Common mental health disorders: identification and pathways to care

NICE guideline

Draft for consultation, November 2010

If you wish to comment on this version of the guideline, please be aware that all the supporting information and evidence is contained in the full version.

Contents

Introduction

Common mental health disorders, such as depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and social phobia, may affect up to 15% of the population over the course of a year. They vary considerably in their severity but all of these conditions can be associated with significant long-term disability. Many disorders, for example depression, have a lifelong course of relapse and remission. As a consequence, they have a significant impact on people's social and personal functioning. For example, depression is estimated to be the second greatest contributor to disability-adjusted life years throughout the developed world. It is also associated with high levels of morbidity, high levels of mortality and is the most common disorder contributing to suicide. In contrast, many anxiety disorders, particularly when established, have a chronic course. This may also be associated with a considerable delay in presenting to services with consequent significant personal and social impairment.

The prevalence of individual common mental health disorders varies considerably. The 1-week prevalence rates from the Office of National Statistics (ONS) 2007 national survey[1] were 4.4% for generalised anxiety disorder, 3.0% for PTSD, 2.3% for depression, 1.4% for phobias, 1.1% for OCD, and 1.1% for panic disorder. Estimates of the proportion of people who are likely to experience specific disorders during their lifetime are from 4 to 10% for major depression, 2.5 to 5% for dysthymia, and about 5.7% for generalised anxiety disorder, 1.4% for panic disorder, 12.5% for specific phobias, 12.1% for social anxiety disorder, 1.6% for OCD and 6.8% for PTSD. More than half of people aged 16 to 64 years who meet the diagnostic criteria for at least one disorder experience comorbid anxiety and depressive disorders.

[1] McManus S, Meltzer H, Brugha T, et al (2007) Adult psychiatric morbidity in England, 2007: results of a household survey. Leeds: The Information Centre for Health and Social Care.

Depressive and anxiety disorders are common in both men and women but tend to have a higher prevalence in women (around double the rate in men). Some black and minority ethnic groups also have a higher incidence of common mental health disorders.

For many people the onset of these disorders occurs in adolescence or early adult life, although the disorders can affect individuals at any point in their life (for example, in PTSD onset relates to specific traumatic events). Earlier onset is generally associated with poorer outcomes.

The vast majority of depression and anxiety disorders that are diagnosed (up to 90%) are treated in primary care. However, many individuals do not seek treatment, and both anxiety and depression often go undiagnosed. Of all depressive disorders presenting in the community at any one time, it is likely that only 30% are recognised and treated. Although under-recognition is generally more common in mild rather than severe cases, mild disorders are still a great source of concern. Recognition of anxiety disorders by GPs is particularly poor, and only a small minority of people who experience anxiety disorders ever receive treatment. In part this may stem from GPs' difficulties in recognising the disorder, but it may also be caused by worries about stigma and avoidance on the part of individual patients. Pessimism about possible treatment outcomes may further contribute to this.

The most common method of treatment for these disorders in primary care is psychotropic medication. This is due to the limited availability of psychological interventions, despite the fact that these treatments are generally preferred by patients. Recent developments to increase psychological services through the Improving Access to Psychological Therapies (IAPT) programme have begun to address this issue, but it is unlikely that it will meet all of the identified needs for psychological interventions.

Since 2004, NICE has produced a series of guidelines on the care and treatment of common mental health disorders (see section 6 for details of related guidelines). Some of these guidelines have focused on identification

and recognition (for example, the guideline on depression), whereas others give little advice on identification (for example, the guideline on generalised anxiety disorder and panic disorder). In addition to the variable advice on identification and recognition, NICE guidelines have also varied in the amount of advice they have provided on assessment and appropriate referral for the treatment of these disorders.

The intention of this guideline, which is focussed on primary care, is to improve access to services (including primary care services themselves), improve identification and recognition, and provide advice on the principles that need to be adopted to develop appropriate referral and care pathways. The aim is to bring together advice from existing guidelines and combine them with new recommendations concerning access, assessment and care pathways for common mental health disorders. In common with the other NICE guidelines on common mental health disorders, the recommendations within this guideline are presented with a stepped-care approach in mind.

A number of the recommendations in this guideline were adopted or adapted from recommendations in other NICE guidelines for common mental health disorders. In doing so the GDG were mindful that they had not reviewed the evidence for these recommendations and therefore when transferring them into this guideline were careful to preserve the meaning and intent of the original recommendation. Where recommendations were adopted no change to the wording or structure of the recommendation was made. Where recommendations were adapted, changes to wording or structure were made in order to fit the recommendation into this guideline; these adaptations preserved the meaning and intent of the recommendation but shifted the context in which the recommendation was made. For example, recommendations that presented a number of treatment options in secondary care services in other NICE guidelines were restructured to provide advice on possible referral options in primary care in this guideline. In all cases the origin of any adopted or adapted recommendations is indicated in a footnote.

Patient-centred care

This guideline offers best practice advice on the care of adults with a common mental health disorder.

Treatment and care should take into account patients' needs and preferences. People with a common mental health disorder should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If people do not have the capacity to make decisions, practitioners should follow the Department of Health's advice on consent (available from www.dh.gov.uk/consent) and the code of practice that accompanies the Mental Capacity Act (summary available from www.publicguardian.gov.uk). In Wales, healthcare professionals should follow advice on consent from the Welsh Assembly Government (available from www.wales.nhs.uk/consent).

Good communication between healthcare professionals and patients is essential. It should be supported by evidence-based written information tailored to the patient's needs. Treatment and care, and the information patients are given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English.

If the patient agrees, families and carers should have the opportunity to be involved in decisions about treatment and care.

Families and carers should also be given the information and support they need.

Key priorities for implementation

Improving access to services

- Primary and secondary care clinicians, managers and commissioners should collaborate to develop care pathways that promote access to services for people with common mental health disorders. Care pathways for common mental health disorders should:
  - support the integrated delivery of services across primary and secondary care
  - have clear and explicit criteria for entry to the service
  - focus on entry and not exclusion criteria
  - have multiple means to access the service (including self-referral)
  - provide multiple points of access that facilitate links with the wider healthcare system and community in which the service is located. [1.1.1.4]

Identification

- Be alert to a possible depression (particularly in people with a past history 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 (see section 1.2.2).[2] [1.2.1.1]

- Be alert to possible anxiety disorders (particularly in people with a past history of anxiety or who have experienced a recent traumatic event). Consider asking the person about the extent of their feelings of anxiety and

[2] Adopted from 'Depression: the treatment and management of depression in adults' (NICE clinical guideline 90). Available from: www.nice.org.uk/guidance/CG90

their ability to stop or control worry, using the 2-item Generalized Anxiety Disorder scale (GAD-2; see appendix D).

- If the person scores three or more on the GAD-2 scale, consider an anxiety disorder and follow the recommendations for assessment (see section 1.2.2).
- 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 (see section 1.2.2). [1.2.1.2]

Developing care pathways

- Primary and secondary care clinicians, managers and commissioners should work together to design care pathways that promote a stepped-care model of service delivery providing:
  - the least intrusive, most effective intervention first
  - clear and explicit criteria for the thresholds determining access to and movement between the different levels of the pathway
  - a self-correcting mechanism to ensure the most effective interventions are delivered. [1.4.1.3]

- Primary and secondary care clinicians, managers and commissioners should work together to design 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 service users' engagement with the pathway. [1.4.1.8]

- Primary and secondary care clinicians, managers and commissioners should work together to ensure effective communication about the functioning of the care pathway. There should be protocols for:
  - sharing and communicating information with service users, and where appropriate families and carers, about their care
  - sharing and communicating information about the care of services users with other professionals (including GPs)
  - communicating information between the services provided by the pathway
  - communicating information to services outside the pathway. [1.4.1.9]

1 Guidance

The following guidance is based on the best available evidence. The full guideline ([add hyperlink]) gives details of the methods and the evidence used to develop the guidance.

This guideline was developed to provide an integrated approach to the identification and assessment of common mental health disorders, particularly in primary care. It draws together the recommendations from existing NICE guidance and addresses any gaps in the identification and assessment of these conditions. The guideline also provides advice for primary care and other staff on referral. Finally it sets out guidance for the development of effective care pathways for people with common mental health disorders.

1.1 Improving access to services

1.1.1.1 Primary and secondary care clinicians, managers and commissioners should work together to ensure that there are clear and explicit criteria for entry to the service. They should provide information about the services and interventions that constitute the care pathway, including the:

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

1.1.1.2 When providing information about care pathways to service users, their families and carers, all healthcare professionals should take into account their knowledge and understanding of mental health disorders and their treatment in the communities for which the pathway was developed.

1.1.1.3 All information about services should be provided in a range of languages and formats (visual, verbal and aural) and available in a range settings throughout the whole community to which the service is responsible.

1.1.1.4 Primary and secondary care clinicians, managers and commissioners should collaborate to develop care pathways that promote access to services for people with common mental health disorders (see also section 1.4). Care pathways for common mental health disorders should:

- support the integrated delivery of services across primary and secondary care
- have clear and explicit criteria for entry to the service
- focus on entry and not exclusion criteria
- have multiple means to access the service (including self-referral)
- provide multiple points of access that facilitate links with the wider healthcare system and community in which the service is located. [KPI]

1.1.1.5 In order to support access to services and increase the uptake of interventions, ensure that:

- systems are in place to provide for the overall coordination and continuity of care of people with common mental health disorders, and
- designate a healthcare professional to oversee the whole period of care (usually a GP in a primary care setting).

1.1.1.6 In order to support access to services and increase the uptake of interventions, provide services in a variety of settings. Base the structure and distribution of services on an assessment of local needs, which should usually include delivery of:

- assessment and interventions outside normal working hours
- interventions in the service user's home or other residential settings
- specialist assessment and interventions in non-traditional community-based settings (for example, community centres, social centres) and where appropriate, in conjunction with staff from those settings
- both generalist and specialist assessment and intervention services in primary care settings.

1.1.1.7 Primary and secondary care clinicians, managers and commissioners should consider a range of support services to facilitate access and uptake of services. These may include providing:

- crèche facilities
- assistance with transport or travel
- advocacy services.

1.1.1.8 Consider modifications to the method and mode of delivery of interventions based on the assessed local needs and which may usually include using:

- technology, for example, text messages, email, telephone and computers, to facilitate the delivery of assessment and treatment interventions, and outcome monitoring, for people who may find it difficult to, or choose not to, attend a specific service
- bilingual therapists or independent translators to support the delivery of both assessment and treatment interventions.

1.1.1.9 Be respectful of, and sensitive to, cultural, ethnic and religious backgrounds when working with people with common mental health disorders, and be aware of the possible variations in the presentation of these conditions. 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.

1.1.1.10 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 as there is little evidence to support significant variations to the content and structure of assessments or interventions.

1.2 Identification and assessment

1.2.1 Identification

1.2.1.1 Be alert to a possible depression (particularly in people with a past history 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 (see section 1.2.2).[3] [KPI]

1.2.1.2 Be alert to possible anxiety disorders (particularly in people with a past history of anxiety or who have experienced a recent traumatic event). Consider asking the person about the extent of their feelings of anxiety and their ability to stop or control worry, using the 2-item Generalized Anxiety Disorder scale (GAD-2; see appendix D).

- If the person scores three or more on the GAD-2 scale, consider an anxiety disorder and follow the recommendations for assessment (see section 1.2.2).
- 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 (see section 1.2.2). [KPI]

1.2.1.3 For people with significant language or communication difficulties, for example people with sensory impairments or a learning disability, consider using the Distress Thermometer[4] and/or asking a family member or carer about the person’s symptoms to identify a possible common mental health disorder. If a significant level of

[3] Adopted from ‘Depression: the treatment and management of depression in adults’ (NICE clinical guideline 90). Available from: www.nice.org.uk/guidance/CG90

[4] The Distress Thermometer is a single-item question screen that will identify distress coming from any source. The person places a mark on the scale answering: ’How distressed have you been during the past week on a scale of 0 to 10?’ Scores of 4 or more indicate a significant level of distress that should be investigated further. (Roth AJ, Kornblith AB, Batel-Copel L, et al. (1998) Rapid screening for psychologic distress in men with prostate carcinoma: a pilot study. Cancer 82: 1904–8.)

distress is identified, consider further assessment or seek the advice of a specialist.[5]

1.2.2 Assessment

1.2.2.1 If the practitioner is not competent to perform a mental health assessment, refer the person to an appropriate healthcare professional. If this professional is not the person's GP, inform the GP of the referral.[6]

1.2.2.2 If a person scores positively on the identification questions (see section 1.2.1), 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.[7]

1.2.2.3 When assessing a person with a suspected common mental health disorder, consider using:

- a diagnostic or problem identification tool or algorithm, for example, the IAPT screening prompts tool[8]
- a validated measure relevant to the disorder or problem being assessed, for example, the 9-item Patient Health Questionnaire (PHQ-9), the Hospital Anxiety and Depression Scale (HADS) or the 7-item Generalized Anxiety Disorder scale (GAD-7) to inform the assessment and support the evaluation of any intervention.

1.2.2.4 All staff carrying out the assessment of common mental health disorders should be trained and competent to perform an

[5] Adapted from 'Depression: the treatment and management of depression in adults' (NICE clinical guideline 90). Available from: www.nice.org.uk/guidance/CG90
[6] Adapted from 'Depression: the treatment and management of depression in adults' (NICE clinical guideline 90). Available from: www.nice.org.uk/guidance/CG90
[7] Adapted from 'Depression: the treatment and management of depression in adults' (NICE clinical guideline 90). Available from: www.nice.org.uk/guidance/CG90
[8] For further information see the IAPT Data Handbook Appendix C: IAPT Provisional Diagnosis Screening Prompts (available from www.iapt.nhs.uk/services/measuring-outcomes).

assessment of the presenting problem in line with the service setting in which they work, and be able to:

- determine the nature, duration, and severity of the presenting problem(s)/disorder
- take into account not only symptom severity but also the associated functional impairment
- identify appropriate treatment and referral options in line with relevant NICE guidance.

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

- verbal and non-verbal communication skills relevant to the assessment of common mental health disorders, including the ability to elicit problems, the perception of the problem(s) and their impact, tailoring information, supporting participation in decision making, and discussing treatment options
- the use of formal assessment measures and routine outcome measures in a variety of settings and environments.

1.2.2.6 In addition to assessing symptoms and associated functional impairment, consider how the following factors may have affected the development, course and severity of a person's presenting problem:

- any history of a common mental health disorder and comorbid mental health or physical disorders
- any past experience of, and response to, treatments
- the quality of interpersonal relationships
- living conditions and social isolation
- family history of mental illness.

The impact of the presenting problem on the care of children and young people should also be assessed.[9]

1.2.2.7 When assessing a person with a suspected common mental health disorder, be aware of any learning disabilities or acquired cognitive impairments, and if necessary consider consulting with a relevant specialist when developing treatment plans and strategies.[10]

1.2.2.8 When providing interventions for people with a learning disability or acquired cognitive impairment who have a diagnosis of a common mental health disorder:

- where possible, provide the same interventions as for other people with a common mental health disorder
- if necessary, adjust the method of delivery or duration of the assessment or intervention to take account of the disability or impairment.[11]

1.2.2.9 Always ask people with a common mental health disorder 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 section 1.2.3)
- advise the person to seek further help if the situation deteriorates.[12]

[9] Adapted from 'Depression: the treatment and management of depression in adults' (NICE clinical guideline 90). Available from: www.nice.org.uk/guidance/CG90
[10] Adapted from 'Depression: the treatment and management of depression in adults' (NICE clinical guideline 90). Available from: www.nice.org.uk/guidance/CG90
[11] Adapted from 'Depression: the treatment and management of depression in adults' (NICE clinical guideline 90). Available from: www.nice.org.uk/guidance/CG90
[12] Adapted from 'Depression: the treatment and management of depression in adults' (NICE clinical guideline 90). Available from: www.nice.org.uk/guidance/CG90

1.2.3 Risk assessment and monitoring

1.2.3.1 If a person with a common mental health disorder 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.

1.2.3.2 If a person with a common mental health disorder presents considerable and immediate risk to themselves or others, refer them urgently to the emergency services or specialist mental health services.[13]

1.2.3.3 If a person with depression is assessed to be at risk of suicide:

- take into account toxicity in overdose if a drug is prescribed or the person is taking other medication; if necessary, limit the amount of drug(s) available
- consider increasing the level of support, such as more frequent direct or telephone contacts
- consider referral to specialist mental health services.[14]

1.3 Referral for treatment

1.3.1 Identifying the correct treatment options

1.3.1.1 When discussing treatment options with people with a common mental health disorder, consider:

- their past experience of the disorder
- their experience of and response to previous treatment
- the trajectory of symptoms

[13] Adapted from 'Depression: the treatment and management of depression in adults' (NICE clinical guideline 90). Available from: www.nice.org.uk/guidance/CG90
[14] Adopted from 'Depression: the treatment and management of depression in adults' (NICE clinical guideline 90). Available from: www.nice.org.uk/guidance/CG90

- the diagnosis or problem specification, severity and duration of the problem
- the extent of any associated functional impairment arising from the disorder itself or any chronic physical health problem
- the presence of any comorbid disorders.

1.3.1.2 When discussing treatment options with a person with a common mental health disorder, provide information about:

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

1.3.1.3 When making a referral for the treatment of a common mental health disorder, follow the stepped-care approach, usually offering the least intrusive, most effective intervention first.

1.3.1.4 When a person presents with symptoms of anxiety and depression, assess the nature and extent of the symptoms, and 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, consult the NICE guidelines for the relevant anxiety disorder and consider treating the anxiety disorder first
- both anxiety and depressive symptoms, with no formal diagnosis, that are associated with functional impairment, discuss with the service user the choice of intervention.[15]

[15] Adapted from 'Depression: the treatment and management of depression in adults' (NICE clinical guideline 90). Available from: www.nice.org.uk/guidance/CG90

1.3.1.5 When a person presents with a common mental health disorder and harmful or dependent drinking, refer them for treatment of the alcohol misuse first, as alone this may lead to significant improvements in depressive or anxiety symptoms (see 'Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence' NICE clinical guideline XX[16]).

1.3.1.6 When a person presents with a common mental health disorder and has a mild learning difficulty or mild cognitive impairment, consider referral for the same interventions as for other people with a common mental health disorder.

1.3.1.7 When a person presents with a common mental health disorder and has a moderate to severe learning difficulty or a moderate to severe cognitive impairment, consult a specialist concerning appropriate referral and treatment options.

1.3.1.8 Do not routinely vary referral practice for common mental health disorders based on expected variation in response to treatment arising from factors such as:

- gender or ethnicity
- sub-types of depression (for example, atypical depression).

1.3.1.9 If a person with a common mental health disorder needs social, educational, or vocational support, consider:

- informing them about self-help groups, support groups and other local and national resources
- befriending or a rehabilitation programme for people with long-standing moderate or severe disorders.

[16] NICE is developing the clinical guideline 'Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence' (publication expected February 2011) see http://guidance.nice.org.uk/CG/Wave17/1

1.3.2 Referral advice for mild to moderate common mental health disorders

1.3.2.1 If the presentation and history of a common mental health disorder suggest that it may be mild and self-limiting (that is, symptoms are improving) and the disorder is of recent onset, consider providing psychoeducation and active monitoring before referral for further assessment or treatment. These approaches may improve less severe presentations and avoid the need for further interventions.

1.3.2.2 For people with persistent subthreshold depressive symptoms or mild to moderate depression, consider referral for:

- individual facilitated self-help
- computerised cognitive behavioural therapy (CCBT)
- a structured group physical activity programme
- a group-based peer support (self-help) programme (for those who also have a chronic physical health problem).[17]

1.3.2.3 Consider offering, or refer for an assessment for, antidepressant medication for people with:

- subthreshold depressive symptoms that have been present for a long period (typically at least 2 years) or
- subthreshold depressive symptoms or mild depression that persists after other interventions or
- a past history of moderate or severe depression or
- mild depression that complicates the care of a physical health problem.[18]

[17] Adapted from 'Depression: the treatment and management of depression in adults' (NICE clinical guideline 90) and 'Depression in adults with a chronic physical health problem' (NICE clinical guideline 91). Available from: www.nice.org.uk/guidance/CG90 and www.nice.org.uk/guidance/CG91

[18] Adapted from 'Depression: the treatment and management of depression in adults' (NICE clinical guideline 90) and 'Depression in adults with a chronic physical health problem' (NICE

1.3.2.4 For people with generalised anxiety disorder that has not improved after psychoeducation and active monitoring, consider referral for:

- individual non-facilitated self-help
- individual facilitated self-help
- psychoeducational groups.[19]

1.3.2.5 For people with mild to moderate panic disorder, consider referral for:

- individual non-facilitated self-help
- individual facilitated self-help.

1.3.2.6 For people with mild to moderate OCD, consider referral for cognitive behavioural therapy (CBT) of limited duration (typically <10 hours), which could be provided in the following formats:

- brief individual CBT (including exposure and response prevention [ERP]) using self-help materials
- brief individual CBT (including ERP) by telephone
- group CBT (including ERP) (note, group formats may deliver more than 10 hours of therapy).[20]

1.3.2.7 For people with PTSD, including those with mild to moderate PTSD, consider referral for a formal psychological intervention (trauma-focused CBT or eye movement desensitisation and reprocessing [EMDR]).[21]

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clinical guideline 91). Available from: www.nice.org.uk/guidance/CG90 and www.nice.org.uk/guidance/CG91

[19] Adapted from 'Generalised anxiety disorder and panic disorder (with or without agoraphobia in adults) (partial update)' (NICE clinical guideline XX). NICE is developing this clinical guideline and publication is expected February 2011 see http://guidance.nice.org.uk/CG/WaveR/86

[20] Adapted from 'Obsessive-compulsive disorder and body dismorphic disorder (BDD)' (NICE clinical guideline 31). Available from: www.nice.org.uk/guidance/CG31

[21] Adapted from 'Post-traumatic stress disorder' (NICE clinical guideline 26). Available from: www.nice.org.uk/guidance/CG26

1.3.3 Referral advice for persistent subthreshold depressive symptoms or mild to moderate common mental health disorders with inadequate response to initial interventions, or moderate to severe common mental health disorders

1.3.3.1 If there has been an inadequate response following the delivery of a first-line treatment, consider referral for psychological, pharmacological or combined intervention in line with the relevant NICE guideline for the specific disorder.

1.3.3.2 For people with persistent subthreshold depressive symptoms or mild to moderate depression that has not responded to a low-intensity intervention, consider referral for:

- antidepressant medication or
- a psychological intervention (CBT, interpersonal therapy [IPT], behavioural activation, behavioural couples therapy).[22]

1.3.3.3 For people with an initial presentation of moderate or severe depression, consider referral for a psychological intervention (CBT or IPT) in combination with antidepressant medication.[23]

1.3.3.4 For people with moderate to severe depression and a chronic physical health problem consider referral to collaborative care if there has been no, or only a limited, response to psychological or drug treatment alone or combined in the current or in a past episode.[24]

[22] Adapted from 'Depression: the treatment and management of depression in adults' (NICE clinical guideline 90). Available from: www.nice.org.uk/guidance/CG90
[23] Adapted from 'Depression: the treatment and management of depression in adults' (NICE clinical guideline 90). Available from: www.nice.org.uk/guidance/CG90
[24] Adapted from 'Depression in adults with a chronic physical health problem' (NICE clinical guideline 91). Available from: www.nice.org.uk/guidance/CG91

1.3.3.5 For people with generalised anxiety disorder who have marked functional impairment or have not responded to a low-intensity intervention, consider referral for one of the following:

- CBT or
- applied relaxation or
- if the person prefers, drug treatment.[25]

1.3.3.6 For people with moderate to severe panic disorder, consider referral for CBT.[26]

1.3.3.7 For people with OCD and moderate or severe functional impairment, and in particular where there is significant comorbidity with other common mental health disorders, consider referral for:

- CBT or antidepressant medication for moderate impairment
- CBT combined with antidepressant medication and case management for severe impairment
- home-based treatment where the person is reluctant to attend a clinic or has specific problems (for example, hoarding).[27]

1.3.3.8 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. For people who have not benefitted from two courses of CBT combined with antidepressant

[25] Adapted from 'Generalised anxiety disorder and panic disorder (with or without agoraphobia in adults) (partial update)' (NICE clinical guideline XX). NICE is developing this clinical guideline and publication is expected February 2011 see http://guidance.nice.org.uk/CG/WaveR/86

[26] Adapted from 'Generalised anxiety disorder and panic disorder (with or without agoraphobia in adults) (partial update)' (NICE clinical guideline XX). NICE is developing this clinical guideline and publication is expected February 2011 see http://guidance.nice.org.uk/CG/WaveR/86

[27] Adapted from 'Obsessive-compulsive disorder and body dismorphic disorder (BDD)' (NICE clinical guideline 31). Available from: www.nice.org.uk/guidance/CG31

medication, this should be to a service with specialist expertise in OCD.[28]

1.3.3.9 For people with PTSD, refer for a psychological intervention (trauma-focused CBT or EMDR). Do not delay referral, particularly for people with severe and escalating symptoms in the first month after the traumatic event.[29]

1.3.3.10 For people with PTSD, consider offering or referring for drug treatment only if a person declines an offer of a psychological intervention or expresses a preference for drug treatment.[30]

1.3.4 Referral advice to help prevent relapse

1.3.4.1 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 and refer to the interventions as set out in the relevant NICE guideline. The choice of referral should be informed by previous treatment, including consequences of relapse, response of residual symptoms to previous treatment and any discontinuation symptoms when stopping medication, and the person's preference.

1.3.4.2 For people with a previous history of depression and who are considered at risk of relapse despite taking antidepressant medication, or those who are unable to continue or choose not to continue antidepressant medication, consider referral for:

- individual CBT
- mindfulness-based CBT.[31]

[28] Adapted from 'Obsessive-compulsive disorder and body dismorphic disorder (BDD)' (NICE clinical guideline 31). Available from: www.nice.org.uk/guidance/CG31
[29] Adapted from 'Post-traumatic stress disorder' (NICE clinical guideline 26). Available from: www.nice.org.uk/guidance/CG26
[30] Adapted from 'Post-traumatic stress disorder' (NICE clinical guideline 26). Available from: www.nice.org.uk/guidance/CG26

1.3.4.3 For people who have had previous treatment for depression but continue to have residual depressive symptoms, consider referral for:

- high-intensity individual CBT (for those who have relapsed despite antidepressant treatment or have a significant history of depression and residual symptoms despite treatment)
- mindfulness-based CBT (for those who have had three or more episodes).[32]

1.4 Developing care pathways

Primary and secondary care clinicians, managers and commissioners should work together to develop all elements of the care pathway to promote implementation of key principles of good care, and focus on clinical and cost-effectiveness outcomes. Care pathways should be negotiable, workable and understandable for service users, carers and professionals, and responsive to their needs. Commissioners should also take care to ensure that pathways are accessible and acceptable to all populations served by the pathway, and that movement between elements of the pathway does not present any barriers.

1.4.1.1 Care pathways should be developed to promote implementation of key principles of good care. Care pathways should be:

- negotiable, workable and understandable for service users, carers and professionals
- accessible and acceptable to all people in need of the services served by the pathway
- responsive to service users and carers needs

[31] Adapted from 'Depression: the treatment and management of depression in adults' (NICE clinical guideline 90) and 'Depression in adults with a chronic physical health problem' (NICE clinical guideline 91). Available from: www.nice.org.uk/guidance/CG90 and www.nice.org.uk/guidance/CG91

[32] Adapted from 'Depression: the treatment and management of depression in adults' (NICE clinical guideline 90). Available from: www.nice.org.uk/guidance/CG90

- integrated so that there are no barriers to movement between different levels of the pathway
- outcomes focused (on both clinical and cost-effectiveness).

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

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

1.4.1.3 Primary and secondary care clinicians, managers and commissioners should work together to design care pathways that promote a stepped-care model of service delivery providing:

- the least intrusive, most effective intervention first
- clear and explicit criteria for the thresholds determining access to and movement between the different levels of the pathway
- a self-correcting mechanism to ensure the most effective interventions are delivered. [KPI]

1.4.1.4 Primary and secondary care clinicians, managers and commissioners should work together to design care pathways so that they promote and support the service user in the choice of a range of evidence-based interventions delivered at each step in the pathway.

1.4.1.5 All staff should ensure effective engagement with families and carers, where appropriate, to:

- inform and improve the care of the service user and
- meet identified needs of the families and carers.

1.4.1.6 Primary and secondary care clinicians, managers and commissioners should work together to design care pathways that promote the active engagement of all populations served by the pathway. Pathways should:

- offer prompt assessments and interventions that are appropriately adapted to the cultural, gender, age and communication needs of service users
- keep to a minimum the number of assessments needed to access interventions.

1.4.1.7 Primary and secondary care clinicians, managers and commissioners should work together to design care pathways that respond promptly and effectively to the changing needs of all populations served by the pathways. Pathways should have in place:

- clear and agreed goals for the services offered to a person
- robust and effective means for measuring and evaluating the outcomes associated with the agreed goals
- clear and agreed mechanisms for responding promptly to identified changes to the service user's needs.

1.4.1.8 Primary and secondary care clinicians, managers and commissioners should work together to design 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 service users' engagement with the pathway. [KPI]

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

- sharing and communicating information with service users, and where appropriate families and carers, about their care
- sharing and communicating information about the care of services users with other professionals (including GPs)
- communicating information between the services provided by the pathway
- communicating information to services outside the pathway. [KPI]

1.4.1.10 Primary and secondary care clinicians, managers and commissioners should work together to design care pathways that have robust systems for outcome measurement in place, which should inform all involved in a care pathway about its effectiveness. This should include providing:

- individual routine outcome measurement systems
- effective electronic systems for the routine reporting and aggregation of outcome measures
- effective systems for the audit and review of the overall clinical and cost-effectiveness of the care pathway.

2 Notes on the scope of the guidance

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover. The scope of this guideline is available from http://guidance.nice.org.uk/CG/WaveR/83.

How this guideline was developed

NICE commissioned the National Collaborating Centre for Mental Health to develop this guideline. The Centre established a guideline development group (see appendix A), which reviewed the evidence and developed the recommendations. An independent guideline review panel oversaw the development of the guideline (see appendix B).

There is more information about how NICE clinical guidelines are developed on the NICE website (www.nice.org.uk/HowWeWork). A booklet, 'How NICE clinical guidelines are developed: an overview for stakeholders, the public and the NHS' (fourth edition, published 2009), is available from NICE publications (phone 0845 003 7783 or email publications@nice.org.uk and quote reference N1739).

3 Implementation

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

4 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future.

4.1 Comprehensive assessment versus a brief assessment

For people with a suspected common mental health disorder, what is the clinical and cost-effectiveness of using a comprehensive assessment (conducted by mental health professional) versus a brief assessment (conducted by a paraprofessional)?

Why this is important

Uncertainty remains about the accuracy and consequent identification of appropriate treatment by paraprofessionals in primary care. An assessment by a mental health professional is likely to result in more accurate identification of problems and appropriate treatment, but is likely to entail greater cost and potentially significant longer wait times for interventions, both of which can have deleterious effects on care.

This question should be answered using a randomised controlled design that reports short- and medium-term outcomes (including cost-effectiveness outcomes) of at least 12 months' duration.

4.2 'Walking across' from one assessment instrument to another

What methodology should be used to allow 'walking across' from one assessment instrument for common mental health disorders to another?

Why is this important?

A number of different ratings scales for depression and anxiety disorders are in current use, both in research studies and clinical practice. This makes obtaining comparative estimates of clinical outcomes at the individual level difficult when moving between research and clinical settings, and also between clinical settings. A method that allows for prompt and easy 'walking across' between assessment instruments would have a potentially significant clinical benefit in routine care.

This question should be answered by developing a new method and subsequent data analysis of existing datasets to facilitate comparison between commonly used measures.

4.3 GAD-2 for people with suspected anxiety

In people with suspected anxiety: What is the clinical utility of using the GAD-2 compared with routine GP case identification? Does diagnostic accuracy vary for the different anxiety disorders? Should an avoidance question be added to improve diagnostic accuracy?

Why is this important?

There is good evidence of poor detection and under-recognition in primary care of anxiety disorders. Case identification questions for anxiety disorders are not well developed. There is reasonable evidence that the GAD-2 may have clinical utility as a case identification tool for generalised anxiety disorder, but there is greater uncertainly about its utility for other anxiety disorders, in particular those with an element of phobic avoidance. Understanding whether the GAD-2 plus or minus an additional phobia question would improve diagnostic accuracy would be an important contribution to the identification of anxiety disorders.

These questions should be answered by a well-designed cohort study in which the GAD-2 is compared with a diagnostic gold-standard for a range of anxiety disorders. The cost-effectiveness of this approach should also be assessed.

4.4 Routine outcome measurement

In people with a common mental health disorder, what is the clinical utility of routine outcome measurement and is it cost effective compared with standard care?

Why is this important?

Routine outcomes measurement is increasingly a part of the delivery of psychological interventions, particular in the IAPT programme. There is evidence from this programme and from other studies that routine outcome measurement may bring real benefits. However, there is much less evidence for pharmacological interventions on the cost-effectiveness of routine outcome measurement. If routine outcome measurement were shown to be cost effective across the range of common mental health disorders it could be associated with improved treatment outcomes, because of its impact on healthcare professionals' behaviour and the prompter availability of appropriate treatment interventions in light of feedback from the measurement.

This should be tested in a randomised controlled trial in which different frequencies of routine outcome measurement are compared, for example at beginning and end of treatment at regular intervals and at every appointment.

4.5 Use of a simple algorithm compared with a standard clinical assessment

For people with a common mental health disorder is the use of a simple algorithm (based on factors associated with treatment response) when compared with a standard clinical assessment more clinically and cost effective?

Why is this important?

There are well-established systems for the assessment of mental states, in primary and secondary care services, for common mental disorders. One key function of such assessment is to identify both appropriate treatments and to obtain an indication of likely response to such treatments, thereby informing patient choice and leading to clinically and cost-effective interventions. Although the reliability of diagnostic systems is much improved, data on appropriate treatment response indicators remain poor, with factors such as chronicity and severity emerging as some of the most reliable indicators.

Other factors may also be identified, which, if they could be developed into a simple algorithms, could inform treatment choice decisions at many levels in the healthcare system. Treatment choice can include complex assessment and discussion of options but the validity of such assessments appears to be low. Would the use of a number of simple indicators (for example, chronicity, severity, comorbidity) provide a better indication of likely treatment response? Using existing individual patient data, could a simple algorithm be developed for testing in a prospective study?

This should be tested in a two-stage programme of research: first, a review of existing trial datasets to identify potential predictors and then to develop an algorithm; second, a randomised controlled trial in which the algorithm is tested against expert clinical prediction.

4.6 Priority of treatment for people with anxiety and depression

For people with both anxiety and depression, which disorder should be treated first to improve the outcome for the service user?

Why is this important?

Comorbidity between depression and anxiety disorders is common. At present there is little empirical evidence to guide practitioners or patients in choosing which disorder should be treated first. Given that for many disorders the treatment strategies, particularly for psychological approaches, can be significantly different, guidance for healthcare professionals and patients on the appropriate sequencing of psychological treatment intervention would be likely to significantly improve interventions.

This should be tested in a randomised trial in which patients who have a dual diagnosis of an anxiety disorder and depression, and where there is uncertainty about the appropriate sequencing of treatment, should be randomised to different sequencing of treatment. The clinical and cost

effectiveness of the interventions should be tested at end of treatment and at 12 months' follow-up.

5 Other versions of this guideline

5.1 Full guideline

The full guideline, ['Full guideline title' (in quotes, no italics)] contains details of the methods and evidence used to develop the guideline. It is published by the National Collaborating Centre for Mental Health, and is available from our website (www.nice.org.uk/CGXXfullguideline). **[Note: these details will apply to the published full guideline.]**

5.2 Quick reference guide

A quick reference guide for healthcare professionals is available from www.nice.org.uk/CGXXquickrefguide

For printed copies, phone NICE publications on 0845 003 7783 or email publications@nice.org.uk (quote reference number N1XXX). **[Note: these details will apply when the guideline is published.]**

5.3 'Understanding NICE guidance'

A summary for patients and carers ('Understanding NICE guidance') is available from www.nice.org.uk/CGXXpublicinfo

For printed copies, phone NICE publications on 0845 003 7783 or email publications@nice.org.uk (quote reference number N1XXX). **[Note: these details will apply when the guideline is published.]**

We encourage NHS and voluntary sector organisations to use text from this booklet in their own information about common mental health disorders .

6 Related NICE guidance

Published

- Depression in adults with a chronic physical health problem: treatment and management. NICE clinical guideline 91 (2009). Available from www.nice.org.uk/guidance/CG91
- Depression: the treatment and management of depression in adults. 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: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder. NICE clinical guideline 31 (2005). Available from www.nice.org.uk/guidance/CG31
- Post-traumatic stress disorder (PTSD): the management of PTSD in adults and children in primary and secondary care. NICE clinical guideline 26 (2005). Available from www.nice.org.uk/guidance/CG26

Under development

NICE is developing the following guidance (details available from www.nice.org.uk):

- Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. NICE clinical guideline. Publication expected February 2011.

- Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults. NICE clinical guideline. Publication expected January 2011.

7 Updating the guideline

NICE clinical guidelines are updated so that recommendations take into account important new information. New evidence is checked 3 years after publication, and healthcare professionals and patients are asked for their views; we use this information to decide whether all or part of a guideline needs updating. If important new evidence is published at other times, we may decide to do a more rapid update of some recommendations. Please see our website for information about updating the guideline.

Appendix A: The Guideline Development Group, National Collaborating Centre and NICE project team

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Appendix B: The Guideline Review Panel

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring adherence to NICE guideline development processes. In particular, the panel ensures that stakeholder comments have been adequately considered and responded to. The panel includes members from the following perspectives: primary care, secondary care, lay, public health and industry.

[NICE to add]

[Name; style = Unnumbered bold heading]
[job title and location; style = NICE normal]

Appendix C: The algorithms

Appendix D

GAD-2 to be added when permission has been granted.