National Institute for Health and Clinical Excellence

Commissioning guides

Commissioning stepped care for people with common mental health disorders

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Contents

Please update this field in order to see the table of contents for this document.

1 Executive Summary

To print a PDF or Word version of this commissioning guide, click on the 'Select chapters to save or share' icon above the contents menu.

This guide for commissioners on common mental health disorders is a resource to help commissioners, clinicians and managers commission high-quality and evidence-based services across England.

Reducing the prevalence of common mental health disorders is a major public health concern. In 2007 the annual cost to treat depression and anxiety disorders in England was nearly £3 billion, with an additional economic impact of around £13 billion in lost earnings among people of working age.

The guide highlights the benefits of a partnership approach to commissioning services for people with common mental health disorders (see section 3.1). It also recommends commissioning for outcomes (see section 3.3) – principally increasing the proportion of people with common mental health disorders who are identified, assessed and receive treatment in accordance with NICE guidance, and the proportion that go on to make a clinically significant improvement or recover.

It is estimated that around 17.7% of adults aged 18 and older meet the diagnostic criteria for at least one common mental health disorder. Section 4 will help commissioners determine local service levels for people with common mental health disorders by considering prevalence and a range of demographic factors that may affect local need.

Section 5 of the guide provides support for commissioners to commission services using the stepped care model:

- Chapter 5.1 helps commissioners to specify step 1 services for people presenting with known or suspected common mental health disorders.
- Chapter 5.2 helps commissioners to specify step 2 services for people with subthreshold, mild and moderate common mental health disorders.
- Chapter 5.3 helps commissioners to specify step 3 services for people with moderate to severe common mental health disorders.

- Chapter 5.4 helps commissioners to specify step 4 services for people with severe functional impairment or complex mental health disorders.

Section 5.5 offers examples of service models, including case studies and ideas for using Quality, Innovation, Productivity and Prevention (QIPP) and Commissioning for Quality and Innovation (CQUIN) to drive improvements to common mental health disorder services. There is also an outline service specification (see section 6) to assist commissioners when tendering or contract managing common mental health disorder services.

The guide contains a commissioning and benchmarking tool that can be used to calculate the costs of commissioning or redesigning local common mental health disorder services. The tool identifies a number of primary and secondary care costs that may be avoided by commissioning common mental health disorder services.

2 Commissioning care for people with common mental health disorders

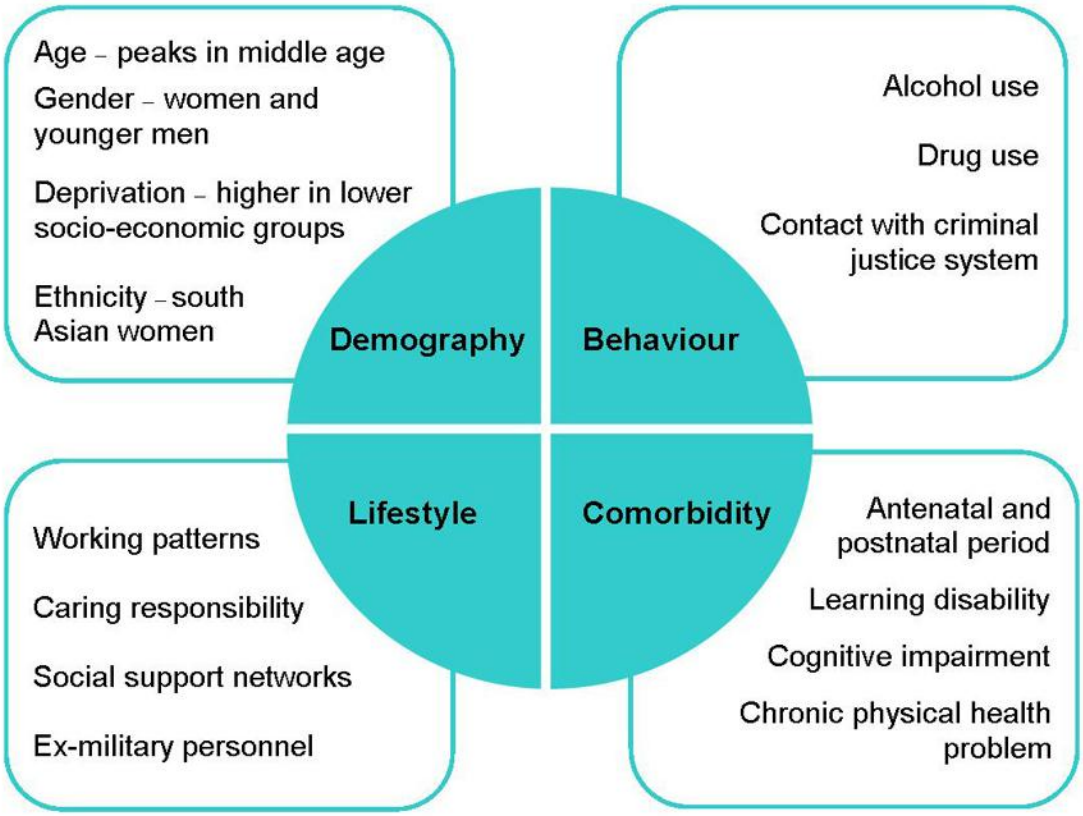
For the purposes of this guide for commissioners, common mental health disorders are defined as a range of depression and anxiety disorders that include:

- depression
- generalised anxiety disorder
- mixed depression and anxiety
- panic disorder
- obsessive-compulsive disorder
- phobias
- social anxiety disorder (social phobia)
- post-traumatic stress disorder.

The Topic Advisory Group recognised that the diagnosis of common mental health disorders can be complex. For some people common mental health disorders are recurrent or lifelong conditions, and often they occur with a range of other physical, mental health and behavioural comorbidities. Figure 1 shows factors that can increase the risk of developing a common mental

health disorder. A localised approach and integration with a range of other physical and mental health pathways is needed when commissioning services for common mental health disorders.

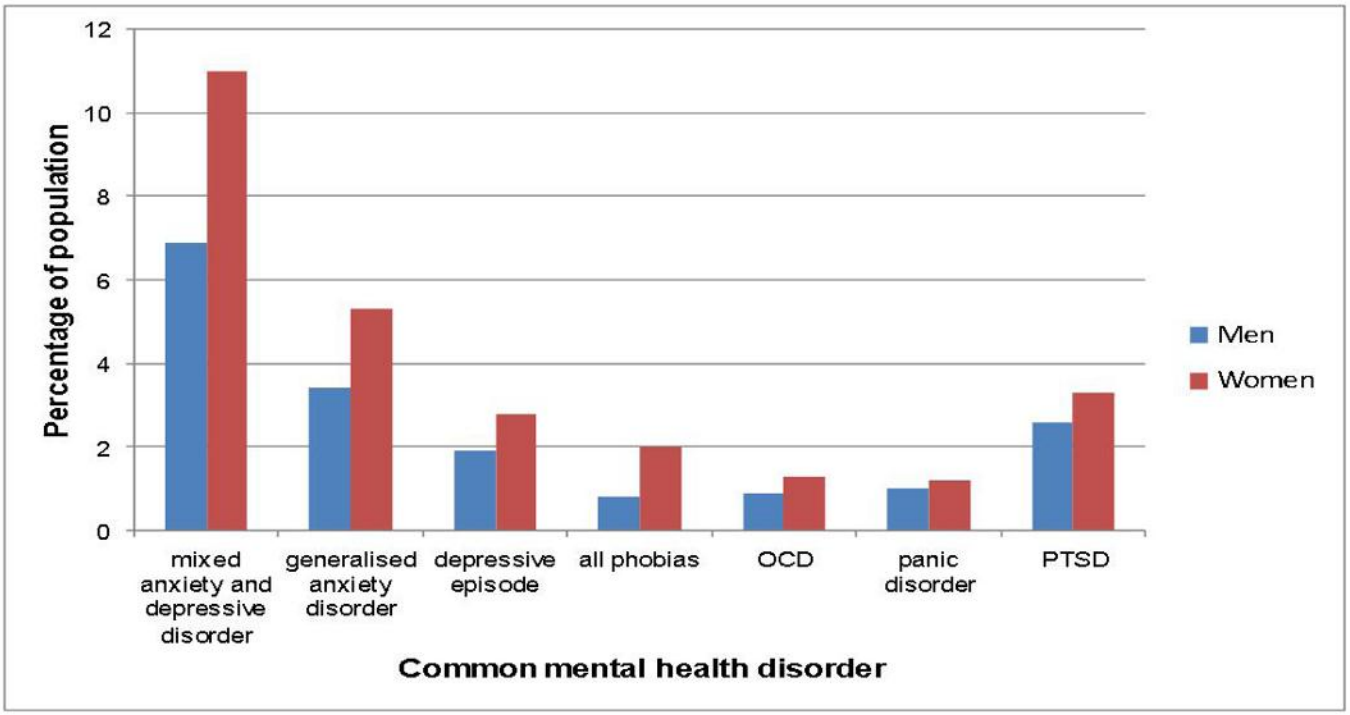
Figure 1 Risk factors for common mental health disorders



Overall it is estimated that 17.7% of adults meet the diagnostic criteria for at least one common mental health disorder (see section 4.1)[1]. Data from the Adult Psychiatric Morbidity Survey 2007 show the prevalence of the various types of disorder (see figure 2).

Figure 2 Prevalence of common mental health disorders

[1] McManus S, Meltzer H, Brugha T et al. (2009) Adult psychiatric morbidity in England, 2007. Results of a household survey. The NHS Information Centre for health and social care: Leeds



Reducing the prevalence of common mental health disorders is a major public health concern. In 2007 the annual health and social care costs to treat depression and anxiety disorders were estimated to be nearly £3 billion, with an additional economic impact of around £13 billion in lost earnings among people of working age[2].

Most people diagnosed with anxiety and depression disorders are treated in primary and community settings. However, many people do not seek treatment and common mental health disorders often go unrecognised. The reasons for this are complex, but include: the perceived stigma of being diagnosed and receiving treatment for a common mental health disorder; lack of recognition of anxiety disorders in primary care (only a small minority of people experiencing anxiety disorder receive treatment); service design that inhibits access; lack of knowledge about services and differing cultural interpretations of mental health[3].

The most common form of treatment for common mental health disorders in primary care is psychotropic medication because availability of psychological interventions is limited[3]. Since its launch in 2008, the Department of Health's Improving Access to Psychological Interventions (IAPT) programme has delivered significant improvements in access to some of the

[2] McCrone P, Dhanasiri S, Knapp M et al. (2008) Paying the price: the cost of mental health care in England to 2026. London: King's Fund
[3] National Collaborating Centre for Mental Health (2011) Common mental health disorders: identification and pathways to care. London: Royal College of Psychiatrists

psychological interventions recommended by NICE. However there is evidence that the demand for these interventions continues to outstrip capacity in many areas.

3 A stepped-care approach to commissioning high-quality integrated care for people with common mental health disorders

NICE recommends that a stepped-care model is used to organise the provision of services and to help people with common mental health disorders, their families, carers and healthcare professionals to choose the most effective interventions. In stepped care the least intensive intervention that is appropriate for a person is typically provided first, and people can step up or down the pathway according to changing needs and in response to treatment.

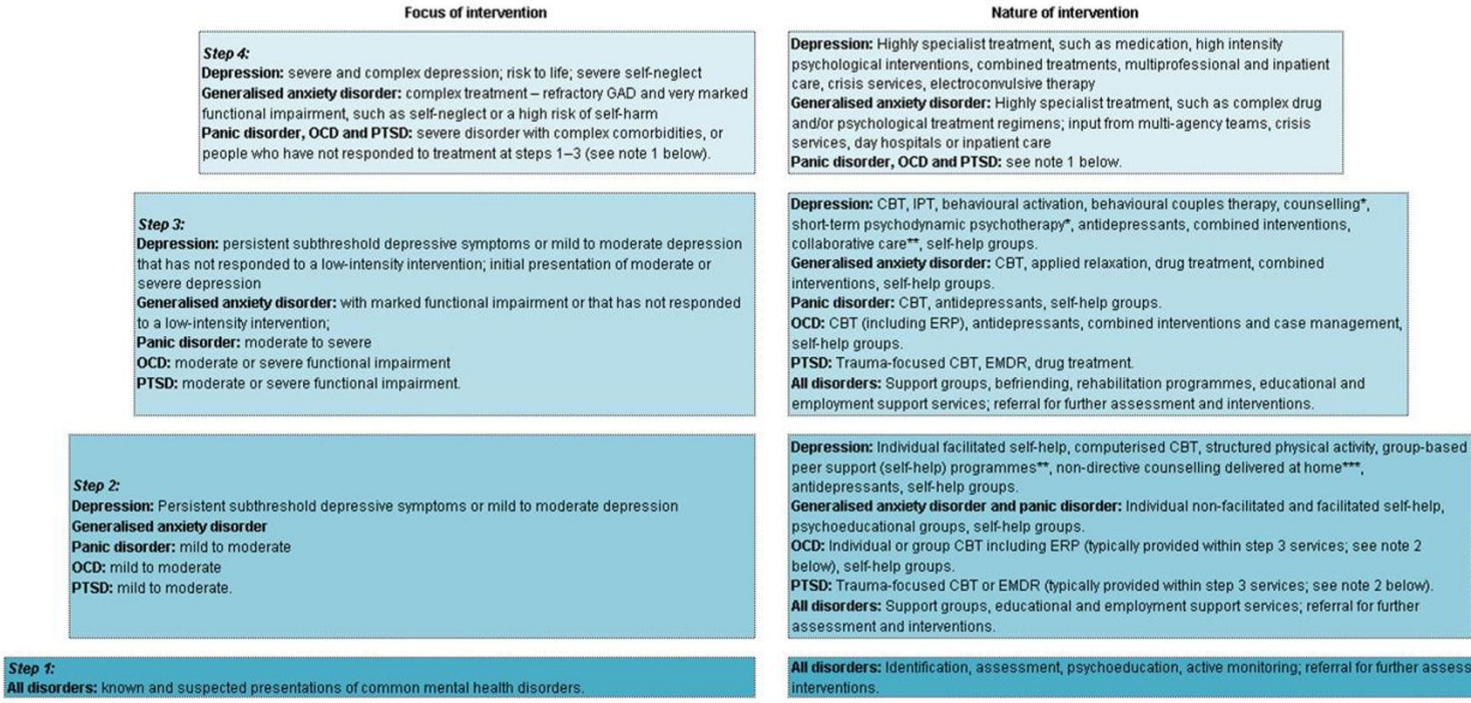
Commissioning services using the stepped-care model is likely to be cost effective because people receive the least intensive intervention for their need. If a less intensive intervention is able to deliver the desired positive service-user outcome, this limits the burden of disease and costs associated with more intensive treatment.

Service users may begin their journey at any step of the pathway, in accordance with their needs. Timely referral to higher or lower steps may be appropriate and cost effective for some people. A study of psychological intervention services shows that services that comply with NICE guidance and provide stepped care have better service-user outcomes and improved recovery rates[4].

Commissioners and their partners should develop integrated care pathways that promote stepped care. Figure 3 shows a stepped-care model for common mental health disorders, covering steps 1 to 4. When commissioning services using the stepped care model, commissioners should ensure that local systems allow for some flexibility in how interventions are provided, with the crucial factors being the patterns of local need and whether a service provider is competent to provide a particular psychological and/or pharmacological intervention.

[4] NHS Confederation (2011) First year study of IAPT initiative reveals key insights [online]. Available from www.nhsconfed.org/Networks/MentalHealth/LatestNews/Pages/Study-of-first-year-IAPT-initiative-reveals-key-insights.aspx [accessed 18 August 2011]

Figure 3 Stepped-care model showing steps 1 to 4 for people with common mental health disorders



Note 1: The NICE clinical guidance on panic disorder (CG113) and OCD (CG31) uses different models of stepped care to the 4 step model used in the NICE clinical guidance on depression (CG90, CG91) and generalised an disorder (CG113). The NICE clinical guideline on PTSD (CG26) does not use the stepped care model. People with panic disorder, OCD or PTSD that has not responded to treatment at steps 1–3, or who have severe disorder complex comorbidities that prevent effective management at steps 1–3, should receive specialist services at step 4, according to individual need and clinical judgement. The principle interventions at step 4 are similar to those for depression and generalised anxiety disorder, with the exception that electroconvulsive therapy is not indicated.

Note 2: The NICE clinical guideline on OCD (CG31) recommends that people with mild to moderate OCD receive individual or group based CBT. The NICE clinical guideline on PTSD (CG26) recommends that people with mil moderate PTSD receive trauma-focussed CBT or EMDR. These interventions may typically be commissioned from, and provided by, trained, high-intensity therapy staff in step 3 services.

* Discuss with the person the uncertainty of the effectiveness of counselling and psychodynamic psychotherapy in treating depression.

** For people with depression and a chronic physical health problem.

*** For women during pregnancy or the postnatal period.

Key: CBT - cognitive behavioural therapy; ERP - exposure and response prevention; EMDR - eye movement desensitisation and reprocessing; OCD - obsessive compulsive disorder; IPT - interpersonal therapy; PTSD - post tr stress disorder.

3.1 Working collaboratively

'Common mental health disorders: identification and pathways to care' (NICE clinical guideline 123) recommends that primary and secondary care clinicians, managers and commissioners collaborate to develop local care pathways that promote access to services for people with common mental health disorders. It states that 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.

Commissioners should develop, or enhance existing, multiagency partnerships to lead on developing and monitoring local care pathways for people with common mental health disorders. Partnerships may include representatives from a range of professional groups and from a variety of statutory, voluntary and private providers. Examples are included in box 1.

Box 1 Possible members of a multiagency common mental health disorder partnership

Primary care representatives including:

- GPs, including clinical commissioning group leads and/or GPs with a special interest in mental health
- Practice nurses
- Practice-based counsellors, mental health or wellbeing workers

Community-based services representatives from:

- Local psychological intervention and counselling services (primary care psychology services/improving access to psychological therapy [IAPT] services, which typically provide services at steps 2 and 3)
- Community mental health team (typically provide more specialist care to people at step 4 and above)
- Social care
- Local employment and education services
- Local drug and alcohol services
- Local debt, welfare or citizens advice or victim support services
- Local relationship counselling services
- Physical activity services
- Occupational therapy
- Criminal justice
- Refugee and asylum seeking services

Secondary care representatives including:

- Psychiatrists, including primary care and/or community psychiatrists
- Mental health nurses
- Practitioner psychologists
- Secondary care physicians and nurse specialists from a range of specialties including musculoskeletal, respiratory, dermatology, diabetes, cardiac, neurology and cancer
- Accident and emergency staff

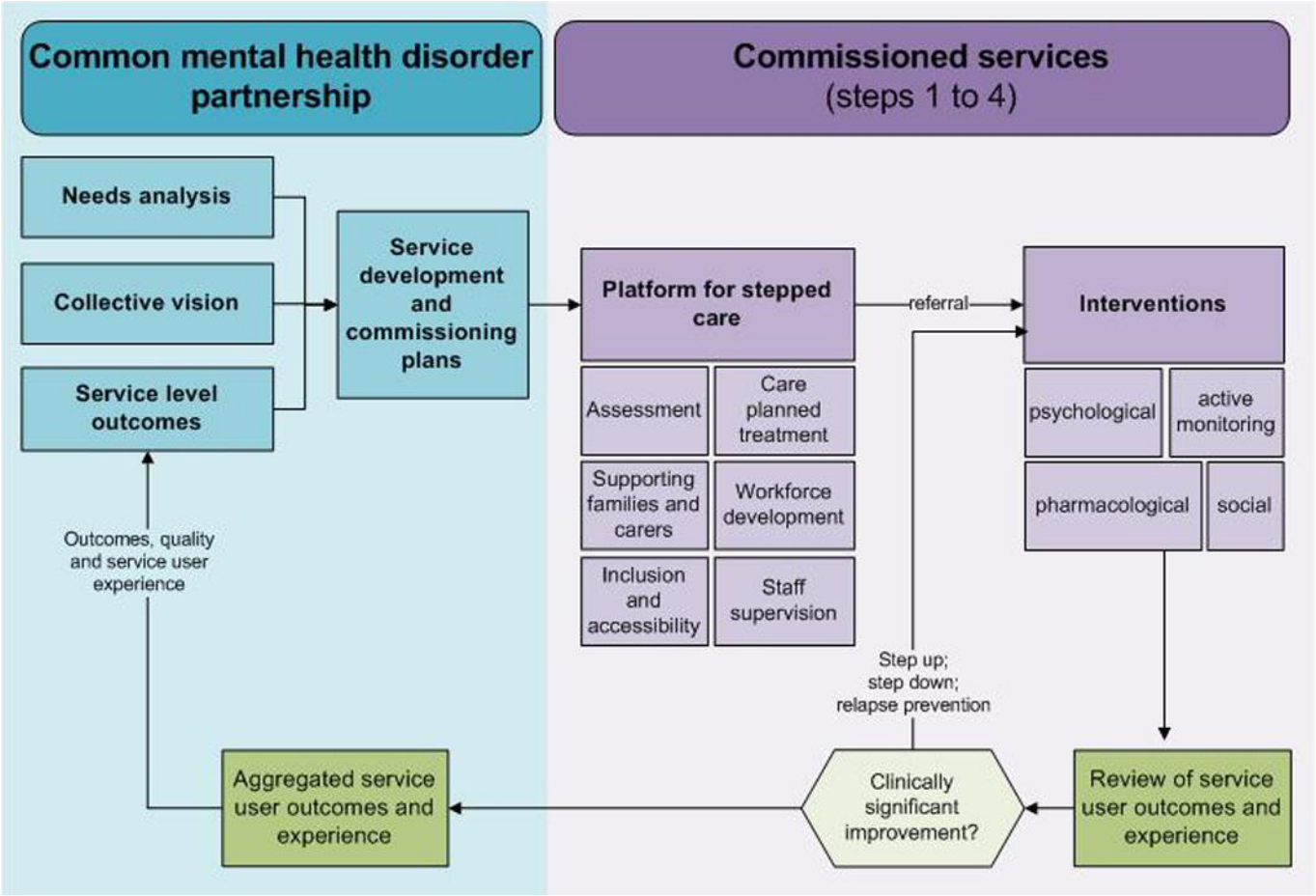
Support services, representatives from:

- Local commissioning organisations
- Data and performance
- Finance

Figure 4 outlines a model for the development of stepped-care services using a partnership approach. Commissioners should encourage their local partnership to:

- Use the partnership as a forum for improving communication between partners, and increasing knowledge of the range of local services for people with common mental health disorders.
- Agree how to promote flexible, integrated and inclusive care pathways based on the stepped-care model (see section 3.2).
- Define local service outcomes (see section 3.3).
- Agree methods to destigmatise common mental health disorder services. This may include using service user feedback to understand barriers to accessing services, exploring language use, public education or local media initiatives, and encouraging services to allow self-referral. A study of psychological intervention services shows that self-referred service-users present with symptoms as severe as those of GP-referred service-users but recover with fewer sessions of treatment, suggesting that services should seek to expand self-referral to improve efficiency, and promote better access for different sectors of the community[4].

Figure 4 A partnership approach to commissioning common mental health disorder services



Commissioners should work with their partnership to develop shared governance procedures for their integrated common mental health disorders service, which support the delivery of the whole pathway of care. Commissioners should ensure that they have the policies and procedures in place for:

- data protection, information sharing and confidentiality
- referral, assessment, treatment and discharge processes
- safeguarding vulnerable children, young people and adults (including adults with common mental health disorders who care for children and young people)
- serious untoward incident reporting
- workforce development, including recruitment, training programmes, induction, appraisal, supervision and continuing professional development
- communications, promotion of services and marketing
- service user, carer and public engagement and involvement.

3.2 Developing local common mental health disorder pathways

NICE clinical guideline 123 makes recommendations for commissioners and their partners who are developing care pathways for people with common mental health disorders, underpinned by the stepped care model. Table 1 has a summary of these recommendations.

Table 1 Designing a local care pathway for common mental health disorders[5]

Promoting the principles of good care	Ensure local care pathways are: • negotiable, workable and understandable for all involved • accessible and acceptable to all people in need of the services • responsive to the needs of people with common mental health disorders and their families and carers • integrated, with no barriers to movement between different levels of the pathway • outcomes focused (including measures of quality, service-user experience and harm).
Promoting access to services	Ensure local care pathways: • support integrated delivery of services across primary and secondary care • include clear and explicit criteria for entry to the service and focus on these rather than 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

[5] Quick reference guide. Common mental health disorders: identification and pathways to care. NICE clinical guideline 123 (2011). Available from www.nice.org.uk/guidance/CG123/QuickRefGuide

	community • promote access to services for people from a range of socially excluded groups including: – black and minority ethnic groups – older people – people in prison or in contact with the criminal justice system – ex-service personnel.
Promoting a stepped-care model of service delivery	Ensure local care pathways: • provide the least intrusive, most effective intervention first • have clear and explicit criteria for the thresholds determining access to and movement between the different levels of the pathway • do not use single criteria (such as symptom severity) to determine movement between steps • monitor progress and outcomes to ensure the most effective interventions are delivered and the person moves to a higher step if needed • promote a range of evidence-based interventions at each step in the pathway • support people in their choice of interventions.
Promoting active engagement of all populations	Ensure local care pathways: • offer prompt assessments and interventions that are appropriately adapted to the cultural, gender, age and communication needs of the person • keep to a minimum the number of assessments needed to access interventions.

Responding promptly and effectively to changing needs	Ensure local care pathways have in place: • clear and agreed goals for the services offered to a person • robust and effective ways to measure and evaluate the outcomes associated with the agreed goals • clear and agreed mechanisms for responding promptly to identified changes to the person's needs.
Providing an integrated programme of care	Ensure local care pathways: • 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.
Having robust systems for outcome measurement	Ensure local care pathways provide: • individual routine outcome measurement systems • effective electronic systems for the routine reporting and aggregation of outcome measures • effective systems to audit and review the overall clinical and cost-effectiveness of the care pathway.

To facilitate service-user choice from a range of local, evidence-based interventions a variety of interventions should be commissioned at each step. Commissioners should specify that their providers offer people information resources that enable them to make an informed choice about the most cost-effective, evidence-based intervention for them. An example is the WHICH talking therapy for depression? produced by the Department of Health. Commissioners should ensure that pathways enable people to receive the least intensive intervention that is appropriate to their needs.

The Topic Advisory Group suggests that in many areas there is disharmony in the defined thresholds for treatment between steps. This means that many people who are referred up to higher steps for treatment, and particularly those with more complex diagnoses or social needs, do not meet the threshold for stepping up and therefore cannot access treatment at the appropriate step. This is thought to be a particular issue between steps 2 and 3 and between steps 3 and 4. The Topic Advisory Group also noted that there is a tendency for more people to be referred upwards through the stepped-care model than for people to be referred back down to lower intensity interventions. Therefore commissioners should:

- Ensure that pathways and service specifications clearly define the characteristics of people who will use each step, including thresholds for the severity of a person's common mental health disorder at each step. Commissioners should ensure that this does not generate gaps in which people in need of interventions may not be eligible for services.
- Define and monitor referral to assessment, and assessment to treatment start times.
- Monitor the numbers of people who are referred to services and the numbers who do and do not take up the offer of interventions. Commissioners and providers should discuss the relative advantages and disadvantages of different referral systems including opt-in, partial booking or set appointment times, and consider supplementing these with reminder systems, including letters, text messages, recorded phone messages and/or personal phone calls, especially before the first appointment for a new intervention.
- Monitor the numbers of people who are referred up or down the local stepped-care pathway, and specify that providers record the reasons for steps up or down.
- Use contract monitoring meetings and multiagency partnership meetings to discuss, understand and agree actions to overcome problems, such as lower than expected uptake

of services, lack of service capacity, rejected or 'bouncing' referrals, lower or higher than expected levels of people stepping up or down.

- Consider specifying that the service has a service user experience lead, agreeing what information about service users' experience should be collected and reported at contract management meetings, and how this information will be used to contribute to service improvement.

The National Audit of Psychological Therapies for Anxiety and Depression: National Report 2011 found that 70% of service-users who had high intensity therapy received less than the minimum number of treatment sessions that NICE recommends[6]. About half of these service-users had not recovered by the time their therapy was discontinued. Commissioners should ensure that they commission sufficient capacity to enable all people referred for treatment to receive the number of sessions of psychological interventions recommended by NICE.

Longer and more intensive interventions are needed for patients with complex needs, which can affect service capacity, therefore commissioners should work with providers to assess the level of need for this group.

When commissioning psychological interventions, commissioners should consider how to optimise funding available as part of the Department of Health's Improving Access to Psychological Therapies (IAPT) programme. Most PCTs have started implementing IAPT, although there is considerable national variation in the maturity and reach of these services. The local implementation and availability of IAPT services is likely to have a considerable impact on the resources needed to meet NICE guidance and achieve the NICE quality standards[7].

From April 2011 funding for existing IAPT services and future expansion has been included within the baselines of participating primary care trusts (PCTs). Therefore commissioners may wish to work with finance leads to maintain existing funding and seek additional investment to expand access to psychological interventions if necessary.

[6] National Audit of Psychological Therapies and Royal College of Psychiatrists (2011) The National Audit of Psychological Therapies for Anxiety and Depression: National Report 2011 London: Royal College of Psychiatrists

[7] See Department of Health (2011) Talking therapies: a four-year plan of action. A supporting document to No health without mental health: a cross-government mental health outcomes strategy for people of all ages [online]. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766

3.3 Measuring the outcomes, quality and performance of the stepped care pathway

NICE clinical guideline 123 recommends that local care pathways should have robust systems for outcome measurement in place, which should be used to inform all involved in a pathway about its effectiveness. Measuring outcomes, progress, recovery and relapse is vital to ensure that people's treatment is reviewed, and where appropriate stopped, in line with the stepped-care model, if there are signs of deterioration or no indications of improvement.

The Topic Advisory Group agreed that commissioning high quality services for people with common mental health disorders could contribute to delivering the following outcomes:

Box 2 Service level outcomes for common mental health disorder services[8]

- Reducing the **stigma and discrimination** associated with a diagnosis of, or treatment for, common mental health disorders
- Increasing the proportion of people with common mental health disorders who are **identified, assessed and receive treatment** in accordance with NICE guidance
- Improving the proportion of people with common mental health disorders who **make a clinically significant improvement or recover**
- Reducing the proportion of people with common mental health disorders who **relapse**
- Identifying risk and **preventing avoidable harm**
- Improving **emotional wellbeing, quality of life and functional ability** in people with common mental health disorders
- Preventing sick leave and helping people stay in **education, employment or meaningful activities**
- Reducing **long-term unemployment, homelessness and family breakdown**
- Improving **service-user choice and experience** of mental health services
- Improving the **interface** between services for people with common mental health disorders

[8] Adapted from: Department of Health (2011) No health without mental health: a cross-government mental health outcomes strategy for people of all ages. London: Department of Health; Department of Health (2010) NHS Outcomes Framework 2011/12. London: Department of Health and Department of Health (2011) Talking therapies: a 4 year plan of action. London: Department of Health

A stepped-care approach to commissioning high-quality services for people with common mental health disorders may also contribute to the following outcomes in the NHS outcomes framework 2011/12:

Domain 2 enhancing quality of life for people with long-term conditions:

- Enhancing quality of life for carers
- Enhancing quality of life for people with mental illness

Domain 4 ensuring that people have a positive experience of care:

- Improving experience of healthcare for people with mental illness

Commissioners should work with their partners to agree local outcome measurement tools and ensure that the tools are appropriate to the intervention and setting. The Topic Advisory Group agreed that the IAPT data standard (see box 3) is a comprehensive outcomes-focused measurement tool that would be suitable for all providers in the pathway to monitor service-user and aggregated outcomes, clinical improvement and performance.

Box 3 The IAPT data standard

The IAPT data standard forms the basis of national data collection for IAPT services and is a clinical management tool that is used to record service-user outcomes measures. The measures include:

- **Service-user details** – demographic details that can be used to demonstrate compliance with the Equality Act 2010
- **Disability details** – comorbid physical or mental health disorders, learning disability, sensory impairment
- **Referral data** – provisional diagnosis to inform the clinical approach, and key dates including waiting times
- **Appointment data** – clinical, work and social functioning outcome scores, including disorder-specific measures, and key dates to measure recovery rates

The clinical, work and social functioning outcome measures are:

- Patient health questionnaire (PHQ-9) for depression
- Generalised anxiety disorder assessment (GAD-7)
- IAPT phobia scales
- A range of anxiety disorder specific measures (ADSMs)
- Work and social adjustment scale (WSAS)
- IAPT employment status questions
- IAPT patient choice and experience questionnaire

Appropriate measures should be taken at every service-user contact.

Further information can be found in the IAPT data handbook: guidance on recording and monitoring outcomes to support local evidence-based practice and the data collection in IAPT training presentation.

Commissioners should:

- Ask primary care and contracted services to demonstrate that service-user outcomes are measured at assessment, and routinely monitored before or during every service-user contact throughout treatment. If outcomes are not routinely monitored, there is a risk that people continue with unnecessary or inappropriate treatment, which may compromise recovery, service-user outcomes and cost effectiveness. There is evidence that routinely discussing therapeutic scores with service-users can help them understand their condition and assist the therapeutic relationship[9].
- Specify when and for how long outcomes should continue to be measured after the completion of treatment, to monitor levels of relapse.
- Specify that relevant staff are competent in using the agreed outcomes measurement tools.
- Specify that information on service users' progress and outcomes, and treatment completion, are fed back to the agency that made the initial referral and other services working with the service users (for example, the GP or the case managers of people with comorbid chronic physical health conditions).

[9] Improving Access to Psychological Therapies (2011) The IAPT data handbook: guidance on recording and monitoring outcomes to support local evidence-based practice. Version 2.0.1. London: Department of Health

In addition to outcomes measurement, commissioners and their partners may wish to define locally-agreed performance measures and waiting times. They should ensure that they have measures for:

- how many people are offered and take up the offer of interventions
- how many people are assessed, start and complete treatment programmes.

Commissioners should specify that outcomes measurements are collected using secure electronic systems, to ease data collection, collation and analysis.

Commissioners will wish to ensure that there is dedicated data analyst time available to monitor aggregated outcomes, ideally provided by an analyst with an interest in mental health.

3.4 Commissioning care-planned treatment

NICE makes a range of recommendations about the coordination and planning of care for people with common mental health disorders. Recommendation 1.1.1.6 of NICE clinical guideline 123 states that care pathways should 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).

NICE also recommends case management for people with obsessive-compulsive disorder and collaborative care for people with comorbid chronic physical health conditions (see also section 3.5.2). At steps 3 and 4 NICE recommends using combined interventions for depression, generalised anxiety disorder and obsessive-compulsive disorder, so good care coordination is needed.

Commissioners should ensure that all people with common mental health disorders receive care-planned treatment[10]. Together with assessment (see section 5.1.2), care-planned treatment acts as a platform for determining the intensity of support and most suitable interventions, in line with the stepped-care model (see figure 3).

[10] In this section, ensuring the coordination and continuity of care is described as 'care planned treatment'.

Commissioners should:

- Specify that everyone receiving psychological, pharmacological or social interventions for common mental health disorders has a care plan that is routinely monitored and includes service-user outcome measures (see also section 3.3).
- Work with partners and providers to agree local approaches to care-planned treatment. Typically care-planned treatment will involve a case manager or care coordinator who oversees the care plan, stepped care and continuity of care. The model may vary depending on the step of care being received, and is more intense for people at higher steps or with more complex needs. This service is often provided by a GP, nurse specialist, psychological wellbeing practitioner or psychological intervention therapist, but may be provided by a range of professionals according to service-user needs.
- Specify that people receiving treatment have a named care-coordinator or case manager who has received training on providing care-planned treatment.
- Specify that people receiving treatment know who their care coordinator is, what their role is, how to contact them and who to contact in case of crisis outside their working hours.

Recommendation 1.4.4.1 of NICE clinical guideline 123 recommends that:

'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 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.'

Commissioners and their partners should satisfy themselves that the care planning process includes relapse prevention and is suitable for people with recurrent or chronic common mental health disorders, and should monitor practice locally.

3.5 Commissioning inclusive and accessible services

Commissioners should use their needs analysis (see section 4) and service-user feedback, to ensure that they understand local barriers to accessing common mental health disorder services, and have plans in place to improve the accessibility of services. They should pay

particular attention to groups who are often excluded from services, people with comorbidities and families and carers of people with common mental health disorders.

3.5.1 Socially excluded groups

Recommendation 1.1.1.5 of NICE clinical guideline 123 states that primary and secondary care clinicians, managers and commissioners should collaborate to develop local care pathways that promote access to services for people with common mental health disorders from a range of socially excluded groups.

People from some socially excluded groups are less likely to visit their GP, receive a diagnosis of a common mental health disorder and receive treatment[11].

Commissioners and their partners should give particular attention to the needs of the following groups:

- black and minority ethnic groups, including people who do not have English as their first language
- older people, including people living in nursing homes or with dementia
- younger people, especially young men
- people in prison or in contact with the criminal justice system
- ex-service personnel
- people from deprived communities, including people who are on low incomes, unemployed or homeless, single-parents and carers.

Depending on local circumstances, commissioners may need to consider:

- Commissioning services that have bilingual therapists who speak the language of local minority groups, or commissioning independent translation services. Commissioners should specify that both written communication (such as appointment letters, information leaflets and bibliotherapy) and verbal communication (such as psychological interventions) are appropriate to these groups.
- Asking services to provide visually-based resources for people who do not speak English as their first language, and for people with learning disabilities.

[11] National Collaborating Centre for Mental Health (2011) Full guideline. Common mental health disorders: identification and pathways to care. Leicester and London: The British Psychological Society and the Royal College of Psychiatrists

- Using technology to improve access for people who may struggle, or be less willing, to attend social or psychological interventions, such as young men, older people, single parents, people with caring responsibilities or people who work long hours. Commissioners should ensure that services use a range of technologies such as telephone-based psychological interventions, text messaging, video-based internet conferencing and computerised interventions.
- Options to improve access, such as crèche facilities, subsidised public transport or taxis, and home-based assessment and interventions (for example for older people and people whose mobility is impaired by a chronic physical health condition).
- Options for assessment and interventions to be provided in a person's home, GP practices or discreet non-traditional community settings such as job centres or children's centres.

Commissioners should also work with commissioners of child and adolescent mental health services (CAMHS) to ensure optimal transition between pathways for children aged 16 to 18 who are moving to adult services.

Commissioners should note, and satisfy themselves that providers comply with, recommendation 1.1.1.11 of NICE clinical guideline 123, which states:

'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.'

Commissioners may wish to refer to the Department of Health's publication 'Commissioning IAPT for the whole community: improving access to psychological therapies', which can help commissioners develop services that are effective and appropriate for the whole community.

3.5.2 People with comorbid chronic physical health conditions

'Depression in adults with a chronic physical health problem' (NICE clinical guideline 91) details recommendations for managing depression in people with a chronic physical health condition[12].

[12] A number of NICE clinical guidelines related to chronic physical health problems also include recommendations for identifying and managing depression and/or anxiety. Examples include, but are not limited to, NICE clinical guidelines 87 (type 2 diabetes), 101 (chronic obstructive pulmonary disease) and 108 (chronic heart failure).

Commissioners should be aware an ageing population and improving medical interventions mean that larger numbers of people are living longer with multiple chronic physical health conditions. Consequently there is likely to be an increasing demand for services that can provide psychological support to people with chronic physical health conditions. There is evidence that addressing these psychological needs can reduce costs relating to their physical health conditions and improve patient experience and quality of life[13].

Recommendation 1.5.1.8 of NICE clinical guideline 123 states that common mental health disorder pathways should establish clear links, including access and entry points, to pathways for people with physical healthcare needs. Commissioners should work closely with the commissioners of clinical specialties in which chronic physical health conditions are common (see box 4), to discuss common commissioning issues and develop commissioning plans for these groups.

Box 4 Clinical specialities in which a large number of people may have chronic physical health conditions

- Cancer services
- Diabetes services
- Heart disease services, for example services for chronic heart failure
- Renal services
- Musculoskeletal services, for example rheumatology, orthopaedics
- Respiratory services, for example services for chronic obstructive pulmonary disease or asthma
- Neurological services, for example services for stroke or autoimmune conditions
- Dermatology, for example services for psoriasis
- Chronic pain services, for example services for lower back pain

Commissioners should specify that services for people with chronic physical health conditions proactively identify common mental health disorders by incorporating measures of psychological wellbeing into assessments of functional impairment, treatment and rehabilitation.

[13] Imison C, Naylor C, Goodwin N et al. (2011) Transforming our health care system: ten priorities for commissioners. London: Kings Fund

Commissioners should agree with healthcare professionals and service managers the most appropriate place for people with common mental health disorders and comorbid chronic physical health conditions to be identified, assessed and managed. Commissioners and their partners may wish to consider the following:

- For people whose depression and anxiety is directly related to their chronic physical health condition, consider commissioning psychological support within the pathway for the physical condition. An example would be anxiety that directly relates to breathing difficulties in people with chronic obstructive pulmonary disease (COPD), or needle phobia in people with diabetes. This may use the skills of nurse specialists or may need dedicated psychological therapy staff with an expertise in chronic physical health conditions.
- For people who have an identified common mental health disorder that is not related to the chronic physical health condition, consider commissioning services within their wider pathway for people with common mental health disorders.

Commissioners and their partners may wish to consider:

- Using the expertise of practitioner psychologists and psychiatrists with an interest in chronic physical health conditions, when developing pathways for this group.
- Specifying that providers of group-based physical activity or rehabilitation programmes for people with chronic physical health conditions include the management of depression and anxiety disorders as part of their programme.
- Working with providers to identify resources and opportunities to develop the skills of nurse specialists to deliver psychological interventions, working with local psychological intervention services as appropriate.
- Working with providers to identify resources and opportunities for psychological wellbeing practitioners and psychological therapists to develop an understanding of chronic physical health conditions and to understand the nature of comorbid depression and anxiety issues. For example, by enabling psychological intervention staff to visit or shadow nurse specialists working in local diabetes or COPD clinics.
- Working with providers to encourage systematic coding and recording of mental health needs in people with chronic physical health conditions.

Quality statement 9 of the NICE quality standard on depression in adults states that:

'People with moderate to severe depression and a chronic physical health problem with associated functional impairment, whose symptoms are not responding to initial interventions, receive collaborative care.'

[Quality statement 9 includes a definition of collaborative care.]

NICE clinical guideline 91 on depression in adults with a chronic physical health problem states that collaborative care should be used at step 3 for people with chronic physical health conditions and comorbid depression, by bringing services and professionals together to provide individualised, needs-led care. Collaborative care should include a dedicated care coordinator.

Commissioners and their partners should work together to agree the local model for collaborative care for people with chronic physical health conditions and comorbid common mental health disorders. In addition to the considerations set out in section 3.4 for care-planned treatment, commissioners should specify:

- the professionals who will provide case management for this group
- the steps in which case management will be provided.

There is an argument that collaborative care should also be engaged at step 2 to build up the confidence of the service-user. This may lead to a smoother care-pathway or earlier discharge.

3.5.3 People with comorbid mental health conditions, substance misuse, learning disabilities or cognitive impairment

Common mental health disorders may present alongside other mental health or behavioural disorders.

Recommendation 1.4.1.6 of NICE clinical guideline 123 states:

'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.'

Harmful drinking is defined as a pattern of alcohol consumption causing health problems directly related to alcohol, including psychological disorders such as depression. Alcohol dependence is associated with increased rates of mental health disorders, including common mental health

disorders[14]. Commissioners may wish to refer to the NICE commissioning guide on alcohol services when commissioning services for people with common mental health disorders who are harmful drinkers or alcohol dependent. Commissioners should ensure that:

- pathways for common mental health disorders are integrated with local alcohol and/or substance misuse pathways so that people can receive treatment in the most appropriate place for their individual needs
- local substance-misuse services have sufficient capacity and can provide timely access to treatment
- treatment for alcohol misuse includes psychological interventions in line with NICE guidance[15].

Commissioners should also note recommendation 1.4.1.7 of NICE clinical guideline 123, which states that 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 or if providing interventions, adjust the method of delivery or duration of the assessment or intervention to take account of the disability or impairment. However, recommendation 1.4.1.8 states that:

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

Therefore commissioners should ensure that their common mental health disorder pathways identify the action that healthcare professionals should take if they suspect or have identified a common mental health disorder in a person with moderate or severe learning disability or cognitive impairment, and that pathways include links to relevant local specialist learning disability services.

Commissioners should work with providers to ensure that there are ring-fenced resources for training psychological wellbeing practitioners and therapists to work with people with comorbid mental health disorders, learning disabilities or cognitive impairment.

[14] Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. NICE clinical guideline 115 (2011)
[15] See 'Alcohol-use disorders' (NICE clinical guideline 115) and the NICE quality standard 'Alcohol dependence and harmful alcohol use'.

3.5.4 Families and carers

All NICE clinical guidelines on common mental health disorders make recommendations for supporting families and carers. Commissioners should:

- Ensure that providers can offer a carer's assessment appropriate to the common mental health disorder and in accordance with NICE guidance. This may include an assessment of their caring, physical, social, occupational and/or mental heath needs, as appropriate.
- Specify that providers give families and carers written and verbal information on relevant common mental health disorders and their management, including information on how families or carers can support the person[16].
- Specify that providers give carers and families information about local family or carer support groups, and help families and carers access these. They may also wish to request that they provide contact details for families or carers at times of crisis.
- Review local provision of carers' support groups, and consider supporting the establishment of new groups and networks where there are identified gaps in the service. Commissioners may wish to encourage local providers to make rooms available in treatment centres or GP surgeries for carers' support group meetings during the day, evenings and/or weekends.
- Specify that providers negotiate between the person with the common mental health disorder and their family or carer about confidentiality and sharing of information. Commissioners and their partners should have policies and agreements in place for consent, confidentiality and the sharing of information between partner services and between service users and their families or carers.

Recommendation 1.1.5.1 of 'Obsessive compulsive disorder' (OCD) (NICE clinical guideline 31) states that:

'Because OCD and body dysmorphic disorder (BDD) often have an impact on families and carers, healthcare professionals should promote a collaborative approach with people with OCD or BDD and their family or carers, wherever this is appropriate and possible.'

Therefore commissioners should specify that a family-based collaborative approach is offered by services working with people with obsessive-compulsive disorder.

[16] For example, MIND and the Royal College of Psychiatrists produce information for carers of people with mental ill health

Recommendation 1.5.4 of 'Post-traumatic stress disorder' (NICE clinical guideline 26) notes that:

'When a family is affected by a traumatic event, more than one family member may suffer from PTSD. If this is the case, healthcare professionals should ensure that the treatment of all family members is effectively coordinated.'

Therefore commissioners should specify that the needs of the whole family are considered and effectively coordinated when managing post-traumatic stress disorder.

4 Assessing service levels for people with common mental health disorders

NICE clinical guideline 123 recommendation 1.1.1.7 states that commissioners and their partners should conduct a local needs assessment to estimate local service need, plan capacity and develop plans to improve the accessibility and inclusivity of services. This assessment should include:

- prevalence and incidence of common mental health disorders (see section 4.1)
- additional factors that influence local service need (see section 4.2)
- existing local practice and determination of optimum capacity (see section 4.3).

Commissioners should ensure that local needs assessment takes into account the views and experience of local service users. Commissioners may wish to refer to the NICE quality standard on service user experience in adult mental health.

Commissioners and their partners should work with the local health and wellbeing board, public health team and local authority, to ensure that their joint strategic needs assessment (JSNA) and/or health and wellbeing plans include information on the local prevalence of common mental health disorders, service capacity and demand. A wide range of data may be used for the needs assessment.

Commissioners should ensure that they engage with the public and service users when developing their needs assessment in order to understand service-user experience of the local

care pathway, and local barriers to accessing treatment. This information should be used to inform commissioning plans and to improve the accessibility of local services.

4.1 Prevalence and incidence of common mental health disorders

Available data suggest that the indicative benchmark rate for common mental health disorders is **17.7%,** or 17,700 per 100,000 of the population aged 18 years and older.

For a standard population of 100,000 around 79%, or 79,000, will be aged 18 or older. Of this population 17.7%, or around 14,000, will have a common mental health disorder.

Service capacity should be locally defined, but it should assume that around 15%, or 2100 per 100,000 population, of those aged 18 or older will need access to treatment at steps 2 or 3 each year.

A small proportion (around 5% of the prevalent population, or 900 per 100,000 population [0.9%] aged 18 or over) will have more complex needs and need interventions at step 4 or above.

For this guide for commissioners and benchmark, common mental health disorders are defined as:

- depression
- generalised anxiety disorder
- mixed depression and anxiety
- panic disorder
- obsessive-compulsive disorder
- phobias (including social anxiety disorder (social phobia))
- post-traumatic stress disorder.

Commissioners can use section 7 of this guide to determine the level of service that might be needed locally and to calculate the cost of commissioning the service using the indicative benchmark and/or local data.

4.1.1 Treated and untreated common mental health disorders

The Adult Psychiatric Morbidity Survey (APMS) provides data on the prevalence of both treated and untreated common mental health disorders in the English adult population aged 16 and older[17]. For the purpose of this benchmark and to be consistent with published NICE guidance, the proportions in the APMS have been applied to the England population aged 18 or older.

The APMS defines common mental health disorders as potentially comorbid mental conditions that cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. They comprise different types of depression and anxiety[18]. The APMS does not include post-traumatic stress disorder in its definition of a common mental health disorder.

The APMS found that 16.2% of adults met the diagnostic criteria for at least one common mental health disorder (excluding post-traumatic stress disorder). Table 2 sets out the conditions and the 1-week prevalence rate. Note that some people may be diagnosed with more than one condition. A person diagnosed with more than one condition will be counted only once in the overall prevalence, so the sum of the individual conditions will be higher than the stated prevalence.

Table 2 APMS 1-week prevalence rates of common mental health disorders18

Condition	1-week prevalence rate
Generalised anxiety disorder	4.4%
Depressive episode (mild moderate and severe)	2.3%
Phobias	1.4%
Obsessive and compulsive disorder	1.1%
Panic disorder	1.1%

[17] McManus S, Meltzer H, Brugha T et al. (2009) Adult psychiatric morbidity in England, 2007. Results of a household survey. Leeds: The NHS Information Centre for health and social care

[18] The APMS defines a common mental health disorder as one or more of the following conditions: generalised anxiety disorder, depressive episode (mild moderate and severe), phobias, obsessive and compulsive disorder (OCD) and panic disorder.

Mixed anxiety and depressive disorder	9%

The APMS also found that 3% of adults met the diagnostic criteria for post-traumatic stress disorder. Around half of these will have a comorbid common mental health disorder[19]. For the purpose of this benchmark, it is assumed that 1.5% of the population will have post-traumatic stress disorder on top of the 16.2% of people with other common mental health disorders. Therefore the 1-week prevalence of common mental health disorders is calculated to be 17.7% of the population aged 18 and older.

The prevalence and incidence of common mental health disorders are likely to vary locally. Commissioners will need to consider local demographics when carrying out their needs analysis; the data in table 2 is an estimate of the numbers likely to be diagnosed with each condition at any point in time. However, not everyone with these conditions will seek or agree to treatment, some may have previously received it, and a few cases will resolve spontaneously.

Mixed anxiety and depression is by far the most common condition in the community. However, this is a subsyndromal condition that often has a short lifespan and a high rate of spontaneous remission.

For the purposes of this benchmark, it is estimated that up to 60% of the prevalent population are not identified or not seeking treatment (see section 4.3).

4.1.2 Diagnosed common mental health disorders

Data extracted from IMS Disease Analyser, a database that holds data from a sample of GP practice systems, shows the recorded incidence of common mental health disorders is 1.23% (service-users aged 18 years and older with a first diagnosis of a common mental health disorder during 2010/11). The number of people with a diagnosed disorder is likely to be an underestimate of the true level of need, because not everyone will be diagnosed or have sought treatment.

Around 25% of people in England, aged 18 years or older, have at some point had a diagnosis of a common mental health disorder. Of those, about 27% were being prescribed

[19] Kessler RC, Sonnega A, Bromet E et al. (1995) Posttraumatic stress disorder in the National Comorbidity Survey. Archives of General Psychiatry 52: 1048–60

antidepressants in 2010/11, around 5 times as many as were receiving psychological interventions (see table 3).

Table 3 Current treatments for diagnoses of common mental health disorders

Treatment in the study year (2010/11)	% of those with a CMHD
CMHD and prescribed antidepressants[a]	26.70%
CMHD and prescribed antipsychotics[a]	1.40%
CMHD and prescribed psychological treatment[b]	5.30%
CMHD and prescribed self help[b]	0.50%
CMHD and prescribed anxiolytics[a]	3.60%
Abbreviations: CMHD, common mental health disorder [a] Problem linked to therapy. [b] treatment cannot be linked to the problem.	

4.2 Additional factors that influence local service need

Commissioners will need to consider local demographics when carrying out their needs analysis. The following equalities and demographic factors can have a significant effect on the local need and uptake of common mental health services:

- age and gender (see section 4.2.1)
- black and minority ethnic groups (see section 4.2.2)
- persons in prison or in contact with the criminal justice system (see section 4.2.3)
- service and ex-service personnel (see section 4.2.4)
- deprivation (see section 4.2.5)
- housing and homelessness (see section 4.2.6)
- refugees and asylum seekers (see section 4.2.7)
- long term conditions (see section 4.2.8)

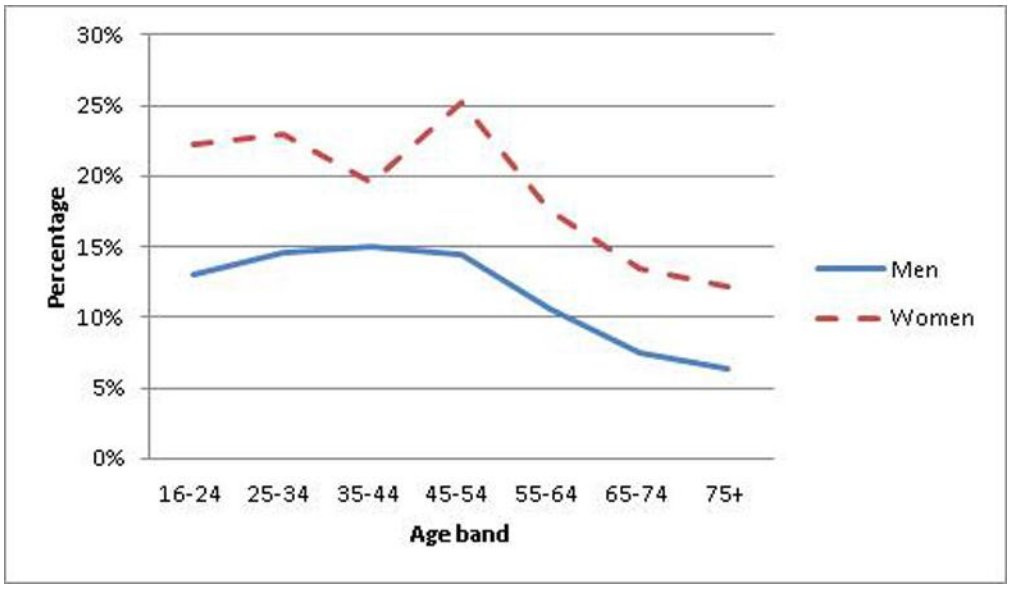
- lesbian, gay, bisexual and transgender people (see section 4.2.9)
- regional and local variation (see section 4.2.10).

Commissioners should use information on these factors to assess local need and to plan for inclusive local services.

4.2.1 Age and gender

The prevalence of common mental health disorders varies widely with age. Prevalence peaks between the ages of 35 and 44 for men and between 45 and 54 for women, then declines sharply. This may have a significant impact on the level of need in communities that have a higher or lower than average proportion of their population in these age groups.

Figure 5 Prevalence of common mental health disorders by age and gender18,[20]



Overall, the prevalence of common mental health disorders is highest among those aged 45–54 and lowest in those aged 75 or older. Studies in other high-income countries also show that, although people aged 55 years and older have more chronic physical health conditions and are more likely to face the loss of partners, friends and family, this age group suffers less anxiety and depression than younger people[21,22]. The lower recorded rates of common mental health

[20] CMHDs as defined in APMS as one or more of the following conditions: generalised anxiety disorder, depressive episode (mild moderate and severe), phobias, obsessive and compulsive disorder and panic disorder plus 50% of post traumatic stress disorder (see section 4.1.1)
[21] Scott KM, Von Korff M, Alonso J (2008) Age patterns in the prevalence of DSM-IV depressive/anxiety disorders with and without physical comorbidity. Psychological Medicine. 38: 1659–69

disorders in older people could result from underdiagnosis or an inappropriate method for measuring disorders in older people. Many surveys of common mental health disorders, including the APMS, measure only people living in private households and therefore do not account for the level of need in residential homes or care settings.

The review 'Improving access to psychological therapies: a review of the progress made by sites in the first roll-out year' showed that 4% of people receiving psychological interventions were 65 or older and overall the gender ratio was just under two women to each man[23].

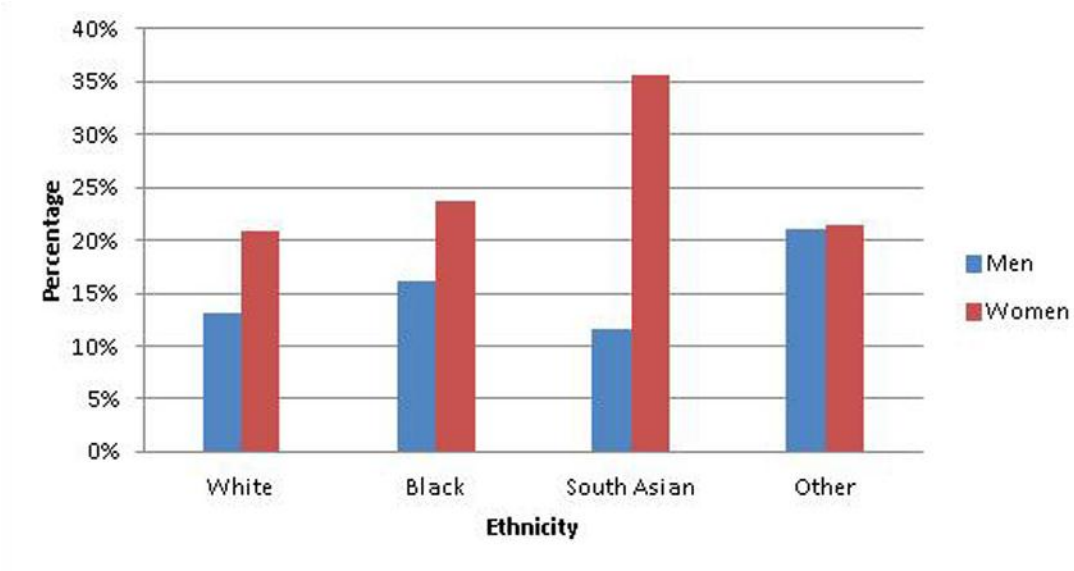
Other studies have found an increased prevalence of common mental health disorders in older people. One study found that depression affects one in five older people living in the community and two in five living in care homes[24].

4.2.2 Black and minority ethnic groups

Figure 6 looks at common mental health disorders for men and women, split by ethnicity[21,25]. In each ethnic group women have a higher prevalence of common mental health disorders than men. In particular, communities with a high proportion of south Asian women may need additional capacity.

Figure 6 Common mental health disorders, age standardised by ethnicity and gender[26]

[22] Streiner DL, Cairney J, Veldhuizen S (2006) The epidemiology of psychological problems in the elderly. Canadian Journal of Psychiatry 52: 185–91
[23] Glover G, Webb M, Evison F (2010) Improving access to psychological therapies. A review of the progress made by sites in the first roll-out year. Stockton- on- Tees: North East Public Health Observatory
[24] Jacoby R and Oppenheimer C (2002) Psychiatry in the elderly Oxford: Oxford University Press
[25] CMHDs is here defined as one or more of the following conditions: generalised anxiety disorder, depressive episode (mild, moderate or severe), phobias, obsessive compulsive disorder and panic disorder, plus a proportion of post-traumatic stress disorder (see section 3.1.1).
[26] McManus S, Meltzer H, Brugha T et al. (2009) Adult psychiatric morbidity in England, 2007. Results of a household survey. The NHS Information Centre for health and social care: Leeds



The review 'Improving access to psychological therapies: a review of the progress made by sites in the first roll-out year' showed that people from Asian and black ethnic groups were under- represented in psychological intervention services, as were men from white minority ethnic groups[24].

4.2.3 Persons in prison or in contact with the criminal justice system

Up to 200,000 people move in and out of prison each year, many staying only a few months[27]. Prisoners have both an extremely high prevalence and complexity of mental disorders, often combined with vulnerability factors such as homelessness or a history of drug or alcohol misuse. They include some of the most socially excluded members of society and can present a considerable challenge to those charged with their care.

Although now more than 10 years old, the survey for the Office for National Statistics on psychiatric morbidity among prisoners[28] was a comprehensive attempt to provide robust baseline information about the prevalence of psychiatric disorders among remand[29] and sentenced[30] prisoners. Table 4 summarises the 1-week prevalence of common mental health disorders split by condition among this group.

[27] HM Prison Service (2011) Mental health primary care in prison [online]. Available from www.prisonmentalhealth.org/about_this_site.html
[28] Singleton N, Meltzer R, Gatward J et al. (1998) Psychiatric morbidity among prisoners in England and Wales. London: Office for National Statistics,
[29] A person remanded in custody will be detained in a prison until a trial or sentencing hearing takes place. The majority of prisoners on remand have not been convicted of a criminal offence and are awaiting trial following a not guilty plea.
[30] 'Sentenced' is used here to mean those sentenced to a term of imprisonment after conviction.

Table 4 Information about the prevalence of psychiatric disorders in prisons29

	Male remand %	Male sentenced %	Female remand %	Female sentenced %
Depressive episode	17	8	11	11
Generalised anxiety disorder	11	8	11	11
Mixed anxiety and depressive disorder	26	19	36	31
Phobia	10	6	18	11
Obsessive-compulsive disorder	10	7	12	7
Panic	6	3	5	4
Any common mental health disorder	59	40	76	63

The prevalence rates of these conditions for male remand prisoners were higher than those for their sentenced counterparts, although the differences for generalised anxiety disorder and obsessive-compulsive disorder were not significant.

Female prisoners in this survey were significantly more likely than men to suffer from a common mental health disorder, as is the case in the general population[27]. While 59% of remand and 40% of sentenced male prisoners in the sample had a common mental health disorder, the corresponding figures for women were 76% and 63%. For both sexes, remand prisoners were significantly more likely to have a common mental health disorder. These figures are much higher than the equivalent figures is the general household survey (see section 4.1.1).

4.2.4 Service and ex-service personnel

The 2009 study 'The prevalence of common mental disorders and post-traumatic stress disorder in the UK military' showed post-traumatic stress disorder prevalence was higher among serving personnel (regular and reserve) and ex-service personnel than in the general population[31] (4.8% for service and ex-service personnel, compared with 3% for the general population). The prevalence of other common mental health disorders was also similar to or higher than that in the general population, as shown in table 5).

Table 5 The prevalence of common mental disorders in the UK military33

Diagnosis	Prevalence (%)
Post-traumatic stress disorder	4.8
Any common mental health disorder	13.5
Any depressive syndrome	11
Any anxiety syndrome	4.5
Panic syndrome	1.1
Other anxiety syndrome	3.8
Somatisation disorder (a chronic condition in which there are numerous physical complaints that can last for years, and result in substantial impairment; the physical symptoms have a psychological cause and no underlying physical problem can be identified)	1.8

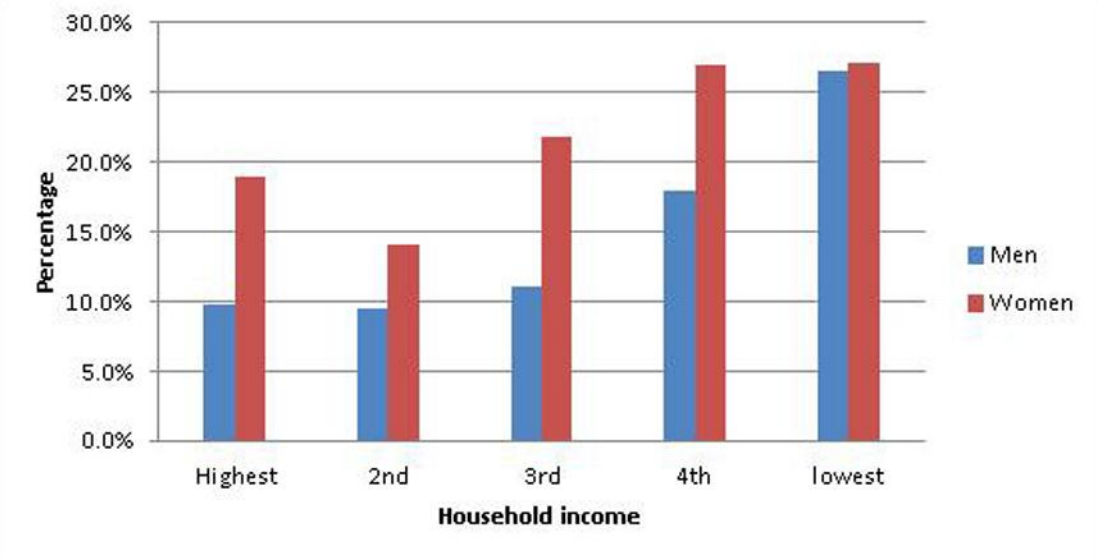
[31] Iversen AC, van Staden L, Hacker Hughes J et al. (2009) The prevalence of common mental disorders and PTSD in the UK military: using data from a clinical interview-based study. BMC Psychiatry 9: 68

4.2.5 Deprivation

Deprivation can include social exclusion, unemployment (or lack of engagement in meaningful activities), under-employment, low income, homelessness and housing problems.

There is a correlation between household income and the prevalence of common mental health disorders in both men and women. Figure 7 shows that, as household income rises, the prevalence of common mental health disorders generally falls for both men and women.

Figure 7 Common mental health disorders by household income and gender21,32



Around half of people with common mental health disorders recover within 18 months. Disorders are more likely to persist in people in lower socioeconomic groups such as people who are on low incomes, long-term sick or unemployed[29]. The Marmot report 'Fair society, healthy lives: a strategic review of health inequalities in England post-2010' showed that, among other factors, poor housing and unemployment increase the likelihood that people will experience mental health disorders and affect the course of any subsequent recovery. These factors vary across different sections of society, with the result that some groups suffer multiple disadvantages.

The review 'Improving access to psychological therapies: a review of the progress made by sites in the first roll-out year' showed that 78% of service-users at initial assessment were economically active and 54% were in full or part-time employment. Thirty per cent reported receiving some type of benefit[24]. Commissioners should ensure that their common mental

health disorder services are accessible to both people who are economically active and people who are not in employment or who are retired.

4.2.6 Housing

It is commonly accepted that mental health disorders are much more common among homeless and vulnerably housed people than in the general population[32]. In many instances mental health disorders play a significant part in the circumstances that cause people to lose their accommodation. The mental health disorder may then be exacerbated by the stresses associated with being homeless, which in turn will make it even harder for the person to achieve stability in their housing.

Studies suggest that although the largest group of homeless people are white men, the proportion of homeless people with a mental health disorder who come from black and minority ethnic groups is disproportionate in relation to their proportion in the general population[33].

4.2.7 Refugees and asylum seekers

Refugees and asylum seekers are known to have high rates of mental health disorder, particularly depression and post-traumatic stress disorder[34]. Refugees and asylum seekers are also at risk of homelessness because of constraints on their ability to work or claim benefits[35].

4.2.8 Long-term conditions

There are clear links between physical and mental health and there are shared risk factors for physical and mental illnesses. People with physical illnesses frequently present with both psychological and physical symptoms; and being physically ill, particularly chronic illness and disability, often negatively affects mental health.

People with two or more long-term conditions, such as cardiovascular disease or diabetes, are seven times more likely to have comorbid depression than those without long-term conditions[36].

[32] Rees S (2009) Mental ill health in the adult single homeless population: a review of the literature. London: Crisis
[33] Austin EL, Andersen R and Gelberg L (2008) Ethnic differences in the correlates of mental distress among homeless women. Women's Health Issues 18: 26–34
[34] Ryan DA, Benson CA and Dooley BA (2008) Psychological distress and the asylum process: a longitudinal study of forced migrants in Ireland. Journal of Nervous and Mental Disease 196: 37–45
[35] Palmer D (2006) Imperfect prescription: Mental health perceptions, experiences and challenges faced by the Somali community in the London Borough of Camden and service responses to them. Primary Care Mental Health 4: 45–56
[36] Moussavi S, Chatterji S, Verdes E et al. (2007) Depression, chronic disease and decrements in health: results from the World Health Surveys. Lancet 370: 851–8

Depression has been associated with a four-fold increase in the risk of heart disease, even when other factors are controlled for[37].

There is also evidence that people with mental health problems smoke much more than the rest of the population, consuming 42% of all cigarettes smoked in England[38]. This increases their risk of developing chronic physical health problems, such as chronic obstructive pulmonary disease (COPD), which in turn increases their risk of developing depression or anxiety. Studies show that a significant proportion of people with COPD have depression or anxiety[39].

4.2.9 Lesbian, gay, bisexual and transgender people

Information about the mental health of lesbian, gay, bisexual and transgender people is not collected at national level.

However, the available evidence suggests that lesbian, gay, bisexual and transgender people are at higher risk than heterosexual people of suicidal feelings, self-harm, drug or alcohol misuse and mental health disorders such as depression and anxiety. The reasons for these findings are complex and not yet fully understood. However, poor mental health in lesbian, gay, bisexual and transgender people has often been linked to experiences of homophobic discrimination and bullying.

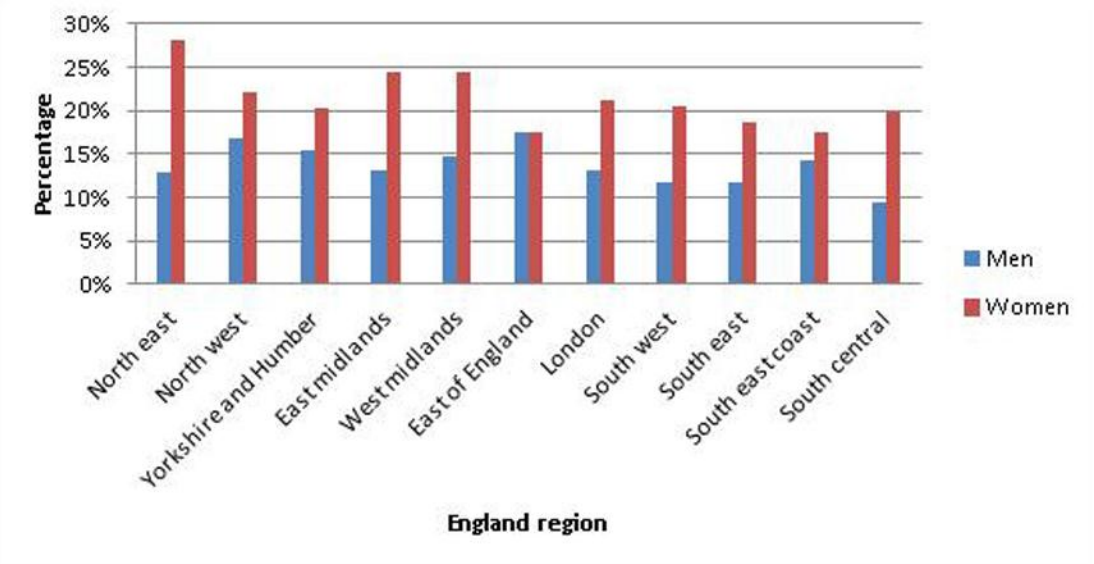
A recent study conducted by researchers in London and Leicester found that mental health disorders are more common in gay, lesbian and bisexual people than heterosexual people[40].The study found that 4.1% of gay, lesbian and bisexual people had a depressive episode during the previous week compared with 2.1% of heterosexual people. Commissioners in areas with higher than average proportions of lesbian, gay, bisexual and transgender people may need to consider additional capacity and tailor services to meet the needs of this group.

[37] Osborn DPJ, Levy G, Nazareth I et al. (2007) Relative risk of cardiovascular and cancer mortality in people with severe mental illness from the United Kingdom's general practice research database. Archives of General Psychiatry 64: 242–9. Available from http://archpsyc.ama-assn.org/cgi/content/abstract/64/2/242
[38] McManus S, Meltzer H, Campion J Cigarette smoking and mental health in England. Data from the Adult Psychiatric Morbidity Survey. National Centre for Social Research, 2010
[39] Department of Health (2011) An outcomes strategy for chronic obstructive pulmonary disease (COPD) and asthma in England. London: Department of Health
[40] Chakraborty A, McManus S, Brugha TS et al. (2011) Mental health of the non-heterosexual population of England. British Journal of Psychiatry 198: 143–8. Available from http://bjp.rcpsych.org/content/198/2/143.abstract

4.2.10 Regional and local variation

All of the factors explored in section 4.2 vary geographically, meaning that some communities will have a significantly higher or lower than average prevalence of common mental health disorders. This will affect the service capacity needed. Figure 8 shows the variation across England for common mental health disorders[41]. The highest prevalence for men is in the East of England strategic health authority and for women the highest prevalence is in the North East strategic health authority.

Figure 8 Prevalence of common mental health disorders, by strategic health authority and gender (age standardised)27



4.3 Assessing existing local practice and determining optimum service capacity

Optimum service levels for people with common mental health disorders should be determined locally, and informed by a local needs assessment (see section 4.1) and local demography (see section 4.2).

The Department of Health's 'Talking therapies: a four year plan of action'[42] considers that full roll-out of the Improving Access to Psychosocial Therapies (IAPT) programme will have been achieved when an estimated 15% of people with common mental health disorders can access

[41] Common mental health disorders here uses the same definition as in APMS (see section 3.1.1).
[42] Department of Health (2011) Impact assessment. Talking therapies: a four year plan of action. London: Department of Health

psychological interventions locally[43]. In England this would equate to around 1 million people receiving treatment each year (15% of the 7.2 million people aged 18 years or older with a common mental health disorder, see section 4.1).

For the purposes of this benchmark, it is assumed that low-intensity interventions are provided at step 2 in the stepped-care model, and high-intensity interventions are provided at step 3. The proportion of people receiving treatment at steps 2 and 3 varies locally depending on need and the availability of commissioned psychological intervention services.

'Talking therapies: a four year plan of action' estimates that two-thirds of people with common mental health disorders have mild mental health disorders and so need low-intensity treatment at step 2. One-third have moderate or severe mental health disorders and so need higher intensity treatment at step 3. However, a review of the progress made by sites in the first year of IAPT roll out in England showed that services differed greatly in the proportion of sessions delivered by low-intensity workers (Agenda for Change grades 1 to 5) and high-intensity therapists (Agenda for Change grades 6 and above). The median pattern was 45% low intensity (step 2) to 55% high intensity(step 3). This data suggests that there may be a lack of capacity in low intensity services, or that robust outcomes measurement data is not routinely collected by these services.

Table 6 and figure 9 show an estimate of the proportion of people who may enter each step of care. The model is based on the expert opinion of the Topic Advisory Group and other reviewed data[24,44,45]. Commissioners should use these estimates in table 6 and figure 9 to facilitate local discussion on optimum service levels.

It should be noted that a significant number of people may step up or step down and receive more than one type of treatment. This is examined in 'Enhancing recovery rates in IAPT services: lessons from analysis of the year one data'[24].

Table 6 Estimated proportion of the prevalent population who will enter each step

Step of care	Percentage of prevalent population

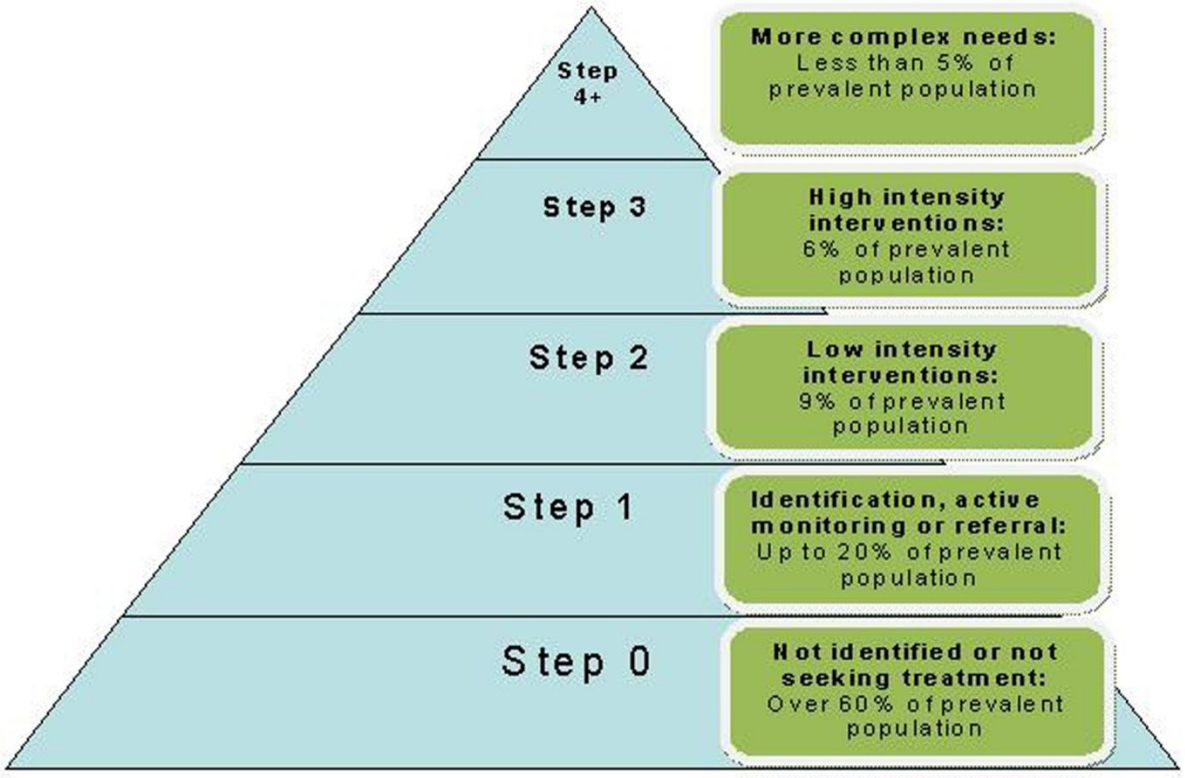
[43] Department of Health (2010) Realising the benefits. IAPT at full roll out. London: Department of Health
[44] Department of Health (2011) Impact assessment. Talking therapies: a four year plan of action. London: Department of Health
[45] Data (unpublished) from the East of England region shows that 60% of people who completed treatment in 2010/11 had low-intensity treatments and 40% had high-intensity treatments (this includes people who stepped up or down within the pathway).

Step 0 (Not identified or not seeking treatment)	More than 60%
Step 1 (Identification, advice or referral, watchful waiting)	Up to 20%[a]
Step 2 (Low-intensity psychological interventions)	9%[b]
Step 3 (High-intensity psychological interventions)	6%[b]
Step 4 and above (More complex needs)	Less than 5%[a]

[a] Estimate based on the expert opinion of the Topic Advisory Group.

[b] It is assumed that 15% the prevalent population will be able to receive psychological treatment at steps 2 and 3 each year, in accordance with Department of Health (2011) 'Realising the benefits. IAPT at full roll-out', and that of these 60% will receive treatment at step 2 and 40% at step 3.

Figure 9 Estimated proportion of the prevalent population with common mental health disorders who will enter each step of care



4.4 Conclusion

Based on the epidemiological data and other information outlined above, table 7 summarises the 1-week prevalence rates for a range of common mental health disorders.

Table 7 1-week prevalence rates for common mental health disorders27

Condition	1-week prevalence rates
Generalised anxiety disorder	4.4%
Depressive episode (mild, moderate and severe)	2.3%
Phobias	1.4%
Obsessive compulsive disorder	1.1%

Panic disorder	1.1%
Mixed anxiety and depressive disorder	9%
Post-traumatic stress disorder	3%

The population benchmark for the number of people with a common mental health disorder is 17.7%, or 1770 per 100,000 population aged 18 or older. It is assumed that 50% of people with post-traumatic stress disorder will also have another common mental health disorder.

Table 8 summarises the likely proportion of people at each step of the pathway.

Table 8 Estimated proportion of the prevalent population who will enter each step

Step of care	**Percentage of prevalent population**
Step 0 (Not identified or not seeking treatment)	More than 60%
Step 1 (Identification, advice or referral, watchful waiting)	Up to 20%[a]
Step 2 (Low-intensity psychological interventions)	9%[b]
Step 3 (High-intensity psychological interventions)	6%[b]
Step 4 and above (More complex needs)	Less than 5%[a]

[a] Estimate based on the expert opinion of the Topic Advisory Group.

[b] It is assumed that 15% the prevalent population will be able to receive psychological treatment at steps 2 and 3 each year, in accordance with Department of Health (2011) 'Realising the benefits. IAPT at full roll-out', and that of these 60% will receive treatment at step 2 and 40% at step 3.

Commissioners should use their local needs assessment to determine optimum levels for local service provision. Commissioners should note that the benchmark rates do not represent NICE's view of desirable, or maximum or minimum, service levels.

Commissioners should use this benchmark and local data to facilitate local discussion on optimum service levels. There is considerable variation in the prevalence and identification of common mental health disorders. This is influenced by the social, economic and demographic profile of the local population. Therefore commissioners are encouraged to consider local assumptions.

Use the common mental health disorders commissioning and benchmarking tool to determine the level of service that might be needed locally and to calculate the cost of commissioning the service using the indicative benchmark and/or your own local data.

5 Service components for stepped care

The key service components when commissioning stepped care for people with common mental health disorders are:

- Section 5.1: specifying step 1 services for people presenting with known and suspected common mental health disorders
- Section 5.2: specifying step 2 services for people with subthreshold, mild and moderate common mental health disorders
- Section 5.3: specifying step 3 services for people with moderate to severe common mental health disorders
- Section 5.4: specifying step 4 services for people with severe functional impairment or complex common mental health disorders
- Section 5.5: service models.

5.1 Specifying step 1 services for people presenting with known and suspected common mental health disorders

Commissioning services for people with common mental health disorders at step 1, underpinned by NICE guidance and the NICE quality standards, is likely to contribute to achieving the following service outcomes:

- Reducing the stigma and discrimination associated with a diagnosis of, or treatment for, common mental health disorders.
- Increasing the proportion of people who are identified, assessed and receive treatment in accordance with NICE guidance.
- Identifying risk and preventing avoidable harm.
- Improving service-user choice and experience of mental health services.
- Improving the interface between services for people with common mental health disorders.

Table 9 summarises step 1 of the stepped-care model for common mental health disorders.

Table 9 Step 1 services

Focus of the intervention	Nature of the intervention
Presentation with known or suspected common mental health disorders	Identification Assessment Psychoeducation Active monitoring Referral for further assessment and interventions.

The key service components when commissioning effective services at step 1 are:

- Improving identification and awareness of common mental health disorders and pathways to care (see section 5.1.1)
- Assessment and referral (see section 5.1.2)

5.1.1 Improving identification and awareness of common mental health disorders and pathways to care

Raising awareness and improving identification of common mental health disorders is crucial to ensure that people are identified as early as possible, and are assessed and offered the most appropriate interventions in accordance with the stepped-care model.

It is estimated that around one in five people presenting at their GP practice has a common mental health disorder. It is the consensus of the Topic Advisory Group that although awareness of common mental health disorders has improved in the past decade, there remains variation in the confidence of primary care professionals to appropriately assess and manage these disorders. The identification of anxiety disorders in primary care is particularly poor. Therefore only a small minority of people experiencing anxiety disorders ever receives treatment[46].

Many other services also regularly come into contact with people with common mental health disorders (see box 1 in section 3.1). The ability of healthcare, social care, education and welfare professionals to identify suspected common mental health disorders, and to provide or refer people to an appropriate service for assessment and interventions, is variable.

Commissioners should work with their common mental health disorder partnerships to ring fence resources to deliver formal ongoing programmes of training to raise awareness of common mental health disorders. Training programmes may differ in length and content depending on the target audience; box 5 summarises some key components.

Box 5 Common mental health disorders awareness-raising training

As a minimum, raising awareness is likely to include:

- destigmatisation of mental ill health
- typical symptoms and presentations of depression, anxiety, panic disorder, obsessive-compulsive disorder, social anxiety disorder and post-traumatic stress disorder
- local population groups who may be at increased risk of common mental health disorders

[46] Common mental health disorders: identification and pathways to care. NICE clinical guideline 123 (2011). Available from www.nice.org.uk/guidance/CG123

- common comorbidities, including drug and alcohol misuse and chronic physical health conditions, and the local care pathway for people with these comorbidities
- questions that can be used to identify possible common mental health disorders, in accordance with NICE guidance
- NICE guidance and quality standards on common mental health disorders, including psychological, pharmacological and social interventions; the NICE slide sets and NICE pathways can be used to support this
- the local stepped-care pathway, including how to make referrals to an appropriate service (including primary care) that can provide an assessment and/or management of the condition

Depending on the target audience for the training, it may also be appropriate to raise awareness of:

- other prevalent mental health disorders (such as bipolar disorder, personality disorder and eating disorders) and pathways to care for these
- assessing common mental health disorders using validated tools recommended by NICE (see sections 3.3 and 5.1.2)
- measuring outcomes using locally agreed tools (see section 3.3)
- the evidence base behind NICE guidance on stepped care and the interventions that are, and are not, recommended by NICE

When developing awareness-raising training for GPs, it may also be appropriate to raise awareness of:

- when it is appropriate to use active monitoring
- key components of interventions that can be provided by the GP, such as psychoeducation
- service models that can be provided in primary care settings

To maximise the uptake of this training, commissioners may wish to:

- Work with local GPs with a special interest in mental health, local psychological intervention providers and medicines management teams to develop and deliver peer-led awareness-raising training.
- Consider offering incentives, such as payments or personalised follow-up support, to improve the uptake of training.
- Consider the location, time and length of training to maximise accessibility for different professional groups.
- Consider using a variety of training media, including conferences, accredited courses, informal drop-in sessions, and internet- or CD-based training programmes[47].
- Ensure that training is accredited as part of continuing professional development (CPD).

Commissioners should note that improving the identification of common mental health disorders may initially increase the number of people diagnosed and referred for treatment. However, successful treatment may decrease longer-term healthcare use among this group.

The Topic Advisory Group agreed that a barrier to successful referral is often a lack of information on what services are available within the local common mental health disorder pathway. Commissioners should work with local partners to commission a 'single point of information' on the local pathway, which can be in form of information booklets and/or an online resource.

5.1.2 Assessment and referral

The identification and assessment of a person's common mental health disorder, and any functional impairment and risk, is an early determinant of their subsequent path through the stepped care pathway, and thus their use of health resources. There is evidence that people with common mental health disorders often have several assessments, involving a high level of duplication and creating excess paperwork for mental health workers. Inaccurate decisions based on poor assessment can lead to inappropriate treatment and poor cost-effectiveness[48].

Commissioners should:

[47] Commissioners may wish to promote training modules developed by BMJ learning and NICE on anxiety disorders in adults, depression in adults and depression in adults with a chronic physical health problem, which includes when to prescribe medication or psychological interventions for the treatment of these disorders.
[48] Naylor C and Bell A (2010) Mental health and the productivity challenge: improving quality and value for money. London: Kings Fund

- Specify that assessment is based on a locally agreed assessment tool (such as the appropriate elements of the IAPT data standard, see section 3.3) that can determine the nature, duration and severity of the presenting disorder, and associated functional impairment. The assessment should elicit the information needed to decide appropriate referral and treatment options.
- Specify that assessment information is shared between providers, to prevent unnecessary additional assessments.
- Specify that all people with common mental health disorders receive assessment from an appropriately trained, qualified and competent professional. Commissioners should note that a practitioner may not be competent to assess all common mental health disorders. For example a GP may be more competent to assess depression or anxiety than less common conditions such as obsessive-compulsive disorder or post-traumatic stress disorder.
- Specify that assessment details are discussed with the person, so they are informed about their condition and can use this information when considering which social, psychological or pharmacological interventions may be appropriate for them.
- Monitor and compare identification, assessment, prescribing and referral in local primary care services, and among other providers as appropriate. Commissioners should use this information to identify and respond to variations in practice (for example by alerting GPs and other professionals to variation in practice that cannot be explained by local demographic differences and service-user cohort), and if appropriate offer one-to-one training or support to change practice (see also section 5.1.1).

Recommendation 1.3.3.2 of NICE clinical guideline 123 states:

'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.'

Commissioners and their partners should:

- Ensure that their local care pathway clearly identifies what action professionals should take if they suspect there is a risk of harm to a person with a common mental health disorder or others (see also section 5.4).

- Specify that providers adhere to local safeguarding policies for children, young people, and vulnerable adults.
- Specify that assessment includes considering the impact of a person's common mental health disorder on any dependents.

5.2 Specifying step 2 services for people with subthreshold, mild and moderate common mental health disorders

Commissioning services at step 2, underpinned by NICE guidance and quality standards, is likely to contribute to achieving the following service outcomes:

- Reducing the stigma and discrimination associated with a diagnosis of, or treatment for, common mental health disorders.
- Increasing the proportion of people who are identified, assessed and receive treatment in accordance with NICE guidance.
- Improving the proportion of people who make a clinically significant improvement or recover.
- Improving emotional wellbeing, quality of life and functional ability in people with common mental health disorders.
- Improving service-user choice and experience of mental health services.
- Improving the interface between services for people with common mental health disorders.

Table 10 summarises step 2 of the stepped-care model for common mental health disorders. The majority of people needing treatment for a common mental health disorder will need treatment in step 2.

Table 10 Step 2 services

Focus of the intervention	Nature of the intervention
Depression: persistent subthreshold depressive symptoms or mild to moderate	• Individual facilitated self-help • Computerised cognitive behavioural therapy (CBT) • Structured physical activity • Group-based peer support (self-help) programmes (for

depression	people with depression and a chronic physical health condition) • Non-directive counselling delivered at home (for women during pregnancy and the postnatal period) • Antidepressants • Self-help groups
Generalised anxiety disorder **Panic disorder:** mild to moderate panic disorder	• Individual non-facilitated and facilitated self-help • Psychoeducational groups • Self-help groups
Obsessive-compulsive disorder: mild to moderate obsessive-compulsive disorder	• Individual or group CBT (including exposure and response prevention [ERP]) (typically provided within step 3 services[a]) • Self-help groups
Post-traumatic stress disorder: including mild to moderate post-traumatic stress disorder.	• Trauma-focused CBT (typically provided within step 3 services[a]) • Eye movement desensitising and reprocessing (EMDR) (typically provided within step 3 services[a])
All disorders	• Support groups • Educational and employment support services • Referral for further assessment and interventions
[a] These interventions may typically be commissioned from, and provided by, trained, high-intensity therapy staff in step 3 services (see section 5.3).	

The Topic Advisory Group agreed that although there have been recent improvements in the awareness of common mental health disorder pathways at step 1 and the commissioning of psychological interventions at step 3, the greatest room for improvement remains in the

commissioning of step 2 services. In many areas there is a high turnover of staff at step 2 and competition for resources with step 3 services.

The key service components when commissioning effective step 2 services are:

- low intensity psychological interventions (see section 5.2.1)
- pharmacological interventions (see section 5.2.2).

Advice for commissioning additional support services at steps 2 and 3 is provided in section 5.3.3.

Note that although there are some similarities in the key components of step 2 and 3 services there are significant differences in the unit costs of these services, which are clearly demonstrated in the commissioning and benchmarking tool. Commissioning sufficient capacity at step 2 may improve productivity by reducing inappropriate use of higher-intensity psychological interventions and inappropriate prescribing of antidepressants.

5.2.1 Low-intensity psychological interventions

Table 11 summarises the low-intensity psychological interventions recommended by NICE for each common mental health disorder at step 2.

Table 11 Low-intensity psychological interventions recommended at step 2

Psychological intervention	Disorder
Cognitive behavioural therapy (computerised)	• Depression
Cognitive behavioural therapy (individual) including exposure and response prevention[a]	• Obsessive-compulsive disorder
Cognitive behavioural therapy (group) including exposure and response prevention[a]	• Obsessive-compulsive disorder

Cognitive behavioural therapy (trauma-focused)[a]	• Post-traumatic stress disorder
Eye movement desensitising and reprocessing[a]	• Post-traumatic stress disorder
Group-based peer support (self-help) programmes	• Depression (with a chronic physical health condition)
Non-directive counselling delivered at home	• Depression (antenatal and postnatal)[b]
Psychoeducational groups	• Generalised anxiety disorder • Panic disorder
Self-help groups	• Depression • Generalised anxiety disorder • Obsessive-compulsive disorder • Panic disorder
Self help (individual facilitated)	• Depression • Generalised anxiety disorder • Panic disorder
Self help (individual non-facilitated)	• Generalised anxiety disorder • Panic disorder
Structured physical activity	• Depression

[a] These interventions may typically be commissioned from, and provided by, trained, specialist staff in step 3 services (see section 5.3).

[b] Commissioners may also wish to refer to the NICE commissioning guide 'Antenatal and postnatal mental health services' when developing services for this group

To ensure people have a choice of evidence-based psychological interventions at step 2, commissioners should:

- use their local needs assessment (see section 4) to estimate the number of people who are likely to be offered and accept low-intensity psychological interventions at step 2
- have plans that work towards commissioning adequate levels of all of the low intensity psychological interventions recommended by NICE
- ensure that they commission a range of low-intensity psychological interventions that meet the needs of the whole population and enable people to make an informed choice of evidence-based interventions
- specify that people have access to service-user-centred information to enable them to make an informed choice about which low-intensity psychological interventions, delivered by qualified providers, best meet their needs.

When commissioning low-intensity psychological interventions, commissioners may wish to:

- begin by commissioning interventions for depression and generalised anxiety disorder, and interventions that are recommended for more than one condition, such as individual facilitated self-help, and for which there is likely to be the greatest demand
- explore options for commissioning group-based activities, such as self-help groups and pscyhoeducational groups, that are cost effective in terms of service-user outcomes, increasing capacity and reducing waiting lists.

Commissioners should ensure that their providers of low-intensity psychological interventions can demonstrate cost effectiveness and high quality. This will include measures of the following:

- **Quality assurance:** commissioners should ensure providers are meeting, or working towards meeting, the quality measures specified in the contract and NICE quality standards. They should ensure that providers follow NICE guidance on delivering low-intensity psychological interventions, including offering service users the recommended length, number and frequency of sessions (including additional sessions for followup and relapse prevention if indicated).
- **Use of validated tools:** commissioners should ask providers to demonstrate that they use evidence-based assessment, monitoring and outcomes tools (such as the IAPT data standard, see section 3.3). Providers should also be able to demonstrate that psychological interventions are provided using competence frameworks or structured models developed from evidence-based treatment manuals.

- **Accessibility:** commissioners should specify that services are accessible, for example providing services outside normal working hours, delivering interventions or assessments in a person's home and in accessible venues, and using appropriate technology (see section 3.5). Commissioners should be attentive to the location, time and accessibility of services (see also section 3.5.1). Technological solutions such as computerised cognitive behavioural therapy and phone-based services can be effectively used in step 2, and may reduce some of the costs associated with staff travel and room hire. Commissioners should work closely with providers when selecting the computerised cognitive behavioural therapy packages because license costs, service user preferences and service-user outcomes vary.
- **Workforce competencies:** commissioners should specify that providers' staff:
  - are trained to deliver any psychological therapies that they provide
  - receive regular supervision from a person competent in both supervision and the intervention
  - receive ongoing programmes of workforce or personal development, which may include the management of more complex cases such as people with common comorbidities. More experienced step 2 practitioners could receive training to provide assessments and referral and/or clinical supervision.
- **Unit cost:** per service-user and per outcome. See the commissioning and benchmarking tool.

Commissioners may wish to refer to 'Guidance for Commissioning IAPT training 2011/12 to 2014/15' for further information about workforce development and training. Commissioners should note that staff who deliver psychological interventions at step 2 are commonly psychological wellbeing practitioners (PWPs) although other staff models may be appropriate, such as using graduate mental health or nursing staff. Commissioners should ensure that they commission adequate local capacity each year for psychological wellbeing practitioner training programmes.

5.2.2 Pharmacological interventions

Commissioners should be aware that antidepressants are not routinely recommended by NICE for managing common mental health disorders at step 2, but may be considered for people with:

- a past history of moderate or severe depression
- initial presentation of subthreshold depressive symptoms present for at least 2 years
- subthreshold depressive symptoms or mild depression persisting after other interventions
- mild depression that complicates the care of a physical health condition.

Commissioners should work with their medicines management team to examine the prescribing of antidepressants for people at step 2, and to explore the reasons behind any variations. Commissioners should:

- ensure that their awareness-raising training for GPs (see section 5.1.1) includes information on NICE recommendations for antidepressants for people in step 2.
- talk to GPs about their prescribing, and show them how it compares with their peers in the local clinical commissioning group, in terms of what and how they prescribe.

5.3 Specifying step 3 services for people with moderate to severe common mental health disorders

Commissioning services at step 3, underpinned by NICE guidance and quality standards, is likely to contribute to achieving the following service outcomes:

- Reducing the stigma and discrimination associated with a diagnosis of, or treatment for, common mental health disorders.
- Increasing the proportion of people who are identified, assessed and receive treatment in accordance with NICE guidance.
- Improving the proportion of people who make a clinically significant improvement or recover.
- Reducing the proportion of people who relapse.
- Identifying risk and preventing avoidable harm.
- Improving emotional wellbeing, quality of life and functional ability in people with common mental health disorders.
- Preventing sick leave and maintaining people in education, employment or meaningful activities.
- Reducing long-term unemployment, homelessness and family breakdown.

- Improving service-user choice and experience of mental health services.
- Improving the interface between services for people with common mental health disorders.

Table 12 summarises step 3 of the stepped-care model for common mental health disorders.

Table 12 Step 3 services

Focus of the intervention	Nature of the intervention
Depression: 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	• Antidepressants • Behavioural activation • Behavioural couples therapy • CBT • Collaborative care (for people with depression and a chronic physical health condition) • Combined interventions • Counselling (for people who decline an antidepressant, CBT, IPT, behavioural activation or behavioural couples therapy) • IPT • Self-help groups • Short-term psychodynamic psychotherapy (for people who decline an antidepressant, CBT, IPT, behavioural activation or behavioural couples therapy)
Generalised anxiety disorder: with marked functional impairment or that has not responded to a low-intensity intervention	• Applied relaxation • CBT • Combined interventions • Drug treatment • Self-help groups
Obsessive-compulsive disorder: with moderate or	• Antidepressants • CBT (including ERP)

severe functional impairment	• Combined interventions and case management • Self-help groups
Panic disorder: moderate to severe panic disorder	• Antidepressants • Bibliotherapy based on CBT principles • CBT • Self-help groups
Post-traumatic stress disorder	• Drug treatment EMDR • Trauma-focused CBT
All disorders	• Befriending • Educational and employment support services • Referral for further assessment and interventions • Rehabilitation programmes • Support groups
Abbreviations: CBT, cognitive behavioural therapy; EMDR, eye movement desensitisation and reprocessing; ERP, exposure and response prevention; IPT, interpersonal psychotherapy.	

The key service components when commissioning effective services at step 3 are:

- high intensity psychological interventions (see section 5.3.1)
- pharmacological interventions (see section 5.3.2)
- additional support services (see section 5.3.3)

Note that although there are some similarities in the key components of step 2 and 3 services there are significant differences in the costs of commissioning these services, which are clearly demonstrated in the commissioning and benchmarking tool.

5.3.1 High intensity psychological interventions

Table 13 summarises the high-intensity psychological interventions recommended by NICE for each common mental health disorder at step 3.

Table 13 High-intensity psychological interventions at step 3

Psychological intervention	Disorder
Applied relaxation	• Generalised anxiety disorder
Behavioural activation	• Depression
Behavioural couples therapy	• Depression
Bibliotherapy based on cognitive behavioural therapy principles	• Panic disorder
Cognitive behavioural therapy (CBT)	• Depression • Generalised anxiety disorder • Panic disorder
Cognitive behavioural therapy including exposure and response prevention	• Obsessive-compulsive disorder
Cognitive behavioural therapy (trauma-focused)	• Post-traumatic stress disorder
Counselling	• Depression (for people who decline an antidepressant, cognitive behavioural therapy, interpersonal psychotherapy, behavioural activation or behavioural couples therapy)
Eye movement desensitising and reprocessing	• Post-traumatic stress disorder
Interpersonal psychotherapy	• Depression
Self-help groups	• Depression • Generalised anxiety disorder • Panic disorder

	• Obsessive-compulsive disorder
Short-term psychodynamic psychotherapy	• Depression (for people who decline an antidepressant, cognitive behavioural therapy, interpersonal psychotherapy, behavioural activation or behavioural couples therapy)
Combined interventions	• Depression • Generalised anxiety disorder • Obsessive-compulsive disorder

Commissioners should use their local needs assessment (see section 4) to estimate the number of people likely to be offered and to accept high-intensity psychological interventions at step 3. They should ensure that they commission a range of high-intensity psychological interventions that meet the needs of the whole population and enable people to make an informed choice of evidence-based interventions.

Commissioners should have plans to work towards commissioning adequate levels of all of the high-intensity psychological interventions recommended by NICE. Commissioners may wish to begin by commissioning, and improving capacity within:

- CBT services and self-help groups; these are recommended for the largest number of disorders
- interpersonal therapy, behavioural activation and behavioural couples therapy; these are recommended for depression and generalised anxiety disorder, which are the most prevalent conditions.

Nationally there is a shortage of trained staff to provide all psychological interventions, but in particular interpersonal therapy and behavioural activation. Commissioners should work closely with their regional IAPT workforce commissioners and local providers to identify resources for ongoing workforce training and development, to improve access to psychological interventions for which there is a local shortage.

Commissioners should ensure that their providers of high-intensity psychological interventions can demonstrate cost effectiveness and high quality. In addition to unit costs, service user outcomes and cost-per-outcome commissioners should consider the following indicators:

- **Quality assurance:** commissioners should ensure providers are meeting, or working towards meeting, the quality measures specified in the contract and NICE quality standards. They should ensure that providers follow NICE guidance on delivering high-intensity psychological interventions, including offering service users the recommended length, number and frequency of sessions (including additional sessions for follow-up and relapse prevention if indicated).
- **Use of validated tools:** commissioners should ask providers to demonstrate that they use evidence-based assessment, monitoring and outcomes tools (such as the IAPT data standard, see section 3.3). Providers should also be able to demonstrate that psychological interventions are provided using competence frameworks or structured models developed from evidence-based treatment manuals.
- **Accessibility:** commissioners should specify that services are accessible, for example providing services outside normal working hours, delivering interventions or assessments in a person's home and in accessible venues, and using appropriate technology (see section 3.5.1).
- **Workforce competencies:** commissioners should specify that providers' staff:
  - are trained to deliver any psychological therapies that they provide
  - receive ongoing programmes of workforce/personal development, which may include the management of more complex cases such as people with common comorbidities
  - receive regular supervision from a person competent in both supervision and the intervention.
- **Unit cost:** per service-user and per outcome. See commissioning and benchmarking tool.

Commissioners may wish to refer to the Guidance for Commissioning IAPT training 2011/12 to 2014/15 for further information about workforce development and training. Staff who deliver psychological interventions at step 3 are commonly referred to as high-intensity therapy workers. Commissioners should ensure that they commission adequate local capacity each year for high-intensity psychological therapy training.

Recommendation 1.5.1.4 of 'Depression in adults' (NICE clinical guideline 90) states:

'For people with depression who decline an antidepressant, CBT, IPT, behavioral activation or behavioural couples therapy, consider:

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

Discuss with the person the uncertainty of the effectiveness of counselling and psychodynamic psychotherapy in treating depression.'

The expert clinical opinion of the Topic Advisory Group is that a large number of people are inappropriately offered counselling for the management of common mental health disorders, having not previously been offered and declined psychological interventions or antidepressants. Therefore commissioners and their partners should:

- Actively monitor the local use of counselling services for depression and other common mental health disorders.
- Explore the reasons behind any inappropriate use of counselling services, such as lack of:
  - availability of first-line psychological interventions
  - knowledge of the high intensity psychological interventions recommended by NICE, or
  - knowledge on how to make appropriate referrals.

  These points should be covered by awareness-raising training (see section 5.1.1). Commissioners should make GPs and other professionals who make referrals aware of any inappropriate use of counselling and discuss alternatives with them.
- Ensure that service-user information explains the evidence base behind first-line psychological interventions (see service models in section 5.5).
- Work with local counselling services to ensure that both counselling and psychological intervention services are used appropriately and to enable cross-referral of people who may be inappropriately referred for counselling or psychological interventions.
- Consider making training available for counsellors to deliver psychological interventions such as cognitive behavioural therapy or interpersonal psychotherapy.

Counselling is often provided by a counsellor contracted to a GP surgery, so commissioners should consider opportunities to provide regular psychological intervention sessions in GP surgeries.

5.3.2 Pharmacological interventions

Commissioners should be aware of NICE's recommendations on the use of antidepressants and other medication to manage common mental health disorders. Note that medication is usually recommended in combination with psychological interventions and may be considered for relapse prevention.

At around £6 per person per month[49], antidepressants are not considered to be high cost drugs. However because of the high volume of prescribing, they are one of the top 30 British National Formulary sections by overall cost and number of items[50].

Commissioners and their partners should ensure that their local care pathways include a regular medication review for all service-users taking medication for common mental health disorders. This may help to prevent inappropriate prescribing and ensure that alternative interventions or medication, or referral, are considered for people whose condition is not responding to their current medication, and to ensure that people whose condition has sufficiently improved cease treatment or are stepped down in a planned and timely manner.

Commissioners may wish to involve psychiatrists or GPs with a special interest in common mental health disorders in pharmacological intervention pathways. The clinicians may provide support to healthcare professionals who are prescribing for people with comorbidities or more treatment-resistant conditions, and assist with risk management.

To ensure appropriate prescribing of medication, commissioners should monitor the volume and cost of primary care prescribing of antidepressants and other medication that is, and is not, recommended by NICE for managing common mental health disorders at step 3. Commissioners should use this information to:

[49] Average cost based on six common selective serotonin reuptake inhibitors, see the cost impact and commissioning assessment for the NICE quality standard 'Depression in adults'.
[50] NHS Information Centre for health and social care (2011) Top 30 BNF sections by cost in 2010–11. Items spreadsheet [online]. Available from http://www.ic.nhs.uk/

- Ensure that antidepressants and other drugs are prescribed in accordance with NICE recommendations, paying particular attention to the offer and uptake of combination psychological interventions, and the timeliness and frequency of medication reviews.
- Work with their medicines management team and prescribers to ensure that prescribers are using the cheapest suitable drug.
- Ensure that prescribers are aware of when to prescribe antidepressants in combination with or instead of psychological interventions (see also section 5.1.1).

5.3.3 Additional support services

NICE recommends a range of additional support services for people with common mental health disorders. These include:

- education and employment support services – steps 2 and 3; these may be provided by local job centres or occupational health/therapy departments
- support groups – steps 2 and 3; these are typically provided by not-for-profit organisations
- befriending – step 3; these are typically provided by not-for-profit organisations
- rehabilitation programmes – step 3.

Common mental health disorders rarely occur in isolation from wider social circumstances, and can have a considerable impact on them. Commissioning additional support services can reduce isolation, improve confidence and manage some of the underlying stresses that can increase the risk of common mental health disorders.

Commissioners should ensure that their pathway identifies a range of additional support services for people with common mental health disorders, including those listed above. In addition, commissioners may also wish to develop relationships with services that provide advice on debt or welfare, and with victim support services.

Commissioners should ensure that any additional support services use referral and outcomes monitoring tools that are integrated with the other providers in the pathway.

5.4 Specifying step 4 services for people with severe functional impairment or complex common mental health disorders

Commissioning services at step 4, underpinned by NICE guidance and quality standards, is likely to contribute to achieving the following service outcomes:

- Reducing the stigma and discrimination associated with a diagnosis of, or treatment for, common mental health disorders.
- Increasing the proportion of people who are identified, assessed and receive treatment in accordance with NICE guidance.
- Improving the proportion of people who make a clinically significant improvement or recover.
- Reducing the proportion of people who relapse.
- Identifying risk and preventing avoidable harm.
- Improving emotional wellbeing, quality of life and functional ability in people with common mental health disorders.
- Preventing sick leave and maintaining people in education, employment or meaningful activities.
- Reducing long-term unemployment, homelessness and family breakdown.
- Improving service-user choice and experience of mental health services.
- Improving the interface between services for people with common mental health disorders.

Table 14 summarises the interventions recommended by NICE for the management of common mental health disorders at step 4.

Table 14 Step 4 services

Focus of the intervention	Nature of the intervention
Depression: severe and complex depression; risk to life; severe self-neglect	Highly specialist treatment, such as medication, high intensity psychological interventions, combined treatments, multiprofessional and inpatient care, crisis services, electroconvulsive

	therapy
Generalised anxiety disorder: complex treatment-refractory generalised anxiety disorder and very marked functional impairment, such as self-neglect or a high risk of self-harm	Highly specialist treatment, such as complex drug and/or psychological treatment regimens; input from multi-agency teams, crisis services, day hospitals or inpatient care
Panic disorder, obsessive compulsive disorder and post-traumatic stress disorder: People that have not responded to treatment at steps 1–3, or who have severe disorders and complex comorbidities that prevent effective management at steps 1–3	Specialist services at step 4 will vary according to individual need and clinical judgement. The principle interventions at step 4 are similar to those listed for depression and generalised anxiety disorder above, with the exception that electroconvulsive disorder is not indicated.

The population prevalence in section 4 shows that only a small minority of people are likely to need treatment in step 4 services, often as a result of treatment resistance, risk of self-neglect or harm, functional impairment, the complexity of their condition and other social factors.

Commissioners should use the commissioning and benchmarking tool and their local needs assessment to plan services for people with common mental health disorders who may not respond to treatment in steps 1–3, or who have more complex needs and would benefit from treatment at step 4.

It was the view of the Topic Advisory Group that nationally there is often a gap between the severity and complexity of cases managed in step 3 and those managed in step 4 services, meaning that some people who do not respond to treatment in step 3 may not be eligible for treatment at step 4. This may be a result of recent investment in steps 1 to 3 using Improving Access to Psychological Therapies (IAPT) resources, which have created issues in the capacity and interface with step 4 services. Commissioners should ensure that they provide sufficient capacity at step 4 and that the thresholds for steps 3 and 4 are complementary and do not excessively overlap or leave treatment gaps.

Unlike steps 2 and 3, which are usually provided by IAPT-funded services, step 4 care is typically provided by psychology services, specialist community services or secondary care mental health services. Commissioners may wish to consider greater integration and joint working protocols for commissioning and providing some step 3 and 4 services.

When commissioning step 4 services, commissioners should be attentive to:

- **Assessment:** Step 4 services should be an integral part of the stepped-care pathway for common mental health disorders. Commissioners should consider options to ensure that any assessments from previous steps are made available to step 4 services, and that assessments made in step 4 follow people who step down into lower step services. Commissioners should specify that assessment at step 4 includes a social care assessment, and assessment of other support needs, including employment and welfare.
- **Care-planned treatment:** The needs of people receiving step 4 services are likely to be more complex, so it is probable that people will be receiving a combination of medication and other interventions. Although some interventions may be similar to those in steps 2 and 3, the treatment is likely to be more intense or for a longer duration. Commissioners should specify that all people in step 4 services have a management plan that includes relapse prevention.
- **Psychological interventions:** The Care Quality Commission (CQC) 2011 survey of community mental health services found that 39% of service users in community mental health teams had received talking therapy, and that 47% of people had not had the option of talking therapy discussed with them. Commissioners should specify that all people in step 4 services are offered psychological interventions recommended by NICE. Commissioners should satisfy themselves that their tier 4 providers can provide high-quality psychological interventions, and may wish to use the same monitoring and outcomes evaluation criteria as in step 3 psychological interventions (see section 5.3.1). They should pay particular attention to specifying the length and frequency of sessions; the number of sessions will typically be governed by service-user need and clinical response.
- **Pharmacological interventions:** The CQC 2011 survey of community mental health services found that majority of people whose disorder is managed by community mental health teams receive prescribed medications. There will be a greater proportion of people

needing prescribed medication in step 4 than in lower steps, and the prescribing is more specialist. Therefore commissioners should specify that prescribing in step 4 is overseen by a psychiatrist or a GP with a special interest in mental health who has had appropriate training. They may wish to audit the use of psychotropic medication in step 4 and to consider incentives to encourage the use of the most cost-effective drugs.

- **Crisis response:** Commissioners should ensure that their tier 4 services include same-day crisis response assessment and management.
- **Additional support services:** Commissioners should ensure step 4 services remain integrated with the additional support services recommended in steps 1 to 3 (see section 5.3.3).
- **Other services:** Commissioners should work with providers to ensure there is sufficient capacity in other services recommended at step 4, including electroconvulsive therapy for depression and residential care for people with severe obsessive-compulsive disorder.

5.5 Service models

Quality, innovation, productivity and prevention

Commissioners may wish to work with their local Quality, Innovation, Productivity and Prevention (QIPP) lead to develop service models for implementing stepped care for people with common mental health disorders, as part of a strategy to improve the identification and management of common mental health disorders. Example models are included in table 15.

Table 15 Delivering QIPP through stepped care for common mental health disorders

QIPP model	Example output
Partnership	• Development of common mental health disorder partnership, with shared governance procedures
Improving recognition of common mental health disorders	• Development of programme of local awareness raising for targeted healthcare, education, social care and welfare

	professionals.
Improving assessment and diagnosis of common mental health disorders	• Increasing assessment and diagnosis of common mental health disorders in primary care, using tools validated for primary care
Reducing inappropriate prescribing of antidepressants	• Reducing inappropriate prescribing of antidepressants by following NICE guidance recommendations for the treatment of sub-threshold, mild and moderate conditions
Reducing inappropriate or unnecessary referrals to community mental health teams and/or secondary care psychiatry services	• People with common mental health disorders are first assessed and receive interventions at the lowest step suitable for their needs

Commissioning for quality and innovation

Commissioners may wish to consider using the Commissioning for Quality and Innovation (CQUIN) payment framework as a lever for improving quality through a change in practice or service redesign in provider settings.

The CQUIN framework will be important for implementing NICE quality standards, improving service-user experience and driving improvement of outcomes (including patient reported outcomes measures)[51]. Commissioners may wish to use the NICE quality standards for depression and as a basis for agreed local quality improvement goals. These may include:

- improving assessment for people with common mental health disorders, resulting in more timely and responsive services and improved service-user experience
- improving availability of carer and family assessments for the families and carers of people using psychological intervention services, resulting in improved mental health for families and carers, and improved carer and family experience

[51] Department of Health (2010) Equity and excellence: liberating the NHS, paragraph 3.20. London: Department of Health. Available from www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

- improving access and outcomes among people from locally targeted socially excluded groups, and people with defined chronic physical health conditions, learning disabilities or cognitive impairment
- improved wellbeing for people receiving psychological interventions, measured using locally agreed indicators such as the IAPT data standard
- ensuring assessment includes indicators of employment status, or other targeted indicators, to improve recovery and outcomes for people with common mental health disorders.

Case studies

Commissioners may wish to refer to examples of commissioned common mental health disorder services.

Examples of integrated stepped care psychological intervention services are provided in table 16. Additional case studies illustrating elements of stepped care discussed in sections 3 and 5 are provided in table 17.

Table 16 Examples of commissioned psychological intervention services

Sheffield Improving Access to Psychological Therapies (IAPT) service	Sheffield Health and Social Care NHS Foundation Trust has integrated its step 2 to 4 services for people with common mental health disorders. It offers a choice of interventions at each step so that there is a suitable intervention for everyone. It proactively contacts everyone referred to enable them to make an informed choice about treatment. It monitors referral and uptake, and reports back to referrers including GPs. Examples of innovative step 2 services include: • 6-week evening courses, in community venues in the city centre, to help people to manage anxiety, stress and depression. The groups are offered as part of a range of step 2 support for people with

	common mental health disorders, and are particularly popular among men and younger people. Outcomes show that efficacy is similar to one-to-one sessions for people attending between three and six sessions. • Half day healthy-living workshops, focusing on guided self-help on issues like managing anxiety, self-esteem and sleep disorders. Some are developed in conjunction with local community groups in order to improve access among people from local black and minority ethnic groups. Self-referral is encouraged via the internet, booklets and word of mouth. • Computerised cognitive behavioural therapy • One-to-one work with psychological wellbeing practitioners, delivered face-to-face or on the phone. Step 3 services include one-to-one counselling and cognitive behavioural therapy and a group behavioural activation programme. The service provides employment advice in partnership with a local occupational health advisory service.
Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust Community Therapies Impact model	Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust has commissioned a community therapies impact model across steps 2 to 4. The model is underpinned by collaboration with service users, who are proactive in their treatment and care. Care is provided by a multidisciplinary team in the community, including a consultant psychiatrist, and nursing, social care, occupational health and

	psychological therapy staff. Care-planned treatment is provided by qualified case managers, who coordinate initiation of an appropriate step of treatment and by care navigators who coordinate care for people with chronic common mental health disorders. Most people are referred into the service by their GP surgery, where a psychological wellbeing practitioner (PWP) will be part of the team, or by self-referral via Talking Shop (a town centre walk-in facility offering signposting and lifestyle and wellbeing advice). People are offered a menu of step 2 social and emotional wellbeing programmes, including community groups, facilitated self-help and individual tailored sessions provided by PWPs and support workers. At step 3, one-to-one support is provided by a senior clinical team member, including medication management (overseen by non-medical prescribers such as nurse specialists), psychological interventions and additional telephone-based support for people with chronic common mental health disorders. The service is enhanced by 'Talking sense' – a bespoke internet-based telehealthcare service providing online support for people with common mental health disorders, links to recommended websites, crisis help, self-help information and online psychological intervention sessions. Evaluations from a range of bodies (including stress control, sleep and self-esteem groups) praise the accessibility of the interventions and show clinically significant improvement, including improved self-

	esteem, awareness and self-management.
NHS Halton & St Helens step 1 services, and pathways into psychological and social interventions at steps 2 to 4	NHS Halton & St Helens has worked closely with its public health team and GPs to commission stepped-care services for people with common mental health disorders. It has particularly invested in step 1 services, to raise awareness and confidence among communities and GPs to identify and manage depression. It set up an 'early detection of depression project board', comprising GPs, commissioners, third sector organisations, the local authority, and local patient and public involvement networks and forums. The board: • Provided awareness-raising training for GPs and primary care nurses, delivered at appropriate times to ensure clinical engagement. • Provided commissioned training for primary care to use mental health promotion CDs and MP3 downloads, which are given to service-users as an early intervention and an adjunct to watchful waiting. • Arranged a range of health promotion and media events to raise awareness of common mental health disorders, with an emphasis on building community resilience during difficult times. This included working closely with local rugby league clubs to deliver community events with a focus on men and families, physical activity and destigmatising mental health. • Commissioned training for more than 300 people who have 'listening roles' as part of their work, such as bar staff, taxi drivers and hairdressers, to

	act as community champions. The training was based on CBT principles and included how to recognise common mental health disorders, normalising reactions to stressful life events and reducing personalisation and magnification of problems. They provided 4month follow-up to find out how people were using the training and found that 85% of people who responded felt confident about being able to spot the signs and symptoms of depression and anxiety and 80% felt able to help someone using the information they learned at the event. NHS Halton and St Helens has also commissioned the local citizens advice bureau (CAB) to provide 'debt advice on prescription', to which people with a common mental health disorder and underlying financial problems can be referred by GPs or local psychological therapy services and be contacted within 24 hours. The CAB uses the PHQ9 (patient health questionnaire tool for depression) after their intervention to measure the impact of their support on people's mental health. It has also adopted a 'single point of access' for all primary and secondary mental health care services, including crisis response in hours. Access to services is managed in partnership between community and specialised mental health services, ensuring pathways into stepped care are jointly owned. This ensures that service-users will always be directed to the appropriate step. GPs are encouraged to provide initial screening, and if appropriate offer early interventions, before referring people for assessment and treatment. Self

	referral is an option. All services and providers in the pathway use the same referral form to ease referral and assessment to a range of psychological and social interventions. There is a menu of interventions available at steps 2 to 4, delivered by one of three providers. At the end of any intervention with a provider, feedback is provided to the GP and referrer.

Table 17 Case studies for stepped care for common mental health disorders

Example	Case studies
Common mental health disorder partnership	The depression and anxiety spectrum disorder care pathway case study on the NICE shared learning database is an example of a small multi-agency partnership that has developed a single point of information to improve awareness and identification of common mental health disorders and pathways to care.
Inclusion	The crossing the language barrier with a dedicated mental health interpreting service case study on the NICE shared learning database is an example of a dedicated mental health interpreting service that aims to improve access and uptake of psychological interventions among people who do not speak English as a first language.
Single point of information	NHS Milton Keynes mild to moderate depression service review included localising online software with information about community, voluntary and health services available in Milton Keynes Bexley PCT have developed a hard-copy and

	online resource to address the need for a robust local protocol for the management of depression and anxiety disorders and practical treatment guidelines to support GPs
Destigmatisation and increasing self-referral	The talking therapies provider KCA supplies patient information about all services via leaflets and their website. The service uses a flyer 'Need some space for yourself' circulated in venues across local communities to encourage self-referrals. The flyer is non-stigmatising in the wording used and uses low threshold indicators of emotional distress (for example, 'I cry over silly things or for no reason at all', 'Going into work or seeing people often feels like too much'*)* and everyday language to encourage anyone feeling distressed to contact the service. They also publish an information leaflet regarding psychological therapies, which they ask GPs to give to service-users when they are referring them into the service and which they also send out to service-users. The leaflet explains the range of services and support available.
Screening and identification	Involvement in the detection of depression and anxiety in long term sickness absence cases and the development of a care pathway on the NICE shared learning database is an example of routine screening for depression and anxiety disorders in an occupational health setting, which has improved the detection of common mental health disorders.

Stepped care	NHS Avon and Wiltshire has adopted the stepped-care approach, known locally as 'least intervention first time' (LIFT), delivered by the primary care psychology service. It operates a three-tier model providing a fast response and acting as a gateway to higher tiers of treatment.
Cognitive behavioural therapy in an occupational health setting	How CBT and a stepped care approach to mental health was adapted and implemented for use in the Occupational Health department on the NICE shared learning database is an example of how occupational health staff have been trained to provide cognitive behavioural therapy and computerised cognitive behavioural therapy for people with depression and anxiety, which has reduced the numbers of people stepped up.
Script switch	A number of PCTs have used script switch to alert GPs who are prescribing antidepressants to consider: • referring people for social or psychological interventions, in line with the local pathway and NICE guidance • using alternative, cheaper, antidepressants.
Prescribing for common mental health disorders – primary care pathways	Bristol, North Somerset and South Gloucestershire primary care trusts have developed a Prescribing for Depression algorithm that can be used to guide GPs through the assessment of depression and management using antidepressants. The algorithm includes guidance on: • assessment of depression

	• assessment of suicide risk • consideration of active monitoring and psychological interventions • first- and second-line selective serotonin reuptake inhibitors • third-line pharmacotherapy • remission and review.
Psychoeducation groups	The self directed anxiety support group for older people case study on the NICE shared learning database is an example of psychoeducational groups targeting older people at risk of common mental health disorders, which improved the ability of people in this group to self-manage their condition.
Befriending services	Mental health promotion and mental illness prevention: the economic case has a case study of befriending of older adults, usually provided by volunteers, which promotes social inclusion and reduces loneliness and can help to reduce common mental health disorder symptoms.
Debt and mental health services	Mental health promotion and mental illness prevention: the economic case has a case study of the potential for debt advice interventions to alleviate debt and reduce resulting mental health disorders.
Care-planned treatment	The Tier 2 Salford Primary Care Mental Health Service run by Six Degrees Social Enterprise CIC has adopted a collaborative approach to service design that combines:

	• close collaboration with service-users, based on an understanding of their wishes and circumstances • a personalised plan of care • education in self-management • active follow-up by a designated case manager • systematic monitoring of treatment outcomes • access to expert support, through supervision and specialist advice • stepped care protocols. A team of gateway workers and psychological wellbeing practitioners act as case managers. A case registry system is used to track the progress of people who use the service and provide reminders for scheduling follow-up contacts. Clinics are provided in GP practices and case managers work in close partnership with the local primary care teams, developing joint goals and sharing real time feedback via notes entered directly onto the practice information systems. Service users have reported a very high level of satisfaction with the service, stressing the importance of the services accessibility and its supportive character. The service was a finalist in the 2010 Patient Experience Awards. People who had previously felt overwhelmed by their difficulties reported that they have developed a sense of balance and control that has enabled them to deal with the

	challenges they face in their lives.

These case studies are offered as examples of practice. NICE makes no judgement on the compliance of these services with its guidance.

6 Service specification for common mental health disorder services

Commissioners should collaborate with clinicians, local stakeholders, and service users when determining what is needed from common mental health disorder services in order to meet local needs. The care pathway should be person-centred and integrated with other elements of care for people with common mental health disorders.

Commissioners may wish to consider commissioning services in a number of different ways, and local mixed models of provision are likely to be appropriate. Commissioners may wish to take action to stimulate the local market if there are identified shortages of providers at any point in the pathway and should note that any qualified providers may include health, local authority, other statutory partners, or private or third sector organisations.

Commissioners should ensure that providers implement the recommendations stipulated in NICE guidance and that providers are taking steps to achieve the standards set out in NICE quality standard for depression in adults.

Commissioners should ensure the services they commission represent value for money and offer the best possible outcomes for their service users. Commissioners should refer to NICE quality standards when commissioning services and should include quality statements and measures within the service specification element of the standard contract where appropriate. If poor performance is identified, commissioners can discuss the level of performance with their providers and address any issues and concerns before introducing more formal contractual remedies.

Commissioners may use NICE quality standards to ensure that high-quality care is being commissioned through the contracting process, to establish key performance indicators as part of a tendering process and/or to incentivise provider performance by using the indicators in

association with incentive payments such as Commissioning for Quality and Innovation (CQUIN).

Commissioners should ensure that they consider both the clinical and cost effectiveness of the service, and any related services, and take into account clinicians' and service users' views and those of other stakeholders when making commissioning decisions.

Table 18 includes considerations for commissioners when developing a contract specification for common mental health disorder services.

Table 18 Considerations for contract specification

Contract section	Contract sub-section	To specified in contract specification
Purpose	Policy context	National policy drivers. Evidence base, for example NICE guidance, Quality standards, NHS Evidence accredited sources, national strategies.
	Local strategic context	Local commissioning drivers (for example reducing inappropriate admissions to community mental health teams, improving the quality of referrals, reducing inappropriate prescribing of antidepressants, reducing worklessness, QIPP, CQUIN). Invest to save. Results of joint strategic needs assessment (JSNA).
	Aims and objectives of	The expected outcomes of the

	service	service(s) The partnership's vision for the service(s)
Service scope	Define service user groups	Demographic profile of the local population (age, gender, ethnicity, socioeconomic status, socially-excluded groups, ex-service personnel, persons in contact with the criminal justice system). Evidence of inequalities in outcomes between specific groups. Local recorded and expected prevalence of depression, generalised anxiety disorder, obsessive-compulsive disorder, post-traumatic stress disorder, phobias, social anxiety disorder (social phobia). Estimated prevalence of comorbidities (for example long term conditions, other mental health disorders, drug and alcohol misuse, pregnancy, learning disabilities, cognitive impairment). Number of people currently being treated in community-based psychological therapy services or specialist community mental health teams, and other relevant services.

		Number of people who see their GP and have a recorded incidence of one or more common mental health disorders. Population-groups that will be targeted.
	Exclusion criteria	Define exclusion criteria in accordance with NICE guidance and locally determined criteria. Services should be as inclusive as possible.
	Geographical population	Proportion of people living in urban and/or rural areas. Areas of higher-than-average need (for example, areas of deprivation and areas with a high population of older people). Population coverage required or geographical boundaries.
	Service description / care package	Mapping existing services for people with common mental health disorders. Commissioning of core service components. Interface with other local services including social care, residential and nursing care, community mental health services, welfare and debt advice, employment

		services.
Service delivery	Location	Service location(s), defining accessibility requirements and discreet location(s). Integration with other health and social care services for people with common mental health disorders.
	Days/hours	Expected hours of operation, including days, evenings and weekends. Expected number of people for assessment, interventions, prescribing, care coordination, case management, collaborative care and aftercare and relapse prevention, taking into account potential increased flow through the system over defined periods.
	Referral processes	Referral criteria and processes for people with common mental health disorders. Management of 'unable to attend' (UTAs) and 'did not attends' (DNAs).
	Response times	This should be needs-based and outcomes-based. Setting specific times, particularly for accessing psychological

		interventions
	Care pathways	Agreed clinical protocols or guidelines to support decision-making in the service-user pathway. Pathways for people with complex needs and comorbidities. Care coordination.
	Discharge Processes	Process for discharge from services for people with common mental health disorders, including aftercare and relapse prevention and communication with GPs and other relevant services.
	Staffing	Profile of existing health, social care and welfare workforce. Staffing levels to be funded: minimum band or levels of experience and competency and expected skill mix. Skill mix and competencies of staff for specific areas of care, for example low and high intensity psychological interventions.
	Information sharing	Define information-sharing, confidentiality and audit requirements, including IT support and infrastructure.

		Raising awareness of services for people with common mental health disorders among relevant health, social care and welfare professionals.
Quality assurance and clinical governance	Patient and public involvement	Processes to understand service-user experience of common mental health disorder services, in order to develop and monitor services. Expectations of how service-user opinion, preference and experience will be used to inform service delivery for example, focus groups, representation on working groups, and surveys. Monitoring of complaints and complements and how used to inform service.
	Quality indicators	Use NICE quality standards to define high-quality care. Service-user satisfaction surveys and access to treatment. Define outcomes measures.
	Performance monitoring	Local need and demand for treatment. Impact of service(s) on admissions to community mental health disorder services.

	Equality	Measures to ensure equality of access to services, taking into account the risks of unintentional discrimination against groups who are often under-represented, such as people who do not speak English as a first language. Consider equity of access for people living within residential and nursing homes and those who are housebound; or people within prisons.
	Staff training and competency	Training and competencies on recruitment and for ongoing development. Processes for monitoring clinical practice and competency, including professional registration and clinical supervision arrangements. Skill mix and competencies required across the care pathway, including competencies in: assessment, behavioural change, personalised care planning, management skills. See Skills for Health for examples. Staff development – appraisal and personal development plans, and mandatory training.

	Audit	Specify expectations for audit, which may include assessment, intervention, prescribing practices and successful treatment outcomes.
	Staff and service-user safety	Procedures for risk assessment. Formal procedures for incident reporting and monitoring. Address any safeguarding concerns and promote the welfare of vulnerable adults.
Activity Plan		Long-term impact of increased access to low and high intensity psychological interventions on referrals to other services and prescribing. Long-term impact of improved diagnosis of common mental health disorders on referrals to low and high intensity psychological interventions and on prescribing. Planned service development setting out any productivity improvements.
Cost	Value for money	Likely cost of new or additional services Anticipated set-up costs. Potential for better value for

		money. Are service-users receiving most appropriate services for the severity of their disorder? Cost of facilities, for example venue hire. Cost of staff travel to services and service-users' homes. QIPP.

7 The commissioning and benchmarking tool

Download the common mental health orders commissioning and benchmarking tool

Use the **commissioning and benchmarking tool** for common mental health disorders to determine the level of service that might be needed locally and to calculate the cost of commissioning the service, as described below.

7.1 Identify indicative local service requirements

There are 4 indicative benchmark rates used in the tool:

- At step 1, the indicative benchmark for people receiving services is 3.5%, or 3500 per 100,000 population aged 18 years and older per year.
- At step 2, the indicative benchmark for people receiving services is 1.6%, or 1600 per 100,000 population aged 18 years and older per year.
- At step 3, the indicative benchmark for people receiving services is 1.1%, or 1100 per 100,000 population aged 18 years and older per year.
- At step 4 and above, the indicative benchmark for people receiving services is 0.9%, or 900 per 100,000 population aged 18 years and older per year.

The commissioning and benchmarking tool helps you to assess local service requirements using the indicative benchmarks as a starting point. With knowledge of your local population

and its demographic, you can amend the benchmarks to better reflect your local circumstances. For example, if your population is significantly younger or older than the average population, or has an ethnic composition different from the national average, or has a significantly higher or lower rate of common mental health disorders (see section 4.2), you may need to provide services for relatively fewer or more people.

7.2 Review current commissioned activity

You may already commission a common mental health disorder service for your population. The tool provides tables that you can populate to help you calculate your total current commissioned activity and costs.

7.3 Identify future change in capacity required

Using the indicative benchmarks provided, or your own local benchmarks, you can use the commissioning and benchmarking tool to compare the activity that you might need to commission against your current commissioned activity. This will help you to identify the future change in capacity required. Depending on your assessment, your future provision may need to be increased or decreased.

7.4 Model future commissioning intentions and associated costs

You can use the commissioning and benchmarking tool to calculate the capacity and resources needed to move towards the benchmark levels, and to model the required changes over a period of 4 years.

Use the tool to calculate the level and cost of activity you intend to commission and to consider the settings in which services for people with common mental health disorders may be provided. Where possible the tool is pre-populated with data on the potential recurrent and non-recurrent cost elements that may need to be considered in future service planning, which can be reviewed and amended to better reflect your local circumstances.

The summary section of the tool calculates unit costs per service-user analysed by each step of the stepped care pathway. There are also unit cost calculations for indirect costs such as service design and management and improving access to services. This analysis, along with the supporting costing pages included in the tool may be helpful in assisting commissioners to identify local costs of such activities which are recommended in the guidance.

Commissioning decisions should consider both the clinical and economic viability of the service, and take into account the views of local people. Commissioning plans should also take into account the costs of monitoring the quality of the services commissioned.

7.5 Potential savings

Savings at local level are difficult to predict and are therefore not estimated in the commissioning and benchmarking tool. This section describes the type of savings and benefits that could occur from commissioning a common mental health disorder service:

- fewer inappropriate referrals to secondary mental health care services, including community mental health teams
- reduced use of hospital-based services as a result of increasing access to services in the local community and in primary care
- costs avoided from successful use of psychological interventions reducing the inappropriate use of medications such as antidepressants
- fewer GP visits to monitor progress and response to medication
- fewer GP visits, because of earlier identification
- wider economic savings from improved employability of people recovering from a common mental health disorder; this would deliver savings in the form of additional tax receipts and reduced welfare benefits payments.

Primary care: costs avoided and benefits

There may be cost savings in primary care as a result of reduced use of medication such as antidepressants if people respond to psychological therapies, and resources released in terms of reduced GP visits to monitor progress and response to medication. In research carried out by the Mental Health Foundation, 60% of GPs surveyed said they would prescribe antidepressants less frequently if other options were available to them[52].

[52] Mental Health Foundation (2005) Up and running! How exercise can help beat depression [online]. Available from www.mentalhealth.org.uk/content/assets/PDF/publications/up_running.pdf

Early intervention is important because this reduces the chance of subsequent admission to hospital. Early psychological treatment, though expensive, can significantly reduce repeat GP visits and drug prescriptions, which are becoming a serious burden on the NHS[53].

Secondary care: costs avoided and benefits

Providing psychological therapies to people who can benefit from them can help commissioners deliver greater efficiencies to the local health economy. A review of 91 studies showed that implementing psychological interventions achieved average savings of 20%, including immediate gains achieved by reducing outpatient appointments and treating people with long-term conditions[54].

A cost-benefit analysis study for psychological therapy[55] set out the likely cost savings achievable through completing the implementation of IAPT adult talking therapy services. This estimated that recovery from a common mental health disorder leads to reductions in healthcare use relating to GP consultations, outpatient appointments and referrals. As a result of improved access and earlier intervention there may be fewer cases of undetected common mental health disorders.

Other benefits and savings

Implementing the guidance is likely to result in benefits and savings outside the health service. The economic case for fully implementing the guidance is that it will improve employability of people who have been successfully treated. Improving access to services and providing choice and continuity of service is likely to result in people successfully completing treatment and allowing them to retain or regain employment. The effect of this is to deliver savings in the form of additional tax receipts and reduced welfare benefits payments.

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8 Further information

Table 19 summarises national drivers relevant to commissioning services for people with common mental health disorders. Local service redesign may address only one or two of them.

Table 19 National policy on common mental health disorders

Document	Author	Year	Significance
No health without mental health: a cross-Government mental health outcomes strategy for people of all ages	Department of Health	2011	Details shared objectives to improve mental health outcomes for the population, including improving recovery and service-user experience.
Talking therapies: a four year plan of action	Department of Health	2011	Details plan to complete roll-out of Improving Access to Psychological Therapies programme for adults of all ages who have depression or anxiety disorders.
NHS Outcomes Framework 2011/12	Department of Health	2011	Includes measures to enhance the quality of life and employment of people with mental illness and to improve service-user experience of community mental health services.
Transparency in outcomes: a framework for adult social	Department of Health	2011	Includes measures to enhance the quality of life

care			and employment of people with mental illness.
NHS operating framework for 2011/12	Department of Health	2011	Sets out focus on early intervention and prevention to reduce the likelihood of mental illness developing and increasing access to psychological interventions through Improving Access to Psychological Therapies.
Healthy lives, healthy people: our strategy for public health in England	Department of Health	2010	Focuses on economic benefits and health outcomes of improving mental health and wellbeing at a population level.
Using the Commissioning for Quality and Innovation (CQUIN) payment framework – a summary guide	Department of Health	2010	Makes a proportion of providers' income conditional on quality and innovation.

Other useful sources of information for developing common mental health disorder services may include:

- The standard NHS contracts for acute hospital, mental health, community and ambulance services.

- NHS Evidence: provides free access to clinical and non-clinical information – local, regional, national and international; includes a QIPP library with case studies and commissioning zone.
- The NICE shared learning database offers examples of how commissioners and service providers have used NICE guidance to create innovative and effective local implementation programmes for service improvements.
- NICE pathway for depression in adults
- NICE public health guidance 22 on promoting mental wellbeing at work
- NICE public health guidance 12 on social and emotional wellbeing in primary education and 20 on social and emotional wellbeing in secondary education
- Skills for Health Digest of National Occupational Standards for psychological therapies.
- The Quality and outcomes framework (QOF) is a voluntary quality incentive scheme that rewards general practices for implementing systematic improvements in the quality of service-user care; the QOF includes indicators on depression.

Sources of further information to help you assess local health needs and reduce health inequalities include:

- NHS Evidence provides free access to clinical and non-clinical information – local, regional, national and international. Information includes evidence, guidance and government policy.
- Department of Health Delivering quality and value – focus on benchmarking.
- NICE Health equity audit – learning from practice briefing.
- NHS Comparators provides comparator data for NHS commissioning and provider organisations to enable users to investigate aspects of local activity, costs and outcomes.
- The Disease management information toolkit (DMIT) is a good-practice tool for decision-makers, commissioners and deliverers of care for people with long-term conditions.
- Disease prevalence models produced by the Association of Public Health Observatories provides primary care trust-level prevalence estimates.
- PRIMIS+ provides support to general practices on information management, recording for, and analysis of, data quality, plus a comparative analysis service focused on key clinical topics.

- SHAPE (Strategic health asset planning and evaluation) application provides support to strategic health authorities and primary care trusts on strategic planning across a whole health economy.
- The Joint Strategic Needs Assessment Information centre resource looks at the wider determinants of health, working with PCTs, Local Authorities and third sector providers.

9 Topic Advisory Group: common mental health disorder services

A topic advisory group was established to review and advise on the content of the guide for commissioners. This group met once, with additional interaction taking place via email.

Lee Beresford - Head of commissioning, NHS Wakefield

Dr Paul Blenkiron - Consultant Psychiatrist and NICE Fellow, NHS North York and Yorkshire

Dr Mark Boon - GP, Conisborough Group Practice and GP IAPT Advisor, Doncaster

Dr Barbara Compitus - GP, Southville Surgery, Bristol and GP lead for Mental Health, NHS Bristol

Erica Crisp - Senior Commissioning Manager (mental health), NHS Halton and St Helens

Professor Linda Gask - Professor of Primary Care Psychiatry, University of Manchester and Honorary Consultant Psychiatrist, Royal College of Psychiatrists and NHS Salford

Dr Anna Higgitt - Consultant Psychiatrist, Central and North West London NHS Foundation Trust

Kevin Jarman - Operations, Delivery and Finance Lead, Department of Health

Pavlo Kanellakis - Consultant Psychologist and Director of Psychology, KCA UK

Rufaro Kausi - Commissioning and Provider Development Manager (Improving Access to Psychological Therapies), Department of Health

Lynn Marsden - Senior Commissioning Manager and CSP early detection of depression lead, NHS Halton and St Helens

Helena Savage - Partnership Project Manager, NHS North Lancashire

Dorothy Spicer - Team Leader primary care mental health and counselling, Selby and York

Dr Michael Taylor - GP, Rochdale, Heywood and Middleton

Fenella Trevillion - Head of Partnerships, NHS Oxfordshire

Alex Walker - Lead Commissioner for primary care and community services, NHS Central Lancashire

Dr Nick White - Consultant Clinical Psychologist, Hertfordshire Partnership NHS Foundation Trust

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Carole Hirst - Director Psychological Therapies, Rotherham Doncaster and South Humber NHS Foundation Trust

Dr Phil McEvoy - Managing Director, Six Degree Social Enterprise CIC

Marie-Claire Shankland - Director, IAPT Sheffield

Dr Rob Tandy - Senior Trainee in general psychiatry, Central and North West London NHS Foundation Trust

Dr Tom Tasker - GP with Special Interest in Mental Health, NHS Salford