National Institute for
Health and Clinical Excellence

Quick reference guide

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# Common mental health disorders

Identification and pathways to care

NICE clinical guideline 123
Developed by the National Collaborating Centre for Mental Health

## About this booklet

This is a quick reference guide that summarises the recommendations NICE has made to the NHS in 'Common mental health disorders: identification and pathways to care' (NICE clinical guideline 123).

## Who should read this booklet?

This quick reference guide is for healthcare professionals, especially those in primary care, and other staff who care for people with common mental health disorders.

## Who wrote the guideline?

The guideline was developed by the National Collaborating Centre for Mental Health, which is based at the Royal College of Psychiatrists and the British Psychological Society. The Collaborating Centre worked with a group of healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

For more information on how NICE clinical guidelines are developed, go to www.nice.org.uk

## Where can I get more information about the guideline?

The NICE website has the recommendations in full, reviews of the evidence they are based on, a summary of the guideline for patients and carers, and tools to support implementation (see page 22 for more details).

# Patient-centred care

Treatment and care should take into account patients' individual needs and preferences. Good communication is essential, supported by evidence-based information, to allow patients to reach informed decisions about their care. Follow advice on seeking consent from the Department of Health or Welsh Assembly Government if needed. If the patient agrees, families and carers should have the opportunity to be involved in decisions about treatment and care.

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# Introduction

- Common mental health disorders, such as depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and social anxiety disorder, may affect up to 15% of the population at any one time.
- They vary considerably in their severity but all of these conditions can be associated with significant long-term disability.
- The vast majority of depression and anxiety disorders that are diagnosed are treated in primary care (up to 90%). However, many individuals do not seek treatment and common mental health disorders often go unrecognised.
- Recognition of anxiety disorders is particularly poor in primary care and only a small minority of people experiencing anxiety disorders ever receive treatment.
- The aim of this guideline, which is focused on primary care, is to improve access to services, improve identification and recognition of common mental health disorders, and provide advice on treatment, referral and developing local care pathways. It brings together advice adapted from existing guidelines (marked with a footnote) with new recommendations.

# Key priorities for implementation

## Improving access to services

- Primary and secondary care clinicians, managers and commissioners should collaborate to develop local care pathways that promote access to services for people with common mental health disorders by:
  - supporting the integrated delivery of services across primary and secondary care
  - having clear and explicit criteria for entry to the service
  - focusing on entry and not exclusion criteria
  - having multiple means (including self-referral) to access the service
  - providing multiple points of access that facilitate links with the wider healthcare system and community in which the service is located.

## Identification

- Be alert to possible depression (particularly in people with a past history of depression, possible somatic symptoms of depression or a chronic physical health problem with associated functional impairment) and consider asking people who may have depression two questions, specifically:
  - During the last month, have you often been bothered by feeling down, depressed or hopeless?
  - During the last month, have you often been bothered by having little interest or pleasure in doing things?

  If a person answers ‘yes’ to either of the above questions consider depression and follow the recommendations for assessment[1].
- Be alert to possible anxiety disorders (particularly in people with a past history of an anxiety disorder, possible somatic symptoms of an anxiety disorder or in those who have experienced a recent traumatic event). Consider asking the person about their feelings of anxiety and their ability to stop or control worry, using the 2-item Generalized Anxiety Disorder scale (GAD-2).
  - If the person scores three or more on the GAD-2 scale, consider an anxiety disorder and follow the recommendations for assessment.
  - If the person scores less than three on the GAD-2 scale, but you are still concerned they may have an anxiety disorder, ask the following: 'Do you find yourself avoiding places or activities and does this cause you problems?'. If the person answers 'yes' to this question consider an anxiety disorder and follow the recommendations for assessment.

*Continued*

[1] Adapted from ‘Depression’ (NICE clinical guideline 90).

### Developing local care pathways

- Primary and secondary care clinicians, managers and commissioners should work together to design local care pathways that promote a stepped-care model of service delivery that:
  - provides the least intrusive, most effective intervention first
  - has clear and explicit criteria for the thresholds determining access to and movement between the different levels of the pathway
  - does not use single criteria such as symptom severity to determine movement between steps
  - monitors progress and outcomes to ensure the most effective interventions are delivered and the person moves to a higher step if needed.
- Primary and secondary care clinicians, managers and commissioners should work together to design local care pathways that provide an integrated programme of care across both primary and secondary care services. Pathways should:
  - minimise the need for transition between different services or providers
  - allow services to be built around the pathway and not the pathway around the services
  - establish clear links (including access and entry points) to other care pathways (including those for physical healthcare needs)
  - have designated staff who are responsible for the coordination of people's engagement with the pathway.
- Primary and secondary care clinicians, managers and commissioners should work together to ensure effective communication about the functioning of the local care pathway. There should be protocols for:
  - sharing and communicating information with people with common mental health disorders, and where appropriate families and carers, about their care
  - sharing and communicating information about the care of service users with other professionals (including GPs)
  - communicating information between the services provided within the pathway
  - communicating information to services outside the pathway.

## Abbreviations used in this booklet

CBT: cognitive behavioural therapy

EMDR: eye movement desensitisation and reprocessing

ERP: exposure and response prevention

GAD: generalised anxiety disorder

GAD-2: 2-item Generalized Anxiety Disorder scale

GAD-7: 7-item Generalized Anxiety Disorder scale

HADS: Hospital Anxiety and Depression Scale

IAPT: Improving Access to Psychological Therapies

IPT: interpersonal therapy

OCD: obsessive-compulsive disorder

PHQ-9: 9-item Patient Health Questionnaire

PTSD: post-traumatic stress disorder

# The stepped-care model

A stepped-care model is used to organise the provision of services and to help people with common mental health disorders, their families, carers and healthcare professionals to choose the most effective interventions. The model presents the key interventions from this guideline. For recommendations focused solely on specialist mental health services see related NICE guidance (page 22).

| Focus of the intervention | Nature of the intervention |
|---|---|
| **Step 3:** Persistent subthreshold depressive symptoms or mild to moderate depression that has not responded to a low-intensity intervention, initial presentation of moderate or severe depression; GAD with marked functional impairment or that has not responded to a low-intensity intervention; moderate to severe panic disorder; OCD with moderate or severe functional impairment; PTSD. | **Depression:** CBT, IPT, behavioural activation, behavioural couples therapy, counselling[2], short-term psychodynamic psychotherapy[2], antidepressants, combined interventions, collaborative care[3], self-help groups.<br>**GAD:** CBT, applied relaxation, drug treatment, combined interventions, self-help groups.<br>**Panic disorder:** CBT, antidepressants, self-help groups.<br>**OCD:** CBT (including ERP), antidepressants, combined interventions and case management, self-help groups.<br>**PTSD:** Trauma-focused CBT, EMDR, drug treatment.<br>**All disorders:** Support groups, befriending, rehabilitation programmes, educational and employment support services; referral for further assessment and interventions. |
| **Step 2:** Persistent subthreshold depressive symptoms or mild to moderate depression; GAD; mild to moderate panic disorder; mild to moderate OCD; PTSD (including people with mild to moderate PTSD). | **Depression:** Individual facilitated self-help, computerised CBT, structured physical activity, group-based peer support (self-help) programmes[3], non-directive counselling delivered at home[4], antidepressants, self-help groups.<br>**GAD and panic disorder:** Individual non-facilitated and facilitated self-help, psychoeducational groups, self-help groups.<br>**OCD:** Individual or group CBT (including ERP), self-help groups.<br>**PTSD:** Trauma-focused CBT or EMDR.<br>**All disorders:** Support groups, educational and employment support services; referral for further assessment and interventions. |
| **Step 1:** All known and suspected presentations of common mental health disorders. | **All disorders:** Identification, assessment, psychoeducation, active monitoring; referral for further assessment and interventions. |

[2] Discuss with the person the uncertainty of the effectiveness of counselling and psychodynamic psychotherapy in treating depression.
[3] For people with depression and a chronic physical health problem.
[4] For women during pregnancy or the postnatal period.

# Step 1 Identification and assessment

## Identification

### Depression

Be alert to possible depression (particularly in people with a past history of depression, possible somatic symptoms of depression or a chronic physical health problem with associated functional impairment) and consider asking:

- During the last month have you often been bothered by
  - feeling down, depressed or hopeless?
  - having little interest or pleasure in doing things?

If a person answers 'yes' to either question, consider depression[5].

### Anxiety disorders

Be alert to possible anxiety disorders (particularly in people with a past history of an anxiety disorder, possible somatic symptoms of an anxiety disorder, or who have experienced a recent traumatic event). Consider using the GAD-2 scale to ask about:

- their feelings of anxiety and
- their ability to stop or control worry.

If a person scores three or more on the GAD-2 scale, consider an anxiety disorder.

If the person scores less than three on the GAD-2 scale, but you are still concerned they may have an anxiety disorder, ask:

- Do you find yourself avoiding places or activities and does this cause you problems?

If the person answers 'yes' to this question, consider an anxiety disorder.

## Assessment

A practitioner who is not competent to perform a mental health assessment should:

- refer the person to an appropriate healthcare professional – if this is not their GP, inform the GP of the referral[5].

A practitioner who is competent to perform a mental health assessment should:

- review the person's mental state and associated functional, interpersonal and social difficulties[5]
- consider using a diagnostic or problem identification tool or algorithm, for example, the IAPT screening prompts tool[6]
- consider using a validated measure relevant to the disorder or problem being assessed, for example the PHQ-9, HADS or GAD-7
- for people with significant language or communication difficulties, consider using the Distress Thermometer[7] and/or asking a family member or carer about symptoms; if significant distress is identified, investigate further[5].

See page 8 for more information about assessment.

[5] Adapted from 'Depression' (NICE clinical guideline 90).
[6] For further information see 'The IAPT Data Handbook' Appendix C IAPT provisional diagnosis screening prompts (available from www.iapt.nhs.uk/services/measuring-outcomes).
[7] A single-item question screen to identify distress by asking the person to mark on a scale of 0 to 10 how distressed they have been during the past week.

## Assessment

- In addition to assessing symptoms and associated functional impairment, consider how the following factors may have affected the person's presenting problem:
  - a history of any mental health disorder
  - a history of a chronic physical health problem
  - any past experience of, and response to, treatments
  - the quality of interpersonal relationships
  - living conditions and social isolation
  - family history of mental illness
  - a history of domestic violence or sexual abuse
  - employment and immigration status[8].
- Assess the impact of the presenting problem on the care of children and young people (if appropriate) and, if necessary, follow local safeguarding procedures[8].
- Be aware of any learning disabilities or acquired cognitive impairments, and if necessary consider consulting with a relevant specialist[8] (see page 10).
- Always ask directly about suicidal ideation and intent. If there is a risk of self-harm or suicide:
  - assess whether the person has adequate social support and is aware of sources of help
  - arrange help appropriate to the level of risk (see page 9)
  - advise the person to seek further help if the situation deteriorates[8].

## Training and competencies for mental health assessment

All staff carrying out the assessment of common mental health disorders should be competent in:

- determining the nature, duration, and severity of the presenting disorder
- assessing not only symptom severity but also associated functional impairment
- identifying appropriate treatment and referral options in line with NICE guidance
- relevant verbal and non-verbal communication skills
- the use of formal assessment measures and routine outcome measures.

[8] Adapted from 'Depression' (NICE clinical guideline 90).

## Cultural, ethnic and religious considerations

Be respectful of, and sensitive to, cultural, ethnic and religious backgrounds, and be aware of possible variations in the presentation of common mental health disorders. Ensure competence in:

- culturally sensitive assessment
- using different explanatory models of common mental health disorders
- addressing cultural and ethnic differences when developing and implementing treatment plans
- working with families from diverse ethnic and cultural backgrounds[9].

Do not significantly vary the content and structure of assessments or interventions to address specific cultural or ethnic factors (beyond language and the cultural competence of staff), except as part of a formal evaluation of such modifications to an established intervention.

## Risk assessment and monitoring

- If a person presents a high risk of suicide or potential harm to others, a risk of significant self-neglect, or severe functional impairment, assess and manage the immediate problem first and then refer to specialist services. Where appropriate inform families and carers.
- If a person presents considerable and immediate risk to themselves or others, refer them urgently to the emergency services or specialist mental health services[9].
- If the person is assessed to be at risk of suicide:
  - take into account toxicity in overdose, if a drug is prescribed, and potential interaction with other prescribed medication; if necessary, limit the amount available
  - consider increasing the level of support, such as more frequent direct or telephone contacts
  - consider referral to specialist mental health services[9].

## Initial management for mild and self-limiting disorders

If the presentation and history suggest a mild and self-limiting (that is, symptoms are improving) common mental health disorder of recent onset, consider psychoeducation and active monitoring before offering or referring for further assessment or treatment.

For further details of assessment of common mental health disorders, see the NICE guideline for the specific disorder (see page 22).

[9] Adapted from 'Depression' (NICE clinical guideline 90).

# Principles for treatment and referral

When discussing treatment options consider:

- past experience of the disorder and experience of and response to previous treatment
- the trajectory of symptoms
- the diagnosis or problem specification, and severity and duration of the problem
- functional impairment due to the disorder or any chronic physical health problem
- social or personal factors that may have a role in the development or maintenance of the disorder
- any comorbid disorders.

Provide information about:

- the nature, content and duration, and acceptability and tolerability of any proposed intervention
- possible interactions with, and any implications for continuing, current interventions.

When offering or referring for treatment:

- take account of patient preference when choosing from a range of evidence-based treatments
- follow the stepped-care approach, usually offering or referring for the least intrusive, most effective intervention first (see page 6).

Do not routinely vary treatment or referral practice for:

- personal characteristics (such as gender or ethnicity)
- subtypes of depression (for example, atypical or seasonal depression)[10].

## Learning disabilities and cognitive impairment

If a person has a mild learning disability or mild cognitive impairment:

- where possible provide or refer them for the same interventions as for other people with the same common mental health disorder
- adjust the method of delivery or duration of the intervention to take account of the disability or impairment[10].

If a person has a moderate to severe learning disability or moderate to severe cognitive impairment:

- consult a specialist concerning appropriate referral and treatment options.

[10] Adapted from 'Depression' (NICE clinical guideline 90).

## Comorbid mental health problems

### Anxiety and depression

When a person presents with symptoms of anxiety and depression, assess the nature and extent of the symptoms. If the person has:

- depression that is accompanied by symptoms of anxiety, the first priority should usually be to treat the depressive disorder
- an anxiety disorder and comorbid depression or depressive symptoms, consider treating the anxiety disorder first
- both anxiety and depressive symptoms, with no formal diagnosis, that are associated with functional impairment, discuss with the person the symptoms to treat first and the choice of intervention[11].

### Harmful drinking or alcohol dependence

When a person presents with a common mental health disorder and harmful drinking or alcohol dependence, refer them for treatment of the alcohol misuse first[12].

For further details, see the NICE guideline for the specific disorder (see page 22).

[11] Adapted from 'Depression' (NICE clinical guideline 90).
[12] Adapted from 'Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence' (NICE clinical guideline 115).

# Step 2 Treatment and referral advice for subthreshold symptoms and mild to moderate disorders

**Step 2 Treatment and referral advice**

| Disorder | Psychological interventions | Pharmacological interventions | Psychosocial interventions |
|---|---|---|---|
| **Depression** – persistent subthreshold symptoms, or mild to moderate depression | Offer or refer for one or more of the following low-intensity interventions:<br>• individual facilitated self-help based on the principles of CBT<br>• computerised CBT<br>• a structured group physical activity programme<br>• a group-based peer support (self-help) programme (for those who also have a chronic physical health problem)<br>• non-directive counselling delivered at home (listening visits) (for women during pregnancy or the postnatal period)[a,b,c]. | Do not offer antidepressants routinely but consider them, or refer for an assessment, for:<br>• initial presentation of subthreshold depressive symptoms that have been present for a long period (typically at least 2 years) **or**<br>• subthreshold depressive symptoms or mild depression that persist(s) after other interventions **or**<br>• a past history of moderate or severe depression **or**<br>• mild depression that complicates the care of a physical health problem[a,b]. | Consider:<br>• informing people about self-help groups, support groups and other local and national resources<br>• educational and employment support services[a]. |
| **GAD** – that has not improved after psychoeducation and active monitoring in step 1 | Offer or refer for one of the following low-intensity interventions:<br>• individual non-facilitated self-help<br>• individual facilitated self-help<br>• psychoeducational groups[d]. | N/A | |
| **Panic disorder** – mild to moderate | Offer or refer for one of the following low-intensity interventions:<br>• individual non-facilitated self-help<br>• individual facilitated self-help. | N/A | |

*Continued*

**Step 2 Treatment and referral advice *(continued)***

| Disorder | Psychological interventions | Pharmacological interventions | Psychosocial interventions |
|---|---|---|---|
| **OCD** – mild to moderate | Offer or refer for individual CBT including ERP of limited duration (typically up to 10 hours), which could be provided using self-help materials or by telephone **or**<br><br>Refer for group CBT (including ERP)[e,f]. | N/A | Consider:<br>• informing people about self-help groups, support groups and other local and national resources<br>• educational and employment support services[a]. |
| **PTSD** – including mild to moderate PTSD | Refer for a formal psychological intervention (trauma-focused CBT or EMDR)[g]. | N/A | |
| **All disorders** – women planning a pregnancy, during pregnancy or following pregnancy who have subthreshold symptoms that significantly interfere with personal and social functioning | For women who have had a previous episode of depression or anxiety, consider providing or referring for individual brief psychological treatment (four to six sessions), such as IPT or CBT[c].<br><br>Women requiring psychological interventions during pregnancy or the postnatal period should be seen for treatment within 1 month of (and no longer than 3 months from) initial assessment[c]. | When considering drug treatments for women who are pregnant, breastfeeding or planning a pregnancy, consult 'Antenatal and postnatal mental health' (NICE clinical guideline 45) for advice on prescribing. | For women who have not had a previous episode of depression or anxiety, consider providing or referring for social support during pregnancy and the postnatal period; such support may consist of regular informal individual or group-based support[c]. |

[a] Adapted from 'Depression' (NICE clinical guideline 90).
[b] Adapted from 'Depression and chronic physical health problems' (NICE clinical guideline 91).
[c] Adapted from 'Antenatal and postnatal mental health' (NICE clinical guideline 45).
[d] Adapted from 'Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults' (NICE clinical guideline 113).
[e] Adapted from 'Obsessive-compulsive disorder' (NICE clinical guideline 31).
[f] Group formats may deliver more than 10 hours of therapy.
[g] Adapted from 'Post-traumatic stress disorder' (NICE clinical guideline 26).

# Step 3 Treatment and referral advice for persistent subthreshold symptoms, mild to moderate disorders with inadequate response to initial interventions, or moderate to severe disorders

**Step 3 Treatment and referral advice**

| Disorder | Psychological or pharmacological interventions | Combined and complex interventions | Psychosocial interventions |
|---|---|---|---|
| **Depression** – persistent subthreshold depressive symptoms or mild to moderate depression that has not responded to a low-intensity intervention | Offer or refer for:<br>• antidepressant medication **or**<br>• a psychological intervention (CBT, IPT, behavioural activation or behavioural couples therapy)[a].<br><br>For people who decline the interventions above consider providing or referring for:<br>• counselling for people with persistent subthreshold depressive symptoms or mild to moderate depression<br>• short-term psychodynamic psychotherapy for people with mild to moderate depression[a].<br><br>Discuss with the person the uncertainty of the effectiveness of counselling and psychodynamic psychotherapy in treating depression[a]. | N/A | Consider:<br>• informing people about self-help groups, support groups and other local and national resources<br>• befriending or a rehabilitation programme for people with long-standing moderate or severe disorders<br>• educational and employment support services[a]. |
| **Depression** – moderate or severe (first presentation) | See combined and complex interventions column. | Offer or refer for a psychological intervention (CBT or IPT) in combination with an antidepressant[a]. | |
| **Depression** – moderate to severe depression and a chronic physical health problem | See combined and complex interventions column. | For people with no, or only a limited, response to psychological or drug treatment alone or combined in the current or in a past episode, consider referral to collaborative care[b]. | |

*Continued*

**Step 3 Treatment and referral advice *(continued)***

| Disorder | Psychological or pharmacological interventions | Combined and complex interventions | Psychosocial interventions |
|---|---|---|---|
| **GAD** – with marked functional impairment or non-response to a low-intensity intervention | Offer or refer for one of the following:<br>• CBT **or**<br>• applied relaxation **or**<br>• if the person prefers, drug treatment[c]. | N/A | Consider:<br>• informing people about self-help groups, support groups and other local and national resources<br>• befriending or a rehabilitation programme for people with long-standing moderate or severe disorders<br>• educational and employment support services[a]. |
| **Panic disorder** – moderate to severe (with or without agoraphobia) | Consider referral for:<br>• CBT **or**<br>• an antidepressant if the disorder is long-standing or the person has not benefitted from or has declined psychological interventions[c]. | N/A | |
| **OCD** – moderate or severe functional impairment, and in particular where there is significant comorbidity with other common mental health disorders[d] | For moderate impairment, offer or refer for CBT (including ERP) or antidepressant medication[e].<br><br>Offer home-based treatment where the person is unable or reluctant to attend a clinic or has specific problems (for example, hoarding)[e]. | For severe impairment offer or refer for CBT (including ERP) combined with antidepressant medication and case management[e,f].<br><br>Offer home-based treatment where the person is unable or reluctant to attend a clinic or has specific problems (for example, hoarding)[e]. | |
| **PTSD** | Offer or refer for a psychological intervention (trauma-focused CBT or EMDR). Do not delay the intervention or referral, particularly for people with severe and escalating symptoms in the first month after the traumatic event[g].<br><br>Offer or refer for drug treatment only if a person declines an offer of a psychological intervention or expresses a preference for drug treatment[g]. | N/A | Consider:<br>• informing people about support groups and other local and national resources<br>• befriending or a rehabilitation programme for people with long-standing moderate or severe disorders<br>• educational and employment support services[a]. |

[a] Adapted from 'Depression' (NICE clinical guideline 90).
[b] Adapted from 'Depression in adults with a chronic physical health problem.' (NICE clinical guideline 91).
[c] Adapted from 'Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults' (NICE clinical guideline 113).
[d] For people with long-standing OCD or with symptoms that are severely disabling and restrict their life, consider referral to a specialist mental health service.
[e] Adapted from 'Obsessive-compulsive disorder' (NICE clinical guideline 31).
[f] For people with OCD who have not benefitted from two courses of CBT (including ERP) combined with antidepressant medication, refer to a service with specialist expertise in OCD.
[g] Adapted from 'Post-traumatic stress disorder' (NICE clinical guideline 26).

# Preventing relapse

For people with a common mental health disorder who are at significant risk of relapse or have a history of recurrent problems, discuss with the person the treatments that might reduce the risk of recurrence. The choice of treatment and referral for treatment should be informed by the response to treatment, including the response of residual symptoms, the consequences of relapse, any discontinuation symptoms when stopping medication, and the person's preference.

Offer or refer people for CBT or, for those who have had three or more episodes, mindfulness-based CBT if they:

- are currently well but have a previous history of depression and are considered at risk of relapse despite taking antidepressant medication
- are unable to continue or choose not to continue antidepressant medication
- have had previous treatment for depression but continue to have residual depressive symptoms[13].

For further details of treatment for common mental health disorders, see the NICE guideline for the specific disorder (see page 22).

[13] Adapted from 'Depression' (NICE clinical guideline 90).

# Improving access to care

Support access to services and increase the uptake of interventions, by ensuring that:

- systems are in place for overall coordination and continuity of care
- a healthcare professional is designated to oversee the period of care (usually a GP in primary care settings)
- services are provided in a variety of settings
- the structure and distribution of services is based on an assessment of local needs. Services should usually deliver:
  - assessment and interventions outside normal working hours
  - interventions in the person's home or other residential settings
  - specialist assessment and interventions in non-traditional community-based settings (for example, community or social centres) and, where appropriate, in conjunction with staff from those settings
  - both generalist and specialist assessment and intervention services in primary care settings.

Consider using modifications to the delivery of interventions and outcome monitoring (based on the assessed local needs), such as:

- technology (for example, text messages, email, telephones and computers) for people who may find it difficult to, or choose not to, attend a specific service
- bilingual therapists or independent translators.

Consider providing a range of support services, such as:

- crèche facilities
- assistance with travel
- advocacy services.

# Local care pathways

Responsibility for the development, management and evaluation of local care pathways should lie with a designated leadership team, including primary and secondary care clinicians, managers and commissioners. The leadership team should have particular responsibility for:

- developing clear policy and protocols for operation of the pathway
- providing training and support on the operation of the pathway
- auditing and reviewing performance of the pathway.

Primary and secondary care clinicians, managers and commissioners should work together to ensure effective communication about the functioning of the local care pathway. There should be protocols for:

- sharing and communicating information with people with common mental health disorders, and where appropriate families and carers, about their care
- sharing and communicating information about the care of people with common mental health disorders with other professionals (including GPs)
- communicating information between the services provided by the pathway and to services outside the pathway.

## Information and support

Provide information about the services and interventions that constitute the local care pathway, including the:

- range and nature of the interventions provided
- settings in which services are delivered
- processes by which a person moves through the pathway
- means by which progress and outcomes are assessed
- delivery of care in related health and social care services.

When providing information about local care pathways to people with common mental health disorders, their families and carers:

- take into account their knowledge and understanding of mental health disorders and treatment
- ensure the information is appropriate to the communities using the pathway.

Provide all information about services in a range of languages and formats (visual, verbal and aural), and ensure it is available from a range of settings.

Ensure effective engagement with families and carers, where appropriate, to:

- inform and improve the care of the person with a common mental health disorder
- identify and meet the needs of families and carers.

## Design of local care pathways

Primary and secondary care clinicians, managers and commissioners should work together to design local care pathways as described on page 19.

| Designing local care pathways for common mental health disorders | |
|---|---|
| Promoting the principles of good care | Ensure local care pathways are:<br>● negotiable, workable and understandable for all involved<br>● accessible and acceptable to all people in need of the services<br>● responsive to the needs of people with common mental health disorders and their families and carers<br>● integrated, with no barriers to movement between different levels of the pathway<br>● outcomes focused (including measures of quality, service-user experience and harm). |
| Promoting access to services | Ensure local care pathways:<br>● support integrated delivery of services across primary and secondary care<br>● include clear and explicit criteria for entry to the service and focus on these rather than exclusion criteria<br>● have multiple means to access the service (including self-referral)<br>● provide multiple points of access that facilitate links with the wider healthcare system and community<br>● promote access to services for people from a range of socially excluded groups including:<br>– black and minority ethnic groups<br>– older people<br>– people in prison or in contact with the criminal justice system<br>– ex-service personnel. |
| Promoting a stepped-care model of service delivery | Ensure local care pathways:<br>● provide the least intrusive, most effective intervention first<br>● have clear and explicit criteria for the thresholds determining access to and movement between the different levels of the pathway<br>● do not use single criteria (such as symptom severity) to determine movement between steps<br>● monitor progress and outcomes to ensure the most effective interventions are delivered and the person moves to a higher step if needed<br>● promote a range of evidence-based interventions at each step in the pathway<br>● support people in their choice of interventions. |
| Promoting active engagement of all populations | Ensure local care pathways:<br>● offer prompt assessments and interventions that are appropriately adapted to the cultural, gender, age and communication needs of the person<br>● keep to a minimum the number of assessments needed to access interventions. |
| Responding promptly and effectively to changing needs | Ensure local care pathways have in place:<br>● clear and agreed goals for the services offered to a person<br>● robust and effective means for measuring and evaluating the outcomes associated with the agreed goals<br>● clear and agreed mechanisms for responding promptly to identified changes to the person's needs. |
| Providing an integrated programme of care | Ensure local care pathways:<br>● minimise the need for transition between different services or providers<br>● allow services to be built around the pathway (and not the pathway around the services)<br>● establish clear links (including access and entry points) to other care pathways (including those for physical healthcare needs)<br>● have designated staff who are responsible for the coordination of people's engagement with the pathway. |
| Having robust systems for outcome measurement | Ensure local care pathways provide:<br>● individual routine outcome measurement systems<br>● effective electronic systems for the routine reporting and aggregation of outcome measures<br>● effective systems for the audit and review of the overall clinical and cost-effectiveness of the care pathway. |

# Glossary

Note: This is not an exhaustive list and a full glossary is available from the guidance documents.

**Applied relaxation:** a psychological intervention that focuses on applying muscular relaxation in situations and occasions where the person is or might be anxious (usually 12 to 15 weekly sessions of 1 hour).

**Behavioural activation:** a psychological intervention for depression that aims to identify the effects of behaviour on current symptoms, mood and problem areas. It seeks to reduce symptoms and problematic behaviours through behavioural tasks related to reducing avoidance, activity scheduling and enhancing positively reinforced behaviours (usually 16 to 20 sessions over 3 to 4 months).

**Behavioural couples therapy:** a psychological intervention that aims to help people understand the effects of their interactions on each other as factors in the development and maintenance of symptoms and problems, and to change the nature of the interactions so that the person's mental health problems improve (usually 15 to 20 sessions over 5 to 6 months).

**Collaborative care:** in the context of this guideline, a coordinated approach to mental and physical healthcare involving the following elements: case management which is supervised and has support from a senior mental health professional; close collaboration between primary and secondary physical health services and specialist mental health services; a range of interventions, including patient education, psychological and pharmacological interventions, and medication management; and long-term coordination of care and follow-up.

**Exposure and response prevention (ERP):** a psychological intervention used for people with OCD that aims to help people to overcome their need to engage in obsessional and compulsive behaviour. With the support of a practitioner, the person is exposed to whatever makes them anxious, distressed or fearful. Rather than avoiding the situation, or repeating a compulsion, the person is trained in other ways of coping with anxiety, distress or fear. The process is repeated until the person no longer feels this way.

**Eye movement desensitisation and reprocessing (EMDR):** a psychological intervention for PTSD. During EMDR, the person is asked to concentrate on an image connected to the traumatic event and the related negative emotions, sensations and thoughts, while paying attention to something else, usually the therapist's fingers moving from side to side in front of the person's eyes. After each set of eye movements (about 20 seconds), the person is encouraged to discuss the images and emotions they felt during the eye movements. The process is repeated with a focus on any difficult, persisting memories. Once the person feels less distressed about the image, they are asked to concentrate on it while having a positive thought relating to it. The treatment is usually 8 to 12 sessions and should be regular and continuous (usually at least once a week).

**Mindfulness-based cognitive therapy:** a group-based skills training programme using techniques from meditation and cognitive therapy designed specifically to prevent depressive relapse or recurrence of depression. Its aim is to enable people to learn to become more aware of bodily sensations, and thoughts and feelings associated with depressive relapse (usually eight weekly 2-hour sessions and four follow-up sessions in the 12 months after the end of treatment).

**Somatic symptoms:** physical symptoms of common mental health disorders, which form part of the cluster of symptoms that are necessary for achieving a diagnosis. They may include palpitations or muscular tension in an anxiety disorder, or lethargy and sleep disturbance in depression. In some cases they may be the main symptom with which a person first presents; they do not constitute a separate diagnosis and should be distinguished from somatoform disorders and medically unexplained symptoms.

**Trauma-focused CBT:** a type of CBT specifically developed for people with PTSD that focuses on memories of trauma and negative thoughts and behaviours associated with such memories. The structure and content of the intervention is based on CBT principles with an explicit focus on the traumatic event that led to the disorder. Treatment is usually 8 to 12 sessions and should be regular and continuous (usually at least once a week).

## Severity of common mental health disorders

Assessing the severity of common mental health disorders is determined by three factors: symptom severity, duration of symptoms and associated functional impairment (for example, impairment of vocational, educational, social or other functioning).

- **Mild** generally refers to relatively few core symptoms (although sufficient to achieve a diagnosis), a limited duration and little impact on day-to-day functioning.
- **Moderate** refers to the presence of all core symptoms of the disorder plus several other related symptoms, duration beyond that required by minimum diagnostic criteria, and a clear impact on functioning.
- **Severe** refers to the presence of most or all symptoms of the disorder, often of long duration and with very marked impact on functioning (for example, an inability to participate in work-related activities and withdrawal from interpersonal activities).

# Further information

## Ordering information

You can download the following documents from **www.nice.org.uk/guidance/CG123**

- The NICE guideline – all the recommendations.
- A quick reference guide (this document) – a summary of the recommendations for healthcare professionals.
- 'Understanding NICE guidance' – a summary for patients and carers.
- The full guideline – all the recommendations, details of how they were developed, and reviews of the evidence they were based on.

For printed copies of the quick reference guide or 'Understanding NICE guidance', phone NICE publications on 0845 003 7783 or email publications@nice.org.uk and quote:

- N2541 (quick reference guide)
- N2542 ('Understanding NICE guidance').

## Implementation tools

NICE has developed tools to help organisations implement this guidance (see **www.nice.org.uk/guidance/CG123**).

## Related NICE guidance

For information about NICE guidance that has been issued or is in development, see **www.nice.org.uk**

Published

- Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. NICE clinical guideline 115 (2011). Available from **www.nice.org.uk/guidance/CG115**
- Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults. NICE clinical guideline 113 (2011). Available from **www.nice.org.uk/guidance/CG113**
- Depression in adults with a chronic physical health problem. NICE clinical guideline 91 (2009). Available from **www.nice.org.uk/guidance/CG91**
- Depression. NICE clinical guideline 90 (2009). Available from **www.nice.org.uk/guidance/CG90**
- Drug misuse: psychosocial interventions. NICE clinical guideline 51 (2007). Available from **www.nice.org.uk/guidance/CG51**
- Antenatal and postnatal mental health. NICE clinical guideline 45 (2007). Available from **www.nice.org.uk/guidance/CG45**
- Computerised cognitive behaviour therapy for depression and anxiety. NICE technology appraisal guidance 97 (2006). Available from **www.nice.org.uk/guidance/TA97**
- Obsessive-compulsive disorder. NICE clinical guideline 31 (2005). Available from **www.nice.org.uk/guidance/CG31**
- Post-traumatic stress disorder. NICE clinical guideline 26 (2005). Available from **www.nice.org.uk/guidance/CG26**

Under development

- Social anxiety disorder. NICE clinical guideline. Publication expected 2013.

## Updating the guideline

This guideline will be updated as needed, and information about the progress of any update will be available at **www.nice.org.uk/guidance/CG123**

NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales.

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

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