Consultation on draft guideline – deadline for comments 5pm, 12 January 2022 email: DepressionInAdultsUpdate@nice.org.uk

Checklist for submitting comments

- Use this comments form and submit it as a **Word document (not a PDF)**.
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include **document name, page number and line number** of the text each comment is about.
- Combine all comments from your organisation into 1 response form. **We cannot accept more than 1 response from each organisation**.
- **Do not** paste other tables into this table – type directly into the table.
- Ensure each comment stands alone; **do not** cross-refer within one comment to another comment.
- **Clearly mark any confidential information or other material that you do not wish to be made public. Also, ensure you state in your email to NICE that your submission includes confidential comments.**
- **Do not name or identify any person or include medical information about yourself or another person** from which you or the person could be identified as all such data will be deleted or redacted.
- Spell out any abbreviations you use.
- For copyright reasons, **do not include attachments** such as research articles, letters, or leaflets. We return comments forms that have attachments without reading them. You may resubmit the form without attachments, but it must be received by the deadline.
- **We do not accept comments submitted after the deadline stated for close of consultation.**

You can see any guidance that we have produced on topics related to this guideline by checking NICE Pathways.

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate.

Comments received during our consultations are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees.

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	Please read the checklist above before submitting comments. We cannot accept forms that are not filled in correctly. We would like to hear your views on the draft recommendations presented in the guideline, and any comments you may have on the rationale and impact sections in the guideline and the evidence presented in the evidence reviews documents. We would also welcome views on the Equality Impact Assessment. In addition to your comments below on our guideline documents, we would like to hear your views on these questions. **Please include your answers to these questions with your comments in the table below.** 1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. 2. Would implementation of any of the draft recommendations have significant cost implications? 3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) 4. Please tell us if there are any particular issues relating to COVID-19 that we should take into account when finalising the guideline for publication. See Developing NICE guidance: how to get involved for suggestions of general points to think about when commenting.
Organisation name (if you are responding as an individual rather than a registered stakeholder please specify).	British Association of Behavioural and Cognitive Psychotherapy (BABCP)
Disclosure (please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry).	**None**
Name of person completing form	Professor Shirley Reynolds, Senior Clinical Advisor

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Comment number	**Document** [e.g. guideline, evidence review A, B, C etc., methods, EIA]	**Page number** **'General'** for comments on whole document	**Line number** **'General'** for comments on whole document	**Comments** • Insert each comment in a new row. • Do not paste other tables into this table, because your comments could get lost – type directly into this table. • Include section or recommendation number in this column.
Example 1	Guideline	016	045	Rec 1.3.4 – We are concerned that this recommendation may imply that ……..
Example 2	Guideline	017	023	Question 1: This recommendation will be a challenging change in practice because ……
Example 3	Guideline	037	016	This rationale states that…
Example 4	Evidence review C	057	032	There is evidence that …
Example 5	Methods	034	010	The inclusion criteria …
Example 6	Algorithm	General	General	The algorithm seems to imply that …
Example 7	EIA	010	002	We agree the barriers to access listed, and would also like to add ….
A General				This response has been prepared by BABCP – the British Association of Behavioural and Cognitive Psychotherapy. BABCP is the lead organisation for CBT in the UK and Ireland. BABCP promotes, improves, and upholds standards of CBT practice, supervision and training. We are a professional organisation operating a highly respected voluntary register for accredited cognitive behavioural psychotherapists. We also operate a voluntary register for Psychological Well-being Practitioners (PWPs) and other low intensity clinicians. BABCP accredits CBT training programmes in the UK and Ireland and publishes Minimum Training Standards (i.e. a national curriculum) for training CBT therapists. BABCP members were invited to contribute to this response. Their comments and observations are quoted verbatim appear at places throughout the document to illustrate and highlight specific points.
B General				BABCP would like to highlight grave concern about the implied necessity of dropping the stepped care model for treatment of depression that was previously recommended by NICE in 2004 and 2008.

				The majority of people with depression in England are referred to NHS IAPT services. NHS IAPT (psychological therapy) services are based on a stepped care model and deliver NICE recommended psychological interventions in England. In 2020-2021 IAPT services had 1.45 million referrals and 90% of referrals were seen (virtually in most cases) within 6 weeks. More than 50% of referrals moved to recovery and around 63% of interventions were low intensity interventions, delivered by PWPs. However, the key recommendations made by the committee and illustrated in the Visual Guidance for 'less severe' and 'more severe' depression are not compatible with the stepped care model of service delivery. The draft recommendations state that people with a new episode of depression should normally be offered high intensity psychological therapy in preference to low intensity psychological interventions. Thus, if implemented, the recommendations would massively increase the demand for high intensity psychological interventions and this demand could not be met. Many thousands of extra staff would need to be trained and recruited, with knock on consequences for funding required from Health Education England for HEIs. In contrast there would be a marked reduction in demand for low intensity interventions and thus many PWPs would need to be retrained, redeployed, or made redundant. Implementation of the draft recommendations would therefore have very negative consequences for NHS mental health services and require massive service redesign and re-organisation that would be complex, costly and disruptive. Waiting times would increase and the number of patients treated would reduce. Very significant additional resources would be required. BABCP suggest that the type of evidence that was reviewed in developing the guidelines (predominantly RCTs of treatment efficacy and effectiveness) is not appropriate as a guide to how services should be organised and delivered. Economic modelling and cost-effectiveness analysis was limited and did not consider the costs of changing systems of delivery or of implementing the Draft Guidance.

				It is of particular concern that the extensive data collected from IAPT services and freely available in the NHS Digital Annual Report each year (including 2020/2021) has not been used to inform recommendations about how treatments should be delivered and organised. BABCP is also concerned that no distinction was made between efficacy and effectiveness studies. Whilst RCT evidence is highly relevant to assessments of treatment effectiveness and cost-effectiveness many RCTs reviewed were under-powered and not easily generalisable to the NHS in 2022 (and beyond). BABCP also identified concerns with the transparency of Evidence Review B, with the exclusion of relevant studies and with the informal use of committee members' knowledge of studies that had been excluded from the review. BABCP suggests that this process may have introduced bias to the interpretation of results. BABCP also identified concerns with the PICO used to guide Evidence Review A and Evidence Review B. The range of interventions reviewed in Evidence Review B did not reflect the full range of interventions currently offered in the NHS and this was particularly problematic for low intensity interventions delivered by PWPs in IAPT services. BABCP therefore suggests that the Evidence Reviews on which the draft Guidance is based include a number of fundamental flaws. We also suggest that to implement the Draft Guidance would have a disastrous impact on NHS mental health services and would result in significantly longer waiting times, significantly more costs and inefficiencies, and reduced access to assessment and treatment for people with depression.
1	Evidence review A – Service delivery	30	34 Table 1 'Population'	BABCP are concerned that the PICO table includes as 'population', participants for whom depression is assessed by DSM or ICD, and those for whom depression is assessed by 'validated scales', and that these are treated equally. These methods of recruitment to trials are not equivalent. BABCP suggests that diagnostic interviews based on DSM or ICD (or similar) are of higher quality than validated self-report scales. Therefore we suggest that studies that assess depression diagnosis at baseline (before treatment), and treatment outcome at the end of treatment and follow up should be given greater weight than studies that use only self-report measures of depression.

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2	Evidence review A	31	'Outcomes'	BABCP note that 'critical' outcomes are limited to metrics (scores, response, remission, relapse) related to the symptoms of depression, all of which are based on self-report scores. We suggest that 'critical' outcomes should also reflect functioning and/or quality of life reported by participants. BABCP also suggest that critical outcomes based on structured diagnostic interviews should be weighted more heavily than critical outcomes (e.g. endpoint score) based on responses to a 'validated scale'
3	Evidence review A	33	4-5	BABCP note that only 5 RCTs of stepped care were included in the evidence review. BABCP understands the rationale for selecting studies that follow an RCT design. However, in research on service delivery and implementation the use of RCT designs has important limitations and BABCP suggest that other research designs should be included so that the review is includes the most relevant and most extensive data available e.g.: • Lobb, R., & Colditz, G. A. (2013). Implementation science and its application to population health. *Annual review of public health*, *34*, 235-251. NHS psychological therapy services in England (i.e. IAPT) follows stepped care principles and provides data on 98% of patients who are referred. This data is freely available and there have been many independent analyses of treatment delivery and outcomes e.g. • Radhakrishnan, et al. (2013). Cost of Improving Access to Psychological Therapies (IAPT) programme: An analysis of cost of session, treatment and recovery in selected Primary Care Trusts in the East of England region. *Behaviour research and therapy*, *51*(1), 37-45. • Wakefield, S., et al, (2021). Improving Access to Psychological Therapies (IAPT) in the United Kingdom: A systematic review and meta-analysis of 10-years of practice-based evidence. *British Journal of Clinical Psychology*, *60*(1), 1-37.

				BABCP is very concerned that the freely available data collected by IAPT on the country wide implementation of a stepped care model has not been included in this evidence review. In the view of BABCP this leads to a distorted reflection of the evidence which has important implications for the way in which this guidance has been developed.
4	Evidence review A	73	21-27	'The outcomes that matter most' – BABCP note with interest the committee's view that depression symptoms, response, remission, and relapse are the critical outcomes. BABCP suggest that outcomes that matter 'most' would be better identified in collaboration with people who have depression and their carers. Whilst symptoms, relapse etc are important outcomes BABCP hears from many service users who argue that functioning and quality of life are at least as important as symptoms, and may be more important.
5	Evidence review A	73	36-37	BABCP note that most research on service delivery was graded as low or very low quality. BABCP suggests that evaluating research on implementation may require a different set of quality criteria than research focused on treatment effectiveness and cost-effectiveness.
6	Evidence review A	74	41-44	Separate recommendation for stepped care: the committee considered this but rejected it. This decision is hard to understand given that the current model for delivery of psychological therapies in England is stepped care. The stepped care model is therefore of particular interest and importance to commissioners and NHS providers. BABCP is concerned that the most relevant data relating to the implementation of a stepped care model (i.e. the IAPT dataset and publications based on these data) was not included in this evidence review.
7	Evidence review A	75	48-51	BABCP note with concern the recommendation that a collaborative care model is used to organise the delivery of care and treatment for people with depression. This recommendation is based on economic analysis of a range of RCT studies, many of which were not conducted in the UK and

				which therefore relate to very different health care systems. Only 3 of the reviewed studies were conducted in the UK and these had important limitations (as noted in lines 39-44). The economic analysis also did not consider any costs of de-commissioning existing stepped care services such as IAPT, or any of the costs of developing new services, adapting existing services and re-building the systems of care. BABCP therefore suggest that the economic analysis presented here is, at best, incomplete and at worst completely misleading. BABCP suggest that a full economic analysis needs to calculate and include the true costs of service re-organisation, re-deployment and redundancy of 1000s of NHS staff, re-training of IAPT staff, recruitment and timing of new NHS staff to deliver interventions that have been recommended and for which appropriately trained staff are not currently employed. In addition the personal, social and economic costs of increased waiting times and reduced access to treatments should be included in the economic model. The far reaching systemic and economic implications of this recommendation are not discussed in this document. BABCP do not believe that this recommendation is well founded, that it is based on a comprehensive assessment of costs, or that it would be feasible.
8	Evidence Review B Treatment of a new episode	8	Table 1	PICO table: Population BABCP note that studies were included if participants received a diagnosis of depression (DSM or ICD, or similar) or reported symptoms on a 'validated' scale. BABCP suggests that studies which selected participants on the basis of a diagnostic interview are of higher quality (i.e. more valid) and thus should be given greater weight in a meta-analysis. Likewise,

				studies that selected participants on the basis of 'validated' self-report scales are of lower quality and should be given less weight in a meta-analysis.
9	Evidence review B	8/9	Table 1	PICO table: Interventions BABCP observe that this list of interventions does not properly reflect the range of interventions that are widely used in IAPT services as low intensity treatments for depression as part of the stepped care pathway. As a result an important group of interventions have not been reviewed and thus have been excluded from the guidelines. For example, there is increasing evidence that brief sleep interventions (delivered online) are also effective at treating depression. These are increasingly used in IAPT services and have not been included in the evidence review. • Gee B, Orchard F, Clarke E, Joy A, Clarke T, Reynolds S. The effect of non-pharmacological sleep interventions on depression symptoms: A meta-analysis of randomised controlled trials. Sleep Med Rev. 2019 Feb; 43:118-128. doi: 10.1016/j.smrv.2018.09.004. The list of interventions also does not distinguish between Behavioural Activation delivered as a low intensity treatment (based on the Lejeuz and Hopko model) and Behavioural Activation delivered as a high intensity treatment (based on the Martell model). This consequence of this presents a significant challenge to existing practice and service delivery because many service users with depression, referred to NHS psychological therapy services in England, are offered interventions that do not appear to be have been evaluated e.g low intensity Behavioural Activation. BABCP is extremely concerned that the choice of interventions listed here (and the exclusion of important core interventions) significantly threatens the credibility of the guidelines produced and will result in recommendations that cannot reasonably be implemented without major disruption to delivering services, increased costs, and lower access and equality. By Mindfulness, mediation or relaxation:

				BABCP note that these are not one 'school' or coherent model of therapy or interventions. Mindfulness based CBT is a specific protocol-based intervention for which specific training, quality standards and supervision are available. Meditation and relaxation might refer to a range of activities and are not synonymous with mindfulness. Therefore the evidence reviewed relating to Mindfulness Based CBT is not applicable to 'meditation' or 'relaxation', neither of which are evidence-based treatments for depression. Couples therapy should be in the 'psychological intervention' category instead of the 'psychosocial intervention' category.
10		9	Comparator	5 comparators are listed. BABCP note that these are not of equal validity and note that trials that compare active interventions or plausible placebos should be given greater weight in appraising the evidence of effectiveness and cost-effectiveness. BABCP note that the results of trials that use waiting list, no treatment or TAU as the comparator are less valid than trials that used placebo or active interventions as comparators and thus their results should be given less weight in the evidence review.
11		10	16-28	The definition of 'less severe' and 'more severe' depression caused concern amongst BABCP members. For example one member commented, • 'Using a PHQ9 score of 16 to distinguish severe from less severe depression, is inadequate, it is based on consensus not, evidence. The PHQ9 was validated in a US outpatient setting against the Prime MD, but the questions on the latter are identical to those on the former thus it falls foul of the STARD requirements. The PRIME MD is not a 'gold standard' diagnostic interview. There are therefore major external validity issues with the PHQ9, the fact that its usage is commonplace, does not increase its validity.'

				BABCP suggest that the guidance includes much greater clarity and specificity about the definitions of 'less severe' and 'more severe' depression so that these are explicit and can be implemented by commissioners and by clinicians who assess and treat people with depression. This is likely to require reference to commonly used measures and methods and indications of the appropriate cut-off points that should be used, as well as clarity about other factors that might mitigate the classification (e.g. complexity, co-morbidity, living conditions etc).
12		10	30-32	BABCP note the reliance on network meta-analysis to synthesise evidence across treatments. We agree that quantitative data from RCTs are essential to conduct a minimally biased appraisal. However, BABCP also suggest that a range of complementary forms of evidence are necessary to make the transition from data about efficacy and effectiveness of treatments to recommendations about service delivery and organisation. The NICE guidelines have implications for how services are commissioned, designed, organised, and delivered. Therefore other forms of evidence that should be included in the guidelines should involve qualitative and quantitative evidence about acceptability and feasibility (from patient and clinicians' perspectives), implementation science, and wider economic evaluation of the costs of service redesign and organisational change.
13	Evidence review B	8	4	Couple-based interventions were not included in the network meta-analysis. BABCP hypothesise that this decision was based on the incorrect assumption that couples-based interventions are only relevant to people who are experiencing relationship distress. A recent meta-analysis found that they were equally effective in the treatment of depression for people in distressed and non-distressed relationships • Barbato, A. & D'Avanzo, B. (2020). The findings of a Cochrane Meta-Analysis of couple therapy in adult depression: Implications for research and clinical practice. Family Process, 59 (2), 1-15).

				BABCP suggest that the evidence review is modified to include more studies of couples-based interventions.
14	Evidence review B	16	14	BABCP observe that the 142 RCTs included in Evidence Review B are not listed here and it is not clear where this list can be found. They are not in the Appendix K as indicated. BABCP suggest that for transparency the full list of studies should be easily available. BABCP also observe that the number of excluded studies is not provided. The guideline should include a full list of excluded studies and indicate why each study was excluded. Appendix K did not provide this information. BABCP also note that most studies of Behavioural Couples therapy were excluded from the evidence review. This may be because of an incorrect assumption that Behavioural Couples therapy is only appropriate and effective for people who are in a distressed relationship; this is not the case e.g. • Barbato, A. & D'Avanzo, B. (2020). The findings of a Cochrane Meta-Analysis of couple therapy in adult depression: Implications for research and clinical practice. Family Process, 59 (2), 1-15.) BABCP is concerned that this misunderstanding of the scope of Behavioural Couples therapy is a significant gap in the evidence review and has resulted in incorrect interpretation of the available evidence.
15	Evidence review B	18	Table 2	BABCP note with interest that the majority of self-help interventions listed are computerised treatments. This suggests to us that many self-help interventions and other low intensity interventions have been omitted from the evidence review. BABCP note also that computerised-CBT is not a single intervention and that the specific programme used in research is an important aspect of assessing outcomes.

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16	Evidence review B	44	36-40	'Under an NHS perspective problem solving…. was significantly more expensive than GP care. The number of QALYs gained was practically the same across all interventions.' This statement suggests that the rationale for including problem solving as a treatment for 'less severe' depression is weak. Therefore BABCP suggest that problem solving is not included in the menu of treatments for 'less severe' depression. This is particularly important because NHS services do not currently provide staff who are qualified to provide problem-solving therapy for depression.
17	Evidence review B	46	21-29	The economic evidence in support of exercise as an intervention (Chalder, 2012) is based on data from individuals who completed treatment, not on ITT analysis. Notably attrition was high (line 29) Thus the cost effectiveness is likely to be over-estimated i.e. the intervention is likely to be less cost-effective than reported (lines 23-27). Group exercise could not currently be offered as a treatment for depression because appropriately qualified staff, i.e. with training in mental health and the delivery of exercise-based interventions, are not employed in NHS mental health or psychological therapy services. Thus the recommendation could not be implemented. The implementation of this guideline would have significant resource implications and require new training programmes and recruitment of new staff.
18	Evidence review B	47	24-25	BABCP note that the economic analysis of specific interventions classified as CBT (group and individual) was based on under 15 sessions. The specificity of the number of sessions for CBT (but not other interventions) was not clear and BABCP suggest that this is explained.
19	Evidence review B	58	46-48	'…the committee were aware that a number of important and well-known, often pragmatic, trials were excluded…'. This statement suggests that the PICO and search criteria used for the evidence review may have been too narrow and thus omitted important trials. The committee were able to consider the results of these trials, which is helpful. However, this observation also raises the likelihood, that other important evidence, not known to the committee, was omitted from the evidence review. There is a risk that this informal process introduced bias in the discussions and recommendations.

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				As observed above the PICO excluded interventions that are currently widely used in IAPT services, thus giving additional weight to the concern that the evidence review was incomplete.
20	Evidence review B	61	42-43	BABCP suggests that further consideration be given to explain why interventions that were not cost-effective (non-directive counselling and short-term psychodynamic psychotherapy) were recommended as interventions for 'less severe' depression
21	Evidence review B	62	5-6	The committee observed that some people with depression may not wish to attend group treatment – BABCP agree that this is an important observation and note that it is supported by research with service users. BABCP also suggest that the committee should consider the logistical challenges of organising group treatments and the costs (personal and NHS) of attrition from these groups. Many of our members who work in NHS psychological therapy services highlighted the difficulties of co-ordinating attendance at group treatment. They observed that finding adequate participants for group therapy was challenging, that wait times were artificially extended to accommodate delayed recruitment, that drop out was high, and that many patients were unwilling to accept group therapies. BABCP note that in the studies included in the evidence review these costs of delivering group treatments were not adequately reported and that therefore the evidence review and economic analysis did not take them into account. BABCP suggest that had such additional costs and resource implications been properly assessed that the apparent cost effectiveness of group CBT and group BA would be significantly reduced.
22	Evidence review B –	62	13-14	We agree with the committee's interpretation that unguided (unsupported) self-help is likely to result in high dropout / low engagement and with their observation that the therapeutic alliance is important. Thus, we also agree with their recommendation that self-help is offered with support as a treatment option for individuals with mild depression.

23	Evidence review B	62	19-20	BABCP also agrees with the committee that it is important to offer a choice of therapy to people with a new episode of mild depression. However, BABCP do not think it realistic or feasible to offer people with 'less severe' depression a choice of 11 different interventions.
24	Evidence review B	62	35-44	BABCP could not follow the rationale for offering or recommended treatments that are not cost-effective compared with usual GP care. This is also likely to present a challenging change to practice – how are GPs or other primary care staff to assess and then identify the individuals for whom these not cost-effective interventions are indicated?
25		63	1-15	BABCP strongly support and endorse the committee's observation that commissioners of mental health services need explicit guidance on the length and structure of psychological therapies that they commission. We also note that the committee used a range of information in making explicit statements about the length of psychological therapies (e.g. resource use from the economic analysis and RCT data, as well as the committee's expertise). We do not agree with the conclusions of the committee about the length of treatments, which deviates substantially from the data presented in evidence review B (e.g. table 2, page 18).
25	Evidence review B	82	Table 16	CT/CBT Individual CBT (and variants) and group CBT have been classified as 15 session and over, and under 15 sessions. This distinction is not made for other therapies and the reason for this is not clear. BABCP suggest that the rationale is explained. Behavioural activation – No distinction is made between high intensity behavioural activation (Jacobson, Martell model) typically 12-16 sessions delivered by Band 7+ therapists and low intensity behavioural activation (Lejeuz and Hopko model) with fewer sessions and typically delivered by PWPs (Band 5s). This is an important distinction and essential to assess cost effectiveness. BABCP suggest that in the evidence review these two forms of Behavioural Activation are clearly distinguished and evaluated separately.

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26	Evidence review B	122	43-44	BABCP note that the economic analysis of specific interventions classified CBT (group and individual) as under 15 sessions. The specificity of the number of sessions for CBT (but not other interventions) was not clear and BABCP suggest that this is explained.
27	Evidence review B	140	48-50	'…the committee were aware that a number of important and well-known, often pragmatic, trials were excluded…'. This statement suggests that the search criteria used for the evidence review may have been too narrow and thus omitted important trials. The committee were able to consider the results of these trials, which is helpful. However, this observation also raises the likelihood, that other important evidence, not known to the committee, was omitted from the evidence review. As observed above the PICO excluded interventions that are currently widely used in IAPT services, thus giving additional weight to the concern that the evidence review was incomplete.
28	Evidence review B	141	21-28	BABCP agrees that the results of high quality and relevant RCTs that did not meet inclusion criteria for the meta-analysis are consistent and that their findings are important to consider in making recommendations. However, BABCP is concerned that this raises questions about the validity of the inclusion criteria and increases the risk that relevant data, not personally known to committee members was unintentionally excluded from review. Thus there is a significant risk that the evidence review is incomplete. BABCP suggest that all excluded studies are listed and the reasons for their exclusion noted. BABCP also suggest that the excluded studies that were considered are clearly identified.
29	Evidence review B	141	43-49	Again, the BABCP agrees that the results of high quality and relevant RCTs that did not meet inclusion criteria for the meta-analysis are consistent and that their findings are important to consider in making recommendations. However, as noted above this raises concerns that the evidence review missed important and relevant evidence.

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30	Evidence review B	145	47-50	The observation that 'there may be specific groups for whom IPT and STPP may be effective' may be accurate. However, without clear guidance about how to identify these individuals the recommendation that these therapies be offered to people with more severe depression will present a significant challenge to practice – who are these 'specific groups' and how will they be identified?
31	Evidence review B	146	4-18	BABCP strongly support and endorse the committee's observation that commissioners of mental health services need explicit guidance on the length and structure of psychological therapies that they commission. We also note that the committee used a range of information in making explicit statements about the length of psychological therapies (e.g. resource use from the economic analysis and RCT data, as well as the committee's expertise). BABCP do not agree with the recommendations of the committee about the length of treatments (e.g. 8 sessions of CBT for 'less severe' depression, in Table 1 of the guidance), which deviates substantially from the data presented in the evidence review B (e.g. table 24, page 104) in which CBT is classified as being fewer than 15 sessions or more than 15 sessions. There is no reference at all in the evidence review to 8 sessions being the appropriate length of CBT but this is the recommended number of sessions of CBT for patients with 'less severe' depression (Table 1: Guidance). Many patients will require more than 8 sessions of CBT. This is especially important for patients with co-morbid mental health problems, chronic physical health problems, specific learning difficulties, learning disabilities, or complex social needs.
32	Evidence review B	146	28-30	BABCP welcome the discussion of Barkham (2021) and Cuijpers (2021) and note that both the RCT and the meta-analysis suggest that counselling may be a less effective treatment for depression than CBT (Barkham) and other psychological interventions (Cuijpers).
33	Evidence review B	325	Line numbers not provided Intervention resource use and costs	It is noted that economic modelling of group CBT and group Behavioural Activation is based on costs of one Band 7 High Intensity therapist and one Band 6 High intensity therapist. This assumption for modelling purposes is incorrect – High intensity therapists are employed on Band 7 (or higher). Band 6 is used only for trainees, not qualified staff.

			Psychological interventions section	Table 87, page 329 is therefore redundant / irrelevant as these costs would not be incurred by services providing 'high intensity' psychological therapies. This is an important issue as it would change the outcome of the cost effectiveness analysis which favours group CBT (and Group BA)
34	Evidence review B	326	Line Numbers not provided Sensitivity analysis	In relation to the sensitivity analysis to reflect different costs of staff providing psychological therapists, Band 5 staff are not qualified to provide psychological therapies and should not be doing so anywhere in the country. BABCP are concerned therefore this sensitivity analysis may be highly misleading and is not relevant. BABCP suggest that a more logical sensitivity analysis would assess costs for Band 8a therapists because this group are employed to deliver psychological therapies in NHS mental health services.
35	Evidence review B	327	Table 84	This table shows assumed unit costs for therapists. A cost is allocated to 'High Intensity' therapist Band 6 and High Intensity MBCT therapist Band 6 BABCP notes that this is inaccurate – High Intensity therapists are employed at Band 7 (and above). Therefore any costs based on this assumption will be incorrect and this has implications for cost-effectiveness analyses.
36	Evidence review B	329	Table 87	This table is redundant – High intensity therapists are not employed at Band 6 so these costs are not correct and will provide incorrect estimates of the cost of therapy.
37	Evidence review B	331	Table 88, rows 3 to 6	Intervention costs of psychological therapies for adults: This table shows the number of sessions of CBT for 'less severe' depression as 8; however, the evidence review (and primary research) considered treatments of more than 15 and less than 15 sessions. It is not clear why costs were estimated for 8 sessions as this is not equivalent to 'less than 15' or 'more than 15' sessions. BABCP are concerned that the decision taken to model cost effectiveness based on 8 sessions of CBT is flawed and leads to erroneous conclusions. It may also be misleading to commissioners who may

				see this modelling as a suggestion that a maximum of 8 sessions of CBT are offered to people with 'less severe' depression. This would be likely to reduce access to treatment. There are similar assumptions made for other therapies. For example, what is the rationale for 12 sessions of individual BA for 'more severe' depression? BABCP would find it helpful and more transparent if the rationale for modelling specific numbers of treatment were made explicit. Currently BABCP cannot see any justification for the number of sessions allocated to different treatments – this is important because modelling different lengths of treatment (i.e. number of sessions) has a direct impact on the assessment of cost-effectiveness of different treatments and thus on the recommendations made by NICE about the ordering of different treatments for depression in the 'menu' of choices.
38	Evidence review B	333	Physical interventions	BABCP does not understand the logic of costing the delivery of exercise programmes as equivalent to a Band 5 PWP. PWPs are not qualified to deliver exercise programmes or to assess suitability for these interventions. Thus, there would be a significant challenge to clinical practice and potentially serious risk of harm to patients if PWPs or other unqualified staff were employed to carry out these tasks. Following from this, the costs based on the Band 5 PWP equivalent staff in Table 90 are misleading (unless they are based on a different professional group that could be specified).
39	Evidence review B	364	29-34	BABCP appreciates that this is a sensitivity analysis but wish to point out that Band 5 staff (e.g. PWPs) are not qualified to deliver high intensity psychological therapies of any kind and therefore the results of the cost effectiveness analysis (whilst perhaps interesting) are not relevant to practice and would present huge ethical and logistical challenges.
40	Evidence review B	366	31-34	This statement is misleading and unhelpful – it implies that Band 5 PWPs have been trained to deliver high intensity psychological interventions – and that they can do so safely under supervision. This is not accurate. BABCP would have serious concerns if such a scenario were ever considered and would not recognise as acceptable the delivery of CBT (in a group, individually or by any method of delivery)

				by a Band 5 PWP. Delivery of high intensity psychological therapies (CBT and all other therapy modes) must be by properly trained, competent, and qualified therapists, under supervision. The minimum training standards of BABCP outline exactly what competencies, experiences and supervision are required to deliver CBT.
41	Evidence review B	374	Research question 2 – 9 and Table 102	BABCP welcome and strongly endorse this research question and in particular the comments around feasibility i.e. using experimental studies to identify potential mechanisms of treatment, followed by the development of new targeted treatments, assessed via large scale RCTs. We agree that this would require an extensive programme of research.
42	Evidence review B	375	Table 103	BABCP suggest that other study design (in addition to factorial designs) will be appropriate to address the research question. These will include detailed single case experiments, observational studies, qualitative, and process studies. Related to this point BABCP are also concerned that the evidence review on which the revised guidelines are based did not consider any research that has used the IAPT dataset – which is for this purpose the most relevant data available on the delivery and effectiveness of psychological therapies delivered in routine clinical practice in England. The consequence of completely ignoring this research and drawing conclusions exclusively on the results of RCT data has led to recommendations that are unaffordable, unfeasible and which threaten the viability of existing services. The selection of research included in the evidence review included studies that were underpowered, of poor quality, evaluated interventions that are not typically available in the NHS (e.g. problem-solving therapy), failed to include many low intensity interventions delivered in IAPT, and which were conducted with participants and in contexts far removed from the population of England.
43	Evidence review C Prevention of relapse	69	23-24	We are pleased that the guideline committee acknowledged the important social factors that contribute to depression and the need to identify and address these if possible. We would welcome new guidance focused on this topic i.e. interventions to ameliorate social factors that contribute to the aetiology and maintenance of depression, and which moderate outcomes.

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44	Evidence review C	70	16-17	BABCP welcome the suggestion that brief interventions targeted at relapse prevention should be a future research priority.
45	Evidence review C	70	38-41	BABCP agree and welcome the committee's suggestion that psychological interventions for depression should routinely include follow up to assess relapse. This however, will present a clinical and resource challenge in many services, because most are not commissioned to provide follow up sessions – for example IAPT services in England are not paid to follow up and identify relapse or risk of relapse and therefore are not able to offer follow up sessions to their patients.
46	Evidence review C	71	39-49	The committee have presented a range of hypothetical scenarios in which maintenance CBT or MBCT or cCBT may be cost effective – i.e. if CBT is offered in 4 sessions. BABCP strongly endorse the provision of sessions to maintain treatment gains and would welcome these being included in contracts. For this to happen commissioners of psychological therapy services will need to be made aware of this recommendation
47	Evidence review C	72	24-28	BABCP is pleased that the guidelines committee recommend relapse prevention sessions for those at high risk of relapse. The economic modelling suggested that 10 sessions were not cost effective but that 4 sessions of CBT/CT or MCBT would be cost effective – the committee then expressed the view that '4 sessions are adequate to maintain a relapse prevention effect' BABCP could not deduce any clinical rationale for this opinion - the economic modelling is based on a purely hypothetical situation that is not related to clinical practice or based on the outcome data of participants who received 4 relapse prevention sessions. Therefore, whilst BABCP welcome the recommendation that relapse prevention sessions are provided to individuals at high risk of relapse we suggest that the limit of '4 relapse prevention sessions' would be better described as a minimum number that should be commissioned (not a maximum).
48	Evidence review C	73	1-5	BABCP welcome the comment that high risk of relapse should not be limited to those with multiple previous episodes of depression – we agree that other factors, and in particular, personal, social and

				environmental factors are important. We welcome the recommendation that patients with these factors be considered at high risk after 1 or 2 previous episodes.
49	Evidence review C	238	26-27	Document states that group CT/CBT was delivered by one Band 7 high intensity therapist and one Band 6 high intensity therapist – Band 6 staff are not qualified high intensity therapists and thus would not be employed to deliver this treatment. This has an implication for unit costs calculated e.g. in Table 105, page 242, Table 105, page 243 The effect of this will be to over-estimate the cost-effectiveness of Group CBT or Group CT
50	Evidence review C	239	36-47	BABCP are extremely pleased to see that the costs of supervision have been included in the unit cost calculations.
51	Evidence review D	10	PICO table Population	BABCP note that studies were included if participants received a diagnosis of depression (DSM or ICD, or similar) or reported symptoms on a 'validated' scale. BABCP suggests that studies which selected participants on the basis of a diagnostic interview are of better quality and thus should be given greater weight in a meta-analysis. Likewise, studies that selected participants on the basis of 'validated' self-report scales are of lower quality and should be given less weight in a meta-analysis
52	Evidence review D	11	PICO table intervention	BABCP note that "Mindfulness, mediation, or relaxation' are listed as if synonymous. BABCP note that these are not one 'school' or coherent model of therapy or interventions. Mindfulness based CBT is a specific protocol-based intervention for which specific training, quality standards and supervision are available. Meditation and relaxation might refer to a range of activities and are not synonymous with mindfulness. Therefore the evidence reviewed relating to Mindfulness Based CBT is not applicable to 'meditation' or 'relaxation', neither of which are evidence-based treatments for depression.

53	Evidence review D	12	PICO table Comparison	BABCP observe that these comparators are not equivalent to each other – placebo and active interventions are a more stringent test of effectiveness and cost effectiveness than 'no treatment', wait list, or TAU and the results of studies should be weighted according to the strength of the comparison.
54	Evidence review E Chronic depression			BABCP did not have sufficient time or resources to comment fully on this evidence review. We suggest that future consultations provide a reasonable time in which to digest the documentation and obtain expert review and opinion as well as feedback from member and service user representatives. The concerns about the PICO, made in points 8, 9 and 10 apply to this review.
55	Evidence review E	10	11-22	BABCP was pleased to see a list of the studies that were included in this review as well as a summary table of the results (page 12).
56	Evidence review F Depression with coexisting personality disorder			BABCP did not have sufficient time or resources to comment fully on this evidence review. Many of our concerns about the PICO, made in points 8, 9, and 10 apply to this review.
57	Evidence review F	7	8-20	BABCP welcomes the introductory statement outlining some of the complex issues this topic raises. BABCP suggest that the guidelines offer more specificity about the types of personality disorder for which this evidence review is relevant –
58	Evidence review F	7	PICO table	Population How were the participants selected i.e. what criteria were used to assed depression, and what criteria were used to assess personality disorders? Studies which recruited participants based on diagnostic interviews should be given greater weight in the evidence review than those that used self-report measures Which personality disorders were included?

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59	Evidence review F	11-12	Table 4	Shea (1990) – individuals were identified as having a personality disorder on the basis of a self-report questionnaire (the Personality Assessment Form). BABCP suggests that this is a very low quality method of assessment and thus that the results of this study be weighted less heavily than more valid studies NB this study appears in several other comparisons and thus may carry undue weight because it is a four-armed trial
60	Evidence review G Psychotic depression			BABCP did not have sufficient time or resources to comment on this evidence review. Many of our concerns about the PICO, made in points 8, 9 and 10 apply to this evidence review.
61	Evidence review H Access to services			BABCP welcome the inclusion of this evidence review and agree that this is a high priority topic for the NHS
62	Evidence review I Patient choice			BABCP welcome the inclusion of this evidence review and agree that patient choice should be prioritised BABCP also agree that qualitative research is an appropriate method of research to address questions about patient choice.
63	Evidence review I Patient choice	7	Table 1	BABCP note that only qualitative research studies were reviewed – this was surprising given that other methods, including survey research would offer valid data related to this topic. BABCP suggest that the reasons for focusing on qualitative research and excluding quantitative research are made explicit. BABCP also recommend that the evidence review is revised and incorporates quantitative and quantitative data related to patients choice.

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64	Evidence review I Patient choice	8-28	Table 2	BABCP note that a range of different methods of qualitative data analysis were used by studies included in this review. Studies also focused on data obtained from patients, clinicians, and non-mental health professionals and N ranged from 5 to 80 participants. BABCP suggest that there is a clearer and more explicit explanation describing how the quality of primary studies informed their contribution to the analysis and the subsequent interpretation of the analysis by the committee?
65	Visual summary		Less severe depression	Depression in adults: choosing a first line treatment for less severe depression BABCP have a number of comments – in other parts of the response our comments are fuller – here we have tried to focus on key problems • How is the clinician to assess 'less severe' depression? • These guidelines have been based on an incomplete review of the evidence – the committee noted that a number of relevant and important trials were excluded from the review. Thus the search terms appear to have been unhelpfully narrow. • It is not clear with whom or where decision making around treatment choices would take place. How will time be made available as it will be a time-consuming process to discuss this range of options with patients? • Many of the recommended treatments have extremely limited evidence and/or very low quality evidence. Some interventions have been recommended on the basis of studies that recruited fewer than 100 participants whereas other interventions are supported by many more studies, many 1000s of participants, and with research of higher quality. BABCP is puzzled by the recommendation to overhaul existing psychological therapy services and introduce new interventions (e.g. meditation) on the basis of such weak and unconvincing evidence. • Group CBT and Group BA have been recommended as the favoured treatments for ''less severe' depression – BABCP is concerned that the evidence review focused too narrowly on outcomes of small RCTs, conducted in settings and populations that are not representative of NHS patients and NHS services in England, and did not incorporate ITT analyses. Thus they present an overly positive evaluation of effectiveness and cost-effectiveness.

				• Group CBT and Group BA are currently not available in NHS psychological therapy (IAPT) services and clinicians are not trained to deliver group CBT or group BA so all IAPT CBT therapists would need retraining. • Given the lack of trained staff to deliver Group BA and Group CBT as first line treatments for depression, the level of resources required, and on the basis of feedback from patients, clinicians and service managers about acceptability of group treatments, BABCP suggests that Group CBT and Group BA are not viable treatments for less severe depression. • Implementing this guidance would mean that the stepped care model used in IAPT would be redundant. This has huge negative implications for patients and waiting lists would grow exponentially. BABCP do not think that the evidence review underlying this revised guidance has properly considered the true costs of implementing this menu of interventions, including the costs of service redesign, redundancy for 1000s of Band 5 staff, redeployment, retraining, commissioning of new training programmes e.g. for Group CBT and Group BA, and employment of new staff to deliver group exercise interventions. • It is not realistic to offer shared decision making with 11 different treatment options – there is inadequate time, clinicians are not trained to understand the range of options, and depressed patients are unlikely to be able to manage the range of information sufficient to make an informed choice. • Even more importantly, BABCP can find no evidence that acceptability of treatments has been incorporated into the evidence review. The experience of our members, and our service user representatives is that group therapy, (including CBT and BA) is associated with significant problems in delivery and that there is very high drop out from group therapy. • Group psycho-education for less severe depression is not included in these recommendations – this is currently used in IAPT services as part of the stepped care model. It is not clear if the evidence review looked for evidence about this intervention and failed to find it, or if the evidence review did not look for evidence. BABCP suggest that the reasons for this omission are justified and explained. • Group exercise is not currently available as a treatment for 'less severe' depression and this suggests that new staff will need to be recruited and additional staff trained to deliver group exercise. These staff would also need to be co-located within mental health services and thus would require service re-organisation.

				• BABCP suggest that behavioural couples therapy for depression is added to the evidence review and if appropriate added to the 'menu' of interventions.
66	Visual summary		More severe depression	Depression in adults: choosing a first-line treatment for 'more severe' depression This visual summary shows 10 options that can be offered to patients after discussion of their preferences – BABCP have similar concerns to those outlined above in relation to the visual summary for 'less severe depression' • It is not realistic to offer shared decision making with 10 different options – clinicians will not have sufficient understanding of each treatment and patients with depression will struggle to hold the information in mind. Under these conditions, shared decision making is not viable. • Clinicians offering this range of 10 treatment options will need significant time to do this adequately and most will need additional training to understand each of the treatment options and explain them to patients. • Where will this shared decision making take place and with what professional, in what service setting? • How should clinicians make the classification of 'more severe' depression? What information will they need? BABCP suggest that any clinician having to assess depression needs adequate training and resources and that currently this level of training and resources is not widely available in primary care settings. Thus to make this available would require additional staff and resources to be allocated by commissioners. • How should clinicians make decisions about treatment options when their patient has co-morbid mental health problems? Is there a protocol they should follow? How would this influence the shared decision-making process? • It seems illogical to offer a combination of individual CBT and anti-depressant medication as the first option and individual CBT as the second option. A more logical order would offer the individual treatments first (medication or CBT), and then add on the second treatment based on monitoring the patient's response to treatment. • In addition to the lack of logic outlined above, current service delivery models would make this order unfeasible. GPs can offer anti-depressant medication, which will then be available immediately. However they would need to refer their patient to psychological therapy

				services for CBT, which would introduce a delay - thus individual CBT and medication cannot logically be offered at the same time. This recommendation is therefore not feasible in the NHS • BABCP suggest that behavioural couples therapy for depression is added to the evidence review and if appropriate added to the 'menu' of interventions.
67	Guideline	5	4-18	BABCP agree with the principles of care outlined here and welcome the specific observation that the symptoms of depression can interfere with access and participation in treatment. We also note that the guidelines suggest that treatment options are explored – this seems sensible but within the context of most clinical settings is unlikely to be feasible when so many treatment options have been recommended within this guideline. BABCP also question the assumption that primary care physicians or most mental health clinicians would understand and be able to explain, let alone explore, the full range of treatment options with patients. BABCP are also concerned that the costs of providing this level of support in primary care have not been costed and that they are likely to be unaffordable.
68	Guideline	6	7-14	BABCP agree that supporting individuals to develop advance decisions about treatment and care, and recording these in care plans would be helpful. However, it is not clear which professionals, or which providers would have capacity and resources to support this. BABCP do not think this is viable in most parts of England given current resources and service configurations. Again, this recommendation does not seem to have been costed and BABCP are concerned that it would require significant additional investment in primary care.
69	Guideline	6	20-24	BABCP welcome the recommendation to support adult carers of individuals with depression
70	Guideline	7	16-18	BABCP agree with the recommendation to use validated measures to assess depression. We would strongly prefer the committee to give specific recommendations on which measures to use in which settings, by what kind of professional, and with which different types of patients.

				It is essential that these measures are suitable for use by clinicians without specialist mental health training (e.g. GPs) and that all clinicians who use them have sufficient training to interpret the results correctly and feed these back to patients. The recommendation to use validated measures also requires that they are available in multiple languages, that they are cross culturally valid (and that this has been demonstrated empirically) and that professionals are able to read and explain the individual items to patients who have limited literacy or for whom a validated translated version is not available. BABCP is aware of many NHS settings in which self-report questionnaires are used insensitively, inappropriately, and incorrectly. Professionals who ask patients to complete self-report measures should have appropriate training in the administration and interpretation of such measures. Currently this is not part of core training for most primary care professionals or mental health professionals and thus would require extensive investment in CPD. Professionals who do not have this specialist training should only use and interpret the measures under supervision. Clinical psychologists are the only professional group for whom administration and interpretation of self-report measurement is a core competency. However 'psychology' is a 'shortage occupation' and therefore this staff group will not be able to provide adequate support.
71	Guideline	7	22-27	BABCP welcome support for individuals who have communication difficulties – including interpreters. This is essential if mental health services are to be truly accessible to all parts of the community. This recommendation will have significant resource implications. It will increase costs but is also likely to improve engagement and outcomes and thus to be economically neutral or positive.
72	Guideline	8	10-18	BABCP agree that a comprehensive assessment of depression is necessary and that (at a minimum) should include the factors outlined. In addition, BABCP suggest that protected characteristics including ethnicity, disability, history of trauma and gender and sexual orientation are essential components of any mental health assessment. However, BABCP note that elsewhere in the guidance it is suggested that initial sessions of some psychological interventions would normally be 30 minutes

				BABCP do not believe that it is possible to conduct a comprehensive and safe mental health assessment (as suggested here) in 30 minutes. Resources currently allocated to psychological therapy services (IAPT) would not permit this recommendation to be introduced fully unless new commissioning arrangements were in place that include additional resources to support comprehensive assessments. In NHS IAPT services PWPs routinely conduct initial assessments. As the stepped care model would not be possible if the recommendations were followed BABCP suggest that NICE clarify where in the care pathway a comprehensive assessment should take place and how and by whom it is conducted? BABCP suggest that GPs and other primary care staff have neither the time nor the specialist treatment to carry out a comprehensive assessment of depression. If GPs and primary care staff are to conduct comprehensive assessments of depression (and other mental health difficulties) this would require significant additional resources for training and additional staff. This recommendation therefore has significant implications for resources and is likely to increase the costs of NHS mental health treatments.
73	Guideline	10	14-20	BABCP agree that offering patients an informed choice of treatment is important.
74	Guideline	10	21-23	BABCP agree that 'adequate time' is needed to discuss treatment options, involve family members etc. Current commissioning arrangements would normally not include sufficient time as part of an initial assessment. This recommendation is likely to increase costs BABCP suggest that it is important to specify 'adequate time' so that commissioners take this into account when allocating resources.
75	Guideline	11	10	BABCP suggest that this be amended to read '….individual, couple or group….'
76	Guideline	12	19-25	BABCP welcome the recommendation that treatment is reviewed after 2 to 4 weeks and that possible side effects, and suicidal ideation are monitored. BABCP also suggest that NICE provide greater

				specificity about the frequency of monitoring so that this can be included in new commissioning contracts and adequately resourced. This recommendation is likely to increase the costs of treatments for depression.
77	Guideline	12	26-28	BABCP strongly endorse the recommendation that routine outcome measures are used to monitor progress, side effects and suicidal ideation throughout treatment and at follow up. Currently psychological therapy services (IAPT) are not commissioned to provide routine follow up sessions. This will increase costs and so this requirement (i.e. length of follow up) needs to be more clearly specified so that resources can be allocated in new contracts.
78	Guideline	13	6-7	BABCP agree that the form and length of psychological therapies for depression should be guided by treatment manuals. This is important to ensure fidelity and quality. To avoid delivery of treatments that do not have evidence of effectiveness and cost effectiveness we suggest that NICE indicate which treatment manuals should be used to guide treatments. BABCP note that this recommendation introduces an internal contradiction – subsequently (e.g. page 25) NICE recommend that individual CBT for less severe depression is 8 sessions. This length of treatment is not indicated by the majority of treatment manuals that guided the RCTs included in the evidence review. Furthermore in the evidence review, some psychological therapies e.g. individual CBT, were classified as lasting for more than, or fewer than 15 sessions, based on the manuals on which the therapies were delivered. BABCP therefore suggest that the rationale for the recommendations relating to length of treatments is made explicit.
79	Guideline	13	8-16	BABCP welcome the recommendation that therapists are trained and supervised using competence frameworks. It is essential that competence is monitored and evaluated and that supervision of psychotherapy includes reviewing audio or video recordings of treatment sessions.

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80	Guideline	14	11	BABCP welcome the recommendation that young people who are prescribed antidepressant medication be monitored after one week. We would add that they should also be monitored at 2 and 4 weeks, given that suicidal ideation may emerge or worsen over this duration. This would have resource implications and increase costs. BABCP also suggest that the wording be tightened to read '…or after 1 week if a new prescription for a person aged between 18 and 25 years old….' This is important because separate guidelines are available for under 18s and the expression 'young people' could be misinterpreted to refer to adolescents (rather than to only those aged over 18 years)
81	Guideline	18	6-7	BABCP suggest that it is important to modify the wording here to refer to '…people with depression who are aged 18 to 25 years old or are thought to be at increased risk of suicide:' This is because separate guidelines cover treatment of depressed young people under 18 years. All clinicians need to be reminded to use these guidelines when working with young people.
82	Guideline	18	15-17	BABCP suggest that the wording here could helpfully be made more specific – '…as often as needed….' is ambiguous. We suggest that young people aged 18 to 25 and those at increased risk of suicide are routinely reviewed at 1 week, 2 weeks and 4 weeks and that this age range is specified in the guidelines.
83	Guideline	19	7-9	BABCP suggest that the recommendation to consider comorbidities and possible interactions with other medications is unlikely to be within the competence of most GPs or primary care professionals. It would be helpful if NICE were more explicit about who should review multiple medications e.g. community pharmacists. Implementing this recommendation would therefore have required increased resources and may increase the overall costs of treating depression.

84	Guideline	22	20-21	In consulting our members, many of whom work as clinicians and/or service managers in IAPT services, we had many concerned comments about the lack of specificity of the term 'less severe depression'. For example, one member wrote, • "For context, I work in an overstretched, under-resourced IAPT service and I am concerned services might impose a "session cap" for those said to have "less severe depression" (for example scoring moderate on PHQ9) at initial assessment, when further formulation may reveal a more complex picture, or where maintaining processes lead patients to underscore initially and with further awareness more severity is apparent. " Evidence Review B suggests that the classification of 'less severe' and 'more severe' depression used in the evidence review was based on a cut off score on a range of different self-report measure of depression. Psychological therapy service leads and clinicians were strongly of the view that NICE should provide exact guidance on how to identify patients with 'less severe depression' and those with 'more severe depression'. BABCP therefore suggest the following issues need to be clarified: • IAPT services routinely use the PHQ-9 to assess and monitor depression – what cut off should be used? • Is this valid as a standalone measure or should other factors be included? • Should any contextual information be used to modify classification of 'more severe' and 'less severe' depression? • If so what contextual information? • How should patients who are not literate or who do not have access to the English language be assessed?

				In addition, BABCP recommend that the guidelines make explicit that no single score on a self-report measure is sufficient to classify patients as having 'less severe' and 'more severe' depression for the purposes of allocating resources for treatment.
85	Guideline	23	8	BABCP welcome the recommendation that individuals who present with depression are followed up 'with repeated attempts' it is important that adequate time is allocated and resourced. Introducing routine follow up after treatment is an important aspect of care and would require increased funding from commissioners.
86	Guideline	23	13-17	BABCP welcome the emphasis on patient choice and shared decision making. However, many of our members expressed concerns about the practicality of using Table 1 to guide discussions with patients. We were not able to identify any specific research to guide the number of choices available in shared decision making (SDM) but note that most evidence showing the benefits of SDM is based on patients being able to consider two or three options. The cognitive load of weighing the potential benefits, risks, and personal costs of 11 different treatment options seems likely to be excessive for most patients with depression, for whom working memory and decision making are typically impaired, see evidence outlined in: • Rock, et al, (2014). Cognitive impairment in depression: a systematic review and meta-analysis. *Psychological medicine*, *44*(10), 2029-2040. • Lee, et al., (2012). A meta-analysis of cognitive deficits in first-episode major depressive disorder. *Journal of affective disorders*, *140*(2), 113-124.) There was a consensus amongst BABCP members who commented that it would not be feasible to provide sufficient information and time to patients presenting with a new episode of depression to cover and adequately discuss the range of options outlined in Table 1 or Table 2. It is also not clear how this shared decision making would fit into the existing IAPT stepped care model or how

				commissioning models would be able to accommodate or make available the full range of therapies to all new patients. Most initial assessments and decisions about psychological treatments are currently made by clients in collaboration with low intensity workers in IAPT services (PWPs) as part of the stepped care model on which IAPT is based. The proposed guidelines are unclear about who would support patient choice or how this would be resourced. BABCP is of the view that well trained and supervised PWPs currently support shared decision making but that this range of treatments would present excessive demands on PWPs and patients, and could not be supported within routine primary care.
87	Guideline	23-30	Table 1, page 24	Group Cognitive Behavioural Therapy – BABCP members commented that it was unclear if this treatment was conceptualised as a low intensity or high intensity treatment. Currently group CBT (including psychoeducation) is typically provided as a low intensity treatment in IAPT services to large numbers of patients (i.e. 50-100+) in community settings. Group CBT is not normally delivered by High Intensity CBT therapists in IAPT services. However, Evidence Review B indicates that 'Group CBT' is a high intensity treatment delivered by the equivalent of Band 7 accredited CBT therapists. This is consistent with the recommendation that group size is 8 participants. To deliver this recommendation in NHS services would be extremely costly and difficult to implement. Group CBT is not currently taught on national curricula for CBT therapists and is not delivered by High Intensity therapists. To deliver Group CBT by High Intensity therapists as one of the first line treatments for 'less severe' depression would require massive expansion of High Intensity CBT therapists and significant additional investment in both training and service delivery. To ensure that evidence-based treatments are delivered correctly and safely by mental health services BABCP strongly advise that NICE clarify what is meant by 'therapy specific' practitioners (i.e. that

				they should be BABCP accredited CBT therapists). This is because the phrase 'therapy specific practitioners' could also apply to low intensity therapists. In addition, BABCP suggest that the specific therapy manuals that are effective and cost effective are named so that commissioners and services have clear expectations of the likely resources required. BABCP members also noted that the draft guidelines indicate that all group interventions '…may allow peer support from others who may be having similar experiences'. Whilst this may incidentally be true, the content and techniques used in group CBT do not expect or rely on 'peer support' and BABCP members were concerned that this phrase may imply that patients have a responsibility to support the well-being and mental health of other patients. This would not be helpful or desirable and may be experienced as a burden. We suggest therefore that this phrase be removed from the guidelines. BABCP members did suggest that group interventions may help patients recognise that their difficulties are shared and thus might reduce internal stigma and that this may be useful.
88	Guideline	24-25	Table 1,	Group Behavioural Activation – BABCP members commented that Group Behavioural Activation is not routinely offered in IAPT services. IAPT clinicians are not trained to deliver this treatment and thus most services could not currently provide this treatment. At present therefore this recommendation could not be delivered in most IAPT services. To provide this choice to patients would require additional resources for CPD for qualified therapists and amendments to the current national curriculum for IAPT trainees. To ensure that evidence-based treatments are delivered correctly and safely by mental health services BABCP strongly advise that NICE clarify what is meant by 'therapy specific' practitioners (i.e. that they should be BABCP accredited CBT therapists). This is because the phrase 'therapy specific practitioners' could also apply to low intensity therapists. In addition, BABCP suggest that the specific therapy manuals that are effective and cost effective are named so that commissioners and services have clear expectations of the likely resources required. It

				is also important to note that that the introduction of group Behavioural Activation for depression to IAPT services would require additional training and thus additional resources for CPD, as well as amendments to the current national curriculum for CBT trainees. BABCP members also noted that the draft guidelines indicate that all group interventions '….may allow peer support from others who may be having similar experiences'. Whilst this may incidentally be true, the content and techniques used in group Behavioural Activation do not expect or rely on 'peer support' and BABCP members were concerned that this phrase may imply that patients have a responsibility to support the well-being and mental health of other patients. This would not be helpful or desirable and may be experienced as a burden. We suggest therefore that this phrase be removed from the guidelines. BABCP members did suggest that group interventions may help patients recognise that their difficulties are shared and thus might reduce internal stigma and that this may be useful
89	Guideline	25-26	Table 1	Individual CBT – BABCP welcome the inclusion of individual CBT as a first line treatment for 'less severe' depression. However, the guidance on delivery of individual CBT did not appear to be based on the research evidence or the methods of Evidence Review B. Evidence Review B classified relevant research into individual CBT as 'more than' or 'fewer than' 15 sessions. Therefore the selection of 8 sessions as the 'dose' of individual CBT does not appear to be based on the evidence and the rationale for choosing this 'dose' was unclear. BABCP were concerned that this recommendation may lead to unhelpful 'rationing' of CBT therapy by commissioners and service managers. BABCP members noted that it would be helpful to be more specific about how commissioner sand service leads can ensure that clinicians have 'therapy specific training and competence'. As noted above it would also be helpful to specify the therapy models and treatment manuals that are effective and cost effective so that individual CBT is delivered safely and correctly.

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90	Guideline	25-26	Table 1	Individual BA: BABCP welcome and support the inclusion of Individual BA as a first line treatment for 'less severe' depression. However, the guidance on delivery of individual BA does not follow evidence-based treatment manuals. In addition the evidence review classified studies evaluating individual BA as 'more than' or 'less than'15 sessions…it is therefore unclear how a 'dose' of 8 sessions was selected as the appropriate 'dose' of individual BA. Individual BA for depression, delivered by High Intensity therapists currently involves 12-16 sessions of treatment. BABCP is therefore concerned that this recommendation for 8 sessions of individual BA may lead to unhelpful 'rationing' of BA therapy by commissioners and service managers. BABCP members noted that it would be helpful to be more specific about how commissioner and service leads can ensure that clinicians have 'therapy specific training and competence'. As noted above, it would also be helpful to specify the therapy models and treatment manuals that are effective and cost effective so that Individual CBT is delivered safely and correctly.
91	Guideline	26-27	Table 1	Self-help with support – Many BABCP members contacted us with specific concerns about multiple aspects of this recommendation. They noted that the evidence review focused almost entirely on computerised CBT (cCBT) and did not review many commonly used low intensity interventions delivered by PWPs in IAPT services. In addition, some of the computerised CBT programmes (reviewed e.g. Beating the Blues) are no longer used by IAPT services. Members also noted that much of the underpinning research was based on participants who do not reflect the diversity or range of patients who are referred to IAPT services and were conducted in contexts that do not generalise well to NHS mental health services. In research settings cCBT guided self-help sessions are typically brief, i.e. around 15 minutes long. However, BABCP members had very grave concerns about the recommendation that treatment sessions should typically last for 15 minutes. They pointed out that this would make it impossible to

				administer routine outcome measures, monitor risk, manage the therapeutic alliance, and support distressed patients with literacy, language, or other special needs. One member wrote • I worry that this will put patients in danger as you cannot explore risk, complete an intervention, review homework etc adequately in 15 minutes. Several members felt that the recommendations were not well informed by an understanding of the stepped care model or the role of PWPs. For example, • As a PWP of 12 years standing, I feel devalued by the suggestion that effective treatment sessions can be delivered in just 15 minutes. PWPs are typically high-achieving psychology graduates who undergo a rigorous 12-month Post Graduate Certificate while being employed in an IAPT service, and have more to offer than just checking in with a patient on the reading they are doing between sessions. A senior PWP said, • …..it is extremely concerning to note the recommendations made in the consultation and this suggests to me a lack of expertise in and/or understanding of the role of the PWP and the treatment they deliver And also • The PWP workforce has worked tirelessly to achieve integrity within the field of psychologies….The above consultation could very much undermine the value placed on what we do and in my opinion, result in a significant risk to the retention of the low intensity workforce. A service lead for an IAPT service also expressed many concerned about this recommendation, including

				• Only a few, very selective patients would be able to fit within 15-minute timeframe putting unnecessary pressure on other streams. BABCP members were also very concerned that the recommendations could not be implemented in a way that was consistent with services requirement to provide accessible services to a diverse population. cCBT and other online and printed materials rely on individuals who are able to read and understand English and who are computer literate. There is a real risk of increasing inequity if services use more computerised or written materials and fewer 'face to face 'low intensity interventions. BABCP members appreciated that the "….need to consider access and ability to engage with computer programmes' was highlighted in the recommendations but did not feel that this was sufficient to mitigate the risks of excluding vulnerable people from services. BABCP suggest that there is a real danger of excluding many people from psychological interventions if this recommendation is taken literally and implemented in psychological therapy services.
92	Guideline	26-27	Table 1	Group exercise – BABCP members were mystified about how this intervention would or could be delivered within existing mental health services. Group exercise for depression is not on the curriculum for any professional group employed within IAPT services and is not aligned with their current skills and competencies. Is the expectation that this intervention would be delivered in primary care? If so by which group? As currently described in the draft guidance this recommendation would present enormous logistical challenges to commissioners and service providers. It would not be possible to offer this as part of a 'menu' of interventions for 'less severe' depression in the NHS without significant investment in new training programmes, recruitment of new staff, and service redesign. Thus this recommendation has significant implications for resources and would potentially increase NHS training and delivery costs.

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93	Guideline	27	Table 1	Group mindfulness or meditation – The evidence review on which this recommendation is based evaluated studies of Mindfulness Based Cognitive Therapy and Mindfulness Based Stress Reduction. BABCP members therefore wanted to reiterate that the recommendation should be limited to these two methods. Training in Mindfulness Based Cognitive Therapy (MBCT) is currently available as CPD for CBT therapists working in NHS IAPT services. There was broad concern that the guidelines are written in a way that suggests other unrelated interventions (generic 'mindfulness' and 'meditation', as well as relaxation) are synonymous with MBCT One member observed, • Meditation typically refers to formal meditation practices; some of which are secular, and others are within religious or spiritual practices. Which can come from very different origins and basis. There are many types of meditation for instance: • Breath-awareness meditation (Tibetan, Zen, Tiantai and Theravada Buddhism) • Loving-kindness meditation (Many Buddhist Denominations) • Mantra-based meditation (Hinduism, Buddhism, Jainism, and Sikhism) • More secular practices Briefly looking at the evidence they refer to studies about the Mindfulness meditation group (n=38) and Meditation-relaxation group (n=13), but there isn't any specificity as to what they mean by these or the underlying frameworks. Currently the draft guidelines may be read to suggest that generic 'mindfulness groups' are recommended, which is likely to result in interventions that are not supported by evidence. BABCP also suggest that the recommendation related to trained practitioners is also strengthened and this link may be helpful Good Practice Guidelines for Teaching Mindfulness-Based Courses. https://bamba.org.uk/wp-content/uploads/2020/01/GPG-for-Teaching-Mindfulness-Based-Courses-BAMBA.pdf

				BABCP members wanted to draw attention to the potential adverse effects of mindfulness interventions – see the following for relevant research • Shapiro (1992) identified potential adverse effects including physical pain, disorientation, addiction to meditation, suicidal ideation and destructive behaviour • Shonin et al., (2014) review found mindfulness and other forms of meditation can induce psychotic episodes. Six studies (n = 12) reported that meditation-induced psychotic-like symptoms. However, although some patients had practiced mindfulness-based exercises, others had received training in other forms of meditation. • Lomas et al. (2015) although some positive outcomes were identified, 25% of the participants' narratives related to problems arising from their practice. More specifically, the qualitative analysis identified problems including troubling experiences of self, exacerbation of mental health issues and reality being challenged. However, the extent to which these findings can be generalised to other mindfulness practitioners is questionable because most participants belonged to the same meditation centre Another BABCP member noted in their comments • We were not aware of significant evidence for MBCT or equivalents for depression 9rather than relapse prevention). The text below from the evidence review (*copied below*) seems to suggest similar so we are not sure how this is included in the options and above IPT which was previously equal in NICE to CBT? *"Evidence from the NMA shows a clinically important but not statistically significant benefit of a mindfulness or meditation group intervention relative to TAU on depression symptomatology for adults with less severe depression (SMD -0.62, 95% CrI -1.77 to 8 0.35; 376 participants randomised to mindfulness/meditation group included in this NMA). Mindfulness/meditation group is outside the top-10 highest ranked interventions for clinical efficacy as measured by SMD of depression symptom change scores (mean rank 14.47, 11 95% CrI 4 to 28)"*

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94	Guideline	27-28	Table 1	Interpersonal psychotherapy (IPT) - BABCP members noted that it would be helpful to be more specific about how commissioner and service leads can ensure that clinicians have 'therapy specific training and competence' in IPT. As noted above, it would also be helpful to specify the therapy models and treatment manuals that are effective
95	Guideline	28-29	Table 1	Counselling - BABCP members noted that it would be helpful to be more specific about how commissioner and service leads can ensure that clinicians have 'therapy specific training and competence' in counselling. It would also be helpful to specify the specific models and treatment manuals that are effective – Can NICE please reference the 'empirically validated protocol developed specifically for depression' so that commissioners and service leads can ensure the appropriate treatments are offered.
96	Guideline	29-30	Table 1	Short term psychodynamic psychotherapy (STPP) - BABCP members noted that it would be helpful to be more specific about how commissioner and service leads can ensure that clinicians have 'therapy specific training and competence' in counselling. It would also be helpful to specify the specific models and treatment manuals that are effective – Can NICE please reference the 'empirically validated protocol developed specifically for depression' so that commissioners and service leads can ensure the appropriate treatments are offered.
97	Guideline	30	13-15	BABCP members, many of whom work as clinicians and/or service managers in IAPT services, made many concerned comments about the lack of specificity of the term 'more severe depression'. Evidence Review B suggests that this classification was based on a cut off score on a range of different self-report measure of depression. Psychological therapy services and clinicians were strongly of the view that NICE should provide exact guidance on how to identify patients with 'more severe depression' and those with 'less severe depression'.

				For example, IAPT services routinely use the PHQ-9 to assess and monitor depression – • What cut off should be used to distinguish the two groups of patients? • Is this valid as a stand-alone measure or should other factors be included? • Should any contextual information be used to modify classification of 'more severe' and 'less severe' depression. • If so what contextual information? • How should patients who are not literate or who do not have access to the English language be assessed?
98	Guideline	31	6	BABCP supports the principle of shared decision making (SDM) with patients – however Table 2 outlines 10 different options, which is too many for clinicians and patients to review and select. We were not able to identify specific research to guide the number of choices available in shared decision making (SDM) but note that most evidence showing the benefits of SDM is based on patients being able to consider two or three options. The cognitive load of weighing the potential benefits, risks, and personal costs of 10 different treatment options seems likely to be excessive for most patients with depression, for whom working memory and decision making are typically impaired • Rock, et al, (2014). Cognitive impairment in depression: a systematic review and meta-analysis. *Psychological medicine*, *44*(10), 2029-2040. • Lee, et al., (2012). A meta-analysis of cognitive deficits in first-episode major depressive disorder. *Journal of affective disorders*, *140*(2), 113-124.) There was a consensus amongst BABCP members that it would not be feasible to provide sufficient information and time to patients presenting with a new episode of 'more severe' depression to cover and adequately discuss the range of options outlined in Table 1 or Table 2. It is also not clear how this shared decision making would fit into the existing IAPT stepped care model or how commissioning models would be able to accommodate offering the full range of therapies to all new patients.

				Most initial assessments and decisions about psychological treatments are currently made by clients in collaboration with low intensity workers in IAPT services (PWPs) as part of the stepped care model on which IAPT is based. The proposed guidelines are unclear about who would support patient choice or how this would be resourced. BABCP is of the view that well trained and supervised PWPs currently support shared decision making but that this range of treatments would present excessive demands on PWPs and patients, and could not be delivered within routine NHS primary care or mental health primary care services (i.e. IAPT).
99	Guideline	31	Table 2	Combined individual CBT and antidepressant medication – BABCP welcome this recommendation, which follows its interpretation of the best evidence for effectiveness and cost-effectiveness. We agree that it combines the benefits of CBT sessions and medication. However, we do not think the comment 'Sessions with a therapist provide immediate support while the medication takes time to work' has any realistic chance of being delivered in that way. Across England waiting times for CBT therapy in NHS IAPT services exceed the period of time it takes for anti-depressant medication to take effect. Therefore this comment is only meaningful in a context where waiting lists for CBT do not exist – and that is a context that BABCP believes is not realistic

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100	Guideline	31	Table 2	Individual CBT – Many of the comments made in relation to Table 1 are also relevant here. BABCP welcome the inclusion of individual CBT as a first line treatment for 'more severe' depression. We also note the recommendation that the 'dose' of treatment is 12-16 sessions of 60 minutes each. However, the guidance on delivery of individual CBT did not appear to be based on the research evidence or the methods of Evidence Review B. Evidence Review B classified relevant research into individual CBT as 'more than' or 'fewer than' 15 sessions. Therefore the rationale for specifying 12-16 sessions as the 'dose' of individual CBT was unclear. BABCP members noted that it would be helpful to be more specific about how commissioner and service leads can ensure that clinicians have 'therapy specific training and competence'. As noted above it would also be helpful to specify the therapy models and treatment manuals that are effective and cost effective so that Individual CBT is delivered safely and correctly.
101	Guideline	32	Table 2	Individual BA– Many of the comments made in relation to Table 1 are also relevant here. BABCP welcome the inclusion of individual BA as a first line treatment for 'more severe' depression. We also note the recommendation that the 'dose' of treatment is 12-16 sessions of 60 minutes each. However, the guidance on delivery of individual BA did not appear to be based on the research evidence or the methods of Evidence Review B. Evidence Review B classified relevant research into individual BA as 'more than' or 'fewer than' 15 sessions. Therefore the rationale for specifying 12-16 sessions as the 'dose' of individual BA is unclear. BABCP members noted that it would be helpful to be more specific about how commissioners and service leads can ensure that clinicians have 'therapy specific training and competence'. As noted

				above it would also be helpful to specify the therapy models and treatment manuals that are effective and cost effective so that Individual BA is delivered safely and correctly.
102	Guideline	33	Table 2	Individual problem solving – although this was identified as a standalone therapy in the evidence review this mode of treatment is rarely delivered in the UK NHS mental health system. Problem solving therapy is therefore not currently included in the core curriculum for IAPT therapists. Unsurprisingly there is not a workforce who are trained to offer this therapy. In contrast 'problem solving' as a *technique* is a component of other interventions delivered as a low intensity therapy in IAPT services by PWPs. One BABCP member commented • Is Individual problem solving a new high intensity treatment or a low intensity treatment? The 30-minute sessions suggest the latter and sound like it is more a form of Guided Self Help so not sure why this is included separately? BABCP are concerned that the evidence reviewed by the NICE guidelines committee is not immediately generalisable to services in England and that 'problem solving therapy' is not currently available in NHS services. This draws attention to another concern of BABCP, which is that the evidence review did not take any account of the most directly relevant source of evidence for psychological therapies services in England, i.e. the IAPT database. BABCP appreciates that the IAPT dataset is not derived from a randomised controlled study. However, the IAPT data set is representative of all areas of England, all patients referred to IAPT (around 1.5 million per year) and reflects real life clinical practice and clinical outcomes much more readily than small RCTs conducted with selected populations, who are usually unrepresentative of the NHS population. The result of this omission and of the selection criteria used to identify relevant studies has resulted in NICE recommending a treatment that is not conducted in England, for which evidence is not directly relevant to England or the population of England ,and for which there is no national training

				programme and very few qualified therapists. BABCP does not believe that it would be possible to offer individual 'problem solving therapy' to individuals with 'more severe' depression. Further, given the relatively weak evidence supporting this intervention for 'more severe' depression BABCP also suggests that it would not be a good use of resources to develop a new national curriculum, establish new training programmes, and recruit and train additional therapists to deliver this therapy.
103	Guideline	33-34	Table 2	Counselling - BABCP members noted that it would be helpful to be more specific about how commissioner and service leads can ensure that clinicians delivering counselling for depression have 'therapy specific training and competence' in counselling. BABCP suggest that NICE please reference the 'empirically validated protocol developed specifically for depression' so that commissioners and service leads can ensure the appropriate treatments are offered.
104	Guideline	34-35	Table 2	Short term psychodynamic psychotherapy (STPP) and Interpersonal Therapy (IPT) - BABCP members noted that it would be helpful to be more specific about how commissioner and service leads can ensure that clinicians have 'therapy specific training and competence' in counselling. As noted above, it would also be helpful to specify the specific models and treatment manuals that are effective – BABCP suggest that NICE please reference the 'empirically validated protocol developed specifically for depression' so that commissioners and service leads can ensure the appropriate treatments are offered.
105	Guideline	35-36	Table 2	Self-help with support – BABCP members were very concerned that this low intensity treatment was recommended for people with 'more severe' depression.

				Of particular concern was the idea that severely depressed patients could be safely treated in 15-minute sessions delivered by a low intensity therapist (PWP) with limited training and experience in working with severely depressed people. BABCP suggest that 15-minute telephone or online sessions (which may not be synchronised) are inadequate to deal with the levels of risk and complexity likely to be presented by many patients in this category. BABCP are also very concerned that clinicians delivering self-help with support (i.e. PWPs in IAPT services) are not trained to work with severely depressed patients. Therefore all PWPs working in IAPT would require additional training and more intensive supervision to take on work of this complexity. We do not think that the increased costs of supervision have been included in the cost-effectiveness analysis. Working with 'more severely' depressed patients would also expose PWPs to more emotionally demanding work that might lead to increased burnout and staff turnover. This also has not been costed. In addition, the current curriculum for PWPs would require significant expansion which would be expensive and would take several years to be implemented by HEIs. In the view of BABCP this recommendation would be extremely difficult to implement. It could only be done safely if high intensity CBT therapists (who are trained to work with severely depressed patients) delivered guided self-help (which they are not trained to do). However, this would have the consequence of reducing availability of other recommended treatments and therefore increasing waiting lists. Given that this is an untested recommendation (given the RCTs included in the evidence review) BABCP consider that it would be highly dangerous to follow this recommendation. We note the comment made in the guideline - 'In more severe depression, the potential advantages of providing more intensive treatment should be carefully considered' (page 35/6) but in the view of BABCP this statement is far too weak to mitigate the risk.
106	Guideline	36	Table 2	Group exercise – As indicated in our comments relating to Table 1 of the draft guidance BABCP members were mystified about how this intervention would or could be delivered within existing mental health services.

				Group exercise for depression is not on the curriculum for any professional group employed within IAPT services and is not aligned with their current skills and competencies. Is the expectation that this intervention would be delivered in primary care? If so by which group? How would this be resourced and would the professional group have adequate experience and skills to work with patients who are severely depressed and at high risk of self-harm and suicide? As currently described in the draft guidance this recommendation would present enormous logistical challenges to commissioners and service providers. It would not be possible to offer this as part of a 'menu' of interventions for 'more severe' depression without significant investment in new training, recruitment and service redesign. BABCP strongly suggest that this recommendation is removed from the guidelines
107	Guideline	37	4-14	BABCP welcome the recommendation that Behavioural Couples therapy for depression is available to patients with depression. There are a cadre of qualified and experienced therapists who can deliver this in IAPT services and existing training programmes could be expanded to meet any increased demand for this treatment. BABCP note that evidence review B excluded a number of relevant studies of Behavioural Couples therapy and believe this was based on the incorrect assumption that is it only appropriate and effective for people who are in a distressed relationship; this is not the case • Barbato, A. & D'Avanzo, B. (2020). The findings of a Cochrane Meta-Analysis of couple therapy in adult depression: Implications for research and clinical practice. Family Process, 59 (2), 1-15.)
108	Guideline	37	5	There is compelling evidence that couple-based interventions for depression can be of benefit for patients who are not in a distressed relationship. For example, a recent meta-analysis found that the beneficial effect of couple therapy on symptoms of depression was not more pronounced in studies

				that used relationship distress as an inclusion criterion. This meta-analysis also found comparable moderate effect sizes on symptoms of depression for both individual and couple-based interventions. • Barbato, A. & D'Avanzo, B. (2020). The findings of a Cochrane Meta-Analysis of couple therapy in adult depression: Implications for research and clinical practice. Family Process, 59 (2), 1-15.
109	Guideline	38	2-5	BABCP welcomes the recommendation that treatment may be continued to prevent relapse and note that this should be based on the patient's clinical need and preferences. For this to be feasible commissioners will need to provide additional resources and revise existing contracts for psychological therapies services.
110	Guideline	41	8-11	BABCP strongly supports the recommendations that treatment is reviewed at 4 – 6 weeks and that further line treatments should be available if needed.
111	Guideline	42		BABCP welcome the recommendations on this page relating to further treatment options. For this recommendation to be feasible, contracts for primary mental health and psychological therapy services will need to be amended and additional resources will be required. Without additional resources to fund further treatment options they cannot be provided without referral to secondary care – which is often not possible because patients do not meet inclusion criteria and/ or there are very long waiting times before further treatments can be started.
112	Guideline	45	7-18	BABCP agree that patients with chronic depression should be offered a choice of treatment and that a shared decision about treatment should be reached, based on their clinical needs and preferences.
113	Guideline	46	17-25	BABCP also agree that for patients with chronic depression psychosocial interventions such as befriending and rehabilitation may be helpful. These may improve the patient's quality of life even if they do not address symptoms of depression directly.
114	Guideline	47	11-15	This paragraph refers to 'people with depression and a diagnosis of personality disorder…'. BABCP consider that this is too broad a description to be useful and that being more specific about the type of

				personality disorder would be helpful. Para 1.11.3 implies that the recommendation should be specifically addressed to individuals with depression and **borderline** personality disorder
115	Guideline	48	9-14	BABCP agrees that people with depression and psychotic symptoms should be assessed by a specialist team and would welcome further specificity about how referral pathways to specialist services be resourced. In the experience of our members referrals from IAPT to specialist mental health services often involves lengthy delays and waiting times. We also agree that individuals who have depression with psychotic symptoms should have access to psychological and pharmacological treatments.
116	Guideline	51-52	20-21	BABCP agree that improving access to NHS services is a priority. IAPT services currently operate using a stepped care model, where approximately two thirds of patients referred are treated by low intensity therapists i.e. PWPs (step 2) and one third of patients are treated by high intensity therapists e.g. CBT therapists (step 3). This model means that effectiveness and cost effectiveness, as well as prompt access to treatment are maximised. IAPT has also created a detailed, comprehensive and national database of outcomes which is provided on an open access basis to researchers. BABCP is extremely concerned that the implementation of the NICE recommended treatments for 'less severe' and 'more severe' depression is incompatible with the delivery of a stepped care model. Currently patients with 'less severe' depression normally be treated by PWPs using a range of low intensity treatments, and most are discharged. A minority of 'less severe' depressed patients are offered Counselling for Depression. People who do not respond to low intensity treatment, or who present with severe, complex, and/or co-morbid depression are offered a high intensity treatment for depression (i.e. individual CBT, individual BA, Cognitive Behavioural Couples therapy, IPT). The current draft guidelines suggest that patients who have 'less severe' depression are offered a menu of treatment, starting with Group CBT and Group BA (both not currently offered as described

				in the guidelines), followed by individual CBT and individual BA. Based on your evidence review these are high intensity treatments for which a qualified CBT therapist would be needed. IAPT services could not meet this demand for high intensity therapy and the inevitable result would be an explosion in waiting times and a decrease in availability of treatment. In marked contrast, PWPs who make up the majority of the IAPT workforce would be under used and many would need to be made redundant, or if eligible, to be retrained as high intensity therapists. This would involve a massive investment in training places, training programmes, and supervision and would take many years. In the meantime the impact on PWPs would be very negative as the crucial role that they play in IAPT services would be undermined and undervalued. On a related point, the criteria for inclusion of RCTs in your evidence review resulted in the exclusion of the NIHR funded COBRA study of Behavioural Activation, which is highly relevant to the delivery of treatment for depression in IAPT. Importantly, the COBRA trial demonstrated that PWPs with additional training and supervision, were able to deliver the full BA protocol (based on Martell et al.) safely and effectively. BA delivered by PWPs was more effective and cost effective than CBT delivered by High Intensity CBT therapists. This important data has not influenced the guidelines despite being directly generalisable to the IAPT services in England and providing high quality data that translates directly to delivery.
117	Guideline	52	1-15	BABCP agree with these points.
118	Guideline	53	12-16	BABCP strongly welcome this point about making services accessible and culturally adapted. We would also suggest that routine outcome measures and digital and written therapy resources also need to be translated and that the cross-cultural validity of all measures are assessed. Likewise we recommend that this paragraph is extended to include the use of trained interpreters (not family members or informal interpreters from the community).
119	Guideline	53 54	20-31 1-3	BABCP endorses this essential list of ways to increase access to communities and groups who are under-represented in mental health services.

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120	Guideline	54	4-19	BABCP also welcome this identification of groups whose needs may be relatively unmet in mental health services but suggest that commissioners and service leads should be asked to monitor access across all parts of the community they serve, report this publicly and be required to take actions to increase access.
121	Guideline	54-55	21-25 1-11	Collaborative care – Evidence review A showed that most research on service delivery has focused on collaborative care and that there were fewer studies focused on the stepped care model. BABCP agree that the collaborative care model may be particularly useful for vulnerable groups such as those identified here. However, BABCP are extremely concerned about the implications of the draft guidance on current service delivery via IAPT services. IAPT services are delivered using a stepped care model and there is extensive data demonstrating that this provides effective and cost-effective treatment. As noted above, however, the recommendations contained in these draft guidelines are incompatible with a stepped care model. To implement the draft guidelines would require complete service redesign for IAPT with associated costs and risks. In the view of BABCP the quality of the evidence included in 'Evidence Review B' was inadequate to justify such a service redesign. To implement the draft guidelines would require extensive investment in recruiting and training new high intensity therapists (CBT, IPT, STPP, BA) and redeployment of many PWPs as most of the interventions they deliver were not covered by the evidence review. There would also be a highly negative impact on waiting times, access to treatments, staff morale, and costs.
122	Guideline	55	16-18	BABCP welcome the recommendation that multi-disciplinary specialist care services are available to those with more severe or chronic depression.
123	Guideline	56	3-4	The reference to 24-hour support services is important and welcomed by BABCP. Currently this support is often only available via Accident and Emergency services.

				BABCP would welcome expansion of specialist mental health support to manage crises and 24-hour care.
124	Guideline	57	8-11	The recommendation that psychological therapies are available for patients in inpatient settings is strongly supported by BABCP.
125	Guideline	57	14-16	BABCP agree that interventions for inpatients should be continued once patients are discharged. Where these interventions are psychological continuing treatment should ideally be provided by the same therapist in the in-patient and out-patient setting. Where this is not possible, treatment should be co-ordinated via appropriate handover.
126	Guideline	59	3-4	BABCP recommend that NICE provide clear, evidence-based criteria for clinicians and clinical services to identify and assess 'less severe' depression
127	Guideline	59	10-11	BABCP recommend that NICE provide clear, evidence-based criteria for clinicians and clinical servicse to identify and assess less severe depression
128	Guideline	61	11-13	BABCP welcome the identification of key research questions outlined; we particularly welcome the research question about increasing access to people with depression who are under-served and under-represented in current services
129	Guideline	62	7-8	BABCP agree that identifying the mechanisms of action of effective psychological treatments for acute episodes of depression in adults is a priority for research.
130	Guideline	64	6-10	Informed choice is an important pillar of effective collaborative treatment and BABCP strongly support this principle of care. We agree also that offering meaningful choice is likely to mean longer consultation times and thus increased resources will be needed. BABCP suggest that to make this choice meaningful and informed, clinicians working with individuals with depression are likely to need additional training so that they are properly informed about the range of evidence-based treatments, how they are delivered, potential adverse effects, and

				the demands and expectations on clients. This will have a resource impact on the NHS, but may lead to better outcomes and thus offset additional costs of training.	
131	Guideline	66	8-9	Based on evidence review B, Group CBT and group BA were found to be cost effective for adults with less severe depression. BABCP are concerned that the evidence reviewed was limited in number, excluded key studies, (e.g. the COBRA study of individual BA), largely of low quality, lacked relevance to the NHS in England, did not report patient preferences, adherence or attrition, or the additional costs and complexities of organising and delivering group based psychological therapies. In addition the cost-effectiveness analysis was based on delivering 8 sessions of therapy, whereas the evidence review classified therapy as fewer than 15 sessions or 15 or more sessions. Group BA and Group CBT would also not be aligned with the stepped care model of IAPT as they are delivered by High Intensity therapists (not PWPs). Therefore BABCP do not agree with the view of the NICE committee that Group CBT and Group BA should be prioritised as first line treatments for 'less severe' depression. In addition, group CBT and group BA are not widely available in IAPT services and clinicians are not trained in these modes of delivery. Introducing these two treatments into IAPT services would constitute a huge upheaval would require extensive retraining of staff, and may increase drop-out, costs and reduce recovery rates.	
132	Guideline	69	15	This section of the guideline refers to 'some very limited evidence for the effectiveness of behavioural couples therapy for people with depression and who had problems in their relationship'. It is certainly the case that evaluating the efficacy and effectiveness of couple-based interventions for depression is fraught with methodological complications. However, there are some studies that should be taken into account in addition to the sole study that was considered in the development of these guidelines, e.g.: • Baucom, D., Fischer, M., Worrell, M., Corrie, S., Belus, J., Molyva, E. and Boeding, S. (2018) Couple-based intervention for depression: an effectiveness study in the national health service in England. Family Process, 57: 275–92	5

				• Bodenman, G. et al. (2008). Effects of coping-oriented couple therapy on depression: a randomised controlled trial. Journal of Consulting and Clinical Psychology, 76, 944-954. Furthermore, couple-based interventions for depression are also effective for people who are in a non-distressed relationship, see • Barbato, A. & D'Avanzo, B. (2020). The findings of a Cochrane Meta-Analysis of couple therapy in adult depression: Implications for research and clinical practice. Family Process, 59 (2), 1-15).	
133	Equality Impact Assessment	2	3.2 Point 4	BABCP welcome the recognition that online, text based, and remote consultations can increase access but may not be suitable for some people. The statement 'The committee made clear in their recommendations that alternatives such as face to face consultations must be available too' is welcome. However BABCP suggest that the guidelines are reworded so that this recommendation is much clearer and stronger.	
134	Supplement B1	Excluded studies page		A number of couple therapy outcome studies were excluded for questionable reasons and should be reconsidered. For example, Bodenman (2008) was excluded as 25% participants had dysthymia. However, the mean BDI score of participants at the start of therapy was 24-26 (in the moderate range for depression). The Leff (2000) study was excluded because of the high drop-out rate in the medication arm of treatment (56.8%). However, the drop-out rate in the couple therapy condition was only 15% and the patients in this group showed significant improvements on the BDI post-treatment and at follow-up. This suggests couple therapy is an effective treatment for depression, and furthermore that it is more acceptable than medication.	

Insert extra rows as needed

Consultation on draft guideline – deadline for comments 5pm, 12 January 2022 email: DepressionInAdultsUpdate@nice.org.uk

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