**Depression in adults: treatment and management**

NICE National Institute for Health and Care Excellence

**Consultation on draft guideline – deadline for comments 5pm on 12 June 2018 email: DepressionInAdultsUpdate@nice.org.uk**

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| | Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly.<br><br>We would like to hear your views on the draft recommendations presented in the short version and any comments you may have on the evidence presented in the full version. We would also welcome views on the Equality Impact Assessment.<br><br>We would like to hear your views on these questions:<br>1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why.<br>2. Would implementation of any of the draft recommendations have significant cost implications?<br>3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.)<br><br>See section 3.9 of Developing NICE guidance: how to get involved for suggestions of general points to think about when commenting. |

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| **Organisation name – Stakeholder or respondent** (if you are responding as an individual rather than a registered stakeholder please leave blank): | British Association for Counselling and Psychotherapy |
| **Disclosure**<br>Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry. | N/A |
| **Name of commentator person completing form:** | Dr Hadyn Williams, Chief Executive |
| **Type** | [office use only] |

| **Comment number** | **Document** (**full** version, | **Page number** Or | **Line number** Or | **Comments** |
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| | **short** version or the **appendices** | **'general'** for comments on the whole document | **'general'** for comments on the whole document | Insert each comment in a new row.<br>Do not paste other tables into this table, because your comments could get lost – type directly into this table. |
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| Example 1 | Full | 16 | 45 | We are concerned that this recommendation may imply that …….. |
| Example 2 | Full | 16 | 45 | Question 1: This recommendation will be a challenging change in practice because …… |
| Example 3 | Full | 16 | 45 | Question 3: Our trust has had experience of implementing this approach and would be willing to submit its experiences to the NICE shared learning database. Contact……. |
| 1 | Full | General | General | **Context of response:** BACP have prepared this response to the exceptional 2018 second consultation on the revised *Guideline for Depression in Adults: Treatment and Management*, in our role as a professional body for UK counsellors and psychotherapists. As the largest British professional body for those providing psychological therapies and as laid out in our mission statement (https://www.bacp.co.uk/about_bacp/) we aim to campaign for the highest standards of care for those experiencing depression. Moreover, our responsibility to both our members and the British public means that we campaign for a range of treatments to be available through the NHS for those with depression. This commitment reflects the considerable evidence of broad equivalence between therapies for depression (Gyani, Shafran, Layard & Clark, 2013; Pybis, Saxon, Hill, & Barkham, 2017; Stiles, Barkham, Twigg, Mellor- Clark, & Cooper, 2006; Stiles, Barkham, Mellor-Clark, & Connell, 2008) but also the evidence that it is important to give clients choice about treatment options because doing so improve treatment outcomes (Lindhiem, Bennett, Trentacosta, & McLear, 2014; Williams et al., 2016).<br><br>It is important to note that this means that BACP has a commitment to support choice for all evidence-based therapies and as such welcomes the recommendations in the draft Guideline for the three main modalities practiced in the UK, namely Cognitive Behavioural Therapy (CBT), Psychodynamic Psychotherapy, and what is termed in the Guideline 'Counselling'. This second consultation response however focusses predominantly on counselling. |
| 2 | Full | General | General | **Preparation of this response:** This document was prepared by members of the BACP Research Department and draws on feedback on the draft Guideline from senior counselling and psychotherapy academic researchers in the UK and beyond. The document also draws on further review by an academic team independent of both NICE and BACP that was specifically commissioned by BACP to review the revised network meta-analysis that informed the |

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| | | | | revised Guideline. |
| 3 | Full | General | General | **Length of consultation period:** We welcome the provision of an exceptional 2nd consultation period however we wish to state again our view that the time provided for making a response is insufficient to allow a proper scrutiny of the documents given their length (over 800 pages for the main report, over 800 pages for the response to the consultations plus hundreds of further pages in the appendices) and the great complexity of the analyses conducted.<br><br>We suggest that the limited time for document review undercuts the very purpose of the consultation, which is to allow NICE to benefit from robust stakeholder feedback. We would recommend that the length of a consultation period should not be standardised but flexible to accommodate for documents of great length/analytic complexity as well as in contexts where the outcomes have huge import for the population, as in the case of this guideline on depression. |
| 4 | Full | General | General | **Insufficient consideration of potential negative workforce impacts:** The issue of appropriate time to respond to NICE consultations is particularly key in contexts where the guideline may have negative impacts on segments of the workforce. BACP maintains in the strongest possible terms that detailed scrutiny of not only the evidence but the methods utilised is critical because historically the NICE Guideline for depression in adults has been significantly influential in shaping service delivery, in particular in England. As described by Clark (2011), the NICE recommendations for depression from 2004 onwards contributed to the development and roll-out of the Improving Access to Psychological Therapies (IAPT) programme, which in England and Wales now provides the bulk of treatment for depression in primary care (Gyani, Pumphrey, Parker, Shafran, & Rose, 2012). Indeed NICE's response to stakeholder feedback includes the statement: "The IAPT programme has been central to the implementation of NICE recommendations on treatment of depression" (p170 of the consultation comments and responses document). As we stated previously, a key impact has been in terms of workforce makeup and numbers overall.<br><br>In BACP's previous consultation response we pointed out the significant negative impact prior NICE guidelines have had on the counselling workforce as result of counselling being recommended as a second-tier treatment. The response to the point made by NICE was: "As you point out there has been significant expansion in IAPT workforces, and a significant number of counsellors will be employed in that service" (p170, NICE comments and responses document). **This response constitutes a wholly dismissive response the concerns that BACP is raising** about the |

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| | | | | potential negative impact of the NICE guideline on one sector of the mental health workforce.<br><br>These concerns rightfully require that BACP raise concerns over the limited time available to respond; in our view the lack of time to provide a very detailed response means that NICE has failed to facilitate a rigorous response to the consultation and in doing so has not acted in the best interests of the public. |
| 5 | Full | General | General | ***Failure to include large standardised routine datasets:*** The existing analysis still privileges RCT evidence and fails to consider evidence arising from the IAPT dataset, a routine outcomes dataset which shows how those with depression fare in response to NHS primary care treatment. Note that this is not an argument to abandon RCT/NMA analyses but to consider their results alongside those from relevant routine outcome datasets. As NICE state in their stakeholder responses: "The IAPT programme has been central to the implementation of NICE recommendations on treatment for depression" (p170 of consultation comments and responses document).<br><br>The aim of the NICE guideline is to improve treatment of depression in NHS primary care and the IAPT database provides the key (and only) evidence of how actual NHS patients with depression have responded to the treatment recommendations of the 2009 NICE depression guideline, in other words how NICE recommendations work in clinical reality. To ignore this hugely pertinent data is thus extraordinary. Further while the key analysis used to derive the recommendations of this guideline, the NMA, consists of a sample of "several thousand" (p117, of consultation comments and responses document) this dataset comprises over half a million per year. The idea that the guideline committee members' understanding of "the 'reality' for people experiencing depression" (p116, of consultation comments and responses document) can substitute for the evidence from millions of actual NHS patients is absurd and, the fact that this is considered justification to ignore this practice-based evidence, illustrates **the failure to consider in any serious way this point raised by BACP**.<br><br>Similarly, the justification given to ignore these datasets that: "we cannot be sure that the populations treated with various interventions are the same and to assume so would be potentially misleading" (p117, of consultation comments and responses document) is also unconvincing; it is clearly very important to establish how the populations treated in the NHS respond to NICE recommended treatments and the use in IAPT of the PHQ-9 (one of the instruments in the NMA analyses conducted) provides a useful point of read-across to consider diagnostic equivalence with the populations considered in the NMAs. The IAPT dataset also allows consideration of whether |

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| | | | | different care pathways do, as claimed in the NICE stakeholder response, provide evidence for the idea that IAPT populations are different: "For example a large proportion of people receiving CBT for depression have been "stepped up" from a low intensity intervention. In contrast a large proportion of people receive counselling as their first line intervention" (p251, of consultation comments and responses document). In contrast to this statement, the most recent IAPT annual report, *Psychological Therapies Annual Report on the Use of IAPT Services, further analyses on 2016-2017,* (NHS Digital, 2018) evidences that there is not a big difference between counselling and CBT in terms of pathway, with 41% of 'Counselling for depression' clients and 36% of CBT clients receiving these respective therapies as their first and last intervention (Table 4c); in other words the most recent publicly available data suggests similar care pathways.<br><br>Overall the arguments made to ignore this critical source of data on NHS primary care mental health treatment are not convincing. This is troubling since evidence from the IAPT dataset is that counselling is as effective as CBT as an intervention for depression (Barkham et al, 2017). Existing evidence from IAPT annual reports (NHS Digital, 2014, 2015, 2016) demonstrates that patient recovery rates have been virtually equivalent between CBT and counselling (Barkham et al., 2017). Research on different portions of the IAPT dataset in relation to the treatment of depression have reported comparable outcomes between CBT and counselling (Gyani et al, 2013; Pybis et al, 2017). Given this, it is our view that IAPT data now needs to be considered alongside evidence from trials to form a more complete and accurate assessment of the comparative effectiveness of psychological therapies. |
| 6 | Full | 15-16; 51 | General | ***Guideline Committee membership:*** In our last response we raised an issue about the checks carried out on the committee members to ensure that as a committee they represented (overall) an unbiased group. Given the reliance in the production of these guidelines on the views of the Guideline Committee this is critical. We previously outlined our concerns about the failure to (apparently) consider or provide information on the specific professional allegiances of the members of the guideline group, such as which therapies and interventions they have been trained in, or which they research, train others in, and currently use/ recommend to patients. We note that some of this information might be inferred from the Declaration of Interests in Appendix B of the Guideline and – from what can be gleaned – the committee membership included a number of members with probable allegiance to CBT, BA and MBCT; potentially two members with allegiance to psychodynamic models and no members with allegiances to counselling. The apparent evidence thus is that the membership of the committee may not have been neutral in this crucial area of allegiance to therapy models. **The failure to consider this source of bias in the committee is deeply problematic** given the fact that 'researcher allegiance' to therapy models is a known and significant biasing factor in |

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| | | | | psychotherapy research (Munder, Brutsch, Leonhart, Gerger & Barth, 2013) and potentially in the context of Guideline recommendations. |
| 7 | Full | 50; 70-85 | General | ***Consideration of service user voice in revised Guideline:*** We noted in our last response that the section on the patient user experience in the 2009 Guideline had not been updated which means that by release this section will be over a decade old. While there was some inclusion of service user voices in the process of the guideline development this is not any substitute for seriously considering the considerable and growing literature on how those with depression experience treatment for depression. As such we maintain that the current revised guideline has failed to sufficiently consider service user voices, in contradiction with both NICE and NHS mandates in this regard. **This remains hugely problematic and significantly undercuts confidence in the recommendations**. It is also contrary to both NHS and NICE policies around prioritising the service user voice. |
| 8 | Full | General | General | **Approach to consideration of NMA analyses in Revised Guideline:** The following sections focus on the issues of concern in the network meta-analyses as this analysis was the key evidence the Guideline Committee used to draw up their recommendations. While not the focus of this stakeholder response, it is acknowledged that the NMAs conducted had many strengths, including: the attempt of limiting clinical heterogeneity by stratifying the population, the careful statistical modelling, the use of multiple outcomes, the conduct of several sensitivity and moderator analyses, and the careful interpretation of the statistical results. |
| 9 | Full | 52-59; 215-218 | General | ***Selection of studies for inclusion:*** In summary BACP is expressing concern about this foundational aspect of the NMAs.<br><br>**Lack of clarity about included studies** - As in our prior consultation response, we remain concerned about the fact that it is still very difficult to understand which studies have been included in the various analyses conducted. The implication of the lack of clarity about the included studies is that a core process in the NICE analysis is not transparent and not thus amenable to review.<br><br>**Confidence that the review of the literature was systematic and comprehensive** – BACP acknowledges inclusion of 15 new RCTs in the NMA analysis as a result of BACP bringing them to the attention of NICE (p2 of consultation comments and responses document). However as stated in our prior consultation response the limited consultation time given the significant length of the documentation (main report plus all appendices) and the great complexity of the analyses run, made it impossible for BACP to do more than a cursory search for additional literature. The fact |

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| | | | | that even so we were able to locate considerable relevant missing literature does not allow us to feel confident that NICE has engaged in a comprehensive and systematic search of the relevant literature as it pertains to counselling and the treatment of depression. Our confidence is further undermined by the various errors in recording of studies/reference lists as detailed in the NICE response to the BACP consultation responses (p4 of consultation comments and responses document). A lack of confidence in the literature review which identified the relevant research for the NMA and other analyses obviously makes it difficult to have confidence in the findings.<br><br>**Confidence that the included literature is up-to-date** – No studies published after June 2016 (p126 of consultation comments and responses document) have been included in the analysis which means that by the time this guideline is published (potentially end of 2018) the literature review will be over two years out of date. This is also problematic. |
| 10 | Full | 56-59; 281-284 | General | ***Insufficient consideration of bias:*** BACP notes the various efforts to manage risk of bias but remains unconvinced that these were appropriate.<br><br>**Failure to use GRADE system developed for NMA:** We made an important point about this in our last consultation response. **No response to this feedback has been given. In our view this is a serious omission that has implications for being able to be confident in the overall analysis**. In our last consultation response we noted that the Guideline authors did not use the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system for rating the quality of evidence and we identified systems that were, "because GRADE was not developed with network meta-analysis in mind" (Section 7.4 and 7.5). Although it is true, at least two GRADE-based evaluation systems are available for network-meta-analysis (Salanti et al., 2014; Puhan et al., 2014). It is acknowledged that these systems are recent yet although the Guideline authors address important GRADE-related issues while rating the quality of evidence, the assessment of quality of evidence conducted falls short of what is required by the two referenced systems, particularly with regard to the assessment of direct and indirect evidence (along with their methodological quality) for each effect estimate as well as regarding ranking treatments.<br><br>**Researcher allegiance:** In our last consultation response we raised concerns about the failure to systematically consider this issue. We had previously argued that it is critical to assess researcher allegiance (RA) in psychotherapy research because this form of bias has been found to considerably impact the result of apparently 'neutral' trials |

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| | | | | (Munder, Brutsch, Leonhart, Gerger & Barth, 2013). Failure to assess RA thus makes it highly likely that the findings of the NMA analyses are inaccurate.<br><br>RA was not assessed by the Guideline developers because, according to the consultation responses and comments document (p412), RA was not captured by Cochrane risk of bias tool used to assess studies. The importance of RA is then dismissed with the statement: "In head-to-head trials, one might assume, that this bias would balance out as the researchers for 1 study could be committed to 1 type of treatment whereas researchers of another study could show reverse allegiance, and thus across studies the positive and negative sources of bias should balance" (ibid). The idea of researcher allegiance "balancing out" in head-to-head trials is a very strong assumption, without any empirical or theoretical rationale. This might be true if the number/N of studies in each treatment class were equal however this is patently not the case in the studies that are included in the NICE analyses; this means that the impact of RA on the analyses was likely considerable. This is problematic as shown by the previously cited meta-meta-anlaysis of RA in psychotherapy trials; RA is also problematic outside this domain, as shown by findings suggesting that head-to-head trials are frequently industry sponsored and their findings mostly favour the sponsor (Flacco et al., 2015). There is currently no easily applicable method to deal with this issue on the scale of the network meta-analyses that were performed in the Revised Guideline, but it would have deserved a more intensive discussion, particularly as RA has been both assessed in a number of meta-analytic reviews of depression and found to significantly impact findings (e.g. Cuijpers, 2016). **Overall the dismissal of the importance of RA as a source of bias is both unconvincing and worrying**.<br><br>**Failure to conduct bias-adjusted analysis:** Bias adjustment models were fitted to adjust for small-study bias, considered a proxy for publication bias by the Revised Guideline authors (7.3.6). Although the authors should be acknowledged for these analyses, other methods (e.g., a more intensive search for studies, including unpublished ones) may have limited publication bias even more effectively. Adjusting for methodological quality (risk of bias) domains in individual trials was not considered, although could have been performed rather easily. The justification for not performing a bias-adjusted analysis using domains of the risk of bias assessment (NICE consultation comments and responses document, p412) is thus not convincing. Based on the findings regarding risk of bias (7.4.1, 7.4.5), there was considerable spread regarding quality ratings of the single domains. Using these domain ratings (as recommended, instead of using a "global study quality" judgment; Juni, Altman & Egger, 2001)) would have been feasible and would have allowed for a more thorough consideration of risk of bias. Although, as stated, the small |

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| | | | | study adjustment is likely to have compensated for some of the methodological factors, it is unnecessarily simplistic.<br><br>**In general, risk of bias within and across the primary studies was sub-optimally addressed in the analyses reported in the Revised Guideline. Erroneous conclusions due to risk of bias in the primary studies (crudely addressed through the small study adjustment), researcher allegiance (unaddressed), and publication bias (very crudely accounted for through the small study adjustment but not seriously addressed through intensively searching for unpublished studies, see 3.5) cannot be excluded.** |
| 11 | Full | 218 | General | ***Homogeneity of study population:*** Combining studies on pharmacotherapy, psychotherapy, and (computerized) self-help interventions can be seen as problematic in terms of assumptions about the homogeneity of the study population. Populations in these studies are likely to be different with regard to characteristics that are not or only weakly correlated with treatment severity, jeopardizing the transitivity assumption behind the performed network meta-analyses. Although the Revised Guideline authors discuss this issue at several points (e.g., 7.4.1), in absence of an empirical investigation of the distribution of possible effect moderators across these trials, their arguments remain somewhat speculative.<br>**In summary, the failure to more properly investigate the population homogeneity or to consider running NMAs for psychotherapy versus pharmacotherapy separately casts doubt on the findings of the NMAs run since a central assumption of network meta-analysis is that the populations investigated in a network are clinically homogeneous.** |
| 12 | Full | 206-210 | General | **Classification of interventions**<br>***Clinical heterogeneity of interventions:*** As BACP noted in our last consultation response, the decision how to define interventions and interventions classes remains immanently subjective (Kriston, 2013). As Linde et al. (2015a) state: "Because psychological treatments are considered complex interventions, grouping them can be performed along several dimensions and remains controversial" [see also Craig et al, 2008]. The fact that the decision on the classification of interventions was informed by expertise and previous work is encouraging. However, this decision is and cannot be a purely scientific one (even if different scientists group the interventions similarly across reviews). The grouping of (more or less complex) interventions in mental health care is rarely unequivocal and is based on some assumptions regarding modes of action and active components that are unlikely to be shared by every recipient. Similarly to the definition of interventions, the definition of classes can also be debated; especially for |

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| | | | | psychological interventions (particularly self-help and computerized treatments), for which no generally accepted classification exists.<br><br>It might be considered somewhat confusing that similarity of mechanisms of action was used to justify the definition of treatments and grouping them into classes (7.3.3), but at the same time the Revised Guideline authors recommend further research exactly on these mechanisms of action in psychological treatments (7.8.1). Thus, definition and grouping of psychological treatments should be considered preliminary.<br><br>**Treatment as usual** - Section 7.3.3 states that "it was agreed that the treatment effect of an intervention added onto TAU should mainly be attributed to the active intervention, in particular if TAU comprises 'basic' care and support. For this reason, active interventions added onto TAU were treated as variations of the active intervention and formed different interventions within the active intervention's class", which can be considered a reasonable form of dealing with interventions provided with or without TAU. Unfortunately, the results reported in Section 7.4 and 7.5 do not inform on interventions added to TAU (detailed results are to find in the Appendices). As the decision whether an intervention should be added to TAU or replace it may be a clinically important one, addressing this issue in the main document would be desirable.<br><br>**In summary, the NMA utilises categorisation of the included studies into classes but the judgement about class membership is necessarily subjective; it is thus entirely possible that different groupings would have resulted in different findings from the NMA.** |
| 13 | Full | 210 | General | **Outcome variables**<br><br>***Development of a hierarchy of depression scales:*** In our prior response we pointed out one example of where there has been insufficient time to allow for proper scrutiny would be section 7.3.4, p210-211 of the draft Guideline, which refers to the development of a "hierarchy of depression scales" "based on GC expert advice"; this hierarchy led to the inclusion in the network meta-analysis of data related to some scales but not others. No information is given in the documentation about either the rationale for the prioritising of some instruments over others or the impact of data 'lost' from the analyses; it is possible that the impact of these decisions on the findings of the analyses was considerable. **In the consultation response from NICE this point has not been addressed** which means |

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| | | | | both that no rationale has been provided for the choices made by the GC (Guideline Committee) and it is still entirely unclear what impact the preferential ranking of instruments had on the analysis.<br><br>***Issues with SMD outcome and response variables may have biased results*:** Standardised mean difference of change from baseline scores, response, and remission were used as efficacy outcomes in the network meta-analyses (7.3.4). In our prior consultation response, we argued that there were problems with the decision to focus on change from baseline SMDs as the key outcome variable for the clinical NMA. The authors of the Revised Guideline argue that change-from-baseline scores counteract baseline differences within studies, which is indeed a clear advantage over end-of-treatment scores. However, the majority of the change-from-baseline SMDs could not be directly calculated from reported data and the standard deviations that are needed to calculate them had to be estimated. An assumption behind this estimation was that the correlation between baseline and end-of-treatment scores is .5. However, this assumption was not supported by corresponding analyses (Appendix N1/1.2.7), and it remains unclear, whether and how it influenced the results, which is particularly problematic given that this uncertainty effects the majority of the SMDs used in the analyses.<br><br>The same applies to response data, which was frequently estimated from the standardized mean differences.<br><br>Further, as SMDs are extremely sensitive to the standard deviations that are used for calculation, it remains unclear, whether and how the results were influenced by using estimated change-from-baseline rather than observed end-of-treatment data. A corresponding sensitivity analysis could have provided some insight but was not conducted.<br><br>The Revised Guideline authors themselves do acknowledge that the mixture of methods of imputation of missing continuous data in the primary studies (e.g., baseline vs. last observation carried forward) may have biased the results; **overall important questions still remain about whether the approach taken for the key outcome variables has led to biased findings**.<br><br>**Failure to focus on long-term follow-up data:** The Revised Guideline authors state that data on follow-up was not extracted because it was not available for many studies. However, data on economic outcomes were also sparse, but they were extracted and used for analyses anyway. Missing results on the long-term outcomes of the investigated treatments is missing a very important piece of clinically highly relevant information that is essential for |

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| | | | | choosing between treatment options in routine depression care.<br><br>**In summary, it is the view of BACP that there are a number of important concerns about the outcome variables selected for the NMAs which cast doubt on the findings.** |
| 14 | Full | General | General | **Inconsistency**<br>BACP's prior consultation response identified concerns with a number of aspects of the homogeneity of the NMA analyses**. It is our view that in the revised Guideline, there remain important questions about homogeneity, which is important as another key assumption of network meta-analysis which, if violated, impacts the credibility of the NMA findings**. These concerns are further detailed below.<br><br>***Global inconsistency:*** The Revised Guideline authors attempted to limit statistical heterogeneity through defining clinically fairly homogeneous populations, treatments, and treatment classes, as well as through performing sub-analyses, which can be considered an adequate strategy. However, several estimates showed statistical heterogeneity, which limited the possibilities of testing inconsistency. In some cases, inconsistency was detected. It is reported that both heterogeneity and inconsistency were considered by the Guideline Committee in making recommendations but it remains unclear, how this was done exactly.<br><br>***Local inconsistency*** It is stated that "a local assessment of inconsistency was not practical to do for all comparisons due to the size and complexity of the networks" and that "it would produce a very large amount of comparisons to analyse and interpret, leading to a very high risk of finding spurious results". It would definitely be tedious and produce a large amount of information to evaluate. However, ignoring this issue completely means that for all local pairwise comparisons and rankings of treatments, consistency of the evidence is assumed, with very weak empirical support from global and practically almost inevitably underpowered inconsistency tests.<br><br>***Difficulties in testing inconsistency:*** It is apparent in the Revised Guideline that the limitations of comparing pharmacological with psychological treatments and the presence of a pharmacological and a psychological subnetwork were acknowledged. However, the fitting of complex and unusually innovative (or innovatively unusual) statistical models (e.g., classes to connect otherwise unconnected nodes, borrowing evidence or using informative priors when it is necessary), only to ignore, or at least seriously downplay, their results during interpretation is not |

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| | | | | an easily comprehensible strategy. Keeping the subnetworks separated from the beginning and admitting that they cannot be compared statistically due to diverse populations and treatments might have led to somewhat clearer and more transparent findings. |
| 15 | Full | General | General | **Transitivity**<br><br>In BACP's prior consultation response, concerns were raised about the third key assumption of network meta-analysis is transitivity (sometimes termed similarity). The role of transitivity is addressed more clearly in the Revised Guideline, particularly in the "Evidence to recommendation" sections (7.4.5, 7.7) however, the issues raised around "Inconsistency" (see above) apply here as well. In particular the presence of two sub-networks of primarily psychological and primarily pharmacological interventions, means that transitivity of the analysed networks can certainly be questioned. |
| 16 | Full | General | General | **Judgements related to rankings of treatments**<br><br>In the Revised Guideline less emphasis was placed on rankings of treatments which BACP raised as a concern in our prior consultation response. |
| 17 | Full | General | General | ***Overall concerns about the economic analysis:*** Concerns were raised by BACP in the previous consultation response about the validity of the economic analysis. Adding the complexity of economic models to the complexity of the underlying network meta-analyses may render virtually any output highly uncertain. Even the authors of the Revised Guideline repeatedly state that the encountered complexities and limitations apply to most network meta-analyses (and economic analyses building upon them), this makes only clear that they are frequent, but does not invalidate the concerns resulting from them. **Overall, our conclusion is still that the results are potentially misleading and that the cost effectiveness of counselling as an intervention for depression in adults is not appropriately represented.** |
| 18 | Full | General | General | **Concerns around assumption of grade equivalence for mental health practitioners in the economic analysis:** In BACP's prior consultation response we raised concerns about the fact that the economic analysis is based on the assumption that all psychological therapies are delivered by practitioners who are on the same pay scale as a band 7 |

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| | | | | clinical psychologist. This is not correct, many counsellors and psychotherapists delivering psychological therapies at step 3 within IAPT services and more broadly within the NHS are working at band 6, which makes them considerably more cost effective than this analysis would suggest. The NICE response to this concern was to argue that the assumption was justified as it reflected: "variations in clinical practice, rather standard, optimal practice for the delivery of counselling in the UK, hence the results based on these scenarios were not deemed to reflect the cost effectiveness of counselling across UK routine practice" (NICE consultation comments and responses document, p472). However, we would argue that this issue, as it pertains to counsellors in particular, is not about 'optimal' practice but about the reality of service delivery and the fact that counselling is, in general, not a post-graduate qualification, in contrast to the majority of CBT and psychodynamic qualifications.<br><br>**On this basis, BACP would argue that the hourly costs of counselling are systematically lower than those for other psychological interventions and that as a result the relative cost effectiveness of counselling is underestimated.** |
| 19 | Full | 264 | 9 | **The evidence for the recommendation that any counselling intervention should be one developed specifically for depression (7.4.6):** In our prior consultation response, BACP asked why this requirement is only specified for counselling and short-term psychodynamic psychotherapy but not for CBT and IPT.<br><br>The response from the committee states:<br>*"Thank you for your comment. IPT and CBT were both developed specifically for the treatment of depression. In contrast, there has been less development of models of STPT and counselling that are specifically for treating depression. The committee thought it important to highlight this."*<br><br>We don't believe that the response adequately addresses our point and we once again request that an evidence-based rationale for what condition's modalities of psychological therapies have been developed to work with is given, rather than one that appears to be based on the personal judgement of the guideline development committee.<br><br>The impact of these opinions has a significant effect on the composition of the psychological therapies workforce and its ability to deliver choice of evidence based therapies within the NHS. |

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| 20 | General | General | General | **Recommendations for research**<br><br>In our prior consultation report we made a number of suggestions for additional focusses for research. One of these was for RCTs which utilise CBT as a comparator; specifically, RCTs on Humanistic Therapies focussed on both mild to moderate and severe depression. The NICE response to this was: "There is a large trial which is nearing completion in this area so we did not prioritise recommending further research" (NICE consultation comments and responses document, p611). The trial is not named but we assume that this might be the PRACTICED trial? If so this trial provides the first RCT on Counselling for Depression, a model of Person-Centred/Experiential counselling developed specifically to work with depression, as recommended/preferred in this revised Guideline. However, one trial is not enough. A big issue in the field is the imbalance of research on interventions, with much more research on some interventions, in particular CBT, than on others. The Revised Guideline discusses the importance of patient choice of psychological interventions (p257); if NICE wishes to honour this commitment to patients in the view of BACP it must advocate RCTs on NICE recommended treatments which have a limited evidence base in comparison with CBT, such as Humanistic counselling. |
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Insert extra rows as needed

**Checklist for submitting comments**

**Depression in adults: treatment and management**

NICE National Institute for Health and Care Excellence

**Consultation on draft guideline – deadline for comments 5pm on 12 June 2018 email: DepressionInAdultsUpdate@nice.org.uk**

- Use this comment form and submit it as a **Word document (not a PDF).**
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include **page and line number (not section number)** of the text each comment is about.
- Combine all comments from your organisation into 1 response. **We cannot accept more than 1 response from each organisation**.
- **Do not paste other tables into this table** – type directly into the table.
- Underline and highlight any confidential information or other material that you do not wish to be made public.
- Do not include medical information about yourself or another person from which you or the person could be identified.
- Spell out any abbreviations you use
- For copyright reasons, comment forms **do not include attachments** such as research articles, letters or leaflets (for copyright reasons). We return comments forms that have attachments without reading them. The stakeholder may resubmit the form without attachments, but it must be received by the deadline.

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.