosis of depression according to DSM, ICD or similar criteria, or depressive symptoms as indicated by baseline depression scores on validated scales). Studies using depression symptom scales were included (in addition to studies that limited inclusion to those with a diagnosis of depression) on the basis that such scales are widely used in RCT research and clinical practice and are validated in the diagnosis of depression and the assessment of depression symptom severity. The

						committee were concerned that excluding studies that did not use diagnostic interviews would result in the exclusion of a large number of studies, would have a disproportionate impact on the evidence base for some interventions for example for self-help studies, and would not allow examination of those with subthreshold symptoms of depression which were included in the review question and protocol.

11.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	08-Sep	Table 1	PICO table: InterventionsBABCP observe that this list of interventions does not properly reflect the range of interventions that are widely used in IAPT services as low intensity treatments for depression as part of the stepped care pathway. As a result an important group of interventions have not been reviewed and thus have been excluded from the guidelines. For example, there is increasing evidence that brief sleep interventions (delivered online) are also effective at treating depression. These are increasingly used in IAPT services and have not been included in the evidence review. Gee B, Orchard F, Clarke E, Joy A, Clarke T, Reynolds S. The effect of non-pharmacological sleep interventions on depression symptoms: A meta-analysis of randomised controlled trials. Sleep Med Rev. 2019 Feb; 43:118-128. doi: 10.1016/j.smrv.2018.09.004.Top of FormBottom of FormThe list of interventions also does not distinguish between Behavioural Activation delivered as a low intensity treatment (based on the Lejeuz and Hopko model) and Behavioural Activation delivered as a high intensity treatment (based on the	Thank you for your comment. In response to stakeholder comments, in particular around implementation issues in the context of IAPT, some changes have been made to the tables of interventions for the treatment of a new episode of depression guided by the principles of offering the least intrusive intervention first, reflecting clinical and cost effectiveness, and reinforcing patient choice. The self-help with support section has been relabelled as guided self-help, included earlier in the treatment pathway, and the description of guided self-help has been amended to recommend that printed or digital materials that follow the principles of guided self-help are used including

					Martell model). This consequence of this presents a significant challenge to existing practice and service delivery because many service users with depression, referred to NHS psychological therapy services in England, are offered interventions that do not appear to be have been evaluated e.g low intensity Behavioural Activation. BABCP is extremely concerned that the choice of interventions listed here (and the exclusion of important core interventions) significantly threatens the credibility of the guidelines produced and will result in recommendations that cannot reasonably be implemented without major disruption to delivering services, increased costs, and lower access and equality. By Mindfulness, mediation or relaxation:BABCP note that these are not one 'school' or coherent model of therapy or interventions. Mindfulness based CBT is a specific protocol-based intervention for which specific training, quality standards and supervision are available. Meditation and relaxation might refer to a range of activities and are not synonymous with mindfulness. Therefore the evidence	structured CBT, structured BA, problem solving or psychoeducation materials, delivered face-to-face or by telephone or online. The BA referred to in the recommendations is a high intensity intervention, and changes to recommendations for low intensity interventions are described above. The committee did not consider sleep interventions to be interventions that were in regular clinical use for the treatment of depression. Therefore these interventions were not specified in any of the review protocols and consequently the systematic review that

					reviewed relating to Mindfulness Based CBT is not applicable to 'meditation' or 'relaxation', neither of which are evidence-based treatments for depression. Couples therapy should be in the 'psychological intervention' category instead of the 'psychosocial intervention' category.	you cite (Gee et al. 2019) would not have met the inclusion criteria for the reviews. As such the evidence on sleep interventions has not been appraised and we are not able to make any recommendations on their use. Due to the large number of interventions included in this review, comparing all pairs of interventions individually within the network meta-analysis (NMA) or in the pairwise meta-analyses would not be feasible and would require particularly complex consideration and interpretation of the evidence. Moreover, some interventions included in the systematic review had been tested on small numbers of participants and their

						effects were characterised by considerable uncertainty. For these reasons, the analyses utilised class models: each class consisted of interventions with a similar mode of action or similar treatment components or approaches, so that interventions within a class were expected to have similar (but not necessarily identical) effects. Mindfulness and meditation approaches were combined into group and individual classes, and progressive muscle relaxation (individual and group) interventions were considered as distinct classes. The committee agreed that mindfulness based cognitive therapy (MBCT)

						should be given as an exemplar of the mindfulness and meditation class and in Table 1 of the recommendations, in considering how to deliver group mindfulness or meditation it is recommended that 'a programme such as mindfulness-based cognitive therapy specifically designed for people with depression' is used. The misclassification of behavioural couples therapy as a psychosocial rather than psychological intervention was a copy and paste error in creating the summary of the protocol from the full protocol in Appendix A. It has now been amended.

12.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)		9	Comparator	5 comparators are listed. BABCP note that these are not of equal validity and note that trials that compare active interventions or plausible placebos should be given greater weight in appraising the evidence of effectiveness and cost-effectiveness. BABCP note that the results of trials that use waiting list, no treatment or TAU as the comparator are less valid than trials that used placebo or active interventions as comparators and thus their results should be given less weight in the evidence review.	Thank you for your comment. The committee agree that not all comparators are equally desirable. However, the committee did not agree that studies with waitlist, no treatment or TAU comparators are necessarily less valid, although these comparators are potentially less effective (not necessarily TAU) and TAU may also be characterised by heterogeneity. All relevant comparators were included, as restricting the review to only studies with a placebo or active comparator would considerably limit and potentially bias the evidence base. However, different comparators were categorised separately in the network,

						and the committee considered comparators when assessing risk of bias and quality of the evidence using GRADE, and when interpreting the evidence and making recommendations.

13.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)		10	16-28	The definition of 'less severe' and 'more severe' depression caused concern amongst BABCP members. For example one member commented, 'Using a PHQ9 score of 16 to distinguish severe from less severe depression, is inadequate, it is based on consensus not, evidence. The PHQ9 was validated in a US outpatient setting against the Prime MD, but the questions on the latter are identical to those on the former thus it falls foul of the STARD requirements. The PRIME MD is not a 'gold standard' diagnostic interview. There are therefore major external validity issues with the PHQ9, the fact that its usage is commonplace, does not increase its validity.'BABCP suggest that the guidance includes much greater clarity and specificity about the definitions of 'less severe' and 'more severe' depression so that these are explicit and can be implemented by commissioners and by clinicians who assess and treat people with depression. This is likely to require reference to commonly used measures and methods and indications of the appropriate cut-off points that should be used, as well as clarity about other factors that might	Thank you for your comment. An anchor point of 16 on the PHQ-9 was selected as the cut-off between less severe and more severe depression, on the basis of alignment with the clinical judgement of the committee and eligibility criteria in the included studies. Published standardization of depression measurement crosswalk tables (Carmody 2006; Rush 2003; Uher 2008; Wahl 2014) were used in order to 'read-across' different symptom severity scales that were used in different studies, and thresholds to distinguish between less severe and more severe depression were outlined for all eligible scales (including but not limited to the PHQ-9) in the review

					mitigate the classification (e.g. complexity, co-morbidity, living conditions etc).	protocols. The committee were aware that a proper assessment of severity cannot be based solely on a symptom scale and the guideline includes a recommendation to conduct a comprehensive assessment that does not rely simply on a symptom count but also takes into account both the degree of functional impairment and/or disability associated with the possible depression and the length of the episode. The committee considered the studies identified by the review and agreed that although baseline symptom scores have limitations as an indicator of severity, this information was available for the majority of studies, whereas other

						factors such as complexity, duration of disorder or functional impairment were not reported in a sufficiently consistent manner for them to be of use in determining severity. The committee considered the current NICE classifications of mild to moderate and moderate to severe depression, and agreed that although these classifications have been adopted quite widely there is potential uncertainty with regards to the management of moderate depression. The committee agreed that a dichotomy of less and more severe depression was clearer, and the guideline includes definitions (that less severe depression

						includes the traditional categories of subthreshold symptoms and mild depression, and more severe depression includes the traditional categories of moderate and severe depression) in order to improve practical utility.

14.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)		10	30-32	g	Thank you for your comment. The committee considered RCTs as the most appropriate study design to assess clinical and cost effectiveness. This is consistent with the NICE guidelines manual which recognises RCTs as the most valid evidence of the effects of interventions, and this was outlined a priori in the review protocols. The costs of service redesign and organisational change are considered and estimated by NICE where relevant support activity is being planned. When making recommendations, the committee interpreted the RCT evidence in light of their knowledge of the clinical context (including drawing on their knowledge of the IAPT

						dataset) so that the 'reality' for people experiencing depression was taken into consideration. In response to stakeholder comments, the committee have re-structured treatment recommendations in order to take into account implementation factors. In January 2020 NICE published a statement of intent signalling the ambition for the future use of wider sources of data and analytic methods (including sources commonly referred to as real-world data and evidence). To make decisions about the relative effectiveness of interventions, RCTs will continue to be prioritised in line with the NICE guidelines manual, in order to ensure that the

						populations treated with various interventions are equivalent. However it is possible that in the future, high-quality real-world datasets such as the IAPT dataset, could inform questions about access and engagement.

15.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	8	4	Couple-based interventions were not included in the network meta-analysis. BABCP hypothesise that this decision was based on the incorrect assumption that couples-based interventions are only relevant to people who are experiencing relationship distress.A recent meta-analysis found that they were equally effective in the treatment of depression for people in distressed and non-distressed relationships Barbato, A. & D'Avanzo, B. (2020). The findings of a Cochrane Meta-Analysis of couple therapy in adult depression: Implications for research and clinical practice. Family Process, 59 (2), 1-15).BABCP suggest that the evidence review is modified to include more studies of couples-based interventions.	Thank you for your comment. As pre-specified in the review protocol, the committee identified couple interventions, including behavioural couples therapy, as interventions that would be more appropriate for subgroups of adults with depression (for people with problems in the relationship with their partner) and as such these interventions were considered only in pairwise comparisons (and not included in the NMA).

16.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	16	14	BABCP observe that the 142 RCTs included in Evidence Review B are not listed here and it is not clear where this list can be found. They are not in the Appendix K as indicated. BABCP suggest that for transparency the full list of studies should be easily available. BABCP also observe that the number of excluded studies is not provided. The guideline should include a full list of excluded studies and indicate why each study was excluded. Appendix K did not provide this information. BABCP also note that most studies of Behavioural Couples therapy were excluded from the evidence review. This may be because of an incorrect assumption that Behavioural Couples therapy is only appropriate and effective for people who are in a distressed relationship; this is not the case e.g. Barbato, A. & D'Avanzo, B. (2020). The findings of a Cochrane Meta-Analysis of couple therapy in adult depression: Implications for research and clinical practice. Family Process, 59 (2), 1-15.)BABCP is concerned that this misunderstanding of the scope of Behavioural Couples therapy is a significant gap in the evidence review	Thank you for your comment. Given the numbers of included and excluded studies, the committee agreed that it would be more appropriate to provide this information in supplementary documents so as not to make the evidence report too unwieldy. Appendix C of Evidence report B provides the numbers of included and excluded studies for both less and more severe depression. Study characteristics of included studies including full references, and excluded studies including reasons for exclusion, are provided in Supplement B1 for clinical evidence. Economic evidence included and excluded studies are provided in Supplement 3. Cross-references to these

					and has resulted in incorrect interpretation of the available evidence.	supplementary documents are included in Appendix K of the evidence report. As pre-specified in the review protocol, the committee identified couple interventions, including behavioural couples therapy, as interventions that would be more appropriate for subgroups of adults with depression (for people with problems in the relationship with their partner) and as such these interventions were considered only in pairwise comparisons (and not included in the NMA).

17.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	18	Table 2	BABCP note with interest that the majority of self-help interventions listed are computerised treatments. This suggests to us that many self-help interventions and other low intensity interventions have been omitted from the evidence review.BABCP note also that computerised-CBT is not a single intervention and that the specific programme used in research is an important aspect of assessing outcomes.	Thank you for your comment. Different self-help approaches (with or without support) were searched for and were eligible for inclusion. In addition to computerised approaches, there are also RCTs of cognitive bibliotherapy, behavioural bibliotherapy, expressive writing, mindfulness meditation CD, relaxation training CD, and third-wave cognitive therapy CD, included in the network meta-analyses (NMAs) for treatment of a new episode of depression. One intervention per class was used as an exemplar in the economic analysis, as it was not feasible to model all interventions included in the NMA. Computerised CBT (cCBT) was selected as the

						exemplar from the class of self-help with support as it had a large evidence base and a high effect compared with other interventions in the same class. Thus, the clinical evidence and resource use data used to inform the economic analysis were specific to cCBT; consequently, the results of the economic analysis were specific to cCBT (but could also be extrapolated to any other intervention with similar acceptability, effectiveness and resource use). However, the treatment class effect size for self-help (with or without support) that was estimated from the NMA and reported in the clinical evidence sections of evidence review B, was informed by evidence from all interventions

						included in the treatment class. In addition, individual intervention effects have been reported in the evidence review B for all interventions within each class for the SMD outcome (for both less and more severe depression). In response to stakeholder comments, the self-help with support section has been relabelled as guided self-help, and moved so it is listed first in Table 1, and the description of guided self-help has been amended to clarify that this is not restricted to cCBT.

18.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	44	36-40	'Under an NHS perspective problem solving…. was significantly more expensive than GP care. The number of QALYs gained was practically the same across all interventions.'This statement suggests that the rationale for including problem solving as a treatment for 'less severe' depression is weak. Therefore BABCP suggest that problem solving is not included in the menu of treatments for 'less severe' depression. This is particularly important because NHS services do not currently provide staff who are qualified to provide problem-solving therapy for depression.	Thank you for your comment. This statement referred to an economic study undertaken alongside a RCT, which was included in the systematic economic evidence review. Problem solving was considered in the guideline economic analysis, which was given more weight than the review of economic studies when formulating recommendations, because it was informed by the guideline NMAs. Based on the results of the economic analysis, problem solving has not been recommended as a separate intervention for less severe depression (but only as part of guided self-help), as it was not shown to be cost-effective in this population. However, problem solving was

						recommended as an option for more severe depression, given the results of the NMA and the guideline economic analysis, in which problem solving was shown to be the most cost-effective treatment option in this population. Nevertheless, the committee considered the fact that clinical evidence on problem solving was derived mostly from US studies and also took into account practicality issues around delivery and availability of problem solving therapy in the NHS and decided to place problem solving towards the middle places of Table 2, which lists first-line options for a new episode of more severe depression in the suggested order in which they should be

						considered, based on the committee's interpretation of their clinical and cost effectiveness and consideration of implementation factors.

19.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	46	21-29	The economic evidence in support of exercise as an intervention (Chalder, 2012) is based on data from individuals who completed treatment, not on ITT analysis. Notably attrition was high (line 29) Thus the cost effectiveness is likely to be over-estimated i.e. the intervention is likely to be less cost-effective than reported (lines 23-27).Group exercise could not currently be offered as a treatment for depression because appropriately qualified staff, i.e. with training in mental health and the delivery of exercise-based interventions, are not employed in NHS mental health or psychological therapy services. Thus the recommendation could not be implemented. The implementation of this guideline would have significant resource implications and require new training programmes and recruitment of new staff.	Thank you for your comment. The economic evidence in support of exercise as an intervention was based on data from the guideline primary economic analysis, in which group exercise ranked relatively highly in cost-effectiveness ranking, both for less and more severe depression, suggesting it is likely a cost-effective intervention. Chalder 2012 was indeed included in the systematic review of economic evidence, but, as you note, in the evidence report it is stated that, although directly applicable to the NICE decision-making context, the study was "characterised by potentially serious limitations, mainly its notably high attrition

						rates". This was taken into account when interpreting this evidence. The committee is aware that group exercise is not currently routinely available in the NHS, and that this has potential resource implications. However, it was recommended because evidence suggested it was a clinically and cost-effective intervention. Implementation issues relating to this recommendation will be considered by NICE when preparing implementation support tools for this guideline.

20.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	47	24-25	BABCP note that the economic analysis of specific interventions classified as CBT (group and individual) was based on under 15 sessions. The specificity of the number of sessions for CBT (but not other interventions) was not clear and BABCP suggest that this is explained.	Thank you for your comment. The committee wanted to explore if there was a difference in the effects of briefer versus longer CBT. For each level of severity, for the class of cognitive and cognitive behavioural therapies, both individual and group, the NMA classification system made a distinction between CBT ≥15 sessions and CBT<15 sessions, which were considered as separate interventions within the class. This differentiation by intensity (number of sessions) was possible for the CT/CBT class because there was large variation in the number of sessions reported across RCTs, and there was also a large evidence base that allowed formation of 2 separate groups of interventions according to

						the number of sessions offered. It was not possible to create distinct intervention categories according to intensity for other treatment classes because there was either no great variation in the number of sessions reported for an intervention within the class in the RCTs included, or the evidence base was too narrow. In response to your comment, this explanation has been added to Evidence review B. For each level of severity, the economic analysis selected and analysed one intervention per effective class as an exemplar, as it was not feasible to model every single intervention considered in the NMA. The criteria for selection were (see Appendix J,

						section 'Interventions assessed'): • the size of the evidence base for each intervention • the availability of interventions within the NHS: more commonly used interventions had a priority over less commonly used interventions • relative effectiveness: more effective interventions within a class were better candidates for selection • side-effect profile in the case of pharmacological treatments. For <u>less severe depression</u>, the Cognitive and cognitive behavioural therapies individual included CBT≥15 sessions and CBT<15 sessions as separate interventions. The two interventions had a similar SMD vs TAU

						(CBT≥15 sessions individual -0.68, 95% CrI -1.36 to 0.01; CBT<15 sessions individual -0.66, 95% CrI -1.45 to 0.16), and CBT<15 sessions had a somewhat larger evidence base across RCTs on the SMD outcome (N=233 vs 123) - see Table 10, results of bias-adjusted analysis for less severe depression, in evidence review B. CBT<15 sessions individual was considered to have an appropriate intensity for a population with less severe depression by the committee, it had also a larger evidence base than CBT≥15 sessions, and given that CBT≥15 sessions and CBT<15 sessions had similar effectiveness, CBT<15 sessions individual was selected for consideration

						as an exemplar of its class in the economic modelling (which ultimately informed guideline recommendations). This has now been explained in evidence review B, under 'The committee's discussion of the evidence'. The Cognitive and cognitive behavioural therapies group also included CBT≥15 sessions and CBT<15 sessions as separate interventions. CBT<15 sessions had a better SMD vs TAU than CBT≥15 sessions (CBT<15 sessions group -1.25. 95% CrI -1.72 to -0.83; CBT≥15 sessions group -0.84, 95% CrI -1.91 to 0.78) and also a much larger evidence base (N=316 vs 10) - see also Table 10, results of bias-adjusted analysis, in

						evidence review B. Therefore, as CBT<15 sessions group was shown to have better effects and a much larger evidence base than CBT≥15 sessions group, it was selected for consideration as an exemplar of its class in the economic modelling (which ultimately informed recommendations). This has now been explained in evidence review B, under 'The committee's discussion of the evidence'. The exact number of sessions (8) modelled for individual and group CBT<15 sessions was based on relevant information reported in the respective RCTs that informed the guideline NMA and economic analysis, supplemented by

						the committee's clinical experience on optimal delivery of interventions within the NHS. This information has now been added in evidence review B, under Appendix N.

21.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	58	46-48	'…the committee were aware that a number of important and well-known, often pragmatic, trials were excluded…'. This statement suggests that the PICO and search criteria used for the evidence review may have been too narrow and thus omitted important trials. The committee were able to consider the results of these trials, which is helpful. However, this observation also raises the likelihood, that other important evidence, not known to the committee, was omitted from the evidence review. There is a risk that this informal process introduced bias in the discussions and recommendations. As observed above the PICO excluded interventions that are currently widely used in IAPT services, thus giving additional weight to the concern that the evidence review was incomplete.	Thank you for your comment. The committee drew on their knowledge of the IAPT dataset to inform recommendations and to re-structure treatment recommendations in response to stakeholder comments. The committee were also aware of pragmatic RCTs that were excluded from the NMA typically because the samples in the trials were <80% first-line treatment or <80% non-chronic depression. These were stipulations of the review protocol in order to create a homogenous data set, but the committee used their knowledge of these studies in the round when interpreting the evidence from the systematic review and making recommendations. By

						way of illustration some of these studies were listed in Evidence report B, however, in response to stakeholder comments the committee agree that it would be more consistent to name all UK-based studies which were excluded on this basis but which the committee were aware of when making recommendations.

22.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	61	42-43	BABCP suggests that further consideration be given to explain why interventions that were not cost-effective (non-directive counselling and short-term psychodynamic psychotherapy) were recommended as interventions for 'less severe' depression	Thank you for your comment. The committee agreed that for some people with specific depression characteristics or contributory factors (which are outlined in Table 1 and Table 2 in the guideline) there may be benefits for counselling or short-term psychodynamic therapy, and for these people, these interventions may be more likely to be cost-effective, compared to the overall population of people with depression.

23.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	62	05-Jun	The committee observed that some people with depression may not wish to attend group treatment – BABCP agree that this is an important observation and note that it is supported by research with service users. BABCP also suggest that the committee should consider the logistical challenges of organising group treatments and the costs (personal and NHS) of attrition from these groups. Many of our members who work in NHS psychological therapy services highlighted the difficulties of co-ordinating attendance at group treatment. They observed that finding adequate participants for group therapy was challenging, that wait times were artificially extended to accommodate delayed recruitment, that drop out was high, and that many patients were unwilling to accept group therapies. BABCP note that in the studies included in the evidence review these costs of delivering group treatments were not adequately reported and that therefore the evidence review and economic analysis did not take them into account. BABCP suggest that had such additional costs and resource implications been	Thank you for your comment. The committee considered it important to provide a wide range of interventions to take into account individual needs and allow patient choice. The committee agreed that decisions on treatment should be made in discussion with the person with depression, and recommended that a shared decision should be made. The committee recognised that some people with depression may not wish to attend group treatment. Although the economic model considered attrition costs of discontinuers on top of cost of missing group therapy as it was assumed that even if people

					properly assessed that the apparent cost effectiveness of group CBT and group BA would be significantly reduced.	discontinued therapy, or continued but missed some sessions, the cost of the group intervention would remain the same (i.e. discontinuers or non-attenders would still incur the cost). The committee acknowledged that there may be some implementation issues including coordinating attendance and waiting lists. Based on these considerations and the evidence of clinical and cost-effectiveness for guided self-help, individual CBT and individual BA, the committee considered offering these as alternatives to people who did not wish to attend group therapy. Furthermore, in response to stakeholder comments, in particular around

						implementation issues in the context of IAPT, some changes have been made to the tables of interventions for the treatment of a new episode of depression guided by the principles of offering the least intrusive intervention first, reflecting clinical and cost effectiveness, and reinforcing patient choice. The self-help with support section has been relabelled as guided self-help, included earlier in the treatment pathway, and the description of guided self-help has been amended. These changes essentially mean that group interventions are not the first treatment options in terms of the order of recommended use.

24.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B –	62	13-14	We agree with the committee's interpretation that unguided (unsupported) self-help is likely to result in high dropout / low engagement and with their observation that the therapeutic alliance is important. Thus, we also agree with their recommendation that self-help is offered with support as a treatment option for individuals with mild depression.	Thank you for your comment and support for this recommendation.
25.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	62	19-20	BABCP also agrees with the committee that it is important to offer a choice of therapy to people with a new episode of mild depression. However, BABCP do not think it realistic or feasible to offer people with 'less severe' depression a choice of 11 different interventions.	Thank you for your comment. Table 1 (and Table 2 for more severe depression) and the visual summary provide information to aid discussions and shared decision-making between clinicians and people with depression and it is made clear that patient preference should also be taken into consideration when making an individualised choice of treatment. As all the interventions included in the table are effective and

						appear cost-effective, it is hoped that NHS commissioners will ensure these interventions are available to all people with depression.
26.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	62	35-44	BABCP could not follow the rationale for offering or recommended treatments that are not cost-effective compared with usual GP care. This is also likely to present a challenging change to practice – how are GPs or other primary care staff to assess and then identify the individuals for whom these not cost-effective interventions are indicated?	Thank you for your comment. The committee agreed that for some people with specific depression characteristics or contributory factors (which are outlined in Table 1 and Table 2 in the guideline) there may be benefits for counselling or short-term psychodynamic therapy, and for these people, these interventions may be more likely to be cost-effective, compared to the overall population of people with depression.

27.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)		63	1 to 15	BABCP strongly support and endorse the committee's observation that commissioners of mental health services need explicit guidance on the length and structure of psychological therapies that they commission. We also note that the committee used a range of information in making explicit statements about the length of psychological therapies (e.g. resource use from the economic analysis and RCT data, as well as the committee's expertise). We do not agree with the conclusions of the committee about the length of treatments, which deviates substantially from the data presented in evidence review B (e.g. table 2, page 18).	Thank you for your comment. The committee provided guidance on the number of sessions of psychological interventions based on relevant information reported in the RCTs that informed the guideline NMA and economic analysis, supplemented by their clinical experience on optimal delivery of interventions within the NHS. The information on resource use derived from the RCTs has now been added in evidence review B, under Appendix N, and shows that there is consistency between the committee's guidance on usual number of sessions and the resource use reported in the RCTs (it is noted that Table 2, page 18 only shows the different classes and interventions included in

						the NMA but does not give information on the number of sessions reported in the RCTs that informed the NMA and the economic analysis). The committee provided guidance on the 'usual' number of sessions expected for the delivery of each intervention, which is also relevant to the person's level of symptom severity (number of sessions suggested for an intervention may differ between less or more severe depression). This usual number of sessions serves only as guidance and can be modified depending on individual needs, as it is now clarified in the recommendations. The committee has now removed guidance on the duration of sessions of

						each intervention from the recommendations, to allow flexibility in the delivery of interventions.

28.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	82	Table 16	CT/CBTIndividual CBT (and variants) and group CBT have been classified as 15 session and over, and under 15 sessions. This distinction is not made for other therapies and the reason for this is not clear. BABCP suggest that the rationale is explained.Behavioural activation – No distinction is made between high intensity behavioural activation (Jacobson, Martell model) typically 12-16 sessions delivered by Band 7+ therapists and low intensity behavioural activation (Lejeuz and Hopko model) with fewer sessions and typically delivered by PWPs (Band 5s). This is an important distinction and essential to assess cost effectiveness. BABCP suggest that in the evidence review these two forms of Behavioural Activation are clearly distinguished and evaluated separately.	Thank you for your comment. The committee wanted to explore if there was a difference in the effects of briefer versus longer CBT. For each level of severity, for the class of Cognitive and cognitive behavioural therapies, both individual and group, the NMA classification system made a distinction between CBT ≥15 sessions and CBT<15 sessions, which were considered as separate interventions within the class. This differentiation by intensity (number of sessions) was possible for CBT because there was large variation in the number of sessions reported across RCTs, and there was also a large evidence base that allowed formation of 2 separate groups of interventions according to

						the number of sessions offered. It was not possible to create distinct intervention categories based on intensity for other interventions (including BA) because there was either no great variation in the number of sessions reported for an intervention in the RCTs included, or the evidence base was too narrow. In response to your comment, this explanation has been added to Evidence review B. In response to stakeholder comments, in particular around implementation issues in the context of IAPT, some changes have been made to the tables of interventions for the treatment of a new episode of depression

						guided by the principles of offering the least intrusive intervention first, reflecting clinical and cost effectiveness, and reinforcing patient choice. The self-help with support section has been relabelled as guided self-help, included earlier in the treatment pathway, and the description of guided self-help has been amended to recommend that printed or digital materials that follow the principles of guided self-help are used including structured CBT, structured BA, problem solving or psychoeducation materials, delivered face-to-face or by telephone or online. The BA referred to in the recommendations is a high intensity

						intervention, and changes to recommendations for low intensity interventions are described above.

29.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	122	43-44	BABCP note that the economic analysis of specific interventions classified CBT (group and individual) as under 15 sessions. The specificity of the number of sessions for CBT (but not other interventions) was not clear and BABCP suggest that this is explained.	Thank you for your comment. The committee wanted to explore if there was a difference in the effects of briefer versus longer CBT. For each level of severity, for the class of Cognitive and cognitive behavioural therapies, both individual and group, the NMA classification system made a distinction between CBT ≥15 sessions and CBT<15 sessions, which were considered as separate interventions within the class. This differentiation by intensity (number of sessions) was possible for the CT/CBT class because there was large variation in the number of sessions reported across RCTs, and there was also a large evidence base that allowed formation of 2 separate groups of interventions according to

						the number of sessions offered. It was not possible to create distinct intervention categories according to intensity for other treatment classes because there was either no great variation in the number of sessions reported for an intervention within the class in the RCTs included, or the evidence base was too narrow. In response to your comment, this explanation has been added to Evidence review B. For each level of severity, the economic analysis selected and analysed one intervention per effective class as an exemplar, as it was not feasible to model every single intervention considered in the NMA. The criteria for selection were (see Appendix J,

						section 'Interventions assessed'): • the size of the evidence base for each intervention • the availability of interventions within the NHS: more commonly used interventions had a priority over less commonly used interventions • relative effectiveness: more effective interventions within a class were better candidates for selection • side-effect profile in the case of pharmacological treatments. For more severe depression, the Cognitive and cognitive behavioural therapies individual included CBT≥15 sessions and CBT<15 sessions as separate interventions. CBT≥15 sessions individual seemed to have

						a somewhat smaller effect vs placebo compared with CBT<15 sessions individual (CBT≥15 sessions individual SMD -0.60, 95% CrI -0.90 to -0.30; CBT<15 sessions individual SMD -0.73, 95% CrI -1.08 to -0.41), but had a somewhat larger evidence base across RCTs on the SMD outcome (CBT≥15 sessions individual had N=626 vs CBT<15 sessions individual had N=369) - see Table 25, results of bias-adjusted analysis for more severe depression, in evidence review B. CBT≥15 sessions individual was considered to have a more appropriate intensity for a population with more severe depression by the committee, it had also a larger evidence base than

						CBT<15 sessions, and given that CBT≥15 sessions and CBT<15 sessions had broadly similar effects versus placebo, CBT≥15 sessions individual was selected for consideration as an exemplar of its class in the economic modelling (which ultimately informed guideline recommendations). This has now been explained in evidence review B, under 'The committee's discussion of the evidence'. The Cognitive and cognitive behavioural therapies group also included, in principle, CBT≥15 sessions and CBT<15 sessions as separate interventions. However, for the primary clinical outcome of SMD, there was only evidence

						on CBT<15 sessions (as shown in Table 24 of evidence review B), and therefore this was selected as the only intervention within its class in the economic modelling (which ultimately informed recommendations). This has now been explained in evidence review B, under 'The committee's discussion of the evidence'. The exact number of sessions modelled for individual CBT≥15 sessions (16 sessions modelled) and group CBT<15 sessions (10 sessions modelled) was based on relevant information reported in the respective RCTs that informed the guideline NMA and economic analysis, supplemented by

						the committee's clinical experience on optimal delivery of interventions within the NHS. This information has now been added in evidence review B, under Appendix N.

30.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	140	48-50	'…the committee were aware that a number of important and well-known, often pragmatic, trials were excluded…'. This statement suggests that the search criteria used for the evidence review may have been too narrow and thus omitted important trials. The committee were able to consider the results of these trials, which is helpful. However, this observation also raises the likelihood, that other important evidence, not known to the committee, was omitted from the evidence review. As observed above the PICO excluded interventions that are currently widely used in IAPT services, thus giving additional weight to the concern that the evidence review was incomplete.	Thank you for your comment. When making recommendations, the committee interpreted the RCT evidence in light of their knowledge of the clinical context (including drawing on their knowledge of the IAPT dataset) so that the 'reality' for people experiencing depression was taken into consideration. In response to stakeholder comments, the committee have re-structured treatment recommendations in order to take into account implementation factors. The committee were also aware of pragmatic RCTs that were excluded from the NMA typically because the samples in the trials were <80% first-line treatment or <80% non-chronic depression.

						These were stipulations of the review protocol in order to create a homogenous data set, but the committee used their knowledge of these studies in the round when interpreting the evidence from the systematic review and making recommendations. By way of illustration some of these studies were listed in Evidence report B, however, in response to stakeholder comments the committee agree that it would be more consistent to name all UK-based studies which were excluded on this basis but which the committee were aware of when making recommendations.

31.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	141	21-28	BABCP agrees that the results of high quality and relevant RCTs that did not meet inclusion criteria for the meta-analysis are consistent and that their findings are important to consider in making recommendations. However, BABCP is concerned that this raises questions about the validity of the inclusion criteria and increases the risk that relevant data, not personally known to committee members was unintentionally excluded from review. Thus there is a significant risk that the evidence review is incomplete.BABCP suggest that all excluded studies are listed and the reasons for their exclusion noted. BABCP also suggest that the excluded studies that were considered are clearly identified.	Thank you for your comment. The committee drew on their knowledge of the IAPT dataset to inform recommendations and to re-structure treatment recommendations in response to stakeholder comments. The committee were also aware of pragmatic RCTs that were excluded from the NMA typically because the samples in the trials were <80% first-line treatment or <80% non-chronic depression. These were stipulations of the review protocol in order to create a homogenous data set, but the committee used their knowledge of these studies in the round when interpreting the evidence from the systematic review and making recommendations. By

						way of illustration some of these studies were listed in Evidence report B, however, in response to stakeholder comments the committee agree that it would be more consistent to name all UK-based studies which were excluded on this basis but which the committee were aware of when making recommendations. A full list of excluded studies with reasons for exclusion is provided in Supplement B1.

32.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	141	43-49	Again, the BABCP agrees that the results of high quality and relevant RCTs that did not meet inclusion criteria for the meta-analysis are consistent and that their findings are important to consider in making recommendations. However, as noted above this raises concerns that the evidence review missed important and relevant evidence.	Thank you for your comment. The committee drew on their knowledge of the IAPT dataset to inform recommendations and to re-structure treatment recommendations in response to stakeholder comments. The committee were also aware of pragmatic RCTs that were excluded from the NMA typically because the samples in the trials were <80% first-line treatment or <80% non-chronic depression. These were stipulations of the review protocol in order to create a homogenous data set, but the committee used their knowledge of these studies in the round when interpreting the evidence from the systematic review and making recommendations. By

						way of illustration some of these studies were listed in Evidence report B, however, in response to stakeholder comments the committee agree that it would be more consistent to name all UK-based studies which were excluded on this basis but which the committee were aware of when making recommendations.
33.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	145	47-50	The observation that 'there may be specific groups for whom IPT and STPP may be effective' may be accurate. However, without clear guidance about how to identify these individuals the recommendation that these therapies be offered to people with more severe depression will present a significant challenge to practice – who are these	Thank you for your comment. The committee agreed that for some people with specific depression characteristics or contributory factors (which are outlined in Table 1 and Table 2 in the guideline) there may be

					‘specific groups’ and how will they be identified?	benefits for interpersonal therapy or short-term psychodynamic therapy, and for these people, these interventions may be more likely to be cost-effective, compared to the overall population of people with depression.

34.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	146	Apr-18	BABCP strongly support and endorse the committee's observation that commissioners of mental health services need explicit guidance on the length and structure of psychological therapies that they commission. We also note that the committee used a range of information in making explicit statements about the length of psychological therapies (e.g. resource use from the economic analysis and RCT data, as well as the committee's expertise). BABCP do not agree with the recommendations of the committee about the length of treatments (e.g. 8 sessions of CBT for 'less severe' depression, in Table 1 of the guidance), which deviates substantially from the data presented in the evidence review B (e.g. table 24, page 104) in which CBT is classified as being fewer than 15 sessions or more than 15 sessions. There is no reference at all in the evidence review to 8 sessions being the appropriate length of CBT but this is the recommended number of sessions of CBT for patients with 'less severe' depression (Table 1: Guidance). Many patients will require more than 8 sessions of CBT. This is especially important for patients with co-	Thank you for your comment. The committee provided guidance on the number of sessions of psychological interventions based on relevant information reported in the RCTs that informed the guideline NMA and economic analysis, supplemented by their clinical experience on optimal delivery of interventions within the NHS. The information on resource use derived from the RCTs has now been added in evidence review B, under Appendix N, and shows that there is consistency between committee's guidance on number of sessions and the resource use reported in the RCTs. Table 25 on page 104 lists the bias-adjusted results on the SMD outcome of classes and interventions versus

					morbid mental health problems, chronic physical health problems, specific learning difficulties, learning disabilities, or complex social needs.	placebo in more severe depression and does not provide any information on the resource use reported in the RCTs that informed the guideline NMA and the economic analysis. The comment probably refers to the distinction between CBT ≥15 sessions and CBT<15 sessions, which were considered as separate interventions within the class of cognitive and cognitive behavioural therapies (both individual and group). This distinction was made because there was large variation in the number of sessions reported across RCTs for the CT/CBT class, and there was also a large evidence base that allowed formation of 2 separate interventions within the class, according

						to the number of sessions offered. The economic analysis selected and analysed one intervention per effective class as an exemplar, as explained in response to a related comment. For less severe depression, the Cognitive and cognitive behavioural therapies individual included CBT≥15 sessions and CBT<15 sessions as separate interventions. The two interventions had a similar SMD vs TAU (CBT≥15 sessions individual -0.68, 95% CrI -1.36 to 0.01; CBT<15 sessions individual -0.66, 95% CrI -1.45 to 0.16), and CBT<15 sessions had a somewhat larger evidence base across RCTs on the SMD outcome (N=233 vs 123) - see Table

						10, results of bias-adjusted analysis for less severe depression, in evidence review B. CBT<15 sessions individual was considered to have an appropriate intensity for a population with less severe depression by the committee, it had also a larger evidence base than CBT≥15 sessions, and given that CBT≥15 sessions and CBT<15 sessions had similar effectiveness, CBT<15 sessions individual was selected for consideration as an exemplar of its class in the economic modelling (which ultimately informed guideline recommendations). This has now been explained in evidence review B, under 'The committee's

						discussion of the evidence'. Given the volume of the evidence base, the guideline NMA and economic results that favoured less intensive CBT (<15 sessions), and their clinical expertise, the committee decided to recommend CBT<15 sessions, both for individual and group mode of delivery, for people with less severe depression. As shown in Appendix N of evidence review B, the resource use described in the RCTs for individual CBT<15 sessions in less severe depression was 7 sessions in the majority of studies, with 3 studies reporting a range of 8-10 sessions. This RCT-reported resource use, alongside the committee's clinical

						expertise, informed the respective recommendation and it is consistent with the 'usually' 8 sessions recommended. The committee considered that offering a high intensity intervention in 8 sessions (usually) was appropriate and adequate for a population with less severe depression. This number of 'usual' sessions serves only as guidance and can be modified depending on individual needs. This has now been clarified in the recommendation.

35.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	146	28-30	BABCP welcome the discussion of Barkham (2021) and Cuijpers (2021) and note that both the RCT and the meta-analysis suggest that counselling may be a less effective treatment for depression than CBT (Barkham) and other psychological interventions (Cuijpers).	Thank you for your comment and support for this section of the discussion.
36.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	325	Line numbers not providedIntervention resource use and costs Psychological interventions section	It is noted that economic modelling of group CBT and group Behavioural Activation is based on costs of one Band 7 High Intensity therapist and one Band 6 High intensity therapist. This assumption for modelling purposes is incorrect – High intensity therapists are employed on Band 7 (or higher). Band 6 is used only for trainees, not qualified staff. Table 87, page 329 is therefore redundant / irrelevant as these costs would not be incurred by services providing 'high intensity' psychological therapies. This is an important issue as it would change the outcome of the cost effectiveness analysis which favours group CBT (and Group BA)	Thank you for your comment. The committee agreed with the comment and the term 'high intensity' has been removed for 'Band 6 therapists'. Unit costs for Band 6 therapists were used only for the estimation of high intensity group therapies, which were assumed to be led by a high intensity Band 7 therapist, supported by a Band 6 therapist, which might be, for example, a trainee clinical psychologist. This support may be of particular importance for larger groups of

						participants, although support by a Band 6 therapist may not be essential for the delivery of the intervention. This assumption was based on the committee's expert advice, considering optimal clinical practice. To clarify this point, the recommended delivery for high intensity group interventions has now been amended accordingly, to read "delivered by 2 practitioners, at least 1 of whom has therapy-specific training and competence".

37.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	326	Line Numbers not providedSensitivity analysis	In relation to the sensitivity analysis to reflect different costs of staff providing psychological therapists, Band 5 staff are not qualified to provide psychological therapies and should not be doing so anywhere in the country. BABCP are concerned therefore this sensitivity analysis may be highly misleading and is not relevant. BABCP suggest that a more logical sensitivity analysis would assess costs for Band 8a therapists because this group are employed to deliver psychological therapies in NHS mental health services.	Thank you for your comment. The committee agreed that this sensitivity analysis is not relevant and it has now been removed from the economic analysis appendix. Assuming that all high intensity (HI) interventions are exclusively delivered by Band 8a therapists would be unrealistic (although some of the high intensity therapists delivering these interventions will be Band 8a), hence this scenario was not added in the analysis. In any case, HI individual interventions are already costlier than HI group interventions or low intensity interventions, so assuming an even higher unit cost for therapists would not have a strong impact on the results regarding the relative

						cost-effectiveness between these types of interventions.

38.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	327	Table 84	This table shows assumed unit costs for therapists. A cost is allocated to 'High Intensity' therapist Band 6 and High Intensity MBCT therapist Band 6BABCP notes that this is inaccurate – High Intensity therapists are employed at Band 7 (and above). Therefore any costs based on this assumption will be incorrect and this has implications for cost-effectiveness analyses.	Thank you for your comment. The committee agreed with the comment and the term 'high intensity' has been removed for 'Band 6 therapists'. Unit costs for Band 6 therapists were used only for the estimation of high intensity group therapies, which were assumed to be led by a high intensity Band 7 therapist, supported by a Band 6 therapist, which might be, for example, a trainee clinical psychologist. This support may be of particular importance for larger groups of participants, although support by a Band 6 therapist may not be essential for the delivery of the intervention. This assumption was based on the committee's expert advice, considering

						optimal clinical practice. To clarify this point, the recommended delivery for high intensity group interventions has now been amended accordingly, to read "delivered by 2 practitioners, at least 1 of whom has therapy-specific training and competence".

39.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	329	Table 87	This table is redundant – High intensity therapists are not employed at Band 6 so these costs are not correct and will provide incorrect estimates of the cost of therapy.	Thank you for your comment. The committee agreed and the term 'high intensity' has now been removed for 'Band 6 therapists'. Unit costs for Band 6 therapists were used only for the estimation of high intensity group therapies, which were assumed to be led by a high intensity Band 7 therapist, supported by a Band 6 therapist, which might be, for example, a trainee clinical psychologist. This support may be of particular importance for larger groups of participants, although support by a Band 6 therapist may not be essential for the delivery of the intervention. This assumption was based on the committee's expert advice, considering optimal clinical practice.

						To clarify this point, the recommended delivery for high intensity group interventions has now been amended accordingly, to read "delivered by 2 practitioners, at least 1 of whom has therapy-specific training and competence".

40.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	331	Table 88, rows 3 to 6	Intervention costs of psychological therapies for adults:This table shows the number of sessions of CBT for 'less severe' depression as 8; however, the evidence review (and primary research) considered treatments of more than 15 and less than 15 sessions. It is not clear why costs were estimated for 8 sessions as this is not equivalent to 'less than 15' or 'more than 15' sessions. BABCP are concerned that the decision taken to model cost effectiveness based on 8 sessions of CBT is flawed and leads to erroneous conclusions. It may also be misleading to commissioners who may see this modelling as a suggestion that a maximum of 8 sessions of CBT are offered to people with 'less severe' depression. This would be likely to reduce access to treatment. There are similar assumptions made for other therapies. For example, what is the rationale for 12 sessions of individual BA for 'more severe' depression?BABCP would find it helpful and more transparent if the rationale for modelling specific numbers of treatment were made explicit. Currently BABCP cannot see any justification for the number of	Thank you for your comment. The economic analysis based the number of sessions of psychological interventions on relevant information reported in the RCTs that informed the guideline NMA and the economic analysis, supplemented by the committee's clinical experience on optimal delivery of interventions within the NHS. The information on resource use derived from the RCTs has now been added in evidence review B, under Appendix N, and shows that there is consistency the number of sessions modelled in the guideline economic analysis and the resource use reported in the RCTs. Regarding the number of sessions of individual CBT,

					sessions allocated to different treatments – this is important because modelling different lengths of treatment (i.e. number of sessions) has a direct impact on the assessment of cost-effectiveness of different treatments and thus on the recommendations made by NICE about the ordering of different treatments for depression in the 'menu' of choices.	the guideline NMA, which informed the economic analysis, made a distinction between CBT ≥15 sessions and CBT<15 sessions, which were considered as separate interventions within the class of individual cognitive and cognitive behavioural therapies. This distinction was made because there was large variation in the number of sessions reported across RCTs for the CT/CBT class, and there was also a large evidence base that allowed formation of 2 separate interventions according to the number of sessions offered. The economic analysis selected and analysed one intervention per effective class as an exemplar, as explained in response to a related comment.

						For <u>less severe depression</u>, the Cognitive and cognitive behavioural therapies individual included CBT≥15 sessions and CBT<15 sessions as separate interventions. The two interventions had a similar SMD vs TAU (CBT≥15 sessions individual -0.68, 95% CrI -1.36 to 0.01; CBT<15 sessions individual -0.66, 95% CrI -1.45 to 0.16), and CBT<15 sessions had a somewhat larger evidence base across RCTs on the SMD outcome (N=233 vs 123) - see Table 10, results of bias-adjusted analysis for less severe depression, in evidence review B. CBT<15 sessions individual was considered to have an appropriate intensity for a population with less severe

						depression by the committee, it had also a larger evidence base than CBT≥15 sessions, and given that CBT≥15 sessions and CBT<15 sessions had similar effectiveness, CBT<15 sessions individual was selected for consideration as an exemplar of its class in the economic modelling (which ultimately informed guideline recommendations). This has now been explained in evidence review B, under 'The committee's discussion of the evidence'. As shown in Appendix N of evidence review B, the resource use described in the RCTs for individual CBT<15 sessions for less severe depression was 7 sessions in the majority of

						studies, with 3 studies reporting a range of 8-10 sessions. This RCT-reported resource use, alongside the committee's clinical expertise, informed the economic analysis, which modelled 8 sessions of individual CBT for people with less severe depression. Based on the reported resource use in the RCTs and the economic modelling, along with the committee's expert opinion that 8 sessions of a high intensity intervention are usually adequate for people with less severe depression, the recommendation for individual CBT for people with less severe depression suggests 'usually' 8 sessions. This is not suggestive of 'maximum' of 8 sessions and more sessions may be

						delivered according to individual needs. This has now been clarified in the recommendation. For individual BA in more severe depression, the reported resource use in RCTs informing the NMA and the economic analysis ranged from 8 to 20 sessions. Based on this information and using their expertise, the committee advised that the economic analysis model 12 sessions for individual BA in more severe depression. However, the committee acknowledged that in routine practice there is usually more variation in the number of individual BA sessions delivered to people with more severe depression, and recommended ("usually") a range of 12-16 sessions.

						As with all other recommended numbers of sessions, this is only indicative and not suggestive of a maximum number of sessions. More sessions may be delivered according to individual needs. This has now been clarified in the recommendation.

41.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	333	Physical interventions	BABCP does not understand the logic of costing the delivery of exercise programmes as equivalent to a Band 5 PWP. PWPs are not qualified to deliver exercise programmes or to assess suitability for these interventions. Thus, there would be a significant challenge to clinical practice and potentially serious risk of harm to patients if PWPs or other unqualified staff were employed to carry out these tasks. Following from this, the costs based on the Band 5 PWP equivalent staff in Table 90 are misleading (unless they are based on a different professional group that could be specified).	Thank you for your comment. Exercise programmes are not currently available in the NHS, therefore it was not possible to determine a specific professional group for the delivery of the intervention ("It is acknowledged that exercise programmes are not routinely offered within the NHS context, although people with depression may be advised to attend exercise programmes at their own expense"). Based on the demands and expertise required to deliver exercise programmes, the committee estimated that such programmes would likely be delivered by a Band 5 practitioner. In order to consider the potential cost of exercise programmes and due to lack of more relevant

						data, “exercise programmes were assumed to be delivered by an AfC band 5 practitioner, with a unit cost equivalent to that of PWP”- in the report it was not stated that PWPs should deliver such interventions and the text has been further reworded to clarify this point.

42.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	364	29-34	BABCP appreciates that this is a sensitivity analysis but wish to point out that Band 5 staff (e.g. PWPs) are not qualified to deliver high intensity psychological therapies of any kind and therefore the results of the cost effectiveness analysis (whilst perhaps interesting) are not relevant to practice and would present huge ethical and logistical challenges.	Thank you for your comment. The committee agreed with the comment and the results of this sensitivity analysis have now been removed. It should be emphasised that the base-case economic analysis, which was the analysis that informed recommendations, assumed that high intensity interventions are delivered by Band 7 therapists, or, in the case of group interventions, are led by a Band 7 therapist and supported by a Band 6 therapist. Therefore please be reassured that the results of the guideline cost-effectiveness analysis are relevant to practice and do not present ethical or logistical challenges.

43.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	366	31-34	This statement is misleading and unhelpful – it implies that Band 5 PWPs have been trained to deliver high intensity psychological interventions – and that they can do so safely under supervision. This is not accurate. BABCP would have serious concerns if such a scenario were ever considered and would not recognise as acceptable the delivery of CBT (in a group, individually or by any method of delivery) by a Band 5 PWP. Delivery of high intensity psychological therapies (CBT and all other therapy modes) must be by properly trained, competent, and qualified therapists, under supervision. The minimum training standards of BABCP outline exactly what competencies, experiences and supervision are required to deliver CBT.	Thank you for your comment. The committee agreed and this sensitivity analysis and the accompanying statement has now been removed. The costing of high intensity therapists has taken into account respective qualification costs as well as supervision time.
44.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	374	Research question 2 – 9 and Table 102	BABCP welcome and strongly endorse this research question and in particular the comments around feasibility i.e. using experimental studies to identify potential mechanisms of treatment, followed by the development of new targeted treatments, assessed via large scale RCTs. We agree that this would	Thank you for your comment and support for this research recommendation.

					require an extensive programme of research.	
45.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review B	375	Table 103	BABCP suggest that other study design (in addition to factorial designs) will be appropriate to address the research question. These will include detailed single case experiments, observational studies, qualitative, and process studies. Related to this point BABCP are also concerned that the evidence review on which the revised guidelines are based did not consider any research that has used the IAPT dataset – which is for this purpose the most relevant data available on the delivery and effectiveness of psychological therapies delivered in routine clinical practice in England. The consequence of completely ignoring this research and drawing conclusions exclusively on the results of RCT data has led to recommendations that are unaffordable, unfeasible and which threaten the viability of existing services. The selection of research included in the evidence review included studies that	Thank you for your comment. The modified PICO table is provided as a guide to the conduct of the research to address this question, but inclusion of other types of data could be considered by the researcher, and this could include the other study types you suggest or the IAPT data set if appropriate. The committee agreed to use RCT evidence as the evidence source most likely to provide evidence of effectiveness and to allow determination of cost-effectiveness, but based on stakeholder feedback the recommendations have

					were underpowered, of poor quality, evaluated interventions that are not typically available in the NHS (e.g. problem-solving therapy), failed to include many low intensity interventions delivered in IAPT, and which were conducted with participants and in contexts far removed from the population of England.	been modified to take into consideration the delivery of interventions by IAPT services.
46.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review CPrevention of relapse	69	23-24	We are pleased that the guideline committee acknowledged the important social factors that contribute to depression and the need to identify and address these if possible. We would welcome new guidance focused on this topic i.e. interventions to ameliorate social factors that contribute to the aetiology and maintenance of depression, and which moderate outcomes.	Thank you for your comment. The guideline recommendations have been expanded in several places to give a greater emphasis on the social, personal and environmental determinants that contribute to depression, and support that can help alleviate the effects of these determinants.

47.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review C	70	16-17	BABCP welcome the suggestion that brief interventions targeted at relapse prevention should be a future research priority.	Thank you for your comment and support for this research recommendation.
48.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review C	70	38-41	BABCP agree and welcome the committee's suggestion that psychological interventions for depression should routinely include follow up to assess relapse. This however, will present a clinical and resource challenge in many services, because most are not commissioned to provide follow up sessions – for example IAPT services in England are not paid to follow up and identify relapse or risk of relapse and therefore are not able to offer follow up sessions to their patients.	Thank you for your comment and support of the relapse prevention recommendations. The resourcing of relapse prevention psychological therapies is an implementation issue, and will be considered by NICE when implementation support activity is being planned.
49.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review C	71	39-49	The committee have presented a range of hypothetical scenarios in which maintenance CBT or MBCT or cCBT may be cost effective – i.e. if CBT is offered in 4 sessions. BABCP strongly endorse the provision of sessions to maintain treatment gains and would welcome these being included in contracts. For this to happen commissioners of	Thank you for your comment. The committee agreed that provision of maintenance psychological interventions is important in maintaining treatment gains for people who have remitted from depression,

					psychological therapy services will need to be made aware of this recommendation	and based on the clinical and economic evidence they made relevant recommendations. Implementation issues relating to these recommendations will be considered by NICE when preparing implementation support tools for the guideline.

50.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review C	72	24-28	BABCP is pleased that the guidelines committee recommend relapse prevention sessions for those at high risk of relapse. The economic modelling suggested that 10 sessions were not cost effective but that 4 sessions of CBT/CT or MCBT would be cost effective – the committee then expressed the view that '4 sessions are adequate to maintain a relapse prevention effect' BABCP could not deduce any clinical rationale for this opinion - the economic modelling is based on a purely hypothetical situation that is not related to clinical practice or based on the outcome data of participants who received 4 relapse prevention sessions. Therefore, whilst BABCP welcome the recommendation that relapse prevention sessions are provided to individuals at high risk of relapse we suggest that the limit of '4 relapse prevention sessions' would be better described as a minimum number that should be commissioned (not a maximum).	Thank you for your comment. The committee considered the available clinical and economic evidence and concluded that for people who have remitted from depression following psychological treatment and have been assessed as being at a higher risk of relapse it is clinically sensible to offer further sessions of the same intervention. However, they expressed the opinion that these people do not need a full course of the same intervention, as reflected in 10 sessions, given that they have already remitted from depression. Instead, the committee agreed that these people would benefit from receiving a shorter number of sessions with a focus on a relapse prevention component, to

						further build their therapeutic relationship and consolidation. The recommendation suggests "at least 4 more sessions of the same treatment with a focus on a relapse prevention component". No maximum number of sessions has been suggested in the recommendation.
51.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review C	73	01 to 05	BABCP welcome the comment that high risk of relapse should not be limited to those with multiple previous episodes of depression – we agree that other factors, and in particular, personal, social and environmental factors are important. We welcome the recommendation that patients with these factors be considered	Thank you for your comment. The committee agreed that a number of factors may increase the risk of relapse, and this has been reflected in respective recommendations.

					at high risk after 1 or 2 previous episodes.	
52.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review C	238	26-27	Document states that group CT/CBT was delivered by one Band 7 high intensity therapist and one Band 6 high intensity therapist – Band 6 staff are not qualified high intensity therapists and thus would not be employed to deliver this treatment. This has an implication for unit costs calculated e.g. in Table 105, page 242, Table 105, page 243 The effect of this will be to over-estimate the cost-effectiveness of Group CBT or Group CT	Thank you for your comment. The committee agreed with the comment and the term 'high intensity' has been removed for 'Band 6 therapists'. Unit costs for Band 6 therapists were used only for the estimation of high intensity group therapies, which were assumed to be led by a high intensity Band 7 therapist, supported by a Band 6 therapist, which might be, for example, a trainee clinical psychologist. This support may be of particular importance for larger groups of participants, although support by a Band 6

						therapist may not be essential for the delivery of the intervention. This assumption was based on the committee's expert advice, considering optimal clinical practice. Therefore, the economic analysis has not overestimated the cost-effectiveness of group CBT or group CT. To clarify this point, the recommended delivery for high intensity group interventions has now been amended accordingly, to read "delivered by 2 practitioners, at least 1 of whom has therapy-specific training and competence".
53.	British Association of Behavioural and Cognitive	Evidence review C	239	36-47	BABCP are extremely pleased to see that the costs of supervision have been included in the unit cost calculations.	Thank you for your comment. The committee advised that supervision costs are important and an essential part of the

	Psychotherapy (BABCP)					cost of providing psychological interventions, hence their inclusion in the estimation of the unit cost.
54.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review D	10	PICO table ****Population	BABCP note that studies were included if participants received a diagnosis of depression (DSM or ICD, or similar) or reported symptoms on a 'validated' scale. BABCP suggests that studies which selected participants on the basis of a diagnostic interview are of better quality and thus should be given greater weight in a meta-analysis. Likewise, studies that selected participants on the basis of 'validated' self-report scales are of lower quality and should be given less weight in a meta-analysis	Thank you for your comment. As pre-specified in the review protocols, the population included adults with clinically important symptoms of depression (as defined by a diagnosis of depression according to DSM, ICD or similar criteria, or depressive symptoms as indicated by baseline depression scores on validated scales). Studies using depression symptom scales were included (in addition to studies that limited inclusion to those with a diagnosis of depression) on the basis that such scales are

						widely used in RCT research and clinical practice and are validated in the diagnosis of depression and the assessment of depression symptom severity. The committee were concerned that excluding studies that did not use diagnostic interviews would result in the exclusion of a large number of studies, would have a disproportionate impact on the evidence base for some interventions for example for self-help studies, and would not allow examination of those with subthreshold symptoms of depression which were included in the review question and protocol.

55.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review D	11	PICO table intervention	BABCP note that "Mindfulness, mediation, or relaxation' are listed as if synonymous. BABCP note that these are not one 'school' or coherent model of therapy or interventions. Mindfulness based CBT is a specific protocol-based intervention for which specific training, quality standards and supervision are available. Meditation and relaxation might refer to a range of activities and are not synonymous with mindfulness. Therefore the evidence reviewed relating to Mindfulness Based CBT is not applicable to 'meditation' or 'relaxation', neither of which are evidence-based treatments for depression.	Thank you for your comment. For the further-line treatment review, mindfulness-based cognitive therapy (MBCT) is included in the cognitive and cognitive behavioural therapies class and this is outlined in the full protocol in Appendix A. In theory, a separate class included mindfulness based interventions without a cognitive component, meditation or relaxation interventions (including mindfulness-based stress reduction [MBSR]). However, no eligible evidence was found for these interventions for the further-line treatment of depression.

56.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review D	12	PICO table Comparison	BABCP observe that these comparators are not equivalent to each other – placebo and active interventions are a more stringent test of effectiveness and cost effectiveness than 'no treatment', wait list, or TAU and the results of studies should be weighted according to the strength of the comparison.	Thank you for your comment. The committee agree that not all comparators are equally desirable. However, the committee did not consider that studies with waitlist, no treatment or TAU comparators are necessarily less valid, although these comparators are potentially less effective (not necessarily TAU) and TAU may also be characterised by heterogeneity. All relevant comparators were included, as restricting the review to only studies with a placebo or active comparator would considerably limit and potentially bias the evidence base. However, different comparators were categorised separately in the network,

						and the committee considered comparators when assessing risk of bias and quality of the evidence using GRADE, and when interpreting the evidence and making recommendations.
57.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review EChronic depression			BABCP did not have sufficient time or resources to comment fully on this evidence review. We suggest that future consultations provide a reasonable time in which to digest the documentation and obtain expert review and opinion as well as feedback from member and service user representatives.The concerns about the PICO, made in points 8, 9 and 10 apply to this review.	Thank you for your comment and for letting us know that you did not have time to comment on this evidence review.

58.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review E	10	11 to 22	BABCP was pleased to see a list of the studies that were included in this review as well as a summary table of the results (page 12).	Thank you for your comment and support for this section of the evidence review.
59.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review FDepression with coexisting personality disorder			BABCP did not have sufficient time or resources to comment fully on this evidence review. Many of our concerns about the PICO, made in points 8, 9, and 10 apply to this review.	Thank you for your comment and for letting us know that you did not have time to comment on this evidence review.
60.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidencereview F	7	08 to 20	BABCP welcomes the introductory statement outlining some of the complex issues this topic raises. BABCP suggest that the guidelines offer more specificity about the types of personality disorder for which this evidence review is relevant –	Thank you for your comment. The committee noted that this review covered people with depression comorbid with a personality disorder, but that there are different types of personality disorder and it was not always clear from the evidence which types had been included, or if all types had been combined and considered. The committee agreed that one of the most common

						types is emotionally unstable personality disorder (previously known as borderline personality disorder), they were aware that there is existing NICE guidance on borderline personality disorder, and wanted to make sure that recommendations were in line with the existing NICE guidance. It was not possible to provide any greater specificity for any other types of personality disorder as the evidence did not allow clear differentiation.

61.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review F	7	PICO table	Population How were the participants selected i.e. what criteria were used to assed depression, and what criteria were used to assess personality disorders? Studies which recruited participants based on diagnostic interviews should be given greater weight in the evidence review than those that used self-report measuresWhich personality disorders were included?	Thank you for your comment. The type of personality disorder was not pre-specified in the protocol, and any personality disorder could be included providing other eligibility criteria were met. Criteria to assess personality disorder were not restricted. Criteria to assess depression included a diagnosis of depression according to DSM, ICD or similar criteria, or depressive symptoms as indicated by baseline depression scores on validated scales. Studies using depression symptom scales were included (in addition to studies that limited inclusion to those with a diagnosis of depression) on the basis that such scales are widely used in RCT research and clinical

						practice and are validated in the diagnosis of depression and the assessment of depression symptom severity.
62.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review F	1 1 to 12	Table 4	Shea (1990) – individuals were identified as having a personality disorder on the basis of a self-report questionnaire (the Personality Assessment Form). BABCP suggests that this is a very low quality method of assessment and thus that the results of this study be weighted less heavily than more valid studies NB this study appears in several other comparisons and thus may carry undue weight because it is a four-armed trial	Thank you for your comment. Criteria to assess personality disorder were not restricted and thus the results of Shea (1990) were not 'downgraded' on this basis. However, the committee noted that the evidence for this review was of low to very low quality. It was downgraded due to high

						risk of bias across multiple domains and wide confidence intervals (imprecision commonly associated with small sample sizes). Additionally, although there were a large number of comparisons, these largely included only single studies.
63.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review G Psychotic depression			BABCP did not have sufficient time or resources to comment on this evidence review. Many of our concerns about the PICO, made in points 8, 9 and 10 apply to this evidence review.	Thank you for your comment and for letting us know that you did not have time to comment on this evidence review.
64.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review HAccess to services			BABCP welcome the inclusion of this evidence review and agree that this is a high priority topic for the NHS	Thank you for your comment and support for this evidence review.
65.	British Association of Behavioural and Cognitive	Evidence review IPatient choice			BABCP welcome the inclusion of this evidence review and agree that patient choice should be prioritised BABCP also agree that qualitative research is an	Thank you for your comment and support for this evidence review.

	Psychotherapy (BABCP)				appropriate method of research to address questions about patient choice.	
66.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review I Patient choice	7	Table 1	BABCP note that only qualitative research studies were reviewed – this was surprising given that other methods, including survey research would offer valid data related to this topic.****BABCP suggest that the reasons for focusing on qualitative research and excluding quantitative research are made explicit. BABCP also recommend that the evidence review is revised and incorporates quantitative and quantitative data related to patients choice.	Thank you for your comment. As pre-specified in the review protocol, the committee agreed that qualitative studies would best address this question, and searches and review strategies were designed accordingly.

67.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Evidence review I****Patient choice	Aug-28	Table 2	BABCP note that a range of different methods of qualitative data analysis were used by studies included in this review. Studies also focused on data obtained from patients, clinicians, and non-mental health professionals and N ranged from 5 to 80 participants. BABCP suggest that there is a clearer and more explicit explanation describing how the quality of primary studies informed their contribution to the analysis and the subsequent interpretation of the analysis by the committee?	Thank you for your comment. Detail about quality assessment and interpretation of the evidence is provided in the 'Committee discussion of the evidence' section of Evidence review I. The aim of the review was to identify facilitators and barriers to choose for people with depression and the themes which emerged were divided into those from the perspective of people with depression, and those from the perspective of practitioners. The quality of the evidence supporting each emerging theme was assessed using GRADE CERQual, and the overall confidence in the review

						findings ranged from high to very low. Methodological limitations of the primary studies were assessed with the CASP checklist. For the majority of studies some, if not all or most, of the checklist criteria had been fulfilled, and where they had not been fulfilled the conclusions were judged to be very unlikely to change. However, for some of the review findings there were “moderate” or “serious” concerns regarding methodological limitations. The most common issues were insufficient justification of the research design (for example, not discussing how they decided which method to use); potential for recruitment bias; insufficient justification

						for data collection methods and setting; lack of consideration for the relationship between researcher and participants; or insufficient consideration of ethical issues (for example, no discussion of informed consent or no detail on how research was described to participants). Concerns about coherence ranged from "no or very minor" to "minor". For the majority of review findings there were no or very minor concerns about coherence, as there were no data that contradicted the findings nor were there ambiguous data. A small number of review findings demonstrated minor concerns due to vaguely described data in

						the underlying body of evidence, or data that was defined in different ways. Concerns about relevance for the context and population of interest to this guideline ranged from “no or very minor” to “moderate”; for the majority of review findings concerns were minor. The most common reason for concern was under-reporting on ethnicity, gender, age, or diagnostic status which made it difficult to gauge the applicability of evidence, or themes that emerged from a small number of participants which represented one country, gender and/or ethnicity. Concerns about adequacy ranged from “minor” to

						"serious". There were serious concerns for review findings which were based on relatively small sample sizes and where all studies offered thin data. All other review findings were based on studies that offered moderately rich data. The number of studies used for each review finding ranged from 1 to 11.

68.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Visual summary		Less severe depression	Depression in adults: choosing a first line treatment for less severe depression BABCP have a number of comments – in other parts of the response our comments are fuller – here we have tried to focus on key problemsHow is the clinician to assess 'less severe' depression?These guidelines have been based on an incomplete review of the evidence – the committee noted that a number of relevant and important trials were excluded from the review. Thus the search terms appear to have been unhelpfully narrow.It is not clear with whom or where decision making around treatment choices would take place. How will time be made available as it will be a time-consuming process to discuss this range of options with patients?Many of the recommended treatments have extremely limited evidence and/or very low quality evidence. Some interventions have been recommended on the basis of studies that recruited fewer than 100 participants whereas other interventions are supported by many more studies, many 1000s of participants, and with research of higher quality. BABCP is puzzled by the	Thank you for your comment. The committee were aware of pragmatic RCTs that were excluded from the NMA typically because the samples in the trials were <80% first-line treatment or <80% non-chronic depression. These were stipulations of the review protocol in order to create a homogenous data set, but the committee used their knowledge of these studies in the round when interpreting the evidence from the systematic review and making recommendations. By way of illustration some of these studies were listed in Evidence report B, however, in response to stakeholder comments the committee agree that it would be more consistent to name all UK-

					recommendation to overhaul existing psychological therapy services and introduce new interventions (e.g. meditation) on the basis of such weak and unconvincing evidence. Group CBT and Group BA have been recommended as the favoured treatments for ''less severe' depression – BABCP is concerned that the evidence review focused too narrowly on outcomes of small RCTs, conducted in settings and populations that are not representative of NHS patients and NHS services in England, and did not incorporate ITT analyses. Thus they present an overly positive evaluation of effectiveness and cost-effectiveness. Group CBT and Group BA are currently not available in NHS psychological therapy (IAPT) services and clinicians are not trained to deliver group CBT or group BA so all IAPT CBT therapists would need retraining. Given the lack of trained staff to deliver Group BA and Group CBT as first line treatments for depression, the level of resources required, and on the basis of feedback from patients, clinicians and service managers about acceptability of group treatments, BABCP suggests that Group	based studies which were excluded on this basis but which the committee were aware of when making recommendations. The treatment options presented in the tables are in order of recommended use based on the committee's interpretation of their clinical and cost-effectiveness. The effect estimates were based on the bias-adjusted network meta-analysis (NMA) models. As the NMAs included a significant number of small studies, sensitivity analyses were carried out on selected outcomes (including the primary critical outcome for clinical analysis), which adjusted for bias associated with small study size effects. The

					CBT and Group BA are not viable treatments for less severe depression. Implementing this guidance would mean that the stepped care model used in IAPT would be redundant. This has huge negative implications for patients and waiting lists would grow exponentially. BABCP do not think that the evidence review underlying this revised guidance has properly considered the true costs of implementing this menu of interventions, including the costs of service redesign, redundancy for 1000s of Band 5 staff, redeployment, retraining, commissioning of new training programmes e.g. for Group CBT and Group BA, and employment of new staff to deliver group exercise interventions.It is not realistic to offer shared decision making with 11 different treatment options – there is inadequate time, clinicians are not trained to understand the range of options, and depressed patients are unlikely to be able to manage the range of information sufficient to make an informed choice. Even more importantly, BABCP can find no evidence that acceptability of treatments has been incorporated into the evidence review.	analyses, which were based on the assumption that the smaller the study the greater the bias, attempted to estimate the "true" treatment effect that would be obtained in a study of infinite size. When extracting data from the primary papers, an intention to treat (ITT) approach was taken wherever possible, and method of analysis was taken into account when assessing risk of bias by study (using the Cochrane risk of bias tool), and by outcome (using GRADE). In addition to the results of the network meta-analysis (NMA), the committee took other pragmatic factors into consideration when making

					The experience of our members, and our service user representatives is that group therapy, (including CBT and BA) is associated with significant problems in delivery and that there is very high drop out from group therapy.Group psycho-education for less severe depression is not included in these recommendations – this is currently used in IAPT services as part of the stepped care model. It is not clear if the evidence review looked for evidence about this intervention and failed to find it, or if the evidence review did not look for evidence. BABCP suggest that the reasons for this omission are justified and explained.Group exercise is not currently available as a treatment for 'less severe' depression and this suggests that new staff will need to be recruited and additional staff trained to deliver group exercise. These staff would also need to be co-located within mental health services and thus would require service re-organisation.BABCP suggest that behavioural couples therapy for depression is added to the evidence review and if appropriate added to the 'menu' of interventions.	recommendations, including the uncertainty and limitations around the clinical and cost-effectiveness data, the applicability to the UK service setting, and the need to provide a wide range of interventions to take into account individual needs and allow patient choice. The committee agreed that decisions on treatment should be made in discussion with the person with depression, and recommended that a shared decision should be made. The committee cross-referred to the guideline recommendations on choice of treatment which provided more detailed recommendations on how this shared decision should be made and what should be included in the

						discussion. In response to stakeholder comments, in particular around implementation issues in the context of IAPT, some changes have been made to the tables of interventions for the treatment of a new episode of depression guided by the principles of offering the least intrusive intervention first, reflecting clinical and cost effectiveness, and reinforcing patient choice. Also in response to stakeholder comments, the committee agreed that PWPs may need more time and flexibility to fulfil their role and responsibilities. Therefore, the indication about the duration of sessions has now been removed from the

						recommendations, to allow flexibility and ensure effective delivery of low intensity interventions. The committee recognised that some people with depression may not wish to attend group treatment. Although the economic model considered attrition costs of discontinuers on top of cost of missing group therapy as it was assumed that even if people discontinued therapy, or continued but missed some sessions, the cost of the group intervention would remain the same (i.e. discontinuers or non-attenders would still incur the cost). The committee acknowledged that there may be some implementation issues

						including coordinating attendance and waiting lists. Based on these considerations and the evidence of clinical and cost-effectiveness for guided self-help, individual CBT and individual BA, the committee considered offering these as alternatives to people who did not wish to attend group therapy. Furthermore, in response to stakeholder comments, the self-help with support section has been relabelled as guided self-help, included earlier in the treatment pathway, and the description of guided self-help has been amended. These changes essentially mean that group interventions are not the first treatment options in terms of the order of recommended

						use. Psychoeducation groups are not included in the recommendations for less severe depression as evidence from the network meta-analysis shows neither a clinically important nor statistically significant benefit of a psychoeducation group intervention relative to TAU on depression symptomatology for adults with less severe depression. In terms of group exercise as a treatment option, the committee has now removed the suggested duration of exercise sessions and modified the recommended frequency to allow more flexibility in the delivery of exercise programmes. Implementation issues

						will be considered by NICE where relevant support activity is being planned. As pre-specified in the review protocol, the committee identified couple interventions, including behavioural couples therapy, as interventions that would be more appropriate for subgroups of adults with depression (for people with problems in the relationship with their partner) and as such these interventions were considered only in pairwise comparisons (and not included in the NMA). The committee did not consider it appropriate to include behavioural couples therapy in the tables of treatment options in the guideline as the evidence and recommendation for

						behavioural couples therapy was for a subgroup of people with depression, unlike the other interventions listed in these tables.

69.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Visual summary		More severe depression	Depression in adults: choosing a first-line treatment for 'more severe' depression This visual summary shows 10 options that can be offered to patients after discussion of their preferences – BABCP have similar concerns to those outlined above in relation to the visual summary for 'less severe depression'It is not realistic to offer shared decision making with 10 different options – clinicians will not have sufficient understanding of each treatment and patients with depression will struggle to hold the information in mind. Under these conditions, shared decision making is not viable.Clinicians offering this range of 10 treatment options will need significant time to do this adequately and most will need additional training to understand each of the treatment options and explain them to patients.Where will this shared decision making take place and with what professional, in what service setting? How should clinicians make the classification of 'more severe' depression? What information will they need? BABCP suggest that any clinician having to assess depression needs adequate training and resources and that	Thank you for your comment. The issues you have raised will be addressed in turn. Table 2 (for more severe depression) and the visual summary provide information to aid discussions and shared decision-making between clinicians and people with depression and it is made clear that patient preference should also be taken into consideration when making an individualised choice of treatment. This discussion would be held between the person with depression and the healthcare professional discussing first-line treatment options, as would happen in any patient-clinician discussion when treatment was being offered, and the

					currently this level of training and resources is not widely available in primary care settings. Thus to make this available would require additional staff and resources to be allocated by commissioners.How should clinicians make decisions about treatment options when their patient has co-morbid mental health problems? Is there a protocol they should follow? How would this influence the shared decision-making process? It seems illogical to offer a combination of individual CBT and anti-depressant medication as the first option and individual CBT as the second option. A more logical order would offer the individual treatments first (medication or CBT), and then add on the second treatment based on monitoring the patient's response to treatment.In addition to the lack of logic outlined above, current service delivery models would make this order unfeasible. GPs can offer anti-depressant medication, which will then be available immediately. However they would need to refer their patient to psychological therapy services for CBT, which would introduce a delay - thus individual CBT and medication	committee agreed that additional training and resources would not be required, beyond a possible longer consultation time for the initial consultation. The classification between 'less severe' and 'more severe' depression is defined in the guideline, but again will be determined by the healthcare professional, as a part of the process of diagnosing depression. Healthcare professionals, particularly in primary care, are skilled at dealing with patients with multiple comorbidities and therefore again the committee agreed that was part of normal practice. The combination of CBT and an antidepressant was suggested as the first treatment for more

					cannot logically be offered at the same time. This recommendation is therefore not feasible in the NHSBABCP suggest that behavioural couples therapy for depression is added to the evidence review and if appropriate added to the 'menu' of interventions.	severe depression as it appeared to be the most cost-effective option, although it would be possible to start one (for example the antidepressant) and then CBT to be added in later, and for the person to still obtain the benefits of the combination. Behavioural couples therapy was examined only for the treatment of depression in people with relationship problems, and so based on this evidence it was not possible to include it in the main groups of interventions for people with less severe or more severe depression.

70.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	5	04 to 18	BABCP agree with the principles of care outlined here and welcome the specific observation that the symptoms of depression can interfere with access and participation in treatment. We also note that the guidelines suggest that treatment options are explored – this seems sensible but within the context of most clinical settings is unlikely to be feasible when so many treatment options have been recommended within this guideline. BABCP also question the assumption that primary care physicians or most mental health clinicians would understand and be able to explain, let alone explore, the full range of treatment options with patients. BABCP are also concerned that the costs of providing this level of support in primary care have not been costed and that they are likely to be unaffordable.	Thank you for your comment. Table 1 and Table 2 and the visual summary provide information to aid discussions and shared decision-making between clinicians and people with depression and it is made clear that patient preference should also be taken into consideration when making an individualised choice of treatment. As all the interventions included in the table are effective and appear to be cost-effective, it is hoped that NHS commissioners will ensure these interventions are available to all people with depression. The committee recognised that the initial consultation to discuss treatment options may need additional time but

						agreed that the benefits in terms of improved concordance may reduce time in the long-term, and so the overall resource impact would be minimal.
71.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	6	07 to 14	BABCP agree that supporting individuals to develop advance decisions about treatment and care, and recording these in care plans would be helpful. However, it is not clear which professionals, or which providers would have capacity and resources to support this. BABCP do not think this is viable in most parts of England given current resources and service configurations. Again, this recommendation does not seem to have been costed and BABCP are concerned	Thank you for your comment. Development of advance decisions, where appropriate, would form part of standard care and so the committee did not think it would require additional investment.

					that it would require significant additional investment in primary care.	
72.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	6	20-24	BABCP welcome the recommendation to support adult carers of individuals with depression	Thank you for your comment and support for these recommendations.

73.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	7	16-18	BABCP agree with the recommendation to use validated measures to assess depression. We would strongly prefer the committee to give specific recommendations on which measures to use in which settings, by what kind of professional, and with which different types of patients. It is essential that these measures are suitable for use by clinicians without specialist mental health training (e.g. GPs) and that all clinicians who use them have sufficient training to interpret the results correctly and feed these back to patients. The recommendation to use validated measures also requires that they are available in multiple languages, that they are cross culturally valid (and that this has been demonstrated empirically) and that professionals are able to read and explain the individual items to patients who have limited literacy or for whom a validated translated version is not available. BABCP is aware of many NHS settings in which self-report questionnaires are used insensitively, inappropriately, and incorrectly. Professionals who ask patients to complete self-report measures should	Thank you for your comment. As specified in the scope, the recognition, assessment and initial management 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. However, the evidence on recognition, assessment and initial management has not been reviewed and it is therefore not possible to recommend a specific assessment tool as the evidence for the reliability and validity of specific scales has not been assessed as part of this update.

					have appropriate training in the administration and interpretation of such measures. Currently this is not part of core training for most primary care professionals or mental health professionals and thus would require extensive investment in CPD. Professionals who do not have this specialist training should only use and interpret the measures under supervision. Clinical psychologists are the only professional group for whom administration and interpretation of self-report measurement is a core competency. However 'psychology' is a 'shortage occupation' and therefore this staff group will not be able to provide adequate support.	
74.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	7	22-27	BABCP welcome support for individuals who have communication difficulties – including interpreters. This is essential if mental health services are to be truly accessible to all parts of the community. This recommendation will have significant resource implications. It will increase costs but is also likely to	Thank you for your comment and support for this recommendation and the fact that it is likely to be cost neutral.

					improve engagement and outcomes and thus to be economically neutral or positive.	
75.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	8	Oct-18	BABCP agree that a comprehensive assessment of depression is necessary and that (at a minimum) should include the factors outlined. In addition, BABCP suggest that protected characteristics including ethnicity, disability, history of trauma and gender and sexual orientation are essential components of any mental health assessment. However, BABCP note that elsewhere in the guidance it is suggested that initial sessions of some psychological interventions would normally be 30 minutes BABCP do not believe that it is possible to conduct a comprehensive and safe mental health assessment (as suggested here) in 30 minutes. Resources currently allocated to psychological therapy services (IAPT) would not permit this recommendation to be introduced fully unless new commissioning arrangements were in place that include additional resources to	Thank you for your comment. In response to stakeholder comments, the committee agreed that PWPs may need more time and flexibility to fulfil their role and responsibilities. Therefore, the indication about the duration of sessions has now been removed from the recommendations, to allow flexibility and ensure effective delivery of low intensity interventions.

					support comprehensive assessments. In NHS IAPT services PWPs routinely conduct initial assessments. As the stepped care model would not be possible if the recommendations were followed BABCP suggest that NICE clarify where in the care pathway a comprehensive assessment should take place and how and by whom it is conducted? BABCP suggest that GPs and other primary care staff have neither the time nor the specialist treatment to carry out a comprehensive assessment of depression. If GPs and primary care staff are to conduct comprehensive assessments of depression (and other mental health difficulties) this would require significant additional resources for training and additional staff. This recommendation therefore has significant implications for resources and is likely to increase the costs of NHS mental health treatments.	
76.	British Association of Behavioural and Cognitive	Guideline	10	14-20	BABCP agree that offering patients an informed choice of treatment is important.	Thank you for your comment and support for these recommendations.

	Psychotherapy (BABCP)					
77.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	10	21-23	BABCP agree that 'adequate time' is needed to discuss treatment options, involve family members etc. Current commissioning arrangements would normally not include sufficient time as part of an initial assessment. This recommendation is likely to increase costs BABCP suggest that it is important to specify 'adequate time' so that commissioners take this into account when allocating resources.	Thank you for your comment. The committee agreed that an initial consultation to agree treatment choices may require additional time, but that this may lead to benefits later on with improved concordance and improved treatment outcomes, which would save time in the long term. The committee agreed that it was not possible to specify what 'adequate time' was required as this would vary so much between people.

78.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	11	10	BABCP suggest that this be amended to read '….individual, couple or group….'	Thank you for your comment. As pre-specified in the review protocol, the committee identified couple interventions, including behavioural couples therapy, as interventions that would be more appropriate for subgroups of adults with depression (for people with problems in the relationship with their partner) and as such these interventions were considered only in pairwise comparisons (and not included in the NMA). The committee did not consider it appropriate to include couple in the recommendation referred to in your comment as the evidence and recommendation for behavioural couples therapy was for a subgroup of people with

						depression, unlike the other interventions covered by this recommendation. There are recommendations in the choice of treatment section of the guideline that people with depression should be given the option to include family members or carers in the discussion of treatment options, and to attend (some or all of) treatment with a family member or friend. It is also recommended in the access to services section that commissioners and providers of mental health services should promote access, and increased uptake and retention, by ensuring that pathways have in

						place procedures to support active involvement of families, partners and carers (if agreed by the person with depression).
79.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	12	19-25	BABCP welcome the recommendation that treatment is reviewed after 2 to 4 weeks and that possible side effects, and suicidal ideation are monitored. BABCP also suggest that NICE provide greater specificity about the frequency of monitoring so that this can be included in new commissioning contracts and adequately resourced. This recommendation is likely to increase the costs of treatments for depression.	Thank you for your comment and support for this recommendation. The committee agreed that, after initial review, the frequency of monitoring would depend on a number of factors, including the treatment offered, the person with depression, the results of a risk assessment, so it was not possible to

						stipulate ongoing frequency. For example, people receiving a psychological therapy will be seeing their therapist regularly, while people taking antidepressants will need to agree a review schedule with their prescriber (as described in the section of the guideline on starting antidepressants).
80.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	12	26-28	BABCP strongly endorse the recommendation that routine outcome measures are used to monitor progress, side effects and suicidal ideation throughout treatment and at follow up. Currently psychological therapy services (IAPT) are not commissioned to provide routine follow up sessions. This will increase costs and so this requirement (i.e. length of follow up) needs to be more clearly specified so that resources can be allocated in new contracts.	Thank you for your comment. This recommendation refers to routine outcome monitoring and follow-up at the next agreed appointment during treatment. It does not refer to additional follow-up appointments after a course of treatment has completed, and so will not have a resource impact.

81.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	13	06-Jul	BABCP agree that the form and length of psychological therapies for depression should be guided by treatment manuals. This is important to ensure fidelity and quality. To avoid delivery of treatments that do not have evidence of effectiveness and cost effectiveness we suggest that NICE indicate which treatment manuals should be used to guide treatments. BABCP note that this recommendation introduces an internal contradiction – subsequently (e.g. page 25) NICE recommend that individual CBT for less severe depression is 8 sessions. This length of treatment is not indicated by the majority of treatment manuals that guided the RCTs included in the evidence review. Furthermore in the evidence review, some psychological therapies e.g. individual CBT, were classified as lasting for more than, or fewer than 15 sessions, based on the manuals on which the therapies were delivered.BABCP therefore suggest that the rationale for the recommendations relating to length of treatments is made explicit.	Thank you for your comment. The committee provided guidance on the number of sessions of psychological interventions based on relevant information reported in the RCTs that informed the guideline NMA and economic analysis, supplemented by their clinical experience on optimal delivery of interventions within the NHS. The information on resource use derived from the RCTs has now been added in evidence review B, under Appendix N, and shows that there is consistency between committee's guidance on number of sessions and the resource use reported in the RCTs. CBT ≥15 sessions and CBT<15 sessions were considered as separate

						interventions within the class of cognitive and cognitive behavioural therapies individual. This distinction was made because there was great variation in the number of sessions reported across RCTs for the CT/CBT class, and there was also a large evidence base that allowed formation of 2 separate interventions according to the number of sessions offered. The economic analysis selected and analysed one intervention per effective class as an exemplar, as explained in response to a related comment. For less severe depression, the Cognitive and cognitive behavioural therapies individual included both CBT≥15 sessions and CBT<15 sessions as separate

						interventions. The two interventions had a similar SMD vs TAU, and CBT<15 sessions had a somewhat larger evidence base across RCTs on the SMD outcome - see Table 10, results of bias-adjusted analysis for less severe depression, in evidence review B. CBT<15 sessions individual was considered to have an appropriate intensity for a population with less severe depression by the committee, it had also a larger evidence base than CBT≥15 sessions, and given that CBT≥15 sessions and CBT<15 sessions had similar effectiveness, CBT<15 sessions individual was selected for consideration as an exemplar of its class in the economic modelling, which

						ultimately informed guideline recommendations. This has now been explained in evidence review B, under 'The committee's discussion of the evidence'. Given the volume of the evidence base, the guideline NMA and economic results that favoured less intensive CBT (<15 sessions), and their clinical expertise, the committee decided to recommend individual CBT<15 sessions for people with less severe depression. As shown in Appendix N of evidence review B, the resource use described in the RCTs for individual CBT<15 sessions was 7-8 sessions in the majority of studies, with 1 study reporting 10 sessions. Similarly, the majority of BA studies on less severe depression

						reported a range of sessions (1-10) with the two larger studies reporting 8 sessions. For counselling there was variation between the 2 RCTs included, with the larger one reporting 6-12 sessions. This reported resource use, alongside the committee's clinical expertise, informed the respective recommendations and is consistent with the 'usually' 8 sessions recommended for individual BA, individual CBT and counselling for less severe depression. The committee considered that offering a high intensity intervention in 8 sessions was (usually) appropriate and adequate for a population with less severe depression. This number of 'usual' sessions

						serves only as a guidance, it should not be considered as a 'maximum' and can be modified depending on individual needs. This has now been clarified in the recommendations. The committee considered whether providing references to specific manuals would be helpful but given the wide range of manuals available and the potential for this to be seen as NICE endorsing a particular manual, the committee decided not to do so. Instead the committee recommended that interventions should be delivered in line with current treatment manuals and outlined how they should be delivered and key

						features in the tables of treatment options.

82.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	13	08 to 16	BABCP welcome the recommendation that therapists are trained and supervised using competence frameworks. It is essential that competence is monitored and evaluated and that supervision of psychotherapy includes reviewing audio or video recordings of treatment sessions.	Thank you for your comment and support of these recommendations.
83.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	14	11	BABCP welcome the recommendation that young people who are prescribed antidepressant medication be monitored after one week. We would add that they should also be monitored at 2 and 4 weeks, given that suicidal ideation may emerge or worsen over this duration. This would have resource implications and increase costs.BABCP also suggest that the wording be tightened to read '…or after 1 week if a new prescription for a person aged between 18 and 25 years old….' This is important because separate guidelines are available for under 18s and the expression 'young people' could be misinterpreted to refer to adolescents (rather than to only those aged over 18 years)	Thank you for your comment. The recommendations on prescribing antidepressants for young people and those at increased risk of suicide state that they should be monitored at 1 week and then as often as needed, but no later than 4 weeks after the antidepressant was started (i.e. not more than 3 weeks after the original review). The committee agreed this was a pragmatic review period which allowed flexibility and was likely to be achievable. The lower

						age limit has been set as 18 as you suggest to prevent overlap with the NICE guidelines for depression in children and young people.
84.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	18	06to 07	BABCP suggest that it is important to modify the wording here to refer to '…people with depression who are aged 18 to 25 years old or are thought to be at increased risk of suicide:' This is because separate guidelines cover treatment of depressed young people under 18 years. All clinicians need to be reminded to use these guidelines when working with young people.	Thank you for your comment. The lower age limit has been set as 18 as you suggest to prevent overlap with the NICE guidelines for depression in children and young people.

85.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	18	15-17	BABCP suggest that the wording here could helpfully be made more specific – '…as often as needed….' is ambiguous. We suggest that young people aged 18 to 25 and those at increased risk of suicide are routinely reviewed at 1 week, 2 weeks and 4 weeks and that this age range is specified in the guidelines.	Thank you for your comment. The recommendation states that they should be monitored at 1 week and then as often as needed, but no later than 4 weeks after the antidepressant was started (i.e. not more than 3 weeks after the original review). The committee agreed this was a pragmatic review period which allowed flexibility and was likely to be achievable. The lower age limit has been set as 18 as you suggest to prevent overlap with the NICE guidelines for depression in children and young people.
86.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	19	07 to 09	BABCP suggest that the recommendation to consider comorbidities and possible interactions with other medications is unlikely to be within the competence of most GPs or primary care professionals. It would be helpful if NICE were more	Thank you for your comment. The committee agreed that considering comorbidities and drug interactions was part of the everyday role of GPs

					explicit about who should review multiple medications e.g. community pharmacists. Implementing this recommendation would therefore have required increased resources and may increase the overall costs of treating depression.	and primary care professionals such as practice pharmacists and so would not increase the costs of treating depression.

87.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	22	20-21	In consulting our members, many of whom work as clinicians and/or service managers in IAPT services, we had many concerned comments about the lack of specificity of the term 'less severe depression'. For example, one member wrote,"For context, I work in an overstretched, under-resourced IAPT service and I am concerned services might impose a "session cap" for those said to have "less severe depression" (for example scoring moderate on PHQ9) at initial assessment, when further formulation may reveal a more complex picture, or where maintaining processes lead patients to underscore initially and with further awareness more severity is apparent. "Evidence Review B suggests that the classification of 'less severe' and 'more severe' depression used in the evidence review was based on a cut off score on a range of different self-report measure of depression. Psychological therapy service leads and clinicians were strongly of the view that NICE should provide exact guidance on how to identify patients with 'less severe depression' and those with 'more severe depression'. BABCP therefore suggest	Thank you for your comment. The committee were aware that a proper assessment of severity cannot be based solely on a symptom scale and the guideline includes a recommendation to conduct a comprehensive assessment that does not rely simply on a symptom count but also takes into account both the degree of functional impairment and/or disability associated with the possible depression and the length of the episode. The committee considered the studies identified by the review and agreed that although baseline symptom scores have limitations as an indicator of severity, this information was available for the majority of studies, whereas other factors such as duration

					the following issues need to be clarified: IAPT services routinely use the PHQ-9 to assess and monitor depression – what cut off should be used? Is this valid as a standalone measure or should other factors be included? Should any contextual information be used to modify classification of 'more severe' and 'less severe' depression? If so what contextual information? How should patients who are not literate or who do not have access to the English language be assessed?In addition, BABCP recommend that the guidelines make explicit that no single score on a self-report measure is sufficient to classify patients as having 'less severe' and 'more severe' depression for the purposes of allocating resources for treatment.	of disorder or functional impairment were not reported in a sufficiently consistent manner for them to be of use in determining severity. The committee considered the current NICE classifications of mild to moderate and moderate to severe depression, and agreed that although these classifications have been adopted quite widely there is potential uncertainty with regards to the management of moderate depression. The committee agreed that a dichotomy of less and more severe depression was clearer, and the guideline includes definitions (that less severe depression includes the traditional categories of

						subthreshold symptoms and mild depression, and more severe depression includes the traditional categories of moderate and severe depression) in order to improve practical utility. The committee considered the distinction between less severe (subthreshold/mild) and more severe (moderate/severe) depression to be clinically meaningful in terms of supporting effective clinical decision making and being aligned with how clinicians conceptualize depression (in particular, GPs and other primary care staff, given that the majority of people with depression and almost all first line presentations of depression are managed

						in primary care). Based on this distinction, an anchor point of 16 on the PHQ-9 was selected as the cut-off between less severe and more severe depression, on the basis of alignment with the clinical judgement of the committee and eligibility criteria in the included studies. Published standardization of depression measurement crosswalk tables (Carmody 2006; Rush 2003; Uher 2008; Wahl 2014) were used in order to 'read-across' different symptom severity scales that were used in different studies.

88.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	23	8	BABCP welcome the recommendation that individuals who present with depression are followed up 'with repeated attempts' it is important that adequate time is allocated and resourced.Introducing routine follow up after treatment is an important aspect of care and would require increased funding from commissioners.	Thank you for your comment. This recommendation relates to people with less severe depression who do not want treatment, and not routine follow-up after treatment, so this would not require increased funding as GPs would carry this out as part of routine care.

89.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	23	13-17	BABCP welcome the emphasis on patient choice and shared decision making. However, many of our members expressed concerns about the practicality of using Table 1 to guide discussions with patients. We were not able to identify any specific research to guide the number of choices available in shared decision making (SDM) but note that most evidence showing the benefits of SDM is based on patients being able to consider two or three options. The cognitive load of weighing the potential benefits, risks, and personal costs of 11 different treatment options seems likely to be excessive for most patients with depression, for whom working memory and decision making are typically impaired, see evidence outlined in: Rock, et al, (2014). Cognitive impairment in depression: a systematic review and meta-analysis. Psychological medicine, 44(10), 2029-2040.Lee, et al., (2012). A meta-analysis of cognitive deficits in first-episode major depressive disorder. Journal of affective disorders, 140(2), 113-124.)There was a consensus amongst BABCP members who commented that it would not be	Thank you for your comment. In response to stakeholder comments, in particular around implementation issues in the context of IAPT, some changes have been made to the tables of interventions for the treatment of a new episode of depression guided by the principles of offering the least intrusive intervention first, reflecting clinical and cost effectiveness, and reinforcing patient choice. The self-help with support section has been relabelled as guided self-help, and placed earlier in the treatment pathway. Interventions are arranged in Tables 1 and 2 of the guideline in the suggested order in which options should be considered, based on the

					feasible to provide sufficient information and time to patients presenting with a new episode of depression to cover and adequately discuss the range of options outlined in Table 1 or Table 2. It is also not clear how this shared decision making would fit into the existing IAPT stepped care model or how commissioning models would be able to accommodate or make available the full range of therapies to all new patients. Most initial assessments and decisions about psychological treatments are currently made by clients in collaboration with low intensity workers in IAPT services (PWPs) as part of the stepped care model on which IAPT is based. The proposed guidelines are unclear about who would support patient choice or how this would be resourced. BABCP is of the view that well trained and supervised PWPs currently support shared decision making but that this range of treatments would present excessive demands on PWPs and patients, and could not be supported within routine primary care.	committee's interpretation of their clinical and cost effectiveness and consideration of implementation factors. However, this is not a rigid hierarchy, all treatments included in Tables 1 and 2 can be used as first-line treatments, and it may be appropriate to recommend an intervention from lower down in the table where this best matches the person's preferences and clinical needs. The committee were aware of the need to provide a wide range of interventions to take into account individual needs and allow patient choice and considered it important that the treatment of choice can be selected without

						having to fail other treatments first. The committee cross-referred to the guideline recommendations on choice of treatment which provided more detailed recommendations on how a shared decision on treatment should be made and what should be included in the discussion. It was recognised by the committee that people who have had prior episodes of depression may have preferences for their treatment based on prior experience or insight into their own depression patterns. The committee agreed that PWPs may need more time and flexibility to fulfil their role and responsibilities, including assessment and

						discussing treatment options. Therefore, the indication about the duration of sessions has now been removed from the recommendations, to allow flexibility and ensure effective delivery of low intensity interventions.

90.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	23-30	Table 1, page 24	Group Cognitive Behavioural Therapy – BABCP members commented that it was unclear if this treatment was conceptualised as a low intensity or high intensity treatment. Currently group CBT (including psychoeducation) is typically provided as a low intensity treatment in IAPT services to large numbers of patients (i.e. 50-100+) in community settings. Group CBT is not normally delivered by High Intensity CBT therapists in IAPT services.However, Evidence Review B indicates that 'Group CBT' is a high intensity treatment delivered by the equivalent of Band 7 accredited CBT therapists. This is consistent with the recommendation that group size is 8 participants. To deliver this recommendation in NHS services would be extremely costly and difficult to implement. Group CBT is not currently taught on national curricula for CBT therapists and is not delivered by High Intensity therapists. To deliver Group CBT by High Intensity therapists as one of the first line treatments for 'less severe' depression would require massive expansion of High Intensity CBT therapists and significant additional	Thank you for your comment. In response to stakeholder comments, the committee considered a number of practical issues around the waiting times for high intensity psychological interventions and implementation issues relating to the structure of IAPT services and has now updated recommendations for the treatment of a new episode of depression guided by the principles of offering the least intrusive intervention first, reflecting clinical and cost effectiveness, and reinforcing patient choice. The self-help with support section has been relabelled as guided self-help, placed earlier in the treatment pathway, and the description of guided self-help has been

					investment in both training and service delivery.To ensure that evidence-based treatments are delivered correctly and safely by mental health services BABCP strongly advise that NICE clarify what is meant by 'therapy specific' practitioners (i.e. that they should be BABCP accredited CBT therapists). This is because the phrase 'therapy specific practitioners' could also apply to low intensity therapists. In addition, BABCP suggest that the specific therapy manuals that are effective and cost effective are named so that commissioners and services have clear expectations of the likely resources required. BABCP members also noted that the draft guidelines indicate that all group interventions '…may allow peer support from others who may be having similar experiences'. Whilst this may incidentally be true, the content and techniques used in group CBT do not expect or rely on 'peer support' and BABCP members were concerned that this phrase may imply that patients have a responsibility to support the well-being and mental health of other patients. This would not be helpful or desirable and	amended to recommend that printed or digital materials that follow the principles of guided self-help are used including structured CBT, structured BA, problem solving or psychoeducation materials, delivered face-to-face or by telephone or online. The frequency and duration of sessions of psychological therapies has also now been removed from the recommendations, to allow more flexibility in the delivery of interventions. The CBT group referred to in the recommendations is a high intensity intervention, and changes to recommendations for low intensity

					may be experienced as a burden. We suggest therefore that this phrase be removed from the guidelines.****BABCP members did suggest that group interventions may help patients recognise that their difficulties are shared and thus might reduce internal stigma and that this may be useful.	interventions are described above. Psychoeducation groups are not included in the recommendations for less severe depression as evidence from the network meta-analysis shows neither a clinically important nor statistically significant benefit of a psychoeducation group intervention relative to TAU on depression symptomatology for adults with less severe depression. The committee assumed that the CBT group therapy would be led by a high intensity Band 7 therapist, supported by a Band 6 therapist, who might be, for example, a trainee clinical psychologist. This support may be of particular

						importance in larger groups of participants, although it is not an essential element of delivery. This assumption was based on the committee's expert advice, considering optimal practice. The text has now been reworded to clarify that delivery is led by a band 7 HI therapist, supported by a band 6 therapist. Training costs (in terms of qualification costs of low- and high-intensity therapists and additional training required for low-intensity therapists) have already been considered in the guideline economic modelling. The vast majority of recommended interventions are already available in current routine practice. Where recommended treatments

						are currently not available or where their availability is limited, NICE will consider implementation issues when producing supporting tools for implementation of the guideline. Such treatments were recommended on the basis of their clinical and cost-effectiveness, as demonstrated by the available evidence. The committee did consider whether providing references to specific manuals would be helpful but given the wide range of manuals available and the potential for this to be seen as NICE endorsing a particular manual, it was decided not to do so. However, details about how the intervention is delivered and key

						features of the intervention in the treatment tables was informed by the interventions found to be clinically and cost effective in the guideline analyses. The committee agreed that the wording in the tables provided enough information about the purpose of peer support and did not place an undue expectation on participants as it used the phrase 'may allow'.

91.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	24-25	Table 1,	Group Behavioural Activation – BABCP members commented that Group Behavioural Activation is not routinely offered in IAPT services. IAPT clinicians are not trained to deliver this treatment and thus most services could not currently provide this treatment. At present therefore this recommendation could not be delivered in most IAPT services. To provide this choice to patients would require additional resources for CPD for qualified therapists and amendments to the current national curriculum for IAPT trainees.To ensure that evidence-based treatments are delivered correctly and safely by mental health services BABCP strongly advise that NICE clarify what is meant by 'therapy specific' practitioners (i.e. that they should be BABCP accredited CBT therapists). This is because the phrase 'therapy specific practitioners' could also apply to low intensity therapists. In addition, BABCP suggest that the specific therapy manuals that are effective and cost effective are named so that commissioners and services have clear expectations of the likely resources required. It is also important to note	Thank you for your comment. In response to stakeholder comments, in particular around implementation issues in the context of IAPT, some changes have been made to the tables of interventions for the treatment of a new episode of depression guided by the principles of offering the least intrusive intervention first, reflecting clinical and cost effectiveness, and reinforcing patient choice. The self-help with support section has been relabelled as guided self-help, placed earlier in the treatment pathway, and the description of guided self-help has been amended to recommend that printed or digital materials that follow the principles of guided self-help are used including

					that that the introduction of group Behavioural Activation for depression to IAPT services would require additional training and thus additional resources for CPD, as well as amendments to the current national curriculum for CBT trainees.BABCP members also noted that the draft guidelines indicate that all group interventions '….may allow peer support from others who may be having similar experiences'. Whilst this may incidentally be true, the content and techniques used in group Behavioural Activation do not expect or rely on 'peer support' and BABCP members were concerned that this phrase may imply that patients have a responsibility to support the well-being and mental health of other patients. This would not be helpful or desirable and may be experienced as a burden. We suggest therefore that this phrase be removed from the guidelines.BABCP members did suggest that group interventions may help patients recognise that their difficulties are shared and thus might reduce internal stigma and that this may be useful	structured CBT, structured BA, problem solving or psychoeducation materials, delivered face-to-face or by telephone or online. The frequency and duration of sessions of psychological therapies has also now been removed from the recommendations, to allow more flexibility in the delivery of interventions. The BA referred to in the recommendations is a high intensity intervention, and changes to recommendations for low intensity interventions are described above. Training costs (in terms of qualification costs of low-

						and high-intensity therapists and additional training required for low-intensity therapists) have already been considered in the guideline economic modelling. The vast majority of recommended interventions are already available in current routine practice. Where recommended treatments are currently not available or where their availability is limited, NICE will consider implementation issues when producing supporting tools for implementation of the guideline. Such treatments were recommended on the basis of their clinical and cost-effectiveness, as demonstrated by the available evidence. The guideline does not refer to therapy specific

						practitioners but to therapy-specific training and competence. The committee expressed the view that group interventions should be optimally delivered by two therapists, one leading the delivery of the intervention and another one observing. The information and committee's considerations on optimal delivery of group interventions have been reflected in the economic modelling and the respective recommendations. In response to stakeholder comments, the recommendation on the number of therapists has now been modified, to clarify that at least one of the therapists (rather than both) needs to have therapy-specific training

						and competence. The committee did consider whether providing references to specific manuals would be helpful but given the wide range of manuals available and the potential for this to be seen as NICE endorsing a particular manual, it was decided not to do so. However, details about how the intervention is delivered and key features of the intervention in the treatment tables was informed by the interventions found to be clinically and cost effective in the guideline analyses. The committee agreed that the wording in the tables provided enough information about the

						purpose of peer support and did not place an undue expectation on participants as it used the phrase 'may allow'.

92.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	25-26	Table 1	Individual CBT – BABCP welcome the inclusion of individual CBT as a first line treatment for 'less severe' depression. However, the guidance on delivery of individual CBT did not appear to be based on the research evidence or the methods of Evidence Review B. Evidence Review B classified relevant research into individual CBT as 'more than' or 'fewer than' 15 sessions. Therefore the selection of 8 sessions as the 'dose' of individual CBT does not appear to be based on the evidence and the rationale for choosing this 'dose' was unclear. BABCP were concerned that this recommendation may lead to unhelpful 'rationing' of CBT therapy by commissioners and service managers. BABCP members noted that it would be helpful to be more specific about how commissioner sand service leads can ensure that clinicians have 'therapy specific training and competence'. As noted above it would also be helpful to specify the therapy models and treatment manuals that are effective and cost effective so that individual CBT is delivered safely and correctly.	Thank you for your comment. The committee provided guidance on the number of sessions of psychological interventions based on relevant information reported in the RCTs that informed the guideline NMA and economic analysis, supplemented by their clinical experience on optimal delivery of interventions within the NHS. The information on resource use derived from the RCTs has now been added in evidence review B, under Appendix N, and shows that there is consistency between committee's guidance on number of sessions and the resource use reported in the RCTs. CBT ≥15 sessions and CBT<15 sessions were considered as separate

						interventions within the class of cognitive and cognitive behavioural therapies individual. This distinction was made because there was large variation in the number of sessions reported across RCTs for the CT/CBT class, and there was also a large evidence base that allowed formation of 2 separate interventions according to the number of sessions offered. The economic analysis selected and analysed one intervention per effective class as an exemplar, as explained in response to a related comment. For less severe depression, the Cognitive and cognitive behavioural therapies individual included CBT≥15 sessions and CBT<15 sessions as separate interventions.

						The two interventions had a similar SMD vs TAU (CBT≥15 sessions individual -0.68, 95% CrI -1.36 to 0.01; CBT<15 sessions individual -0.66, 95% CrI -1.45 to 0.16), and CBT<15 sessions had a somewhat larger evidence base across RCTs on the SMD outcome (N=233 vs 123) - see Table 10, results of bias-adjusted analysis for less severe depression, in evidence review B. CBT<15 sessions individual was considered to have an appropriate intensity for a population with less severe depression by the committee, it had also a larger evidence base than CBT≥15 sessions, and given that CBT≥15 sessions and CBT<15 sessions had similar effectiveness, CBT<15

						sessions individual was selected for consideration as an exemplar of its class in the economic modelling (which ultimately informed guideline recommendations). This has now been explained in evidence review B, under 'The committee's discussion of the evidence'. Given the volume of the evidence base, the guideline NMA and economic results that favoured less intensive CBT (<15 sessions), and their clinical expertise, the committee decided to recommend individual CBT<15 sessions for people with less severe depression. As shown in Appendix N of evidence review B, the resource use described in the RCTs

						for individual CBT<15 sessions was 7 sessions in the majority of studies, with 3 studies reporting a range of 8-10 sessions. This reported resource use, alongside the committee's clinical expertise, informed the respective recommendation and it is consistent with the 'usually' 8 sessions recommended. The committee considered that offering a high intensity intervention in 8 sessions was (usually) appropriate and adequate for a population with less severe depression. This number of 'usual' sessions serves only as guidance, it should not be considered as a 'maximum' and can be modified depending on individual needs. This has now been clarified in the recommendation.

						The committee expressed the view that group interventions should be optimally delivered by two therapists, one leading the delivery of the intervention and another one observing. In response to stakeholder comments, the recommendation on the number of therapists has now been modified, to clarify that at least one of the therapists (rather than both) needs to have therapy-specific training and competence. The committee did not consider it appropriate to further specify training and competencies as these will be matters for implementation. The committee did consider whether providing references to

						specific manuals would be helpful but given the wide range of manuals available and the potential for this to be seen as NICE endorsing a particular manual, it was decided not to do so. However, details about how the intervention is delivered and key features of the intervention in the treatment tables was informed by the interventions found to be clinically and cost effective in the guideline analyses, supplemented by the committee's clinical experience on optimal delivery of interventions within the NHS.

93.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	25-26	Table 1	Individual BA: BABCP welcome and support the inclusion of Individual BA as a first line treatment for 'less severe' depression. However, the guidance on delivery of individual BA does not follow evidence-based treatment manuals. In addition the evidence review classified studies evaluating individual BA as 'more than' or 'less than'15 sessions…it is therefore unclear how a 'dose' of 8 sessions was selected as the appropriate 'dose' of individual BA.Individual BA for depression, delivered by High Intensity therapists currently involves 12-16 sessions of treatment. BABCP is therefore concerned that this recommendation for 8 sessions of individual BA may lead to unhelpful 'rationing' of BA therapy by commissioners and service managers. BABCP members noted that it would be helpful to be more specific about how commissioner and service leads can ensure that clinicians have 'therapy specific training and competence'. As noted above, it would also be helpful to specify the therapy models and treatment manuals that are effective and	Thank you for your comment. The committee provided guidance on the number of sessions of psychological interventions based on relevant information reported in the RCTs that informed the guideline NMA and economic analysis, supplemented by their clinical experience on optimal delivery of interventions within the NHS. The information on resource use derived from the RCTs has now been added in evidence review B, under Appendix N, and shows that there is consistency between committee's guidance on number of sessions and the resource use reported in the RCTs. For individual BA there was no distinction between 'more than' and

					cost effective so that Individual CBT is delivered safely and correctly.	'less than' 15 sessions. As shown in Appendix N of evidence review B, the resource use described in the RCTs for individual BA for less severe depression was 8 sessions in the two larger studies. Four small studies also reported 1, 4, 5, and 10 sessions. This reported resource use, alongside the committee's clinical expertise, informed the guideline economic analysis and, subsequently, the respective recommendation and it is consistent with the 'usually' 8 sessions recommended for a new episode of less severe depression. The committee considered that offering a high intensity intervention in 8 sessions was (usually) appropriate and adequate for a population with less

						severe depression. This number of 'usual' sessions serves only as guidance, it should not be considered as a 'maximum' and can be modified depending on individual needs. This has now been clarified in the recommendation. For more severe depression, the resource use described in the RCTs for individual BA ranged from 6 to 20 sessions. This reported resource use, alongside the committee's clinical expertise, informed the guideline economic analysis and, subsequently, the respective recommendation and it is consistent with the 'usually' 12-16 sessions recommended for a new episode of more severe depression. As for less severe depression, this

						number of 'usual' sessions serves only as guidance, it should not be considered as a 'maximum' and can be modified depending on individual needs. This has now been clarified in the recommendation The committee expressed the view that group interventions should be optimally delivered by two therapists, one leading the delivery of the intervention and another one observing. In response to stakeholder comments, the recommendation on the number of therapists has now been modified, to clarify that at least one of the therapists (rather than both) needs to have therapy-specific training and competence. The committee did not consider it appropriate to

						further specify training and competencies as these will be matters for implementation. The committee did consider whether providing references to specific manuals would be helpful but given the wide range of manuals available and the potential for this to be seen as NICE endorsing a particular manual, it was decided not to do so. However, details about how the intervention is delivered and key features of the intervention in the treatment tables was informed by the interventions found to be clinically and cost effective in the guideline analyses, supplemented by the committee's clinical experience on

						optimal delivery of interventions within the NHS.

94.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	26-27	Table 1	Self-help with support – Many BABCP members contacted us with specific concerns about multiple aspects of this recommendation. They noted that the evidence review focused almost entirely on computerised CBT (cCBT) and did not review many commonly used low intensity interventions delivered by PWPs in IAPT services. In addition, some of the computerised CBT programmes (reviewed e.g. Beating the Blues) are no longer used by IAPT services. Members also noted that much of the underpinning research was based on participants who do not reflect the diversity or range of patients who are referred to IAPT services and were conducted in contexts that do not generalise well to NHS mental health services.In research settings cCBT guided self-help sessions are typically brief, i.e. around 15 minutes long. However, BABCP members had very grave concerns about the recommendation that treatment sessions should typically last for 15 minutes. They pointed out that this would make it impossible to administer routine outcome measures, monitor risk, manage the therapeutic	Thank you for your comment. In response to stakeholder comments, in particular around implementation issues in the context of IAPT, some changes have been made to the tables of interventions for the treatment of a new episode of depression guided by the principles of offering the least intrusive intervention first, reflecting clinical and cost effectiveness, and reinforcing patient choice. The self-help with support section has been relabelled as guided self-help, and moved so it is listed first in Table 1, and the description of guided self-help has been amended to clarify that this is not restricted to computerised CBT (cCBT). Different self-help

					alliance, and support distressed patients with literacy, language, or other special needs. One member wroteI worry that this will put patients in danger as you cannot explore risk, complete an intervention, review homework etc adequately in 15 minutes.Several members felt that the recommendations were not well informed by an understanding of the stepped care model or the role of PWPs. For example,As a PWP of 12 years standing, I feel devalued by the suggestion that effective treatment sessions can be delivered in just 15 minutes. PWPs are typically high-achieving psychology graduates who undergo a rigorous 12-month Post Graduate Certificate while being employed in an IAPT service, and have more to offer than just checking in with a patient on the reading they are doing between sessions.A senior PWP said,.....it is extremely concerning to note the recommendations made in the consultation and this suggests to me a lack of expertise in and/or understanding of the role of the PWP and the treatment they deliver And alsoThe PWP workforce has worked tirelessly to achieve integrity	approaches (with or without support) were searched for and were eligible for inclusion. In addition to computerised approaches, there are also RCTs of cognitive bibliotherapy, behavioural bibliotherapy, expressive writing, mindfulness meditation CD, relaxation training CD, and third-wave cognitive therapy CD, included in the network meta-analyses (NMAs) for treatment of a new episode of depression. The committee considered applicability of the studies to the UK service setting when interpreting the evidence. One intervention per class was used as an exemplar in the economic analysis, as it was not feasible to model all interventions

					within the field of psychologies….The above consultation could very much undermine the value placed on what we do and in my opinion, result in a significant risk to the retention of the low intensity workforce.A service lead for an IAPT service also expressed many concerned about this recommendation, including Only a few, very selective patients would be able to fit within 15-minute timeframe putting unnecessary pressure on other streams. ****BABCP members were also very concerned that the recommendations could not be implemented in a way that was consistent with services requirement to provide accessible services to a diverse population. cCBT and other online and printed materials rely on individuals who are able to read and understand English and who are computer literate. There is a real risk of increasing inequity if services use more computerised or written materials and fewer 'face to face 'low intensity interventions. BABCP members appreciated that the "….need to consider access and ability to engage with computer programmes' was highlighted in the recommendations but	included in the NMA. cCBT was selected as the exemplar from the class of self-help with support as it had a large evidence base and a high effect compared with other interventions in the same class. Thus, the clinical evidence and resource use data used to inform the economic analysis were specific to cCBT; consequently, the results of the economic analysis were specific to cCBT (but could also be extrapolated to any other intervention with similar acceptability, effectiveness and resource use). However, the treatment class effect size for self-help (with or without support) that was estimated from the NMA and reported in the clinical evidence sections of evidence review B, was

					did not feel that this was sufficient to mitigate the risks of excluding vulnerable people from services.BABCP suggest that there is a real danger of excluding many people from psychological interventions if this recommendation is taken literally and implemented in psychological therapy services.	informed by evidence from all interventions included in the treatment class. In addition, individual intervention effects have been reported in the evidence review B for all interventions within each class for the SMD outcome (for both less and more severe depression). In response to stakeholder comments, the committee agreed that PWPs may need more time and flexibility to fulfil their role and responsibilities. Therefore, the indication about the duration of sessions has now been removed from the recommendations, to allow flexibility and ensure effective delivery of low intensity

						interventions. The guideline recommends that people with depression are offered a choice about how all interventions will be delivered including options of face-to-face or remote delivery. The committee discussed the importance of patient choice and problems associated with digital exclusion or digital poverty: some people may prefer a face-to-face intervention either because they are not comfortable using technology, because they lack the appropriate device or internet connection, lack a private and confidential space, or because of wider issues associated with difficulties in accessing services. The committee

						therefore recommended interventions be available via a range of different methods, and the methods of delivery should be guided by patient choice.

95.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	26-27	Table 1	h	Thank you for your comment. The committee considered it important to provide a wide range of interventions to take into account individual needs and allow patient choice. It was recognised by the committee that people who have had prior episodes of depression may have preferences for their treatment based on prior experience or insight into their own depression patterns. The committee recognised that group exercise interventions were currently not available or have limited availability in routine practice, but the committee decided to recommend them based on the favourable available clinical and economic evidence. The

						committee has now removed the suggested duration of exercise sessions and modified the recommended frequency to allow more flexibility in the delivery of exercise programmes. Implementation issues will be considered by NICE where relevant support activity is being planned. The committee noted that group exercise was ranked in the table after a number of other options and this is consistent with these interventions being considered for use after taking into account the other treatments that appear higher in the table.

96.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	27	Table 1	Group mindfulness or meditation – The evidence review on which this recommendation is based evaluated studies of Mindfulness Based Cognitive Therapy and Mindfulness Based Stress Reduction. BABCP members therefore wanted to reiterate that the recommendation should be limited to these two methods. Training in Mindfulness Based Cognitive Therapy (MBCT) is currently available as CPD for CBT therapists working in NHS IAPT services. There was broad concern that the guidelines are written in a way that suggests other unrelated interventions (generic 'mindfulness' and 'meditation', as well as relaxation) are synonymous with MBCTOne member observed, Meditation typically refers to formal meditation practices; some of which are secular, and others are within religious or spiritual practices. Which can come from very different origins and basis. There are many types of meditation for instance: Breath-awareness meditation (Tibetan, Zen, Tiantai and Theravada Buddhism)Loving-kindness meditation (Many Buddhist Denominations)Mantra-based meditation (Hinduism, Buddhism,	Thank you for your comment. Due to the large number of interventions included in this review, comparing all pairs of interventions individually within the network meta-analysis (NMA) or in the pairwise meta-analyses would not be feasible and would require particularly complex consideration and interpretation of the evidence. Moreover, some interventions included in the systematic review had been tested on small numbers of participants and their effects were characterised by considerable uncertainty. For these reasons, the analyses utilised class models: each class consisted of interventions with a similar mode of action or similar

					Jainism, and Sikhism)More secular practices Briefly looking at the evidence they refer to studies about the Mindfulness meditation group (n=38) and Meditation-relaxation group (n=13), but there isn't any specificity as to what they mean by these or the underlying frameworks. Currently the draft guidelines may be read to suggest that generic 'mindfulness groups' are recommended, which is likely to result in interventions that are not supported by evidence. BABCP also suggest that the recommendation related to trained practitioners is also strengthened and this link may be helpful Good Practice Guidelines for Teaching Mindfulness-Based Courses. https://bamba.org.uk/wp-content/uploads/2020/01/GPG-for-Teaching-Mindfulness-Based-Courses-BAMBA.pdfBABCP members wanted to draw attention to the potential adverse effects of mindfulness interventions – see the following for relevant researchShapiro (1992) identified potential adverse effects including physical pain, disorientation, addiction to meditation, suicidal ideation and	treatment components or approaches, so that interventions within a class were expected to have similar (but not necessarily identical) effects. However, the committee did agree that MBCT should be given as an exemplar of this class and in Table 1 of the recommendations, in considering how to deliver group mindfulness or meditation it is recommended that 'a programme such as mindfulness-based cognitive therapy specifically designed for people with depression' is used. Training costs (including additional training required for some therapies such as MBCT) have been considered in the guideline economic modelling. The committee did not consider it

					destructive behaviourShonin et al., (2014) review found mindfulness and other forms of meditation can induce psychotic episodes. Six studies (n = 12) reported that meditation-induced psychotic-like symptoms. However, although some patients had practiced mindfulness-based exercises, others had received training in other forms of meditation.Lomas et al. (2015) although some positive outcomes were identified, 25% of the participants' narratives related to problems arising from their practice. More specifically, the qualitative analysis identified problems including troubling experiences of self, exacerbation of mental health issues and reality being challenged. However, the extent to which these findings can be generalised to other mindfulness practitioners is questionable because most participants belonged to the same meditation centreAnother BABCP member noted in their commentsWe were not aware of significant evidence for MBCT or equivalents for depression 9rather than relapse prevention). The text below from the evidence review (copied below) seems to suggest similar	appropriate to strengthen the recommendation for training as this is a matter for implementation. There is evidence included in the NMA for MBCT as a first-line treatment for depression (and not as an intervention for preventing relapse). The committee reviewed the bias-adjusted NMA rankings for the classes of interventions and noted the very wide credible intervals in the ranks provided. When the SMD for the treatment classes was reviewed by the committee alongside the SMD results for individual interventions within those classes, the committee noted that some individual interventions demonstrated a difference compared to

					so we are not sure how this is included in the options and above IPT which was previously equal in NICE to CBT? "Evidence from the NMA shows a clinically important but not statistically significant benefit of a mindfulness or meditation group intervention relative to TAU on depression symptomatology for adults with less severe depression (SMD -0.62, 95% CrI -1.77 to 8 0.35; 376 participants randomised to mindfulness/meditation group included in this NMA). Mindfulness/meditation group is outside the top-10 highest ranked interventions for clinical efficacy as measured by SMD of depression symptom change scores (mean rank 14.47, 11 95% CrI 4 to 28)"	treatment as usual that had not been seen when reviewing the class level data – this included group mindfulness-based cognitive therapy and group mindfulness and meditation. The committee agreed that, to allow choice of treatments, a wide range of treatments should be offered – these would provide alternatives to people who did not wish to have CBT or BA, or had tried them for a previous episode of depression and not found them to be effective. The committee discussed that other cost-effective interventions should be included in these alternatives and so recommended group mindfulness and meditation (as well as group exercise and

						interpersonal therapy) as alternative interventions.

97.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	27-28	Table 1	Interpersonal psychotherapy (IPT) - BABCP members noted that it would be helpful to be more specific about how commissioner and service leads can ensure that clinicians have 'therapy specific training and competence' in IPT. As noted above, it would also be helpful to specify the therapy models and treatment manuals that are effective	Thank you for your comment. The committee did consider whether providing references to specific manuals would be helpful but given the wide range of manuals available and the potential for this to be seen as NICE endorsing a particular manual, it was decided not to do so. However, details about how the intervention is delivered and key features of the intervention in the treatment tables was informed by the interventions found to be clinically and cost effective in the guideline analyses, supplemented by the committee's clinical experience on optimal delivery of interventions within the NHS. The committee did not consider it

						appropriate to further specify training and competencies as these will be matters for implementation.

98.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	28-29	Table 1	Counselling - BABCP members noted that it would be helpful to be more specific about how commissioner and service leads can ensure that clinicians have 'therapy specific training and competence' in counselling. It would also be helpful to specify the specific models and treatment manuals that are effective – Can NICE please reference the 'empirically validated protocol developed specifically for depression' so that commissioners and service leads can ensure the appropriate treatments are offered.	Thank you for your comment. All the evidence for counselling that was included in the review for the treatment of a new episode of depression was non-directive counselling, and the committee therefore did not consider it appropriate to recommend a specific intervention (for example, Counselling for Depression/Person-Centred Experiential Therapy [PCET]) as the evidence was not reviewed for these interventions. However, based on informal consensus, the committee agreed that counselling should use an empirically validated protocol developed specifically for depression and this was included in the recommendation. The

						committee did not consider it appropriate to further specify training and competencies as these will be matters for implementation.

99.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	29-30	Table 1	Short term psychodynamic psychotherapy (STPP) - BABCP members noted that it would be helpful to be more specific about how commissioner and service leads can ensure that clinicians have 'therapy specific training and competence' in counselling. It would also be helpful to specify the specific models and treatment manuals that are effective – Can NICE please reference the 'empirically validated protocol developed specifically for depression' so that commissioners and service leads can ensure the appropriate treatments are offered.	Thank you for your comment. The committee did consider whether providing references to specific manuals would be helpful but given the wide range of manuals available and the potential for this to be seen as NICE endorsing a particular manual, it was decided not to do so. However, details about how the intervention is delivered and key features of the intervention in the treatment tables was informed by the interventions found to be clinically and cost effective in the guideline analyses, supplemented by the committee's clinical experience on optimal delivery of interventions within the NHS. Based on informal consensus, the committee

						agreed that short-term psychodynamic psychotherapy should use an empirically validated protocol developed specifically for depression and this was included in the recommendation. The committee did not consider it appropriate to further specify training and competencies as these will be matters for implementation.

100.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	30	13-15	BABCP members, many of whom work as clinicians and/or service managers in IAPT services, made many concerned comments about the lack of specificity of the term 'more severe depression'. Evidence Review B suggests that this classification was based on a cut off score on a range of different self-report measure of depression. Psychological therapy services and clinicians were strongly of the view that NICE should provide exact guidance on how to identify patients with 'more severe depression' and those with 'less severe depression'. For example, IAPT services routinely use the PHQ-9 to assess and monitor depression – What cut off should be used to distinguish the two groups of patients? Is this valid as a stand-alone measure or should other factors be included? Should any contextual information be used to modify classification of 'more severe' and 'less severe' depression. If so what contextual information? How should patients who are not literate or who do not have access to the English language be assessed?	Thank you for your comment. The committee were aware that a proper assessment of severity cannot be based solely on a symptom scale and the guideline includes a recommendation to conduct a comprehensive assessment that does not rely simply on a symptom count but also takes into account both the degree of functional impairment and/or disability associated with the possible depression and the length of the episode. The committee considered the studies identified by the review and agreed that although baseline symptom scores have limitations as an indicator of severity, this information was available for the majority of studies, whereas other factors such as duration

						of disorder or functional impairment were not reported in a sufficiently consistent manner for them to be of use in determining severity. The committee considered the current NICE classifications of mild to moderate and moderate to severe depression, and agreed that although these classifications have been adopted quite widely there is potential uncertainty with regards to the management of moderate depression. The committee agreed that a dichotomy of less and more severe depression was clearer, and the guideline includes definitions (that less severe depression includes the traditional categories of

						subthreshold symptoms and mild depression, and more severe depression includes the traditional categories of moderate and severe depression) in order to improve practical utility. The committee considered the distinction between less severe (subthreshold/mild) and more severe (moderate/severe) depression to be clinically meaningful in terms of supporting effective clinical decision making and being aligned with how clinicians conceptualize depression (in particular, GPs and other primary care staff, given that the majority of people with depression and almost all first line presentations of depression are managed

						in primary care). Based on this distinction, an anchor point of 16 on the PHQ-9 was selected as the cut-off between less severe and more severe depression, on the basis of alignment with the clinical judgement of the committee and eligibility criteria in the included studies. Published standardization of depression measurement crosswalk tables (Carmody 2006; Rush 2003; Uher 2008; Wahl 2014) were used in order to 'read-across' different symptom severity scales that were used in different studies.

101.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	31	6	BABCP supports the principle of shared decision making (SDM) with patients – however Table 2 outlines 10 different options, which is too many for clinicians and patients to review and select. We were not able to identify specific research to guide the number of choices available in shared decision making (SDM) but note that most evidence showing the benefits of SDM is based on patients being able to consider two or three options. The cognitive load of weighing the potential benefits, risks, and personal costs of 10 different treatment options seems likely to be excessive for most patients with depression, for whom working memory and decision making are typically impaired Rock, et al, (2014). Cognitive impairment in depression: a systematic review and meta-analysis. Psychological medicine, 44(10), 2029-2040.Lee, et al., (2012). A meta-analysis of cognitive deficits in first-episode major depressive disorder. Journal of affective disorders, 140(2), 113-124.)There was a consensus amongst BABCP members that it would not be feasible to provide sufficient information and time to	Thank you for your comment. Interventions are arranged in Tables 1 and 2 of the guideline in the suggested order in which options should be considered, based on the committee's interpretation of their clinical and cost effectiveness and consideration of implementation factors. However, this is not a rigid hierarchy, all treatments included in Tables 1 and 2 can be used as first-line treatments, and it may be appropriate to recommend an intervention from lower down in the table where this best matches the person's preferences and clinical needs. The committee were aware of the need to provide a wide range of

					patients presenting with a new episode of 'more severe' depression to cover and adequately discuss the range of options outlined in Table 1 or Table 2. It is also not clear how this shared decision making would fit into the existing IAPT stepped care model or how commissioning models would be able to accommodate offering the full range of therapies to all new patients. Most initial assessments and decisions about psychological treatments are currently made by clients in collaboration with low intensity workers in IAPT services (PWPs) as part of the stepped care model on which IAPT is based. The proposed guidelines are unclear about who would support patient choice or how this would be resourced. BABCP is of the view that well trained and supervised PWPs currently support shared decision making but that this range of treatments would present excessive demands on PWPs and patients, and could not be delivered within routine NHS primary care or mental health primary care services (i.e. IAPT).	interventions to take into account individual needs and allow patient choice and considered it important that the treatment of choice can be selected without having to fail other treatments first. The committee cross-referred to the guideline recommendations on choice of treatment which provided more detailed recommendations on how a shared decision on treatment should be made and what should be included in the discussion. It was recognised by the committee that people who have had prior episodes of depression may have preferences for their treatment based on prior experience or insight into their own depression patterns.

102.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	31	Table 2	Combined individual CBT and antidepressant medication – BABCP welcome this recommendation, which follows its interpretation of the best evidence for effectiveness and cost-effectiveness. We agree that it combines the benefits of CBT sessions and medication. However, we do not think the comment 'Sessions with a therapist provide immediate support while the medication takes time to work' has any realistic chance of being delivered in that way. Across England waiting times for CBT therapy in NHS IAPT services exceed the period of time it takes for anti-depressant medication to take effect. Therefore this comment is only meaningful in a context where waiting lists for CBT do not exist – and that is a context that BABCP believes is not realistic	Thank you for your comment. The committee agreed that is some cases the antidepressant medication would be started first, before commencing a psychological therapy, but in other cases, people may start a psychological therapy before the medication, and so have left both these options in the table.

103.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	31	Table 2	Individual CBT – Many of the comments made in relation to Table 1 are also relevant here.BABCP welcome the inclusion of individual CBT as a first line treatment for 'more severe' depression. We also note the recommendation that the 'dose' of treatment is 12-16 sessions of 60 minutes each. However, the guidance on delivery of individual CBT did not appear to be based on the research evidence or the methods of Evidence Review B. Evidence Review B classified relevant research into individual CBT as 'more than' or 'fewer than' 15 sessions. Therefore the rationale for specifying 12-16 sessions as the 'dose' of individual CBT was unclear. BABCP members noted that it would be helpful to be more specific about how commissioner and service leads can ensure that clinicians have 'therapy specific training and competence'. As noted above it would also be helpful to specify the therapy models and treatment manuals that are effective and cost effective so that Individual CBT is delivered safely and correctly.	Thank you for your comment. The number of sessions in the recommendations was determined based on relevant information reported in the RCTs that informed the guideline NMA and the economic analysis, supplemented by the committee's clinical experience on optimal delivery of interventions within the NHS. The information on resource use derived from the RCTs has now been added in evidence review B, under Appendix N. For more severe depression, the economic analysis modelled individual CBT≥15 sessions, as the committee considered that this was more appropriate intensity for people with more severe

						depression. The recommended sessions for individual CBT have now been amended to 'usually' 16, to be consistent with the reported resource use in the respective RCTs for individual CBT≥15 sessions in more severe depression. The recommended number of sessions serves only as a guidance and can be modified depending on individual needs. This has now been clarified in the recommendations. The committee did consider whether providing references to specific manuals would be helpful but given the wide range of manuals available and the potential for this to be seen as NICE endorsing a particular manual, it was

						decided not to do so. However, details about how the intervention is delivered and key features of the intervention in the treatment tables was informed by the interventions found to be clinically and cost effective in the guideline analyses, supplemented by the committee's clinical experience on optimal delivery of interventions within the NHS. The committee did not consider it appropriate to further specify training and competencies as these will be matters for implementation.

104.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	32	Table 2	Individual BA– Many of the comments made in relation to Table 1 are also relevant here.BABCP welcome the inclusion of individual BA as a first line treatment for 'more severe' depression. We also note the recommendation that the 'dose' of treatment is 12-16 sessions of 60 minutes each. However, the guidance on delivery of individual BA did not appear to be based on the research evidence or the methods of Evidence Review B. Evidence Review B classified relevant research into individual BA as 'more than' or 'fewer than' 15 sessions. Therefore the rationale for specifying 12-16 sessions as the 'dose' of individual BA is unclear. BABCP members noted that it would be helpful to be more specific about how commissioners and service leads can ensure that clinicians have 'therapy specific training and competence'. As noted above it would also be helpful to specify the therapy models and treatment manuals that are effective and cost effective so that Individual BA is delivered safely and correctly.	Thank you for your comment. The number of sessions in the recommendations was determined based on relevant information reported in the RCTs that informed the guideline NMA and the economic analysis, supplemented by the committee's clinical experience on optimal delivery of interventions within the NHS. The information on resource use derived from the RCTs has now been added in evidence review B, under Appendix N. It is not correct that individual BA was classified as 'more than' or 'fewer than' 15 sessions. This distinction was made only for CT/CBT. The recommended sessions for individual BA were based on the reported resource use in the

						respective RCTs in more severe depression, which ranged from 8 to 20 sessions. The recommended number of sessions serves only as a guidance and can be modified depending on individual needs. This has now been clarified in the recommendations. The committee did consider whether providing references to specific manuals would be helpful but given the wide range of manuals available and the potential for this to be seen as NICE endorsing a particular manual, it was decided not to do so. However, details about how the intervention is delivered and key features of the intervention in the treatment tables was

						informed by the interventions found to be clinically and cost effective in the guideline analyses, supplemented by the committee's clinical experience on optimal delivery of interventions within the NHS. The committee did not consider it appropriate to further specify training and competencies as these will be matters for implementation.

105.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	33	Table 2	Individual problem solving – although this was identified as a standalone therapy in the evidence review this mode of treatment is rarely delivered in the UK NHS mental health system. Problem solving therapy is therefore not currently included in the core curriculum for IAPT therapists. Unsurprisingly there is not a workforce who are trained to offer this therapy. In contrast 'problem solving' as a technique is a component of other interventions delivered as a low intensity therapy in IAPT services by PWPs. One BABCP member commentedIs Individual problem solving a new high intensity treatment or a low intensity treatment? The 30-minute sessions suggest the latter and sound like it is more a form of Guided Self Help so not sure why this is included separately?BABCP are concerned that the evidence reviewed by the NICE guidelines committee is not immediately generalisable to services in England and that 'problem solving therapy' is not currently available in NHS services. ****This draws attention to another concern of BABCP, which is that the evidence review did not take any account of the most directly relevant	Thank you for your comment. Individual problem solving has been evaluated as a stand-alone intervention and some of those trials were assessed in Evidence review B. In fact, individual problem-solving appeared to be the most cost-effective therapy based on the bias-adjusted ranking of interventions for adults with a new episode of more severe depression. The committee agreed to recommend individual problem-solving based on the clinical and cost-effectiveness and the importance of offering a choice of treatments. However, the committee agreed that it was not appropriate to move individual problem-solving any higher up in terms of the order of

					source of evidence for psychological therapies services in England, i.e. the IAPT database. BABCP appreciates that the IAPT dataset is not derived from a randomised controlled study. However, the IAPT data set is representative of all areas of England, all patients referred to IAPT (around 1.5 million per year) and reflects real life clinical practice and clinical outcomes much more readily than small RCTs conducted with selected populations, who are usually unrepresentative of the NHS population. The result of this omission and of the selection criteria used to identify relevant studies has resulted in NICE recommending a treatment that is not conducted in England, for which evidence is not directly relevant to England or the population of England ,and for which there is no national training programme and very few qualified therapists. BABCP does not believe that it would be possible to offer individual 'problem solving therapy' to individuals with 'more severe' depression. Further, given the relatively weak evidence supporting this intervention for 'more severe'	recommended use as the committee noted that in some conceptualisations, it is only a variant of CBT, with very similar efficacy with individual CBT but higher uncertainty around the mean effect (as demonstrated by the network meta-analysis on depression symptomatology outcome). The committee recognised that individual problem solving interventions were currently not available or have limited availability in routine practice, but the committee decided to recommend them based on the favouring available clinical and economic evidence. The frequency and duration of sessions of psychological therapies has now been removed

					depression BABCP also suggests that it would not be a good use of resources to develop a new national curriculum, establish new training programmes, and recruit and train additional therapists to deliver this therapy.	from the recommendations, to allow more flexibility in the delivery of interventions. Implementation issues will be considered by NICE where relevant support activity is being planned. In response to stakeholder comments, the committee considered a number of practical issues around the waiting times of high intensity psychological interventions and implementation issues relating to the structure of IAPT services and has now updated recommendations for the treatment of a new episode of depression and placed emphasis on guided self-help offered at step 2. The description of guided self-help has

						also been amended to recommend that printed or digital materials that follow the principles of guided self-help are used including structured CBT, structured BA, problem solving or psychoeducation materials, delivered face-to-face or by telephone or online. The individual problem solving referred to in the recommendations is a high intensity intervention, and the described changes to recommendations for low intensity interventions should hopefully make this distinction clearer. When making recommendations, the committee interpreted the RCT evidence in light of their knowledge of the clinical context (including

						drawing on their knowledge of the IAPT dataset) so that the 'reality' for people experiencing depression was taken into consideration. In response to stakeholder comments, the committee have re-structured treatment recommendations in order to take into account implementation factors. In January 2020 NICE published a statement of intent signalling the ambition for the future use of wider sources of data and analytic methods (including sources commonly referred to as real-world data and evidence). To make decisions about the relative effectiveness of interventions, RCTs will continue to be prioritised in line with the NICE

						guidelines manual, in order to ensure that the populations treated with various interventions are equivalent. However it is possible that in the future, high-quality real-world datasets such as the IAPT dataset, could inform questions about access and engagement.

106.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	33-34	Table 2	Counselling - BABCP members noted that it would be helpful to be more specific about how commissioner and service leads can ensure that clinicians delivering counselling for depression have 'therapy specific training and competence' in counselling. BABCP suggest that NICE please reference the 'empirically validated protocol developed specifically for depression' so that commissioners and service leads can ensure the appropriate treatments are offered.****	Thank you for your comment. All the evidence for counselling that was included in the review for the treatment of a new episode of depression was non-directive counselling, and the committee therefore did not consider it appropriate to recommend a specific intervention (for example, Counselling for Depression/Person-Centred Experiential Therapy [PCET]) as the evidence was not reviewed for these interventions. However, based on informal consensus, the committee agreed that counselling should use an empirically validated protocol developed specifically for depression and this was included in the recommendation. The

						committee did not consider it appropriate to further specify training and competencies as these will be matters for implementation.

107.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	34-35	Table 2	Short term psychodynamic psychotherapy (STPP) and Interpersonal Therapy (IPT) - BABCP members noted that it would be helpful to be more specific about how commissioner and service leads can ensure that clinicians have 'therapy specific training and competence' in counselling. As noted above, it would also be helpful to specify the specific models and treatment manuals that are effective – BABCP suggest that NICE please reference the 'empirically validated protocol developed specifically for depression' so that commissioners and service leads can ensure the appropriate treatments are offered.	Thank you for your comment. The committee did consider whether providing references to specific manuals would be helpful but given the wide range of manuals available and the potential for this to be seen as NICE endorsing a particular manual, it was decided not to do so. However, details about how the intervention is delivered and key features of the intervention in the treatment tables was informed by the interventions found to be clinically and cost effective in the guideline analyses, supplemented by the committee's clinical experience on optimal delivery of interventions within the NHS. The committee did not consider it

						appropriate to further specify training and competencies as these will be matters for implementation.

108.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	35-36	Table 2	Self-help with support – BABCP members were very concerned that this low intensity treatment was recommended for people with 'more severe' depression. Of particular concern was the idea that severely depressed patients could be safely treated in 15-minute sessions delivered by a low intensity therapist (PWP) with limited training and experience in working with severely depressed people. BABCP suggest that 15-minute telephone or online sessions (which may not be synchronised) are inadequate to deal with the levels of risk and complexity likely to be presented by many patients in this category. BABCP are also very concerned that clinicians delivering self-help with support (i.e. PWPs in IAPT services) are not trained to work with severely depressed patients. Therefore all PWPs working in IAPT would require additional training and more intensive supervision to take on work of this complexity. We do not think that the increased costs of supervision have been included in the cost-effectiveness analysis. Working with 'more severely' depressed patients would also expose PWPs to more	Thank you for your comment. The 'more severe' categorisation encompasses moderate and severe depression. The committee noted that there was some evidence that self-help with support was both effective and cost-effective for more severe depression. However, the committee were uneasy about recommending self-help with support for more severe depression, based on their knowledge and experience, and concerns that it may not be suitable for people with more severe depression as this intervention does not require the development of a therapeutic relationship in the same way that the more intensive psychological therapies do, or that

					emotionally demanding work that might lead to increased burnout and staff turnover. This also has not been costed. In addition, the current curriculum for PWPs would require significant expansion which would be expensive and would take several years to be implemented by HEIs.In the view of BABCP this recommendation would be extremely difficult to implement. It could only be done safely if high intensity CBT therapists (who are trained to work with severely depressed patients) delivered guided self-help (which they are not trained to do). However, this would have the consequence of reducing availability of other recommended treatments and therefore increasing waiting lists.Given that this is an untested recommendation (given the RCTs included in the evidence review) BABCP consider that it would be highly dangerous to follow this recommendation. We note the comment made in the guideline - 'In more severe depression, the potential advantages of providing more intensive treatment should be carefully considered' (page 35/6) but in the view	would occur when people are monitored regularly if on antidepressants. However, the committee agreed that, as the evidence had shown benefit and cost-effectiveness, self-help with support could be considered for use in people with more severe depression who wished to try it, or who did not want to consider any other treatment options. In response to stakeholder comments, the frequency and duration of sessions of psychological therapies has now been removed from the recommendations, to allow more flexibility in the delivery of interventions. The costs of supervision

					of BABCP this statement is far too weak to mitigate the risk.	have been considered in the model.

109.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	36	Table 2	Group exercise – As indicated in our comments relating to Table 1 of the draft guidance BABCP members were mystified about how this intervention would or could be delivered within existing mental health services. Group exercise for depression is not on the curriculum for any professional group employed within IAPT services and is not aligned with their current skills and competencies. Is the expectation that this intervention would be delivered in primary care? If so by which group? How would this be resourced and would the professional group have adequate experience and skills to work with patients who are severely depressed and at high risk of self-harm and suicide?As currently described in the draft guidance this recommendation would present enormous logistical challenges to commissioners and service providers. It would not be possible to offer this as part of a 'menu' of interventions for 'more severe' depression without significant investment in new training, recruitment and service redesign.BABCP strongly suggest that this	Thank you for your comment. The committee noted that there was some evidence that group exercise was both effective and cost-effective for more severe depression. However, the committee were uneasy about recommending group exercise for more severe depression, based on their knowledge and experience, and concerns that it may not be suitable for people with more severe depression. The committee agreed that, as the evidence had shown benefit and cost-effectiveness, group exercise could be considered for use in people with more severe depression who wished to try it, or who did not want to consider any other treatment options.

					recommendation is removed from the guidelines	The committee recognised that group exercise interventions were currently not available or have limited availability in routine practice. The committee decided to include them in the table based on the evidence for clinical and cost effectiveness and in order to promote patient choice. However, group exercise appears at the end of Table 2 and this is consistent with these interventions being considered for use after taking into account the other treatments that appear higher in the table. Implementation issues will be considered by NICE where relevant support activity is being planned.

110.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	37	Apr-14	BABCP welcome the recommendation that Behavioural Couples therapy for depression is available to patients with depression. There are a cadre of qualified and experienced therapists who can deliver this in IAPT services and existing training programmes could be expanded to meet any increased demand for this treatment.BABCP note that evidence review B excluded a number of relevant studies of Behavioural Couples therapy and believe this was based on the incorrect assumption that is it only appropriate and effective for people who are in a distressed relationship; this is not the case Barbato, A. & D'Avanzo, B. (2020). The findings of a Cochrane Meta-Analysis of couple therapy in adult depression: Implications for research and clinical practice. Family Process, 59 (2), 1-15.)	Thank you for your comment. As pre-specified in the review protocol, the committee identified couple interventions, including behavioural couples therapy, as interventions that would be more appropriate for subgroups of adults with depression (for people with problems in the relationship with their partner) and as such these interventions were considered only in pairwise comparisons (and not included in the NMA).

111.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	37	5	There is compelling evidence that couple-based interventions for depression can be of benefit for patients who are not in a distressed relationship. For example, a recent meta-analysis found that the beneficial effect of couple therapy on symptoms of depression was not more pronounced in studies that used relationship distress as an inclusion criterion. This meta-analysis also found comparable moderate effect sizes on symptoms of depression for both individual and couple-based interventions. Barbato, A. & D'Avanzo, B. (2020). The findings of a Cochrane Meta-Analysis of couple therapy in adult depression: Implications for research and clinical practice. Family Process, 59 (2), 1-15.	Thank you for your comment. As pre-specified in the review protocol, the committee identified couple interventions, including behavioural couples therapy, as interventions that would be more appropriate for subgroups of adults with depression (for people with problems in the relationship with their partner) and as such these interventions were considered only in pairwise comparisons (and not included in the NMA).
112.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	38	02-May	BABCP welcomes the recommendation that treatment may be continued to prevent relapse and note that this should be based on the patient's clinical need and preferences. For this to be feasible commissioners will need to provide additional resources and revise existing contracts for psychological therapies services.	Thank you for your comment and support of the relapse prevention recommendations. The resourcing of relapse prevention psychological therapies is an implementation issue, and will be considered by

						NICE when implementation support activity is being planned.
113.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	41	8 to 11	BABCP strongly supports the recommendations that treatment is reviewed at 4 – 6 weeks and that further line treatments should be available if needed.	Thank you for your comment and support for this recommendation.
114.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	42		BABCP welcome the recommendations on this page relating to further treatment options. For this recommendation to be feasible, contracts for primary mental health and psychological therapy services will need to be amended and additional resources will be required. Without additional resources to fund further treatment options they cannot be provided without referral to secondary care – which is often not possible because patients do not meet inclusion criteria and/ or there are very long waiting times before further treatments can be started.	Thank you for your comment and support of the further-line treatment recommendations. The resourcing of further-line treatment psychological therapies is an implementation issue, and will be considered by NICE when implementation support activity is being planned.

115.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	45	Jul-18	BABCP agree that patients with chronic depression should be offered a choice of treatment and that a shared decision about treatment should be reached, based on their clinical needs and preferences.	Thank you for your comment and support for this recommendation.
116.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	46	17-25	BABCP also agree that for patients with chronic depression psychosocial interventions such as befriending and rehabilitation may be helpful. These may improve the patient's quality of life even if they do not address symptoms of depression directly.	Thank you for your comment and support for this recommendation.

117.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	47	Nov-15	This paragraph refers to 'people with depression and a diagnosis of personality disorder…'. BABCP consider that this is too broad a description to be useful and that being more specific about the type of personality disorder would be helpful. Para 1.11.3 implies that the recommendation should be specifically addressed to individuals with depression and borderline personality disorder	Thank you for your comment. The committee noted that this review covered people with depression comorbid with a personality disorder, but that there are different types of personality disorder and it was not always clear from the evidence which types had been included, or if all types had been combined and considered. The committee agreed that one of the most common types is emotionally unstable personality disorder (previously known as borderline personality disorder) and they were aware that there is existing NICE guidance about the treatment of people with borderline personality disorders with comorbid depression which recommends treatment

						within a well-structured treatment programme for borderline personality disorder. The committee therefore wanted to make recommendations that were in line with the existing NICE guideline on borderline personality disorder, and so recommended that referral to a specialist personality treatment disorder programme should be considered. However, the committee did not feel able to make the recommendations any more specific due to a lack of clarity in the evidence reviewed.

118.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	48	9 to 14	BABCP agrees that people with depression and psychotic symptoms should be assessed by a specialist team and would welcome further specificity about how referral pathways to specialist services be resourced. In the experience of our members referrals from IAPT to specialist mental health services often involves lengthy delays and waiting times. We also agree that individuals who have depression with psychotic symptoms should have access to psychological and pharmacological treatments.	Thank you for your comment and support for these recommendations. The resourcing of referral pathways is an implementation issue, and will be considered by NICE when implementation support activity is being planned.

119.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	51-52	20-21	BABCP agree that improving access to NHS services is a priority. IAPT services currently operate using a stepped care model, where approximately two thirds of patients referred are treated by low intensity therapists i.e. PWPs (step 2) and one third of patients are treated by high intensity therapists e.g. CBT therapists (step 3). This model means that effectiveness and cost effectiveness, as well as prompt access to treatment are maximised. IAPT has also created a detailed, comprehensive and national database of outcomes which is provided on an open access basis to researchers. BABCP is extremely concerned that the implementation of the NICE recommended treatments for 'less severe' and 'more severe' depression is incompatible with the delivery of a stepped care model. Currently patients with 'less severe' depression normally be treated by PWPs using a range of low intensity treatments, and most are discharged. A minority of 'less severe' depressed patients are offered Counselling for Depression. People who do not respond to low intensity treatment, or who present with severe,	Thank you for your comment. In response to stakeholder comments, in particular around implementation issues in the context of IAPT, some changes have been made to the tables of interventions for the treatment of a new episode of depression guided by the principles of offering the least intrusive intervention first, reflecting clinical and cost effectiveness, and reinforcing patient choice. The self-help with support section has been relabelled as guided self-help, and placed earlier in the treatment pathway. When making recommendations, the committee interpreted the RCT evidence in light of their knowledge of the clinical context (including

					complex, and/or co-morbid depression are offered a high intensity treatment for depression (i.e. individual CBT, individual BA, Cognitive Behavioural Couples therapy, IPT).The current draft guidelines suggest that patients who have 'less severe' depression are offered a menu of treatment, starting with Group CBT and Group BA (both not currently offered as described in the guidelines), followed by individual CBT and individual BA. Based on your evidence review these are high intensity treatments for which a qualified CBT therapist would be needed. IAPT services could not meet this demand for high intensity therapy and the inevitable result would be an explosion in waiting times and a decrease in availability of treatment. In marked contrast, PWPs who make up the majority of the IAPT workforce would be under used and many would need to be made redundant, or if eligible, to be retrained as high intensity therapists. This would involve a massive investment in training places, training programmes, and supervision and would take many years. In the meantime the impact on PWPs would be very negative as the crucial role that they	drawing on their knowledge of the IAPT dataset) so that the 'reality' for people experiencing depression was taken into consideration. In response to stakeholder comments, the committee have re-structured treatment recommendations in order to take into account implementation factors. In January 2020 NICE published a statement of intent signalling the ambition for the future use of wider sources of data and analytic methods (including sources commonly referred to as real-world data and evidence). To make decisions about the relative effectiveness of interventions, RCTs will continue to be prioritised

					play in IAPT services would be undermined and undervalued. On a related point, the criteria for inclusion of RCTs in your evidence review resulted in the exclusion of the NIHR funded COBRA study of Behavioural Activation, which is highly relevant to the delivery of treatment for depression in IAPT. Importantly, the COBRA trial demonstrated that PWPs with additional training and supervision, were able to deliver the full BA protocol (based on Martell et al.) safely and effectively. BA delivered by PWPs was more effective and cost effective than CBT delivered by High Intensity CBT therapists. This important data has not influenced the guidelines despite being directly generalisable to the IAPT services in England and providing high quality data that translates directly to delivery.	in line with the NICE guidelines manual, in order to ensure that the populations treated with various interventions are equivalent. However it is possible that in the future, high-quality real-world datasets such as the IAPT dataset, could inform questions about access and engagement. The COBRA trial was excluded from the NMA because it did not meet inclusion criteria for a new episode of depression. This is because <80% of the study sample received first-line treatment for a new episode of depression. This was a requirement of the review protocol in order to create a homogenous dataset. Nevertheless, the committee used their

						knowledge of pragmatic trials such as the COBRA trial when interpreting the evidence from the systematic review and making recommendations.

120.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	52	01 to 15	BABCP agree with these points.	Thank you for your comment and support for this recommendation.
121.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	53	12 to 16	BABCP strongly welcome this point about making services accessible and culturally adapted. We would also suggest that routine outcome measures and digital and written therapy resources also need to be translated and that the cross-cultural validity of all measures are assessed. Likewise we recommend that this paragraph is extended to include the use of trained interpreters (not family members or informal interpreters from the community).	Thank you for your comment and support for this recommendation. This recommendation relates to access and so the included examples are about pathways and models. There is an over-arching recommendation at the beginning of the guideline about information that states that this should be appropriate to language, cultural and communication needs, and another recommendation in the section on delivery of interventions that advises that treatments must be

						appropriate for people's language needs.
122.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	5354	20-311-3	BABCP endorses this essential list of ways to increase access to communities and groups who are under-represented in mental health services.	Thank you for your comment and support for these recommendations.
123.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	54	04 to 19	BABCP also welcome this identification of groups whose needs may be relatively unmet in mental health services but suggest that commissioners and service leads should be asked to monitor access across all parts of the community they serve, report this publicly and be required to take actions to increase access.	Thank you for your comment. The recommendation on monitoring access to treatment in the section of the guideline on choice have been amended to include that this monitoring should include monitoring of equality of access, provision, outcomes and experience.

124.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	54-55	21-251-11	Collaborative care – Evidence review A showed that most research on service delivery has focused on collaborative care and that there were fewer studies focused on the stepped care model. BABCP agree that the collaborative care model may be particularly useful for vulnerable groups such as those identified here. However, BABCP are extremely concerned about the implications of the draft guidance on current service delivery via IAPT services. IAPT services are delivered using a stepped care model and there is extensive data demonstrating that this provides effective and cost-effective treatment. As noted above, however, the recommendations contained in these draft guidelines are incompatible with a stepped care model. To implement the draft guidelines would require complete service redesign for IAPT with associated costs and risks. In the view of BABCP the quality of the evidence included in 'Evidence Review B' was inadequate to justify such a service redesign. To implement the draft guidelines would require extensive investment in recruiting and training new high intensity	Thank you for your comment. In response to stakeholder comments, in particular around implementation issues in the context of IAPT, some changes have been made to the tables of interventions for the treatment of a new episode of depression guided by the principles of offering the least intrusive intervention first, reflecting clinical and cost effectiveness, and reinforcing patient choice. The self-help with support section has been relabelled as guided self-help, and placed earlier in the treatment pathway.

					therapists (CBT, IPT, STPP, BA) and redeployment of many PWPs as most of the interventions they deliver were not covered by the evidence review. There would also be a highly negative impact on waiting times, access to treatments, staff morale, and costs.	
125.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	55	16-18	BABCP welcome the recommendation that multi-disciplinary specialist care services are available to those with more severe or chronic depression.	Thank you for your comment and support for this recommendation.
126.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	56	03 to 04	The reference to 24-hour support services is important and welcomed by BABCP. Currently this support is often only available via Accident and Emergency services. BABCP would welcome expansion of specialist mental	Thank you for your comment. The committee were aware of different models for the provision of 24 hour care including helplines, so did not

					health support to manage crises and 24-hour care.	amend this recommendation.
127.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	57	08-Nov	The recommendation that psychological therapies are available for patients in inpatient settings is strongly supported by BABCP.	Thank you for your comment and support for this recommendation.
128.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	57	14-16	BABCP agree that interventions for inpatients should be continued once patients are discharged. Where these interventions are psychological continuing treatment should ideally be provided by the same therapist in the in-patient and out-patient setting. Where this is not possible, treatment should be co-ordinated via appropriate handover.	Thank you for your comment and support for this recommendation.

129.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	59	03-Apr	BABCP recommend that NICE provide clear, evidence-based criteria for clinicians and clinical services to identify and assess 'less severe' depression	Thank you for your comment. The committee were aware that a proper assessment of severity cannot be based solely on a symptom scale and the guideline includes a recommendation to conduct a comprehensive assessment that does not rely simply on a symptom count but also takes into account both the degree of functional impairment and/or disability associated with the possible depression and the length of the episode. The committee considered the studies identified by the review and agreed that although baseline symptom scores have limitations as an indicator of severity, this information was available for the majority of studies, whereas other factors such as duration

						of disorder or functional impairment were not reported in a sufficiently consistent manner for them to be of use in determining severity. The committee considered the current NICE classifications of mild to moderate and moderate to severe depression, and agreed that although these classifications have been adopted quite widely there is potential uncertainty with regards to the management of moderate depression. The committee agreed that a dichotomy of less and more severe depression was clearer, and the guideline includes definitions (that less severe depression includes the traditional categories of

						subthreshold symptoms and mild depression, and more severe depression includes the traditional categories of moderate and severe depression) in order to improve practical utility. The committee considered the distinction between less severe (subthreshold/mild) and more severe (moderate/severe) depression to be clinically meaningful in terms of supporting effective clinical decision making and being aligned with how clinicians conceptualize depression (in particular, GPs and other primary care staff, given that the majority of people with depression and almost all first line presentations of depression are managed

						in primary care). Based on this distinction, an anchor point of 16 on the PHQ-9 was selected as the cut-off between less severe and more severe depression, on the basis of alignment with the clinical judgement of the committee and eligibility criteria in the included studies. Published standardization of depression measurement crosswalk tables (Carmody 2006; Rush 2003; Uher 2008; Wahl 2014) were used in order to 'read-across' different symptom severity scales that were used in different studies.

130.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	59	10-Nov	BABCP recommend that NICE provide clear, evidence-based criteria for clinicians and clinical servicse to identify and assess less severe depression	Thank you for your comment. The committee were aware that a proper assessment of severity cannot be based solely on a symptom scale and the guideline includes a recommendation to conduct a comprehensive assessment that does not rely simply on a symptom count but also takes into account both the degree of functional impairment and/or disability associated with the possible depression and the length of the episode. The committee considered the studies identified by the review and agreed that although baseline symptom scores have limitations as an indicator of severity, this information was available for the majority of studies, whereas other factors such as duration

						of disorder or functional impairment were not reported in a sufficiently consistent manner for them to be of use in determining severity. The committee considered the current NICE classifications of mild to moderate and moderate to severe depression, and agreed that although these classifications have been adopted quite widely there is potential uncertainty with regards to the management of moderate depression. The committee agreed that a dichotomy of less and more severe depression was clearer, and the guideline includes definitions (that less severe depression includes the traditional categories of

						subthreshold symptoms and mild depression, and more severe depression includes the traditional categories of moderate and severe depression) in order to improve practical utility. The committee considered the distinction between less severe (subthreshold/mild) and more severe (moderate/severe) depression to be clinically meaningful in terms of supporting effective clinical decision making and being aligned with how clinicians conceptualize depression (in particular, GPs and other primary care staff, given that the majority of people with depression and almost all first line presentations of depression are managed

						in primary care). Based on this distinction, an anchor point of 16 on the PHQ-9 was selected as the cut-off between less severe and more severe depression, on the basis of alignment with the clinical judgement of the committee and eligibility criteria in the included studies. Published standardization of depression measurement crosswalk tables (Carmody 2006; Rush 2003; Uher 2008; Wahl 2014) were used in order to 'read-across' different symptom severity scales that were used in different studies.

131.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	61	Nov-13	BABCP welcome the identification of key research questions outlined; we particularly welcome the research question about increasing access to people with depression who are under-served and under-represented in current services	Thank you for your comment and support for this research recommendation.
132.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	62	07-Aug	BABCP agree that identifying the mechanisms of action of effective psychological treatments for acute episodes of depression in adults is a priority for research.	Thank you for your comment and support for this research recommendation.
133.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	64	06-Oct	Informed choice is an important pillar of effective collaborative treatment and BABCP strongly support this principle of care. We agree also that offering meaningful choice is likely to mean longer consultation times and thus increased resources will be needed. BABCP suggest that to make this choice meaningful and informed, clinicians working with individuals with depression are likely to need additional training so that they are properly informed about the range of evidence-based treatments, how they are delivered, potential adverse effects, and the demands and	Thank you for your comment. The committee agreed that it would not always be practical to continue with the same therapist between inpatient and outpatient settings and so did not add this to their recommendation, and agreed that handover on discharge would be part of standard care

					expectations on clients. This will have a resource impact on the NHS, but may lead to better outcomes and thus offset additional costs of training.	

134.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	66	08-Sep	Based on evidence review B, Group CBT and group BA were found to be cost effective for adults with less severe depression. BABCP are concerned that the evidence reviewed was limited in number, excluded key studies, (e.g. the COBRA study of individual BA), largely of low quality, lacked relevance to the NHS in England, did not report patient preferences, adherence or attrition, or the additional costs and complexities of organising and delivering group based psychological therapies. In addition the cost-effectiveness analysis was based on delivering 8 sessions of therapy, whereas the evidence review classified therapy as fewer than 15 sessions or 15 or more sessions. ****Group BA and Group CBT would also not be aligned with the stepped care model of IAPT as they are delivered by High Intensity therapists (not PWPs). Therefore BABCP do not agree with the view of the NICE committee that Group CBT and Group BA should be prioritised as first line treatments for 'less severe' depression.In addition, group CBT and group BA are not widely available in IAPT services and clinicians are not trained in these modes	Thank you for your comment. Conclusions on the cost-effectiveness of treatments for a new episode of depression were primarily based on the guideline economic analysis, which allowed to simultaneously compare the relative cost-effectiveness of all relevant treatment options that were assessed in the guideline. This simultaneous comparison was practically impossible to be made by single RCTs. The COBRA trial was excluded from the systematic review and the NMA because it did not meet inclusion criteria for a new episode of depression. This is because <80% of the study sample received first-line treatment for a new episode of

					of delivery. Introducing these two treatments into IAPT services would constitute a huge upheaval would require extensive retraining of staff, and may increase drop-out, costs and reduce recovery rates.	depression. This was a requirement of the review protocol in order to create a homogenous data set. Nevertheless, the committee used their knowledge of pragmatic trials such as the COBRA trial when interpreting the evidence from the NMAs and the economic analysis and making recommendations. The guideline economic analysis considered a wide range of evidence as it utilised clinical data from the guideline NMAs, which included 142 RCTs of treatments for less severe depression and 534 RCTs of treatments for more severe depression. Data utilised in the guideline economic model did include attrition rates and also continuous data as well data on dichotomous

						response and remission. Intervention resource use was obtained from the RCTs included in the NMAs, supplemented by the committee's expert opinion to reflect optimal routine practice in the UK. Other healthcare resource use associated with management of depression was derived from a large cohort UK study. National UK unit costs were used. Therefore, the committee was confident that the guideline economic analysis utilised a very large evidence base of RCTs and other appropriate types of data, and was relevant to the NHS context. Attrition was considered in the model. For group interventions, attrition had a negative impact on outcomes (people

						discontinuing treatment early were excluded from receiving treatment benefits) but no impact on total intervention costs (i.e. a person attending a group intervention was assumed to incur the cost of a full course of treatment, whether they attended the full course or discontinued treatment early). The economic analysis selected one intervention per class as an exemplar, as it was infeasible to assess every single intervention considered in the NMA. For group CBT class in less severe depression, there were 2 separate interventions: group CBT≥15 sessions and group CBT<15 sessions. CBT<15 sessions had a better SMD vs TAU than CBT≥15 sessions (CBT<15 sessions group -1.25, 95%

						CrI -1.72 to -0.83; CBT≥15 sessions group -0.84, 95% CrI -1.91 to 0.78) and also a much larger evidence base (N=316 vs 10) - see also Table 10, results of bias-adjusted analysis, in evidence review B. Therefore, as CBT<15 sessions group was shown to have better effects and a much larger evidence base than CBT≥15 sessions group, it was selected for consideration as an exemplar of its class in the economic modelling (which ultimately informed recommendations). The modelled resource use was based on relevant information reported in the RCTs that informed the guideline NMA and economic analysis, supplemented by the committee's clinical experience on the optimal

						delivery of interventions within the NHS. The information on resource use derived from the RCTs has now been added in evidence review B, under Appendix N. For group CBT<15 sessions in less severe depression, it can be seen that the number of sessions ranged from 5 to 14 across RCTs considered in the NMA, with larger studies reporting 5-8 sessions. For group BA, the RCTs considered in the NMA reported 5-8 sessions. Based on these figures and their clinical expertise, the committee advised that 8 sessions be modelled for group CBT and group BA in the economic analysis, which, subsequently, informed the respective recommendations. The economic analysis did

						consider additional costs of organising and delivering group interventions including therapists' indirect time (i.e. time related to organising therapy but not spent with the client), supervision time, and the fact that optimal delivery of group interventions can be achieved by 2 therapists, one leading and delivering the intervention and the other making observations. Issues around patient choice were covered in evidence review I and were considered by the committee when formulating recommendations. The treatment recommendations have now been updated to reflect more clearly the key principles of stepped

						care, which is the prevailing model of care in IAPT.

135.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Guideline	69	15	This section of the guideline refers to 'some very limited evidence for the effectiveness of behavioural couples therapy for people with depression and who had problems in their relationship'. It is certainly the case that evaluating the efficacy and effectiveness of couple-based interventions for depression is fraught with methodological complications. However, there are some studies that should be taken into account in addition to the sole study that was considered in the development of these guidelines, e.g.:Baucom, D., Fischer, M., Worrell, M., Corrie, S., Belus, J., Molyva, E. and Boeding, S. (2018) Couple-based intervention for depression: an effectiveness study in the national health service in England. Family Process, 57: 275–92Bodenman, G. et al. (2008). Effects of coping-oriented couple therapy on depression: a randomised controlled trial. Journal of Consulting and Clinical Psychology, 76, 944-954.Furthermore, couple-based interventions for depression are also effective for people who are in a non-distressed relationship, seeBarbato, A. & D'Avanzo, B. (2020). The findings of a Cochrane Meta-Analysis	Thank you for your comment. As pre-specified in the review protocol, the committee identified couple interventions, including behavioural couples therapy, as interventions that would be more appropriate for subgroups of adults with depression (for people with problems in the relationship with their partner) and as such these interventions were considered only in pairwise comparisons (and not included in the NMA). The Baucom et al. (2018) study was not appropriate for inclusion in the review as it was not a randomised controlled trial. Bodenmann 2008 was identified by the searches

					of couple therapy in adult depression: Implications for research and clinical practice. Family Process, 59 (2), 1-15).	and assessed for eligibility, however it did not meet inclusion criteria as less than 80% of participants were receiving first-line treatment for depression (56% taking medication at baseline). This study is on the 'PA-Couple excluded studies' list of Supplement B1.
136.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Equality Impact Assessment	2	3.2Point 4	BABCP welcome the recognition that online, text based, and remote consultations can increase access but may not be suitable for some people. The statement 'The committee made clear in their recommendations that alternatives such as face to face consultations must be available too' is	Thank you for your comment. Several recommendations refer to the use of remote on in-person methods of communication and all emphasise a choice of methods, and this is

					welcome. However BABCP suggest that the guidelines are reworded so that this recommendation is much clearer and stronger.	reinforced in the section on access, so the committee did not amend recommendations relating to this.
137.	British Association of Behavioural and Cognitive Psychotherapy (BABCP)	Supplement B1	Excluded studies page		A number of couple therapy outcome studies were excluded for questionable reasons and should be reconsidered. For example, Bodenman (2008) was excluded as 25% participants had dysthymia. However, the mean BDI score of participants at the start of therapy was 24-26 (in the moderate range for depression).The Leff (2000) study was excluded because of the high drop-out rate in the medication arm of treatment (56.8%). However, the drop-out rate in the couple therapy condition was only 15% and the patients in this group showed significant improvements on the BDI post-treatment and at follow-up. This suggests couple therapy is an effective treatment for depression, and furthermore that it is more acceptable than medication.	Thank you for your comment. Bodenmann 2008 was excluded from the behavioural couples review as less than 80% of participants were receiving first-line treatment for depression (56% taking medication at baseline). This study is on the 'PA-Couple excluded studies' list of Supplement B1. The Leff (2000) study was not excluded based on drop-out, although there is a note in Supplement B that this study was excluded in the 2004 NICE depression guideline with the reason for exclusion

						provided as '>50% drop out in one arm'. Leff (2000) was excluded in this update of the guideline because there was no assessment at endpoint (first assessment at 1-year).