National Institute for Health and Clinical Excellence
Common mental health disorders: Identification and pathways to care
Monday 15 November to Monday 13 December
Guideline Consultation Comments Table

Stakeholder	Full/ NICE	Sect.	Page	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Anxiety UK	NICE	Introduction	3	Line 6 – "Many disorders, for example depression" With regards to this statement we feel this again reinforces the commonly found belief about depression being lifelong course and severe impact, whereas anxiety and anxiety disroders are seen as less serious. Would suggest an amendment to state that both anxiety and depression can have a lifelong course of relapse and remission.	Thank you we have amended this section to reflect your concerns.
Anxiety UK	NICE	Introduction	4	3rd paragraph – AUK certainly welcomes the point about under recognition by GPs, but would we include under recognition in people themselves? Many people with anxiety struggle on with their lives without realising what they have is a recognised condition that can be treated (particularly things like GAD and OCD). A recent survey undertaken by AUK found this to be the case.	We did identify some evidence that evaluated the effectiveness of mass media campaigns to improve immunisation screening for cancer (e.g. Grilli 2002). However, there was insufficient evidence to review the effectiveness of increasing public awareness of mental health issues.
Anxiety UK	NICE	Introduction	4	AUK would welcome a more holistic treatment approach being taken whereby psychological and pharmacological approaches are combined	Thank you for your comment. As described in the introduction, the purpose of this guideline was not to re-evaluate the evidence for treatment as this was done in the existing disorder specific guidelines.
Anxiety UK	NICE	1.2.2	8	With regard to GAD-2, there are some concerns that the sole use of this will not pick up the Full range of anxiety disorders, for example specific phobias including agoraphobia and social phobia, or even panic attacks which are episodic in nature. We would suggest asking all 3 questions from the start if a presentation of anxiety is suspected, rather than the GAD-2 followed by a 3rd question if a certain score is obtained.	Thank you for your comment. The GDG spent a great deal of time considering the issue of case identification and specifically the issue you raise about picking up the full range of anxiety disorders. The consensus was that a pragmatic approach should be taken given the time available during a typical consultation and the evidence reviewed. The GDG acknowledge further research would be useful, hence the research recommendation about the GAD-2. With regard to asking all three questions if a presentation of anxiety is suspected, it was the opinion of the GDG that it is only

					necessary to ask the 3rd question if the GAD-2 did not suggest anxiety, but the healthcare professional still suspected an anxiety disorder, and this has been clearly stated in the relevant recommendation.
Anxiety UK	NICE	1.2.1 .2	7	With regards identification many individuals with anxiety present initially with somatic complaints, so it may be useful to include this in the recommendation.	Thank you but we do not think that the available evidence would suggest that this would lead to increased case identification.
Anxiety UK	NICE	1.1.1 .6	12	We very much welcome the suggestion that appointments are offered outside of normal working hours and to offer home visits – this is particularly important for individuals with difficulties getting outside such as agoraphobia and social phobia. We would like to see wider endorsement of the delivery of therapies and treatments via different modes including the internet and telephone.	Thank you for your comment, we agree and have provided recommendation 1.1.1.9 to address the use of technology.
Anxiety UK	NICE	1.1.1 .8	12	Again we very much welcome the use of technology to increase access to services; Anxiety UK has used email, webcam therapy, phone therapy and live chat instant messaging support with great success over the past 5 years.	Thank you for your comment.
Anxiety UK	NICE	1.2.2 .6	16	We feel the inclusion of a bullet point around substance/ alcohol use would be useful here.	Thank you for your comment, but we consider that substance misuse is included in the wider definition of comorbid mental health disorders.
Anxiety UK	NICE	1.2.3 .3	18	With regard to risk assessment – why does it only here refer to depression? Individuals with anxiety may also have suicidal thoughts and actions.	Thank you for your comment. We have amended the text to say: ‘’If a person with a common mental health disorder, in particular depression, is assessed to be at risk of suicide….’
Anxiety UK	NICE	1.3.1 .9	20	We would suggest removing the word ‘consider’ as this provides an option not to tell people with common mental health disorders about self help groups, third sector and national resources when in fact such individuals should be routinely advised of such resources.	Thank you but we think that consider is the correct term – there may be circumstances were it might be neither necessary or appropriate to offer such information.
Anxiety UK	NICE	1.3.2	21-22	This section describes referral advice for mild – moderate disorders but does not include agoraphobia (which is in the previous NICE anxiety guidance), or social phobia (which is an upcoming guidance). If these issues are not included they may be overlooked as this guidance will have a direct impact on service delivery and design – if there is no available evidence could the upcoming guidance be referred to?	Thank you for your comment; the referral advice is adapted or adopted from existing NICE guidance; as you point out the social phobia guideline is currently in the early stages of development. We have included reference to agoraphobia in the moderate to severe panic disorder recommendation (in line with previous guidance) regarding referral advice but the GDG did not consider it appropriate to include agoraphobia within a

					definition of ‘mild to moderate’ panic disorder.
Anxiety UK	NICE	1.3.2.2	21	Whilst we would support individuals with common mental health difficulties being referred to/made aware of cCBT packages – it is our experience that most ‘NHS commissioned cCBT services will not allow services users to access cCBT programmes if their initial GAD7 PHQ9 score was sub clinical threshold.	Thank you – this is a matter for local implementation but the data is clear that CCBT can be effective for sub threshold disorders.
Anxiety UK	NICE	1.3.3.6	24	We are concerned that no reference is made to agoraphobia and that there is an assumption that the term ‘panic disorder’ covers agoraphobia. It does not.	Thank you for your comment; we have now included reference to agoraphobia in the guideline.
Anxiety UK	NICE	1.4.1.3	27	We welcome this aspect of the guidance but would recommend it be strengthened by adding that particular attention should be paid to those service users requiring a step 3 and above intervention. The stepped care model at present and the way that services are organised is resulting in many individuals whose needs cannot be met at step 2 enduring very long waits for treatment of often over a year. This cannot be right that those with more intensive needs are left waiting without support for long periods of time.	Thank you for your comment, however it would be outside of the guideline to make prescriptive recommendations
Anxiety UK	NICE	1.4.1.4	27	AUK supports this statement however in reality with the inception of IAPT, many PCTs are configuring their services in order to meet IAPT targets. The consequence of which is that patient choice is often secondary.	Thank you for your comment.
Anxiety UK	NICE	1.4.1.9	29	We would recommend adding a specific reference to Third Sector organisations who are often ‘outside of the loop’ and not privy to information. The use of ‘information sharing protocols’ between relevant parties (including TSOs) should be routine.	Thank you for this comment. Third sector organisations are largely outside of the scope of this guideline, although their role in promoting access is noted by the developers.
Association For Family Therapy and Systemic Practice in the UK (AFT)	General			AFT welcomes improved guidance for primary care. There is a dearth of psychological therapies available for patients, although they are effective and often preferred over medication by patients. HopeFully the IAPT programme will continue to address this with the developments of a wider range of therapies to ensure patient choice, therapies that can address the relationship or other issues that are linked to the common mental health problem, and other options for those patients who do not easily respond to CBT or react adversely to the more directive nature of this intervention.	Thank you for your comment.
Association	Gene			References to Post natal depression in women is included	Thank you for this comment. We have reviewed the

For Family Therapy and Systemic Practice in the UK (AFT)	ral			briefly in the FULL guidance, but not mentioned in NICE, along with some other gender and relationship issues. As there is reference to the NICE guidance on Ante and Post Natal Mental Health, it would be helpful to include the necessary relationship issues into the NICE guidance – when doing assessments, and to provide early interventions for various mental health problems. Interestingly partners may also develop depression after the birth of a baby, indicating the impact of changes in family relationships, although mothers will usually have more responsibility for the care of infants and young children while the fathers work, and becoming a parent will have some impact on the couple relationship. Paulson, J & Bazemore, S. (2010) Post natal depression: fathers have it too. The Lancet. 375. 9729. 1846	assessment recommendation in light of your comment and have amended them to take into account the NICE guidance on Antenatal and postnatal mental health guidance on common mental health disorders.
Association For Family Therapy and Systemic Practice in the UK (AFT)	NICE	1.4.	26	The stepped care process is welcomed and ensures good use of resources but it is important (as stated in the guideline) that levels of care work together and are able to respond appropriately to more severe presentations without wasting time on interventions, which are not powerful enough.	Thank you for your comment. We agree with your point.
Association For Family Therapy and Systemic Practice in the UK (AFT)	Full/ NICE	1.4.1 .5. 1.2.2 .	27 11.	One major consideration in the guidelines is the lack of attention paid to the consideration of the context of the patient. It is welcome that it suggests information is available, accessible and culturally sensitive, but it does not do enough to encourage those in primary care to: 1. Access the impact of the illness on the wider family and the impact of the wider family on the illness. One major concern is the impact on young children and although this is rather generally alluded to, it needs to be made explicit. We have good information on the number of young carers who have to care for parents with mental health needs and the vastly greater likelihood that they will develop mental health problems in the future. Some may be at more immediate risk. Specific questions relating to the impact on the children must be a vital part of the assessment. However it is not only children but other vulnerable adults that need to be considered. It is also important to know about current stresses, relationship stresses, domestic violence and concerns about finance,	Thank you for your comments. Regarding point 1: during development, the GDG acknowledged the importance of the wider family and the impact on young children. In this respect, a specific recommendation was drafted which includes the issues you have raised. Regarding point 2: as described in the introduction to the NICE version of this guideline, the purpose of this guideline was not to review the evidence for treatment, which is covered in existing disorder specific guidelines. Therefore, referral advice drew on existing recommendations, some of which do recommend behavioural couples therapy (for example, recommendation 1.4.3.1).

				housing or immigration status. Without a wide view, important needs for other interventions and services may be missed. 2. Suggest relationship based therapies to address some of those issues. Depression rarely comes entirely out of the blue and relationship issues play a significant part in the stresses that may precipitate or maintain depression. Behavioural couple therapy has a good evidence base and should be considered in the first instance for anything but mild depression. If relevant it should be provided on its own or in addition to other interventions. Although currently there is not a large body of research evidence to support two interventions, clinical experience points to this, and government policy embraces the need to attend to relationships as an important component of wellbeing and to take a "think family" approach.	
Association For Family Therapy and Systemic Practice in the UK (AFT)	NICE	1.1.1 .9.	12-13	The continual individual focus on treatment is culturally unacceptable to many who come from less individualistic societies and does not fit with the realities of peoples' lives. The reference to the need for 'competence in working with families from diverse ethnic and cultural backgrounds' suggests that more references are made to addressing relationships	Thank you for this comment. The treatment recommendations in NICE guidelines are evidence based and these guidelines do take into account cultural issues in relation to their delivery. This is reflected in the development of recommendations in this guideline. You do not provide sufficient detail or supporting evidence to support changes to the recommendations.
Association For Family Therapy and Systemic Practice in the UK (AFT)	General			*Competencies and occupational standards for Systemic Family and Couples Therapy*,(due for publication soon) is based on effective interventions and the best practice addresses those recommended in the relevant NICE guidelines. See also: http://www.ucl.ac.uk/clinical-psychology/CORE/systemic_framework.htm#Map	Thank you for this information
Association For Family Therapy and Systemic Practice in the UK (AFT)	Full/ NICE	1.1.1 .9.	69 12-13	When providing treatments that address BME or other community issues, there are examples of good practice that may not fit an evidence base, eg Post Natal Depression Project for Pakistani and Pushto women in Birmingham.	Thank you for your comment. Given the difficulty of reviewing this area, we believe that utilising existing systematic reviews (some of which had included a wide variety of evidence) was the best use of time and resources. However, we acknowledge that examples of good practice (particularly if they have not been subject to formal evaluation) in the UK may not come to light using this approach.
Association For Family Therapy and	Full/ NICE	5.3.8 .6. 1.2.2	142 16	The 'quality of interpersonal relationships' is mentioned in the recommendation for assessment, but there is very little details given of the kinds of relationship issues that will be important	Thank you but we were unable to identify any good quality evidence that would support such recommendations.

Systemic Practice in the UK (AFT)		.6		when considering what counselling or psychotherapy would be beneficial.	
Association For Family Therapy and Systemic Practice in the UK (AFT)	Full NICE	2.2.2. 1.4.1.6.	20 28	The data on age and other factors indicates the importance of linking such information to understand the development and course of prognoses: eg for young women with ante natal depression, it is important to know whether they have a supportive partner or relative or are in the process of separating. Factors such as marital status, exposure to domestic / sexual violence, experiences in childhood, experiences of good parenting and the risks of children developing mental health problems, mentioned briefly in the FULL guideline do not seem to be acknowledged in the NICE guideline. These factors may have triggered common mental health problems and could explain why the diagnosis is not made – because the concerns about the factors leading to the stress.	Thank you for your comments. We believe that the assessment recommendations in the NICE guideline do ensure that the factors you note are taken into account. However, recommendations concerning aetiology are outside the scope of this guideline.
Association For Family Therapy and Systemic Practice in the UK (AFT)	Full	2.4.2	37	Patients may feel that they cannot discuss their stress about relationship issues when talking to a GP, especially if they feel embarrassed or humiliated about the circumstances or the stigma that often goes with having emotional / mental health problems. Some patients may prefer not to have a diagnosis, but would like to have psychotherapy – and this may not be easy to research because of their reluctance to seek help.	Thank you for your comment. During development the GDG discussed this issue and acknowledged it may be a problem for some potential patients. We have developed a number of recommendations which attempt to address this issue. For example, see recommendation 1.3.2.5 (in the current version): All staff carrying out the assessment of common mental health disorders should be trained and competent in: • verbal and non-verbal communication skills relevant to the assessment of common mental health disorders, including the ability to elicit problems, the perception of the problem(s) and their impact, tailoring information, supporting participation in decision making, and discussing treatment options The question of whether or not it is helpful for service users to be diagnosed falls outside of the scope of this guideline. This issue will be addressed in the NICE guideline on service user experience, which is currently in development.
Association	Full	Tabl	159	Suggest that couple therapy is included in this Table (referred	Thank you for this suggestion, we agree and have amended

For Family Therapy and Systemic Practice in the UK (AFT)		e 27		to later in Table 33)	Table 27.
Association For Family Therapy and Systemic Practice in the UK (AFT)	Full	6.3.8.	176	When discussing options for treatment it would be helpful to ask if they would like their partner / some other family member to be involved, especially if there are relationship issues that have been discussed.	Thank you for this comment. We agree that it is important to discuss a range of referral options with service users, as well as their family and carers where appropriate. However, we believe this issue is already covered in a number of the recommendations about assessment, including 1.1.1.10, 1.5.1.1 and 1.3.2.6 (in the post-consultation version of the guideline).
Association For Family Therapy and Systemic Practice in the UK (AFT)	General			Couple therapy has a strong recommendation in the Alcohol Dependence and Harmful Alcohol Use, because of recognition of the importance of relationships both in triggering the misuse of alcohol as well as the impact on relationships. This is another factor for including couple therapy in the recommendations.	Thank you for this comment but primary drug and alcohol problems are outside the scope of the guideline.
British Association for Counselling and Psychotherapy	Full	1.2 3.3	10 43	BACP is concerned that the common mental health guideline has been developed without input into the guideline development group from professionals from counselling and/or psychotherapy organisations. BACP, as the largest professional body for counselling and psychotherapy has over 35,000 members, working across many sectors including providing counselling for the NHS. BACP is research and policy active and its continued absence from guideline development groups on issues which are core to the counselling and psychotherapy professions and which have an impact on the mental health of the public is very disappointing.	The membership of the GDG was the subject of an initial consultation. As can be seen from the guideline the focus is on access, assessment and referral. Treatment considerations (in which members of various psychological, psychotherapy and counselling organisations were involved) informed the recommendations of the GDG
British Association for Counselling and Psychotherapy	Full	2.3.2	33	BACP strongly challenges section 2.3.2 on psychological treatments for depression, which states that “effective psychological treatments for depression (in the) depression guideline update includes CBT, behavioural activation, interpersonal therapy, behavioural couples therapy and mindfulness based couples therapy. BACP is at a lost to understand why this section on treatments for depression does	Thank you for this comment. The guideline in section 2.3.2 accurately summarises the evidence in stating that effective treatments include CBT, BA, IPT, BCT and MBCT. It does not reference a number of other treatments such as counselling and psychodynamic therapy for which the evidence is more limited but which are also included in the update. As you will be aware this is reflected in the more restricted recommendations

				not include counselling and would welcome clarification from NICE as to why counselling has been excluded.	included in the guideline. We feel that as a summary of some of the key aspects of the update the text as currently drafted is sufficient.
British Association for Counselling and Psychotherapy	Full	2.4.4	41	The section on pathways to care, where IAPT is mentioned does not include reference to the Glover report, which gives a critical review of the progress made to date in the IAPT programme. BACP would suggest that reference to the Glover report and its findings are incorporated into this section.	Thank you for this comment, We have made reference to the Glover report in this section.
British Association for Counselling and Psychotherapy	Full	4.3.4	80	The evidence noted from Balas (1997) on evaluating various electronic communication methods, shows that telephone follow-up and counselling was more effective than control for individuals keeping appointments and was rated higher for user satisfaction. BACP would suggest that this needs to be reflected in the recommendations in section 4.5.	Thank you for this comment. Your comment concerns a review that is almost 15 years old. Although all of the guideline searches went back to 1995, our review focused on contemporary systematic reviews (identified as described in the clinical review protocol) and the outcome of those reviews are reflected in our recommendations. These reviews provide an up to date account of the evidence and so are more inclusive review of the literature that that contained in Balas (1997) – it would therefore not be appropriate to make the changes you suggest.
British Association for Counselling and Psychotherapy	Full	4.4	83	BACP would suggest that evidence from the Bower and Rowland Cochrane review of counselling in primary care is included as it gives robust information on client satisfaction data around accessing counselling services, which could usefully inform this mental health guideline. Bower, P. J and Rowland, N. (2006) Effectiveness and cost effectiveness of counselling in primary care *The Cochrane Library*, Issue 3.	Thank you for this suggestion. However, this section of the guideline aimed to review evidence which assesses the effectiveness of service developments which are specifically designed to promote access. We do not believe that the Cochrane review of Bower and Rowland meets the eligibility criteria set out in Table 10, and therefore should not be included in section 4.4. Moreover, the issue addressed in the Bower and Rowland review is more of a treatment issue, and therefore, is outside the scope of this guideline.
British Association for Counselling and Psychotherapy	Full	6.3.4	159	The NICE guideline for depression includes counselling as an intervention. BACP is unclear why on page 159 counselling is not included under the recommendations for depression. Since the guideline was developed, it has become evident through IAPT evaluations (Glover et al, 2010) that counselling is as effective as CBT, and may even be more cost effective. It is noted that in table 33 counselling is mentioned as a service	Thank you for your comments. We agree that some relevant recommendations were missing from Table 27 and this has been amended. Regarding Glover *et al*. (2010), we would like to draw your attention to page 31-32 of the report which states "PHQ-9 scores fell more in patients given counselling than CBT alone, but more still in those given the two in combination. However it should be repeated here, that this is in no sense a

				user preference and therefore recommended. The recommendation for counselling needs to be cited across the guideline in the appropriate sections where the other psychological therapy recommendations for depression are cited. BACP is at a lost to understand why there is no mention of counselling in the recommendations on pages 178-9. Again, BACP would strongly suggest that the recommendation for counselling is inserted.	comparison of the efficacy of the treatments as individuals were assigned to treatment packages on the basis of clinical judgments about what seemed most appropriate." (pp. 31-32). Such data therefore does not support your view of the equivalent efficacy of counseling and CBT.
British Association for Psychopharmacology	Full	General	General	We congratulate NICE on a careFully crafted document of major clinical relevance. Common mental disorders impact hugely on the nation's health and this guideline is most welcome. Our comments are to be interpreted in this context.	Thank you for your comment.
British Association for Psychopharmacology	Full	General	General	The document introduces immediately the concept of service user, without discussion or review of the evidence. There are now many studies showing that patients with mental health problems actually prefer to be called "patients". Clearly the terminology used to address or categorise the person is very important in influencing care-related behaviour, This guideline is perfectly suited to review the published evidence on te use of the terms to address patients (patients, clients, users, etc) and provide evidence-based recommendations on the best term(s) to use.	Thank you for your comment. We have not conducted a review on patient terminology as this was not in the scope of the guideline. However, in light of your comments we have made some changes to the terminology in the guideline and have been specific about 'people with a common mental health problem' where possible.
British Association for Psychopharmacology	Full	General	General	Much emphasis is placed on increasing access for BME but there is no mentioning of asylum seekers and refugees. Asylum seekers are actively prevented from accessing care by a variety of institutional barriers including physical restriction within holding centres, lack of access to any financial support, and no legal access to NHS services. This of course in the context of being perhaps the most vulnerable individuals in our society, with the highest risk of mental health problems. This guideline should review the protocol to facilitate/allow access to care for this group of people, and, if needed, be brave enough to propose recommendations that go against the	Thank you for your comment. We have amended recommendation 1.3.2.6, which advises clinicians to take immigration and employment status into account during assessment.

				current government approach to this problem.	
British Association for Psychopharmacology	Full	6	144	There is no discussion of the special risks associated with mental health problems during pregnancy, and in particular the high risk for the physical and emotional wellbeing of an infant or a child when the mother or father has mental health problems. For infants, this is particularly important in case of maternal depression or OCD. There should be specific recommendation on assessing safeguarding risks to infants and children.	Thank you, we have amended several recommendations in light of your comment. We have included a sub-section of recommendations on antenatal and postnatal mental health within the assessment section of the NICE guideline, and recommendation 1.4.2.2 in the referral section of the NICE guideline is specifically concerned with subthreshold anxiety or depression symptoms in pregnant women. In addition, the last part of recommendation 1.3.2.6 now reads: "If appropriate, the impact of the presenting problem on the care of children and young people should also be assessed and where necessary local safeguarding procedures followed."
British Association for Psychopharmacology	Full	2	17	Social anxiety disorder is a prevalent and disabling anxiety disorder that is associated with marked behavioural avoidance, and individuals with SAD are frequently missed by health services. We would encourage the guideline group to attempt to raise the profile of SAD (e.g. identification and paths into care) throughout the document, via literature reviews, despite the absence of a prior NICE treatment guideline for the disorder.	Thank you, we agree services often miss social anxiety. To address this issue we have recently started a clinical guideline on social anxiety disorder.
British Association for Psychopharmacology	Full	5	126, 127	OCD is a disorder shrouded in secrecy and patients often need to be actively questioned to divulge symptoms, often for fear of stigma. Individuals with OCD often present to GPs with comorbid depression, and if the OCD is missed they may receive the wrong treatment from the outset, since OCD and the comorbid depression associated with the disorder appear to show a selective response to SRIs and specific forms of CBT. The NICE OCD/BDD treatment guideline did pay this problem considerable attention. A single question about generalised anxiety /apprehension – or avoidance of places- is unlikely to reveal OCD. Perhaps the guideline group could consider an additional question to screen for OCD in depressed and anxious individuals.	This guideline is intended to provide guidance for practitioners, principally those working in primary care, on the initial assessment and subsequent treatment/referral of people with a common mental health disorder. As such, evidence about the treatment of people with common mental health disorders was not reviewed in the development of this guideline – recommendations regarding treatment from previous NICE guidelines were adopted or adapted, as appropriate, and readers are 'signposted' to the relevant NICE guideline, where more information is required. The focus in this section of the guideline was on initial case identification. We agree that this alone would be insufficient to identify all potential cases of OCD (or indeed other anxiety disorders), and with this in mind we make further

					recommendations about the nature and content of the assessment which is to follow initial case identification. We did consider other specific questions relation to anxiety disorders (including OCD and PTSD) but decided against this on grounds of feasibility for routine use in primary care.
British Association for Psychopharmacology	Full	5	128	In line with point 3, A research question looking at the most effective single screening question to identify specific ADs could be helpful.	Thank you for this suggestion. The GDG considered this issue at length, but came to the conclusion that in the context of primary care, a 2-3 item instrument (in addition to the two questions for depression) would be the maximum that could be used. Therefore, the GDG felt that a research question about the GAD-2 compared with routine case identification to accurately identify different anxiety disorders should be the priority.
British Association for Psychopharmacology	Full	2.2.5	26	We consider it would be helpful to add that for depression, the long term risk of suicide in secondary care cohorts is 10-15%.	Thank you for this suggestion, but we would need a reference before making this claim. In a review conducted in 1998, the lifetime risk was estimated to be 6% (Inskip HM, Harris EC, Barraclough B. Lifetime risk of suicide for affective disorder, alcoholism and schizophrenia. Br J Psychiatry. 1998 Jan;172:35-7.)]
British Association for Psychopharmacology	Full	2.2.5	26	There is no mention of how the very features of depression impair access to and requests for appropriate health care.	Thank you for this comment in light of which we have made some amendments to the text.
British Association for Psychopharmacology	Full	2.2.5	26	The House of Commons library also estimated the UK cost of depression and put it at £8.8 billion per year (2009)	Thank you, we have added this information in the text.
British Association for Psychophar	Full	General	General	Importantly, there is little mention of the need to assess chronicity and treatment resistance. The pathways to care for such people are not well defined and vary enormously between localities. A significant proportion of patients do not have	Thank you for this comment but we think this issue has been addressed in two points in the guideline. Firstly, in the initial advice to assess chronicity and previous treatment response, in the assessment section. Secondly, in the referral guidance

macology				access to services in spite of being severely disabled over a prolonged period of time because they do not present with the symptoms that require intense monitoring, such as suicide intent or psychomotor retardation.	in section 1.4.4.
British Association for Psychopharmacology	Full	General	General	There is no mention of the importance of detailed psychopharmacological knowledge in light of the fact that robust effectiveness data from large trials does not exist in most conditions beyond the application of a treatment after the first treatment failure. There is a lack of distinction between the temporal course of illness: so some people will experience mental illness episodically while for many others the conditions can be chronic, especially if under treated.	Thank you for these comments. We have not reviewed the evidence for effectiveness in this guideline but have referred to other NICE guidelines, because as far as is possible these guidelines deal with that issue. In addition, we have reviewed the text and clarified the different courses that common mental health disorders take.
British Psychological Society, The	Full	1.1.2	8	The degree of trust in the relationship between a mental health professional and service user is key to effective interventions and the emphasis on the quality of the therapeutic relationship is welcomed in the document. There is a concern that sections may be lifted from the document without reference to this key factor. (Would there be a way to re-iterate it through the document through eg a running footer?)	Thank you for this suggestion, we appreciate your concern but think that the issue of the importance of the relationship is covered in a number of recommendations and therefore it is not necessary to take up your suggestion.
British Psychological Society, The	Full	1.2.2	11	The report says “The experience of people with common mental health disorders can affect the whole family and often the community.” Consider a statement that makes service users seem more empowered and less passive, also showing a two-way relationship. For example, the reciprocal relationship between a person’s mental health and family and community are part of experience of service users. The people to whom a service user relates can either maintain depression or help to support recovery – this includes mental health workers. Ways of ensuring children in family are included in communication of information. If they are not actively involved they may learn by eavesdropping and will use their imagination to fill in gaps. The children of service users’ needs must be appropriately considered.	Thank you for your comment. We agree that you raise an important issue and this is dealt with in a number of other NICE guidelines on common mental health disorders as these issues are within the scope of those guidelines. The main focus of this guideline was access, assessment and referral. However, some of the issues you raise are also addressed. For example, with regard to ensuring children and family are involved, and children of service users’ needs are appropriately considered, the GDG would like to draw your attention to the section on patient-centred care in the NICE version of the guideline, and recommendations 1.1.1.2, 1.3.2.6, 1.3.3.1, 1.5.1.1, 1.5.1.5, 1.5.1.9 (in the current version).
British Psychologica	NICE		6	In order to make choices to move through care pathway, service users (SU) will need some understanding. All service	Thank you we agree with this comment and feel it is reflected in the recommendations we have made.

l Society, The				users will bring different amounts of prior knowledge. Will need a map of options in order to decide on path, also some understanding of condition and how system works eg what NICE is. Also an assessment of where the SU is in terms of prior knowledge. When having the first ever contact with mental health services there should be distinctive, much more comprehensive advice.	
British Psychological Society, The	NICE	Improving access	7	This paragraph needs to take into account issues around Single Point of Access protocol which are intended to streamline and aid access. Perhaps it's just the wording - all routes should lead to same point?	Thank you for your comment but we disagree as our review of the evidence does not endorse the use of the single point of access protocol.
British Psychological Society, The	NICE		7	"clear and explicit criteria for entry to service." Should services instead be developed to accommodate service users who are referred to them?	We agree with this comment but would point out that even when this is has been established (i.e. the service is responsive to client need) criteria for entry still need to be clear and explicit.
British Psychological Society, The	NICE		8	Have designated staff who are responsible for the co-ordination of service user engagement with the pathway.	Thank you for your comment. We are not sure whether you are suggesting a change or emphasising responsibility and so find it difficult to respond to your comment.
British Psychological Society, The	NICE	1.1.1.5	11	Healthcare professional to take responsibility for whole period of care.	Thank you – we believe this issue is dealt with in 1.1.1.6 (in the post-consultation version of the guideline).
British Psychological Society, The	NICE	1.2.2.5	16	Therapeutic relationship is more important for assessment, development of trust is more important than verbal and non-verbal communication skills. The study that this evidence was based on was possibly measuring the quality of the therapeutic relationship not non-verbal communication per se.	Thank you – this comment is a little difficult to follow but we would point out that as the guideline is focused on assessment and not interventions the emphasis on communication skills is more appropriate.
British Psychological Society, The	NICE	1.2.2.6	16	Assessment include assessment of at least current sources of stress eg financial health and life stage eg does the person have a child under 2 years?	Thank you we have included some examples of current and other stressors.
British Psychological Society, The	NICE	1.2.2.6	16-17	Safeguarding children and vulnerable adults assessments should also be considered.	Thank you, we have amended the recommendations in light of your comments.
British Psychologica	NICE	1.3.1.3	19	This needs more clarification suggest that the appropriate intervention will be at the right level for the individual.	Thank you but we think this is clear and express much the same as you have said in your comment

l Society, The					
British Psychological Society, The	NICE	1.3.1.4	19	The bullet points don't really help clarify - they seem contradictory. For example, bullet point 3, who has provided the diagnosis present in bullet point 1 and 2? It should be clearer stating that where there is a diagnosis – this is how you should manage it. It is also unclear how different 1 and 2 are from each other.	Thank you but we do not see the problem. The reasoning behind how this is set out is as follows: Bullet point 1 – diagnosis of depression but not anxiety disorder Bullet point 2 – diagnosis of depression and anxiety disorder Bullet point 3 – no diagnosis of depression or anxiety disorder but symptoms of both present The question of who has made the diagnosis is not relevant.
British Psychological Society, The	NICE	1.3.2.1	21	There should be reference to IAPT and access to it.	Thank you for this comment but we are not sure why you are making such a proposal and we cannot see how it would improve on the current recommendation.
British Psychological Society, The	NICE	1.3.1.9	20	For other suggestions see Bipolar Report Social support – look at re-establishing contact with old neglected friends. Does not have to be restricted to stigmatising ."self-help groups".	Thank you but this is outside of the scope of the guideline
British Psychological Society, The	NICE	1.4.1.3	28	"meet identified needs of the families and carers" – including age appropriate information for children of service user.	Thank you for your comment. However, this guideline is about the treatment and referral of adults with common mental health disorders, and so questions about providing information for children fall outside of its scope.
British Psychological Society, The	NICE	1.4.1.5	29	Leadership team should include service user and carer representatives.	Thank you for your comment, However, it would not be appropriate for this guideline to make specific recommendations about how services are organised.
British Psychological Society, The	NICE	1.4.1.9	29	Services to be built around pathway and not pathway around services, then 1.4.1.9 should be about listening to service users.	Thank you for your comment, however we believe that recommendation 1.4.1.9 in the consultation version of the guideline is appropriately worded, as it emphasises the importance of communication with service users.
British Psychological Society, The	NICE	4.1	31	Accurate and cost effective treatment is far more cost effective.	Thank you for your comment.
British Psychologica	NICE	4.6	34	Priority of treatment for people with anxiety and depression: Need a theory to underpin understanding of the cause. If	Thank you please see the relevant guides for an explorations of these issues

l Society, The				being anxious causes you to be depressed, then if you treat anxiety depression will go away.	
British Psychological Society, The	General	General		On the whole we thought it was a helpful document collating all the guidance but it still reads in a bit of a stilted way. We liked the recommendations around care pathways and measurement. Also, recommendations around research were good to see.	Thank you for your comment.
British Psychological Society, The	General	General		Mention of access for older people or those who might find it hard to access care through this approach and where additional support or improved care pathways would need to developed to ensure equity. This would be helpful to reiterate.	Thank you for your comment, in light of which we have added recommendation 1.1.1.5 to the guideline.
British Psychological Society, The	NICE	General		The document does not mention the workplace. Many people with common mental health problems will be in work at the time the problem arises. It is important to consider this context and the impact it might have on all aspects covered by this guidance. For example: • Workplace support mechanisms, such as occupational health and employee assistance programmes can play an important role in the identification, assessment and treatment of common mental health problems. They can provide an alternative and more accessible care pathway for those in work: non-workplace providers, such as GPs should be encouraged to liaise with workplace providers and vice versa. • Where possible, keeping an individual in work should be a key consideration when assessing and treating with someone with a common mental health problem. Work can be a source of social support, meaning, sense of purpose, achievement and positive feedback that are beneficial to those with common mental health problems. • Where someone is absent from work due to common mental health problems, returning that person to work as quickly as possible can be beneficial to them and to the employer – it might be part of the process of recovery for the person and prevent them from dropping out of the workforce (and all the consequent problems for health and	Thank you for your comment, however we feel that this issue falls outside of the scope of this guideline. We would refer you to the NICE public health guideline 22, on well-being at work (2009). We have included a reference to this guideline in the 'related NICE guidance' section of this guideline, following your comment.

				wellbeing that are likely to result). The workplace can be a route for providing relevant information to potential service users about what services are available and how to access them.	
British Psychological Society, The	General	General		Medical, diagnostically driven terminology is used frequently (as opposed to psychologically, formulation based terminology). However, we recognise this is the framework used for many NICE guidelines which are usually diagnostically driven.	Thank you for your comment.
British Psychological Society, The	General	General		In the Introduction section, we welcomed the focus on patient centred care. However, we would have liked more emphasis on this throughout the document. We know from various studies (can cite a few if required) that there is variation in how health and illness is perceived and that, of course, this affects how people manage their psychological (and physical) difficulties. We recognise there is a tension here between this and the need to follow evidence based guidance. However, as so much of managing common mental health difficulties (and IAPT with LTC and MUS) is concerned with self help and empowerment, We would have liked to have seen an increased emphasis on this throughout the document.	Thank you for this comment – we do however feel that we have addressed this issue throughout the guideline (for example, see recommendations 1.1.1.2, 1.1.1.10), as well as in new recommendation 1.4.1.3.
British Psychological Society, The	General	General		Section 4 - Research recommendations: We wondered if research is also indicated on transdiagnostic good practice guidelines for common mental health problems. It may be that where various problems coexist, common approaches could be helpful. There is research we can cite from work with people with long term mental health difficulties (and their families) and also some research on physical health which is relevant.	Thank you for your comment. However, the focus of this guideline is on access, assessment and referral, and we have therefore restricted our research recommendations to these areas.
Connecting for Health	Full/ NICE	General	General	These draft guidelines are excellent and highlight the correct assessment and management of common primary care and unscheduled care in the NHS. We will certainly at NHS Pathways consider them in our appropriate symptom based pathways and with our joint work with NHS Direct.	Thank you for your comment.
Department for Education	Full	1.2.2	11	*The experience of people with common mental health disorders can affect the whole family and often the community. The guideline recognises the role of both in the treatment and support of people with common mental health disorders.* There	Thank you for your comments. The GDG acknowledge the importance of families, and make a specific recommendation which highlights family history of mental illness as a potential factor have affected the development, course and severity of a

				is a great deal of evidence that problems that affect one family member can have an impact on other members of the family and that problems can be passed down through generations, particularly for families with multiple problems. It would be good if this was referenced and the need for interventions to taken into account the whole family and not just the individual(s) with the mental health problems. Would also be good to reference the evidence that intensive whole family support led by key workers through family interventions can help to reduce mental health problems **(http://www.education.gov.uk/rsgateway/DB/STR/d000956/osr09-2010.pdf)** The Coalition Gvt has made a commitment to run a national campaign to support families with multiple problems underpinned by pooled community budgets. We know that some family intervention key workers have struggled to access mental health services for parents and children due to the thresholds being too high and lack of availability.	person's presenting problem (see rec 1.3.2.6 in the current NICE version of the guideline). In addition, a number of other recs acknowledge the role of the family (see 1.1.1.2, 1.3.3.1, 1.5.1.1, 1.5.1.5, 1.5.1.9 in the current version) and the importance of personal or social factors that may have a role in the development or maintenance of common mental health disorders (1.4.1.1). In the full guideline in section 1.2.2 it would not be appropriate to reference the evidence specifically for family intervention. However, elsewhere we have made reference to the guidelines on depression and anxiety that have covered treatment issues.
Department for Education	Full	2.2.3	22	Would be good to reference here the review by the National Institute for Clinical Excellence which highlighted the value of parenting programmes in improving the behaviour of children with conduct disorder. Eleven out of fifteen studies showed statistical long-term effects (between one and ten years)**(NICE (2006) Parent - Training/education programmes in the management of children with conduct disorders. In NICE)** Technology appraisal guidance 102The estimated cost of a one-year cohort of children with conduct disorders in the UK is £5.2 billion **(Scott S, Knapp M, Henderson J and Maughan B, 2001, *Financial Cost of Social*** **Exclusion: follow up study of anti-social children into adulthood. British Medical Journal 323)**	Thank you but this issue is outside scope of the guideline.
Department for Work and Pensions	Full/ NICE	General	General	The issue of employment and its relation to mental health should be addressed within this guidance. Work is generally good for people's mental health, and can also contribute to recovery from mental health conditions. Conversely, being out of work increases the risk of developing mental health conditions such as depression or anxiety – as well as increasing social isolation. The evidence base for these statements is well established:	Thank you for our comment. We have revisited one of the recommendations on assessment to take account of your comment. However, although we agree with you about the importance of work a detailed review of occupational rehabilitation is outside the scope of the guide. We would draw your attention to the recent NICE public health guidance on wellbeing in the workplace. Additionally, we will draw NICE's attention to this issue.

				• Healthcare professionals endorsement of the above messages http://dwp.gov.uk/docs/hwwb-healthcare-professionals-consensus-statement-04-03-2008.pdf • Independent evidence review to answer the question "Is Work Good For Your Health and Wellbeing?" http://dwp.gov.uk/docs/hwwb-is-work-good-for-you.pdf • Royal College of Psychiatrists report – In particular conclusion 7.3 http://dwp.gov.uk/docs/hwwb-mental-health-and-work.pdf • "Vocational rehabilitation – what works, for whom and when?" http://dwp.gov.uk/docs/hwwb-vocational-rehabilitation.pdf • Foresight Project Report on Mental Capital and Wellbeing, which confirms that work is generally good for mental health. http://www.foresight.gov.uk/Mental%20Capital/Final_Project_Report_part4.pdf) It is important that NICE guidance reflects this, so that clinicians are aware of the latest knowledge about the role of employment, and how best to support patients to make meaningful and holistic recovery. Other national guidelines recently published also include issues of employment (eg commissioning guidance for the IAPT programme, the public health white paper) and so this NICE publication should reflect this. In addition, work can sometimes also be a risk factor to mental health (as evidenced by the c12m working days lost to work-related stress reported in the Labour Force Survey), which is a further reason for consideration of employment issues when treating mental health conditions. We have made some specific suggestions below as to how this could be accomplished.	

Department for Work and Pensions	NICE	Introduction	3	Suggest the sentence beginning “Many disorders, for example depression,” includes the word “can” after “for example depression”.	Thank you for your comment; we have made the change you have suggested.
Department for Work and Pensions	NICE	Key priorities for implementation	7	An additional bullet under “Improving Access to Services” to read ‘reflect the Full range of factors which can contribute to mental health conditions and recovery such as employment and housing.”	Thank you for this comment but we do not think this would be an appropriate amendment for this recommendation.
Department for Work and Pensions	NICE	Key priorities for implementation	9	Additional words for final bullet to include “for example, employment, housing or financial support services”.	Thank you, we have amended our recommendations to take into account employment and other matters.
Department for Work and Pensions	NICE	1.1.1.4	11	As with comment 3, an additional bullet to read ‘reflect the Full range of factors which can contribute to mental health conditions and recovery such as employment and housing.”	Thank you. We have amended several of the recommendations to take into account these factors.
Department for Work and Pensions	NICE	1.3.1.1	19	Additional bullet to read “the wider context of an individual’s circumstances such as their employment status, housing situation.”	Thank you. We have amended the recommendations in light of your comment.
Department for Work and Pensions	NICE	1.3.1.9	20	Change the first sentence to read “Consider whether a person with common mental health disorder would benefit from social, employment, educational or vocational support. If so, consider:”.	Thank you, but we do not think this is an improvement on the original wording.
Department for Work and Pensions	NICE	1.3.1.9	20	Add a bullet reading: “employment support services and the Access to Work scheme, which can offer financial support for workplace adjustments.”	Thank you for your comment, we have added a bullet point about educational support services.
Department for Work and Pensions	NICE	1.3.2.1	21	Add a sentence reading “Consider the potential benefits of social contact and interaction, for example as provided by remaining in work or education where possible.”	Thank you for this comment we do not think that this would be appropriate to include in this recommendation. We have made reference to employment issues elsewhere (1.3.1.9).
Department	NICE	1.4.1	27	Add the words “and which take account of an individual’s wider	Thank you for your comment. Although we have not made the

for Work and Pensions		.4		circumstances such as their employment and social environment".	suggested change, we have made a number of amendments along these lines to the recommendations in this guideline.
Department for Work and Pensions	NICE	1.4.1 .8	29	Add bullet reading "build links with other local services which provide support for people's wider circumstances – eg employment support and the Access to Work scheme, debt advice, housing support".	Thank you for your comment. We have made a number of recommendations advising clinicians to take the person's personal circumstances into account, and these have been strengthened since the consultation on this guideline. However we do not think it would be appropriate to make this particular change because it is for services to adapt the recommendations appropriately.
Department of Health	Full	4.1.2	61	We are concerned that access to healthcare for CMHD for socially excluded groups in general and for offenders (within prisons and before and after incarceration) does not appear to be mentioned. There are many other socially excluded people who can be categorised by their addictions, their homelessness, their poverty, their traveller status, asylum seekers, sex workers, young people from the looked after system and so on. Offenders are a group derived from all of the above. In our view, this is very important since common mental health problems are very prevalent, 90% of people in prison suffer from mental health or addiction problems, and 10% having severe and enduring mental illness overlaid again by common problems. In addition the CMHD suffered by offenders is often a driver of their substance misuse, alcohol addiction and offending behaviours and of course vice versa. There are important issues for society and individuals. Many of the issues mentioned later in the guidance is heightened by considering offenders who are often shunned by primary care concerned by risks of violence, fear of stigma by the offenders, and in prison the difficulties of the environment and paucity of services which heighten the impact of the CMHD on well being.	We agree this is an important issue and we have added a new recommendation to the current version (1.1.1.5) in light of your comments. In addition, we have recommended that practitioners should be culturally competent, and should take into account the effect that immigration and employment status, social isolation and other factors have on the development of common mental health disorders (1.3.2.6 in the current version).
Department of Health	Full	Ch. 4	63	In addition, the focus on older people and BME groups misses a major group again who are over-represented in offenders. Young men suffer many CMHD and also do not routinely seek help. The resulting self-medication with illicit substances and	Thank you for your comment. We agree that young men are a group that often suffer from poor access to healthcare. Unfortunately there was little evidence concerning young men, with no indication about specific methods to improve access

				alcohol drives the deleterious life effects and again drives offending. Improving access to healthcare for young men should be a major focus for the guidance.	that are not the same for all people.
Department of Health	Full	4.2.1		Could you please clarify what factors, or attributes of the individual who requires mental healthcare, can inhibit access to services. As above – social exclusion, offender status, substance misuse and alcohol, young males. Could you please clarify what practitioner-level factors or attributes can inhibit an individual from accessing healthcare. As above – in primary care socially excluded people and in particular offenders are perceived to be undesirable in a standard general practitioner service so their ease of registration is impaired. These patients are bad for the GPs business. There is then a lack of capacity in practices specializing in social exclusion and in the available primary care mental health support. (note Inclusion Health DH 2010, and Marmot. Could you please confirm whether systems and processes utilised in mental healthcare services inhibit access to healthcare. As above - access via prisons or specialized practices is difficult mainly through capacity as other practitioner factors are managed in these settings. Services tend to be fragmented and not integrated resulting in lack of coordinated care, poor clinical information sharing and extreme difficulty for patients in navigating through the services and staying on care pathways. Could you please clarify what practical or resource-based factors inhibit access to mental healthcare services. In our view, access to the primary care medical record can be difficult in prisons, the criminal justice system and in primary care between and within services.	Thank you for your comment. We did not exclude offenders from the populations of interest who may need additional consideration. The chapter concerned presents the available evidence. There was available evidence that pertained to BME groups and older people. However, this section of the review also addresses factors that may impede access to healthcare for the 'general population'. It should be noted that although a review of prison healthcare services was outside the scope, the factors that affect access to healthcare identified in this review could be applied to the healthcare professionals who care for the offender population.
Department of Health	Full	General		The failure to address the impact of social exclusion, including people in contact with the criminal justice system, being a young deprived male, and the huge impact of substance and alcohol dependence in this guidance are very significant deficits which will appear so in the final product we would	Thank for you for this comment – we agree that these are important issues but in significant part (drugs and alcohol, the criminal justice system) are outside the scope of the guideline. However in both the ASPD guideline and the drug alcohol

				implore NICE to address them effectively.	guidelines we have made serious attempts to address the issues you raise – developing recommendations which support the provision of interventions within the criminal justice system.
Department of Health	Full	Ch. 4	74	Service developments or changes that are specifically designed to promote access. Develop capacity in specialized primary care services to meet the need of socially excluded groups and co-locate and integrate with services to support CMHD. Specialised and trained gps will be able to deliver much of this care without needing to refer and therefore more cheaply. This is the stuff of these services. Improve the sharing of clinical information across the criminal justice pathway. We are doing this through providing gp clinical systems in prisons but a lot remains to join up across the cjs pathway. Specific models of service delivery (that is, community- based outreach clinics, clinics or services in non-health settings). Methods designed to remove barriers to access (including stigma (both cultural and self and stigmatization), misinformation or cultural beliefs about the nature of mental disorder). Offenders since 2006 have their care commissioned by the NHS and they must be treated with absolute equivalence and so issues of access, stigma, continuity, trained providers and professionals, and support to manage the drivers of people's social exclusion must be major features of the guidance.	This guideline aims to make recommendations about general principles that underpin effective care pathways, in order that individual services can interpret them in an appropriate manner. In this sense, the guideline is true to its scope, which was consulted on during October 2009, which states: "the guideline will not provide specific recommendations for prison medical services but it will be relevant to their work." In spite of this, recommendations in the consultation version of this guideline regarding access, stigma, social exclusion and practitioner competence are relevant to the issues your raise. However, we have added recommendation 1.1.1.6 (in the current version) to further address this issue.
Department of Health	Full	Ch. 4	83	Could you please clarify whether new service developments targeted at changing the behavior of the individual or the practitioner improve access to healthcare services. Primary care mental health services in prisons have evidence in relation to reducing offending behavior. – offender health research network, contact Jenny Shaw at Manchester University. Could you please clarify whether service developments targeted at the healthcare system improve access to healthcare services, and do specific treatments or interventions developed for vulnerable groups improve access to healthcare services?	Thank you for your comment. As can be seen in the review of service developments and interventions that are specifically designed to promote access (section 4.4), there is a paucity of evidence relating specifically to mental healthcare. In addition, this section relied on existing systematic reviews to evaluate new service developments targeted at the individual or practitioner that are specifically designed to improve access to healthcare . Therefore, the aim of the majority of review was to evaluate the benefit of these interventions in improving access-focused outcomes, patient satisfaction and patient understanding and not the effectiveness of interventions per

				Could you please note the reference to the Cabinet office report 'Inclusion Health" 2010 – contact kate.oakes@dh.gsi.gov.uk regarding the references and evidence of effectiveness of a number of services for socially excluded people including offenders.	se. A review of the suggested area (the effectiveness of interventions) was not appropriate for this section of the guideline as the key focus was changing the health practitioner's behaviour.
Department of Health	Full	4.4.5	93	We support the list of issues both in offenders and in asylum seekers.	Thank you for your comment.
Department of Health	Full	4.5		Could you please ensure that there are recommendations related to the issues above, in relation to care provided to socially excluded groups in general and to offenders in particular. Perhaps best addressed by the difficulty in constructing stable care pathways and helping people in these categories to stay on these pathways.	Thank you for this comment, we have made a number of amendments to the recommendations (see 1.1.1.5) in relation to your comment **.**
Humber NHS Foundation Trust	NICE	General	General	Once again, they have overlooked the effectiveness of counselling. We all know CBT produces good statistics, but it does not mean counselling is not as effective – sometimes the patient needs to tell their story and grieve for what has happened to them, rather than be psychoeducated, and as counsellors are multimodal trained, we can do both anyway! In the past NICE did a turn around and included counselling, think they've gone back a step with this guidance and are undermining confidence in our profession. As for the term IPT (Interpersonal therapy), they've just reinvented the wheel – all counselling is interpersonal – it's the backbone of what we do. Also note that there still isn't a guideline for survivors of childhood abuse – a huge area of concern, where we are receiving rising numbers of referrals in Primary and Secondary Care, and an ideal issue for counselling proper, not CBT	Thank you for your comment. The evidence that we reviewed about interventions including counselling, CBT and IPT did not support the statements you make here about their equivalence and effectiveness. However, please note that counselling is included in the stepped care model represented in this guideline. Although it is the case that this guideline does not specifically focus on the treatment of people who have been victims of sexual abuse, however please note that the evidence for this is reviewed in the PTSD guideline (CG26).
Lilly UK	Full/ NICE	General	General	Eli Lilly and Company Limited commend the Guideline Development Group (GDG) on work conducted and the quality of the draft guideline recommendations for common mental health disorders. We believe that in general the guidelines reflect current practice and offer a rational approach to the identification of, and pathways to care for patients with common mental health disorders. We understand that the treatment of these conditions is covered in more depth in other related NICE Guidelines.	Thank you for these comments. We agree remission is important but commenting on detail in treatment outcomes, which are not reviewed here, is outside of the scope of this guideline.

				We do however have a few comments which we would like to draw to the attention of the GDG for consideration. These relate to the inclusion of a recommendation for screening for depression in patients presenting with unexplained somatic symptoms, and the inclusion of an assessment for somatic symptoms. We also consider that the guidelines should make reference to remission being the primary goal of treatment. Globally recognised treatment guidelines for depression produced by the American Psychiatric Association 2010, The Canadian Psychiatric Association 2004, Australian and New Zealand Clinical Practice Guidelines 2004 and the WHO Regional Office for Europe 2005 make this recommendation and we believe it applies to the broader group of common mental health disorders, including depression and generalised anxiety disorder (GAD).	
Lilly UK	Full NICE	2.3.1	32	Summary of pharmacological treatments for depression and GAD omit serotonin noradrenaline reuptake inhibitors (SNRIs) such as duloxetine. Cymbalta (duloxetine) is licensed for the treatment of major depressive disorder (MDD) and GAD in adults (SPC).	Thank you for your comment – given this section is in the introduction, we have simplified the text to read: "There is a wide range of antidepressant drugs available for people with depression. These can be grouped into tricyclic antidepressants (TCAs), selective serotonin reuptake inhibitors (SSRIs), monoamine oxidase inhibitors (MAOIs) and a range of other chemically unrelated antidepressants (British National Formulary [BNF] 57, 2009)."
Lilly UK	Full NICE	5.2.1 1.1 1.2.1 .1	127 13	A high proportion of patients consulting a GP will present with unexplained somatic symptoms. The Full guidelines, page 37 cites that "*of 80 depressed people per 1000 population who consult their GP 49 are not recognised as depressed as they are consulting for a somatic symptom, and do not consider themselves mentally unwell, despite having the presence of symptoms of depression."* In order to make practitioners aware of this fact and highlight the fact they need to question the patient in more depth we would recommend the inclusion of the following text:	Thank you, we have amended recommendation 1.3.1.1, which is about somatic presentation of depression. Medically unexplained symptoms are outside of the scope of this guideline, and additionally there has not been a guideline about this issue; so for these reasons it would be inappropriate for any further changes to be made to the guideline.

				Practitioners should be alert to the possibility that more than 50% of patients with depression may present with somatic symptoms and may not consider themselves to have depression	
Lilly UK	Full/ NICE	5.3.8 .3 1.2.2 .3	141 15	The Full guidelines recognise pain as a symptom of depression. Page 15 states: *"Behavioural and physical symptoms typically include tearfulness, irritability, social withdrawal, an exacerbation of pre-existing pains and pains secondary to increased muscle tension"* As there are a proportion of patients that remain unrecognised on the grounds of presentation of somatic symptoms only (see comment 2) we would suggest that the guidelines include a recommendation for the assessment of somatic symptoms. The validated assessment measures suggested for depression in the NICE version 1.2.2.3 (PHQ-9 and HADS) do not evaluate for painful symptoms.	Thank you – we have amended recommendation 1.3.1.1 in light of your previous comment, which we believe addresses your concern here in part. The recommendation on assessment of functional impairment (1.4.1.1) we believe is the most appropriate way to address the issue of co-existing pain.
Lilly UK	NICE	1.4.1 .4	28	The Full guidelines page 213 state: *"A number of clear principles emerged from the evidence review that were associated with positive outcomes and these are reflected in the recommendations below. They focus on the provision of information, the active involvement of the patient in the process of care, clarity about the pathways through care and the processes by which this is assessed, the provision of effective follow up, the need for inter-professional communication, and an overarching principle that all of these approaches should be delivered in an integrated manner"* Thus the provision of effective follow up for interventions is an important part of the care pathway and this is not reflected in the NICE guidelines. We suggest amending this recommendation to specifically include the provision of effective follow up as follows:	Thank you for your comment. We have not made the suggested change to the text because it is not supported by a review of evidence in this and other NICE guidelines.

				Primary and secondary care clinicians, managers and commissioners should work together to design care pathways so that they promote and support the service user in the choice of a range of evidence-based interventions with the provision of effective follow up, at each step in the pathway	
Lilly UK	Full/ NICE	General	General	**References** American Psychiatric Association. Practice guidelines for the treatment of patients with major depressive disorder, Third Edition. American Journal of Psychiatry October 2010. http://www.psychiatryonline.com/pracGuide/pracGuideChapToc_7.aspx Accessed December 2010 Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Depression. Australian New Zealand Journal of Psychiatry 2004; 38: 389-407 Cymbalta. Summary of Product Characteristics. Lilly ; March 2009 Möllher HJ. WHO Regional Office for Europe. Health Evidence Network Report 2005 O'Donovan C. The Canadian Psychiatric Association in conjunction with the Canadian Network for Mood and Anxiety Treatments. Canadian Journal of Psychiatry 2004; 49 (1); 5S-9S	Thank you for this information.
Ministry of Defence (MoD)	Full	General	General	There is no mention of the occupational impact of CMHDs nor is there any mention of the role of occupational rehabilitation in the management of the conditions. It would make good sense to link in the Government's Agenda to get people to work (even if suffering from some level of ill health).	Thank you for this comment, in light of which we have reviewed the recommendations and made reference to the impact of occupational factors on common mental health disorders. However, a specific focus on occupational rehabilitation is outside of the scope of this guideline – not least because the evidence for it has not be fully evaluated in the existing NICE guidelines.
Ministry of Defence (MoD)	Full/ Appendice	General	General	No mention is made of the UK military mental health research which has examined the outcomes of service personnel who suffer with a range of conditions (mostly CMHDs) although	Thank you for this comment – the delivery of services for the military is outside the scope of the guideline and so much of the research will not directly apply. However the guideline will

	s			there are some US military health research papers quoted. Much (but not all) of the UK military mental health research is on www.kcl.ac.uk/kcmhr	of course apply to ex-service personnel who will access and be treated in the NHS, and we will review our recommendations and text to make sure this is clear.
National Treatment Agency for Substance Misuse	NICE	1.1.1 .4	11	1.1.1.4: Given the high co-occurrence of CMHD and drug and alcohol problems, clarity on eligibility with specific regard to drug and alcohol use and problems would be welcomed. Service users often experience inconsistent and unfounded exclusion criteria with regard to drug and alcohol use when seeking help for CMHD.	Thank you – we agree this is an issue and have developed and amended a number of recommendations on this issue to address your concerns. We do not feel that amendment of this recommendation would properly address the issue you have raised.
National Treatment Agency for Substance Misuse	NICE	1.2.1 .1	13	1.2.1.1. Suggest addition of drug and or alcohol use to triggers to asking depression screening questions given the high prevalence of co-occurrence	Thank you - where a drug or alcohol problems is identified – other guidance provided advice on the structure and content of the assessment and the identification of comorbid CMHDs We think it best that we keep clearly within the scope of the guideline to follow up on your suggestion would we believe take us a outside of that scope.
National Treatment Agency for Substance Misuse	NICE	1.2.2 .6	16	1.2.2.6: Add; drug or alcohol use. Reference to screening tools may be useful e.g. for alcohol see NICE PHG 24 2010.	Thank you but screening for alcohol and substance misuse is outside the scope of the guideline
National Treatment Agency for Substance Misuse	Full	2.2.5	28	2.2.5: The recognition of the potential for timely treatment of CMHD in avoiding the later development of drug and alcohol problems is helpful.	Thank you for your comment.
National Treatment Agency for Substance Misuse	FULL	6.3.4	163	Table 29: This does not include reference to NICE 51 Drug Misuse; Psychosocial Interventions (2007) and NICE (2010) Draft Guidelines on Alcohol Use Disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. Both make specific reference to following the range of NICE CG regarding CMHD, e.g. NICE 51 "*there is no evidence supporting the view that psychological treatments for common mental disorders are ineffective for people with substance misuse disorders (see for example, Woody et al., 1985)*." Page 116.	Thank you for this suggestion. Where appropriate, we have added the drug misuse and alcohol guideline recommendations to the analysis of existing guidelines (Table 27).

National Treatment Agency for Substance Misuse	FULL	6.3.8.5	177	6.3.8.5: Reference to co-existing alcohol problems is helpful given high co-occurrence. Sequential treatment beginning with alcohol treatment is appropriate in the first instance, but ensuring service users also receive subsequent treatment for CMHD is essential. Not doing so may lead to relapse of both problems. Further guidance would be helpful on the provision of treatment for service users who do not respond to first line substance misuse treatment; and where parallel treatment and close working between substance misuse and CMHD services might be essential to achieve any improvement in either problem. Formulation-based psychological interventions that conceptualise the inter-relationship between CMHD and substance misuse would be appropriate; delivered by psychological practitioners with addictions and mental health competences. As referenced elsewhere in this guidance (pg. 172) – untreated drug and alcohol use predicts poor outcomes for treatment of CMHD. Similarly, untreated CMHD predicts poor outcomes for drug and alcohol problems.	Thank you for this comment. Unfortunately in the development of this guideline we were not able to review interventions or make recommendations that were not covered by existing NICE guidelines. We will however consider your comment in any future updates of the NICE alcohol guidelines.
National Treatment Agency for Substance Misuse	FULL	6.3.8.5	177	6.3.8.5: No similar reference is made to co-existing drug use problems and CMHD. See comments above regarding the limits of sequential treatment models.	Thank you for this comment, as stated in our previous comment we were not able in this guideline to review interventions or make recommendations that were not covered by existing guidelines. We will however review this issue if requested by NICE to update clinical guidelines on drug misuse.
National Treatment Agency for Substance Misuse	FULL	6.3.8.5.	177	6.3.8.5: Opiate dependent service users who have reached a level of stability with opiate substitution therapy and continue to use prescribed opiate substitution should not be routinely excluded from treatment services for CMHD. Close working with substance misuse treatment services would be warranted.	Thank you for this comment. As previously mentioned, in the development of this guideline we were not able to review interventions or make recommendations that were not covered by existing NICE guidelines. We will review this issue if requested by NICE to update clinical guidelines on drug misuse, and would expect that practice will develop along the lines you suggest.

NETSCC, Health Technology Assessment (Ref 1)	Full	General	General	**2.2 Please comment on the health economics and/or statistical issues depending on your area of expertise.** Statistical aspects of the review appear to have been well handled.	Thank you for your comment.
NETSCC, Health Technology Assessment (Ref 1)	Full	General	General	**3.1 How far are the recommendations based on the findings? Are they a) justified i.e. not overstated or understated given the evidence? b) Complete? i.e. are all the important aspects of the evidence reflected?** Overall I felt that that the recommendations were justified by the findings. The one exception to this is regarding ROMs in Chapter 6. No Economic evaluation was undertaken and I assume that this was because no evidence was found but this should be made clear. Given the very small effect size of the benefit of ROMs found in the review a cost-effectiveness analysis is therefore very important and I would feel needed prior to recommending using ROMs.	Thank you for your comments. We've added section 6.4.6 to the review of ROM to indicate that no health economic evidence was found. During consultation, Lambert and colleagues published an update to the meta-analysis included in Chapter 6 (LAMBERT2003). The new review added three more studies, and provides further support for ROM. This update will be added to the chapter. Furthermore, during consideration of the evidence, the GDG considered that the benefits of ROM stretch beyond just clinical benefits into understanding patient flows, and there is good evidence that routine collection of data informs service review and evaluation.
NETSCC, Health Technology Assessment (Ref 1)	Full	Chapter 5	General	**4.1 Is the whole report readable and well presented? Please comment on the overall style and whether, for example, it is easy to understand how the recommendations have been reached from the evidence.** It would be useful at the beginning of this chapter to include definitions of 'case ascertainment' and 'formal assessment' in order for the distinction to be clear to the reader.	Thank you for your comment. We do not use the term 'case ascertainment' and the terms case identification and formal assessment are defined later in the chapter.
NETSCC, Health Technology Assessment (Ref 1)	Full	5.3.8.11	143	**4.2 Please comment on whether the research recommendations, if included, are clear and justified.** The issue of comparability of different assessment tools had not previously been raised. While this is obvious to people with research methodology expertise this recommendation does come somewhat out of the blue.	Thank you for your comment. We have amended section 5.3.7 to include a paragraph about why the research recommendations were made.
NETSCC, Health Technology Assessment	Full	3.5.2	48	**Section five – additional comments** **Please make any additional comments you want the NICE Guideline Development Group to see, feel free to use as much or as little space as you wish.**	The section 3.5.2 is about the search process, therefore it's not appropriate to describe review manager. The appropriate place to cite Review Manager is in section 3.5.3 where the version number is given in the first paragraph

(Ref 1)				Review Manager has not been described in any way or a version number given. It is given later on page 49.	
NETSCC, Health Technology Assessment (Ref 1)	Full	Throughout	General	**Section five – additional comments** **Please make any additional comments you want the NICE Guideline Development Group to see, feel free to use as much or as little space as you wish.** References to page footnotes have not been superscripted so can make text confusing	Thank you for pointing out this formatting error, which has been corrected.
NETSCC, Health Technology Assessment (Ref 1)	Full	General	81	**Section five – additional comments** **Please make any additional comments you want the NICE Guideline Development Group to see, feel free to use as much or as little space as you wish.** Last sentence of first paragraph should be next sub-heading	Thank you for pointing out this error, which has now been amended.
NETSCC, Health Technology Assessment (Ref 1)	Full	5.2.10	126	**Section five – additional comments** **Please make any additional comments you want the NICE Guideline Development Group to see, feel free to use as much or as little space as you wish.** Second paragraph – about halfway down, it says 'who has a consequence..'. Should say 'as a consequence'.	Thank you, we agree and have made this amendment.
NETSCC, Health Technology Assessment (Ref 1)	Full	5.2.10	132	**Section five – additional comments** **Please make any additional comments you want the NICE Guideline Development Group to see, feel free to use as much or as little space as you wish.** Last line – Has APMH been expressed in Full? Can not remember what it stands for.	Thank you, it appears that APMH (Antenatal and postnatal mental health) had not been expressed in full in the consultation draft. This has been amended in the current draft.
NETSCC, Health Technology Assessment (Ref 1)	Full	5.2.10	171	**Section five – additional comments** **Please make any additional comments you want the NICE Guideline Development Group to see, feel free to use as much or as little space as you wish.** 2nd sentence of 2nd paragraph. Sure the OR indicates that for each additional year of age at onset the risk is lowered by 4% not 96%.	Thank you for this comment. We think you are referring to section 6.3.5 (not 5.2.10) where the text reads: "A large number of clinical factors have been found to predict rates of recurrence. Age of onset of first depressive episode in particular is an important factor, with each additional year of age at onset lowering the risk by 0.96 (95% CI 0.93-0.99)." This comes from HARDEVELD2010 who quoted Eaton WW,

					Shao H, Nestadt G, Lee HB, Bienvenu OJ, Zandi P. Population-based study of first onset and chronicity in major depressive disorder. Achieves of General Psychiatry 2008;65:513–520. We have checked the original reference, and the text in the guideline appears correct. In addition, the text as it stands indicates that the risk was reduced by just under 1%, not 96%.
NETSCC, Health Technology Assessment (Ref 1)	Full	5.2.10	207	**Section five – additional comments** **Please make any additional comments you want the NICE Guideline Development Group to see, feel free to use as much or as little space as you wish.** Table 40 – CHANGQUAN2009 entry. The first two sets of OR and CIs indicate negative ORs which are not possible, maybe they are meant to be effect sizes?	Thank you, the text in Table 40 (in section 7.2.4 not 5.2.10, of the consultation version) should have read: At 18 and 24 months, collaborative care interventions were superior to usual care in improving depression scores (MD = -0.44, 95% CI, -0.55 to -0.33 and MD = -0.35, 95% CI, -0.46 to -0.24, respectively), response rates (OR = 2.38, 95% CI, 1.88 to 3.02 and OR = 1.67, 95% CI, 1.63 to 2.12, respectively) and remission rates (OR = 2.29, 95% CI, 1.42 to 3.10 and OR = 1.83, 95% CI, 1.34 to 1.98, respectively). This has been corrected in the current version.
NETSCC, Health Technology Assessment (Ref 2)	Full	General	General	**1.1 Are there any important ways in which the work has not fulfilled the declared intentions of the NICE guideline (compared to its scope – attached)** No, the intentions of the scope seem to have been covered adequately.	Thank you for your comment.
NETSCC, Health Technology Assessment (Ref 2)	Full	General	General	**2.1 Please comment on the validity of the work i.e. the quality of the methods and their application (the methods should comply with NICE's Guidelines Manual available at http://www.nice.org.uk/page.aspx?o=guidelinesmanual).** In general, the methods appear sound. I have made a few specific comments about the economic methods in the next section.	Thank you for your comment.
NETSCC, Health Technology Assessment	Full	3.6	General	**2.2 Please comment on the health economics and/or statistical issues depending on your area of expertise.** This is an unusually clear and well presented economics	Thank you for your comment.

(Ref 2)				methods section.	
NETSCC, Health Technology Assessment (Ref 2)	Full	3.6	54	**2.2 Please comment on the health economics and/or statistical issues depending on your area of expertise.** The section states that modeling was undertaken in areas with likely major resource implications or where the current extent of uncertainty was significant. However, I get the impression that the model undertaken was more about being the only area with any data. Perhaps the authors could clarify.	Thank you for your suggestion, we have clarified this issue in the text. Modelling was undertaken in areas with major resource implications, where available clinical data allowed the development of an economic model.
NETSCC, Health Technology Assessment (Ref 2)	Full	3.6.1	55	**2.2 Please comment on the health economics and/or statistical issues depending on your area of expertise.** “Searches were restricted to economic studies…” Please clarify ‘economic study’. Full economic evaluation? Partial? Costing?	Thank you for your comment. Inclusion criteria for economic studies are listed in the next sub-section. However, we have now clarified this issue also in this paragraph.
NETSCC, Health Technology Assessment (Ref 2)	Full	3.6.1	56	**2.2 Please comment on the health economics and/or statistical issues depending on your area of expertise.** Explain what is meant by a filter for ‘health economics’. This is related to the previous point. What type of ‘health economic’ studies were being searched for? Also, add reference to the filter designed by CRD.	The search filter for health economics is an adaptation of a pre-tested strategy designed by the CRD, and is used to retrieve records of economic evidence from the vast amount of literature indexed to major medical databases. The filter for health economic studies is included in appendix 8 – we have added the cross-reference and expanded on the methodological text as required. We have also added the reference to the filter designed by CRD.
NETSCC, Health Technology Assessment (Ref 2)	Full	4.5	97-	**2.2 Please comment on the health economics and/or statistical issues depending on your area of expertise.** A number of recommendations in this (and indeed other) section(s) (e.g. assessment and interventions outside normal working hours, interventions in the service user's home or other residential settings, crèche facilities, assistance with transport or travel and advocacy services) may involve relatively substantial additional expenditure. Whilst there is no economic evidence to draw upon, was this discussed by the GDG and an informal consensus arrived at, as described in Section 3.5.5 for areas where data are not available? I see no reason why informal consensus wouldn’t be as relevant for gaps in the economic evidence as for gaps in the clinical	Thank you for this comment. We have made a number of amendments to the text in light of your and other comments to clarify the methods.

				evidence, but this section does not allude to such consensus.	
NETSCC, Health Technology Assessment (Ref 2)	Full	5	100-	**2.2 Please comment on the health economics and/or statistical issues depending on your area of expertise.** The clinical section focuses on anxiety because of recent reviews as part of other NICE guidelines in depression. Did these guidelines not explore cost-effectiveness?	Thank you for your comment. The clinical section in chapter 5 focused on anxiety because no existing guideline on anxiety had examined brief case identification instruments. Regarding cost-effectiveness, although health economic modelling was undertaken in both the depression guideline and the update to the anxiety guideline, this focused on treatment interventions rather than identification strategies. it was therefore thought that modelling the relative cost effectiveness of identification methods for people with anxiety disorders would be most useful in this guideline.
NETSCC, Health Technology Assessment (Ref 2)	Full	5.2.7	120	**2.2 Please comment on the health economics and/or statistical issues depending on your area of expertise.** “Depending upon the woman’s actual state of anxiety and her diagnosis she was then assigned to one of the three treatment components and followed up for 34 weeks until the model end point.” Presumably this shouldn’t be ‘woman’ or ‘she’? The term ‘people’ was used previously in the description of this model.	Thank you for pointing out this error, which has now been corrected.
NETSCC, Health Technology Assessment (Ref 2)	Full	5.2.7	120	**2.2 Please comment on the health economics and/or statistical issues depending on your area of expertise.** **“**The economic analysis adopted the perspective of the NHS and personal social services, as recommended by NICE (2009b). Costs consisted of intervention costs (GP visit costs and low- and high-intensity psychological interventions).” This sentence suggests only intervention costs included, which doesn’t match with the stated perspective. Clarify that in fact this is not the case to avoid confusion.	Thank you for your comment. Costs consisted of identification costs, treatment costs, as well as further health and social care costs incurred by people with GAD not identified or not responding to treatment. We have now clarified this issue in the final text.
NETSCC, Health Technology Assessment (Ref 2)	Full	5.2.7	122	**2.2 Please comment on the health economics and/or statistical issues depending on your area of expertise.** The low intensity intervention is extremely cheap for a psychological intervention. Is this a group-based intervention? Some description would be useful, alongside the description given for the high intensity intervention.	Thank you, we have provided all the details of costing low intensity psychological interventions in table 17.

NETSCC, Health Technology Assessment (Ref 2)	Full	5.2.7	121	**2.2 Please comment on the health economics and/or statistical issues depending on your area of expertise.** The main assumption not tested in sensitivity analysis relates to the treatment options received ("Those identified positive for anxiety, were assumed to receive one of the following treatment options"). This could do with some discussion. What exactly is this assumption based upon? The guideline on generalised anxiety disorder (partial update)? Does it reflect what actually happens to people in clinical practice, or is it more aspirational (i.e. based on guidelines of what should happen)?	Thank you for your comment. We have now clarified in the text (model structure) that the care pathways for people identified as having GAD reflect the care pathways described in the NICE guideline on anxiety disorders, partial update, supported by further GDG expert opinion.
NETSCC, Health Technology Assessment (Ref 2)	Full	5.2.7	General	**2.2 Please comment on the health economics and/or statistical issues depending on your area of expertise.** There is quite a lot of reference to data contained within the guideline on generalised anxiety disorder (partial update), which is not yet available. It would perhaps be more useful to refer to original publications, where relevant, or to explain exactly how the data was generated. In other words, does the data in the guideline come from other publications or is it generated as part of some analysis such as modelling undertaken for the guideline?	Thank you for your comment. At the time of consultation for this guideine, the consultation version of the the NICE anxiety, partial update, guideline (CG 113) was also publically, although this was not made clear in the guideline. Nevertheless, we agree that further explanation of how the data were generated could be made, and the text, especially table 17 providing input parameters of the economic model, has been amended to reflect this. It should be noted the partial update of the anxiety guideline has now been published.
NETSCC, Health Technology Assessment (Ref 2)	Full	7.3	212	**2.2 Please comment on the health economics and/or statistical issues depending on your area of expertise.** How come the two studies identified in the clinical review that included both costs and outcomes (BADAMGARAV2003 and NEUMEYERGROMEN2004) were not located via the economic review?	Thank you for your comment. We have reviewed the studies in these reviews, however they have not been included. A number of the clinical studies assess collaborative care, which was not recommended in the NICE updated guideline on depression (CG 90), and so it would not be appropriate to review them here (as is explained in the methods chapter of the full guideline). Other papers did not meet the inclusion criteria.
NETSCC, Health Technology Assessment (Ref 2)	Full	7.3	212	**2.2 Please comment on the health economics and/or statistical issues depending on your area of expertise.** It's not entirely clear to me how a CBT versus brief therapy study is an example of an evaluation of different care pathways. Seems more like an evaluation of alternative interventions.	Thank you for your comment. This study evaluated stepped care vs. standard 'matched' care; the interventions discussed were provided within alternative care pathways, as the stepped care approach offered CBT of different intensities at different phases of the pathway. This has now been clarified in the text.

NETSCC, Health Technology Assessment (Ref 2)	Full	General	General	**3.1 How far are the recommendations based on the findings? Are they a) justified i.e. not overstated or understated given the evidence? b) Complete? i.e. are all the important aspects of the evidence reflected?** The recommendations are based on a combination of the evidence and GDG consensus. The authors are quite clear where evidence was limited and consensus was relied on instead.	Thank you for your comment.
NETSCC, Health Technology Assessment (Ref 2)	Full	General	General	**3.2 Are any important limitations of the evidence clearly described and discussed?** No	Thank you for your comment. We are not sure if you are suggesting there is no problem, or if we haven't described important limitations. If the latter, then please see the clinical summaries and evidence to recommendations sections where we detail important limitations if they existed.
NETSCC, Health Technology Assessment (Ref 2)	Full	General	General	**4.1 Is the whole report readable and well presented? Please comment on the overall style and whether, for example, it is easy to understand how the recommendations have been reached from the evidence.** Very readable and well presented	Thank you for your comment.
NETSCC, Health Technology Assessment (Ref 2)	Full	General	General	**4.2 Please comment on whether the research recommendations, if included, are clear and justified.** All seem clear and justified.	Thank you for your comment.
NHS Direct	General			NHS Direct welcome the guidance and have no comments on the content.	Thank you for your comment.
Pfizer Limited	NICE	1.2.1.2	14	We suggest including the enclosed text as the second sentence for this point "These may present as psychic or somatic symptoms or as co-morbidities with other psychological conditions e.g. depression" (Wittchen HU, *et al*. J Clin Psychiatry. 2002; 63: 24–34) after 'Be alert to possible anxiety disorders (particularly in people with a past history of anxiety or who have experienced a recent traumatic event)'.	Thank you but we do not think that the available evidence would suggest that this would lead to increased case identification.
Pfizer Limited	NICE	1.2.2.4	15	We welcome points 1.2.2.4 and 1.2.2.5 which emphasise the need for all staff carrying out the assessment of common	Thank you for this comment. We have made it clear that our recommendations apply to all staff, and do not think it would be

				mental health disorders should be trained in the assessment of the presenting problem, verbal and non-verbal communication and use of formal assessment measures given that “both anxiety and depression often go undiagnosed”(page 4, NICE version). However as “Recognition of anxiety disorders by GPs is particularly poor, and only a small minority of people who experience anxiety disorders ever receive treatment” ” (page 4, NICE version) we believe that the “all staff’ should be amended to “all staff including GPs”.	helpful to single out GPs in this particular case.
Pfizer Limited	NICE	1.2.2 .4	15	The point states that staff should be trained to determine the severity of the presenting problem(s)/disorder. The NICE version of the guideline appropriately refers to the GAD-7, PHQ-9 and HADS which are appropriate for use in primary care and give an indication of severity. However, formal assessment of the nature and severity of the common mental health disorders is only discussed in section 5.3 of the Full version of the guideline. Text on formal assessment should be included in the NICE version of the guideline.	Thank you for your comment. We agree this issue is important, however the format of NICE guidelines is fixed; all guidelines only contain recommendations and not explanatory text. More detailed discussion can be found in the full guideline text.
Pfizer Limited	NICE	1.3.1 .4	19	We propose adding two bullet point that state 1) “If anxiety and depression are both present without a clear predominant condition, consider treatment of both conditions simultaneously. 2) If the patient doesn’t respond to an initial treatment for the predominant condition, consider adding a treatment for anxiety or depression”	Thank you but we do not have any evidence which suggest that your strategy would be more effective than the one we suggest which is based on the reviews of treatment undertaken for the other NICE guidelines.
Pfizer Limited	NICE	1.3.1 .4	19	We propose that the third bullet point may be more appropriate if revised to read “both anxiety and depressive symptoms, with no formal diagnosis, that are associated with functional impairment, discuss with the service user the symptoms to treat first and the choice of intervention”	Thank you, we have adopted the suggestion you make.
Pfizer Limited	NICE	1.3.2 .4	22	Whilst the guideline refers to stepped care “Developing care pathways - Primary and secondary care clinicians, managers and commissioners should work together to design care pathways that promote a stepped-care model of service delivery” stepped care is not defined in the guideline. Stepped care needs to be outlined as presently the guideline does not adequately reflect that common mental disorders can be treated in primary care by appropriately trained staff. Points	Thank you for your comment. We have now added a stepped care model and an explanation of the model to both the NICE and full guidelines. We do not agree that referral to these services will increase the work load of specific mental health services, as they will be provided in general primary care settings and not specific mental health services

				1.3.2.4 and 1.3.3.5 on referral could be misconstrued as suggesting that generalised anxiety disorder should be immediately referred. This could result in unnecessary referral and increase the waiting list for specialist mental health services.	
Pfizer Limited	NICE	1.3.3.5	24	Given that the stepped care model has not been included in the guideline it is not clear when interventions such as pharmacological interventions should be introduced. Point 1.3.3.5 suggests referral for pharmacological interventions following failure on a low intensity intervention or due to marked functional impairment. Closer alignment to treatment guidelines such as “Generalised anxiety disorder and panic disorder guideline (with or without agoraphobia in adults) (partial update)” and cross referencing would increase the usefulness of this guideline.	Thank you for your comment. We have added a stepped care diagram to the NICE guideline and also made it clear the provenance of adapted or adopted recommendations with web links to the relevant guidelines.
Pfizer Limited	NICE	1.3.3.5	24	Presently the three treatment options of CBT, applied relaxation and ‘if the person prefers, drug treatment’ are treated as independent options. It is important to remember that anxiolytix may be required in order to enable some patients to actively and positively take part in CBT and moderate to severe symptoms may require a combination of these options.	Thank you for your comment. Recommendation 1.3.3.5 in the consultation version of the NICE guideline is about the referral of people with generalised anxiety disorder. As explained in the methods chapter of the full guideline, the referral recommendations in this guideline are drawn from previous NICE guidance, and so it would not be appropriate for this guideline to make recommendations that are not related to those in the NICE clinical guideline on anxiety (partial update) 113.
Princess Royal Trust for Carers, The	Full/ NICE	General	General	The right to the provision of information and support to all carers of people with mental health problems needs to be made more explicit throughout the document.	Thank you – we agree this is important and think it is dealt with in several recommendations, for example, recommendation 1.5.1.5.
Princess Royal Trust for Carers, The	Full/ NICE	General	General	The requirement and need for Primary Health Care practitioners to identify carers should be made more explicit throughout the document.	Thank you for this comment but we feel that the involvement of carers is considered at a number of key points throughout this guideline, in the introduction to the NICE guideline (patient centred care) and in a number of recommendations.
Princess Royal Trust for Carers, The	Full/ NICE	General	General	The inclusion of carers in the care planning of the “patient” (so long as consent has been provided) should be made more explicit through the document.	Thank you for this comment but we feel that the involvement of carers in the planning of care is considered in several recommendations.

Ridgeway Partnership	NICE	1.2.1 .3	14	Our comments are as follows: This section should refer to significant cognitive needs as well as language difficulties. The suggestion of a specialist LD health practitioner should be signposted.	Thank you, we have dealt with this issue in several recommendations.
Ridgeway Partnership	NICE	1.2.2 .1	15	Our comments are as follows: GPs may require additional training to identify common mental health disorders in people with a more severe learning disability.	Thank you this may be the case but strictly speaking training is outside of the scope of the guideline but see 1.2.2.7 for advice on consulting a specialist
Ridgeway Partnership	NICE	1.2.2 .3	15	Our comments are as follows: When assessing people with a learning disability, psychiatric diagnoses are particularly difficult as they may present with different psychopathology. Reference to the DC-LD manual should be made. This was developed by the Royal College of Psychiatrists to complement the use of the ICD10 manuals. The use of PASSAD and Honos LD should also be considered in the assessment / screening process for people with a learning disability.	Thank you for this comment. We agree that for specialists the kind of assessment tools that you refer to may be useful. However we do not think they would be appropriate for routine use in primary care, which is the focus of the guideline.
Ridgeway Partnership	NICE	1.2.2 .8	17	Our comments are as follows: This should include the proviso that any variations in treatment / interventions should due to e.g. level or significance of learning disability should be explained and evidenced.	Thank you, we have revised the guideline in light of your comments.
Ridgeway Partnership	NICE	1.2.2 .9	17	Our comments are as follows: If there is a significant Learning Disability the questioning and assessment should be led by a specialist learning disability health practitioner.	Thank you for your comment. We agree that this may be the case in follow up or specialist care, however it will not necessarily possible at initial assessment.
Ridgeway Partnership	NICE	1.2.3 .2	18	Our comments are as follows: Where Learning Disability Services are already involved, they should be the first port of call. Details of who to contact and when should be included in the persons Care Programme Approach (CPA) Crisis / Contingency Plan.	Thank you, we agree, however this guideline is focused on common mental health disorders in primary care, and as such we feel this recommendation is appropriate.
Ridgeway Partnership	NICE	1.3.1 .6	20	Our comments are as follows: Reference is made to Learning Difficulty. Else where reference is made to Learning Disability. Learning Disability should be used consistently throughout. The two terms are not synonymous and should not be confused.	Thank you. we have amended the text to ‘disability’.
Ridgeway Partnership	NICE	1.3.1 .8	20	Our comments are as follows: This should include Learning Disability as a bullet point. This sentence could be written a little more clearly	Thank you for your comment, but we disagree as we have specific recommendations on learning disabilities where we say that there should be no variation for people with mild learning disabilities.

Ridgeway Partnership	NICE	1.3.3 .8	24	Our comments are as follows: A specific pathway should be developed for the referral of people who have an Autistic Spectrum Disorder.	Thank you this is outside the scope of the guideline and is under consideration in the adult autism guideline.
Ridgeway Partnership	NICE	1.1.1 .5	11	Our comments are as follows: many patients may not be proactive consumers of mental health care. In some areas services are under resources and in the current climate this may get worse. Should there be some guidance to how to concerns if patients / health care practitioners cannot access the services they require.	Thank you for this comment but we consider this issue to be outside of the scope of the guideline and a matter for service commissioners.
Ridgeway Partnership	Full	Secti on 1.1, 1.2, 1.3,	11-13	Our comments are as follows. This guidance refers to providing an integrated approach to the identification and assessment of common mental health disorders. At no point does the guidance make any reference to the Care Programme Approach which should be an integrate approach to the effective coordination of mental health care. CPA should be referred to throughout but particularly in relation to assessment, risk and prevention of relapse	Thank you for your suggestion. However, the focus of this guideline is primary care, where the CPA does not apply. However, the GDG do agree that the integration of care between primary and secondary care is important in the delivery and coordination of treatment in specialist services which are largely outside the scope of the guideline
Ridgeway Partnership	Full	2.2.2	18-21	Our comments are as follows: This section should include specific reference and evidence relating to the prevalence of mental health disorders in people with a learning disability. This group experiences a higher level of mental health disorders than the general population due to the increased access to predisposing factors. Difficulties in identifying the symptoms of common mental health disorders should also be commented on. People with a learning disability may present with different psychopathology and the causes of their symptoms may be multi-factorial.	Thank you we have amended the section in light of your comments.
Ridgeway Partnership	Full	2.2.3	21 - 23	Our comments are as follows: This section should include reference to the impact of social environmental factors on mental health and wellbeing in relation to people with a learning disability.	Thank you for your comment; we have added a section on learning disabilities to section 2.2.2 of the full guideline.
Royal College of General Practitioners	Full/ NICE	Gene ral	Gene ral	Generally I think this is a really good guideline.	Thank you for your comment.
Royal	Full/	Gene	Gene	I think that the recommendation that there should be multiple	Thank you for this comment. In light of yours and other

College of General Practitioners	NICE	ral	ral	points of access is very welcome and the principal of developing different (more appropriate) care pathways for different conditions is important. The emphasis (presumably because the evidence is there) still tends towards the bio-psycho - should the 'social' have more prominence (or have i missed it?)	comments we have further adapted the recommendations to take into account social factors, including immigration and employment status, and social exclusion.
Royal College of General Practitioners	NICE	1.2.2 .1		Does point 1.2.2.1 need clarifying - should there be sentence in to state that for a patient in primary care the GP should be competent to perform a MH assessment (the way i read it, suggests that the GP may not need to be (or could be considered not) competent. I think this is important both for commissioning but also for GP training.	Thank you for this comment. We have made some minor adjustments to make it clear that the emphasis should be on competence of the professional (including GPs) undertaking the assessment.
Royal College of General Practitioners		1.3.4		the whole of this section is on referral you need to relook at this In the future - referral might not be the treatment option. it might be "discuss with collegues", "discuss with specialists" etc not referral	Thank you for this comment. In developing these recommendations we were keen to preserve the original meaning and intent. We have used the following terms: 'consider', 'offer' and 'refer', on occasion in combination. We agree that any of the above decisions may arise in consultation with colleagues, however we feel this would be a matter for clinical judgement.
Royal College of General Practitioners	NICE	1.2.3 .2		you imply that if a person is a risk of suicide then the gp must refer i disagree the good GP might reassess, might put in place saftey netting, might invovle teh out of hours services, might recruit family, friends to support during the crises. it is rather dismissive of the GP to assume the only option is referral	Thank you for your comment. The recommendation to which you refer (1.3.3.2 in the post-consultation version of the guideline) is in the context of considerable and immediate risk. In the recommendation that precedes this we advise that the GP should assess and manage high risk of suicide.
Royal College of General Practitioners	NICE	1.2.2 .4	15	can you remove the word Trained - if you are competent then it doesnt matter how you achieved this competence. you mention this further down as well	Thank you for your comment; we have removed the word 'trained'.
Royal College of General Practitioners	NICE	1.3.1 .5		the point on co-morbid alcohol (1.3.1.5) - for a GP, they would tackle both alcohol and depression/anxiety- i think this point needs re-writing.	Thank you for your comment, but the recommendation here draws on the alcohol guideline and as we have not reviewed the evidence base for it we do not think it would be appropriate to make the change that you suggest.
Royal College of General	NICE	1.2.3 .7		EMDR i am very worried about the prominence this form of therapy is being given in this NICE guidelines	Thank you for your comment. The GDG did not review the evidence for treatment effectiveness as this was done by each of the existing NICE guidelines. The rationale for this approach

Practitioners				i think you need to describe what it is and the evidence for it over and above CBT	is provided in the introduction. We have also made it clearer in the full guideline how the recommendations for referral were developed, and the rationale for them.
Royal College of General Practitioners	NICE	1.1.1.7 and 1.1.1.9		Two more positives about the guideline the emphasis on cultural competence and the suggestion that providers would consider creche and transport to facilitate attendance	Thank you for your comment.
Royal College of Nursing	General			There are no further comments to make on the above draft guideline consultation. Thank you for the opportunity to review this document.	Thank you for your comment.
Royal College of Psychiatrists	Full/ NICE	General	General	The authors of this report are to be congratulated on compiling a generally helpful document, within tight constraints defined by the scope. As practitioners in primary care are identified as principle targets for this guideline, it is important that it retains credibility for this audience. The scope has defined which disorders are included within the term “common mental disorders”, & this clearly does not include medically unexplained symptoms, somatisation, etc. Some explanation of this may be helpful: these conditions may not be all that common in the population, but they are in the GP’s surgery; & to many GP’s, these conditions are a source of considerable concern.	Thank you for your comment. The GDG discussed this issue in detail and share your concern that it would be useful for GPs to have some explanation of what the guideline covers. With this in mind, a glossary of terms has been added to the guideline, which includes a definition of ‘somatic symptoms/presentation’, and also clarifies what this guideline does and does not cover (for example medically unexplained symptoms are outside of the scope).
Royal College of Psychiatrists	Full NICE	5.2.1 5.2.1 1.1 1.2.1.1	102 127 14	The use of the 2 questions to help identify people who may be depressed is referred to several times in the text. The text also makes clear that people with a chronic physical health condition are at increased risk of depression. It may be worth mentioning that, for people with a chronic physical health condition, a deterioration in that condition may be a sign of a developing depression: there is certainly evidence of this in relation to diabetes & COPD.	Thank you for this comment. We have not taken up your suggestion of an amendment of altering the recommendation as we think the issue your raise might not apply to all disorders. In addition, the issue is covered by the over-arching nature of the current recommendation.
Royal College of Psychiatrists	Full NICE	5.2.1 1.2	127	The advice to include a question about avoidance as an addition to using the GAD2 is pertinent, and to be applauded.	Thank you for your comment.
Royal College of		5.2.1 2.1	128	The research recommendation (on avoidance) could be worded stronger.	Thank you for this comment – we have amended the recommendation.

Psychiatrists					
Royal College of Psychiatrists		5.3.8.11	143	Not sure about the term “walking across”.	This term is the current ‘technical term’ used to describe the process of comparing scores (including cut off points) from different measures which assess the same domains but have different scoring/scaling systems.
Royal College of Psychiatrists	Full	6.2.8.3	150	The advice about toxic drugs being limited in supply could be extended to other people in the household: many overdoses are taken using the drugs prescribed to other members of the family.	Thank you for this suggestion. We accept that the issue that you raise is important but strictly speaking is outside of the scope of the guideline and refers to a more general issue about safety and prescribed medication. We will draw this issue to the attention of NICE for further consideration.
Royal College of Psychiatrists	Full	6.3.8.5	177	It would be wise to include a rider on this recommendation: “however, do not assume that resolution of a drinking problem will always lead to a resolution of the common mental health problem. A further assessment of the individual’s mental state will always be necessary”.	Thank you for this comment, we agree with the approach to care you set out and this is followed in the NICE guideline on harmful and dependent alcohol misuse, which will be published shortly. However in this guideline we are concerned primarily with referral, and we therefore do not think it would be appropriate to amend the recommendation along the lines you suggest.
Royal Pharmaceutical Society of Great Britain & College of Mental Health Pharmacy	Full	General	General	This guideline is aimed at improving access to mental health services, improving identification and recognition and developing principles for referral and care pathways particularly in primary care. Pharmacy has not been mentioned in the draft guideline however community pharmacists and their staff have a valuable role to play in improving access and assisting with identification and recognition of mental health disorders and then signposting to appropriate services and/or healthcare professionals. Pharmacists are frequently consulted for help and advice by people who may be reluctant to visit their GP. Pharmacists in both primary and secondary care are also closely involved in monitoring treatment and counselling patients with chronic conditions who may be more likely to experience mental health disorders.	Thank you for this comment. We agree that pharmacists have a key role to play. In our guidelines we do not as a general rule single out any professional group – we would expect all healthcare professionals to follow the guidance in line with their clinical competencies. In our review of the evidence we found no specific research which supported recommendations focused on pharmacists.
Royal Pharmaceutical Society of Great Britain & College of Mental	NICE	Key priorities	8	We agree that primary and secondary care clinicians should work together to design integrated care pathways however pharmacists (from both primary and secondary care) have valuable expertise and experience to contribute and should be included.	Thank you for your comment, however it would not be appropriate for this guideline to comment on the expertise of specific groups of healthcare professionals.

Health Pharmacy					
Royal Pharmaceutical Society of Great Britain & College of Mental Health Pharmacy	Full	General	General	Pharmacists can contribute to identification and care of patients with mental health disorders. For example the following references describe the role of pharmacists in the care of patients with dementia • Arlt, S; Lindner, R; Rosler, A; von Renteln-Kruse; W. Adherence to medication in patients with dementia: predictors and strategies for improvement. *Drugs Aging* 2008;**25(120)**:1033-47 • Feinberg, MV; Michocki, RJ. Clinical and regulatory concerns in Alzheimer's disease management: role of the pharmacist. *Am J Health-Syst Pharm.* 1998;**55(Suppl 2):**S26-31 • Skelton, JB. White Paper on expanding the role of pharmacists in caring for individuals with Alzheimer's disease. *J Am Pharm Assoc* 2008;**48**:715-721 • Brauner, DJ; Muir, JC; Sachs, GA. Treating nondementia illness in patients with dementia. *JAMA* 2000;**283(24):**3230-3235 • Manthorpe, J; Iliffe, S; Eden, A. The implications of the early recognition of dementia for multiprofessional team working: conflicts and contradictions in practitioner perspectives. *Dementia* 2003;**2**:163-179 • Wagner, EH. The role of patient care teams in chronic disease management. *BMJ* 2000;**320**:569-57 A reference describing a pharmacist led medicines management clinic for patients with mental health issues http://www.pjonline.com/content/best_practice_mental_health_patients The Royal Pharmaceutical Society mental health toolkit for	Thank you for your comment and for this information.

				pharmacists includes practice guidance covering recognition of signs and symptoms for a range of mental health conditions including BPAD, dementia, depression, sleep disorders, psychosis and schizophrenia. http://www.rpharms.com/public-health-issues/mental-health.asp	
Royal Pharmaceutical Society of Great Britain & College of Mental Health Pharmacy	NICE	Key priorities	8	The Department of Health's publication in 2005 'New ways of working for psychiatrists: Enhancing effective, person-centred services through new ways of working in multidisciplinary and multi-agency context: Appendices' (www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance /DH_4122342) established and recognised the input of secondary care pharmacists in the care pathway of these patients. Community pharmacies should also be included when developing care pathways and this has been suggested in the Royal Pharmaceutical Society mental health toolkit developed in conjunction with the then UKPPG.	Thank you for your comment. As mentioned previously, it would not be appropriate for this guideline to comment on the expertise of particular groups of professionals. However, it should be noted that in developing this guideline the GDG kept in mind that services vary in their organisation, and so they aimed to keep the principles underpinning the recommendations as general as possible. The developers would consider pharmacists as clinicians, however it would be up to local services to interpret and adapt the recommendations to suit their needs.
Royal Pharmaceutical Society of Great Britain & College of Mental Health Pharmacy	Full	General	General	Additional examples of how community pharmacy can improve access and support patients with mental health issues: SHEFFIELD PCT COMMUNITY PHARMACY MENTAL HEALTH CAMPAIGN 'Looking after your Mental Health'. Launched in February 2009, the community pharmacy campaign was coordinated by the PCT's Health Improvement Manager and supported by a project group. The PCT's Pharmacy team representatives were responsible for assisting in engaging the community pharmacies. Furthermore, the PCT's Enhanced Public Health Programme (EPHP) representatives were responsible for engaging with PCT colleagues to ensure all community pharmacies in the EPHP areas were provided with support, and particularly information on where lifestyle interventions can be accessed. CAMDEN PCT Community pharmacy mental health self-help support to individuals with mental health problems. This pilot project, implemented for nine months in 2007-8, was collaboratively developed by the London Development Centre (LDC), Camden	Thank you for your comment and for this information.

				PCT and Primhe (Primary Care, Mental Health and Education). The service aimed to enhance the support and information sharing activity already routinely offered by many pharmacists to their clients but with a focus on, and information about, specific mental health issues (depression and anxiety and encompassed information about self-harm and other difficulties that may also be present when an individual is suffering from depression or anxiety).	
Royal Pharmaceutical Society of Great Britain & College of Mental Health Pharmacy	Full	General	General	Pharmacists can support patients with mental health disorders in the following ways • Awareness and promotion of good mental health • Simple mechanisms to help people understand and take their medicines as intended • Liaison with GPs and community health teams • Instalment dispensing and supervised administration • Training for patients and carers about medicines • Involvement in evidence based alternatives to medicines, e.g. information about/provision of computerised cognitive behavioural therapy and general information about talking therapies • Information about local support networks, mental health help lines, etc. • Involvement in outreach to minority communities • Identification of people who may show signs of depression and referring them on appropriately • Senior leadership on medicines issues and governance in mental health trusts and ensuring that appropriate service level agreements are in place with provider organisations The Choice and medication website can be used by organisations to offer a choice tool for service users in the selection of the most appropriate treatment for them. E.g. http://www.choiceandmedication.org.uk/norfolk-and-waveney/ Further information is available in the Royal Pharmaceutical Society Mental Health toolkit which outlines care pathways and	Thank you for your comment and for this information.

				different levels of engagement for pharmacists with patients with mental health issues	
Royal Pharmaceutical Society of Great Britain & College of Mental Health Pharmacy	NICE	1	11	We agree that care pathways should have multiple points of access and believe that this should include community and primary care pharmacies. We agree that services should be provided in a variety of settings and we believe that community pharmacy should be included as community pharmacies are convenient to access without an appointment and with longer opening hours than other healthcare providers.	Thank you for your comment. As can be seen from the recommendations, the evidence supports multiple points of access (for example, see recommendation 1.1.1.4 in the post-consultation version of the guideline). However, we have not specified what these points of access may be, as we do not feel it would be appropriate for single out certain but not other settings.
Ultrasis Ltd	NICE	1.3.2.2	21	CCBT can be offered as ' facilitated' (guided) self-help as well as non-facilitated self help. It is confusing to suggest that only work-book based intervention is offered with' facilitation'.	Thank you for this comment - we agree and would favour CCBY being offered with some form of facilitation but we do not think that non-facilitation is suggested in this recommendation and so does not need to change
Ultrasis Ltd	NICE	1.3.2.4	22	Computerised CBT is also recommended for GAD as a low intensity intervention. See Appendix B at http://www.iapt.nhs.uk/wp-content/uploads/iapt-data-handbook-appendices-v10.pdf. See point 1 above too with reference to inclusion of CCB in facilitated and/or non-facilitated self - help	Thank you for your comment. As has been clarified in the methods section of the full guideline, the referral for treatment recommendations are drawn from previous NICE guidance. CCBT was not recommended in the GAD section of the updated anxiety guideline (CG 113) and so it would not be appropriate to recommend it here.
Ultrasis Ltd	NICE	1.3.2.5	22	Computerised CBT is also recommended for panic disorder. See Appendix B http://www.iapt.nhs.uk/wp-content/uploads/iapt-data-handbook-appendices-v10.pdf	Thank you for your comment. As has been clarified in the methods section of the full guideline, and is mentioned above, the referral for treatment recommendations in this guideline are drawn from previous NICE guidance. FearFighter was recommended as an option for managing panic and phobia in NICE technology appraisal TA97 (2006), however when this technology appraisal was partially updated by the recent anxiety (partial update) clinical guideline 113, this recommendation was removed from the panic disorder section of the guideline. This was due to the fact there was insufficient evidence that CCBT is effective for panic disorder alone (the original recommendation was based on a study that looked at a mixed, predominantly phobic, population).
Ultrasis Ltd	NICE	1.3.2 and 1.3.3	21-24	May be mistaken – but couldn't find any reference to social phobia	In developing this guideline the GDG looked at evidence regarding assessment for all anxiety disorders; however the recommendations about referral for treatment are drawn from previous NICE guidance, and so do not provide advice about

					referral for social phobia or specific phobias. This is regrettable, however the forthcoming NICE guideline on social phobia should help address this imbalance. The text has now been amended to make the relationship between the guidelines clearer.
United Kingdom Council of Psychotherapists	NICE	1.1.15	11	The designated professional may not be a GP, this needs further emphasis and the overseeing health professional needs to be clearly designated, accessible and communicated to the whole team	The GDG did not feel it was the place of this guideline to make overly prescriptive recommendations about how individual services are organised and managed. Instead the group aimed to make recommendations about general principles, which could be interpreted appropriately at a local level (including the recommendation you make reference to, which is numbered 1.1.1.6 in the post-consultation version of the guideline).
United Kingdom Council of Psychotherapists	NICE	1.2.1	13	While it is commendable that the person with depression is identified by health care workers, care needs to be taken when asking the identified questions as the health care professional need to be able to respond appropriately to the response by the patient. Questions like this are designed to elicit psychological distress and the result could be harmful to the patient if the person asking the questions is not competent to do a mental health assessment There needs to be the facility for immediate consultation and assistance from someone who has the appropriate skills and competences to deal with the response to these questions if the healthcare professional asking them is not competent to make and respond to a mental health assessment.	Thank you but we know of no evidence to support this view. We are clear in our recommendation that a positive answer to the initial question should be followed by an assessment.
United Kingdom Council of Psychotherapists	Full	General		While we welcome the direction of travel and the increase of psychological services in Primary Care, one of the main difficulties in providing a coherant and cohesive service is the splitting of funding and operational arrangements between IAPT providers and Mental Health Trusts. Individuals do not always fall into clear categories and we have had reported incidents of disputes about who should be providing treatment, resulting in individuals being passed between two care providers and the potential for referrals to fall between the gap in service provisions	Thank you for your comment. We agree this might well present problems but unfortunately is outside the scope of the guideline.
United Kingdom	Full	General		We welcome the improved guidance for primary care. There is a dearth of psychological therapies available for patients	Thank you for this comment. With regard to your specific points, we have reviewed our recommendations in this area,

Council of Psychotherapists				although they are effective and preferred over medication by patients. HopeFully the IAPT programme will continue to address this with the added developments of a wider range of therapies to ensure patient choice and other options for those patients who do not easily respond to CBT or react adversely to the more directive nature of this and the other interventions currently and proposed to be available through IAPT. We continue to question the lack of provision of short-term integrative models of psychotherapy, which have had their efficacy established through the skills for health mapping of NOS and our own mapping of Professional Occupational Standards; this is a serious omission and reduction of patient choice, as such approaches have been well established in the NHS previously. The stepped care process is welcomed and ensures good use of resources but it is important (as stated in the guidelines) that levels of care work together and are able to respond appropriately to more severe presentation without wasting time on interventions that are not powerful enough. Protocols need to ensure that at the point of contact with the service patients are assessed by clinicians who are able to determine the level of intervention required. (anecdotal evidence suggests that Psychological Wellbeing Practitioners are not always aware of the severity and significance of the difficulties patients are presenting to them with and are wanting to work beyond the limits of their competence) One of the major disappointments in the guidelines is the lack of attention paid to the consideration of the context of the patient. It is welcome that it suggests information is available, accessible and culturally sensitive but it does not do enough to encourage those in primary care to 1. assess the impact of the illness on the wider family and the impact of the wider family on the illness. One major concern is the impact on young children and while this is rather generally alluded to it needs to be made more	making some amendments in light of your and other comments. These include the impact of mental health problems on children or severe physical illness on other family members. In addition, as is described in the methods section of the full guideline we did not review any new treatment interventions and drew specifically on existing NICE guidance that is referred to in the relevant sections of this guideline. However, please note that the guideline recommendations do include treatment such as behavioural couples therapy and also stress the importance of cultural competence in practitioners. Also, please note that the scope of this guideline restricts it to consideration of adults with common mental health disorders, and so it would not have been possible for us to consider the impact of common mental health disorders on young children here.

				explicit. We have good information on the numbers of young carers who have to care for parents with mental health needs and the vastly greater likelihood that they will develop mental health problems in the future. Some may even be at immediate risk. Specific questions relating to the impact on children must be a vital part of the assessment. However it is not only children but other vulnerable adults that need to be considered. It is important to know about current stresses, domestic violence and concerns about finance, housing or immigration status. Without this wide view, important needs for other interventions and services may be missed. 2. We suggest relationship based therapies to address some of these issues. Depression rarely comes entirely out of the blue and relationship issues play a significant part in the stressors that may precipitate and maintain depression. Behavioural couple therapy has a good evidence base and should be considered in the first instance for anything but mild depression.If relevant it should be provided on it's own or in addition to other interventions. Although there is currently not a large body of research evidence to support two interventions, clinical experience points to this and government policy embraces the need to attend to relationships as an important component of well being and to take a 'think family' approach. This continued individual focus on treatment is culturally unacceptable to many who come form less individualistic societies and does not fit with the realities of people's lives. Primary care is an important point for the delivery of services and it is welcomed that GP's will receive more guidance on responding to patients. However with such a narrow focus, opportunities for damage limitation and broader understanding will be lost.	
United Kingdom Council of Psychothera	NICE	1.4.1.2	27	There needs to be some clear consideration of the demands of the roles of staff working within the care pathway and means of ensuring staff have adequate support, continuing training and a ratio of referrals to practitioners to ensure the performance of	Thank you for your comment. We agree that these issues are important for helping to ensure the performance of care pathways, however to make recommendations about referral ratios and staff experience would be outside of the scope of

pists				the care pathway.	this guideline.
Whitstone Head Educational (Charitable) Trust Ltd	Full	1.1.2	8	The statement that “Guidelines are not a substitute for professional knowledge and clinical judgement” is particularly pertinent and useful Given the statistical evidence presented relating to current diagnostic and treatment levels in the general population, the statement values should be repeated and more strongly reinforced throughout the guideline.	Thank you for your suggestion. The statement you refer to is common to all NICE guidance and we do not think it would be appropriate to repeat and more strongly reinforce it in this particular guideline.
Whitstone Head Educational (Charitable) Trust Ltd	Full	5.3.8 .6	142	While it is stated that “The impact of the presenting problem on the care of children and young people should also be assessed”, the guideline fails to suggest the need to assess the impact on adult mental health of caring for children with significant/chronic presenting problems. Serious consideration should be given to addressing this omission and, perhaps, making reference to it at this juncture.	Thank you for this comment. We agree that this is an important issue, however it would not be possible to specifically discuss the number of circumstances that could lead an individual to be more likely to develop a common mental health disorder here. For this reason we have aimed to be more general in formulating the recommendations.

These organisations were approached but did not respond:

Association for Rational Emotive Behaviour Therapy
Association of British Insurers (ABI)
Association of Dance Movement Therapy UK
Association of Psychoanalytic Psychotherapy in the NHS
AstraZeneca UK Ltd
Berkshire Healthcare NHS Foundation Trust
Big White Wall
BMJ
Boehringer Ingelheim Ltd
Bouenemouth University
Bradford District Care Trust
British Acupuncture Council
British Association for Behavioural & Cognitive Psychotherapies (BABCP)
British Association of Drama Therapists
British Association of Psychodrama and Sociodrama (BPA)
British Dietetic Association
British National Formulary (BNF)
British Psychoanalytic Council
British Psychodrama Association

Business Boosters Network CIC
Care Quality Commission (CQC)
Cerebra
CIS'ters
Citizens Commission on Human Rights
Cochrane Depression Anxiety & Neurosis Group
College of Occupational Therapists
Commissioning Support for London
Department for Communities and Local Government
Department of Health Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI)
Department of Health, Social Services & Public Safety, Northern Ireland (DHSSPSNI)
Derbyshire Mental Health Services NHS Trust
Diabetes UK
English Community Care Association
Faculty of Public Health
Flintshire County Council
Hampshire Partnership NHS Foundation Trust
Hertfordshire Partnership NHS Trust
Institute of Psychiatry
Intapsych Ltd
Janssen-Cilag Ltd
Journeys
Kent & Medway NHS and Social Care Partnership Trust
King's College London
King's College London Dental Institute
Lambeth Community Health
Leeds PCT
Liverpool Community Health
Liverpool PCT Provider Services
Lundbeck Ltd
Medicines and Healthcare Products Regulatory Agency (MHRA)
Men's Health Forum
Mental Health Providers Forum
Mental Heath and Vascular Wellbeing Service
MIND
National Association for Children of Alcoholics
National Organisation for Fetal Alcohol-UK (NOFAS-UK)
National Patient Safety Agency (NPSA)

National Pharmacy Association
National Public Health Service for Wales
National Self Harm Network
Newcastle and North Tyneside Community Health
NHS Blackburn With Darwen
NHS Buckinghamshire
NHS Clinical Knowledge Summaries Service (SCHIN)
NHS Health Scotland
NHS Isle of Wight
NHS Knowsley
NHS Plus
NHS Quality Improvement Scotland
NHS Sefton
NHS Sheffield
NHS Western Cheshire
Northern Ireland Chest Heart & Stroke
Northumberland Tyne & Wear Trust
Oxfordshire & Buckinghamshire Mental Health Partnership NHS Trust
PAPYRUS (Prevention of Suicides)
Parkinsons UK
PERIGON Healthcare Ltd
Poole and Bournemouth PCT
Positively Pregnant
Primary Care Mental Health Forum, RCGP
Rotherham, Doncaster & South Humber Mental Health NHS Foundation Trust
Royal College of General Practitioners Wales
Royal College of Paediatrics and Child Health
Royal College of Pathologists
Royal Society of Medicine
Sainsbury Centre for Mental Health
Sandwell PCT
SANE
Sanofi-Aventis
Scottish Intercollegiate Guidelines Network (SIGN)
Sheffield Health and Social Care Foundation Trust
Sheffield PCT
Sheffield Teaching Hospitals NHS Foundation Trust
Social Care Institute for Excellence (SCIE)

Social Exclusion Task Force
Society for Coaching Psychology
South Staffordshire PCT
South West Yorkshire Partnership NHS Foundation Trust
Survivors Trust, The
Sussex Partnership NHS Foundation Trust
Swansea University
Tees Esk & Wear Valleys NHS Trust
Telemedcare Ltd
Telford and Wrekin PCT
Tuke Centre, The
Turning Point
UK National Screening Committee
UnitedHealth UK
VBAC Information and Support
Welsh Assembly Government
Welsh Scientific Advisory Committee (WSAC)
West Hertfordshire PCT & East and North Hertfordshire PCT
West London Mental Health NHS Trust
Western Cheshire Primary Care Trust
Western Health and Social Care Trust
WISH - Women in Secure Hospitals
Worcestershire PCT
York NHS Foundation Trust
Youth Access