

Common mental health problems: identification and pathways to care

Clinical guideline

Published: 25 May 2011

www.nice.org.uk/guidance/cg123

Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

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This guideline is the basis of QS50, QS53 and QS167.

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^[1], may affect up to 15% of the population at any one time. Depression and anxiety disorders can have a lifelong course of relapse and remission. There is considerable variation in the severity of common mental health disorders, but all can be associated with significant long-term disability. 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 and mortality, and is the most common disorder contributing to suicide.

The prevalence of individual common mental health disorders varies considerably. The 1-week prevalence rates from the Office of National Statistics 2007 national survey^[2] 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, 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 common mental health disorder experience comorbid anxiety and depressive disorders.

The vast majority (up to 90%) of depressive and anxiety disorders that are diagnosed are treated in primary care. However, many individuals do not seek treatment, and both anxiety and depression often go undiagnosed. Although under-recognition is generally more common in mild rather than severe cases, mild disorders are still a 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 patients' worries about stigma, and avoidance on the part of individual patients.

The most common method of treatment for common mental health 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.

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 focus 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 focused 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 local care pathways. It brings together advice from existing guidelines and combines it with new recommendations concerning access, assessment and local care pathways for common mental health disorders.

A number of the recommendations in this guideline were adapted from recommendations in other NICE guidelines for common mental health disorders. In doing so the Guideline Development Group 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 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. In all cases the origin of any adapted recommendations is indicated in a footnote.

^[1] NICE is developing the clinical guideline 'Social anxiety disorder: diagnosis and treatment' (publication expected 2013).

^[2] 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.

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, healthcare professionals should follow the [Department of Health's advice on consent](#) and the [code of practice that accompanies the Mental Capacity Act](#). In Wales, healthcare professionals should follow [advice on consent from the Welsh Government](#).

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 local care pathways (see also section 1.5) 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 (see section 1.3.2)^[3]

- 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; 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 1.3.2).
- 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 1.3.2).

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.

^[3] Adapted from 'Depression' ([NICE clinical guideline 90](#)).

1 Guidance

The following guidance is based on the best available evidence. The [full guideline](#) 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 local care pathways for people with common mental health disorders.

The guideline is organised according to the principles of stepped-care (see section 1.2).

1.1 *Improving access to services*

1.1.1.1 Primary and secondary care clinicians, managers and commissioners should collaborate to develop local care pathways (see also section 1.5) 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.

1.1.1.2 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.

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

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

1.1.1.4 Provide all information about services in a range of languages and formats (visual, verbal and aural) and ensure that it is available from a range of settings throughout the whole community to which the service is responsible.

1.1.1.5 Primary and secondary care clinicians, managers and commissioners should collaborate to develop local care pathways (see also section 1.5) that promote access to services for people with common mental health disorders from a range of socially excluded groups including:

- black and minority ethnic groups
- older people
- those in prison or in contact with the criminal justice system
- ex-service personnel.

1.1.1.6 Support access to services and increase the uptake of interventions by:

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

1.1.1.7 Support access to services and increase the uptake of interventions by providing services for people with common mental health disorders in a variety of settings. Use an assessment of local needs as a basis for the structure and distribution of services, which should typically include delivery of:

- 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 centres and social centres) and where appropriate, in conjunction with staff from those settings
- both generalist and specialist assessment and intervention services in primary care settings.

1.1.1.8 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 travel
- advocacy services.

1.1.1.9 Consider modifications to the method and mode of delivery of assessment and treatment interventions and outcome monitoring (based on an assessment of local needs), which may typically include using:

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

1.1.1.10 Be respectful of, and sensitive to, diverse 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^[4].

1.1.1.11 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 *Stepped care*

A stepped-care model (shown below) 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 an integrated overview of the key assessment and treatment interventions from this guideline. Recommendations focused solely on specialist mental health services are not included (these can be found in related guidance). Recommendation 1.5.1.3 sets out the components of a stepped-care model of service delivery, which should be included in the design of local care pathways for people with common mental health disorders.

Figure 1: Stepped-care model: a combined summary for common mental health disorders

Focus of the intervention	Nature of the intervention
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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*, short-term psychodynamic psychotherapy*, antidepressants, combined interventions, collaborative care**, self-help groups.

GAD: CBT, applied relaxation, drug treatment, combined interventions, self-help groups.

Panic disorder: CBT, antidepressants, self-help groups.

OCD: CBT (including ERP), antidepressants, combined interventions and case management, self-help groups.

PTSD: Trauma-focused CBT, EMDR, drug treatment.

All disorders: Support groups, befriending, rehabilitation programmes, educational and employment support services; referral for further assessment and interventions.

<p>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).</p>	<p>Depression: Individual facilitated self-help, computerised CBT, structured physical activity, group-based peer support (self-help) programmes **, non-directive counselling delivered at home†, antidepressants, self-help groups.</p> <p>GAD and panic disorder: Individual non-facilitated and facilitated self-help, psychoeducational groups, self-help groups.</p> <p>OCD: Individual or group CBT (including ERP), self-help groups.</p> <p>PTSD: Trauma-focused CBT or EMDR.</p> <p>All disorders: Support groups, educational and employment support services; referral for further assessment and interventions.</p>
<p>Step 1: All disorders – known and suspected presentations of common mental health disorders.</p>	<p>All disorders: Identification, assessment, psychoeducation, active monitoring; referral for further assessment and interventions.</p>
<p>* Discuss with the person the uncertainty of the effectiveness of counselling and psychodynamic psychotherapy in treating depression.</p> <p>** For people with depression and a chronic physical health problem.</p> <p>† For women during pregnancy or the postnatal period.</p> <p>CBT, cognitive behavioural therapy; ERP, exposure and response prevention; EMDR, eye movement desensitisation and reprocessing; GAD, generalised anxiety disorder; OCD, obsessive compulsive disorder; IPT, interpersonal therapy; PTSD, post-traumatic stress disorder.</p>	

1.3 Step 1: Identification and assessment

1.3.1 Identification

1.3.1.1 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 (see section 1.3.2).

1.3.1.2 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; 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 1.3.2).
- 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 1.3.2).

1.3.1.3 For people with significant language or communication difficulties, for example people with sensory impairments or a learning disability, consider using the Distress Thermometer^[5] 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 distress is identified, offer further assessment or seek the advice of a specialist^[4].

1.3.2 Assessment

- 1.3.2.1 If the identification questions (see section 1.3.1) indicate a possible common mental health disorder, but 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^[4].
- 1.3.2.2 If the identification questions (see section 1.3.1) indicate a possible common mental health disorder, 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^[4].
- 1.3.2.3 When assessing a person with a suspected common mental health disorder, consider using:
- a diagnostic or problem identification tool or algorithm, for example, the Improving Access to Psychological Therapies (IAPT) screening prompts tool^[6]
 - 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.
- 1.3.2.4 All staff carrying out the assessment of suspected common mental health disorders should be competent to perform an 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 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.
- 1.3.2.5 All staff carrying out the assessment of common mental health disorders should be competent in:
- relevant verbal and non-verbal communication skills, 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.

1.3.2.6 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:

- 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
- a family history of mental illness
- a history of domestic violence or sexual abuse
- employment and immigration status.

If appropriate, the impact of the presenting problem on the care of children and young people should also be assessed, and if necessary local safeguarding procedures followed^[4].

1.3.2.7 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^[4].

1.3.2.8 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 offering or referring for further assessment or treatment. These approaches may improve less severe presentations and avoid the need for further interventions.

1.3.2.9 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 1.3.3)
- advise the person to seek further help if the situation deteriorates^[4].

Antenatal and postnatal mental health

1.3.2.10 During pregnancy or the postnatal period, women requiring psychological interventions should be seen for treatment normally within 1 month of initial assessment, and no longer than 3 months afterwards. This is because of the lower threshold for access to psychological interventions during pregnancy and the postnatal period arising from the changing risk–benefit ratio for psychotropic medication at this time^[7].

1.3.2.11 When considering drug treatments for common mental health disorders in women who are pregnant, breastfeeding or planning a pregnancy, consult 'Antenatal and postnatal mental health' ([NICE clinical guideline 45](#)) for advice on prescribing.

1.3.3 Risk assessment and monitoring

1.3.3.1 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.

1.3.3.2 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^[4].

1.3.3.3 If a person with a common mental health disorder, in particular depression, 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 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^[7].

1.4 *Steps 2 and 3: Treatment and referral for treatment*

The recommendations for treatment and referral are also presented in table form organised by disorder in Appendix F.

1.4.1 Identifying the correct treatment options

1.4.1.1 When discussing treatment options with a person 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
- 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 social or personal factors that may have a role in the development or maintenance of the disorder
- the presence of any comorbid disorders.

1.4.1.2 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.

1.4.1.3 When making a referral for the treatment of a common mental health disorder,

take account of patient preference when choosing from a range of evidence-based treatments.

1.4.1.4 When offering treatment for a common mental health disorder or making a referral, follow the stepped-care approach, usually offering or referring for the least intrusive, most effective intervention first (see figure 1).

1.4.1.5 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, in line with the NICE guideline on depression
- 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 person the symptoms to treat first and the choice of intervention^[4].

1.4.1.6 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 as this may lead to significant improvement in depressive or anxiety symptoms^[8].

1.4.1.7 When a person presents with a common mental health disorder and a mild learning disability or mild cognitive impairment:

- where possible provide or refer for the same interventions as for other people with the same common mental health disorder
- if providing interventions, adjust the method of delivery or duration of the assessment or intervention to take account of the disability or impairment^[9].

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

1.4.1.9 Do not routinely vary the treatment strategies and referral practice for common mental health disorders described in this guideline either by personal characteristics (for example, sex or ethnicity) or by depression subtype (for example, atypical depression or seasonal depression) as there is no convincing evidence to support such action^[4].

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

- informing them about self-help groups (but not for people with PTSD), support groups and other local and national resources
- befriending or a rehabilitation programme for people with long-standing moderate or severe disorders
- educational and employment support services^[10].

1.4.2 Step 2: Treatment and referral advice for subthreshold symptoms and mild to moderate common mental health disorders

1.4.2.1 For people with persistent subthreshold depressive symptoms or mild to moderate depression, offer or refer for one or more of the following low-intensity interventions:

- individual facilitated self-help based on the principles of cognitive behavioural therapy (CBT)
- computerised CBT
- a structured group physical activity programme
- a group-based peer support (self-help) programme (for those who also have a chronic physical health problem)
- non-directive counselling delivered at home (listening visits) (for women during pregnancy or the postnatal period)^[11].

1.4.2.2 For pregnant women who have subthreshold symptoms of depression and/or anxiety that significantly interfere with personal and social functioning, consider providing or referring for:

- individual brief psychological treatment (four to six sessions), such as interpersonal therapy (IPT) or CBT for women who have had a previous episode of depression or anxiety
- social support during pregnancy and the postnatal period for women who have not had a previous episode of depression or anxiety; such support may consist of regular informal individual or group-based support^[4].

1.4.2.3 Do not offer antidepressants routinely for people with persistent subthreshold depressive symptoms or mild depression, but consider them for, or refer for an assessment, people with:

- initial presentation of subthreshold depressive symptoms that have been present for a long period (typically at least 2 years) or
- subthreshold depressive symptoms or mild depression that persist(s) after other interventions or
- a past history of moderate or severe depression or
- mild depression that complicates the care of a physical health problem^[12].

1.4.2.4 For people with generalised anxiety disorder that has not improved after psychoeducation and active monitoring, offer or refer for one of the following low-intensity interventions:

- individual non-facilitated self-help
- individual facilitated self-help
- psychoeducational groups^[9].

1.4.2.5 For people with mild to moderate panic disorder, offer or refer for one of the following low-intensity interventions:

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

1.4.2.6 For people with mild to moderate OCD:

- offer or refer for individual CBT including exposure and response prevention (ERP) of

- limited duration (typically up to 10 hours), which could be provided using self-help materials or by telephone or
- refer for group CBT (including ERP) (note, group formats may deliver more than 10 hours of therapy)^[13].

1.4.2.7 For people with PTSD, including those with mild to moderate PTSD, refer for a formal psychological intervention (trauma-focused CBT or eye movement desensitisation and reprocessing [EMDR])^[10].

1.4.3 Step 3: Treatment and 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

If there has been an inadequate response following the delivery of a first-line treatment for persistent subthreshold depressive symptoms or mild to moderate common mental health disorders, a range of psychological, pharmacological or combined interventions may be considered. This section also recommends interventions or provides referral advice for first presentation of moderate to severe common mental health disorders.

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

- antidepressant medication or
- a psychological intervention (CBT, IPT, behavioural activation or behavioural couples therapy)^[4].

1.4.3.2 For people with an initial presentation of moderate or severe depression, offer or refer for a psychological intervention (CBT or IPT) in combination with an antidepressant^[4].

1.4.3.3 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^[4].

1.4.3.4 For people with depression who decline an antidepressant, CBT, IPT,

behavioural activation and behavioural couples therapy, consider providing or referring for:

- counselling for people with persistent subthreshold depressive symptoms or mild to moderate depression
- short-term psychodynamic psychotherapy for people with mild to moderate depression.

Discuss with the person the uncertainty of the effectiveness of counselling and psychodynamic psychotherapy in treating depression^[4].

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

- CBT or
- applied relaxation or
- if the person prefers, drug treatment^[9].

1.4.3.6 For people with moderate to severe panic disorder (with or without agoraphobia), consider referral for:

- CBT or
- an antidepressant if the disorder is long-standing or the person has not benefitted from or has declined psychological interventions^[9].

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

- CBT (including ERP) or antidepressant medication for moderate impairment
- CBT (including ERP) combined with antidepressant medication and case management for severe impairment.

Offer home-based treatment where the person is unable or reluctant to attend a clinic or has specific problems (for example, hoarding)^[13].

- 1.4.3.8 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^[13].
- 1.4.3.9 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^[13].
- 1.4.3.10 For people with 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^[10].
- 1.4.3.11 For people with PTSD, offer or refer for drug treatment only if a person declines an offer of a psychological intervention or expresses a preference for drug treatment^[10].

1.4.4 Treatment and referral advice to help prevent relapse

- 1.4.4.1 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. The choice of treatment or referral for treatment should be informed by the response to previous treatment, including residual symptoms, the consequences of relapse, any discontinuation symptoms when stopping medication, and the person's preference.
- 1.4.4.2 For people with a previous history of depression who are currently well 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, offer or refer for one of the following:
- individual CBT
 - mindfulness-based cognitive therapy (for those who have had three or more episodes)^[12].
- 1.4.4.3 For people who have had previous treatment for depression but continue to have residual depressive symptoms, offer or refer for one of the following:

- individual CBT
- mindfulness-based cognitive therapy (for those who have had three or more episodes)^[4].

1.5 *Developing local care pathways*

1.5.1.1 Local care pathways should be developed to promote implementation of key principles of good care. Pathways should be:

- negotiable, workable and understandable for people with common mental health disorders, their families and carers, and professionals
- accessible and acceptable to all people in need of the services served by the pathway
- responsive to the needs of people with common mental health disorders and their families and carers
- integrated so that there are no barriers to movement between different levels of the pathway
- outcomes focused (including measures of quality, service-user experience and harm).

1.5.1.2 Responsibility for the development, management and evaluation of local 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 pathway
- providing training and support on the operation of the pathway
- auditing and reviewing the performance of the pathway.

1.5.1.3 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.

1.5.1.4 Primary and secondary care clinicians, managers and commissioners should work together to design local care pathways that promote a range of evidence-based interventions at each step in the pathway and support people with common mental health disorders in their choice of interventions.

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

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

1.5.1.6 Primary and secondary care clinicians, managers and commissioners should work together to design local 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 people with common mental health disorders
- keep to a minimum the number of assessments needed to access interventions.

1.5.1.7 Primary and secondary care clinicians, managers and commissioners should work together to design local 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 with a common mental health disorder
- 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 person's needs.

1.5.1.8 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.

1.5.1.9 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.

1.5.1.10 Primary and secondary care clinicians, managers and commissioners should work together to design local care pathways that have robust systems for outcome measurement in place, which should be used to inform all involved in a 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 pathway.

^[4] Adapted from 'Depression' ([NICE clinical guideline 90](#)).

^[5] 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, Batel-Copel L, et al. (1998) Rapid screening for psychologic distress in men with prostate carcinoma: a pilot study. *Cancer* 82: 1904–8.)

^[6] For further information see ['The IAPT Data Handbook' Appendix C: IAPT Provisional Diagnosis Screening Prompts](#).

^[7] Adapted from 'Antenatal and postnatal mental health' ([NICE clinical guideline 45](#)).

^[8] Adapted from 'Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence' ([NICE clinical guideline 115](#)).

^[9] Adapted from 'Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults' ([NICE clinical guideline 113](#)).

^[10] Adapted from 'Post-traumatic stress disorder' ([NICE clinical guideline 26](#)).

^[11] Adapted from 'Depression' ([NICE clinical guideline 90](#)), 'Depression and chronic physical health problems' ([NICE clinical guideline 91](#)) and 'Antenatal and postnatal mental health' ([NICE clinical guideline 45](#)).

^[12] Adapted from 'Depression' ([NICE clinical guideline 90](#)) and 'Depression and chronic physical health problems' ([NICE clinical guideline 91](#)).

^[13] Adapted from 'Obsessive-compulsive disorder' ([NICE clinical guideline 31](#)).

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.

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.

3 Implementation

NICE has developed tools to help organisations implement this guidance.

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 disorders*

In people with suspected anxiety disorders, what is the clinical utility of using the GAD-2 compared with routine case identification to accurately identify different anxiety disorders? Should an avoidance question be added to improve case identification?

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 anxiety disorders, in particular generalised anxiety disorder, but there is greater uncertainty about its utility for other anxiety disorders, especially those with an element of phobic avoidance. Understanding whether the GAD-2 plus or minus an additional phobia question would improve case identification for different anxiety disorders would be an important contribution to their identification.

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 outcome measurement is increasingly a part of the delivery of psychological interventions, particularly 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 the 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 health 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 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 and 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 their outcomes?

Why is this important?

Comorbidity between depression and anxiety disorders is common. At present there is little empirical evidence to guide healthcare professionals or patients in choosing which disorder should be treated first. Given that for many disorders the treatment strategies, particularly for psychological approaches, can be very different, guidance for healthcare professionals and patients

on the appropriate sequencing of psychological interventions would be likely to significantly improve outcomes.

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 the end of treatment and at 12 months' follow-up.

5 Other versions of this guideline

5.1 *Full guideline*

The [full guideline](#) contains details of the methods and evidence used to develop the guideline. It is published by the National Collaborating Centre for Mental Health.

5.2 *Information for the public*

NICE has produced [information for the public](#) explaining this guideline.

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

6 Related NICE guidance

- [Post-traumatic stress disorder \(2018\) NICE guideline NG116](#)
- [Antenatal and postnatal mental health: clinical management and service guidance \(2014\) NICE guideline CG192](#)
- [Social anxiety disorder: recognition, assessment and treatment \(2013\) NICE guideline CG159](#)
- [Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence \(2011\) NICE guideline CG115](#)
- [Generalised anxiety disorder and panic disorder in adults: management \(2011\) NICE guideline CG113](#)
- [Depression in adults with a chronic physical health problem: recognition and management \(2009\) NICE guideline CG91](#)
- [Depression in adults: recognition and management \(2009\) NICE guideline CG90](#)
- [Mental wellbeing at work \(2009\) NICE guideline PH22](#)
- [Drug misuse in over 16s: opioid detoxification \(2007\) NICE guideline CG52](#)
- [Drug misuse in over 16s: psychosocial interventions \(2007\) NICE guideline CG51](#)
- [Obsessive-compulsive disorder and body dysmorphic disorder: treatment \(2005\) NICE guideline CG31](#)

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.

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.

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Mr Robin Beal

Consultant in Accident and Emergency Medicine, Isle of Wight

Mrs Ailsa Donnelly

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Dr Mark Hill

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Clinical Governance and Prescribing Lead and General Practitioner, North Tees Primary Care Trust

Appendix C: The algorithms

The NICE Pathway on [common mental health disorders in primary care](#) contains a stepped-care model for common mental health disorders and an algorithm for the identification and assessment of common mental health disorders.

Appendix D: The GAD-2 and GAD-7

The [full guideline](#) contains the GAD-2 and GAD-7.

Appendix E: Glossary

This provides definitions of a number of terms, based on definitions from related NICE guidelines. The list aims to cover the most commonly used terms and is not intended to be exhaustive.

Active monitoring: an active process of assessment, monitoring symptoms and functioning, advice and support for people with mild common mental health disorders that may spontaneously remit. It involves discussing the presenting problem(s) and any concerns that the person may have about them, providing information about the nature and course of the disorder, arranging a further assessment, normally within 2 weeks, and making contact if the person does not attend follow-up appointments. Also known as 'watchful waiting'.

Applied relaxation: a psychological intervention that focuses on applying muscular relaxation in situations and occasions where the person is or might be anxious. The intervention usually consists of 12 to 15 weekly sessions (fewer if the person recovers sooner, more if clinically required), each lasting 1 hour.

Alcohol dependence: characterised by craving, tolerance, a preoccupation with alcohol and continued drinking in spite of harmful consequences.

Befriending: meeting and talking with someone with a mental health problem usually once a week; this would be provided as an adjunct to any psychological or pharmacological intervention. The befriender may accompany the befriender on trips to broaden their range of activities and offer practical support with ongoing difficulties.

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. The intervention usually consists of 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. The intervention should be based on behavioural principles and usually consists of 15 to 20 sessions over 5 to 6 months.

Cognitive behavioural therapy (CBT): a psychological intervention where the person works

collaboratively with the therapist to identify the effects of thoughts, beliefs and interpretations on current symptoms, feelings states and problems areas. They learn the skills to identify, monitor and then counteract problematic thoughts, beliefs and interpretations related to the target symptoms or problems, and appropriate coping skills. Duration of treatment varies depending on the disorder and its severity but for people with depression it should be in the range of 16 to 20 sessions over 3 to 4 months; for people with GAD it should usually consist of 12 to 15 weekly sessions (fewer if the person recovers sooner, more if clinically required), each lasting 1 hour.

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 consistent with those recommended in this guideline, including patient education, psychological and pharmacological interventions, and medication management; and long-term coordination of care and follow-up.

Computerised cognitive behavioural therapy: a form of cognitive behavioural therapy that is provided via a stand-alone computer-based or web-based programme. It should include an explanation of the CBT model, encourage tasks between sessions, and use thought-challenging and active monitoring of behaviour, thought patterns and outcomes. It should be supported by a trained practitioner who typically provides limited facilitation of the programme and reviews progress and outcome. The intervention typically takes place over 9 to 12 weeks, including follow-up.

Counselling: a short-term supportive approach that aims to help people explore their feelings and problems, and make dynamic changes in their lives and relationships. The intervention usually consists of six to ten sessions over 8 to 12 weeks.

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 should normally be 8 to 12 sessions when the PTSD results from a single event. When the trauma is discussed in the treatment session, longer sessions than usual are generally necessary (for example 90 minutes). Treatment should be regular and continuous (usually at least once a week).

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 behaviours. 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.

Facilitated self-help: in the context of this guideline, facilitated self-help (also known as guided self-help or bibliotherapy) is defined as a self-administered intervention, which makes use of a range of books or other self-help manuals, and electronic materials based on the principles of CBT and of an appropriate reading age. A trained practitioner typically facilitates the use of this material by introducing it, and reviewing progress and outcomes. The intervention consists of up to six to eight sessions (face-to-face and via telephone) normally taking place over 9 to 12 weeks, including follow-up.

Group-based peer support (self-help) programme: in the context of this guideline, a support (self-help) programme delivered to groups of patients with depression and a shared chronic physical health problem. The focus is on sharing experiences and feelings associated with having a chronic physical health problem. The programme is supported by practitioners who facilitate attendance at the meetings, have knowledge of the patients' chronic physical health problem and its relationship to depression, and review the outcomes of the intervention with the individual patients. The intervention consists typically of one session per week over a period of 8 to 12 weeks.

Harmful drinking: a pattern of alcohol consumption causing health problems directly related to alcohol. This could include psychological problems such as depression, alcohol-related accidents or physical illness such as acute pancreatitis.

Interpersonal therapy (IPT): a psychological intervention that focuses on interpersonal issues. The person works with the therapist to identify the effects of problematic areas related to interpersonal conflicts, role transitions, grief and loss, and social skills, and their effects on current symptoms, feelings states and problems. They seek to reduce symptoms by learning to cope with or resolve such problems or conflicts. The intervention usually consists of 16 to 20 sessions over 3 to 4 months.

Low-intensity interventions: brief psychological interventions with reduced contact with a trained practitioner, where the focus is on a shared definition of the presenting problem, and the practitioner facilitates and supports the use of a range of self-help materials. The role adopted by the practitioner is one of coach or facilitator. Examples include: facilitated and non-facilitated self-

help, computerised CBT, physical activity programmes, group-based peer support (self-help) programmes, and psychoeducational groups.

Mindfulness-based cognitive therapy: a group-based skills training programme using techniques drawn 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. The intervention usually consists of eight weekly 2-hour sessions and four follow-up sessions in the 12 months after the end of treatment.

Non-facilitated self-help: in the context of this guideline, non-facilitated self-help (also known as pure self-help or bibliotherapy) is defined as a self-administered intervention, which makes use of written or electronic materials based on the principles of CBT and of an appropriate reading age. The intervention usually involves minimal contact with a practitioner (for example an occasional short telephone call of no more than 5 minutes) and includes instructions for the person to work systematically through the materials over a period of at least 6 weeks.

Paraprofessional: a staff member who is trained to deliver a range of specific healthcare interventions, but does not have NHS professional training, such as a psychological wellbeing practitioner.

Physical activity programme: in the context of this guideline, physical activity programmes are defined as structured and group-based (with support from a competent practitioner) and consist typically of three sessions per week of moderate duration (24 minutes to 1 hour) over 10 to 14 weeks (average 12 weeks).

Psychoeducation: the provision of information and advice about a disorder and its treatment. It usually involves an explanatory model of the symptoms and advice on how to cope with or overcome the difficulties a person may experience. It is usually of brief duration, instigated by a healthcare professional, and supported by the use of written materials.

Psychoeducational groups: a psychosocial group-based intervention based on the principles of CBT that has an interactive design and encourages observational learning. It may include presentations and self-help manuals. It is conducted by trained practitioners, with a ratio of one therapist to about 12 participants and usually consists of six weekly 2-hour sessions.

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.

Short-term psychodynamic psychotherapy: a psychological intervention where the therapist and person explore and gain insight into conflicts and how these are represented in current situations and relationships including the therapeutic relationship. Therapy is non-directive and recipients are not taught specific skills (for example, thought monitoring, re-evaluating, and problem solving.) The intervention usually consists of 16 to 20 sessions over 4 to 6 months.

Severity: see the section on 'assessing severity of common mental health disorders' below.

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 are based on CBT principles with an explicit focus on the traumatic event that led to the disorder. The intervention normally consists of 8 to 12 sessions when the PTSD results from a single event. When the trauma is discussed in the treatment session, longer sessions than usual are generally necessary (for example 90 minutes). Treatment should be regular and continuous (usually at least once a week).

Assessing severity of common mental health disorders: definitions

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).

Persistent subthreshold refers to symptoms and associated functional impairment that do not meet full diagnostic criteria but have a substantial impact on a person's life, and which are present for a significant period of time (usually no less than 6 months and up to several years).

Appendix F: Tables for treatment and referral

The [full guideline](#) contains tables for treatment and referral.

About this guideline

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

The guideline was developed by the National Collaborating Centre for Mental Health. 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.

The methods and processes for developing NICE clinical guidelines are described in the [guidelines manual](#).

We have produced [information for the public](#) explaining this guideline. Tools to help you put the guideline into practice and information about the evidence it is based on are also [available](#).

ISBN: 978-1-4731-3383-9

Accreditation

