NHS
National Institute for
Health and Clinical Excellence

Cognitive behavioural therapy for the management of common mental health problems

Commissioning guide

Implementing NICE guidance

April 2008

Cognitive behavioural therapy for the management of common mental health problems

This commissioning guide provides support for the local implementation of NICE clinical guidelines through commissioning, and is a resource to help health professionals in England to commission appropriate levels of cognitive behavioural therapy (CBT) for the treatment of depression, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and anxiety in primary care.

Although this commissioning guide focuses on CBT, other available psychological therapies include behaviour therapy, interpersonal therapy, problem-solving therapy, non-directive counselling and short-term psychodynamic psychotherapy. Commissioners should therefore consider securing the appropriate provision of psychological therapies services according to the needs of their population.

This commissioning guide covers the commissioning of CBT services for adults only. The commissioning arrangements for Child and Adolescent Mental Health Services are separate and distinctive from those for adults and are not covered in this guide.

References to anxiety within this guide mean generalised anxiety disorder or panic disorder (with or without agoraphobia) as per the definition of anxiety in the NICE clinical guideline CG22 (amended) 'Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care.

This commissioning guide should be read in conjunction with the following NICE guidance:

- NICE clinical guideline CG22 (amended) 'Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care'
- NICE clinical guideline CG90 Depression (update)
- NICE clinical guideline CG26 'Post-traumatic stress disorder (PTSD): the management of PTSD in adults and children in primary and secondary care'
- NICE clinical guideline CG31 'Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder'
- NICE technology appraisal TA97 'Computerised cognitive behaviour therapy for depression and anxiety'.

The guidance covers clinical and cost effectiveness in detail and underpins the content of this guide. Implementation of the guidance noted above is the

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

The guide:

- makes the case for commissioning a service providing CBT
- specifies service requirements
- helps you determine local service levels
- helps you ensure corporate and quality assurance.

The full text of this commissioning guide is accessed from the navigation menu on the right hand side of the screen. The associated commissioning tool (add link to the commissioning tool) is available until 25 June 2010 to primary care organisations in England who are already registered to use the tool. New registrations for the existing commissioning tool will not be possible after 31 March 2010.

From 1 April 2010 the new freely available commissioning and benchmarking tool can be downloaded here. There is no need to register.

We are keen to improve the commissioning guides in order to better meet the needs of commissioners. Please send us your ideas for future topic-specific guides or other comments.

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Topic-specific Advisory Group: cognitive behavioural therapy

Commissioning a service providing cognitive behavioural therapy for the management of common mental health problems

Cognitive behavioural therapy (CBT) is an effective treatment option for many mental health problems and is indicated for people with depression, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and anxiety. The purpose of therapy is to reduce distress or unwanted behaviour by undoing previous learning or by providing new, more adaptive learning experiences.

CBT is one of a broad range of psychotherapies. Other psychotherapies are behaviour therapy, interpersonal therapy, problem-solving therapy, non-directive counselling and short-term psychodynamic psychotherapy. CBT is brief, highly structured, problem orientated and prescriptive, and individuals are active collaborators. The way in which CBT is delivered varies depending on the individual's needs. For example, it may be delivered by trained therapists who can be from a number of disciplines, including clinical psychologists, mental health nurse specialists and psychiatrists, or via an interactive computer interface - computerised CBT (CCBT). The optimal length of therapy will vary among individuals and conditions.

CBT's evidence base, short-term nature and economical use of resources have made it attractive to clients, practitioners and service purchasers. However, in many places around the country NHS psychological therapies, including CBT, are either unavailable or subject to significant delays. This is because of the high level of demand, the limited availability of therapists and a lack of clear referral criteria and pathways. Improving access to psychological therapies is the subject of a public service agreement between the Department of Health and the Treasury, and is an NHS Operating Framework 2008/09 'vital sign'. The operating framework states that primary care trusts should start preparing for these services being more widely available in the future, and that they should begin planning now how they will implement a stepped care psychological therapies service following the NICE guidelines. The first step for primary care trusts is to carry out a needs assessment of their local population.

Benefits

The potential benefits of robustly commissioning an effective service providing CBT for the management of common mental health problems include:

- **reducing the risk** of people proceeding to a more severe form of their condition
- **reducing the suicide risk**

- **reducing the number of antidepressant medications prescribed**
- **reducing referrals to secondary care services**
- **providing access to coping** strategies and support as an alternative to taking sick leave from work because of depression
- **retaining employment**, even where the individual may suffer from stress, anxiety or depression, and enabling people on benefits to return to work more quickly
- **improving performance and patient-centred clinical care** through implementing the recommendations outlined in NICE clinical guidelines CG22 on anxiety, CG90 on depression, CG26 on PTSD, CG31 on OCD and NICE technology appraisal TA97 on CCBT.
- **reducing inequalities** and improving access to CBT
- **increasing patient choice**, and improving partnership working, patient experience and engagement
- **better value for money**, through helping commissioners to manage their commissioning budgets more effectively – this may include opportunities for clinicians to undertake local service redesign to meet local requirements in novel ways.

Key clinical issues

Key clinical issues in providing an effective service offering CBT for the management of common mental health problems are:

- **recognising and accurately diagnosing common mental health problems**
- **providing comprehensive assessment and accurately differentiating** between people with either mild/moderate depression or severe depression, **identifying** PTSD despite the presence of comorbidities and **assessing** the degree of functional impairment of people with OCD
- **ensuring that services providing CBT are integrated** with other services for people with depression, OCD, PTSD or anxiety to ensure continuity of care
- **providing a quality assured service**.

National priorities

National priorities and initiatives relevant to commissioning a service providing CBT for the management of common mental health problems include:

- National service framework for mental health: modern standards and service models

- Improving Access to Psychological Therapies implementation plan: national guidelines for regional delivery
- Improving Access to Psychological Therapies commissioning toolkit
- Improving Access to Psychological Therapies (IAPT) programme: computerised cognitive behavioural therapy (CCBT) implementation guidance
- Choices in Mental Health
- Commissioning a brighter future: improving access to psychological therapies – positive practice guide
- Delivering the 18 week patient treatment pathway
- World class commissioning
- The NHS in England: The operating framework for 2009/10
- Commissioning framework for health and well-being
- The Expert patients programme
- Implementation of NICE clinical and public health guidelines. These are core standards, and performance against these standards will be assessed by the Care Quality Commission in line with Standards for better health.

Although many or all of these priorities may be relevant to the services nationally, your local service redesign may address only one or two of them.

Specifying a service providing cognitive behavioural therapy for the management of common mental health problems

Service components

The key components of a service providing cognitive behavioural therapy (CBT) for the management of common mental health problems are:

- recognising and diagnosing common mental health problems
- using stepped care
- developing a high-quality service providing CBT.

Recognising and diagnosing

The recognition and diagnosis of common mental health problems can be challenging. The NICE clinical guidelines make recommendations for accurately diagnosing patients presenting with depression, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and anxiety. Commissioners will wish to ensure that adequate arrangements are in place so that patients can be properly diagnosed. It is important as part of the diagnostic process to assess the severity of the patient's illness as this determines the intensity of intervention recommended by the guidance. See a summary of CBT interventions recommended by NICE guidance.

Stepped care

The NICE clinical guidelines for the management of depression and anxiety but not PTSD, and the treatment of OCD, follow a stepped care model. Stepped care provides a framework in which the provision of services can be organised to support patients, carers and healthcare professionals to identify and access the most effective, but least intrusive, intervention appropriate to a person's needs.

The intervention given in stepped care models ranges from 'low intensity' to 'high intensity'. Relatively brief interventions provided at step 2 are often described as low-intensity treatment. Treatment provided at step 3 for patients with more severe symptoms or who have not responded to low-intensity treatment is known as high intensity. It is expected that many patients will have had access to treatments on lower steps before receiving treatments from higher steps. Starting treatments on lower steps may produce several benefits. For example, where patients with moderate or severe depression benefit from initial brief psychological interventions, this could reduce the burden of more intensive treatment on the patient, service providers and commissioners. Stepped care systems need to ensure a smooth transition between steps so that patient experience is not disjointed.

Any local **care pathway** should describe the way in which patients move through the stepped care process, by whom they are treated and at what point.

In line with the stepped care model, commissioners will wish to ensure that services providing CBT are part of a comprehensive care pathway for patients. However, it is important to recognise that psychotherapies other than CBT – including behaviour therapy, interpersonal therapy, problem-solving therapy, non-directive counselling and short-term psychodynamic psychotherapy – may be appropriate for some patients. Commissioning a brighter future: Improving Access to Psychological Therapies – positive practice guide describes the key stages that primary care trusts (PCTs) need to consider in order to commission the appropriate range of psychological therapies to meet the common mental health needs of the local community.

Developing a high-quality service providing CBT for the management of common mental health problems

Improving Access to Psychological Therapies **outlines service specification**, produced by the Care Services Improvement Partnership (CSIP) and National Institute of Mental Health in England (NIMHE), describes general **service principles** and provides a broad framework to enable and encourage opportunities for service innovation of individual commissioners and providers.

Within the NHS, a wide range of health professionals deliver psychological therapies. Most of these practitioners have a primary professional qualification, but the extent of training in psychological therapy in general, and in CBT in particular, varies between the professions, as does the extent to which the practitioners have acquired additional post-qualification training. Commissioners will wish to ensure that **therapists are competent** to deliver low-intensity and high-intensity CBT to a high standard, and that the service has enough therapists to meet the needs of the local population. The competences required to deliver effective cognitive and behavioural therapy for people with depression and with anxiety disorders identifies the activities associated with the delivery of high-quality cognitive and behavioural therapy and the competences required to achieve these.

Computerised CBT (CCBT) is an alternative to therapist-delivered CBT, and is a generic term used to refer to a number of methods of delivering CBT via an interactive computer interface. It can be delivered on a personal computer, over the Internet or via the telephone using interactive voice response systems. A wide range of health or social care personnel can be used to facilitate the sessions. Improving Access to Psychological Therapies programme (IAPT): computerised cognitive behavioural therapy (CCBT) implementation guidance provides advice and support on how PCTs can provide CCBT to their local communities.

Commissioners may wish to consider CBT for the management of common mental health problems in a number of different ways, and mixed **service**

models of provision may be appropriate across a local health economy. Commissioners may want to consider a range of access routes to services providing CBT, although the majority of referrals will be from primary care, and will need to be confident that appropriate referral and/or self-referral processes are in place to support such access. The Department of Health has launched a programme of talking therapy projects.

The Improving Access to Psychological Therapies Commissioning Toolkit can help PCTs improve or establish stepped care psychological therapies following NICE guidelines. Structured around the commissioning cycle, and linked to the world class commissioning competencies, it brings together a wide range of existing tools and guides and includes positive practice examples throughout. The Improving Access to Psychological Therapies implementation plan: national guidelines for regional delivery provides strategic health authorities, PCTs, training providers and service providers with an overview of what is needed to deliver IAPT, including CBT.

Local stakeholders, including service users and carers, should be involved in determining what level and character of CBT is provided for the management of common mental health problems in order to meet local needs. CBT should be patient-centred and integrated with other elements of care for people/patients with depression, OCD, PTSD and anxiety. As part of this, consideration should be given to ease of access and service location; commissioners should engage with service users and other relevant individuals and organisations locally.

The service specification needs to consider:

- the required competences of, and training for, staff responsible for providing the service
- the expected number of patients (this should take into account how quickly any changes in service provision are likely to take place)
- ease of access and service location; commissioners should engage with service users and other relevant individuals and organisations locally
- care and referral pathways
- information and audit requirements, including IT support and infrastructure
- planned service improvement, including redesign, quality, equitable access, and referral-to-treatment times according to the 18 week patient pathway or equitable waiting times locally for those services currently outside 18 weeks
- service monitoring criteria.

Further useful sources of information may include:

- ‘Delivering the 18 week patient pathway: 18 week commissioning pathways’
- The ‘Map of medicine’ provides an information resource that visually organises the latest evidence and best practice guidelines
- The NICE ‘shared learning’ database offers examples of how organisations have implemented NICE guidance locally
- NICE cost impact report for NICE clinical guideline CG90 on depression
- NICE cost impact report for NICE clinical guideline CG31 on obsessive-compulsive disorder
- NICE implementation advice for NICE clinical guideline CG31 on obsessive-compulsive disorder
- NICE cost impact report for NICE clinical guideline CG26 on post-traumatic stress disorder
- NICE analysis of cost impact for NICE technology appraisal TA97 on computerised cognitive behavioural therapy for anxiety and depression

Summary of cognitive behavioural therapy interventions recommended by NICE

Depression

Mild severity

The NICE clinical guideline CG90 on depression states that a number of brief psychological interventions are effective in mild depression. The choice of treatment should reflect the patient's preference based on informed discussion, past experience of treatment and the fact that the patient may not have benefited from other brief interventions. Psychological treatment specifically focussed on depression such as brief cognitive behavioural therapy (CBT) of 6–8 sessions over 10–12 weeks (low intensity) should be considered.

NICE technology appraisal TA97 on computerised CBT for depression and anxiety recommends a computerised CBT (CCBT) package called Beating the Blues as an option for delivering CBT in the management of mild depression.

Moderate severity

The NICE clinical guideline CG90 on depression recommends that all patients with moderate depression should be offered antidepressant medication before psychological interventions. Psychological treatment specifically focussed on depression such as brief cognitive behavioural therapy (CBT) of 6–8 sessions over 10–12 weeks (low intensity) should be considered.

NICE technology appraisal TA97 on computerised CBT for depression and anxiety recommends a computerised CBT (CCBT) package called Beating the Blues as an option for delivering CBT in the management of moderate depression.

Moderate to severe

A number of structured psychological interventions of longer duration, usually of 16–20 sessions over 6–9 months (high intensity) from an appropriately trained member of the mental health team are effective. In addition to the evidence for their effectiveness, the choice of treatment will reflect patient preference and past experience of treatment. When patients present initially with severe depression, a combination of antidepressants and individual CBT should be considered as the combination is more cost-effective than either treatment on its own.

Anxiety

The NICE clinical guideline CG22 on anxiety does not distinguish between mild, moderate and severe forms of generalised anxiety disorder or of panic

disorder. A higher intensity of treatment is recommended for generalised anxiety disorder than for panic disorder.

Panic disorder

Low-intensity CBT in the optimal range of duration (7–14 hours in total) should be offered for people with panic disorder, and for most people CBT should take the form of weekly sessions of 1–2 hours and be completed within a maximum of 4 months of commencement.

NICE technology appraisal TA97 on CCBT for depression and anxiety recommends a CCBT package called Fear Fighter as an option for delivering CBT in the management of panic disorder.

Generalised anxiety disorder

High-intensity CBT in the optimal range of duration (16–20 hours in total) should be offered to people with generalised anxiety disorder, and for most people CBT should take the form of weekly sessions of 1–2 hours and be complete within a maximum of 4 months from commencement.

Obsessive-compulsive disorder

Mild functional impairment

NICE clinical guideline CG31 on obsessive-compulsive disorder recommends that in the initial treatment of adults with obsessive-compulsive disorder (OCD), low-intensity psychological treatments (including exposure and response prevention [ERP]) (up to 10 therapist hours per patient) should be offered if the patient's degree of functional impairment is mild and/or the patient expresses a preference for a low-intensity approach. Low-intensity treatments include:

- brief individual CBT (including ERP) using structured self-help materials
- brief individual CBT (including ERP) by telephone
- group CBT (including ERP) (note, the patient may be receiving more than 10 hours of therapy in this format).

Moderate functional impairment

Adults with OCD with moderate functional impairment or those with mild functional impairment who are unable to engage in low-intensity CBT (including ERP), or for whom low-intensity treatment has proved to be inadequate, should be offered the choice of either a course of a selective serotonin reuptake inhibitor (SSRI) or more intensive CBT (including ERP) (more than 10 therapist hours per patient), because these treatments appear to be comparably efficacious.

Severe functional impairment

Adults with OCD with severe functional impairment should be offered combined treatment with an SSRI and CBT (including ERP).

Body dysmorphic disorder

Mild functional impairment

NICE clinical guideline CG31 on OCD recommends that adults with body dysmorphic disorder (BDD) with mild functional impairment be offered a course of CBT (including ERP) that addresses key features of BDD in individual or group formats. The most appropriate format should be jointly decided by the patient and the healthcare professional.

Moderate functional impairment

Adults with BDD with moderate functional impairment should be offered the choice of either a course of an SSRI or more intensive individual CBT (including ERP) that addresses key features of BDD.

Severe functional impairment

Adults with BDD with severe functional impairment should be offered combined treatment with an SSRI and CBT (including ERP) that addresses key features of BDD.

Post-traumatic stress disorder

PTSD where symptoms are present within 3 months of a trauma

NICE clinical guideline CG26 on post-traumatic stress disorder (PTSD) recommends that trauma-focused CBT should be offered to those with severe post-traumatic symptoms or with severe PTSD in the first month after the traumatic event. These treatments should normally be provided on an individual outpatient basis.

Trauma-focused CBT should be offered to people who present with PTSD within 3 months of a traumatic event.

The duration of trauma-focused CBT should normally be 8–12 sessions, but if the treatment starts in the first month after the event, fewer sessions (about 5) may be sufficient. When the trauma is discussed in the treatment session, longer sessions (for example, 90 minutes) are usually necessary. Treatment should be regular and continuous (usually at least once a week) and should be delivered by the same person.

PTSD where symptoms have been present for more than 3 months after a trauma

All PTSD sufferers should be offered a course of trauma-focused psychological treatment (trauma-focused CBT or eye movement desensitisation and reprocessing). These treatments should normally be provided on an individual outpatient basis.

The duration of trauma-focused psychological treatment should normally be 8–12 sessions when the PTSD results from a single event. When the trauma is discussed in the treatment session, longer sessions than usual are generally necessary (for example 90 minutes). Treatment should be regular and continuous (usually at least once a week) and should be delivered by the same person.

Healthcare professionals should consider extending the duration of treatment beyond 12 sessions if several problems need to be addressed in the treatment of PTSD sufferers, particularly after multiple traumatic events, traumatic bereavement, or where chronic disability resulting from the trauma, significant comorbid disorders or social problems are present. Trauma-focused treatment needs to be integrated into an overall plan of care.

Stepped care models

Anxiety

The quick reference guide (amended) for NICE clinical guideline CG22 on anxiety summarises the stepped approach to care for the management of anxiety, which recommends care at different stages of the patient journey, represented as different steps:

Step 1: Recognition and diagnosis

Step 2: Treatment in primary care

Step 3: Review and consideration of alternative treatments

Step 4: Review and referral to specialist mental health services

Step 5: Care in specialist mental health services

Depression

The quick reference guide (amended) for NICE clinical guideline CG90 on depression identifies a stepped care framework that aims to match the needs of people with depression to the most appropriate services, depending on the characteristics of their illness and their personal and social circumstances. Each step represents increased complexity of intervention, with higher steps assuming interventions in previous steps.

Step 1: Recognition in primary care and general hospital settings

Step 2: Treatment of mild depression in primary care

Step 3: Treatment of moderate to severe depression in primary care

Step 4: Treatment of depression by mental health specialists

Step 5: Inpatient treatment for depression

Obsessive-compulsive disorder

The quick reference guide for NICE clinical guideline CG31 on obsessive-compulsive disorder summarises the stepped care model, which aims to provide the most effective but least intrusive treatment appropriate to an individual's needs. It assumes that the course of the disorder is monitored and that referral to the appropriate level of care is made depending on the person's difficulties. Each step introduces additional interventions; the higher steps normally assume that interventions in previous steps have been offered and/or attempted. However, there may be situations where an individual may be referred to appropriate care at any level.

Step 1: Awareness and recognition by individuals, public organisations and the NHS

Step 2: Recognition and assessment by GPs, primary care and general health settings (including hospitals)

Step 3: Management and initial treatment by GPs, primary care team, primary care mental health workers, family support teams

Step 4: Multidisciplinary care in primary or secondary care

Step 5: Multidisciplinary care with expertise in obsessive-compulsive disorder/body dysmorphic disorder

Step 6: Inpatient care or intensive treatment programmes

Determining local service levels for a service providing cognitive behavioural therapy for the management of common mental health problems

Benchmarks for a standard population

Available data suggest that the standard benchmark rate of referrals for cognitive behavioural therapy (CBT) is **3%**, or 3000 per 100,000 population, aged 15 years or older **per year**. This includes those people who would be suitable for and willing to participate in computerised CBT (CCBT).

For the purpose of this commissioning guide the adult population has been defined as people aged 15 years or older. This is due to the availability of population data at general practice level within certain age bands and its use within the commissioning and benchmarking tool. Approximately 80% of the English population is aged 15 years or older.

For a **standard primary care trust** population of 250,000 (around 200,000 people are aged 15 years or older), the average number of people requiring referral for CBT would be **6000 per year** (or 3% of the population aged 15 years or older).

For an **average practice** with a list size of 10,000 (around 8000 are aged 15 years or older), the average number of people requiring referral for CBT would be **240 per year** (3% of the population aged 15 years or older).

The NICE clinical guideline CG90 on depression states that for mild depression a number of brief psychological interventions are effective. Many patients with milder depression respond to interventions such as exercise or guided self-help, although many improve while being monitored without additional help. More structured therapies, such as problem-solving, brief CBT or counselling can be helpful. The topic-specific advisory group suggested that commissioners may wish to focus their effort on commissioning CBT (high intensity) for people with moderate to severe depression as this is the area where there are greatest deficits in service provision, and where the greatest potential exists for commissioners to make a significant contribution to service improvement.

CBT is likely to fall under the programme budgeting category 205X (other mental health disorders).

Examine the assumptions used in estimating these figures.

Use the CBT 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.

Further information

Sources of further information to help you in assessing local health needs and reducing health inequalities include:

- Annex A of the 'Commissioning framework for health and well-being' outlines the process and data needed to undertake a joint strategic needs assessment.
- Department of Health 'Delivering quality and value – focus on benchmarking'.
- NICE 'Health equity audit – learning from practice briefing'.
- 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.

Assumptions used in estimating a population benchmark

The assumptions used in estimating a population benchmark of referrals for cognitive behavioural therapy (CBT) of 3% per year of the adult population (defined as 15 years or older) are based on the following sources of information:

- **epidemiological data** on the prevalence/incidence of anxiety and depression
- **current practice** on the numbers of people detected in primary care
- **published research** on the detection of anxiety and depression in primary care and treatment preferences
- **expert clinical opinion** of the topic-specific advisory group, based on experience in clinical practice and literature review.

Epidemiological data

Depression and mixed anxiety and depression

The survey on psychiatric morbidity conducted by the Office for National Statistics in 2000[1] found that the prevalence of depression among adults in Great Britain was 2.6%. The prevalence of mixed anxiety and depression was estimated to be 8.8%. This gives a combined total of **11.4%** of adults of whom 36% are expected to have mild depression (with or without anxiety), 43% are expected to have moderate depression (with or without anxiety) and 21% are likely to have severe depression (with or without anxiety).

Mixed anxiety and depression was defined in the psychiatric morbidity survey report as a 'catch-all' category that included people with significant symptoms which could not be coded into any of the other conditions included in the survey.

NICE clinical guideline CG22 on anxiety states that when someone has anxiety with depression the NICE clinical guideline CG90 on depression should be followed.

Panic disorder, generalised anxiety disorder and obsessive-compulsive disorder

The psychiatric morbidity survey found the population prevalence of generalised anxiety disorder (GAD) to be **4.4%,** panic disorder (PD) to be **0.7%**, and obsessive-compulsive disorder (OCD) to be **1.1%**.

In some instances it is difficult to distinguish GAD and PD, and co-morbidity is very common with other anxiety disorders, depression and mood disorders[2].

Post-traumatic stress disorder and body dysmorphic disorder

No large-scale surveys have been conducted to estimate the prevalence of post-traumatic stress disorder (PTSD) and body dysmorphic disorder (BDD) in the English population.

NICE clinical guideline CG31 on obsessive-compulsive disorder (OCD) suggests that the population prevalence of BDD in England is between 0.5% and 0.7%.

The NICE cost impact report for CG26 on PTSD suggests a population prevalence of PTSD in England of around 1.5%. However, commissioners should be aware that the prevalence is likely to be higher in some groups in the population – for example, members of the armed forces[3], asylum seekers and refugees[4].

The psychiatric morbidity survey did not cover PTSD or BDD but did group all people with significant symptoms who could not be coded into any of the other conditions included in the survey into 'mixed anxiety and depression'. Therefore it has been assumed that PTSD and BDD are counted within this group.

Taking these assumptions into account, the combined results from the psychiatric morbidity survey suggest that, at any one time, **17.6%** of the population have either depression, mixed anxiety and depression (which we have assumed includes those people with PTSD and BDD), panic disorder, generalised anxiety disorder or OCD.

However, it should also be recognised that anxiety disorders and depression are often undiagnosed, and many people with anxiety disorders and/or depression do not seek treatment.

The Improving Access to Psychological Therapies programme workforce and gap analysis tool supports commissioners to estimate the number of new workers required to manage the demand for psychological treatment in their area. The tool uses data from the psychiatric morbidity survey, with the assumptions that of those in the population with symptoms, 50% may present to services and of those that present to services, 50% are likely to have the symptoms detected. Applying these two assumptions to the prevalence of **17.6%** estimated above suggests that **4.40%** of the population are likely to present to services and have their symptoms detected per year.

Current practice

IMS Disease Analyser is a database that holds data from a sample of GP practice systems. Data were extracted to give a snapshot of 1 year's activity within general practice.

Results of analysis of these data suggest that around **4.95%** of the population come into contact with GP services per year and are diagnosed as having either depression or mixed anxiety and depression.

The following estimates are based on people with panic disorder (PD), generalised anxiety disorder (GAD), obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD) presenting at GP services within a year. The average rate of detection in general practice per year of:

- PD is estimated to be **0.76%** of the adult population
- GAD is estimated to be **0.23%** of the adult population
- OCD is estimated to be **0.07%** of the adult population
- PTSD is estimated to be **0.05%** of the adult population.

Therefore, it is estimated that around **6.06%** of the adult population (defined as 15 years or older) present to GP services with one or more of the above conditions – that is, depression including mixed anxiety and depression, PD, GAD, OCD and PTSD per year. Some of the people in these groups will have symptoms of recent onset whereas others will have recurrent symptoms that have caused them to present to GP services again in the 12-month period for which data were extracted.

The data used in the analysis of diagnosed depression and anxiety rely on the quality of the information recorded within patients' medical records. Therefore poor recognition and recording of these conditions may lead to an underestimation of total numbers of people who present to general practice each year.

These estimates therefore provide an example of current detection rates and recording practices in primary care, not the rates that may be expected if detection of these conditions in primary care was improved.

Published research

Treatment preferences need to be taken into account, as people who do not receive their preferred treatment often fail to begin or complete treatment[5].

Research by Marks and co-workers (2003)[6] suggested that a maximum of 64% of patients with mild or moderate depression and anxiety would be suitable for and willing to participate in computerised CBT (CCBT).

Expert clinical opinion

The consensus opinion of the topic-specific advisory group was that:

- The take up of CBT among people identified with depression and anxiety conditions is unknown. However, people with depression and anxiety who present to services and have their symptoms recognised tend to be people seeking help for their condition. This means that the take up of services among these groups is likely to be high compared with those people with these conditions in the population who do not actively seek help.

- On average, based on clinical experience, it is expected that around 50% to 70% of people who present to services with either depression or anxiety would take up CBT. However, there is likely to be some variation in the take up of CBT between groups of people with different conditions.

Conclusions

Based on the epidemiological data and other information outlined above, it is concluded that the benchmark for referral for CBT is **3%**. This is based on the following assumptions:

- the detection rate of depression including mixed anxiety and depression, PD, GAD, PTSD and OCD (based on a year's snapshot of activity in general practice) is around 6.06% of the adult population
- the estimated levels of detection of depression, including mixed anxiety and depression, PD, GAD, PTSD and OCD in general practice, based on the prevalence of conditions in the adult population is estimated to be around 4.40% of the adult population per year
- the mid point of the above two estimates (4.40 and 6.06) is 5.23%
- the take up of CBT among people with depression including mixed anxiety and depression, PD, GAD, PTSD, OCD and BDD who present to services is expected to be around 60% (mid point of the estimates provided by the topic-specific advisory group).

Therefore the population benchmark for CBT for the management of common mental health problems is estimated to be **3%**.

The NICE clinical guideline CG90 on depression states that for mild depression a number of brief psychological interventions are effective. Many patients with milder depression respond to interventions such as exercise or guided self-help, although many improve while being monitored without additional help. More structured therapies, such as problem-solving, brief CBT or counselling can be helpful. The topic-specific advisory group suggested that commissioners may wish to focus their effort on commissioning CBT (high intensity) for people with moderate to severe depression as this is the area where there are greatest deficits in service provision, and where the greatest potential exists for commissioners to make a significant contribution to service improvement.

Use the CBT 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.

References

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The commissioning and benchmarking tool

Download the cognitive behavioural therapy (CBT) commissioning and benchmarking tool

Use the cognitive behavioural therapy (CBT) commissioning and benchmarking tool to determine the level of service that might be needed locally and to calculate the cost of commissioning the service.

Identify indicative local service requirements

The indicative benchmark based on the national average for CBT is **3%**.

The commissioning and benchmarking tool helps you to assess local service requirements using the indicative benchmark as a starting point. With knowledge of your local population and its demographic, you can amend the benchmark to better reflect your local circumstances. For example, if your population is significantly younger or older than the average population, or has a greater number of people serving in the armed services, or a higher number of refugees you may need to provide services for relatively fewer or more people.

Review current commissioned activity

You may already commission services providing CBT for your population. The tool provides tables that you can populate to help you calculate your current commissioned activity and costs.

Identify future change in capacity required

Using the indicative benchmark provided, or your own local benchmark, 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.

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 level, 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 the service providing CBT for the management of common mental health problems may be provided, comparing the costs of commissioning the service across the various settings. The tool is pre-populated with data on the 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.

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.

Ensuring corporate and quality assurance

Commissioners should ensure that the services they commission represent value for money and offer the best possible outcomes for patients. Commissioners need to set clear specifications for monitoring and assuring quality in the service contract.

Commissioners should ensure that they consider both the clinical and economic viability of the service, and any related services, and take into account patients' and carers' views and those of other stakeholders when making commissioning decisions.

A service providing cognitive behavioural therapy (CBT) for the management of common mental health problems needs to:

- **Be effective and efficient**.
- **Be responsive to the needs of patients** and carers.
- **Provide treatment and care based on best practice**, as defined in the following NICE clinical guidelines: CG22 on anxiety, CG90 on depression, CG26 on post-traumatic stress disorder (PTSD), CG31 on obsessive-compulsive disorder (OCD); and the NICE technology appraisal TA97 on computerised CBT.
- **Deliver the required capacity**
- **Be integrated** with other elements of care for people with moderate to severe depression, anxiety, OCD and PTSD.
- **Define agreed criteria for referral**, local protocols and the care pathway for people requiring CBT for common mental health problems.
- **Be patient-centred and provide equitable access**, ensuring that patients are treated with dignity and respect, are fully informed about their care and are able to make decisions about their care in partnership with healthcare professionals
- **Demonstrate how it meets requirements under equalities legislation**
- **Demonstrate value for money**. See the NHS Purchasing and Supply Agency framework agreement for the purchase of NICE approved computerised CBT software packages.

Local quality assurance

Any mechanisms for quality assurance at a local level are likely to refer to the following.

- **Service and performance targets**, including estimated activity levels and case mix, and waiting and referral-to-treatment times.

Improving Access to Psychological Therapies Commissioning Toolkit identified that best practice sites are working towards achieving maximum waiting times of ten working days from referral to treatment for people with mild or moderate conditions. When estimated levels of activity have been determined for the local population requirements, commissioners may wish to monitor actual against planned activity levels and to develop local strategies for the early identification and appropriate referral of people with depression and anxiety.

- **Clinical quality criteria**: appropriateness of referral, clinical protocols.
- **Audit arrangements**: frequency of reporting, reporting route and format, and dissemination mechanisms. This should include auditing the proportion of eligible people requiring CBT who are provided with care, and monitoring of patient outcomes. See the IAPT programme outcome framework and data collection tool. The IAPT programme also recommends that services begin to monitor the delivery of waiting times at key points on the care pathway – from referral to treatment at each level of the stepped care model.
- **Health, safety and security**: waste management, confidentiality procedures, legislative requirements.
- **Equipment**: testing.
- **Accreditation requirements**: for some or all elements of the service, the premises and/or staff.
- **Clinical governance** arrangements, including incident reporting.
- **Patient satisfaction**: patient and carer perspective and perception of service provision, complaints.
- **Staff competences**: individual and team baseline requirements, monitoring and performance.
- **Information requirements**, including both patient-specific information (NHS number, referring GP, provision of high-quality information to patients/carers) and service-specific information (referral-to-treatment times, workload trends, number of complaints).
- **The process for reviewing the service with stakeholders**, including decisions on changes necessary to improve or to decommission the service.
- **Achieving targets associated with equalities legislation**.

Further information

General information on quality and corporate assurance can be obtained from the following sources:

- The National Patient Safety Agency (NPSA) oversees the implementation of a system to report and learn from adverse events and near misses occurring in the NHS. The publication 'Seven steps to patient safety' provides an overview of patient safety and gives updates on the tools that the NPSA is developing to support patient safety across the health service.
- .NHS Alliance online resources NHS Alliance is the representational organisation of primary care and primary care trusts, and provides them with an opportunity to network and exchange best practice. The alliance supports its members with an open-access helpline, in-house and joint publications and briefings, internal newsletters and a website.
- The DH commissioning framework provides guidance on the commissioning process in the context of the NHS reform agenda.
- Delivering the 18 week patient pathway provides a range of resources to support the key NHS objective to deliver an 18 week patient pathway from GP referral to the start of treatment by the end of 2008.
- NHS Institute for Innovation and Improvement support for commissioners, includes Commissioning for Health Improvement products to accelerate the achievement of world class commissioning; The Productive Leader programme to enable leadership teams to reduce waste and variation in personal work processes, and Better care, better value indicators to help inform planning, to inform views on the scale of potential efficiency savings in different aspects of care, and to generate ideas on how to achieve these savings.
- 10 Steps to your SES: a guide to developing a single equality scheme This guidance has been developed to assist NHS organisations that have a duty, as public authorities, to comply with the race, disability and gender public sector duties, and in anticipation of new duties in relation to age, religion and belief, and sexual orientation.

Specific information on quality and corporate assurance for a service providing CBT can be obtained from the following sources:

- Better metrics is a pragmatic project that provides clinically relevant measures of performance to support the development of measurable local targets and indicators for local quality improvement projects. See mental health metric 9.
- The IAPT implementation plan has produced curricula for workers of low-intensity and high-intensity therapies. It provides strategic health authorities, primary care trusts, training providers and service providers with an overview of what is needed to implement the IAPT plan.

- 'The competences required to deliver effective cognitive and behavioural therapy for people with depression and with anxiety disorders' identifies the activities associated with the delivery of high-quality cognitive and behavioural therapy and the competences required to achieve these. See the detailed descriptions of the competences associated with each of these activities.
- The 'Quality and outcomes framework (QOF)' was designed to deliver substantial financial rewards for high-quality care. The framework sets out a range of national standards based on the best available research evidence.
- Skills for health works with employers and other stakeholders to ensure that those working in the sector are equipped with the right skills to support the development and delivery of healthcare services. See details of mental health competency framework and of psychological therapies competencies.

Topic-specific Advisory Group: cognitive behavioural therapy

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

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