Depression in adults (update)

Consultation on draft scope
Stakeholder comments table

2nd – 30th March 2015

Stakeholder	Page no.	Line no.	Comments	Developer's response
Acupuncture Association of Chartered Physiotherapists	4	87 -88	We are very pleased to see both acupuncture and exercise listed here. Bear in mind here that Physiotherapists are the recognised health professional as experts in exercise who also use acupuncture as a treatment with assurance the treatment is delivered safely. Physiotherapy could be an option here as the individual treatments mentions are delivered by Physiotherapists.	Thank you for your comment. As mentioned in the scope (under the 'Key areas that will be covered' heading), the examples given for each key area are to provide context and are not an exhaustive list.
Association for Psychoanalytic Psychotherapy in the NHS	2	37 -44	We welcome the full range of types of depression to be covered and also that specific population groups will be looked at in relation to their unmet needs, response to treatment, differential outcomes etc. We think the GDG needs to go further, however, than its existing commitment. Firstly, there is evidence both to show that older people are under-represented in services for depression and that when they are offered psychological therapy they do comparatively well. Both National Audits found this to be the case and the detailed research by Richard Byng has shown the potential benefit that would be realised if pathways for older people were improved. Secondly, there is evidence to show that LGBT people are at higher risk of depression and suicide http://www.nhs.uk/livewell/lgbhealth/pages/mentalhealth.aspx). but are not gaining adequate access and that when they do, conversely, they are also at risk of harm from services (see the sub-analysis published by Crawford, M et al in press). We think that both	Thank you for your comment. However, looking at the aetiology of depression is outside the remit of this scope. Older people are a group that will be given specific consideration in this guideline. When considering groups where there might be equality issues we did not feel that LGBT people warranted specific consideration.

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			these groups merit looking at specifically for these reasons. In addition, however, we think the scope does not go far enough to ask questions about the social origins of depression and the specific social factors that have led to the current episode as well as the important social factors that are responsible for maintaining the person's depression. This is a fundamental point. We know that at least 60% of welfare claimants on ESA benefits are stating their invalidity is due to their depression. What is now very clear from a number of different studies is that it is the interaction of the social factors (unemployment, stigma, poverty etc) with the psychological factors that in combination are causing the ongoing depression. Unless the GDG looks at the interaction of social factors that have a key causal role in the person's chronic and recurrent depression it will fail to recommend the right combination of support and treatment that would address these in such a way that sustained recovery is achieved. Similar points could be made about the social factors (e.g. isolation, loneliness) that cause and maintain depression in many older people and that treatment and support must seek to alleviate in order for recovery to be achieved. For each of the additional specified groups, therefore, (inc. LGBT, older people, welfare claimants) we think the GDG needs to scope the range of social factors that will play a role in the success or failure of the interventions being offered and systematically review the evidence for characteristics of these sub-groups that can be shown to have a clear causal impact on harms and benefits – and should therefore be addressed in any interventions / services offered.	

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Association for Psychoanalytic Psychotherapy in the NHS	5	111 -119	We think the point about settings should be expanded to cover different types of depression and whether different population groups suit different settings more than others. We also welcome the attempt to look at whether different models and pathways may be better for different types of depression e.g. complex depression. However, we are concerned that the limitations of the evidence base from RCTs may act as a disincentive to explore this question more fully unless the GDG are willing to consider a wider range of evidence from real world data. Likewise, we think a closer look at whether a sequence of brief interventions and the possibility of maintenance therapy that the scope refers to is more or less effective than a longer-term therapy where the relational and interpersonal dimensions of the depression can be addressed? What factors would a clinician and patient need to look at and consider to be able to make a good decision on the relative merits between very brief, brief, longer term, group, couple and / or various permutations and combinations of these options? The GDG should review the evidence with a view to differentiating between those interventions that are clearly first-line interventions based on clear evidence of greater effectiveness in head to head comparisons for specific patient types / groups – and those interventions or combinations of interventions where informed choice and monitoring of response by the clinician and patient together is likely to yield better results (ie: where there is uncertainty and where local / individual factors should count.	Thank you for your comment. The guideline will consider service-user preference for service delivery and interventions. A line has been added to the scope (under the 'Key areas that will be covered' section) to indicate that the guideline will consider preference and the sequencing of interventions, along with the mode and format of delivery, but that details of these factors are not included for each intervention as the examples are intended to provide context rather than representing an exhaustive list. This guideline will also consider a number of factors, such as severity, which may predict response to treatment.
Association for Psychoanalytic Psychotherapy in the NHS	5	119 -156	Each of the questions talks about relative benefits and harms but does not address different mechanisms. We do not think any meaningful	Thank you for your comment. However, this is outside of the remit of the scope.

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			choices can be made between interventions that will have a range of relative benefits and harms unless there is a way for the patient and clinician to understand these in the context of how the intervention is meant to work – and whether, therefore, for that patient / for that group of patients it is likely to be better and more effective than another intervention. The GDG must look not only at the evidence about outcomes but also whether there is any empirical evidence that supports the theory for how the treatment works and, therefore, for whom? These explanations should be able to be made accessible so that patient choice is meaningful.	
Association for Psychoanalytic Psychotherapy in the NHS	9	241 -249	What the scope does not sufficiently address are those places in the care pathway that are known to function poorly and that could be improved with the introduction of evidence-based methods. For example, the previous guideline recommended outcome monitoring to track progress of recovery. But how far is this technology being used to enable treatment switching or switching therapist based on an understanding of the trajectory of (non) recovery that may indicate such a change? How far is the alliance with the therapist and factors related to the patient-therapist 'fit' or 'match' being monitored through use of these technologies? There is considerable evidence that this is possibly the single most influential variable in terms of predicting response to treatment so it would be remiss to neglect to look at this. For example, the GDG should review the evidence on how patient preference can be elicited and how patients can be enabled to make choices at different stages of the care pathway based on information and objective considerations about the options that are relevant	Thank you for your comment. We will review the evidence for service delivery models. However, we will not be addressing mechanisms of change and so will not be addressing the alliance referred to in the comment.

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			for that person? Likewise, it is rarely the case that only one professional will be involved in the care of a person with depression. The current scope says very little about how collaborative working and integrated models are most effectively deployed – whether information is shared between teams and if so how? Whether multiple agencies can work towards common outcomes and if so how? Whether models of key worker or liaison roles are effective? In keeping with our previous comments we feel the GDG needs to look at what the factors are for those patients who do not benefit. They are currently the majority of patients. Their needs must be addressed and evidence-based strategies for how to prevent harm and deterioration / drop out should be looked at systematically.	
Association for Psychoanalytic Psychotherapy in the NHS	9	253 -256	Since the previous guideline there have been two National Audits of NHS psychological therapy services for depression. Quality standard 4 in the audit specifically asked whether "the therapy provided is in line with that recommended by the NICE guideline for the service user's condition / problem". In the 2nd Audit data from some 45,000 cases with a primary diagnosis of depression and / or mixed depression and anxiety was audited against this standard. One of the main findings was that length of treatment was sub-optimal. The GDG should look at what factors are causing sub-optimal length of treatment for depression. Similarly, there is now a large amount of real world data on IAPT services reported by HSCIC. This consistently shows that the modal number of sessions for people treated with depression in IAPT is sub-optimal both at Step 2 and Step 3. The GDG should look at what factors are leading to high early attrition and drop out prior to recovery, and what	Thank you for your comment. We will review the evidence on service delivery models.

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			strategies for enabling treatment completion through to recovery would be effective in improving overall recovery rates. The 'big data' that is available for adults with depression both from the Audits and HSCIC needs to be utilised throughout the different questions being asked by the GDG as a complement to its review of RCT evidence, in order to answer questions about factors that lead to variations in outcomes more fully than can be answered from the RCT evidence on its own. Although the GDG will be reliant on the NICE Manual for guidance on methodology we think it would have been more helpful for the Scope to set out not just a set of initial questions but also the relevant sources of evidence that NICE will be looking at to try to answer those questions. The GDG itself can advise on this, of course, but if an initial attempt is made to scope the range of relevant evidence in the draft scope itself then stakeholders can also advise on the extent to which this is comprehensive and adequate to answer the questions asked. To underline the point about data that has direct relevance to NHS services – it would be unacceptable given the investment of time and resource for datasets from 2 National Audits and from hundreds of thousands of IAPT services (2M + patients to date) not to be utilised by the NICE GDG alongside RCT and other evidence. In particular, both the National Audits and HSCIC have shown wide variations in effectiveness of different services and have each identified a range of factors that they suggest may account for these. We think it is NICE's responsibility to draw on this evidence and undertake a more systematic review to establish the causes of variation between services and between groups of therapists and to identify strategies for	

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			quality improvement that are evidence-based and will specifically address under-performing services / therapists.	
Borderland Voices, Arts for Health & Mental Wellbeing	3	76 -77	As a small local charity, we offer informal, free, weekly psychosocial activities based around all forms of art, including creative writing. Workshops are facilitated by professional artists but they are not arts therapists. Peer to peer support and socialisation between participants is crucial, but so too is participants' active involvement in creativity. It can variously both distract them temporarily from underlying concerns and provide a way of articulating those concerns. Invariably it boosts self-esteem.	Thank you for your comment. As mentioned in the scope (under the 'Key areas that will be covered' heading), the examples given for each key area are to provide context and are not an exhaustive list.
Borderland Voices, Arts for Health & Mental Wellbeing	5	129 -131	Participants with mild to moderate depression rely on being able to attend Borderland Voices regularly to prevent relapse.	Thank you for your comment.
Borderland Voices, Arts for Health & Mental Wellbeing	5	142 -144	Even participants with moderate to severe depression (in some cases exacerbated by physical health issues), who may periodically have to be hospitalised, say that knowing they can return to Borderland Voices gives a sense of comfort and security.	Thank you for your comment.
Borderland Voices, Arts for Health & Mental Wellbeing	General	General	As a result of our 17 years' experience in this field, we firmly believe in the benefits, for many adults experiencing depression, of participatory arts.	Thank you for your comment. As mentioned in the scope (under the 'Key areas that will be covered' heading), the examples given for each key area are to provide context and are not an exhaustive list.
Borderland Voices, Arts for Health & Mental Wellbeing	General	General	People who may have had bad experiences within the mental health care system are reassured if these activities are delivered in a setting independent of the formal health system.	Thank you for your comment. Models of care for the coordination and delivery of services, and settings for the delivery of care, will be reviewed as outlined in section 1.3.
British Acupuncture Council	2	41	The first draft made mention here of people with coexisting conditions, but then we were told in the scoping meeting that those with depression plus pain would be excluded, as this is covered elsewhere. This draft no longer includes coexisting	Thank you for your comment. We have amended the scope to include coexisting mental health conditions as a group to be given specific consideration. There is existing NICE guidance on Depression in adults with a chronic physical health problem (CG91)) and this will be included

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			conditions for specific consideration; we are interested in the reasoning behind this. It is of particular relevance for acupuncture treatment as the evidence indicates this to be superior to psychological intervention for those with chronic pain in addition to their depression (but otherwise equivalent) [Hopton A, MacPherson H, Keding A, Morley S. Acupuncture, counselling or usual care for depression and comorbid pain: secondary analysis of a randomised controlled trial. BMJ Open 2014;4:e004964]. We attempted to put this onto the agenda for the multimorbidities guideline but that is apparently not looking at treatment. The value of complementary therapies, including acupuncture, may lie particularly with a person-centred, rather than disease-centred, approach, and hence with multimorbidity.	in the NICE pathway.
British Acupuncture Council	4	87	We are pleased to see that acupuncture is now explicit in the physical intervention examples. There is recent high quality UK evidence to support this.	Thank you for your comment
British Association for Counselling and Psychotherapy	2	General	In the draft scope that was presented at the Depression in Adults Stakeholder Workshop, the scope stated that specific consideration would be given to people with coexisting conditions, including anxiety symptoms and misuse of alcohol or drugs. However, in the draft scope currently being consulted on there is no mention of coexisting conditions. This is problematic as the presenting issues with depression can be many, varied and complex. In reality patients present with multi-morbidities and report wide-ranging difficulties such as bereavement, co-morbid physical ill health, problems in their relationships and so on, and may be worried, anxious, depressed or any combination of these and other symptoms, so they do not always fit neatly into the diagnostic categories on	Thank you for your comment. People with coexisting mental health conditions have been added as a group to be given specific consideration in the guideline.

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			which guidelines rely. The 'Psychological Therapies, Annual Report on the use of IAPT services: England– 2013/14' (Health & Social Care Information Centre, 2014) showed that the most common diagnosis for those referrals entering treatment in the 2013/14 was 'mixed anxiety and depressive disorder' at 15% (108,489) of all referrals entering treatment in the year. Therefore the emphasis on this disorder specific guideline will not always be helpful in routine practice for users where comorbidity is the norm. Given that clinical utility is a key predictor of guideline use, we recommend the inclusion of co-existing conditions in the scope. **Reference:** Health & Social Care Information Centre (2014) Psychological Therapies, Annual Report on the use of IAPT services: England– 2013/14 Experimental statistics. Health and Social Care Information Centre.	
British Association for Counselling and Psychotherapy	3	71 -75	With regard to the areas within the published guideline that will be updated, much new evidence has been published on a range of psychological interventions since the original guideline was developed. Please find below a review of the literature for psychological interventions for consideration in the update of the guideline. **Counselling** Following criticism of the results from a study published in 2000, King, Marston and Bower (2014) have published a re-analysis of their RCT into the effectiveness of CBT and non-directive counselling for patients with an ICD-10 depressive episode. 134 patients were randomised to CBT and 126 to	Thank you for your comment. As mentioned in the scope (under the 'Key areas that will be covered' heading), the examples given for each key area are to provide context and are not an exhaustive list. We will be considering a broad range of interventions, many of which are mentioned in your comment.

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			counselling with 67 randomised to usual care. Both CBT and counselling were found to be superior to GP care at 4 months but not at 12 months with no differences in effectiveness between the two psychological therapies. A randomised controlled trial of 755 patients with depression, aimed to evaluate acupuncture versus usual care and counselling versus usual care for patients who continue to experience depression in primary care (MacPherson et al., 2013). The primary outcome measure was the PhQ-9. Compared to usual care, both interventions were found to be effective in reducing levels of depression on the PhQ-9 at 3 months and 12 months after treatment. There were no significant differences between the interventions. A meta-analysis including 34 studies, with 3962 patients accessing brief CBT, counselling or problem solving therapy reported all three interventions effective for depression with no differences in effectiveness observed between interventions (Cape et al., 2010). Preliminary evidence from a two-arm, parallel group, randomised controlled trial of counselling versus low intensity CBT for persistent sub-threshold and mild depression indicates improvements in levels of depression post intervention for both counselling and CBT (Freire et al., 2015). A cohort study comprising 50 AIDS patients experiencing anxiety and depression reported counselling to be a very effective therapeutic	

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			technique for reducing both anxiety and depression in these patients (Gupta et al., 2010). A cohort preference study of 134 cancer patients experiencing depression reported that when asked for their preference and interest in individual counselling, antidepressant medication or support groups more than 50% ranked individual counselling as their first choice. Preference for counselling was significantly higher than either of the other two options (Wu et al., 2014). A pre-post cohort study with 120 diabetic patients explored levels of depression in those who accessed counselling interventions compared with those who did not. After a three month period levels of depression decreased in the intervention group whilst they increased in the control group (Mansour et al., 2013). **Humanistic and integrative therapies** A Cochrane systematic review comparing behavioural therapies to other psychological therapies for depression included 25 trials involving 955 participants. No significant difference in response rate or acceptability was found between behavioural therapies and other psychological therapies for depression. No significant difference was observed between behavioural therapies and humanistic or integrative therapies. The authors recommend the need for further research to expand the evidence base (Shinohara et al., 2013). A cohort study exploring transactional analysis, gestalt therapies, integrative counselling psychology and person-centred counselling within a	

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			medium-term community based service using routine outcome evaluation and standardised measures found all therapies to be effective for patients who engaged with them (van Rijn, B & Wild, C, 2013). **Interpersonal therapy** A randomised controlled trial evaluating the efficacy of interpersonal counselling compared with selective serotonin reuptake inhibitors (SSRIs) in patients with major depression reported a significantly higher proportion of patients achieving remission in the counselling compared with the SSRI group (Menchetti et al., 2014). Evidence from systematic reviews and meta-analyses have indicated the need for further research into interpersonal therapy due to small sample sizes and small effects in existing studies (van Hees et al., 2013; Jakobsen et al., 2011). **Psychodynamic therapy** Using a Cochrane systematic review methodology Jakobsen et al (2011) compared the benefits and harms of psychodynamic therapy versus no intervention for major depressive disorder. Five trials were included, consisting of 365 participants who all received anti-depressants as the co-intervention. All studies found significantly reduced symptoms of depression compared with no intervention. In 2013 Driesson et al conducted an RCT comparing the efficacy of psychodynamic therapy with CBT. A total of 341 adults meeting DSM-IV criteria for major depressive episode and Hamilton	

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			Depression Rating scale scores of greater than 14 were randomly assigned to 16 sessions of either CBT or short term psychodynamic supportive therapy. Post-treatment psychodynamic therapy was found to be non-inferior to CBT. **Problem solving therapy** A meta-analysis of 21 independent studies found problem solving therapy to be equally effective as other psychological therapies and medication and significantly more effective than no treatment in reducing depressive symptomatology (Bell and Thomas, 2009). **Brief therapies** In 2009, Maina et al conducted a randomised controlled trial which explored the recurrence rates in unipolar major depressed patients comparing brief dynamic therapy in combination with pharmacotherapy and pharmacotherapy alone. The study included 92 patients, 41 who were remitters to combined therapy, and 53 who were remitters to pharmacotherapy alone. Results indicated a significantly lower rate of remittance in patients who were treated with the combined therapy at 48 month follow up. A systematic review and meta-analysis including eight studies of short term psychodynamic psychotherapy (STPP) found no differences between that intervention and other psychotherapies. STPP was found to be superior to waitlist (Abbass, Town and Driesson, 2011). An RCT comparing STPP and treatment as usual	

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			for 60 patients with a DSM-IV diagnosis of depressive or anxiety disorders reported significant improvements for those randomised to STPP compared to those randomised to TAU (Bressi et al., 2014). A meta-analysis of STPP for depression including 23 studies, totalling 1365 participants found STPP to be significantly more effective than control conditions post-treatment (Driessen et al., 2010). An RCT of 198 adults meeting DSM-IV criteria for depression or anxiety were randomised to either STPP or solution focused therapy. Symptoms of depression and anxiety were significantly reduced in both groups during the one year follow-up (Maljanen et al., 2012). **Supportive therapy** A randomised controlled trial which aimed to determine the relative efficacy of CBT and supportive therapy (SPT) reported both therapies to be effective in improving diagnoses of depression and anxiety and reducing depressive symptoms (Ashman et al., 2014). This study included a sample of 77 individuals with a diagnosis of post-traumatic brain injury depression. Patients received up to 16 sessions of either CBT or SPT. **Group interventions** **Group counselling** An RCT assessing the feasibility of a group-counselling intervention for depressed HIV-positive patients in primary health care in South Africa showed significantly greater improvements on	

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			levels of depression on the PhQ-9 in the intervention group compared to the control group (Peterson et al., 2014). **Group metacognitive therapy** A baseline controlled trial evaluating the effectiveness of group meta-cognitive therapy (GMCT) for patients who had not responded with both antidepressants and cognitive behaviour therapy reported significant improvements in levels of depression which were maintained at follow up. 70% of patients were rated as recovered at post-treatment, and a further 20% as improved at both post-treatment and 6 month follow up (Papageorgiou & Wells, 2015). **Guided Self-help** An RCT involving 92 patients with major depressive disorder randomised to either an internet based psychodynamic guided self-help treatment or an active control condition found large and superior improvements in patients randomised to the intervention group. Effects were maintained at 10-months follow up (Johansson et al., 2012). **References:** Abbass, A., Town, J., and Driesson, E. (2011). The efficacy of short-term psychodynamic psychotherapy for depressive disorders with comorbid personality disorder. *Psychiatry: Interpersonal and Biological Processes, 74(1): 58-71.* Ashman, T., Cantor, J. B., Tsaousides, T., Spielman, L. & Gordon, W. (2014). Comparison of	

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			cognitive behavioural therapy and supportive psychotherapy for the treatment of depression following traumatic brain injury: a randomised controlled trial. *The Journal of Head Trauma Rehabilitation, 29(6): 467 – 478.* Bell, A. C. and Thomas, J. (2009). Problem-solving therapy for depression: A meta-analysis, *Clinical Psychology Review, 29(4): 348 – 353.* Bressi, C., Nocito, E. P., Milanese, E. A et al. (2014). Efficacy of short-term psychodynamic psychotherapy vs treatment as suual in a sample of patients with anxiety and depressive disorders. *Rivista di Psichiatria, 49(1): 28 – 33.* Cape, J., Whittington, C., Buszewicz, M., Wallace, P. and Underwood, L. (2010). Brief psychological therapies for anxiety and depression in primary care: meta-analysis and meta-regression, *BMC Medicine, 8(38). doi:10.1186/1741-7015-8-38* Driesson, E., Cuijpers, P., de Maat, S. C. M, Abbass, A. A., de Jongee, F., Dekker, J. J. M. (2010). The efficacy of short-term psychodynamic psychotherapy for depression: A meta-analysis. *Clinical Psychology Review, 30(1): 25 – 36.* Driesson, E., Van Henricus, L., Don, F. J., et al (2013). The efficacy of cognitive –behavioural therapy and psychodynamic therapy in the outpatient treatment of major depression: A randomised clinical trial, *The American Journal of Psychiatry, 170(9), 1041 – 1050.* Freire, E., Cooper., M., Elliott, R., McConnachie, A.,	

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			Morrison, J., Walker, A., Williams, C. (2015). Counselling versus Low-Intensity Cognitive behavioural therapy for persistent sub-threshold and mild Depression (CLICD): A pilot/feasibility randomised controlled trial. Summary report to the Chief Scientist Office. Gupta., A. S., (2009). Impact of counselling upon anxiety and depression in AIDS patients, *Journal of the Indian Academy of Applied Psychology, 36(2): 249 – 254* Jakobsen et al., (2012). The effect of adding psychodynamic therapy to antidepressants in patients with major depressive disorder: A systematic review of randomised clinical trials with meta-analyses and trial sequential analysis. *Journal of Affective Disorders, 137(1-3): 4 – 14.* Johansson, R., Ekbladh, S. Hebert, A. et al (2012). Psychodynamic guided self-help for adult depression through the internet: A randomised controlled trial, *Plos One, 7(5): e38021* King, M., Marston, L and Bower, P (2014). Comparsion of non-directive counselling and cognitive behaviour therapy for patients presenting in general practice with an ICD-10 depressive episode: A randomised controlled trial, *Psychological Medicine, 44(9): 1835 – 1844* MacPherson, H et al., (2013). Acupuncture and Counselling for Depression in Primary Care: A Randomised Controlled Trial, *Plos Medicine, 10(9): e1001518*	

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			Maina, G., et al (2009). Brief dynamic therapy combined with pharmacotherapy in the treatment of major depressive disorder: Long term results. *Journal of Affective Disorders, 111(91-3): 200 – 207* Maljanen, T., Paltta, P., Harkanen, T., et al. (2012). The cost-effectiveness of short-term psychodymanic psychotherapy and solution focused therapy in the treatment of depressive and anxiety disorder during a one-year follow up. *Journal of Mental Health Policy and Economics, 15(1): 13-23.* Mansour, E. A., Gemeay, E. M., Moussa, I. M. (2013). Counseling and depression among diabetic patients, *Saudi Medical Journal, 34(3):295 – 301.* Menchetti, M., Rucci, P., Bortolotti, B., Bombi, A., Scocco, P., Kraemer, H. C., Beradi, D. (2014). Moderators of remission with interpersonal counselling or drug treatment in primary care patients with depression: Randomised controlled trial, *The British Journal of Psychiatry, 204(2): 144 – 150.* Papageorgious, C and Wells, A. (2015). Group meta-cognitive therapy for severe antidepressant and CBT resistant depression: A baseline-controlled trial, *Cognitive Therapy and Research, 39(1): 14-22* Peterson, J., Hanass Hancock, J., Bhana, A and Govender, K. (2014). A group-based counselling intervention for depression comorbid with HIV/AIDS using a task shifting approach in South Africa: a randomised controlled pilot study.	

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			Shinohara, K., Honyashika, M., Imai, H., et al. (2013). Behavioural therapies versus other psychological therapies for depression. *The Cochrane database of systematic reviews, 10, CD008696* Wu, S. M., Brothers, B. M., Farrar, W., Anderson, B. L. (2014). Individual counselling is the preferred treatment for depression in breast cancer survivors. *Journal of Psychosocial Oncology, 32(6): 637-646.*	
British Association for Counselling and Psychotherapy	General	General	The Increasing Access to Psychological Therapies (IAPT) programme provides the largest source of practice-based evidence regarding the provision and effectiveness of psychological therapies for depression at a national level. This provides an ideal opportunity to combine evidence from RCTs, systematic reviews and meta-analyses with practice-based evidence obtained from large datasets collected nationally. This paradigm would enable a better understanding of not only 'what works' but who it works for (Barkham & Mellor-Clark, 2003; Evans et al., 2003). Comparative outcomes data from IAPT services is currently unavailable to the public, but HSCIC have indicated such data will be available this autumn. It is a serious omission to exclude such data from the scope of the evidence for the update of this guideline. The data routinely collected would enable consideration of initial levels of severity for depression, differences in outcome effectiveness and efficiency of the available psychological therapies. Inclusion of such data at a local as well as a national level will contribute to best practice guidance.	Thank you for your comment. The best available evidence will be reviewed throughout the development of this guideline.

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			Being the largest programme delivering psychological therapy for adults, and with the expectation of a 90% completion rate of outcome data, the IAPT dataset provides an ideal opportunity to better understand what is happening in practice (see Glover et al, 2010 and Gyani et al, 2011), which would complement the evidence provided by data collected from randomised controlled trials. It is not suggested that evidence from practice-based evidence be seen as superior to that from RCTs, systematic reviews and meta-analyses but as complementary to them in providing a more complete understanding of the evidence base using a representative national dataset. This can only enhance clinical guidelines development. **References:** Barkham, M., and Mellor-Clark, J., (2003). Bridging Evidence-Based Practice and Practice-Based Evidence: Developing a Rigorous and Relevant Knowledge for the Psychological Therapies, *Clinical Psychology and Psychotherapy,* 10, 319 – 327. Evans, C., Connell, J., Barkham, M., Marshall, C., and Mellor-Clark, J. (2003). Practice-Based Evidence: Benchmarking NHS Primary Care Counselling Services at National and Local Levels, *Clinical Psychology and Psychotherapy,* 10, 374, 388. Glover, G., Webb, M. & Evison, F. (2010). Improving access to psychological therapies: a review of the progress made by sites in the first roll-out year. [pdf] North East Public Health Observatory. Available at:	

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			http://www.iapt.nhs.uk/silo/files/iapta-review-of-the-progress-made-by-sites-in-thefirst-roll8208-out-year.pdf Gyani, A., Shafran, R., Layard, R., & Clark, D. M. (2011). Enhancing recovery rates in IAPT services: Lessons from analysis of the year one data. [pdf] Available at: www.iapt.nhs.uk.	
British Association for Psychopharmacology	2	38	Attention given to the transition from adolescent to adult services. A particularly difficult time where professional help can be interrupted and lost.	Thank you for your comment. Transitions between CYP and adult services is covered in the update to Depression in children and young people (update).
British Association for Psychopharmacology	3	64 -65	Consideration of current inpatient provision. It is very unusual for depressed patients to be admitted as inpatients, partly because the usual NHS environment is so unsuitable for them. Should there be specialist wards for patients with depression?	Thank you for your comment. As set out in the scope, evidence for settings for the delivery of care (including inpatient settings) will be reviewed.
British Association for Psychopharmacology	3	64 -65	Similarly what is the role of CMHTs who often seem reluctant to take on depressed patients unless they are regarded as 'high-risk' - chronic suffering and disability are not enough (and are underrated by HONOS scores). Some chronically depressed patients need long term support from professionals to maintain them in the community at a reasonable level. Can this be acknowledged- and thereby temper the usual practice of discharging depressed patients as soon as possible. Generally depression needs to be acknowledged as serious condition which can merit specialist assessment and treatment.	Thank you for your comment. We will review the evidence on service delivery models.
British Association for Psychopharmacology	3	64 -65	Is there a role for specialist mood disorder services at a regional/national level and how should patients access these? Despite apparently being able to 'choose' a provider, referrals of depressed patients to non-local services continue to be blocked by commissioners.	Thank you for your comment. We will review the evidence on service delivery models.
British Association for	3	78	Some rationalisation of local practice. For example	Thank you for your comment. Local decisions regarding

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Psychopharmacology		-81	GPs may be forbidden to prescribe escitalopram even though it is now generic	recommended drug lists are matters for implementation and outside the scope of this guideline.
British Association for Psychopharmacology	3	78 -81	Assessment of how pricing affects availability of treatment. For example generic tranylcypromine (an essential treatment for a small number of patients) now costs £8 per tablet. Here a single manufacturer is exploiting a monopoly. Cheaper forms of the drug are available in the EU- can they be accessed?	Thank you for your comment. The issues you raise concerning the availability of drugs and differential international pricing are outside the scope of this guideline.
British Association for Psychopharmacology	3	79	The draft scope mentions several classes of antidepressant treatment for consideration. This should include explicit mention of newer classes of drug treatments (e.g. multi-modal) as well as other drug classes commonly used in depression (atypical antipsychotics). A focus on adjunct or combined treatment would be useful.	Thank you for your comment. Antipsychotics and lithium have been added to the list of examples. It is important to bear in mind that the examples given for each key area are to provide context and are not an exhaustive list.
British Association for Psychopharmacology	4	87	Growing evidence for TMS and TDCS in treatment of depression should also be considered.	Thank you for your comment. There is existing NICE guidance for Transcranial magnetic stimulation for severe depression (IPG242) that will be included in the NICE pathway and there is NICE guidance under review for Transcutaneous cranial electrical stimulation for insomnia, depression or anxiety.
British Association for Psychopharmacology	5	131 &144	There has been a growing focus on predictors of treatment response in depression and this literature should be evaluated e.g. Are there any profiles, symptom clusters or biomarkers which recommend one treatment over another?	Thank you for your comment. This guideline will consider a number of factors, such as severity, which may predict response to treatment.
British Association for Psychopharmacology	5	131 &144	Consider adding a specific question relating to function 'in people whose depression has responded to treatment, what strategies are effective in improving function' Recent studies suggest that return to function is not necessarily the same as preventing relapse or reducing symptoms.	Thank you for your comment. This will be covered under 'Adaptive functioning' in the outcomes section.
British Association for Psychopharmacology	6	167	A more defined role for carers in assessment and planning and professional recognition of their crucial role- they should not be fobbed off with the excuse of 'confidentiality'.	Thank you for your comment. However, recognition and assessment falls outside the remit of the scope.

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British Association of Art Therapists	2	41	Could this include mothers and infants? When a mother is depressed it affects her ability to attune to her infant, and this could have lasting effects, especially if depression goes untreated or poorly addressed.	Thank you for your comment. There is existing NICE guidance on Antenatal and postnatal mental health: clinical management and service guidance (CG192)
British Association of Art Therapists	3	75	Art therapy might be mentioned here, as it has the capacity to enhance sense of self – often weakened in depression - and, if in groups, also help with social withdrawal.	Thank you for your comment. As mentioned in the scope (under the 'Key areas that will be covered' heading), the examples given for each key area are to provide context and are not an exhaustive list.
British Association of Art Therapists	General	General	We welcome the review of this guideline. Whilst there is very limited evidence from "Gold Standard" RCTs to support the inclusion of Arts Psychotherapies in the treatment of Depression. We would draw your attention to the most recent National Audit in Psychological Therapies for depression (NAPT) that found 62% of the High Intensity therapists audited provided Art Psychotherapies but had no formal training. Whilst our association acted quickly in support of the national accreditation scheme which has since been ushered in to ensure safeguards are in place for the public to prevent such a reoccurrence. A question remains as to the benefits of arts based intervention for the treatment of depression. Whilst this is beyond the scope of the guideline as it stands, we are aware that issues remain as to which subgroups are not best served by the current scope, (and treatments) we would draw your attention to the prevalence and incidence of Dyslexia in the population which stands at around 10% of which around 4% are affected. Likewise we wonder how well current practice and services support people with a mild learning disability who have an IQ in the range of 50 to 70 and are not	Thank you for your comment and the references. As mentioned in the scope (under the 'Key areas that will be covered' heading), the examples given for each key area are to provide context and are not an exhaustive list. People with coexisting mental health conditions have also been added to the scope as a group that will be given specific consideration.

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			currently using services but are likely, as other population groups to suffer from depression and anxiety. We would advocate screening for dyslexia and the adaption of subsequent literature to support retention in treatment. Arts based interventions and formalised art therapy may well be better suited to working with sub groups of a general population and or marginalised groups. We naturally would welcome further research is this area and would welcome such an endorsement by the CDG. http://www.rcpsych.ac.uk/pdf/NAPT%20second%20round%20National%20report%20%20website%2028-11-13v2.pdf Recent HTA assessment of Art Therapy in Non Psychotic Client Groups. http://www.journalslibrary.nihr.ac.uk/hta/volume-19/issue-18#abstract	
British Autogenic Society	1	11 -22	Does not specifically include (mental) health care professionals who work in the third sector. Perhaps these groups should be included because they may be consulted by self-referral and may also have data relevant to incidence, prevalence, and relapse in the populations they serve.	Thank you for your comment. Professionals in other health, social care and non-health sectors who may have direct contact with or are involved in the provision of health and other public services for those with depression are included in the list of people who should take action.
British Autogenic Society	2	51	Perhaps third sector settings should be included, as inclusion can positively impact the organisations (and thus their members) governing these professionals.	Thank you for your comment. This guideline will cover the care and shared care provided or commissioned by health and social care services.
British Autogenic Society	3	60 -66	Again third sector settings might be included.	Thank you for your comment. This guideline will cover the care and shared care provided or commissioned by

Stakeholder	Page no.	Line no.	Comments	Developer's response
				health and social care services.
British Autogenic Society	3	69 -75	This could include autogenic training, a 10 session training in a meditative form of relaxation incorporating some cognitive components and appearing to affect both emotion and cognition, which has some evidence across different countries. It has a clearly structured and documented format as trained by the British Autogenic Society in the UK. It may be particularly effective where there is an anxiety component to the depression, which is common. Depression is one of the disorders to which autogenic training has been successfully applied both as an adjunctive method and as the mainstay of treatment. It could potentially be helpful as an adjunct to low-intensity or high-intensity CBT. Sleep is one component that appears to be particularly aided. Autogenic training is a 'mind/body' method and therefore operates on a number of levels. The scoping paper mentions that people with depression are often reluctant to seek treatment. Autogenic training is a stress-management and general well-being approach, with which some people may more easily engage, perhaps especially when first seeking help. Autogenic training is self-generated – i.e. clients learn simple techniques to cultivate a calm and meditative state of mind, and this can become a lifelong skill, which has potential economic benefit for service providers.	Thank you for your comment. As mentioned in the scope (under the 'Key areas that will be covered' heading), the examples given for each key area are to provide context and are not an exhaustive list.
British Autogenic Society	4	87 -88	Perhaps add to physical interventions: Relaxation Response induction methods. The RR at the macro level helps people maintain allostatic balance, and reduce allostatic load and overload which contribute to depression as well as chronic illnesses. Autogenic training appears to induce the RR, although it is substantively more than a simple	Thank you for your comment. As mentioned in the scope (under the 'Key areas that will be covered' heading), the examples given for each key area are to provide context and are not an exhaustive list.

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			relaxation technique, so it might more appropriately be considered under psychological therapies.	
British Autogenic Society	6	147 149-50 152-3 155-6	Please clarify what is meant by "in combination". Not clear what is combined with what – or whether it is anything that has been researched in any combinations.	Thank you for your comment. This means combined interventions.
British Dietetic Association	4	87 -88	We agree with the inclusion of physical interventions including exercise as part of the potential treatment for those with depressive episodes. Physical activity may enhance self-efficacy for other components of treatment. In addition it can be carried out alone or in groups in a variety of settings so is both adaptable and flexible.	Thank you for your comment.
British Dietetic Association	5	142 -144	In our view maintaining physical activity as part of day to day life is important for the maintenance of good mental health and may be a helpful adjunct in prevention of relapse.	Thank you for your comment.
British Dietetic Association	General	General	We note that a healthy lifestyle including a balanced diet is likely to enhance mental as well as physical wellbeing, although we recognise that this guidance does not cover prevention of depression.	Thank you for your comment. However, this is outside the scope of this guideline.
British Psychoanalytic Council	4	93	We believe that the scope should take into consideration non-stepped care models of delivery, in particular a collaborative care approach. The stepped care approach in practice means that patients run through several treatments before they reach an appropriate one. We believe that it would be more in the immediate and long-term recovery interests of patients if they had a more thorough initial assessment by an experienced practitioner. Further, that this would be highly cost-effective. This is also why we believe, with reference to page 4, line 93, that updating recognition, assessment and initial management of depression urgently needs to be within the scope of the guideline development group.	Thank you for your comment. We will review the evidence on service delivery models (including stepped care and collaborative care).

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British Psychoanalytic Council	8	203	Particularly in light of the high rates of recurrence mentioned in 3.1, the scope needs to allow for the guideline development group to thoroughly consider evidence including qualitative research and data from routine settings (audit, benchmarking and quality evaluation) so as to ensure the guideline has clinical utility and is relevant and applicable to the NHS.	Thank you for your comment. In developing recommendations the guideline committee will take into account a number of factors concerning service configuration and we will review evidence for service delivery models.
British Psychoanalytic Council	8	203	Given the high rates of recurrence mentioned in 3.1, the scope also needs to allow for the guideline development group to look at long-term treatment approaches to promoting sustained recovery, which will lower such recurrence and be more cost-effective in the long-term.	Thank you for your comment. We will be considering relapse prevention.
British Psychoanalytic Council	General	General	The scope needs to acknowledge and steer throughout the guideline development process non-medicalised ways of understanding depression. Focusing on depression solely in relation to symptoms and gradations of severity risks the development of guidelines which do not apply to all persons under the rubric of depression but only to patients who present with 'pure' depression. Where depression can refer to an acute phase of low mood accompanied by specific symptoms, it can also commonly signify a complex, chronic and refractory condition comorbid with other psychiatric difficulties, such as complex personality problems or personality disorder.	Thank you for your comment. We agree with your view that depression is a heterogeneous disorder. When considering the evidence and developing the recommendations the GC will take this into account. People with coexisting mental health conditions have also been added to the scope as a group that will be given specific consideration. People with persistent subthreshold symptoms will also be included.
British Psychoanalytic Council	General	General	The scope document and in particular the review questions, need to lay more emphasis on the comorbidity of depression with other psychiatric diagnoses, reflecting the commonality found in clinical practice of patients presenting with 'depression' having comorbidity with a range of neurotic disorders, personality disorders and/or substance misuse. There needs to be sufficient	Thank you for your comment. We have amended the scope to include people with coexisting mental health conditions as a group to be given specific consideration.

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			scope for the guideline development group to review the evidence for comorbidity and for the treatment of it.	
British Psychoanalytic Council	General	General	We believe that the scope needs to reflect the clinical reality that individuals respond to treatment approaches in very different ways. Rather than focusing solely on gradations of severity, the scope also needs to consider the role of personal choice and personality in how effectively patients respond to treatment. There is evidence to suggest that choice – between medication and therapy, between a full choice of therapy modalities, where treatment is accessed and when - is associated with better response and is cost-effective.	Thank you for your comment. The guideline will consider service-user preference for interventions. A line has been added to the scope (under the 'Key areas that will be covered' section) to indicate that the guideline will consider preference, along with the mode and format of delivery and the sequencing of interventions, but that details of these factors are not included for each intervention as the examples are intended to provide context rather than representing an exhaustive list.
British Psychoanalytic Council	General	General	The scope also needs to allow for the guideline development group to consider at what point a treatment is not working and to decide what is to be done if a treatment does not work.	Thank you for your comment. We agree and, as with previous guidance, we will consider what actions should be taken when an individual has not responded to an intervention.
British Psychoanalytic Council	General	General	We believe that the scope must allow for the guideline development group to look into the common factors which play a role in the effectiveness of different therapeutic approaches. These include the relationship between patient and practitioner.	Thank you for your comment. However, this is outside the scope of this guideline.
British Thoracic Society	General	General	Specific attention should be given to depression occurring as a comorbidity with other long term conditions, for example COPD, heart disease, arthritis. In relation to patients with COPD there is a need to identify depression, address it, and realise the impact of depression on key outcomes of the condition.	Thank you for your comment. However, this is outside the scope of this guideline. There is existing NICE guidance on Depression in adults with a chronic physical health problem (CG91)).
British Thoracic Society	General	General	We believe it is important to highlight the importance of smoking and smoking cessation neither of which are currently mentioned. (1) Smoking and thus smoking-related illnesses are more common in people with mental health	Thank you for your comment. There is existing NICE guidance on Smoking cessation in secondary care: acute, maternity and mental health services (PH48).

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			problems. A key element of parity of esteem is to ensure that the physical health of people with mental health problems is properly addressed. (2) Smoking is associated with higher rates of anxiety and depression (3) Smoking cessation is associated with a reduction in rates of anxiety and depression and smoking cessation needs to be considered as an element of the treatment of depression.	
College of Mental Health Pharmacy	1	11 -26	It is important that there is a full range of professionals, people with (or previously suffered with depression) and their carers and importantly those commissioning services. It is important to note that community pharmacists are not often included on these guideline groups and they are an important group with regular dealings with people who are depressed.	Thank you for your comment. It is important to note that this section of the scope outlines the people who should take action and not the constituency of the guideline development group. Those with responsibility for planning services for people with depression and their carers (including managers in clinical commissioning groups) are included in the scope under the list of people who should take action, and families/carers are included in the list of people that the guideline will also be relevant for.
College of Mental Health Pharmacy	2	38	It is important to consider if the terminology –mild, moderate and severe has been of value when supporting people with depression to get well.	Thank you for your comment.
College of Mental Health Pharmacy	2	39	The draft scope does not state a definition of complex or chronic depression (e.g. co-morbidities or duration). Co-morbidities considered should include Personality Disorder. No reference is made to physical co- morbidities in this scope. There should be clear reference to the separate NICE guidelines for people with depression and physical co- morbidities.	Thank you for your comment. We agree that the term complex and chronic depression presents some definitional problems. We intended to mean those with chronic depression and coexisting conditions. We have amended the scope to capture both comorbidity (in the specific consideration groups) and chronicity ('including people with chronic conditions') so have removed the term 'complex'. As you point out, there is existing NICE guidance on Depression in adults with a chronic physical health problem (CG91)) and this will be included in the NICE pathway.
College of Mental Health Pharmacy	2	41	I would suggest that specific consideration is given to people living with dementia and their carers.	Thank you for your comment. There is existing NICE guidance on Dementia (CG42). Thank you for your comment. Transitions between CYP

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			In addition, consideration should be given to adolescents transferring to adult services.	and adult services is covered in the update to Depression in children and young people (update).
College of Mental Health Pharmacy	3	60	Some specialist Trust's now have Recovery College's. The Recovery College aims to promote opportunities for the recovery and social inclusion of people with different mental health experiences in a safe environment that draws on the strength of peer-to-peer support. The range of educational courses, workshops and resources provided are available to service users, their supporters (friends, family or carers) and Trust staff. It would be useful to see these Recovery College's included in a review of methods/settings of service delivery.	Thank you for your comment. We will review the evidence on service delivery models.
College of Mental Health Pharmacy	3	61 -63	Some of this terminology in these lines will need further explanation. Collaborative care, stepped care, stratified care are not easy terms to understand. A key comment from patients and their carers is often that they only want to tell the story of their illness once (and if at all if they are suffering from depression) and all these different types of care with a variety of providers needs clear explanation with shared access to information.	Thank you for your comment. The definitions will be set out in full in the guideline.
College of Mental Health Pharmacy	3	64	The most common setting for the delivery of care will be the GP surgery followed by a prescription from a community pharmacy.	Thank you for your comment.
College of Mental Health Pharmacy	3	78	The draft scope states pharmacological interventions but does not include antipsychotics in the list of medicines. Antipsychotics should be included as they may be prescribed in treatment resistant depression. Quetiapine is also licensed for this indication It would be prudent to revisit the evidence for	Thank you for your comment. Antipsychotics have been added to the list of examples.

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			agomelatine	
College of Mental Health Pharmacy	3	80	The draft scope states pharmacological interventions including 'other substances' (example fatty acids). This should be more clearly defined as this statement could also refer to prescribed medication, herbal supplements (e.g. St John's Wort) and illicit substances (e.g. Ketamine). Ketamine is currently being used for treatment resistant depression in the US, it would be useful to have a review of current evidence included in this guidance.	Thank you for your comment. As mentioned in the scope (under the 'Key areas that will be covered' heading), the examples given for each key area are to provide context and are not an exhaustive list.
College of Mental Health Pharmacy	4	85	The draft scope states 'a drug's summary of product characteristics...'. The term medicine should be used to distinguish from prescribed medicines and illicit substances.	Thank you for your comment. This is standard NICE terminology.
College of Mental Health Pharmacy	4	88	It is good to see the physical interventions expanded to include alternative therapies such as yoga.	Thank you for your comment.
College of Mental Health Pharmacy	4	89	This is an important area to get right and to consider where psychological therapies and where pharmacological therapies are best placed. At what point they should be combined? Traditionally these treatments do not come together but work in isolation rather than treating the whole person. Waiting times for psychological therapies and lack of understanding of pharmacological therapies often mean that the relevant window of opportunity is missed.	Thank you for your comment. Combined interventions will be considered.
College of Mental Health Pharmacy	4	92	It is important to consider the outcomes and learning from the current guidance CG 90.	Thank you for your comment. We will take this into consideration while developing the guidance.
College of Mental Health Pharmacy	6	166	The draft scope states that side effects will be considered when assessing the evidence. Side effects should be included for psychological therapies in addition to pharmacological therapies.	Thank you for your comments. Evidence for side effects for psychological and pharmacological interventions will be reviewed.
College of Mental Health Pharmacy	General	General	Barriers to accessing psychological therapies should be considered e.g. they are mainly available	Thank you for your comment. However, this is outside the scope of this guideline.

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			during traditional work hours and this could be a barrier for individuals who work full time and do not want to share their mental health with their employer.	
College of Mental Health Pharmacy	General	General	The questions to answer are appropriate. There is however, no mention of the technology that most people are using and there needs to be some reflection of this in the scope and the guideline.	Thank you for your comment. If you are referring in your comment to the technology used for the delivery of interventions, then as outlined in the scope (under the heading 'Key areas that will be covered'), the examples given for each key area do not include details of the mode or format of delivery of interventions, as these examples are given to provide context rather than to represent an exhaustive list. However, the mode and format of delivery of interventions will be considered in the guideline.
College of Mental Health Pharmacy	General	General	The questions also need to consider what impacts on poor response, is it treatment adherence or resistance to treatment. When pharmacological treatment is considered the access to medicines and information on medicines also needs to be considered. Include strategies to promote adherence to a pharmaceutical care plan.	Thank you for your comment. These are important issues which will be considered when reviewing the evidence for pharmacological interventions; what strategies are effective in preventing relapse including maintenance treatment will also be covered.
Council for Evidence-based Psychiatry	4	92	Experience of care: what is the rationale for excluding this from the areas of the guideline that will be updated? It would be helpful to learn from peoples' experiences (service users' and family members' / carers' views) so that the guideline can be refined in light of this feedback.	Thank you for your comment. The surveillance review did not identify evidence that would impact on recommendations for the experience of care. However, there will be service users and carers on the guideline development group who will provide input into the guideline.
Council for Evidence-based Psychiatry	4	97	Primary prevention of depression: what is the rationale for excluding this from both the existing guideline and the update? The guideline states that depression is 'expected to become the second most common cause … of loss of disability-adjusted life years in the world by 2020' (p.8 lines 220 – 222). This suggests that consideration of prevention would be appropriate. Also appropriate would be	Thank you for your comment. This guideline represents a partial update and we are therefore limited to what was covered in the scope of the published guideline.

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			prevention of the use of antidepressant medication wherever possible, to avoid exposing patients to the risks associated with the medication (see below).	
Council for Evidence-based Psychiatry	6	166	In addition to Side Effects, the scope should include a review of withdrawal effects. Withdrawal support charities report numerous service users taking months and often years to recover from antidepressant use, with lives sometimes devastated as a consequence. The scope should include a review of recent studies on antidepressant withdrawal, including emerging literature on post-SSRI persistent sexual dysfunction both in humans and in animals.	Thank you for your comment. The scope has been amended to include withdrawal effects as a main outcome.
Council for Evidence-based Psychiatry	8	209	The scope should include a review of studies showing how long-term treatment with antidepressants may lead to worse outcomes for patients, and that 'relapse' may often be due to withdrawal effects from the drug rather than the return of an underlying condition or the development of a new one.	Thank you for your comment. We will be considering relapse prevention and withdrawal effects have been added as a main outcome.
Council for Evidence-based Psychiatry	General	General	The scope should address the question of whether 'depression' has been over-diagnosed and over-medicalised in this country, and whether pharmacological interventions are being over-used to treat normal emotional distress.	Thank you for your comment. Our role is to review the best available evidence, not current practices. Certain issues, such as you have raised, can be highlighted in the NICE guideline introduction.
Council for Evidence-based Psychiatry	General	General	The scope should include a review of the duration of antidepressant treatment and cessation guidance, as current guidelines actively encourage long-term use. There is no good research supporting the safety or effectiveness of long-term use of antidepressants.	Thank you for your comment. The issue of when to stop medication and how this could be managed will be considered in the guideline.
Council for Evidence-based Psychiatry	General	General	The scope should include a review of the existing protocol for antidepressant tapering, taking into account the withdrawal charities' experience which suggests that slow tapering over many months or longer is less harmful than a rapid reduction.	Thank you for your comment. The issue of when to stop medication and how this could be managed will be considered in the guideline.

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Council for Evidence-based Psychiatry	General	General	The scope should consider whether the 500% rise in antidepressant prescribing in England since 1992 – with over 53m prescriptions in 2013 – is appropriate, and what can be done to reduce inappropriate prescribing.	Thank you for your comments. The evidence for treatment of depressive episodes of differing severity will be reviewed.
Council for Evidence-based Psychiatry	General	General	The scope should address the gender imbalance, considering why, according to the latest Health Survey for England, almost twice as many women as men take antidepressants.	Thank you for your comment. We recognize that these are important factors however, this is outside the scope of this guideline.
Council for Evidence-based Psychiatry	General	General	The scope should consider whether there is sufficient informed consent when starting antidepressant treatment, as GPs often do not adequately describe the risks or discuss alternative treatments, in particular psychotherapy.	Thank you for your comment. A review of informed consent is outside of the scope of the guideline but, while reviewing the pharmacological interventions, the GC will consider risks and benefits.
Council for Evidence-based Psychiatry	General	General	The scope should include a review of research showing the link between antidepressant use and increased mortality levels, particularly among the elderly.	Thank you for your comment. Specific consideration will be given to the elderly within the guideline. We have also amended the main outcomes to include mortality.
Council for Evidence-based Psychiatry	General	General	The scope should include a review of the evidence of the effectiveness of antidepressant treatment, and in particular consider the clinical significance of antidepressant effects vs placebo, taking into account insufficient blinding (because the drugs have conspicuous side effects).	Thank you for your comment. We will review the benefits and harms of pharmacological interventions.
Council for Evidence-based Psychiatry	General	General	The scope should include a review of whether long-term antidepressant treatment is causing more harm than good, particularly given the rising mental health disability rates in the UK.	Thank you for your comment. We will be considering the benefits and harms of long-term pharmacological treatment in the prevention of relapse review.
Department of Health	General	General	The Department of Health has no substantive comments to make regarding this consultation	Thank you for your comment.
HQT Diagnostics	General	General	Many mental problems have an underlying physical cause. Before talking therapies and pharmaceutical drugs are used, physical tests should be done by GPs. It is better to make improvements in diet & lifestyle	Thank you for your comment. Recognition and assessment are outside the remit of the scope.

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			before offering prescription drugs. These should include tests for Fatty Acids Major improvements in mental health have been seen within 3 months of supplementing levels of Omega-3 Fatty Acids to achieve: • **Omega-3 Index >8%** • **Omega-6/3 Ratio <3:1** The Omega-3 Index is designed to provide a more reliable indicator of the level of specific Fatty Acids than any other method. This can be achieved by eating more oily fish or taking Fish Oil supplements The Omega-6/3 Ratio shows the level of Omega-6 compared to Omega-3 and is a good indicator of Inflammation. This can be improved by eating less Sunflower oil (64% Omega-6), less Corn oil (52%) and less Soybean oil (51%) The HQT Diagnostics Fatty Acid Test shows an average of all Fatty Acids eaten over the previous 60-90 days **Sources:** www.expertomega3.com/omega-3-study.asp?id=38 www.hqt-diagnostics.com/Products/HQT-Analysis (See Demo Report) www.ncbi.nlm.nih.gov/pubmed/17194275?dopt=AbstractPlus http://omega3care.com/wp-content/uploads/2013/11/Omega-3LiteratureListJuly2013.pdf (59 references on Depression)	

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			http://omegametrix.eu/wasistomega3index.html?lang=EN	
HQT Diagnostics	General	General	Many mental problems have an underlying physical cause Before talking therapies and pharmaceutical drugs are used, physical tests should be done by GPs. It is better to make improvements in diet & lifestyle before prescribing prescription drugs. These should include tests for Vitamin D Major improvements in mental health have been seen within 3 months of supplementing levels of Vitamin D so that 25(OH)D is between 100-150 nmol/L **Sources:** www.vitamindwiki.com/Depression	Thank you for your comment and the references. Recognition and assessment are not within the remit of the scope. However, evidence will be considered for pharmacological interventions including 'other substances'.
Janssen	2	39	The draft scope currently doesn't appear to recognise the high prevalence of depressed patients with suicidal ideation/intent. We feel this group should be included as current literature and government policy is highlighting the that clinical depression is a strong confounder of increased suicide risk among physically ill people, explaining some or all of the increased suicide risk in people with a range of physical illnesses. (In Preventing suicide in England: One year on First annual report on the cross-government outcomes strategy to save lives, SCLGCP/ MHED / 11160, 2014)	Thank you for your comment. We have amended the scope to include mortality (including all-cause and suicide) as an outcome. There is existing NICE guidance on Depression in adults with a chronic physical health problem (CG91)) and this will be included in the NICE pathway.
Janssen	2	49	The draft scope refers in brackets to tertiary care. This should perhaps be more clearly clarified and include emergency mental health care.	Thank you for your comment. Emergency care is captured under the settings outlined.
Janssen	3	67 -8	The draft scope states that treatment of depressive episodes of differing severity (including sub-	Thank you for your comment. This will be covered under chronic depression.

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			threshold symptoms). We feel that the guideline should explicitly include at the other end of the spectrum, of treatment resistant depression.	
Janssen	4	87	In the draft scope it includes a few physical intervention examples. We are not sure whether this list is exhaustive. We would encourage an update/coverage of rTMS m as the evidence base has significantly increased (for example for treatment resistant depression) over the last few years.	Thank you for your comment. As mentioned in the scope (under the 'Key areas that will be covered' heading), the examples given for each key area are to provide context and are not an exhaustive list. There is existing NICE guidance for Transcranial magnetic stimulation for severe depression (IPG242) that will be included in the NICE pathway.
Janssen	4	89 -90	The draft scope states it will cover combined psychological and psychosocial and pharmacological interventions. We feel that the scope should include combined physical and pharmacological interventions (eg. ECT followed by maintenance pharmacotherapy)?	Thank you for your comment. The scope has been amended to indicate that combined psychological/psychosocial and pharmacological interventions are but one example of combined interventions.
Janssen	5	128	We would propose adding "alone or in combination" for clarity purposes, even though it is spelled out in line 121	Thank you for your comment. We will consider 'alone or in combination' for each part of the review question.
Janssen	5	141	We would propose adding "alone or in combination", even though it is spelled out in line 134.	Thank you for your comment. We will consider 'alone or in combination' for each part of the review question.
Janssen	6	160 -161	The draft scope highlights the main outcomes that will be considered is depression symptomatology and "recovery and relapse". We feel that "recovery and relapse", are different to response and remission and would suggest inclusion of response and remission.	Thank you for your comment. These will be covered between depression symptomatology and recovery and relapse.
Janssen	6	171	We would also like to see this update linking with NICE guidelines on self-harm, bi-polar disorder and TDCS	Thank you for your comment. We will bring it to the attention of NICE.
Janssen	General	General	Implementing the NICE guidelines on self-harm will be key to improving the experiences and outcomes for people who self-harm, in particular ensuring that people who present to Emergency Departments following self-harm receive a psychosocial	Thank you for your comment. However, implementation is outside the scope of this guideline.

Stakeholder	Page no.	Line no.	Comments	Developer's response
			assessment. And bi-polar	
London Respiratory Network	3	67	Treatment of depressive episodes should include: Assessment of tobacco dependence or other smoked drug dependence which may be closely linked to the depressive episode Support for stopping smoking which has been shown to reduce anxiety symptoms and is therefore a key element of treatment for depression and anxiety http://bjp.rcpsych.org/content/202/1/62 McDermott M et al BJPsych (2013) 202, 62-67 Psychological therapy should include strategies for addressing any dependencies. Psychological therapy should be provided by specialists with the appropriate level of training, knowledge and expertise in working with patients with long term health conditions. Psychological treatments which are delivered as part of the patient's normal package of care by specialists working as a member of the multi-disciplinary team, and including co-working with other professionals as appropriate. Pharmacological interventions should include an appropriate choice from Nicotine Replacement Therapy, Varenicline or Bupropion taking into account history of depression and any other medications. It is well-recognised that medications for depression can interact with medications for other long term conditions and this should be taken into account	Thank you for your comment. However, this is outside the scope of this guideline. There is current NICE guidance on Smoking cessation in secondary care: acute, maternity and mental health services (PH48) and on Depression in adults with a chronic physical health problem (CG91).

Stakeholder	Page no.	Line no.	Comments	Developer's response
			when prescribing. Dumbreck S et al BMJ 2015; 350:h949 Physical Interventions may include specific treatments for other health problems (such as Pulmonary Rehabilitation for COPD) which can have a beneficial effect on mood. Psychological therapy may include support to overcome barriers to engagement with such interventions. Assessment of other physical and mental health problems (including respiratory illness) and optimisation of treatment in order to reduce perpetuating factors for depression.	
Lundbeck UK	2	41	Rationale for subgroups Specific rationale for each of the subgroups should be provided.	Thank you for your comment. This level of detail is not appropriate for the scope.
Lundbeck UK	4	101	Economic evaluation to include data from outcomes of interest Lundbeck is in support of an economic evaluation being undertaken but would stress that outcomes of interest listed in section 1.6, should be, where possible, included into the economic analysis. The economic model supporting the last update of CG90 was a very simplistic representation of the course and treatment of depression. Lundbeck are fully supportive of the outcomes listed in section 1.6 of the draft scope and would suggest that the objective to be to include these into the cost-effectiveness calculations for treatments. Of particular relevance are the side-effects associated with antidepressants which shall be discussed in	Thank you for your comment. The economic models that will be developed as part of this guideline update will aim to consider all outcomes of interest, including side effects (i.e. associated costs and disutility) and employment (i.e. utility from employment), depending on availability of relevant and appropriate data. However, productivity losses will not be considered in the economic analysis, as these are beyond the scope of this guideline. Please note that NICE guidelines do not normally include productivity losses in any analyses (please refer to "Developing NICE guidelines: the manual", Chapter 7, p134, available from http://www.nice.org.uk/article/pmg20)

Stakeholder	Page no.	Line no.	Comments	Developer's response
			Comment No. 4, and employment, in Comment No. 3. The exclusion of these outcomes within the economic evaluation in the last guideline update were explicitly recognised as limitations to the model presented and all should be done to address these(1). References 1. National Collaborating Centre for Mental Health and commissioned by the National Institute for Health and Care Excellence. Depression: The Treatment and Management of Depression in Adults (Updated Edition). National Clinical Practice Guideline 90, 24th edn. Leicester and London: The British Psychological Society and The Royal College of Psychiatrists, 2010.	
Lundbeck UK	5	126 &139	Sequencing of treatment Lundbeck supports the specific research question of the relative benefits and harms of treatments "following poor response" given that inadequate response is a common problem associated with the treatment of depression.(1,2) However, the recommendations in the current guideline are not always consistently interpreted and importantly are based on data in the full MDD population. This is inappropriate and does not provide an accurate estimation of efficacy at later treatment lines; there are consistent indications that relative treatment effects differ by treatment line (3,4). I.e. 1st line relative efficacy is not equivalent to 2nd line relative efficacy. In the work being undertaken in preparation for the STA submission for vortioxetine, it is clear that this is supported by UK clinicians. Lundbeck therefore recommend the	Thank you for your comment and the references. The guideline will consider evidence for sequencing. A line has been added to the scope (under the 'Key areas that will be covered' section) to indicate that the guideline will consider the sequencing of interventions, along with the mode and format of delivery and preference, but that details of these factors are not included for each intervention as the examples are intended to provide context rather than representing an exhaustive list.

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			use only of data available in the specific treatment line being considered. References 1. Rush AJ, Trivedi MH, Wisniewski SR et al. Acute and longer-term outcomes in depressed outpatients requiring one or several treatment steps: a STAR*D report. Am J Psychiatry 2006; 163(11): 1905-1917. 2. European Medicines Agency. Guideline on clinical investigation of medicinal products in the treatment of depression. European Medicines Agency. Updated: 30 May 2013. Last accessed 7 May 2014. 3. Bauer M, Tharmanathan P, Volz HP et al. The effect of venlafaxine compared with other antidepressants and placebo in the treatment of major depression: a meta-analysis. Eur Arch Psychiatry Clin Neurosci 2009; 259(3): 172-185. 4. Papakostas GI, Fava M, Thase ME. Treatment of SSRI-resistant depression: a meta-analysis comparing within- versus across-class switches. Biol Psychiatry 2008; 63(7): 699-704.	
Lundbeck UK	6	157	Outcomes of interest As stated, Lundbeck supports the outcomes of interest stated. The scope currently states that "symptomology" is an outcome of interest. Lundbeck believes that further clarity around this would be beneficial i.e. stipulating that the three main symptom classes of mood, physical and cognitive symptoms (1) are explicitly recognised in the draft scope and therefore assessed through the process. In addition to the outcomes listed, family functioning	Thank you for your comment. The range of outcomes we will be considering can be found in the main outcomes section. Symptomatology is a key outcome indicator and we will review the evidence in relation to this. Whether this allows for the further level of analysis you have outlined is not possible to pre-specify. Thank you for your comment. This is an outcome, 'carer wellbeing'.

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			and burden on carers should be included given that the disorder has marked effects on individuals other than the patient themselves, in terms of both costs and health-related quality of life. 1. American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders 5th edition.	
Lundbeck UK	6	162	Support for the adaptive functioning outcomes Self-reported depression is the single most important cause of workplace absenteeism in the UK. It has been estimated that depression accounts for lost productivity costs 23 times higher than the direct cost to the NHS (1). The opportunities for prevention and early intervention in the workplace are considerable: depression (and stress and anxiety) may or may not be related to the workplace itself. Depression is most prevalent in younger adults. Treatments that enable people to remain socially integrated and emotionally balanced as partners, parents and carers, and which enable people to stay in or return to work introduce a societal and cost-efficiency factor that should be considered by NICE. Cognitive dysfunction and other symptoms play a major role in employment outcomes of people with depression. (2) This is supported by The Work Foundation Report where patients who were interviewed found that cognitive symptoms were an obstacle to returning to work because of difficulty concentrating. (2)	Thank you for your comment and references. The workplace is outside the remit for this scope. There is existing NICE guidance covering Promoting mental wellbeing at work (PH22). Adaptive functioning (for example, employment) are included in the outcomes. Cognitive function has been added as an outcome to the scope.

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			Some evidence suggests that cognitive dysfunction and other symptoms of depression such as insomnia, emotional distress and fatigue, have more significant effect on work-related outcomes than actual illness (3,4,5); for example one recent study showed that workplace performance variability was explained by subjective measures of cognitive dysfunction to a greater extent than total depression symptom severity. (5) Pharmaceutical and psychological interventions were most often referred to by experts for the alleviation of symptoms of depression which might be forming a barrier to work. (2) The Work Foundation concluded in its recently published report that 'There is strong and mainly consistent evidence that poor cognitive dysfunction and other symptoms of depression have negative impact on employment outcomes of people with depression.' (2) Lundbeck would therefore support adaptive functioning, in particular, ongoing employment, to be considered as a main outcome of effective treatment for adults with depression. References 1. Whole in One, Achieving Equality of Status, Access and Resources for People with Depression, Jon Paxman and Julia Manning, 2020 Health, Feb 2015 2. Symptoms of depression and their effects on employment, Karen Steadman and Tyna Taskila, The Work Foundation, March 2015 (In press) 3. Banerjee S, Chatterji P, Lahiri K. Identifying	

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			the mechanisms for workplace burden of psychiatric illness. Medical care. 2014;52(2):112-20. Epub 2013/12/07. 4. Gilbert E, Marwaha S. Predictors of employment in bipolar disorder: a systematic review. Journal of affective disorders. 2013;145(2):156-64. Epub 2012/08/11. 5. McIntyre RS, Soczynska JZ, Woldeyohannes HO, Alsuwaidan MT, Cha DS, Carvalho AF, et al. The impact of cognitive impairment on perceived workforce performance: results from the International Mood Disorders Collaborative Project. Comprehensive psychiatry. 2015;56:279-82. Epub 2014/12/03	
Lundbeck UK	6	166	Support of the consideration of side-effects Intolerability to side-effects of antidepressant therapy is a problem which impacts gravely on a patients' quality of life and may also force patients to discontinue treatment (1). It was noted in CG90 (full guidance) (2) that the extent to which patients are able to tolerate an antidepressant is intertwined with adherence and therefore treatment outcomes. Studies show that as many as 50% of patients may discontinue antidepressant treatments within the first six months of therapy, citing adverse events as the main reason for discontinuation. (3,4) Not only are there important benefits to the patient of well-tolerated treatments, they also impact on resource use. In particular, health care contacts either to seek advice on side-effect management or to enable a treatment switch. References 1. Fava M. Management of nonresponse and	Thank you for your comment and the references.

Stakeholder	Page no.	Line no.	Comments	Developer's response
			intolerance: switching strategies. J Clin Psychiatry 2000; 61(Suppl 2): 10-12. 2. National Collaborating Centre for Mental Health and commissioned by the National Institute for Health and Care Excellence. Depression: The Treatment and Management of Depression in Adults (Updated Edition). National Clinical Practice Guideline 90, 24th edn. Leicester and London: The British Psychological Society and The Royal College of Psychiatrists, 2010. 3. National Institute of Health and Care Excellence. NICE Pathways: Antidepressant treatment in adults. Updated: 16 Dec 2014. Available at: http://pathways.nice.org.uk/pathways/depression#path=view%3A/pathways/depression/antidepressant-treatment-in-adults.xml&content=view-node%3Anodes-sequencing-treatments. Last accessed 8 Jan 2015. 4. Bauer M, Whybrow PC, Angst J et al. World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for Biological Treatment of Unipolar Depressive Disorders, Part 2: Maintenance treatment of major depressive disorder and treatment of chronic depressive disorders and subthreshold depressions. World J Biol Psychiatry 2002; 3(2): 69-86.	
Lundbeck UK	General	General	It should be noted that, although the guideline will be appropriate to guide the treatment for the majority of patients, it cannot and will not be suitable for every patient. This is due to the points highlighted below; we would suggest this is reiterated in the guideline. MDD is a broad and heterogeneous disorder with a highly variable course, and an inconsistent	Thank you for your comment and the references. We agree with your view that depression is a heterogeneous disorder and the GC will take this into consideration while reviewing the evidence and developing the recommendations.

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			response to treatment (1). The diagnosis of MDD requires a distinct change in sadness or anhedonia plus at least four of the following symptoms: irritability, sleep, appetite, sexual desire, concentration, psychomotor retardation and suicidal thoughts (2). Not all symptoms must be present to confirm a diagnosis of MDD, but rather diagnosis is made by a summation of symptom number and severity. Therefore, with such a wide variety of symptom combinations it is likely that many patients with an identical diagnosis of MDD could have an entirely different disease presentation (2). Furthermore, evidence from the US suggests patients vary in their preferences for treatment, whether psychological, pharmacological or both (3,4). Faced with this heterogeneity, the clinician has to be able to recognise all permutations of MDD symptomatology and make the appropriate treatment recommendation. The currently available pharmacological treatments have different mechanisms of action and distinct side-effect liability(5,6). These differences are acknowledged by numerous guidelines (7,8,9) that recommend taking into account the patients' individual needs and preferences, and matching them to the treatments' likely efficacy and side-effect profile. Approximately one-third to one-half of patients treated for depression do not respond satisfactorily to initial antidepressant pharmacotherapy, which is usually an SSRI (10,11) Also, intolerable side-effects can lead to poor adherence or premature withdrawal. Clearly there is a need for some clinical flexibility to allow for these considerations to be taken into account. References	

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			1. Trivedi MH, Hollander E, Nutt D et al. Clinical evidence and potential neurobiological underpinnings of unresolved symptoms of depression. J Clin Psychiatry 2008; 69: 246-258. 2. Thase ME. The multifactorial presentation of depression in acute care. J Clin Psychiatry 2013; 74 Suppl 2: 3-8. 3. Lin P, Campbell DG, Chaney EF et al. The influence of patient preference on depression treatment in primary care. Ann Behav Med 2005; 30(2): 164-173. 4. Backenstrass M, Joest K, Frank A et al. Preferences for treatment in primary care: a comparison of nondepressive, subsyndromal and major depressive patients. Gen Hosp Psychiatry 2006; 28(2): 178-180. 5. Bazire S. Psychotropic Drug Directory 2014. Lloyd-Reinhold Communications LLP, 2014. 6. Taylor D, Paton C, Kapur S. The Maudsley Prescribing Guidelines in Psychiatry, 11th edn. Chichester: Wiley-Blackwell, 2012. 7. Anderson IM, Ferrier IN, Baldwin RC et al. Evidence-based guidelines for treating depressive disorders with antidepressants: a revision of the 2000 British Association for Psychopharmacology guidelines. Journal of Psychopharmacology (Oxford, England) 2008; 22(4): 343-396. 8. National Collaborating Centre for Mental Health and commissioned by the National Institute for Health and Care Excellence. Depression: The Treatment and Management of Depression in Adults (Updated Edition). National Clinical Practice Guideline 90, 24th edn. Leicester and London: The British Psychological Society and The Royal College of Psychiatrists, 2010. 9. Bauer M, Pfennig A, Severus E et al.	

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			World Federation of Societies of Biological Psychiatry (WFSBP) guidelines for biological treatment of unipolar depressive disorders, part 1: Update 2013 on the acute and continuation treatment of unipolar depressive disorders. The World Journal of Biological Psychiatry 2013; 14: 334-385. 10. Rush AJ, Trivedi MH, Wisniewski SR et al. Acute and longer-term outcomes in depressed outpatients requiring one or several treatment steps: a STAR*D report. Am J Psychiatry 2006; 163(11): 1905-1917. 11. European Medicines Agency. Guideline on clinical investigation of medicinal products in the treatment of depression. European Medicines Agency. Updated: 30 May 2013. Last accessed 7 May 2014.	
Maslaha	4 -6	108 -156	Concern that the Draft Review Questions look at 'adults with depression' as a homogenous group; will there be room to go beyond 'one size fits all' in the answers to these questions, and to include a range of answers?	Thank you for your comment. We agree with your view that depression is a heterogeneous disorder. When considering the evidence and developing the recommendations the GC will take this into account. The subgroups defined in 1.1 will be given specific consideration in the guideline. This guideline will consider a number of factors, such as severity, which may predict response to treatment.
Maslaha	5 -6	119 -156	Is it possible to include psychosocial interventions on a par with the main three listed – psychological, pharmacological and physical (as a core aspect rather than an addition)?	Thank you for your comment. These are not divided or listed in order of importance.
Maslaha	9	253 -256	This may be a sidenote for this guideline, but need further examination of what 'for all' truly currently looks like, and should look like, in practice, and how it can be achieved, for the IAPT programme – especially for those from black and minority ethnic (BME) groups.	Thank you for your comment. We will take into account a range of equality issues such as cultural identity while reviewing the evidence.

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			For example, ensuring access to talking therapies must also include ensuring that patients truly grasp what talking therapies are: what happens, who with, why, what confidentiality means etc. – and how best to communicate this information. These are specific and strong barriers to support that we've encountered working with Somali, Pakistani, Bangladeshi communities, and is more widespread amongst other BME groups etc.	
Maslaha	General	General	Would really like to emphasise that 'depression,' as a word and as a concept, doesn't exist in many languages and conceptualisations of health and illness, as it only belongs to the biomedical model. Skilled translation incorporating conceptual belief systems is needed, and communication that allows for a person's social and environmental context, faith, cultural background etc. This needs to be reflected in all aspects of service design and delivery.	Thank you for your comment. We will take into account a range of equality issues including language and different cultural conceptualisations of disease.
National Childbirth Trust	2	41 -42	NCT welcomes the special consideration given to men in this draft scope. We feel specific mention should be made of the increased likelihood for men of mood impairment/ depression during a partner's pregnancy and the year after birth. See research review conducted by the Fatherhood Institute in 2010: http://www.fatherhoodinstitute.org/2010/fatherhood-institute-research-summary-fathers-and-postnatal-depression/	Thank you for your comment. However, this is outside the scope of this guideline.
National Childbirth Trust	4	93	We are concerned that the section on 'Recognition, assessment and initial management of depression' will not be updated, in view of the developing research interest and findings around the issue of postnatal depression in fathers (see reference above).	Thank you for your comment. There is current NICE guidance on Antenatal and postnatal mental health: clinical management and service guidance (CG192)
National Childbirth Trust	6	171	We feel strongly that the recently published updated	Thank you for your comment. We will bring it to the

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			guidance on Antenatal and Postnatal Mental Health (CG192: http://www.nice.org.uk/guidance/cg192) should be included in this section.	attention of NICE.
NHS Choices	General	General	The Digital Assessment Service welcome the guidance and have no comments on the scope as part of the consultation	Thank you for your comment.
NHS England	General	General	NHS England have no substantive comments to make regarding this consultation.	Thank you for your comment.
NHS Lothian	General	General	Comment on Draft Guideline Scope - General Comment We welcome the increased emphasis placed on the treatment and management of adults with complex and chronic depression. As stated in the draft guideline scope, recurrence rates increase with each episode up to 90%. Many chronically depressed adults receive several episodes of care within secondary services with a mean duration falling between the range of 17-30 years. These account for approximately half of all patients being treated in mental health services. Current guidelines recommend the treatment of these adults with additional or continuation of psychological (e.g. CBT) and/or pharmacological therapy, and brief interventions (e.g. MBCT) to attempt to prevent relapse in people who have responded. During the past 10-15 years it has become increasingly clear that the nature of a chronic course of depression presents psychological therapists with challenges that are phenomenologically different and many do not respond to treatment. We strongly recommend the inclusion of CBASP (Cognitive Behavioural Analysis System of Psychotherapy) as an additional treatment option in the new guidelines. This is the only psychotherapy specifically developed to threat	Thank you for your comment. The examples in section 1.3 are illustrative, not exhaustive. Where there is available and eligible evidence we will consider interventions and this is likely to include CBASP.

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			chronic depression and it has a robust evidence base. CBASP has also been found to be an effective and acceptable treatment when delivered within an NHS context in recent open case series. The efficacy of this therapy has already been recognised in Scotland where CBASP will be included in the new revision of The Matrix (NES, 2015) as a recommended treatment for chronic depression in secondary care services.	
Northumberland, Tyne & Wear NHS Trust	1	General	The word "Adult" in Health Services is often associated with people aged 18-65, with the assumption that there are separate guidelines for Older People, LD and minority groups. The draft scope clearly identifies the inclusion of OP, LD & Minority Groups early on but I think this needs to be reflected in the title of the document itself; e.g: NICE guidance for depression in adults (inc Older People, LD & Minority Groups) or all adults aged 18 years and over? I know this may seem a bit pedantic but Older Peoples Functional Mental Health Services in particular have, for a long time, been somewhat of a Cinderella Service within a Cinderella Service, so I think it is important to highlight the inclusion of these groups from the very start.	Thank you for your comment. The current title has been approved and older people are included in the list of groups that will be given specific consideration in the guideline.
Oxford Health NHS Foundation Trust	2	41	Suggest retain people with specific co-morbid psychological conditions that impact on prognosis of depression (anxiety; cognitive impairment [excluding dementia]).	Thank you for your comment. We have amended the scope to include coexisting mental health conditions as a group to be given specific consideration.
Oxford Health NHS Foundation Trust	3	62	Guidance on translation of collaborative care models into NHS services would be valuable. Despite apparent benefits, uptake appears to be poor.	Thank you for your comment. As set out in the scope, evidence on service delivery models (including stepped care and collaborative care) will be reviewed.
Oxford Health NHS Foundation Trust	3	71	Guidance on maintaining treatment fidelity would be useful to commissioners, practitioners, and patients.	Thank you for your comment. These issues will be covered in the guideline.

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			Since the last guideline, there has been expansion in the sources of provision, including online resources that may not match interventions in clinical trials. Guidance on psychological interventions for treatment of severely depressed inpatients could help with commissioning. There tends to be a reliance on biological interventions.	
Oxford Health NHS Foundation Trust	3	76	Advise review of befriending, telephone support, and care home based low-intensity interventions with depressed older people.	Thank you for your comment. As mentioned in the scope (under the 'Key areas that will be covered' heading), the examples given for each key area are to provide context and are not an exhaustive list.
Oxford Health NHS Foundation Trust	3	78	Augmentation of antidepressant drugs using atypical antipsychotics is now common practice and of apparent benefit for some patients. This prescribing is often off-license (e.g. olanzapine). Evidence-based guidance on efficacy and risks (e.g. metabolic syndrome) would be helpful, particularly on duration of treatment. Guidance on use of lithium augmentation in treatment resistance and secondary prevention would also be clinically useful, including specific benefits (e.g. reduced suicide risk: Cipriani *BMJ* 2013;346:f3646). Suggest review of ketamine efficacy and possible place in treatment pathway, given number of recent trials. Suggest review studies of psychostimulant augmentation of antidepressants (e.g. Lavretsky et al. http://dx.doi.org/10.1176/appi.ajp.2014.14070889).	Thank you for your comment. Antipsychotics and lithium have been added to the list of examples. Ketamine and psychostimulants have not been added. However, it is important to bear in mind that the examples given for each key area are to provide context and are not an exhaustive list.
Oxford Health NHS Foundation Trust	4	87	Updated evidence on electroconvulsive therapy in late-life depression would be of value as a large	Thank you for your comment. As mentioned in the scope (under the 'Key areas that will be covered' heading), the

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			proportion of recipients are older, despite smaller evidence base (e.g. Bender *Am J Geriatr Psychiatry.* 2015;23:274-282). There have been a number of recent trials using repetitive transcranial magnetic stimulation for depression and its use is likely to increase within the lifetime of this guideline. Therefore, guidance would be relevant.	examples given for each key area are to provide context and are not an exhaustive list. ECT is included under the examples given for physical interventions and older people are identified as a group that will be given specific consideration in the guideline. There is existing NICE guidance for Transcranial magnetic stimulation for severe depression (IPG242) that will be included in the NICE pathway.
Oxford Health NHS Foundation Trust	6	157	Cognitive function (including executive function) in studies of depressed older adults without dementia would be a clinically meaningfully outcome.	Thank you for your comment. We have added cognitive function to the list of outcomes.
Oxford Health NHS Foundation Trust	General	General	Guidance, where possible, on predictors of response to specific treatments would be of use to patients, commissioners, and practitioners. e.g. demographic characteristics, clinical biomarkers.	Thank you for your comment. The guideline will consider a number of factors, such as severity, which may predict response to different kinds of treatment.
Rotherham, Doncaster & South Humber Mental Health NHS Foundation Trust	General	General	Agreed with the scope.	Thank you for your comment.
Royal College of General Practitioners	1	13	The draft scope/guidance is of relevance in particular to wider community health care professionals e.g. district nurses, health visitors, physio's, people in planning for schools, educational and vocational training establishments, HEI if it is to provide holistic guidance. (LE)	Thank you for your comment. These groups are already covered in so far as they fall under either of the following groups: professionals who share in the treatment and care of people with depression in primary, secondary or specialist mental health care; professionals in other health, social care and non-health sectors who may have direct contact with or are involved in the provision of health and other public services for those with depression.
Royal College of General Practitioners	1	16	Within the acute sector this guidance is particularly relevant for staff working in A&E? (LE)	Thank you for your comment. We agree that this guideline will be applicable to professionals across a range of health care settings, including A&E
Royal College of General Practitioners	2	37	By only advising on age 18 and above, the guidance is excluding those young people 18-25 years. Many CYP mental health and wellbeing services are now commissioned for the 0-25 year age group. (LE)	Thank you for your comment. This guideline will include people aged 18-25 years.

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Royal College of General Practitioners	2	39	The draft scope should define "complexity." Depression as a single condition is a rare clinical presentation and guidance needs to address a range of clinical scenarios to be useful: recurrent depression, LTC and depression, depression and anxiety, co morbidity, depression in perinatal women, dual diagnosis drug and alcohol use and depression. (LE)	Thank you for your comment. We agree that the term complex and chronic depression presents some definitional problems. We intended to mean those with chronic depression and coexisting mental health conditions. We have amended the scope to capture both comorbidity (in the specific consideration groups) and chronicity ('including people with chronic conditions') so have removed the term 'complex'.
Royal College of General Practitioners	2	42	Specific groups currently not identified in the scope – mobile populations e.g. travellers, students. (LE)	Thank you for your comment. When considering groups where there might be equality issues we did not feel that travellers or students warranted specific consideration.
Royal College of General Practitioners	3	64	Does settings need to specifically mention the Crisis care concordat as part of how crisis care pathways are being developed? (LE)	Thank you for your comment. Evidence for service delivery models will be reviewed.
Royal College of General Practitioners	3	76	? include social prescribing (LE)	Thank you for your comment. As mentioned in the scope (under the 'Key areas that will be covered' heading), the examples given for each key area are to provide context and are not an exhaustive list.
Royal College of General Practitioners	4	86	Need to refer to PMO wellbeing recommendations as there was criticism of the evidence base and suggestions for appropriate treatments and management in wellbeing and resilience. (LE)	Thank you for your comment. The evidence which will be reviewed will be done so by following the NICE guideline manual. Please see section 6 for more information on Selecting relevant evidence.
Royal College of General Practitioners	6	169	Include suicide as an outcome? (LE)	Thank you for your comment. The scope has been amended to include mortality (including all-cause and suicide) as a main outcome.
Royal College of General Practitioners	General	General	I have read through the draft scope. It looks most interesting and comprehensive. I like that children and young people are under the same umbrella, although on a separate pathway. It shows that there is a continuum. (JA) Needs to be greater acknowledgement of the role of alcohol and depression if the guidance is to be of use. (LE)	Thank you for your comment. We should point out that this guideline will not be covering children and young people due to the recently published, "Depression in children and young people (2015)," NICE guideline CG28. Thank you for your comment. This is outside of the scope for this guideline but is addressed in the NICE guideline Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (CG115).

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Royal College of Nursing	General	General	The Royal College of Nursing welcome the development of the update of this guideline and the draft scope seems comprehensive.	Thank you for your comment.
Royal College of Psychiatrists	2	61	There is no mention of the change in NHS constitution that allows patient choice since 2014. This should be expressly stated as it is a major change in terminating discrimination of patients with mental ill health compared with other ill health.	Thank you for your comment. The NHS constitution and other policy changes will contribute to the framework within which this guideline will be implemented. However, implementation is outside the scope of this guideline.
Royal College of Psychiatrists	3	64	We feel it is important to explicitly include patients in nursing homes and other institutionalised settings as there is a high prevalence of depression (Evers et al., 2002) and people in these settings are marginalised and frequently excluded from treatment (Cohen et al., 2003). We suggest adding 'nursing homes and other institutionalised settings' in settings of care.	Thank you for your comment. We have identified older people as a group to be given specific consideration in this guideline. If there is evidence, we will consider the settings in which they are cared for.
Royal College of Psychiatrists	3	81	No mention of second generation antipsychotics or of lithium in spite of a number of randomised controlled trials (RCTs) and metanalyses since last document	Thank you for your comment. Antipsychotics and lithium have been added to the list of examples.
Royal College of Psychiatrists	3	88	No mention of VNS, DBS, ablative neurosurgery, transcranial direct current stimulation and rTMS in spite of a number of RCTs since last publication	Thank you for your comment. As mentioned in the scope (under the 'Key areas that will be covered' heading), the examples given for each key area are to provide context and are not an exhaustive list. There is existing NICE guidance on Vagus nerve stimulation for treatment-resistant depression (IPG330) and Transcranial magnetic stimulation for severe depression (IPG242) and these will be included in the NICE pathway.
Royal College of Psychiatrists	5	124 &137	We suggest making specific reference to considering older people when discussing format of delivery of psychological interventions as old people are under-represented in psychological treatment populations and frequently marginalised by existing models of delivery (RCPsych, 2013).	Thank you for your comment. Older people will be considered throughout all the review questions as they are one of the specific consideration groups outlined in 1.1
Royal College of Psychiatrists	6	145	We are disappointed that our many comments on comorbidities at scoping meeting were ignored in	Thank you for your comment. We have amended the scope to include coexisting mental health conditions as a

Stakeholder	Page no.	Line no.	Comments	Developer's response
			spite of newer evidence since last guideline publication. For patients with major depressive disorder what are the implications of psychiatric and physical comorbidities in terms of outcome? In these people what is the effectiveness of psychosocial, pharmacological and physical intereventions?	group to be given specific consideration. There is existing NICE guidance on Depression in adults with a chronic physical health problem (CG91)) and this will be included in the NICE pathway.
Royal College of Psychiatrists	6	148	Do you mean moderate to severe?	Thank you for your comment. No, 'moderate to severe' is covered in draft review question 7 (line 151)
Royal College of Psychiatrists	6	154	Maintenance electroconvulsive therapy should be explicitly considered as it is used for patients with complex and chronic depression. This is particularly important for older adult depression which tends to be more chronic and has higher relapse rates (Mitchell and Subramaniam, 2005) .	Thank you for your comment. We will be reviewing evidence for ECT, including evidence for its use in acute depression as well as maintenance.
Royal College of Psychiatrists	7	165	Should include mortality from all causes. For example, evidence that lithium reduces mortality in major depressive disorder has been synthesised since the last guidelines reflecting 40 years of experience with this medicine.	Thank you for your comment. The scope has been amended to include mortality (including all-cause and suicide) as a main outcome.
Royal College of Psychiatrists	7	196	Concern that the evidence around agomelatine is not going to be reviewed in the guidelines because this document that does not actually review its efficacy.	Thank you for your comment. We will discuss this issue with NICE and if no further action is considered in regard to agomelatine then we will consider agomelatine for inclusion in the guideline.
Royal College of Psychiatrists	8	237	Highly selective and disabled. This latter adjective is important as this group of people can be ignored by secondary services or given inappropriate and ill informed advice and treatment.	Thank you for your comment. The phrase 'Highly selective and disabled' is not used in the scope.
Royal College of Psychiatrists	9	253	We suggest modifying the statement that IAPT is ensuring that 'there is access to psychological therapies for all who would benefit from them'. IAPT is failing older people who are significantly under-represented in their treatment populations (DOH, 2009, DOH, 2013). IAPT commissioners need to be aware of this and the current statement regarding access is misleading.	Thank you for your comment. We have made an adjustment to the scope to clarify that the IAPT programme **aims** to ensure that there is access to psychological therapies for all who would benefit from them. Older people are a group that will be given specific consideration within this guideline.

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Royal College of Psychiatrists	General	General	The Royal College of Psychiatrists wishes to express its disappointment that many of the comments it gave at the scoping workshop do not appear to have been integrated into the revised draft scope.	Thank you for your comment. The stakeholder workshop feedback was recorded and can be found on the NICE website, see: Depression in adults (update): scoping workshop notes A wide range of opinions from the stakeholder workshop were considered and where feasible were included in the scope which went out for consultation. Stakeholder organisations with representatives attending the scoping workshop are also encouraged to submit comments in writing as part of the scope consultation. This is to ensure stakeholder consideration throughout the scoping process.
South London & Maudsley NHS Trust	6	165	Outcome should also include take-up of services	Thank you for your comment. The scope has been amended to include service utilization as a main outcome.
Tees, Esk and Wear Valleys NHS Trust	3	60	Increased flexibility in service delivery is being sought by practitioners in community, specialist and in-patient settings with the focus on enabling comprehensive range of treatments across primary, secondary, specialist and tertiary settings so that differences in locality provision do not disadvantage individual patients and they can access treatments in other localities and level of care settings when there is a gap in optimum or appropriate service. An example of this is 'networks of psychological therapy practitioners' across a Mental health Trust .	Thank you for your comment. This is a matter for local service implementation rather than an issue to be considered in the guideline.
Tees, Esk and Wear Valleys NHS Trust	3	67	2 Treatment of depressive episodes: In addition to the therapies listed, it is suggested that formalised group psychotherapies are listed as additional therapies as they require specific training and skills and rely on a different body of theoretical knowledge. Whilst some psychological therapies use groups simply as a mode of delivery, formal group psychotherapies rely on a different body of knowledge and clinical skills and evidence.	Thank you for your comment. As set out in the scope, the examples given for each key area do not include details of the format of delivery of interventions as the examples are given to provide context and are not an exhaustive list. Mode or format of delivery of interventions will be considered in the guideline.

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			Systematic review data on group therapies is now available and can be updated	
Tees, Esk and Wear Valleys NHS Trust	5	122	1.5 Draft Review Questions 122 'does mode of delivery of psychological interventions (group-based or individual) impact on outcomes' This question limits what can be investigated for the benefit of patients in relation to group therapies. The question of group psychotherapies outcomes will need to include much more than mode of delivery. For example, there is the question concerning difference between groups that are specifically for peer support and self help compared with groups that require therapists trained in specific psychotherapeutic models and group processes. Both need consideration and recognition as separate activities in order to avoid confusion in commissioning. Formalised group psychotherapies also need considering as distinct treatments from individual treatments.	Thank you for your comment. Group treatments are included within the scope and will be considered in this guideline.
Tees, Esk and Wear Valleys NHS Trust	8	226	3.2 Current Practice Stepped Care needs consideration and evaluation in relation to models of service delivery and how stepped care is being implemented differently owing to service constraints and patient choice and experience gained in working practice.	Thank you for your comment. We will review the evidence on service delivery models (including stepped care).
Tees, Esk and Wear Valleys NHS Trust	General	General	Generally pleased with the incorporation of the workshop discussions and comments sent by this trust into the current draft scope.	Thank you for your comment.
UK Council for Psychotherapy	3	61 62	We have concerns about the stepped care model of delivery within psychological therapies. The Depression in Adults, surveillance review decision, highlighted the good evidence base for a	Thank you for your comment. As set out in the scope, evidence on service delivery models (including stepped care and collaborative care) will be reviewed.

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			collaborative care model compared to a stepped care model. We welcome the consideration that will be given to the best approach going forward. We are concerned that the stepped care model is driven by an economic rather than person-centred approach to treating distress. For psychological therapies our clinicians indicate that having a more intensive form of engagement initially – through assessment by an experience practitioner who can then refer on – is a more effective approach rather than clients having to go through and 'fail' at several treatment levels before reaching the type of support they need.	
UK Council for Psychotherapy	4-6	108 - 156	We are concerned at the absence of any review questions which explore the clinical reality that people are individuals who respond very differently to treatment approaches. The only differentiation in the current review questions appears to be between severity of depression (mild / moderate / severe) and the mode and format of delivery of interventions. There needs to be exploration of the extent to which personality, personal preference and choice influence how people respond to different treatment approaches. Without this there is a risk of drafting a guideline which is interpreted as recommending a one-size-fits-all approach to the treatment and management of depression.	Thank you for your comment. The guideline will consider service-user preference for interventions. A line has been added to the scope (under the 'Key areas that will be covered' section) to indicate that the guideline will consider preference, along with the mode and format of delivery and the sequencing of interventions, but that details of these factors are not included for each intervention as the examples are intended to provide context rather than representing an exhaustive list.
UK Council for Psychotherapy	General	General	The scope must be broad enough to ensure that competing conceptualisations of mental health can be acknowledged and held through the subsequent guideline development process. This includes recognition of the limits of a medicalised way of thinking about depression. A narrow, medical way of thinking risks diagnosis based on symptom counting, and treatment then being about the short-term alleviation of such symptoms rather than	Thank you for your comment. Recognition and assessment are outside the remit of the scope. However, what strategies are effective in preventing relapse (including maintenance treatment) will be reviewed in the guideline

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			addressing longer-term need to prevent relapse and promote sustained recovery.	
UK Council for Psychotherapy	General	General	The scope must be broad enough to explore the utility of a common factors approach to understanding the efficacy and effectiveness of psychotherapy. Extensive research indicates that it is the factors common to therapy – the therapeutic relationship, client and therapist factors – rather than the specific modality or techniques deployed which determine the success of therapy. This common factors model calls into question the way NICE guidelines relating to psychotherapy to date have generally been written and interpreted. The broad equivalence of therapeutic approaches, the so-called 'dodo bird' verdict, is well-supported. For only two recent examples please see: **http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001454** and **http://psycnet.apa.org/journals/pst/51/3/372/**. It is vital that NICE guidelines acknowledge and incorporate the evidence supporting the common factors argument into its guidelines. Doing so would improve service provision through ensuring that more people have access to a greater range of high-quality therapeutic interventions. The scope must be framed in such a way to ensure that this critical aspect of understanding effective psychotherapy treatment for depression can be fully explored by the guideline development group.	Thank you for your comment and the references. Common factors are outside the remit for this scope.
UK Council for Psychotherapy	General	General	Given the high-prevalence of co-morbidity in mental health, we would like clarity about the thinking behind the continued production of disorder specific guidelines and where this fits with the move	Thank you for your comment. People with coexisting mental health conditions have been added as a group to be given specific consideration in the guideline.

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			towards guidelines which acknowledge and seek to account for complex co-morbidity.	
Unum	1	12	For the reasons outlined in comment number two and to better fit with government policy, consider adding occupational health professionals to the list.	Thank you for your comment. This group has already been covered in so far as they fall under either of the following groups: professionals who share in the treatment and care of people with depression in primary, secondary or specialist mental health care; professionals in other health, social care and non-health sectors who may have direct contact with or are involved in the provision of health and other public services for those with depression.
Unum	2	45	Our response makes two recommendations. Firstly, we recommend that NICE consider whether the scope should include the workplace as a specific setting for delivering services that treat depression and look at how the workplace can affect depression.	Thank you for your comment. However, the workplace is outside the remit for this scope. There is existing NICE guidance covering Promoting mental wellbeing at work (PH22).
Unum	2	45	Secondly, to better fit with government policy, we strongly recommend the scoping document recognise employment status as a key outcome and benefit of treating depression. Helping people with mental health problems stay in or return to work is a priority for the NHS, public health, the Department of Health and other government departments. Below we outline examples of the high priority given to depression and employment status across the health sector and government. Outcome 2.5 of the NHS Outcomes Framework and outcome 1.8 of the Public Health Outcomes Framework measure "employment of people with mental illness".	Thank you for your comment. Adaptive functioning (for example, employment) are included as an outcome in the scope.

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			The government recently launched a Mental Health Taskforce. The Taskforce includes cabinet ministers from across government including the Secretary of State for Health. It announced its three top priorities, one of which was "welfare and employment issues and helping people back into work". The Taskforce has highlighted that "2.3 million people with a mental health condition are out of work and mental health conditions are the primary reason for claiming health related benefits". The Department for Work and Pensions has launched the new Fit for Work service to help employees stay in or return to work. As highlighted in the previous paragraph, mental health problems are the biggest health reason people fall out of work. More work days are lost to mental health than any other cause, according to the Health and Safety Executive. GPs will be responsible for referring patients in to the service. The Department of Work and Pension is also committed to helping older people (a group marked for key consideration in the draft scope) to work longer through its Fuller Working Lives workstream. Page 7 of *Fuller Working Lives: a framework for action* notes "work is generally good for physical and mental health and well-being. Research suggests that unplanned early labour market exit can be harmful to overall well-being". The Department of Health has recognised the importance of linking mental health care with employment support. In December 2014, it announced "four pilot areas will use the funding to test whether better coordination of mental health	

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			and employment services could help thousands of people find and stay in employment as well as improve their mental health". Last year's Department of Health *Chief Medical Officer annual report: public mental health* stated that "unemployment is consistently related to higher rates of depression and anxiety and suicide". It also noted that "associations with [unemployment and] poorer mental health are stronger in men", a group given specific consideration in the draft scope. The report cited evidence that "90% of the societal cost of depression was due to unemployment and absenteeism". The report recommended that "employment is central to mental health and it needs to be a routine part of patient records". Paragraph four of the executive summary of NHS England's *Five Year Forward View* includes a commitment "to develop and support new workplace incentives to promote employee health and cut sickness-related unemployment". Mental health problems are the largest cause of sickness-related unemployment.	
Unum	2	46	For the reasons outlined in comment number two and to better fit with government policy, consider adding the workplace to the list.	Thank you for your comment. However, the workplace is outside the scope of this guideline. There is current NICE guidance covering Promoting mental wellbeing at work (PH22).
Unum	3	64	For the reasons outlined in comment number two and to better fit with government policy, consider adding the workplace to the list of settings.	Thank you for your comment. However, the workplace is outside the scope of this guideline. There is existing NICE guidance covering Promoting mental wellbeing at work (PH22).
Unum	6	157	For the reasons outlined in comment number two and to better fit with government policy, we recommend employment status (staying in or	Thank you for your comment. This is covered under adaptive functioning within the outcomes section.

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			finding work) be added as a specific outcome. "Participation in work" is listed as the first outcome in section 1.6 of NICE GID-PHG58 *Workplace health: policies and approaches to support employees with disabilities and long-term conditions: scope consultation*. This wording could also be used here.	

Registered stakeholders: http://www.nice.org.uk/guidance/indevelopment/gid-cgwave0725/documents