NHS England

2026/27 NHS Payment Scheme

Mental Health and Neurodevelopmental Resource Groups Guidance

Contents

Who this document is for

This document is primarily intended for finance, costing and data teams in mental health and Talking Therapies (formerly known as IAPT) providers to help them understand and use MHNRGs. We ask chief medical and chief clinical information officers in Trusts to ensure service managers are aware and to monitor data quality at board level. Similarly, mental health, commissioning, population health and analytics leads in systems should draw on this document to ensure that a shared understanding of populations need, system-level costs and ongoing provision is being developed from implementation of MHNRGs.

Executive Summary

Mental Health and Neurodevelopmental Resource Groups (MHNRGs) – the mental health currencies which have replaced clustering – are a patient segmentation tool for providers and systems to plan, fund, benchmark and improve their services in a more data-based way. MHNRGs are a key lever for achieving parity of esteem with the acute sector, with better outcomes reporting and robust costing to demonstrate value for money and improve the quality of care for our patients. They will also support a change to 'year-of-care' and 'best practice tariff' payments as set out in the 10-Year Health Plan in time.

MHNRGs are being developed iteratively, with developments being implemented as guided by sector engagement and policy ambitions. Our long-term vision is that MHNRGs become a tool for understanding population and patient needs, the activity performed to meet those needs, the associated costs and the outcomes achieved for different cohorts. Currencies therefore have the potential to provide a measure of the value created for patients in return for spend on services, giving you the tools to improve outcomes.

The currency models aim to improve data quality, refine our patient segmentation, and understand opportunities to identify value for money in mental health services. MHNRGs will be a key element of the data base to inform funding of services over the coming years.

- In 2025/26, we required providers to flow high quality data within the fields underpinning currencies to the MHSDS (Mental Health Services Data Set), IAPT (Improving Access to Talking Therapies) Dataset and to link this to the National Cost Collection. We also required systems and providers to begin using MHNRGs to support service development, benchmarking, planning, and funding discussions.
- In 2026/27, we continue to expand the use and granularity of the currency models iteratively, as set out in this guidance documentation, linked with the 2026/27 NHS Payment Scheme.
- We continue to proceed flexibly and collaboratively, reacting to the needs of the sector based on engagement and policy priorities.

1. Introduction

This guidance document has been developed to help providers, commissioners, and Integrated Care Systems (ICSs) across England implement the Mental Health Currency Models, named the Mental Health and Neurodevelopmental Resource Groups (MHNRGs).

Adrian James, National Medical Director for Mental Health and Neurodiversity, says: *"The new mental health and neurodevelopmental currency models are a key step toward achieving parity of esteem and addressing inequalities in mental health. By equipping our services with tools to better understand and meet local needs, these currencies will highlight where investment is most needed to improve outcomes. Co-developed with clinicians and service users, they reflect real-world needs, and since they are built on existing data, they add no extra burden to frontline staff. We will continue evolving these models in partnership to support our mental health and neurodiverse patients across the country."*

MHNRGs are a patient segmentation tool for providers and systems to plan, fund, benchmark and improve their services in a more evidence-based way. MHNRGs are a key lever for achieving parity of esteem with the acute sector, with better outcomes reporting and robust costing to demonstrate value for money and improve the quality of care for our patients. The currency model aims to support system based collaborative working based on national policy ambitions, creating a common understanding of care provision, and providing a standardised evidence-base which can support effective and equitable funding models.

MHNRGs have been developed with the input of expert working groups led by clinicians and patients, supported by an overarching steering group. NHS England is dedicated to developing granular patient-level currency models future iterations.

This guidance builds on the first iteration of the model. 2025/26 provided an opportunity to embed the currency models within current and future practices. The 2026/27 model provides an opportunity to build on this model to better understand our patient populations with high quality, consistent data.

1.1 What is a Currency?

A currency model segments patients and activity based on needs and similarities in clinical resource use. Each unit of currency must be evidence-based and analytically identifiable, but most importantly it must be clinically meaningful. The currency must be rooted in the care the patient receives and be practical to implement.

A currency is often confused with a price or a specific payment model, however these terms are not interchangeable. A currency refers to grouping healthcare activities into units of similar resource and clinical need. A price refers to a value assigned to a unit of currency or bundled package of care as part of a funding mechanism. Appropriate valuation is identified via costing processes, which themselves support clinical, operational, and financial improvement processes, as well as planning and funding arrangements.

Currency models can be used within systems to ensure service provision meets the needs of patients in a local health economy. This means currencies are a crucial enabler for transitioning to population and place-based commissioning. Currencies can also inform service development and re-design, thus ensuring the money spent provides best value for patient populations and reimburses providers fairly for the work they do.

Systems and providers should increasingly use MHNRGs to support service development, benchmarking, planning, and funding discussions over the coming years, following improvements to data quality and the development of suitable depth and breadth within the currencies.

For further information on currencies please see [An Introductory Guide to Currencies](#).

2. Mental Health and Neurodevelopmental Resource Groups (MHNRGs)

MHNRGs have been developed based on the following principles:

- **Clinically meaningful:** Currencies must be clinically meaningful and easy for frontline health and care professionals to use.
- **Data driven and practical:** Minimises or does not increase the administrative and clinical burden on the healthcare system by tapping into existing data flows.
- **Homogenous units of resource:** Currency units should be packages of care that require broadly similar levels of resource for each patient receiving that package, at least at local level.
- **Interact with other currencies:** The boundaries of a currency model should be clear and easy to understand and should take other currencies into account to avoid double counting.
- **Future proof:** The currency models should be designed and implemented in a way which is future proof, avoiding the need for fundamental changes in subsequent iterations of the models, whilst realising the opportunities on the horizon.

The new models are derived from clinical data stored locally and submitted through the MHSDS and IAPT datasets in a generally automated process.

The currency development process is iterative and additive. This means we will launch additional, and more granular currency units based on need over time. We will then add granularity where it is most needed and has been validated through piloting, data analysis and engagement.

The currency model will primarily focus on understanding patient needs and activity by providing an evidence-based segmentation of patients across relevant service and need categories. A key component of the currency model will be linking to contact and activity information. Combining currencies to track patient needs with consistent activity-based and outcomes data reflecting provision, will support benchmarking, service planning and commissioning discussions.

For more information in how the MHNRG's were developed, and the benefits of using currency models, please refer to An Introduction to MHNRGs.

MHNRGs consist of the Mental Health and Neurodevelopmental models and the Talking Therapy models. The models are then split into four dimensions – age, patient populations, care setting and severity/assessment – which form a matrix resulting in currency units.

Fig. 1. Populations and currency units
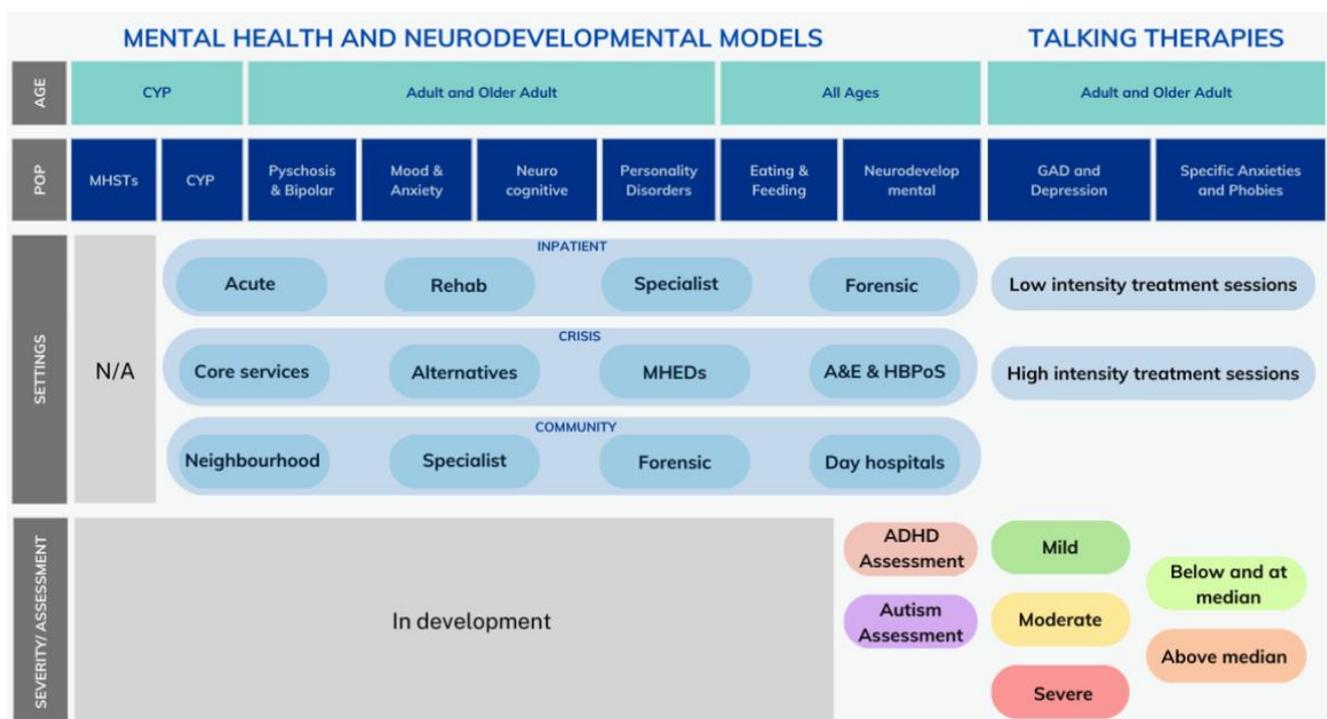
2.1   Grouping Patient Populations

This section sets out how we group patients receiving mental health support. Talking Therapies data has a separate methodology for grouping which is set out in Section 3.

The currency models are designed to group patients based on three levels of data; age, population group and setting. In keeping with our iterative approach, future development is planned to add further levels, especially clinical outcomes. To support users to understand how this will be completed, we are developing tools and guidance, including a grouping methodology. This grouping methodology will continue to be developed and expanded with an aim to minimise burden wherever possible. Please see Section 7 for more detail.

Step 1: Age

Patients are initially segmented by age to split the Children and Young People (CYP) and adult populations. The adult population can be defined by those patients who are referred to a mental health service after their 18th birthday.

The age range for children and young people is from 0 – 25 years as this acknowledges young people 18 or over in a CYP service who may be transitioning to an adult service in this period. The population group will be identified by identifying those patients who have an existing MH referral before their 18th birthday.

Step 2: Population Groups

Once segmented by age, patients will be allocated across the population level groupings. Adult groups are based on diagnostic groupings which cover the majority of the population, whereas CYP are segmented into two main groups, there are also two all-age populations. See Appendix 2 for details of each population group.

Step 3: Deriving Patient Setting

Patients will be grouped into one of twelve settings across three domains: Community, Inpatient, or Crisis. The setting is derived using a methodology which categorises data from the MHSDS. This can be completed locally using the Grouping Methodology.

The methodology covers all care contacts or hospital episodes that take place within referrals where the person is 18 or over at the time of referral for adults or under the age of 18 at referral for CYP.

Community: All activity that is not covered by an inpatient episode, or in any of the crisis team types below are categorised as community activity:

- Community and Neighbourhood
- Specialist teams
- Forensic teams
- Day hospitals and community rehab

Inpatients: All inpatient activity is covered by spells. Inpatient episodes are collected based on the count of all hospital spells and monthly combinations in the financial year. Hospital spells are a count of distinct hospital spells, only counted once throughout the reporting period:

- Acute and PICU beds
- Rehabilitation beds
- Specialist beds
- Forensic beds

Crisis: Contacts will be allocated to the crisis setting when they take place in a crisis team type:

- Core Crisis Services
- Crisis Alternatives
- MH Crisis Assessment Centres
- A&E – linked crisis services

The twelve settings are derived from team types (for community and crisis settings) and bed types (for inpatient settings) reported for the respective care contact or hospital episode. Please see Appendix 2 for details.

See Annex A of the NHS Payment Scheme for details of the currency units.

3. Currency model for NHS Talking Therapies for anxiety and depression

This model has been developed for NHS Talking Therapies (formerly known as Improving Access to Psychological Therapies (IAPT)) and should be used by commissioners, providers and clinicians of services that deliver psychological therapies. For more information, please see the NHS Talking Therapies for anxiety and depression manual, including for:

- Definitions of the conditions in scope of this model;
- Definitions of clinical outcomes (e.g. recovery rates, reliable recovery);
- The responsibilities of providers and commissioners regarding data quality.

The purpose of this currency model is to support commissioners, providers, and clinicians to achieve the best possible reliable recovery rates with their clients by providing guidance on the optimal average number and type of contacts for each presenting complaint and their severity. These numbers are averages of contacts, not maximum contacts, some patients will require more or fewer contacts. The Talking Therapies Data Set was analysed to determine the average number of sessions required to reach reliable recovery for patients with different clinical conditions and severities. The analysis is based on April 2023 to April 2024 England-wide Talking Therapies data (around 670,000 treated cases) and the results can be viewed in Appendix 3.

The Talking Therapies currency model gives commissioners, providers, and clinicians an objective methodology to count their number of high and low intensity contacts and referrals by presenting complaint and severity. Please note that this should be a comparison of **averages** since individual clients will differ in their needs. For a service to achieve optimal levels of reliable recovery, some patients will need more than the average number of

sessions in Fig 3 (and a similar number will need less). All people being treated should receive an adequate dose of the treatment that is provided, in accordance with NICE guidelines. The number of sessions offered should never be restricted arbitrarily. When stepped care is indicated, people who do not respond to low-intensity treatments (and as such, still meet caseness) should be given at least one full dose of high-intensity treatment as well within the same episode of care. When NICE only recommends high intensity treatment, patients should go straight to that level of care after their initial assessment.

Step 1: Presenting Complaint

Referrals of discharged patients are initially segmented by presenting complaint (I603010 - PRESENTING COMPLAINT (CODED CLINICAL ENTRY), referring to the table below. Excluded from the scope of this model are any presenting complaints regarding medically unexplained symptoms since their low number of cases does not presently allow a comparative optimum of sessions to be calculated. However, it should also be recorded where the presenting complaint is unknown or not one of the specified ones.

Problem Descriptor	Problem Descriptor Identifier (ICD-10 code)
Depression	F32.0 F32.1, F32.2, F32.3, F32.8, F32.9, F33.0 F33.1, F33.2, F33.3, F33.4, F33.8, F33.9
Generalised Anxiety	F41.1
Body Dysmorphic Disorder	83482000 (SNOMED CT code)
Post-traumatic Stress	F43.1
Obsessive Compulsive	F42.0, F42.1, F42.2, F42.8 F42.9
Social Phobias (Social Anxiety Disorder)	F40.1
Hypochondrial disorder	F45.2
Specific Phobias	F40.2
Mixed Anxiety	F41.2
Agoraphobia	F40.0
Panic Disorder	F41.0
Other Anxiety	F40.8, F40.9, F41.3, F41.8, F41.9, F43.0, F43.2, F43.8, F43.9
Other Mental Health Problems	Any other F code not listed above
Other/Unknown/Invalid	Any other code or no valid data

Step 2: Severity

Once segmented by presenting complaint, severity is identified via the most appropriate Patient Reported Outcome Measure (PROM), in line with the manual. Segmentation into Mild, Moderate and Severe is used when the primary outcome measure for a clinical

condition (for example PHQ-9 for depression) has published and well-validated cut-off points for a three-fold classification. Equal or above, or below the observed median for cases seen in NHS Talking Therapy services is used when such data is not available. See Appendix 4.

Step 3: Contact intensity type

The final step is to count the number of contacts by intensity of the contact. We split the intensity into high and low, which is defined as per the table below by any contact with at least one of the SNOMED CT codes recorded in the I202110 - CODED PROCEDURE AND PROCEDURE STATUS (SNOMED CT) field with in the IDS202CareContact table.

Category	SNOMED CT Concept ID	SNOMED CT Concept ID
Low Intensity	Guided self-help using book	748051000000105
	Non-guided self-help using book	748101000000105
	Guided self-help using computer	748041000000107
	Non-guided self-help using computer	748091000000102
	Structured physical activity programme	748061000000108
	Psychoeducation	702545008
	Signposting	975131000000104
	IAPT (Improving Access to Psychological Therapies) low intensity therapy	1026111000000108
	Dynamic interpersonal therapy	786721000000109
High Intensity	Applied relaxation	1127281000000100
	Couple therapy for depression	1129471000000105
	Multidisciplinary case management	842901000000108
	Counselling for depression	286711000000107
	Psychodynamic psychotherapy	314034001
	Eye movement desensitization and reprocessing therapy	449030000
	Mindfulness-based therapy	933221000000107
	Cognitive - behaviour therapy	304891004
	Interpersonal psychotherapy	443730003
	IAPT (Improving Access to Psychological Therapies) high intensity therapy	1026131000000100
	Cognitive behavioural therapy	228557008
	Cognitive behavioural therapy parenting programme	883841000000104

A full list of the currency units can be found in Annex A of the [2026/27 NHS Payment Scheme](#).

Comparison to target averages

To compare **with [Appendix 3](#) (Average number and type of contacts required to achieve reliable recovery),** please ensure you are calculating local averages only from treated cases that have achieved reliable recovery. Appropriate statistical tests must be applied to determine the confidence levels with which your local averages are same or different from the national averages. The use of **averages** is intentional, and the results of this analysis are therefore only applicable to population-level data, not individual cases. The care of individuals should always be based on clinical judgement. Services should not set arbitrary limits on the number of sessions that individual patients receive. Instead, patients should be offered up to the NICE recommended full dose, unless they recover earlier, and discharge is mutually agreed.

We intend to develop further guidance and tools to support the use of currencies in conjunction with outcomes data on reliable recovery.

4. Attention-Deficit/Hyperactivity Disorder (ADHD) & Autism Assessments

Guidance has been developed and published alongside the [NHS Payment Scheme 2026/27](#) for ADHD services and Autism assessments. Please see the Attention-Deficit/Hyperactivity Disorder (ADHD) & Autism Payment Guidance Supporting Document.

5. Additional Complexity Factors

The MHNRGs have been developed to provide a holistic view of patient complexity and needs. To do so effectively, an understanding of other factors which could affect a patient's needs are required. Additional Complexity Factors are, "factors which are not directly related to a patient's mental health condition but may increase the needs and complexity of a patient's care or require a tailored approach. Additional Complexity Factors aim to identify standardised data items which will support a better understanding of the patient, their environment, other health factors and factors external to health. These factors will provide an evidence base to support our assumption that more time and resources are required to achieve equitable outcomes where the one or more of these factors are present, compared to when they're not".

We have co-developed these factors with clinicians and lived-experience practitioners from currency development and stakeholder groups. The factors included here have been identified by clinical consensus as being relevant for health inequalities and/ or indicating care complexity and therefore resource use in patient care. All factors are collectable within either the MHSDS or IAPT data sets. The list covers some but not all characteristics that are

out of direct control for the treating team but that may impact the resource required to get to equitable outcomes. As iterative development continues, it is expected that additional factors will be identified and added to these factors.

Factors within the MHSDS

- Issues related to housing
- Identification of older adults
- Deprivation
- Ethnicity
- Need for Translation service
- Learning Disability
- Autism

- Functional impairment and Frailty
- Transition from CYP to adult services
- Addiction and substance abuse
- Looked after child
- Young carer
- Child protection planning

For more detail on these factors, please see Appendix 5.

Alongside these factors, providers should also refer to the Patient and carer race equality framework (PCREF), NHS England's first ever anti-racism framework. This is mandatory for all NHS mental health trusts and mental health service providers to embed across England.

Factors within the IAPT Data Set - Employment Support

There are poorer employment outcomes for people with coexisting mental and physical health problems. There is a high risk of unemployment, absenteeism, and poorer performance. It has been established that the longer people are absent, or out of work, the more likely they are to experience depression and anxiety. Therefore, employment advice, delivered as a core part of an NHS Talking Therapies service, is integral to the success of that service.

NHS Talking Therapies therapists work alongside employment advisers (EAs), to provide combined psychological treatment and employment support to those who have requested this intervention. For this reason, the original NHS Talking Therapies Service Model stated that each team should include one EA for every eight therapists. We now expect about 15% of people who complete NHS Talking Therapies treatment to take up combined treatment and employment support. Employment advice, money guidance and other social assistance should be available within the NHS Talking Therapies service and offered as part of an integrated care plan with close liaison between clinicians and EAs from the point of assessment, through treatment and to discharge.

EAs in NHS Talking Therapies work directly with individuals who are in employment, as well as people who are out of work including those who are on health-related benefits. They provide practical advice and relevant interventions to help individuals retain employment or

enter the workplace. There is employment advice in the NHS Talking Therapies service model and there is scope to adapt aspects of service delivery at a local level.

Senior EAs aim to ensure that employment support is embedded within NHS Talking Therapies services and the work of EAs is sufficiently integrated with relevant employment bodies at a local level. This includes building relationships with Jobcentre Plus, Work & Health Programme and other relevant employment support providers, local chambers of commerce, training providers and local employers.

For more detail, please see Appendix 5.

6. Collecting and using data

Improvement in data quality is essential to aid the development of currency models as it realises the benefits of benchmarking and understanding services provided. Providers should aim for better data quality at a local level and in tandem, to ensure consistent processes for local data to be submitted to the MHSDS.

6.1   Mental Health Services Data Set (MHSDS)

The Mental Health Services Data Set (MHSDS) is a patient level, output based secondary uses data set which aims to deliver robust, comprehensive, nationally consistent and comparable person-based information for people who are in contact with Mental Health Services.

The Mental Health Services Data Set covers Mental Health Services located in England or located outside England but treating patients commissioned by an English Integrated Care Board, NHS England specialised commissioner or an English NHS-led Provider Collaborative.

As a secondary uses data set, the Mental Health Services Data Set re-uses clinical and operational data for purposes other than direct patient care, and defines the data items, definitions, and associated value sets to be extracted or derived from local information systems.

The Mental Health Services Data Set is used across the range of health care providers and organisations that provide Mental Health Services (irrespective of funding arrangements) including:

- NHS Mental Health Trusts
- NHS Learning Disabilities Trusts
- NHS Acute Trusts
- NHS Care Trusts

- Independent Sector Healthcare Providers offering a service model that includes NHS funded and non-NHS funded patients.
- Voluntary sector Health Care Providers
- Any qualified provider offering Mental Health Services
- Community Services offering secondary care to children.

All data items needed to segment into currency models are and will be included within MHSDS. Using nationally agreed terms and definitions supports cross-system working and benchmarking, ensuring comparability. Consistent use of SNOMED CT, ICD classifications, and other standardised data fields required within currencies will facilitate quality data to be collected by clinicians and for this data to move seamlessly through local systems for use both locally and in the MHSDS without need for extensive manipulation.

6.2   Improving Access to Psychological Therapies (IAPT) Data Set

The Improving Access to Psychological Therapies (IAPT) Data Set is a patient level, outcome based, secondary uses data set which aims to deliver robust, comprehensive, nationally consistent, and comparable information for people accessing NHS funded IAPT services located in England. Following a public consultation Improving Access to Psychological Therapy (IAPT) services have been renamed as NHS Talking Therapies for anxiety and depression. The data set will continue to be referred to as IAPT until the next uplift of the data set has received DAPB approval.

This national data set has been developed with the NHS England and the IAPT Programme to support service delivery, inform clinical decision-making and encourage improved access to talking therapies for people with common mental health problems such as depression and anxiety disorders.

As a secondary uses data set it re-uses clinical and operational data for purposes other than direct patient care, for example: commissioning, service improvement and service design. It defines the data items, definitions, and associated value sets to be extracted or derived from local information systems. These national definitions allow providers to extract data from their local systems in a consistent manner, which supports national and local reporting to be undertaken.

6.3   Incorporating patient and population health outcomes

Our mission is for currencies to give you the tools to improve patient outcomes across diverse cohorts, properly understood in the context of the needs of local populations and the services offered to serve those needs.

When commissioning, evaluating, benchmarking and improving services, currencies data should be looked at alongside patient and system outcomes, factoring in the impact of those

interventions and the outcomes achieved. As the 10 Year Health Plan envisions, we will tie incentives to population health outcome measures and patient feedback over time.

This year, we recommend drawing on existing, locally collected and nationally benchmarked data, while considering data quality and completeness carefully. This includes, but is not limited to, the following:

- Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs)
- Clinician Reported Outcome Measures (CROMs)
- A&E attendance for mental health reasons
- Admissions for mental and physical health reasons
- Mental Health Act assessments and detentions
- Mortality and suicide rates (especially comparing people with severe mental illness to the general population)
- The use of Restrictive Interventions and Out of Area Placements (OAPs)
- The physical health of people with severe mental illness

With regards to PROMs, poor data completeness means that the benefits of using this data together with currencies cannot be realised and using an incomplete outcomes picture may be misleading. Therefore, progress on routine outcome collection is an immediate priority as set out within the 10 Year Health Plan.

 Please refer to the core national guidance on patient outcome measures mentioned below:

- NHS Talking Therapies for anxiety and depression manual
- PROMs for people with severe mental illness in community mental health settings - Implementation guidance
- Recording outcome measures for adult and older persons community mental health services - Guidance for the MHSDS
- Recording outcome measures for children and young people's mental health services - Guidance for the MHSDS
- Implementing routine outcome monitoring in specialist perinatal mental health services

7. Tools and Support

NHS England have set up a Futures workspace to feature as a central place for all associated guidance, tools and further information – Currencies, Guidance and Support

The following documents are available:

- Grouping methodology for MHSDS data

- Grouping methodology IAPT data
- SQL code to support providers to extract their local data
- Monthly national data extracts

The workspace will continue to be developed, based on feedback. If you would like to contact the team with queries or suggestions, details can be found on the 'Contact Us' page of the workspace.

8. Appendices

Appendix 1 – Population Definitions

Population Definitions

MHNRGs are needs-based currencies. The currency populations are therefore comprised of those people whose health and care needs are associated with a group of presenting complaints. One person can belong to multiple currency populations, reflecting their individual needs following 'best fit' rather than absolute categorisation.

We have co-developed these with clinical experts, mapping common presenting complaints. team types, and referral reasons based on similarity in needs and service provision. Please refer to the [MHNRG Grouping Methodology](#).

This is a pragmatic mapping reflecting where people and their needs tend to fit more closely to one group than any other. Individuals' cases can be complex, and currencies are not designed to support or influence individual clinical decisions in any way. While linked to common presenting complaints, this mapping does not suggest a person has or should have any particular diagnostic label.

For data coding purposes, please always consult the definitions for any MHSDS fields or codes as provided elsewhere. For definitions of the presenting complaints treated by NHS Talking Therapies, please refer to the latest version of the manual.

Adult Population Groups

Psychosis and Bipolar Disorders Population Group

Includes people whose health and care needs are associated with a group of presenting complaints including Psychosis and Bipolar Disorders; and others identified by clinical experts as having similar needs.

Personality Disorders Population Group

Includes people whose health and care needs are associated with a group of presenting complaints related to Personal Difficulty, and others identified by clinical experts as having similar needs.

Neurocognitive Disorders Population Group

Includes people whose health and care needs are associated with a group of presenting complaints related to Neurocognitive Disorders, and others identified by clinical experts as having similar needs. Neurocognitive disorders are characterised by primary clinical deficits in cognitive functioning that are acquired rather than developmental.

Mood and Anxiety Disorders Population Group

Includes people whose health and care needs are associated with a group of presenting complaints including Mood and Anxiety Disorders; and others identified by clinical experts as having similar needs. This group includes people with needs relating to cyclothymia, however those with needs related to bipolar disorder are included in another group.

Addiction, Alcohol and Substance Misuse Population Group (Removed)

Please note, this population group was removed for the 2026/27 NHS Payment Scheme guidance. Please see Section 5 for information on how we aim to understand this group of patients.

All-Age Population Groups

Eating and Feeding Disorders Population Group

Includes people whose health and care needs are associated with a group of presenting complaints including Eating and Feeding Disorders. The scope of this group has been expanded to include children and young people as guidance has evolved to support the treatment of this population on an all-age basis.

Neurodevelopmental Disorders Population Group

Includes people whose health and care needs are associated with a group of presenting complaints related to behavioural and cognitive disorders that arise during the developmental period; and others identified by clinical experts as having similar needs. This group covers adults and CYP at a population level.

Children and Young People Population Groups

Children and Young People General Population Group

The CYP population includes all children and young people with mental health needs referred to in-scope services which do not fit into another CYP or all age service. Community paediatric provision, including neurodevelopmental provision within those services, is

excluded as the corresponding data flows to the Community Services Data Set and is captured by CYP Community Currency Model. The age range of this population is 0-25 with the majority of patients in the 0-18 range, accepting that there are patients who may be 18-25 and in the process of transitioning to an adult service.

Children and Young People Mental Health Support Teams Population Group

Includes children and young people accessing support through mental health support teams in schools and colleges. These teams provide support for many different needs which may be in the form of personalised sessions, group sessions, help and guidance or referrals to specialist support teams. These teams are likely to become one of the main points of contact for mental health professionals with children and young people and will be a key point of access.

Crisis Population Group

The proposed currency population is comprised of people who present with crisis-related needs, and who cannot yet be grouped to another population. Crisis care is about immediate risk often involving patients without a history in secondary mental health and therefore no diagnosis. This is to ensure we can group these patients consistently, however subsequent recording of specific needs and presenting complaint or diagnosis, and therefore assignment to one or more of the more specific populations, will be recommended.

Appendix 2 – Setting Definitions

Setting granularity for Community and Crisis

Code	Description	Currency Setting
A01	Day Care Service	Community - Day Hospitals & Community Rehab
A02	Crisis Resolution Team/Home Treatment Service	Crisis - Core Crisis Services
A03	Crisis Resolution Team	NA - Retired code Crisis – Core Crisis Services
A04	Home Treatment Service	NA - Retired code Crisis – Core Crisis Services
A05	Primary Care Mental Health Service	– Community - Community & Neighbourhood
-A06	Community Mental Health Team - Functional	– Community – Community & Neighbourhood
A07	Community Mental Health Team - Organic	– Community – Community & Neighbourhood
A08	Assertive Outreach Team	Community - Specialist team
A09	Community Rehabilitation Service	Community - Day Hospitals & Community Rehab
A10	General Psychiatry Service	– Community – Community & Neighbourhood
A11	Psychiatric Liaison Service	Crisis - A&E linked

A12	Psychotherapy Service	– Community – Community & Neighbourhood
A13	Psychological Therapy Service (non IAPT)	– Community – Community & Neighbourhood
A14	Early Intervention Team for Psychosis	Community - Specialist team
A15	Young Onset Dementia Team	Community - Specialist team
A16	Personality Disorder Service	Community - Specialist team
A17	Memory Services/Clinic/Drop in service	Community - Specialist team
A18	Single Point of Access Service	Crisis - Crisis Alternatives
A19	24/7 Crisis Response Line	Crisis - Core Crisis Services
A20	Health Based Place Of Safety Service	Crisis - A&E linked
A21	Crisis Cafe/Safe Haven/Sanctuary Service	Crisis - Crisis Alternatives
A22	Walk-in Crisis Assessment Unit Service	Crisis – MH Crisis Assessment Centres
A23	Psychiatric Decision Unit Service	Crisis - A&E linked
A24	Acute Day Service	Crisis - Crisis Alternatives
A25	Crisis House Service	Crisis - Crisis Alternatives
B01	Forensic Mental Health Service	Community - Forensic
B02	Forensic Learning Disability Service	Community - Forensic
C01	Autism Service	Community - Specialist team
C02	Specialist Perinatal Mental Health Community Service	Community - Specialist team
C04	Neurodevelopment Team	Community - Specialist team
C05	Paediatric Liaison Service	Community - Specialist team
C06	Looked After Children Service	Community - Specialist team
C07	Youth Offending Service	Community - Forensic
C08	Acquired Brain Injury Service	Community - Specialist team
C10	Community Eating Disorder Service	Community - Specialist team
D01	Substance Misuse Team	Community - Specialist team
D02	Criminal Justice Liaison and Diversion Service	Community - Forensic
D03	Prison Psychiatric Inreach Service	Community - Forensic
D04	Asylum Service	Community - Specialist team
D05	Individual Placement and Support Service	Community - Specialist team
D06	Mental Health In Education Service	– Community – Community & Neighbourhood
D07	Problem Gambling Service	Community - Specialist team
D08	Rough Sleeping Service	Community - Specialist team
E01	Community Team for Learning Disabilities	– Community – Community & Neighbourhood
E02	Epilepsy/Neurological Service	Community - Specialist team
E03	Specialist Parenting Service	Community - Specialist team
E04	Enhanced/Intensive Support Service	Community - Specialist team
F01	Education-based Mental Health Support Team	Community – Community & Neighbourhood

F02	Maternal Mental Health Service	Community - Specialist team
F03	Mental Health Services for Deaf people	Community - Specialist team
F04	Veterans Complex Treatment Service	Community – Specialist Team
F05	Enhanced care in care homes teams	Community - Specialist team
F06	Mental Health and Wellbeing Hubs	– Community – Community & Neighbourhood
F07	Armed Forces Veterans Integrated Treatment Services	Community - Specialist team
UNKNOWN	UNKNOWN	NA - Not groupable
Z01	Other Mental Health Service - in scope of National Tariff Payment System	NA - Not groupable – See Grouping Methodology
Z02	Other Mental Health Service - out of scope of National Tariff Payment System	NA - Not groupable – See Grouping Methodology

Setting granularity for Inpatient

Code	Description	Currency setting
200	Acute Adult Mental Health Care	Acute
201	Acute Older Adult Mental Health Care Organic and Functional	Acute
202	Adult Psychiatric Intensive Care Unit Acute Mental Health Care	Acute
203	Adult Eating Disorders	Specialist
204	Mother and Baby	Specialist
205	Acute Mental Health Unit for Adults with a Learning Disability and/or Autism	Specialist
206	Adult Low Secure	Forensic
207	Adult Medium Secure	Forensic
208	Adult High Secure	Forensic
209	Adult Neuro-Psychiatry / Acquired Brain Injury	Specialist
210	Adult Personality Disorder	Specialist
211	Adult Mental Health Services for the Deaf	Specialist
212	Adult Mental Health Rehabilitation Mainstream Service	Inpatient Rehab
213	Adult Mental Health Rehabilitation for Adults with a Learning Disability and/or Autism Specialist Service	Inpatient Rehab
300	General Child and Young Person - Child up to and including 12 years	Acute
301	General Child and Young Person – Young Person 13 years up to and including 17 years	Acute
302	Eating Disorders – Child and Young Person	Specialist
303	Child and Young Person Low Secure Mental Illness	Forensic
304	Child and Young Person Medium Secure Mental Illness	Forensic
305	Child Mental Health Services for the Deaf	Specialist
306	Child and Young Person Low Secure Learning Disabilities	Forensic
307	Child and Young Person Medium Secure Learning Disabilities	Forensic
308	Severe Obsessive Compulsive Disorder and Body Dysmorphic Disorder - Young Person	Specialist

309	Child and Young Person Psychiatric Intensive Care Unit	Acute
310	Child and Young Person Learning Disabilities	Specialist
311	Child and Young Person Autism	Specialist
999	Unknown	NA - Not groupable – See Grouping Methodology

Setting Definitions - Inpatient

Acute & PICU Beds	Acute beds provide 24-hour multidisciplinary assessment and treatment for people in acute mental health crisis who cannot be safely supported in the community. PICUs are locked wards with higher staffing (including 1:1 nursing at times) for detained patients in an acutely disturbed phase of serious mental illness who pose risk to self or others, aiming for short-term stabilisation and step-down to acute wards or community.
Rehabilitation Beds	Provide longer-term inpatient care for people with complex and enduring mental health needs. Focus on symptom stabilisation, recovery, and developing daily living skills to support transition back into the community.
Specialist Beds	Inpatient settings tailored to specific populations or conditions requiring specialist expertise (e.g. eating disorder units, perinatal mother & baby units, learning disability and/or autism wards, neuropsychiatry). Provide intensive, condition-specific interventions not deliverable on general acute wards.
Forensic Beds	For patients detained under the Mental Health Act who pose serious risk to themselves or others. Delivered at three levels: High Secure, Medium Secure, and Low Secure. Provide multidisciplinary forensic treatment in the least restrictive environment, aiming to reduce risk and support step-down.

Setting Definitions - Community

Community – Community & Neighbourhood	Multidisciplinary teams providing assessment, treatment, and care coordination for adults with severe and enduring mental health problems. Under the Community Mental Health Framework, neighbourhood teams integrate with primary care, social care, and voluntary sector to deliver holistic, place-based support.
Specialist Teams	Community teams providing targeted interventions for specific needs, such as Early Intervention in Psychosis (EIP), perinatal mental health,

	eating disorders, and neurodevelopmental conditions. Offer specialist expertise, intensive support, and relapse prevention.
Forensic Teams	Community forensic mental health teams support people with severe mental disorders who present risk of harm and may be in contact with the criminal justice system. Provide specialist risk management, treatment, and supervision in partnership with probation, police, and local authorities.
Day Hospitals & Community Rehab	Day hospitals provide structured, non-residential programmes as an alternative to admission. Community rehabilitation teams support people with complex, long-term mental health needs to develop daily living skills, social networks, and confidence for independent community living.

Setting Definitions - Crisis

Core Crisis Services	Core crisis services are NHS-run multidisciplinary teams (often called Crisis Resolution and Home Treatment Teams) or 24/7 crisis hotlines (NHS 111 Option 2) that provide rapid assessment, intensive support, and home treatment during periods of acute mental health crisis, aiming to prevent unnecessary hospital admission.
Crisis Alternatives	Crisis alternatives provide non-hospital, community-based support during a mental health crisis. These may include crisis cafés, safe havens, or short-stay crisis houses that offer a safe, therapeutic environment as an alternative to inpatient admission. They are typically run by voluntary sector organisations.
Mental Health Crisis Assessment Centres	Specialist crisis hubs or centres offering rapid, intensive assessment and support in a designated location, often as an alternative to A&E. Provide immediate mental health expertise, risk management, and onward referral or step-down to other services.
A&E - linked	A&E liaison teams provide mental health assessment and support in emergency departments, while Health-based Places of Safety (HBPoS) are designated facilities where people detained under Section 136 of the Mental Health Act can be taken for assessment in a safe, therapeutic environment.

Appendix 3 – Average number and type of contacts required to achieve reliable recovery (Talking Therapies Currency Model)

Problem Descriptor	Severity	Average number of contacts	Low intensity appts	High intensity appts
Depression	**Mild**	7	2.7	4.3
	Moderate	8	2.8	5.2
	Severe	9	2.6	6.4
Generalised Anxiety	**Mild**	7	3.1	3.9
	Moderate	7	3.5	3.5
	Severe	8	3.4	4.6
Body Dysmorphic Disorder	Below Median	13	0.8	11.5
	Above/Equal Median	14	1.8	12.3
Post-traumatic Stress	**Below Median**	12	1.3	10
	Above/Equal Median	13	1.2	11.1
Obsessive Compulsive	Below Median	12	2.3	9.8
	Above/Equal Median	13	2.2	10.8
Social Phobias	**Below Median**	12	2.4	9.6
	Above/Equal Median	12	1.6	9.6
Hypochondrial disorder	Below Median	10	2	7.3
	Above/Equal Median	11	2.1	8.9
Specific Phobias	**Below Median**	9	3.2	5.8
	Above/Equal Median	11	2.1	8.3
Mixed Anxiety	Below Median	7	1.8	4.4
	Above/Equal Median	8	2	6
Agoraphobia	**Below Median**	8	4.4	3.6
	Above/Equal Median	9	3	5.4
Panic Disorder	Below Median	9	3.8	5.3
	Above/Equal Median	9	3.2	5.1

Appendix 4 – Measures by problem descriptor for use with Talking Therapies Currency Model

Problem Descriptor	Patient reported outcome measure	Severity
Depression	Patient Health Questionnaire (PHQ-9) 0 – 9 = Mild depression 10 – 14 = Moderate depression 15 – 27 = Severe depression	Mild
		Moderate
		Severe
Generalised Anxiety	Generalised Anxiety Disorder – 7 (GAD-7) 0 – 9 = Mild anxiety 10 – 14 = Moderate anxiety 15 – 21 = Severe anxiety	Mild
		Moderate
		Severe
Body Dysmorphic Disorder	Body Image Questionnaire (BIQ) Weekly Median = 51	Above/Equal Median
		Below Median
Post-traumatic Stress	PTSD Checklist for DSM-5 (PCL-5) Median = 54	Above/Equal Median
		Below Median
Obsessive Compulsive	Obsessive Compulsive Inventory (OCI) Median = 76	Above/Equal Median
		Below Median
Social Phobias	Social Phobia Inventory (SPIN) Median = 47	Above/Equal Median
		Below Median
Hypochondrial disorder	Health Anxiety Inventory (HAI) Median = 36	Above/Equal Median
		Below Median
Specific Phobias	Generalised Anxiety Disorder – 7 (GAD-7) Median = 14	Above/Equal Median
		Below Median
Mixed Anxiety	Generalised Anxiety Disorder – 7 (GAD-7) Median = 14	Above/Equal Median
		Below Median
Agoraphobia	Mobility Inventory (MI) Median = 3.85	Above/Equal Median
		Below Median
Panic Disorder	Panic Disorder Severity Scale (PDSS) Median = 14	Above/Equal Median
		Below Median
Other Anxiety	Generalised Anxiety Disorder – 7 (GAD-7) Median = 14	Above/Equal Median
		Below Median

Appendix 5 – Additional Complexity Factors

Factors identified within the MHSDS

Factor	MHSDS Table	Data item	Unique ID	Notes
Issues related to housing	MHS003	ACCOMMODATION TYPE	M003070	
	MHS003	SETTLED ACCOMMODATION INDICATOR	M003020	
Identification of older adults	MHS001	PERSON BIRTH DATE	M001060	
Deprivation	MHS001	POSTCODE OF USUAL ADDRESS	M001070	
Employment status	MHS004	EMPLOYMENT STATUS	M004010	
Ethnicity	MHS001	ETHNIC CATEGORY	M001100	
Need for Translation service	MHS001	LANGUAGE CODE (PREFERRED)	M001120	Non-English Language Code
Learning Disability	MHS005	PATIENT DIAGNOSIS STATUS (LEARNING DISABILITY)	M005220	Codes 1-4
Autism	MHS005	PATIENT DIAGNOSIS STATUS (AUTISM)	M005230	Codes 1-4
Functional impairment and Frailty	MH607	Coded Scored Assessment (Care Activity)	M607910	Bristol Activities of Daily Living Scale (BADLS) 447162005
				Clinical Frailty Scale 763264000
	Local use only – currently not within MHSDS			Katz Index of Independence in Activities of Daily Living
				Functional Activities Questionnaire (FAQ)
Transition from CYP to adult services	MHS008	CARE PLAN TYPE (MENTAL HEALTH)	M008030	14 - Child or Young Person's Mental Health Transition Plan

Addiction and substance abuse	MHS607	CODED ASSESSMENT TOOL TYPE (SNOMED CT)	M607910	Adapted Alcohol, Smoking and Substance Involvement Screening Test Lite - Alcohol total score (1108211000000104)
				Adapted Alcohol, Smoking and Substance Involvement Screening Test Lite - Cannabis total score (1108221000000105)
				Adapted Alcohol, Smoking and Substance Involvement Screening Test Lite - Opioid total score (1108251000000100)
				Adapted Alcohol, Smoking and Substance Involvement Screening Test Lite - Other psychoactive substance score (1323791000000108)
				Adapted Alcohol, Smoking and Substance Involvement Screening Test Lite - Sedative total score (1108241000000103)
				Adapted Alcohol, Smoking and Substance Involvement Screening Test Lite - Stimulant total score (1108231000000107)
				Adapted Alcohol, Smoking and Substance Involvement Screening Test Lite - Tobacco total score (1108201000000101)
	MHS604	Primary Diagnosis	M604010	F10 - Mental and behavioural disorders due to use of alcohol
				F11 - Mental and behavioural disorders due to use of opioids
				F12 - Mental and behavioural disorders due to use of cannabinoids
				F13 - Mental and behavioural disorders due to use of sedatives or hypnotics
				F14 - Mental and behavioural disorders due to use of cocaine
				F15 - Mental and behavioural disorders due to use of other stimulants, including caffeine
				F16 - Mental and behavioural disorders due to use of hallucinogens
				F17 - Mental and behavioural disorders due to use of tobacco

				F18 - Mental and behavioural disorders due to use of volatile solvents
				F19 - Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances
				F63 - Habit and impulse disorders
	MHS902	SERVICE OR TEAM TYPE (MENTAL HEALTH)	M902030	D07 - Problem Gambling Service
	MHS101	PRIMARY REASON FOR REFERRAL (MENTAL HEALTH)	M101080	28 - Gambling disorder
				9 - Drug and alcohol difficulties
Looked after child	MHS005	Looked After Child Indicator	M005030	Y (Yes)
Young carer	MHS005	Young Carer Indicator	M005020	Y (Yes)
Child protection planning	MHS005	Child Protection Plan Indication Code	M005040	2 - Has previously been subject to a Child Protection Plan

Factors identified within the IAPT Data Set

Factor	MHSDS Table	Data item	Unique ID	Notes
Employment Status	IDS004	All items	All items	
Employment Support	IDS201	Appointment type	I201210	