The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

MEMBER REQUISITION GENERAL MEETING – MOOD DISORDERS CLINICAL PRACTICE GUIDELINE (CPG) AND PSYCHOTHERAPY

Tuesday 3 May 2022 5.00pm AEST

The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

A/PROF VINAY LAKRA

RANZCP PRESIDENT

ACKNOWLEDGEMENT OF COUNTRY

The Royal Australian & New Zealand College of Psychiatrists

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We acknowledge Aboriginal and Torres Strait Islander Peoples as the First Nations and the traditional custodians of the lands and waters now known as Australia, and Māori as tangata whenua in Aotearoa, also known as New Zealand.

We recognise and value the traditional knowledge held by Aboriginal and Torres Strait Islander Peoples and Māori.

We honour and respect the Elders past and present, who weave their wisdom into all realms of life - spiritual, cultural, social, emotional, and physical.

INTRODUCTIONS AND MEETING STRUCTURE

- Chair – A/Prof Vinay Lakra, President
- Presenter – Dr Sue Mackersey, RANZCP Board Director
- Moderator – Dr Nick O'Connor, RANZCP Board Director

- Quorum confirmation
- Presentation on the RANZCP Mood Disorders CPG and long-term psychodynamic psychotherapy in the treatment of mood disorders
- Questions – to consider any written questions from members
- Items of business – the Ordinary Resolutions proposed by the requisitioning members

REQUEST FOR THE MRGM

- On 11 March 2022, the RANZCP received a valid members requisition. This requisition requested that a General Meeting be called to facilitate consideration of four resolutions, which relate to the RANZCP Mood Disorders CPG and long-term psychodynamic psychotherapy in the treatment of mood disorders.

  i) The College forthwith remove its endorsement of the current CPG content relating to psychodynamic psychotherapy pending the outcome of the review referred to in paragraph (ii) below

  ii) The College commission a RANZCP working group, independent to the committee involved in the production of the current CPG:
    - Whose membership includes clinicians with expertise and clinical experience in the psychodynamic psychotherapies; and
    - For the purpose of reviewing the evidence base, consulting with the clinical field and providing feedback, and if deemed appropriate, making recommendations to the College to amend relevant aspects of the current CPG content relating to psychodynamic psychotherapy

REQUEST FOR THE MRGM

iii) If determined appropriate by the independent working group, provide recommendations and revised version of the specific CPG content relating to the psychodynamic psychotherapies in the assessment and treatment of Mood Disorders (including Complex and special presentations), referencing the contemporary evidence base, with a view to obtaining RANZCP endorsement and publication.

iv) The College promptly review the recommendations and any revised version of the abovementioned content and, subject to the recommendations of the independent working group, take immediate steps to replace the current CPG to facilitate multi-stakeholder reference.

Any steps to be taken following the MRGM is at the Board's discretion and may be guided by the manner in which the Fellowship vote. The resolutions as proposed, if passed, would still be non-binding advisory resolutions, in a legal sense.

SUPPORTING STATEMENT

- Requisitioning Members have provided a supporting statement to the Ordinary Resolutions.

PRESENTATION

- This presentation will address:
  (1) Development Process for College CPGs
  (2) Development Process for Mood Disorder CPG
    2.1 Mood Disorders Steering Group
    - Consultation process
    - Consultation feedback regarding psychotherapy and Mood Disorders Steering Group response
    - Editorial process
    - Peer review process
  - RANZCP Board engagement with requisitioning members
  - Next steps
    - Board consideration of MRGM outcome
    - Future CPG Development process

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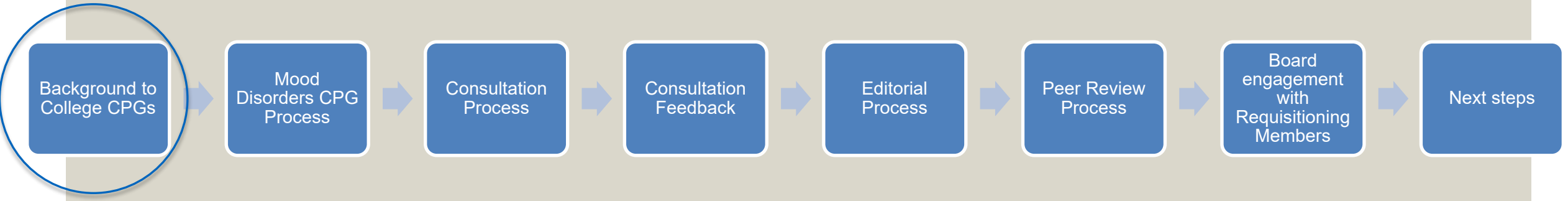
DR SUE MACKERSEY

RANZCP BOARD DIRECTOR

Background to College CPGs



CPG OVERVIEW

- The Purpose of CPGs are to provide general rules, principles, advice and to improve care and outcomes for individuals and the community by:
  - Synthesising and analysing up to date evidence
  - Translating research findings and new insights into clinical practice

- Current RANZCP CPGs
  - Eating Disorders (2014)
  - Schizophrenia (2016)
  - Deliberate Self Harm (2016)
  - Anxiety (2018)
  - Mood Disorders update (2020)

CPG DEVELOPMENT PROCESS

- Identify CPG subject matter / need
- Board establishes a Steering Group to lead development
- Steering Group members provide their expertise and time on a pro-bono basis
- College wide Committee consultation
- Feedback and revisions by the Steering Group
- Approval processes:
  - RANZCP Board endorsement for submission to the ANZJP
  - ANZJP international peer review

CPG DEVELOPMENT PROCESS

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Mood Disorders CPGs

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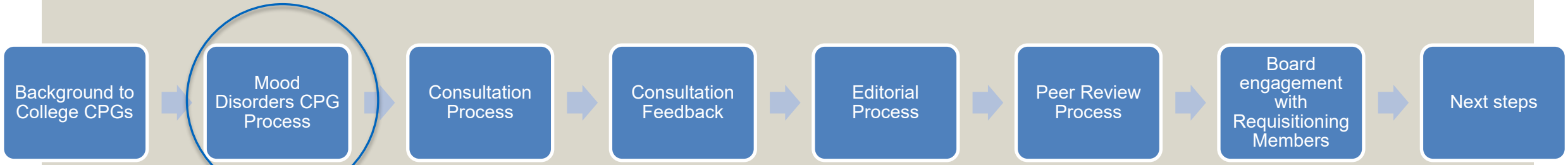

MOOD DISORDERS CPG STEERING GROUP

- The Mood Disorders CPG Update Steering Group was established in July 2019.

- Membership comprised of:
  - Most members from the 2015 Mood Disorders CPG Group
  - Psychiatrists with expertise in Mood Disorders, ECT / rTMS, and Child and Adolescent Mood Disorders
  - Psychologists
  - PhD candidate / research

- The Steering Group held:
  - 29 formal meetings and
  - a number of smaller meetings throughout 2019 and 2020.

MOOD DISORDERS CPG STEERING GROUP

The Royal Australian & New Zealand College of Psychiatrists

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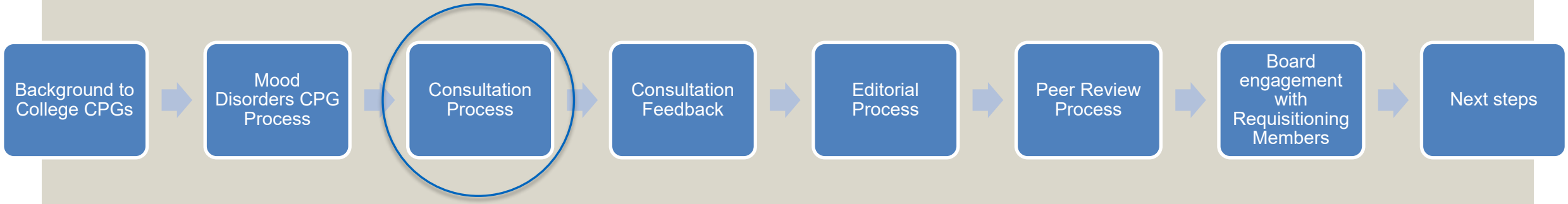
MEMBER	DICIPLINE	EXPERTISE	AFFLIATION/S
Gin S. Malhi (Chair)	Psychiatry	Mood Disorders Bipolar Disorders Research	The University of Sydney, Faculty of Medicine and Health, Northern Clinical School, Department of Psychiatry, Sydney, NSW, Australia. Academic Department of Psychiatry, Royal North Shore Hospital, Northern Sydney Local Health District, St Leonards, NSW Australia. CADE Clinic, Royal North Shore Hospital, Northern Sydney Local Health District, St Leonards, NSW Australia.
Darryl Bassett	Psychiatry	Mood Disorders Bipolar disorders Research	University of Western Australian Medical School, Faculty of Health and Medical Science, University of Western Australia, Perth, WA, Australia
Phil Boyce	Psychiatry	Mood Disorders Perinatal psychiatry Bipolar disorders in perinatal psychiatry Past President	Department of Psychiatry, Westmead Hospital and the Westmead Clinical School, Wentworthville, NSW Discipline of Psychiatry, Sydney Medical School, Faculty of Medicine and Health, University of Sydney, Sydney, NSW, Australia.
Richard Bryant	Psychology	Psychology Research	School of Psychology, University of New South Wales, Sydney, NSW, Australia
Philip Hazell	Psychiatry	Mood Disorders in Children and adolescents	Discipline of Psychiatry, Sydney Medical School, Faculty of Medicine and Health, University of Sydney, Sydney, NSW, Australia
Bill Lyndon	Psychiatry	Mood Disorders ECT rTMS	The University of Sydney, Faculty of Medicine and Health, Northern Clinical School, Department of Psychiatry, Sydney, NSW, Australia.
Malcolm Hopwood	Psychiatry	Mood Disorders Past President	Department of Psychiatry, University of Melbourne and Professorial Psychiatry Unit, Albert Road Clinic, Vic
Roger Mulder	Psychiatry	Mood Disorders Genetics Neurobiology	Department of Psychological Medicine, University of Otago, Christchurch, New Zealand
Richard Porter	Psychiatry	Mood Disorders Psychological treatments ECT	Department of Psychological Medicine, University of Otago, Christchurch, New Zealand
Ajeet Singh	Psychiatry	Mood Disorders Pharmacogenetics rTMS	School of Medicine, Deakin University, Victoria, Australia
Greg Murray	Psychology	Psychology Research	Centre for Mental Health, Swinburne University of Technology, Hawthorn, VIC Australia
Erica Bell	PhD candidate	Research Psychopharmacology	The University of Sydney, Faculty of Medicine and Health, Northern Clinical School, Department of Psychiatry, Sydney, NSW Australia. Academic Department of Psychiatry, Royal North Shore Hospital, Northern Sydney Local Health District, St Leonards, NSW Australia. CADE Clinic, Royal North Shore Hospital, Northern Sydney Local Health District, St Leonards, NSW Australia.

TIMELINE

DATE	ACTION
July 2020	Draft Mood Disorders CPG is circulated to College Committees for feedback
July – August 2020	Mood Disorders Steering Group considers College Committees feedback and provides comments
August 2020	Committee for Evidence-Based Practice reviews draft Mood Disorders CPG and Mood Disorders Guideline Update Steering Group comments to the College Committee feedback
August/September 2020	PPPC Executive approves the draft Mood Disorders CPG to be submitted to the Corporate, Governance and Risk Committee
September 2020	Corporate, Governance and Risk Committee approves the draft Mood Disorders CPG to be submitted to the RANZCP Board
September 2020	RANZCP Board approves the draft Mood Disorders CPG to be submitted to the ANZJP for international peer review
September – October 2020	Updated draft Mood Disorders CPG is submitted to the ANZJP for international peer review
October – November 2020	Mood Disorders Guideline Update Steering Group considers ANZJP international peer review feedback and provides comments
December 2020	Final Mood Disorders CPG is published in the ANZJP

Consultation Process



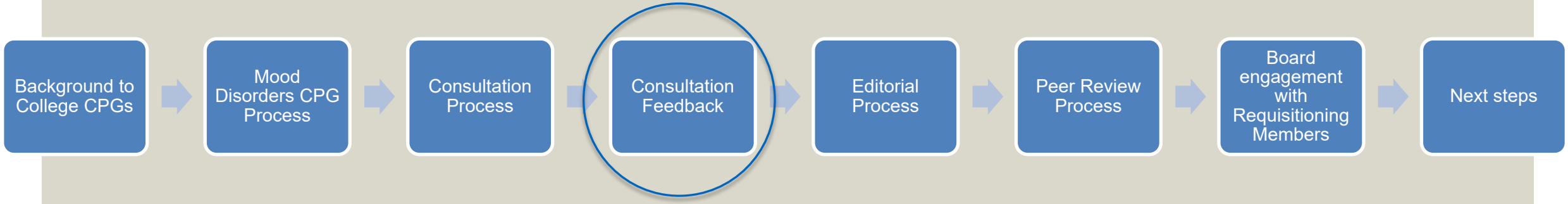
CONSULTATION

- In July 2020, the draft Mood Disorders CPG was circulated for consultation
- **44 College Committees** were consulted, including Faculty of Psychotherapy Committee
- Three (3) members responded regarding psychotherapy content

CONSULTATION

RANZCP Board	Faculty of Adult Psychiatry Committee
Corporate Governance and Risk Committee	Faculty of Child and Adolescent Psychiatry Committee
Education Committee	Faculty of Consultation–Liaison Psychiatry Committee
Membership Engagement Committee	Faculty of Forensic Psychiatry Committee
Practice, Policy and Partnerships Committee	Faculty of Psychiatry of Old Age Committee
Victorian Branch Committee	Faculty of Psychotherapy Committee
ACT Branch Committee	Faculty of Child and Adolescent Forensic Psychiatry Committee
Tasmanian Branch Committee	Section of Early Career Psychiatrists Committee
NSW Branch Committee	Section of Electroconvulsive Therapy and Neurostimulation Committee
NT Branch Committee	Section of History, Philosophy and Ethics of Psychiatry Committee
SA Branch Committee	Section of Leadership and Management Committee
WA Branch Committee	Section of Neuropsychiatry Committee
Tu Te Akaaka Roa (New Zealand National Committee)	Section of Perinatal and Infant Psychiatry Committee
Overseas Trained Psychiatrists Committee	Section of Private Practice Psychiatry Committee
Trainee Representative Committee	Section of Psychiatry of Intellectual and Developmental Disabilities Committee
Committee for Research	Section of Rural Psychiatry Committee
Committee for Professional Practice	Section of Social, Cultural and Rehabilitation Psychiatry Committee
Committee for Evidence-Based Practice	Section of Youth Mental Health Committee
Aboriginal and Torres Strait Islander Mental Health Committee	Asylum Seeker and Refugee Mental Health Network Committee
Te Kaunihera	Attention Deficit Hyperactivity Disorder Network Committee
Community Collaboration Committee	Family Violence Psychiatry Network Committee
Faculty of Addiction Psychiatry Committee	Military, Veterans' and Emergency Services Personnel Mental Health Committee

Consultation Feedback



COMMITTEE FEEDBACK 1

	Is the structure logical and easy to use?	Are there any significant gaps (of topic, literature, other)?	Are there errors in the content?	Do you have any other comments?
	Yes - it is logical though it is also very detailed. The authors are to be applauded to stress an integrated approach.	a. There are a number of reviews on psychodynamic psychotherapy not referenced. I have concerns that some of the comments are too narrow in the psychotherapy section. These include: Abbass AA, Town JM.(2016) Bona Fide Psychotherapy Models Are Equally Effective forMajor Depressive Disorder Future Research Directions. Editorial. JAMA Psychiatry September2016 Volume73,Number9, pp893-894 Barber, J. P., Muran, J.C., McCarthy, K.S., Keefe, R.J. (2013). Research on Psychodynamic Therapies. In M. J. Lambert (Ed.). Bergin and Garfield's Handbook of Psychotherapy and Behavior Change (6th ed.) (pp. 443-494). New - York, NY: John Wiley & Sons, Inc. Barber JP & Sharpless BA (2015): On the future of psychodynamic therapy research, Psychotherapy Research, DOI: 10.1080/10503307.2014.996624 de Maat S, de Jonghe F, de Kraker R, MSc, Leichsenring F, Abbass A, Luyten P, Barber JP, Van R,and Dekker J. (2013) The Current State of the Empirical Evidence for. Psychoanalysis: A Meta-analytic Approach. Harvard Review of Psychiatry Volume 21, Number 3, pp107-137 Fonagy P. (2015). The effectiveness of psychodynamic psychotherapies: an update. World Psychiatry 2015;14:137–150 Fonagy P, Rost F, Carlyle J, McPherson S, Thomas R, Pasco Fearon RM, Goldberg D, Taylor D.(2015) 2Pragmatic randomized controlled trial of long-term psychoanalytic psychotherapy for treatment-resistant depression: the Tavistock Adult Depression Study (TADS). World Psychiatry 2015;14:312–321 Leichsenring F, Leweke F, Klein S, Steinert C.(2015) The Empirical Status of Psychodynamic Psychotherapy – An Update: Bambi's Alive and Kicking. Psychother Psychosom 2015;84:129–148 Leichsenring F, Luyten P, Hilsenroth MJ, Abbass A, Barber JP, Keefe J, Leweke F, Rabung S, Steiner C. (2015) Psychodynamic therapy meets evidence-based medicine: a systematic review using updated criteria. Lancet Psychiatry 2015; 2: 648–60 Leichsenring F, Abbass A, Luyten P, Hilsenroth M, and Rabung S. (2013) The Emerging Evidence for Long-Term Psychodynamic Therapy. Psychodynamic Psychiatry, 41(3) 361–384, 2013 b. In the treatment of Depression in Adolescents, I couldn't find reference to Attachment Based Familty Therapy. A number of relevant references are: Diamond G, Russon J, Levy S. (2016) Attachment-Based Family Therapy: A Review of the Empirical Support. Family Process, Vol. x, No. x, 2016 © 2016 Family Process Institute doi: 10.1111/famp.12241 Ewing E, Diamond G & Levy S. (2015) Attachment-based family therapy for depressed and suicidal adolescents: theory, clinical model and empirical support. Attachment & Human Development, 2015 Vol. 17, No. 2, 136–156 c. There doesn't seem to be reference to the prevalence of the different mood disorders. d. I may have missed it but I couldn't find much on relapse of Depression.	The section headed Formulation is not then describing formulation but more describing approach to clinical assessment. Following on from my response to item 2: a. There are a number of dilemmas in the psychotherapy literature- as well as the issue of common versus specific factor, there is the "Dodo Bird" finding repeatedly and also short versus long term therapy and the findings about this (several of the references in the previous section discuss this). b. I think the evidence for Psychodynamic Therapy (PDT) is stronger than stated in the document. Also, there is evidence that the effects last longer post treatment, and that there is discussion in the references in section 2 of the positive findings of PDT in chronic depression and in the presence of Co morbid Disorders including Personality Disorder.	Thank you for work done.

COMMITTEE FEEDBACK 2

	Is the structure logical and easy to use?	Are there any significant gaps (of topic, literature, other)?	Are there errors in the content?	Do you have any other comments?
	Yes	The discussion around psychotherapeutic aspects of assessment and treatment is limited. There is a significant evidence base for psychotherapeutic treatments beyond those listed in the CPG, including both short and longer term psychodynamic and psychoanalytic treatment, that has not been included in the draft- see the FoP submission to the Vic RC into Mental Health and the British Psychoanalytic Council website https://www.bpc.org.uk/information-support/the-evidence-base/ There are concerns re the presentation of CBT as the gold standard treatment; see Vic FoP RC submission. These concerns have been published in relation to PTSD, and holds relevance for mood disorders also, beyond coexisting C-PTSD comorbidity. See Courtois C & Brown L, 2019, Guideline Orthodoxy and resulting limitations of the American Psychological Association's Clinical Practice Guideline for the Treatment of PTSD in Adults, https://doi.apa.org/fulltext/2019-36160-001.html Page 86: The document presents CBT and MCBT as treatments that should be offered to all patients requiring longer term treatment of MDD. There is no description as to when CBT might not be appropriate and may actually have iatrogenic risks? There is no discussion as to individualising psychotherapeutic treatment to patient presentation or needs or capacities. A psychodynamic component to assessment of patients - part of psychological formulation - has little presence in the CPG; as such, there is no consideration in the document (and potentially via parallel process in the clinical consultations following the CPG) of the meaning of the patient's symptoms and presentation. Likewise, there is no discussion re the need to consider each patient's psychodynamics and personality dimensions in formulation of both their presentation and also in guiding genuine individualised treatment. Pp 51 - 52"There is also strong consensus that the absence of a mechanistic understanding of treatments does not diminish the importance of evidence-based treatments to drive accountable psychological treatment. Hence, the only treatments known to work, and work safely, are the ones subjected to clinical trial." Not only does this paragraph not make sense, but it is non-sensical and misleading to exclude significant clinical experience and practice based evidence, outside of clinical trials, in the discussion of the benefits and safety of psychotherapeutic treatments. The Courtois and Brown article, above, is relevant here also.	See Courtois C & Brown L, 2019, Guideline Orthodoxy and resulting limitations of the American Psychological Association's Clinical Practice Guideline for the Treatment of PTSD in Adults, https://doi.apa.org/fulltext/2019-36160-001.html re limitations in the construction of clinical practice guidelines, relevant to this document also.	No

COMMITTEE FEEDBACK 2 CONTINUED

	Is the structure logical and easy to use?	Are there any significant gaps (of topic, literature, other)?	Are there errors in the content?	Do you have any other comments?
		Page 52 “Box 12. Evidence and methodological considerations for psychological treatment as monotherapy for acute MDD. All evidence for the efficacy of psychological treatment is derived from studies in which the intervention is delivered, (i) by trained therapists, (ii) under supervision, (iii) in a manualised form with high treatment fidelity. The evidence base therefore does not extend to the eclectic selection of elements from existing evidence-based treatments (indeed, one of the arguments for the potential efficacy of digitally-delivered therapies is their high fidelity).” See Courtois and Brown When the evidence base is restricted in this manner, much of practice based evidence and value is lost / removed. P53 “There is strong clinical consensus that manual-driven treatment (based on one of the evidence-based psychological interventions in which the therapist is trained and supported by appropriate ongoing peer supervision) is superior to eclectic practice” Would you please provide the references for this statement? Who are the parties in consensus? P53 “In some instances divergence from manualised depression treatment may reflect best-practice case-formulation-based tailored treatment (The British Psychological Society, 2011), however alternatively it may reflect a suboptimal occasion of care (e.g., a purposeless shift to unstructured or eclectic psychotherapy).” While the second part of the statement may be accurate, would you please reference this when placing it in opposition to The British Psychological Society’s statement? Is there any elaboration for clinicians re The British Psychological Society’s statement and in defining “some instances”? P53, Box 13 “CBT and IPT remain the primary recommended approaches because they have been subjected to more investigation across sites, are more commonly taught in training programs, and are familiar to current practitioner networks.” Are these reasons adequate for CBT and IPT to “remain the primary recommended approaches”? There are multiple cost / funding and political pressures driving CBT to be more commonly taught / in greater exposure / use, as well as factors relating to ease of investigation. There seems to be no critical exploration of these factors / issues. There is an absence of longer term psychodynamic and psychoanalytic psychotherapy from the list of psychological treatments for MDD. Please see the TADS study: https://onlinelibrary.wiley.com/doi/pdf/10.1002/wps.20267 There does not seem to be in the document any critical discussion and exploration as to how to determine / whether the patient is in the most suitable psychological therapy to meet their needs?		

COMMITTEE FEEDBACK 3

	Is the structure logical and easy to use?	Are there any significant gaps (of topic, literature, other)?	Are there errors in the content?	Do you have any other comments?
	It is very long and the information it contains is overly compartmentalised. It is very academic, so I am not sure it is that successful in filling gaps as it promises to do.	1. There is a notable gap in information about insight-oriented/dynamic/schema-based therapies for treatment resistant depression and where there are comorbid severe personality disorder or for use in young adults where there has been substantial attachment trauma or indeed in patients with histories of prominent trauma or attachment disruption. It appears overly skewed towards CBT in general, and DBT for BPD without highlighting the multi-modal approach useful in individuals that dominates private practice. There appears to have been inadequate consultation with Fellows with subspecialty expertise in the intensive psychotherapies. The single comment in the BPD section is revealing stating that treatment using psychodynamic therapies takes years to get benefit, which seems rather dismissive and over-generalising and overlooking the shown benefits for briefer insight-oriented approaches or including dynamically informed approaches. The approach may well divide general psychiatrists and psychodynamic psychiatrists whereas this document provides an opportunity to bridge these diverging groups (not to mention widening the gap between the latter and public psychiatry). 2. Inadequately addresses the massive topic of mixed anxiety-depression as this subpopulation is huge especially in private specialist practice and primary care. It inadequately explores the interrelationship between the two clusters, the management and relationship with (so-called) treatment resistance. Treatment resistance should be noted to be a potentially problem terminology and may be unhelpful in patients with helplessness schemas. 3. Inadequately addresses the massive topic of comorbid ADHD-depression as this subpopulation is huge amongst young adults. It inadequately explores the interrelationship between the two clusters, the management and relationship with (so-called) treatment resistance. Bupropion is becoming notable as a very helpful agent in these latter cases and this should be examined, as is the use of stimulant medication in those patients with treatment resistant depression who have comorbid untreated ADHD.	In an earlier section where severity is being discussed there is mention of pharmacotherapy being important, but it failed to include stimulation therapies and ECT.	It is a shame there were not more private practitioners involved at a high level in this project.

MOOD DISORDERS STEERING GROUP RESPONSE

- The Mood Disorders Steering Group addressed and responded to the feedback received (noting that this response was not provided to those who submitted the feedback directly).

MOOD DISORDERS STEERING GROUP RESPONSE CONTINUED

	Response from the Mood Disorders Guideline Update Steering Group
1.	We are grateful for the positive feedback regarding the level of detail and integration of various concepts. Regarding the gaps in the literature: a. We have now included text regarding the evidence for psychodynamic psychotherapy (see pg 55, and response to error b below) b. Thank you, we have considered this reference and have adjusted the child and adolescent section to include a statement regarding this. c. We have added a table within the Classification section that summarises prevalence statistics for mood disorders d. We mention the use of CBT and MBCBT for the prevention of relapse/recurrence in the Maintenance section of the Management of Major Depressive Disorder (pg. 85). Regarding the errors noted: a. We concur, and this observation is now made at a number of points in the text (see also the 2015 version of the Guidelines). b. We have significantly expanded consideration of psychodynamic psychotherapies by adding a new Box attending specifically to the question of psychodynamic therapies in evidence-based psychological practice. We also make cross-reference to the mention of psychodynamic therapies in the context of comorbid personality disorder.

MOOD DISORDERS STEERING GROUP RESPONSE CONTINUED

	Response from the Mood Disorders Guideline Update Steering Group
2.	We thank the reviewer for a series of rigorous critical comments on our approach to psychological treatments. A couple of initial remarks will situate the specific responses below. We appreciate the reviewer bringing our attention to Courtois and Brown. We agree that their critical appraisal of the process and priorities of the APA PTSD guidelines is important and has relevance to guidelines in other domains. The RANZCP Mood Disorder Guidelines are a particular type of guideline. Clinical Practice Guidelines are characterised by prioritising systematic reviews and outcome data as the basis of treatment recommendations. As Courtois and Brown note, Clinical Practice Guidelines are distinguished from what the APA calls 'Professional Practice Guidelines', which are more focused on the nuanced moderators, mediators and strategies of treatment delivery within given modalities. As Clinical Practice Guidelines, the RANZCP 2020 Mood Disorder update has stayed close to the evidence-based literature, which partly explains the relative importance placed on CBT (and related behaviourally-informed approaches to psychological intervention) over psychodynamic, humanistic, and relationship-based approaches. We are not unaware of the limitations of this epistemological approach, and have highlighted these concerns for readers throughout the 2015 and the 2020 versions of the guidelines (see particularly the Introduction sections). Coincidentally, the approach to 'evidence-based practice' (or 'evidence-informed practice') that underpins the RANZCP Mood Disorder Guidelines is similar to the three-factor approach (external evidence, individual clinical expertise, patient values/expertise) advocated by the APA. We also highlight throughout the importance of collecting data (from the clinician, patient and sometimes family perspectives) on therapy progress for this individual patient, recognising the complementary importance of practice-based evidence. Regarding the evidence base for short and longer term psychotherapeutic treatments: We thank the reviewer for highlighting this issue. We have added text highlighting that short-term psychodynamic therapy is an evidence-based treatment for acute depression, and also added a number of the references provided by the reviewer to encourage the reader to keep an open mind on emerging arguments in this area. Regarding the concerns for CBT as the gold-standard treatment: We share the reviewer's skepticism about the quality of the evidence base for psychological therapies for depression, and have highlighted the fundamental and significant limitations of RCTs in this and the earlier version of the guidelines (e.g., absence of blinding, inappropriateness of the 'pill metaphor' in relation to complex psychological intervention). We also cite in three places a more extensive consideration of the limitations of psychotherapy research (developed by two of the current Guidelines authors), in which we propose a more sophisticated program of research that might move the field beyond the current polarisation of 'brands' (see Mulder et al., 2017 as cited in the guideline. Regarding page 86: We have added some text into the Box on poor response to psychological treatments, highlighting that one strategy might be to consider changing therapeutic approach. That Box already notes the small but measurable risk of deterioration during an evidence-based psychological treatment. Regarding a psychodynamic component to assessment: See consideration of Courtois and Brown above. The details of conducting assessments and delivering psychological interventions are beyond the scope of a Clinical Practice Guideline. Just as there is no discussion of the assessment of psychodynamics and personality dimensions, the guideline does not consider the assessment or modification of , for example, cognitions, schemas, or the steps in developing mindfulness skills. Regarding pgs 51-52: Thank you for picking up this lack of clarity, and have rewritten that paragraph removing the final sentence.

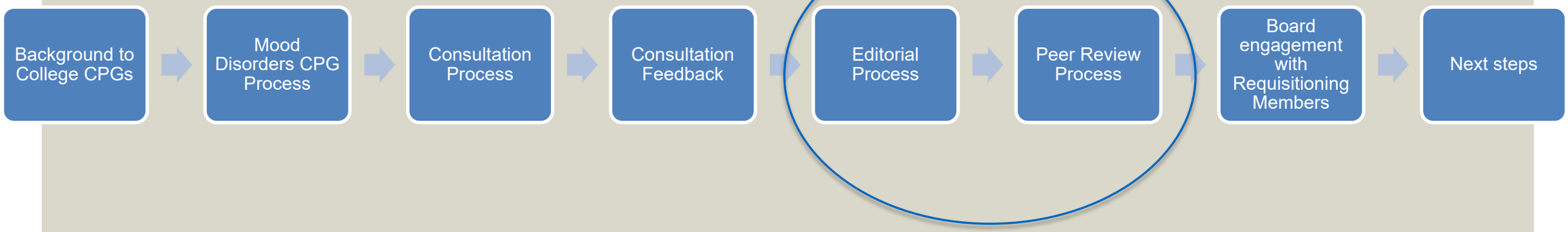
MOOD DISORDERS STEERING GROUP RESPONSE CONTINUED

	Response from the Mood Disorders Guideline Update Steering Group
2.	Regarding Box 12 on page 52: See consideration of Courtois and Brown above - as a Clinical Practice Guideline, the foundational information used in developing the recommendations here was (following the NHMRC's levels of evidence), the outcomes of clinical trials. This underpinning logic of the 2020 guidelines was explicated more fully in the 2015 version. Conscious of the limitations of this approach, however, the 2015 and the present guideline mentions at a number of points the importance of practice-based evidence, careful monitoring of individual patient outcomes, a collaborative working relationship with the client, client preference and empowerment. All of these more contextualised, local features of decision making come together in the Guideline's framework of providing recommendations as Actions, Choices, Alternatives: this approach explicitly recognises the limitations of generalising from RCTs to individual patients, and was designed to support the clinician in tailoring treatment choices to their individual client. We hope this novel approach to providing recommendations will make a small step towards bridging the research-practice divide. Regarding page 53: Thank you for querying the basis of these assertions, and highlighting that our recommendation may appear too rigid. The parties in the consensus are the members of the Guideline development group (see the 2015 Guideline for more detail on the role of clinical consensus as the lowest form of evidence in the hierarchy). But the assertion is common in the literature on evidence-based psychological therapies however, e.g. (Lilienfeld, S. O., Ritschel, L. A., Lynn, S. J., Cautin, R. L. & Latzman, R. D. Why many clinical psychologists are resistant to evidence-based practice: root causes and constructive remedies. Clin Psychol Rev 33, 883-900, doi:10.1016/j.cpr.2012.09.008 (2013)) Regarding pg 53, box 13: We agree that the guidelines adopt an essentially conservative position on this issue. As we reiterate throughout the document, psychotherapy process research remains limited (see above) and we are left largely with psychotherapy outcome research on which to base recommendations. Moreover, psychotherapy process research remains a pre-paradigmatic scientific domain. These are important topics, but in the opinion of the present authors, beyond the scope of a Clinical Practice Guideline which aims to synthesise best available evidence in a format that is useful for the practicing clinician. We do mention these issues in the new Box on psychodynamic treatments. Regarding the absence of longer term psychodynamic and psychoanalystic psychotherapy: We prioritise the NHMRC levels of evidence, and particularly meta-analytic reviews. Longer term psychodynamic and psychoanalytic psychotherapy does not appear as evidence-based in any meta-analytic review (of course, we can forward many reasons why this may be the case beyond its lack of efficacy – absence of evidence is not evidence of absence). Regarding how to determine the suitability of psychological therapy: We thank the reviewer for this comment. The guideline does already mention the important role of patient preference and collaborative decision making, which speaks to this issue. We have also added some consideration of changing therapeutic modality to improve 'fit' should the first psychological intervention offered not generate desired respose. Regarding page 85: We share the reviewer's concerns. We believe we have the balance right in terms of advocacy for trained therapists and optimal access for all (p.37) and a more pragmatic recognition of the potential and demonstrated benefits of online treatments (an important focus of the 2020 version of the guidelines). Regarding page 110: We thank the reviewer for this observation, which highlights that we may not have clearly presented our consideration of this issue. The document goes on to move away from both terms (DTD and TRD), and presents an alternative characterisation of this group of patients according to the Channelling Response Paradigm (CRP): "The CRP also obviates the need to categorise depression using 'difficult-to-treat' or 'treatment-resistant' labels, which imply that there is something unusual about their particular depressive illness or indeed them as individuals." Regarding page 114: We have tended to avoid the words 'psychotherapy' and 'psychotherapist' throughout, because of their association with particular brands of therapies and particular groups of practitioners. Regarding pg 123: We agree that the topics covered in this section are a very particular subset of all the moderators and special groups that could warrant consideration. We have reworded the introductory paragraph to make this clear.

MOOD DISORDERS STEERING GROUP RESPONSE CONTINUED

	Response from the Mood Disorders Guideline Update Steering Group
3.	1. We have included text and added a new Box (13) that addresses the evidence for various psychotherapies, including psychodynamic psychotherapy 2. We thank the reviewer for pointing out the prevalence of mixed anxiety and depression and the importance of providing guidance regarding management. This is inherently complex given that the clinical presentation can be conceptualised as a single disorder or a comorbidity of two disorders. Nevertheless, we have provided brief guidance, adopting a pragmatic approach given the paucity of data. As regards treatment-resistance, we agree that this is problematic terminology and a difficult area. hence, to address this we have included a response-focused approach (See Channelling Response Paradigm section, pg 113) 3. We recognise that depression is often comorbid, and this includes very many psychiatric and medical illnesses. Individual management of these overlapping conditions is beyond the scope of this guideline. As regards bupropion's use, this is clearly anecdotal and hence we have not made mention of this. Finally, regards the additional comment that private practitioners should be involved, we respectfully note that at least 5 members of the working group work significantly in private settings ranging from hospital to outpatients.

Editorial Process & Peer Review



PEER REVIEW FEEDBACK (ANZJP)

- RANZCP Board approved to progress the draft guideline to the ANZJP for peer review
- Through the process of the ANZJP:
  - the guideline was reviewed by five (5) international peer reviewers
  - Three (3) reviewers feedback included psychotherapy content
- Feedback from the peer reviewers was received which was considered by the Mood Disorders Steering Group who provided a response.

- The Chair of the Mood Disorders Steering Group was also the Editor of the ANZJP at the time and excused themselves from the ANZJP process which was independently facilitated.
- An Independent associate editor was assigned to manage the process by editorial manager.
- This was noted at the Corporate Governance and Risk Committee and the Board was satisfied with the independence of the Editorial process.

PEER REVIEW FEEDBACK CONTINUED

	Feedback	Response
1.	1. First sentence in right hand para under Box 14 “A frontier for research into psychological treatments for major depression is persistent or chronic depression and some instances of non-responsive depression (McPherson, 2019). “ To me this sentence referring to treatment responsiveness is out of context with the rest of this section discussing combination therapy and the sentence after it returns to talking about combination therapy…… However the 2nd sentence after the above addressed non- responsiveness and perhaps the above sentence should be re-located to precede the “second sentence” I would also suggest rearranging it to: “Persistent or chronic depression and non-responsive depression have been a frontier for research into psychological treatments for major depression.” (McPherson, 2019). This would then lead in to “Managing Suboptimal Response was divided into……”	We thank the reviewer for this helpful suggestion and agree that this change enhances the clarity and readability of this section. We have therefore included these changes in the document.

PEER REVIEW FEEDBACK CONTINUED

	Feedback	Response
2.	2. This is an extremely well-written and sufficiently detailed article updating the Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for Mood Disorders. I thoroughly enjoyed reading this article and found myself agreeing with the authors even in places where they deviate from DSM-5 and /or ICD-11 (e.g., in relation to Bipolar Type I and Type-II). The authors have clearly put in a tremendous amount of work and have done an outstanding job of synthesising clinical and neurobiological evidence to inform the guidelines they have provided. They have also communicated them very effectively in all areas, including assessment, classification and treatment (both psychological and pharmacological) approaches for mood disorders. The figures are very clear and informative. I have nothing to criticise about this article, except that I noticed a few very minor typos (e.g. repeated full-stops; repeated Table 2 caption) that can be easily fixed through a careful proof-reading.	We thank the reviewer for their positive comments, and we are heartened that the reviewer agrees with our viewpoints regarding the classification of mood disorders. We have proof-read the article and have amended any instances of repeated full-stops and table captions and thank the reviewer for noting these errors.
3.	The guideline is well written, clear and helpful to clinicians (both as a stand-alone reading and as a document to consult). I like the figures and I think some of the concepts introduced (for instance ACE) are a useful tool for psychiatrists. The review of the literature is comprehensive and updated (I cannot find some key references, but they are probably included in more recent publications). It is good to mention COVID (I would probably add an ad hoc paragraph and not just limit it to the section about digital interventions) Just a few comments for potential improvement. The treatment choices in terms of pharmacology for unipolar depression are probably something that the majority of clinicians/researchers would agree upon, while I think that the drug treatment for acute mania is possibly a bit controversial (it is not clear why olanzapine is second level). I think it is probably too late to change the text, but I would add some more emphasis on mood instability as a key feature of bipolar disorder and as psychological interventions as a routine therapeutic option to consider. I suggest to consider the following source to present evidence during COVID pandemic (especially digital mental health): https://oxfordhealthbrc.nihr.ac.uk/our-work/oxppl/covid-19-and-mental-health-guidance and https://pubmed.ncbi.nlm.nih.gov/32658857/ Finally, as the whole document is very long, a summary box at the beginning of each section would be of help.	We have now included text regarding COVID-19, both in the introduction section (pg 7) and we have expanded upon the related text within the digital therapies section (pg 59). We thank the reviewer for the recommended source and have included this in the text on page 7. Regarding olanzapine… Regarding mood instability, we accept the importance of this aspect of bipolar disorder and the role of psychotherapy in its management. However, we feel that we have addressed this adequately within the psychological interventions section, which we recommend throughout the document as an Action that must be considered in all patients. Therefore, we feel we have emphasized this point sufficiently.

Board Engagement with Requisitioning Members

The Royal Australian & New Zealand College of Psychiatrists

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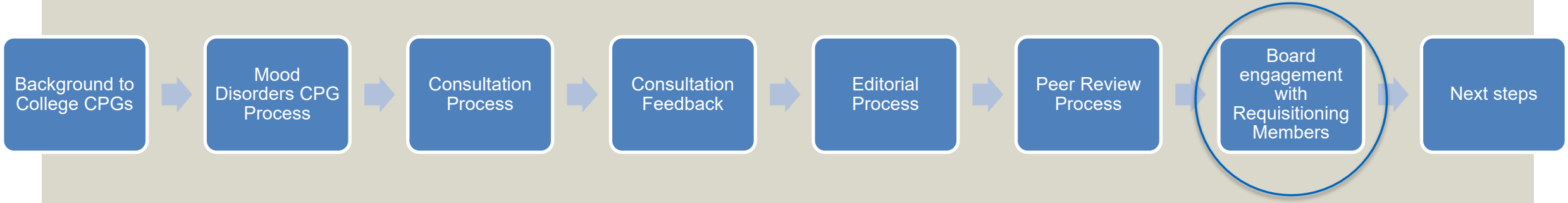


RANZCP BOARD ENGAGEMENT WITH REQUISITIONING MEMBERS

The Board has committed to addressing the concerns raised by the membership:

- met with the requisitioning members on 2 occasions
- clarified matters in writing on 8 occasions .

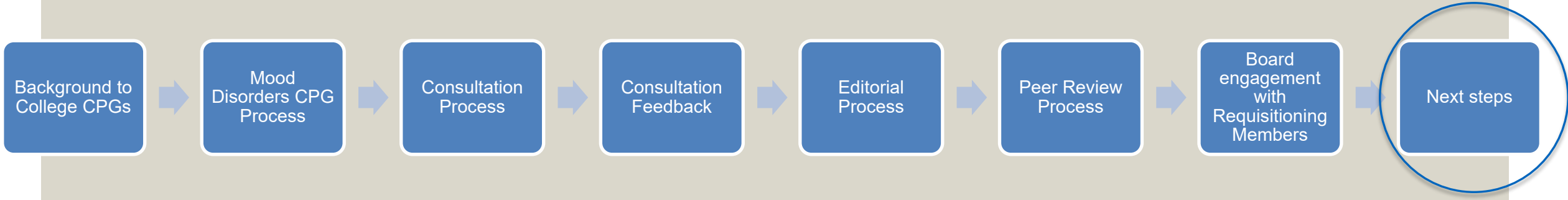
The Board has offered to progress the following:

1. Ongoing and transparent communication with the broader membership the concerns raised about the Mood Disorders CPG.

2. Timely commissioning of an independent external review of the evidence for psychodynamic psychotherapy which would, in part, inform additional work, including potentially amending if relevant, the content in the CPG. It is proposed that the review be conducted in consultation in accordance with accepted College processes, with recommendations being provided to the Board.

3. Request that the FOP Committee consider and make a recommendation to the Board as to the merit of directly submitting an article critiquing the Mood Disorder CPG to the *Australian and New Zealand Journal of Psychiatry (ANZJP).* The College could provide resourcing to facilitate this.

Next Steps


Background to College CPGs
Mood Disorders CPG Process
Consultation Process
Consultation Feedback
Editorial Process
Peer Review Process
Board engagement with Requisitioning Members
Next steps

FUTURE CPG DEVELOPMENT PROCESS

- Board has approved commissioning an external review of the CPG Development Process.
- A Consultation Hub has been implemented and now live.

The Royal Australian & New Zealand College of Psychiatrists

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DR NICK O'CONNOR

RANZCP BOARD DIRECTOR

QUESTIONS

- Questions that were submitted prior to the MRGM will be addressed.

QUESTIONS

- Questions received in writing during the MRGM will be addressed.

The Royal Australian & New Zealand College of Psychiatrists

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A/PROF VINAY LAKRA

RANZCP PRESIDENT

VOTING

- We will now progress to voting of the four (4) Ordinary Resolutions one at a time.

VOTING – RESOLUTION 1

The Royal Australian & New Zealand College of Psychiatrists

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i) The College forthwith remove its endorsement of the current CPG content relating to psychodynamic psychotherapy pending the outcome of the review referred to in paragraph (ii) below

VOTING – RESOLUTION 2

ii) The College commission a RANZCP working group, independent to the committee involved in the production of the current CPG:

- Whose membership includes clinicians with expertise and clinical experience in the psychodynamic psychotherapies; and
- For the purpose of reviewing the evidence base, consulting with the clinical field and providing feedback, and if deemed appropriate, making recommendations to the College to amend relevant aspects of the current CPG content relating to psychodynamic psychotherapy

VOTING – RESOLUTION 3

iii) If determined appropriate by the independent working group, provide recommendations and revised version of the specific CPG content relating to the psychodynamic psychotherapies in the assessment and treatment of Mood Disorders (including Complex and special presentations), referencing the contemporary evidence base, with a view to obtaining RANZCP endorsement and publication

VOTING – RESOLUTION 4

The Royal Australian & New Zealand College of Psychiatrists

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iv) The College promptly review the recommendations and any revised version of the abovementioned content and, subject to the recommendations of the independent working group, take immediate steps to replace the current CPG to facilitate multi-stakeholder reference

NEXT STEPS

- Any steps to be taken following the MRGM is at the Board's discretion and may be guided by the manner in which the Fellowship vote. The resolutions as proposed, if passed, would still be non-binding advisory resolutions, in a legal sense.

THANK YOU

The Royal Australian & New Zealand College of Psychiatrists

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- Thank you for attending the Member Requisition General Meeting.