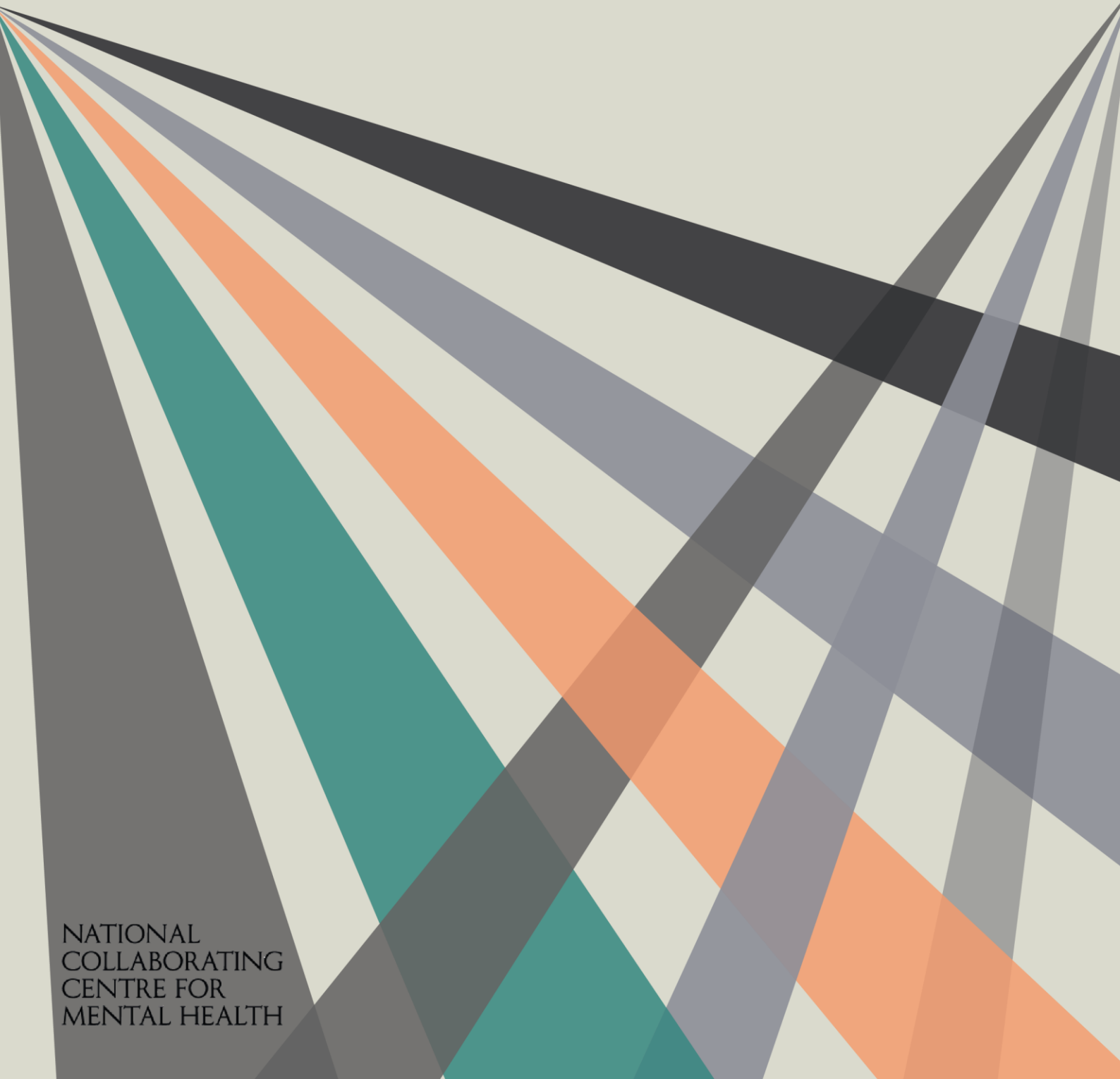
The Improving Access to Psychological Therapies (IAPT) Pathway for People with Long-term Physical Health Conditions and Medically Unexplained Symptoms

Full implementation guidance



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

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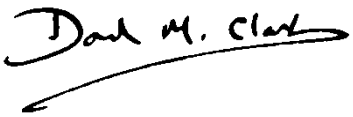
Foreword

Improving Access to Psychological Therapies (IAPT) services are transforming the treatment of depression and anxiety-related disorders in England. Now established in every clinical commissioning group, the services are providing a course of NICE-recommended psychological therapy to over half a million people each year. A new session-by-session outcome monitoring system captures the clinical outcomes of 98% of these individuals, with around half meeting criteria for a full recovery and two thirds showing clinical improvement. This is what we would expect to see in a clinical trial.

This guidance covers the next important step in the development of the IAPT programme. Around 40% of people with depression and anxiety disorders also have a long-term physical health condition (LTC). Currently, they often receive their mental and physical health care in separate services that are rarely coordinated. This is inconvenient for patients, costly to the NHS, and likely to produce sub-optimal outcomes. Building on the skill and tremendous hard work of IAPT's dedicated workforce, the NHS is now developing new IAPT ('IAPT-LTC') services, which will ensure that people with mental and physical health problems receive joined-up health care. The high-quality and evidence-based treatment principles of the IAPT programme will be maintained but provision of psychological therapy will be embedded in physical healthcare pathways and suitably adapted. The IAPT-LTC services will aim to ensure people with long-term physical health problems have the same access to NICE-recommended psychological therapies as other people. They will also provide evidence-based psychological treatments for individuals who are distressed and disabled by medically unexplained symptoms (MUS). Within the IAPT-LTC care pathway, mental and physical health providers will work in a coordinated way to achieve the best outcomes for their patients.

This guidance summarises current knowledge about how to set-up and run IAPT-LTC services. To produce it, the team at the National Collaborating Centre for Mental Health has carefully considered the relevant research literature. The team has also drawn on the experience of clinicians, managers and commissioners who have been early adopters of the IAPT-LTC initiative. Other commissioners, providers and clinicians will benefit from the lessons they have learned. However, IAPT-LTC is a work in progress. Each new IAPT-LTC service has the potential to further contribute to our understanding of the best way to combine NICE-recommended mental and physical health care. With this in mind, this guidance and the accompanying IAPT Manual encourage commissioners and clinicians to use local and national data to better understand the strengths and limitations of their evolving service.



Professor David M. Clark CBE, National Clinical and Informatics Advisor for IAPT

Key statements

The following statements are based on what the Expert Reference Group considered to be the key messages of this guidance. They are written from the perspective of the person to highlight the need to develop IAPT-LTC services with the person at the centre.

Meeting my needs and getting clear information

"I know how to access help for my mental health needs. I can speak to someone who has the knowledge and expertise to advise and refer me for help. If I choose I can also refer myself to services."

"I can go to one place, which is local to me, to receive care for my mental and physical health needs. My mental health problem will be treated with the same urgency, compassion and respect as my physical health problem."

"There is a person I can go to with my questions at any time."

Accessing mental health care

"I know that if I need a psychological intervention, I will be able to start treatment at a time that is right for me. This will be within 6 to 18 weeks of my referral."

"I will be supported by a team of mental and physical health professionals who work together and are appropriately trained and supervised."

Receiving the right care for me

"I will receive an assessment that considers all of my needs. This will help my team and me understand how my physical and mental health interact and impact on my wellbeing."

Working collaboratively and shared decision-making

"I will have access to clear and practical information regarding my treatment options. Where a range of evidence-based treatments are available, I will be able to choose the best option for me."

"I will jointly develop a care plan that outlines my treatment and includes self-management strategies. This will be kept up to date as my needs change."

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1 Introduction

The pathway values statement

This guidance represents a commitment to ensuring that mental health care is delivered in a **person-centred**, **compassionate** and **supportive** way, promoting **safety** and **wellbeing** at the forefront. Mental health service provision should be **needs-led**, **outcome-focused**, responsive and delivered in a way that **empowers** people to build on their strengths, promotes **recovery,** supports **families and carers**, and ensures **equality and fairness** for all.

1.1 Background

The Five Year Forward View for Mental Health[6] and the Next Steps on the NHS Five Year Forward View[7] set out the need for a fundamental redesign in the way that care is delivered. These documents propose a series of measures to bring about the integration of primary and specialist hospital care, of health and social care, and of physical and mental health services. This means that as well as ensuring that a person's mental and physical health needs are valued equally,[8] there is also a recognition of the need to ensure that care is delivered in a coordinated and integrated way. This includes improving the availability and quality of mental health care for people in physical health care settings, as well improving the availability and quality of physical health care for people in mental health settings.

One area where these improvements are being made is the expansion of Improving Access to Psychological Therapies (IAPT) services for people with long-term physical health conditions (LTCs) who also have depression and anxiety disorders, or who have medically unexplained symptoms (MUS).

Other key initiatives and policy documents:

- Five Year Forward View for Mental Health: One Year On[1]
- Implementing the Five Year Forward View for Mental Health[2]
- Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21[3]
- CCG Improvement and Assessment Framework 2016/17[4]
- Closing the Gap: Priorities for Essential Change in Mental Health[5]

1.2 Purpose and scope of this document

This guidance outlines the IAPT pathway, and accompanying benchmarks, to support the national expansion of IAPT services for adults (aged 18 years to the end of life) with LTCs and MUS (in this guidance, this service is called 'IAPT-LTC' for short). This expansion will see IAPT services co-located in existing primary and secondary care physical health pathways (see Box 1 for more information about these developments).

IAPT-LTC services will target the needs of people with depression and anxiety disorders who also have LTCs (such as cardiovascular disease or chronic obstructive pulmonary disease [COPD]), or have MUS (such as chronic fatigue syndrome or irritable bowel syndrome).

The guidance is primarily aimed at clinical commissioning group (CCG) physical and mental health commissioners, as well as physical and mental health providers working collaboratively with people who use the services and their families. It has been organised into five further sections (see the diagram on the page 7).

This guidance is concerned with **the delivery of psychological therapies in IAPT-LTC services only**. It does **not** cover other services that integrate mental and physical health care, such as liaison

mental health services and clinical and health psychology services. It is critical that those implementing the IAPT-LTC pathway are aware of the valuable contribution of these services and establish clear arrangements for joint working (see Box 2 for further information).

Box 1: Timeline of IAPT expansion

2008 – The IAPT programme is established as a systematic way to organise and improve the delivery of evidence-based (NICE-recommended) psychological therapies for people with mild, moderate and severe depression and anxiety disorders.

2016/17 – Work is underway to expand IAPT services into existing physical health care pathways to treat people with LTCs and MUS. NHS England supports 22 early implementer sites with £54 million allocated to train new staff and deliver IAPT-LTC services in early implementer sites.

2017/18 – NHS England supports a further 15 early implementer sites as part of wave 2. The sites cover people with diabetes, respiratory disease, cardiac disease and MUS.

2018/19 – All CCGs will be asked to recruit additional staff and commission IAPT-LTC services. Additional funding will be included in CCG baselines from April 2018.

2020/21 – 1.5 million (25%) of adults with depression or anxiety disorders will start treatment, with two thirds of this expansion to include people with LTCs and MUS. Top-up training in new competences and training of new staff will increase overall capacity of IAPT services.

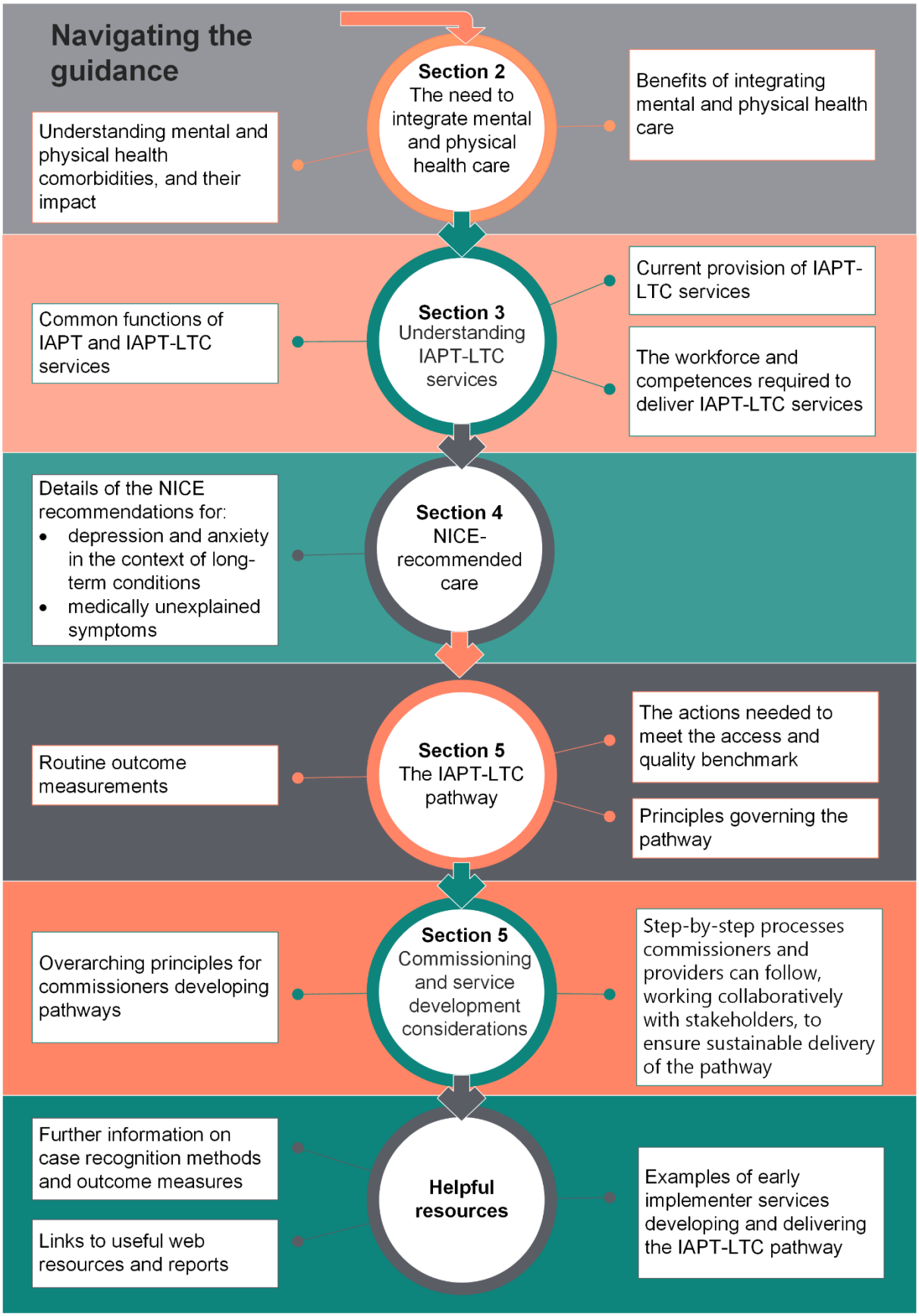
Box 2: Working with the wider system

The expansion of IAPT is part of a wider move towards integrating mental and physical health across the healthcare system. IAPT-LTC services should be developed alongside existing services, with clear arrangements for joint working.

Key partners include:

- Liaison mental health services (including Core 24) sometimes called 'integrated psychological medicine', which provide care in general hospital emergency departments, inpatient units and outpatient clinics (see the urgent and emergency liaison mental health care pathway for adults and older adults)
- **Clinical and health psychology services**, which work as part of healthcare teams within general hospitals, and may form an integral part of the IAPT-LTC workforce
- **Integrated primary and acute care systems (PACS) vanguards**, which aim to improve physical, mental and social health and wellbeing, and reduce inequalities, with general practice at their core
- **Specialist physical health services**, such as pain services or sleep disorder services, which may be based either in inpatient or community settings.

See the helpful resources for further information on the role of these partners and how commissioners can promote joint working.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1.3 How was this guidance developed?

NHS England commissioned the National Institute for Health and Care Excellence (NICE) to provide a package of implementation support for mental health care pathways, including implementation guidance. NICE asked the National Collaborating Centre for Mental Health (NCCMH)[a] to develop this guidance. The NCCMH established an Expert Reference Group. Benchmarks were developed based on NICE guidelines and quality standards, published literature evidencing best practice of care, existing services demonstrating positive practice and expert consensus from a variety of stakeholders.

A list of Expert Reference Group of members is provided at the end of this document. In formulating the pathways and this guidance, the Expert Reference Group and NCCMH technical team followed a manual developed by NICE.

1.4 Expectations of commissioners

During 2016/17 and 2017/18, a targeted, geographical approach has been in place to deliver IAPT-LTC services in 'early implementer' sites (see Section 3.2). From 2018/19, all CCGs must roll out IAPT-LTC services as a key mechanism to ensure the delivery of increased access to psychological therapies.[9]

Commissioners should ensure that IAPT-LTC services:

- are **co-produced** and implemented in collaboration with people using the services and their families and carers (see Section 6.4)
- are **co-located** in physical health care pathways with IAPT clinicians **working effectively with the wider system,** including existing IAPT services, other mental health services and physical health care teams (see Sections 3.1 and 6)
- **place a strong emphasis on the recognition of mental health problems**, with case recognition and assessment systems in place across physical and mental health services (see Section 2 in the helpful resources)
- **have clear access criteria for IAPT-LTC services that are agreed with all relevant services** (see Section 5.4)
- **ensure equity of access for all adults** – local commissioners should make explicit in service and commissioning documents how they have taken into account their duties placed on them under the Equality Act 2010[10] and with regard to reducing health inequalities as set out in the Health and Social Care Act 2012[11] and the 2015 Guidance for NHS commissioners on equality and health inequalities legal duties[12]
- **ensure routine, session-by-session monitoring of mental health and related outcomes,** with services obtaining pre- and post-treatment scores on at least 90% of service users (see Section 5.5 and the IAPT Manual).

[a] The NCCMH, a partnership between the Royal College of Psychiatrists and University College London, was one of the national collaborating centres first established by NICE in 2001 to develop clinical guidelines.

The IAPT-LTC pathway

The IAPT-LTC pathway introduced in this guidance outlines timely access to effective interventions for adults with LTCs who also have depression and anxiety disorders, or who have MUS. Two thirds of people with LTCs will also have a mental health problem, mostly depression and anxiety disorders.[13] A further 70% of people with MUS will experience depression or an anxiety disorder. These rates are much higher than prevalence rates in the general population (see Section 2.1). Left untreated, mental health problems can have a significant impact on the person's physical health as well as the overall cost of their care (see Section 2.2).

A wide range of cost-effective psychological therapies are available for the treatment of depression and anxiety disorders.[14 15 16] Many of these, alone or in combination with pharmacological interventions, are similarly effective in people with and without LTCs. However, for some people such interventions may need to be adapted to their LTC. Specific psychological therapies have also been developed and are available in IAPT services for the treatment of some MUS, such as irritable bowel syndrome and chronic fatigue syndrome (see Section 4). Psychological therapies may be provided through a range of services including primary care, IAPT services and specialist mental health services (including community mental health teams, liaison mental health services, specialist services and clinical and health psychology services).

The following standard for timely access to treatment in IAPT services (including IAPT-LTC services) has been set:

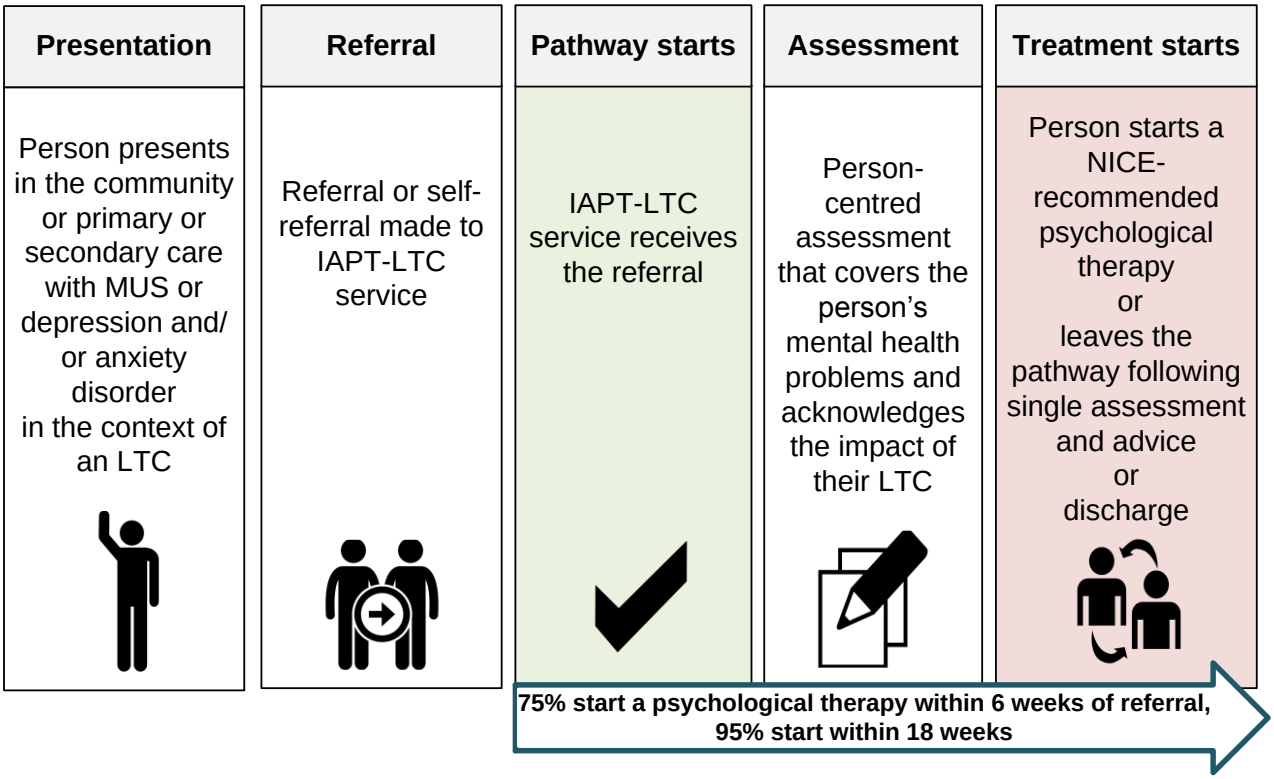
75% of people referred to IAPT services will begin treatment within 6 weeks of referral and 95% begin treatment within 18 weeks of referral

In addition to meeting the above standard, IAPT-LTC services should also deliver existing national standards for access and recovery. Services should ensure that:

- **the same high standards of evidence-based (NICE-recommended) treatment** are delivered in accordance with NICE guidelines and quality standards (see Section 4)
- **at least 25%** of adults with the relevant disorders will have **timely access** to all IAPT services (this includes self-referrals) (see Section 3.1 and the IAPT Manual)
- **at least 50%** of those treated in IAPT services move to **recovery** (see the IAPT Manual).

Among other indicators, IAPT services also have a secondary quality benchmark, which it is recommended that commissioners monitor locally. The benchmark applies to everyone who has at least one session in an IAPT service: 75% of the referrals that are seen at least once should have their first appointment within 6 weeks, and 95% within 18 weeks.

Figure 1: The IAPT-LTC pathway



2 The need to integrate care for people with mental and physical health problems

2.1 Mental and physical health comorbidities

A person's mental and physical health are intrinsically linked. There is clear evidence that the presence of LTCs or MUS markedly increase the risk of a comorbid mental health problem and vice versa. [13 14] See Table 1 for definitions of these terms as used in this guidance.

Over 16.5 million people in England – around 30% of the population – will be diagnosed with one or more LTCs.[16 17] Of these people, over 30% will also experience a mental health problem (see Figure 2).[13 16] This is substantially higher than the prevalence rate in the general population. Comorbid depression and anxiety disorders are most common, but other comorbidities (including drug and alcohol misuse, psychosis and personality disorders) may occur.[13] There is particularly strong evidence for higher rates of depression and anxiety disorders in people with cardiovascular disease,[18] diabetes,[19] COPD[20] and musculoskeletal disorders.[21]

MUS are also common, accounting for over 30% of primary care consultations.[22 23] Rates tend to be higher in secondary care services; for example, one study found that over 40% of people in a range of specialist outpatient clinics had MUS.[23]

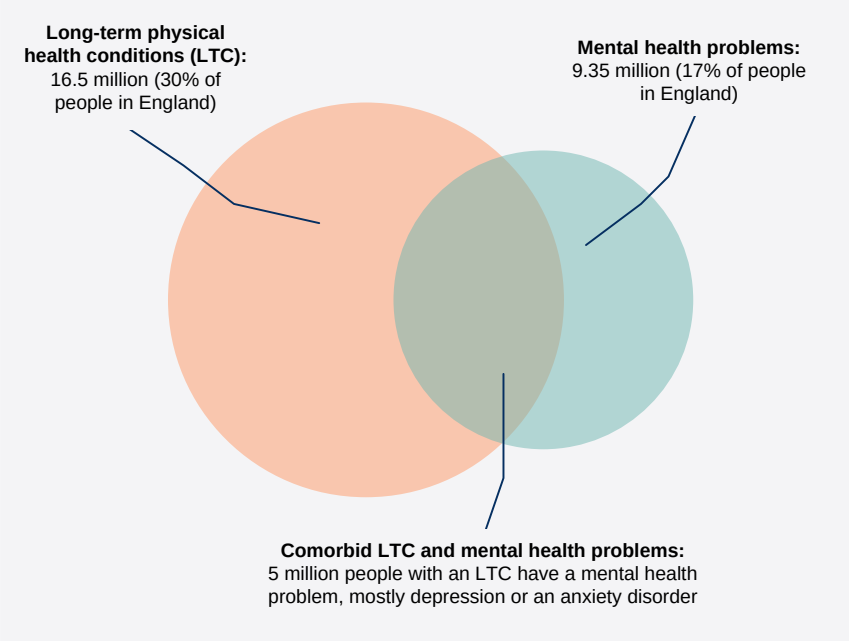
> ***'We should have fewer cases where people are unable to get physical care due to mental health problems affecting engagement and attendance (and vice versa). And we need [the] provision of mental health support in physical health care settings – especially in primary care.'***
>
> Source: The Five Year Forward View for Mental Health

There are a number of factors that increase the likelihood of a mental and physical health problem coexisting. In general, when a person has a greater number of LTCs and more marked functional impairment their mental health tends to be poorer.[13 14 24] This in turn may be linked to (and exacerbated by) socioeconomic disadvantage and age.[25] People who are older or more socially and economically disadvantaged have a greater chance of developing multiple LTCs and having a poorer outcome when they do so.[26 27]

Table 1: Key terms used in this guidance

	Definition used in this guidance
Depression and anxiety disorders	Depression and a range of anxiety disorders (including generalised anxiety disorders, social anxiety disorder, panic disorder, agoraphobia, obsessive-compulsive disorder, specific phobias, post-traumatic stress disorder, health anxiety and mixed depression and anxiety)
Long-term physical health conditions (LTCs)	A range of long-term physical health conditions such as cardiovascular disease, chronic obstructive pulmonary disease, diabetes and musculoskeletal disorders
Medically unexplained symptoms (MUS)	Persistent and distressing bodily symptoms characterised by functional disability that cannot wholly be explained by a known physical pathological cause; psychological processes are often involved in the presentation of MUS Examples of MUS include: chronic fatigue syndrome, chronic pain and irritable bowel syndrome

Figure 2: The overlap between LTCs and mental health problems in England



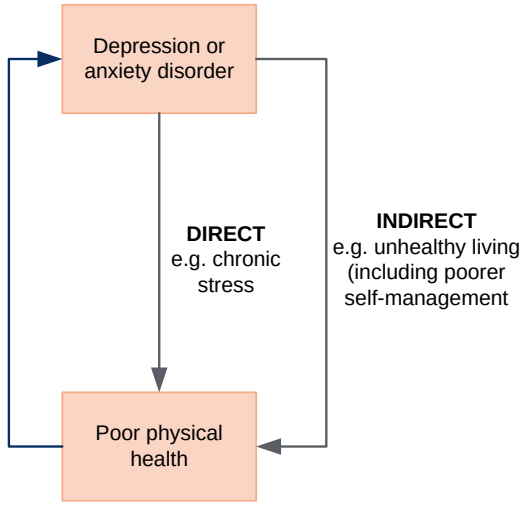
2.2 The impact of depression and anxiety disorders in the context of LTCs

The relationship between poor mental health and poor physical health is complex and bi-directional. It is likely to involve a range of biological, psychosocial, environmental and behavioural factors,[24] which can have an impact on a person's physical health, both directly and indirectly (see Figure 3). The negative consequences on the person's physical health are often greater when the mental health problem is long-standing, more severe or if treatment is delayed or sub-optimal. [13 16 24 28]

'If I go to see someone about my eyes, my eyes are what I am and the rest of me doesn't matter. It's the same with mental health. If I go to see someone for a mental health problem, I am a mental health problem.'

Source: Person with lived experience

Figure 3: How a coexisting mental health problem results in poorer physical health



2.2.1 Untreated depression and anxiety disorders

Despite a wide range of effective NICE-recommended interventions for depression and anxiety disorders[14 15] (see Section 4), many people do not receive the right treatment at the right time. A recent survey found that fewer than one third of people with a mental health problem were identified by their healthcare provider.[24] This compares with treatment rates of up to 90% for physical health problems, such as diabetes.[24] People are even more unlikely to access treatment for their mental health problem when they also have LTCs or MUS.[29]

This may be due to:

- under-recognition of depression and anxiety disorders, with symptoms attributed to a physical cause by the person or their clinician ('diagnostic overshadowing'[30])
- stigma[31]
- inadequate knowledge of diagnostic or treatment options[15]
- unwillingness of physical and mental health clinicians to go beyond their professional silos and explore the person's wider needs[32]
- time pressures on physical health care teams and limited availability of or input from mental health clinicians.[33]

The impact on the person

Untreated depression and anxiety disorders can lead to a range of adverse psychological, social and employment outcomes for the person. These may include:

- **Lower likelihood of engaging with treatment for the physical health problem and reducing the person's ability to effectively self-manage the problem:** coexisting mental health problems can reduce a person's motivation and energy to follow treatment plans and self-manage. For example, depression is associated with poorer adherence to dietary interventions in people with diabetes.[34]
- **Higher likelihood of unhealthy behaviour:** mental health problems are associated with higher rates of smoking, alcohol and drug use, poor diets[16] and decreased physical activity.
- **Poorer physical health, including premature mortality:** people with comorbid mental health problems and LTCs have been shown to have higher rates of functional impairment and a heightened risk of premature morality. For example, in people with COPD,

50% more acute exacerbations were reported in those with common mental health problems than those without.[35] Where diabetes coexists with depression, mortality rates are around 38% higher than those with diabetes alone.[27]

- **Poorer employment outcomes:** there is a higher risk of unemployment in people with coexisting mental and physical health problems and for those in employment a high risk of absenteeism,[24] poorer performance and lower income.[16]
- **Poor social outcomes:** for instance, people are more likely to experience social problems and stress over the first year of recovery from post-myocardial infarction if they have depression.[36] [37]

The impact on the NHS

Healthcare costs for those with coexisting mental health problems and LTCs are significantly (around 50%) higher.[38] A large proportion of this cost is accounted for by increased use of physical health services (not mental health services).[24] For example:

- depression is associated with increased rehospitalisation rates in people with cardiovascular disease and COPD, compared with the general population[32] [39]
- people with MUS account for up to 45% of primary care consultations [37] [40] and up to 66% of outpatient clinics.[41]
- people with MUS who were not offered psychological therapies as part of their care were found to have a higher number of primary care consultations, than those who were;[42] [43] similarly, people with COPD who were not offered psychological therapies as part of their care were found to have a higher number of urgent and emergency department admissions than those who were.[44]

'There was a question that I had about [a depressed person's] diabetes and the use of insulin… I actually just popped my head around the door for one of the practice nurses…just being there [in the same location] meant that I could ask her that.'

Source: A psychological wellbeing practitioner

2.3 Integrating mental and physical health care

There is a growing move towards delivering care in an integrated way that ensures that a person's mental and physical health needs are met along the whole care pathway. A key part of this involves improving the availability and quality of mental health care for people in physical health care settings. This may be achieved through a range of services including liaison mental health services, clinical and health psychology services and IAPT-LTC services.

2.3.1 The benefits of integrating mental and physical health care

The case for integrating mental and physical health care is compelling. As well as being preferred by many people who use services, the benefits will also be felt by health and social care providers, commissioners and the wider society (see Table 2).[15] [33] [32] [45]

Table 2: Potential benefits of integrating mental and physical health care

What this means for the person*		What integrating care means for the commissioner
Separate services	**Integrated services**	
Delivery		
I go to separate professionals for my physical and mental health needs. This means that I often have lots of appointments in different places and have to travel quite far. Sometimes I struggle to attend new places and can miss my appointments.	*I go to one place, which is in my local area, to receive my care. I prefer this as it makes my care more accessible.*	Integrating care enhances the whole team's capability to provide more comprehensive, accessible and holistic care. This reduces costs through encouraging the prompt uptake of treatment and decreases the likelihood of people not attending appointments.
Assessment of mental health		
If I go to see someone for a physical health problem, I am a physical health problem. They do not treat me as a whole person. This means that I often have multiple assessments and have to repeat myself. I don't feel I have the opportunity to voice my mental health concerns.	*All of my needs as a person are assessed and taken into account. This means that I and the staff caring for me arrive at a better and faster understanding of my mental **and** physical health problems.*	Integrating care promotes mental health awareness. Identifying the person's needs more quickly and accurately can potentially reduce the number of frequent attenders and repeat assessments. Ensuring the right care is delivered can also reduce the length of hospital stays and prevent unnecessary admissions.
Coordination of care		
I feel like it is my responsibility to manage my care. I don't have much support. I sometimes feel confused because I hear different advice from different people.	*The professionals involved with my care talk to each other and have been appropriately trained. We all work as a team to develop one care plan which covers all my conditions. I know how to access the right support at the right time, as my needs change. I also have a first point of contact who I can go to with questions at any time.*	A single jointly developed care plan can lead to greater efficiencies by reducing duplication. It can also lead to improved relationships within teams and services.
Service utilisation and cost of care		
When my mental health needs are unmet I am more likely to be distressed by my physical health problems. This means I spend more time with my GP and the hospital more often. Estimated costs: £5,670 per person per year[46]	*When my mental health needs are treated effectively I know how to self-manage. This means that I don't need to go to my GP or hospital as frequently.* Estimated costs: £3,910 per person per year	Integrating care is more cost-effective. Effectively identifying and treating the person's mental health problem can reduce their use of physical health services. This can reduce the annual expenditure per person by £1,760

* *The experiences of services in this table, written by people with lived experience on the Expert Reference Group, have been phrased from the point of view of a service user.*

3 IAPT services for people with long-term conditions and medically unexplained symptoms (IAPT-LTC services)

3.1 What are IAPT-LTC services?

IAPT-LTC services provide evidence-based (NICE-recommended) psychological therapies for people with LTCs who also have depression and anxiety disorders, or who have MUS. While some services will be hospital-based, it is expected that most will be embedded in primary care and community settings. IAPT-LTC services are built on the same key principles that underpin the IAPT programme (see the IAPT Manual).

Common functions of existing IAPT services and IAPT-LTC services include:

- **Ease of access and a prompt assessment:** in addition to referrals being made from primary care and other healthcare professionals, IAPT services also accept self-referrals. Following this, each person should receive an appropriate mental health assessment when first seen by the service (see Section 5.2).
- **Offering the most effective and least intrusive evidence-based (NICE-recommended) psychological therapy first:** services should ensure that the most effective and least intrusive NICE-recommended intervention is offered first (according to the stepped-care model) and that a person can be 'stepped up' if more intensive treatment is needed. All people should receive an adequate course of treatment.
- **Trained and competent psychological therapists:** therapists should be supervised weekly by appropriately trained supervisors (see Section 3.3.2).
- **Choice:** where possible people should be able to make a meaningful choice about their psychological therapy, including how it is provided, where it is delivered, the type of therapy and the therapist (for example, male or female)
- **Routine, session-by-session outcome monitoring:** sessional recording of mental health outcomes must be in place in all IAPT-LTC services. All IAPT services are expected to obtain pre- and post-treatment outcome data on at least 90% of service users (see Section 5.5)
- **Close links with the wider system** (see below and Section 6): services should be embedded within existing local pathways with clear entry points and established links to other services including:
  - **Primary care:** all services should have a local GP lead who will champion the service. Close collaboration should take place with GPs over the management of medication, so that it facilitates rather than hinders effective treatment
  - **Specialist mental health services:** effective links should be established with specialist mental health services. These services provide specialist multidisciplinary assessment and treatment for a wide range of severe and complex mental health problems
  - **Employment support:** this includes employment advice, debt counselling and other social assistance.

In addition, IAPT-LTC services will also provide the following:

- **Case recognition methods in general health care pathways**: all LTC or MUS pathways that involve IAPT should have mental health case recognition tools in routine use. This includes the Generalized Anxiety Disorder two-item scale (GAD-2), the Whooley questions

for depression and the Mini-Social Phobia Inventory Scale (see Section 2 in the helpful resources).

- **Integrated care pathways:** all therapists should be co-located with general health care teams and primary care. This requires participation in multidisciplinary team meetings, care planning and, where required, joint working.
- **Revised IAPT assessment protocols for the integrated pathways:** protocols should reflect the increased complexity associated with the assessment of depression and anxiety disorders in people with LTCs and MUS.
- **Revised IAPT workforce:** including expansion and upskilling (see Section 3.3).
- **Sharing best practice with existing IAPT services:** IAPT-LTC and existing IAPT services would normally have shared personnel and shared management, training and supervision arrangements. This may also contribute to reduced costs. In the long-term, areas should be working towards a single IAPT provision for everyone.
- **Close links with the wider system:** Effective links should be built with:
  - **Core 24 liaison mental health services/integrated psychological medicine:** these services provide care in general hospital emergency departments, inpatient units and outpatient clinics and work with people with mental health problems in the context of an LTC and MUS (see the urgent and emergency liaison mental health care pathway for adults and older adults)
  - **Clinical and health psychology services:** these services focus on the inter-relationships between behavioural, emotional, cognitive, social and biological components of physical health problems. In doing so they are involved in the promotion and maintenance of health, and the prevention, treatment and rehabilitation of illness and disability. Clinical and health psychologists help people who have an LTC and are having difficulties adjusting to the condition. They also support other clinicians in managing the person's condition and are likely to be an integral part of the IAPT-LTC workforce (see Section 3.3).

3.2 Current provision of IAPT-LTC services

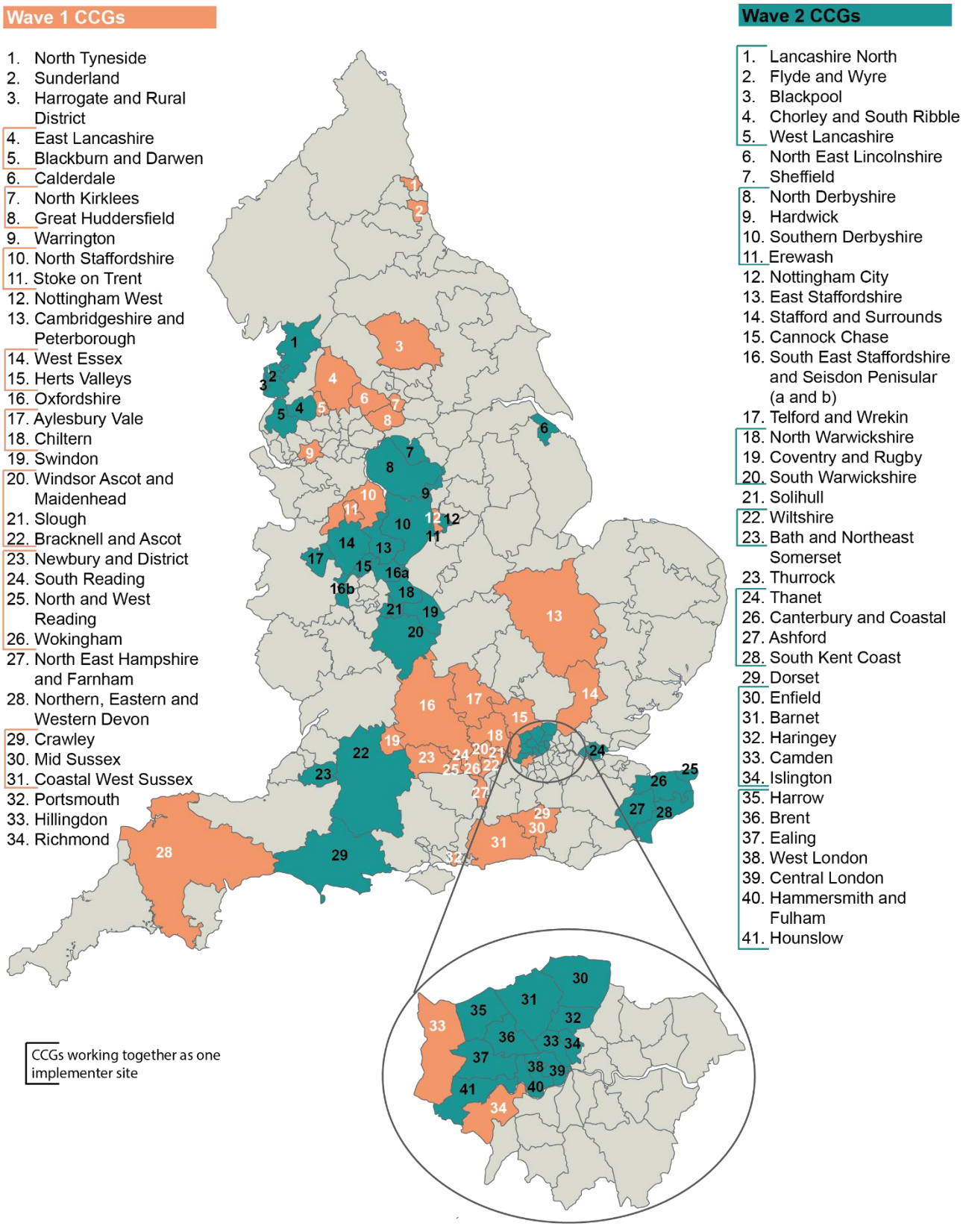
Since September 2016, NHS England has supported 22 early implementer sites in wave 1 and 15 sites in wave 2 (see Figure 4 for further information on the CCGs involved). They include the development of IAPT-LTC services for people with diabetes, respiratory disease, cardiac disease and MUS. From 2018/19, all CCGs are being asked to recruit additional staff and commission IAPT-LTC services.[9]

Further information on the good practice of a number of the IAPT early implementer sites can be found in the section on positive practice examples in the helpful resources.

3.3 Workforce for IAPT-LTC services

The right workforce, appropriately trained, with the right capacity and skills mix, is essential for ensuring the delivery of evidence-based (NICE-recommended) interventions as part of the IAPT-LTC pathway introduced in this guidance. It is expected that 4,500 more clinicians will be required to support the expansion of IAPT-LTC services. Work is currently underway to expand and up-skill the IAPT workforce. This should increase the number of mental health therapists co-located in general practice by 3,000 by 2020/21.[9]

Figure 4: Map of wave 1 and 2 IAPT-LTC early implementer sites by CCG



3.3.1 Recommended workforce

The IAPT workforce consists of psychological wellbeing practitioners (PWPs) and high-intensity therapists who together deliver the full range of evidence-based interventions for people with mild, moderate and severe depression and anxiety disorders, operating within a stepped-care model. National guidance suggests that approximately 40% of the workforce in IAPT services should be PWPs and 60% high-intensity therapists (see the IAPT Manual for further details).

It is expected that within IAPT-LTC services 30% of staff will be PWPs and 60% high-intensity therapists (see Table 3). This ratio is suggested because it is likely that in IAPT-LTC services a larger proportion of high-intensity interventions will be delivered and more complex assessments conducted. The remaining 10% of staff should have specialist expertise in LTCs and MUS (such as clinical and health psychologists) and will have a role in supervision and the assessment and management of people with more complex presentations. All staff will deliver evidence-based (NICE-recommended) interventions (see Section 4).

3.3.2 Competences and training

Trained and competent therapists should have completed an IAPT-accredited training programme (or have acquired the relevant competences or skills before joining an IAPT service).[b] To develop competences for integrated pathways, NHS England and Health Education England have developed a number of specialist training programmes for PWPs and high-intensity therapists.

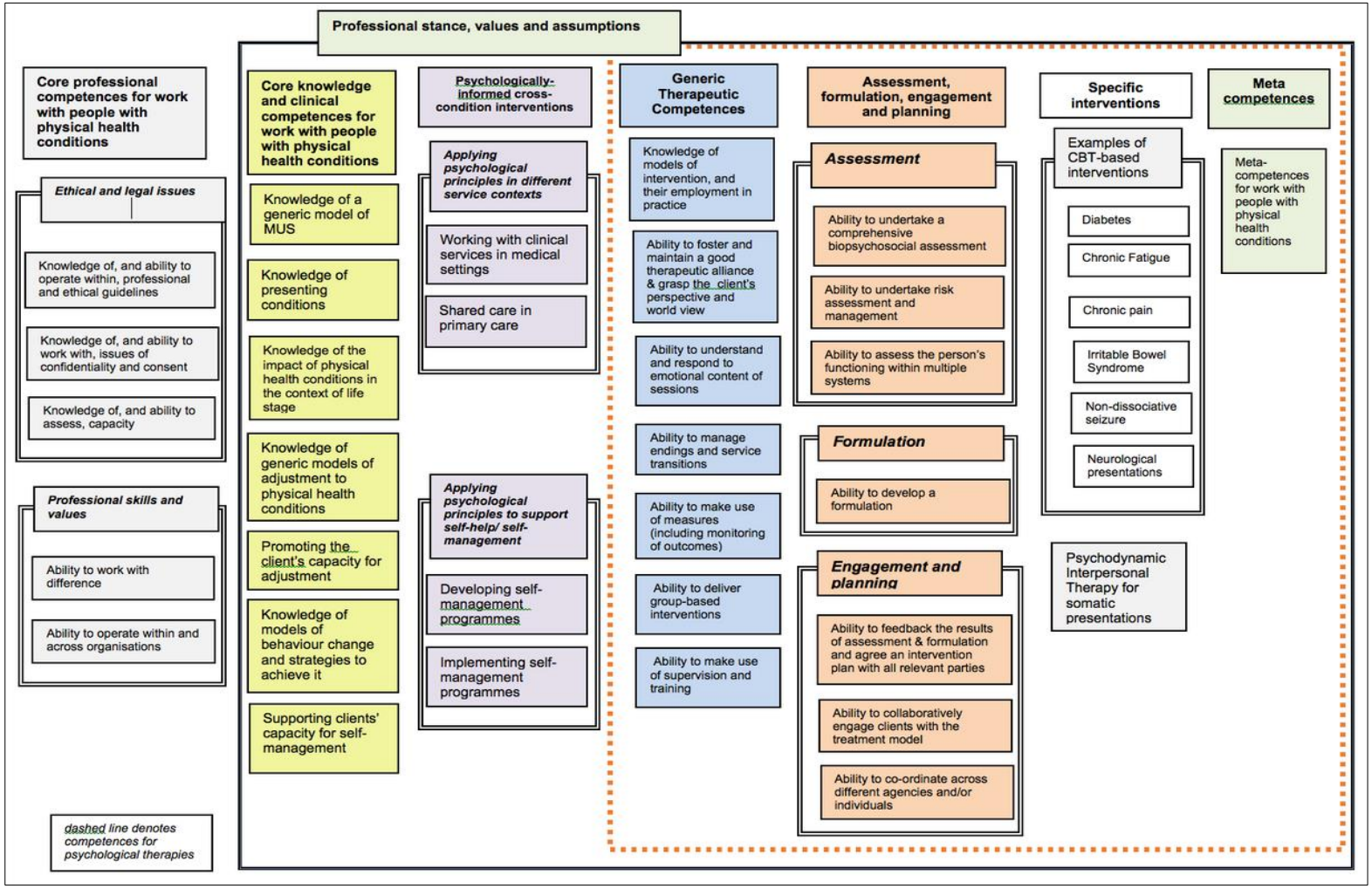
The key skills required to deliver psychological therapies effectively for people with LTCs and MUS are outlined in the Competence Framework for Psychological Interventions with People with Persistent Physical Health Conditions[47] (see Figure 5). The framework sets out seven 'domains', each of which represents a broad area of practice. Where possible, these are evidence-based and designed to ensure the delivery of NICE-recommended interventions in a competent and effective manner. While it is expected that all professionals are familiar with the core domains, the framework is intended to capture the range of skills available in a multidisciplinary team. Further information can be found on the University College London (UCL) website.

Table 3: Recommended workforce for IAPT and IAPT-LTC services

	IAPT services	IAPT-LTC services
PWPs	40%	30%
High-intensity therapists	60%	60%
Senior therapists (including clinical and health psychologists)		10%

[b] It is recognised that a proportion of the workforce may have acquired relevant competences or skills before the development of IAPT training programmes; such professionals are expected to be accredited by a relevant professional body that is recognised by IAPT.

Figure 5: Competence framework for psychological interventions with people with persistent physical health conditions



Reproduced from: UCL website.

4 What is NICE-recommended care in IAPT-LTC services?

4.1 Existing NICE guidance

A wide range of NICE guidance is available for the treatment of depression and anxiety disorders in the general population, for LTCs and for specific diagnostic groups of MUS, including irritable bowel syndrome and chronic fatigue syndrome. Where depression and anxiety disorders are comorbid with LTCs there is more limited guidance. There is also no NICE guidance for people with other patterns of MUS (see Table 4).

4.1.1 Recommendations of an expert advisory group

With this in mind an expert advisory group was convened by NHS England[c] to review[d] existing NICE guidance for the use of psychological therapies for the treatment of depression and anxiety disorders in the context of LTCs and for the treatment of MUS. A summary of this review can be found below and in Table 5. It should be noted that many psychological interventions are effective alone or in combination with pharmacological interventions.

4.1.2 Depression and anxiety disorders in the context of LTCs

The evidence review concluded that:

- psychological therapies are effective in people with and without LTCs
- optimal results are obtained when psychological therapies are delivered to take account of the way LTCs interact with mental health problems and impact on daily functioning.

For this reason, NHS England's expert advisory group recommended that the psychological therapies that are already used in IAPT services should be deployed in IAPT-LTC services. Clinicians should also:

- consider the impact of LTCs on the presentation of mental health problems
- help to promote the self-management of LTCs
- address problematic beliefs and behaviours that may increase the impact of the LTC on the person and their family or on the person's level of engagement
- modify the delivery of the intervention to take into account the LTC; for example, the delivery of cognitive behavioural therapy (CBT) in the form of a structured physical activity programme may need to be modified to treat panic symptoms in a person who has had a myocardial infarction so that they do not think they are having a cardiac arrest while undergoing exercise that might leave them breathless.

4.1.3 Medically unexplained symptoms

The expert advisory group reviewed a number of high-quality existing systematic reviews and made a series of recommendations based on this evidence (see Table 5).

[c] NHS England IAPT Education and Training Group (ETG).

[d] It should be noted that 'review' in this context does not mean appraising the guidance with a view to updating it because of potential new evidence, but rather assessing whether psychological therapies recommended for people with depression and anxiety disorders are suitable for people who also have LTCs and who have MUS.

Table 4: NICE guidance

Disorder	Applicable NICE guidance
Depression and anxiety disorders in the context of LTCs	• Depression in Adults with a Chronic Physical Health Problem: Recognition and Management (NICE clinical guideline 91) • Multimorbidity: Clinical Assessment and Management (NICE guideline 56)
Depression and anxiety disorders in the general population	• Common Mental Health Problems: Identification and Pathways to Care (NICE clinical guideline 123) • Computerized Cognitive Behaviour Therapy for Depression and Anxiety (NICE technology appraisal 97) • Depression in Adults: Recognition and Management (NICE clinical guideline 90) • Depression in Adults with a Chronic Physical Health Problem: Recognition and Management (NICE clinical guideline 91) • Generalised Anxiety Disorder and Panic Disorder in Adults: Management (NICE clinical guideline 113) • Obsessive-compulsive Disorder and Body Dysmorphic Disorder: Treatment (NICE clinical guideline 31) • Post-traumatic Stress Disorder: Management (NICE clinical guideline 26) • Social Anxiety Disorder: Recognition, Assessment and Treatment (NICE clinical guideline 159)
MUS	• Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (or Encephalopathy): Diagnosis and Management (NICE clinical guideline 53) • Irritable Bowel Syndrome in Adults: Diagnosis and Management (NICE clinical guideline 61)

Table 5: Evidence-based psychological therapies (informed by NICE guidance) recommended for use in IAPT-LTC services

	Condition	Psychological therapies	Source
Step 2: Low-intensity interventions *(delivered by PWPs)*	Depression	Individual guided self-help based on CBT, computerised CBT, behavioural activation, structured group physical activity programme	NICE guidelines: CG90, CG91, CG123
	Generalised anxiety disorder	Self-help, or guided self-help, based on CBT, psycho-educational groups, computerised CBT	NICE guidelines: CG113, CG123
	Panic disorder	Self-help, or guided self-help, based on CBT, psycho-educational groups, computerised CBT	NICE guidelines: CG113, CG123
	Obsessive-compulsive disorder	Guided self-help based on CBT	NICE guidelines: CG31, CG123

Step 3: High-intensity interventions	Depression *For individuals with mild to moderate severity who have not responded to initial low-intensity interventions*	CBT or interpersonal therapy Behavioural activation Couples therapy[e] Counselling for depression Brief psychodynamic therapy *Note: psychological interventions can be provided in combination with antidepressant medication.*	NICE guidelines: CG90, CG91, CG123
	Depression *Moderate to severe*	CBT or interpersonal therapy, each with medication	
	Depression *Prevention of relapse*	CBT or mindfulness-based cognitive therapy[f]	
	Generalised anxiety disorder	CBT, applied relaxation	NICE guidelines: CG113, CG123
	Panic disorder	CBT	NICE guidelines: CG113, CG123
	Post-traumatic stress disorder	Trauma-focused CBT, eye movement desensitisation and reprocessing[g]	NICE guidelines: CG26, CG123
	Social anxiety disorder	CBT specific for social anxiety disorder[h]	NICE guideline: CG159
	Obsessive-compulsive disorder	CBT (including exposure and response prevention)	NICE guidelines: CG31, CG123
	Chronic fatigue syndrome	Graded exercise therapy, CBT*	NICE guideline: CG53
	Chronic pain	Combined physical and psychological interventions, including CBT* and exercise	NICE guideline: CG88 Informal consensus of the ETG[i]
	Irritable bowel syndrome	CBT*	NICE guideline: CG61 Informal consensus of the ETG
	MUS not otherwise specified	CBT*	Informal consensus of the ETG

***Note**:* NICE depression guidance currently being updated.* Specialised forms of CBT.

[e] If the relationship is considered to be contributing to the maintenance of the depression, and both parties wish to work together in therapy. IAPT recognises two forms of couples' therapy and supports training courses in each. One closely follows the behavioural couples therapy model. The other is a broader approach with a systemic focus.

[f] CBT during treatment in the acute episode and/or the addition of mindfulness-based cognitive therapy when the episode is largely resolved. Mindfulness is not recommended as a primary treatment for an acute depressive episode.

[g] If no improvement, an alternative form of trauma-focused psychological treatment or augmentation of trauma-focused psychological treatment with a course of pharmacological treatment.

[h] Based on the Clark and Wells model or the Heimberg model.

[i] The NHS England IAPT Education and Training Group (ETG) was convened to undertake a review of problem-specific systematic reviews and extrapolation from NICE guidance for the treatment of depression and anxiety disorders in the context of LTCs and for the treatment of MUS.

5 The IAPT-LTC pathway

5.1 Starting the pathway

The **IAPT-LTC pathway starts** when the IAPT-LTC service receives a referral or self-referral (see Figure 6). Referrals may be made from the community or voluntary sector, primary care or secondary care (including both mental health and physical health services).

It should be noted that:

- If there is more than one referral, the pathway starts when the first referral is received by the service
- When a person self-refers to an IAPT-LTC service, the pathway starts when the request is received by the IAPT-LTC service.

5.2 Assessment

Once the referral or self-referral has been made to the IAPT-LTC service, an assessment that covers the person's mental health problems and acknowledges the LTC should be carried out by an experienced clinician (see Box 3).

The assessment should include:

- clear information about the IAPT-LTC service, the clinician's role and the purpose of assessment
- structured and clear information gathering regarding:
  - the **person's presenting mental** and **physical health problems**
  - any **history of previous** mental health problems and physical health problems
  - the **person's view** of the main problem(s) and the impact on their life, including any difficulties managing their physical health problem
  - the **person's goals** of treatment
  - an exploration of any **adverse circumstances** that maintain a person's presenting symptoms, including factors such as debt, domestic violence, isolation, homelessness or inadequate housing, relationship difficulties and employment status, and information about the person's use of prescribed and non-prescribed medication (for example, drug and alcohol use)
- a **risk assessment** (including self-harm, suicide or harm to others and safeguarding)
- completion of the IAPT Minimum Data Set and appropriate anxiety disorder specific measures and/or the relevant LTC/MUS outcome measures (see Section 5.5).

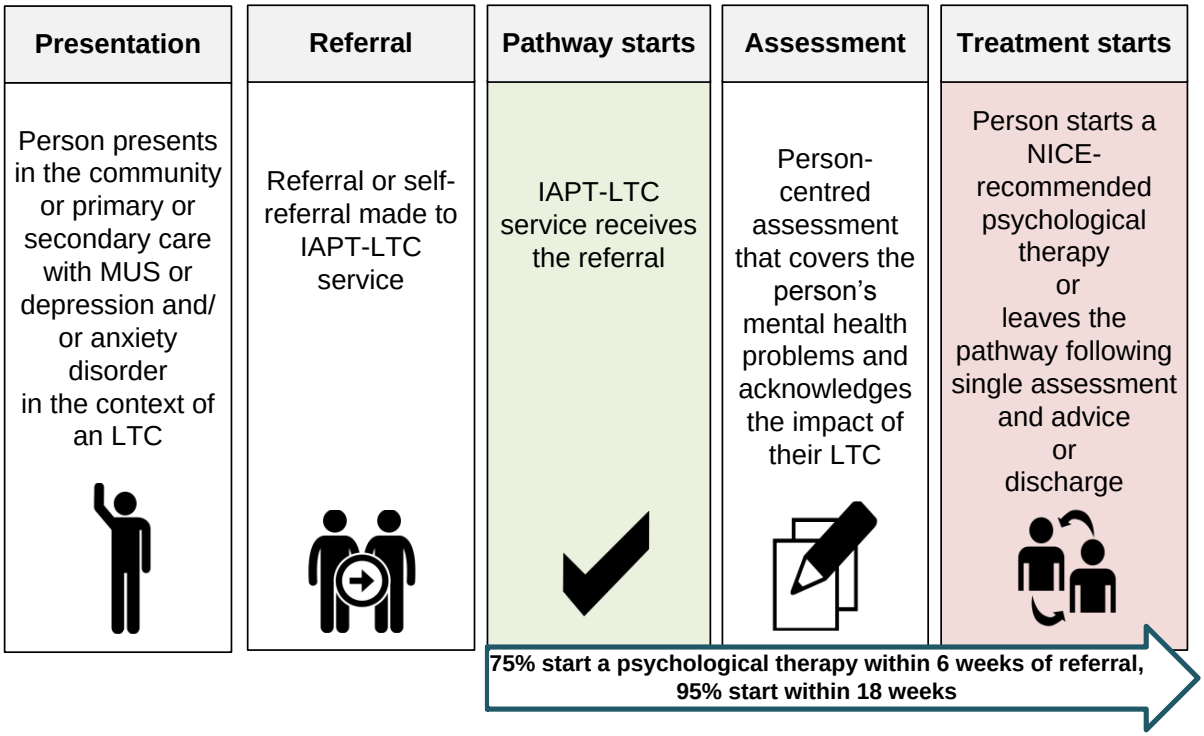
Further details on how to deliver an effective assessment can be found in the IAPT Manual.

Box 3: Functions of a good assessment

A good assessment should lead to:

- the appropriate **problem descriptor**(s) for the mental health problem
- the most appropriate **NICE-recommended intervention** for the **problem descriptor(s)**, taking into account the person's choice and preference (see Section 4)
- enhanced **equity** of access
- **collaborative** and **shared-decision making** about the most appropriate care pathway
- a clear, informed and collaboratively developed **care plan**.

Figure 6: The IAPT-LTC pathway



5.3 Treatment

If it is decided that the person requires psychological therapy, the **IAPT-LTC pathway is completed** when the person receives their first NICE-recommended treatment session (see Section 4).

5.3.1 Single assessment and advice session or no further treatment

Some people may benefit from a single assessment and advice session and need no further treatment or are signposted to another appropriate service (see Box 2). If it is judged that the person does not require a course of treatment, the person will leave the IAPT-LTC pathway.

5.4 Pathway principles

Pathways should be developed locally, with appropriate resources and training in place to ensure that they can deliver high-quality, coordinated care (see Section 6). There are a number of principles that should be followed when establishing and maintaining IAPT-LTC pathways. Many of these principles are built on the key principles and standards of care that exist already in IAPT services (see Section 3.1 and the IAPT Manual).

5.4.1 Establishing IAPT-LTC pathways

IAPT-LTC pathways should:

- have **clear and direct entry** and **exit points**, with clear criteria on how to move between services without barriers to access
- set **criteria for progression** through the pathway and the wider mental health system based on monitoring of outcome data; all people receiving care should be visible in local patient tracking reports and escalated as required
- have a multidisciplinary team composed of senior clinicians and managers to oversee the development **monitoring and auditing** of the pathway
- have **built-in flexibility** around working times and when and where to offer additional appointments, such as weekend clinics
- have regular **clinical supervision** for all psychological therapists, that is outcome-focused and supportive
- be supported with **appropriate infrastructure**, including administrative support and computer systems, to promote information sharing and accessibility of up-to-date patient information.

5.4.2 Ensuring timely treatment

- IAPT-LTC pathways should have **agreed response** times so that no one waits longer than necessary for an assessment or course of treatment
- Protocols should include **agreed response times for when people are 'stepped up'** to a high-intensity treatment. It is good practice that CCGs ensure that the national standards are also met for subsequent courses of treatment, including stepping up
- There should be **no 'hidden waits'** (where the person has an early appointment but is then put on an 'internal' waiting list before a full course of treatment starts).

5.4.3 Ensuring effective treatment

To ensure that treatment is effective and recovery is promoted:

- a **stepped-care model** for the delivery of psychological therapies should be used, when appropriate
- treatment should be **guided by the person's** problem descriptor (see Section 4 and the IAPT Manual). A range and choice of therapies should be available that cover the full range of severities of depression and anxiety disorders (it should be borne in mind that CBT is not a single therapy but rather a broad class of therapies).
- the person should be offered treatment at an **appropriate dose.** The majority

of people should be offered a course of treatment instead of a single session of assessment and advice. Where people do not receive a course of treatment in IAPT, audits should be in place to ensure that the person still receives appropriate health or social care in the wider NHS.

5.4.4 Ensuring person-centred care

- Following the assessment, a person should have a **clear understanding of their treatment options**
- Decisions on the appropriate care pathway should be made **jointly** and **collaboratively** with the person (see the Service User Experience in Adult Mental Health Services quality standard)
- Where NICE recommends a range of different therapies, where possible, people should be offered a **meaningful choice** about their therapy. This should include how it is provided, where it is delivered, the type of therapy and the therapist (for example, male or female).

5.4.5 Ensuring suitability for IAPT-LTC services

The kind of care and where it is provided will for the most part vary in accordance with the nature and the complexity of a person's presenting needs. The delivery of psychological therapies for depression and anxiety disorders in people with LTCs and MUS can be affected by the interactions of the following factors:

- **nature, severity, chronicity and prognosis of mental health problem**; a coexisting personality disorder or significant drug and alcohol misuse may add further to the complexity
- **nature, severity, chronicity and prognosis of the physical health problem**, such as brittle diabetes (hard-to-control diabetes)
- **degree of cognitive and functional impairment or disability**
- **complexity of the physical health interventions** delivered in the settings in which they are provided, such as if the person is undergoing renal dialysis or chemotherapy treatment
- **social and environmental factors** that influence access to or delivery of care.

Decisions about an individual's suitability for an IAPT-LTC service should be taken in collaboration with the treating clinical teams following a thorough assessment of the above factors. When a person's needs are not best met by IAPT-LTC services, local protocols should be in place to ensure that the person can promptly and easily access the wider health systems (including secondary care mental health services, clinical health psychology services and core 24 liaison mental health services).

5.4.6 Working with the wider health system

The following principles should be applied during transitions:

- **Clearly defined local pathways**: in line with Section 5.4.1 clear pathways and processes should be in place to enable a person to progress within or between services and existing pathways. This should include appropriate follow-up and transfer of responsibility after the person has been discharged
- **Providing timely care:** no one should be disadvantaged when they move between services or pathways. In such instances, providers and commissioners should use their judgement to guide an appropriate overall response time
- **Taking a collaborative approach to care planning:** this should include providing the person with a named contact responsible for the coordination of their care and developing an agreed care plan that is shared with all agencies involved in the person's care
- **Working proactively with other services:** this should include agreed arrangements to facilitate coordination of discharge or transfer of care
- **Providing clear information** to the person (and if appropriate their family):

this should include contact details and support services appropriate to their needs.

5.5 Reporting and outcome measurement

IAPT-LTC services will be part of the national data collection system for IAPT and will use the IAPT Minimum Data Set. The data set is currently being expanded to capture the benefits of IAPT-LTC services. In the interim, services will be expected to collect this information before it becomes part of the formal dataset and produce separate local reports on the performance of IAPT-LTC services. Routine, session-by-session outcome measurement should be supported by appropriate computer systems (see Section 6.6.2).

Four domains will need to be captured for IAPT-LTC services:

- **Mental health outcomes:** this is the primary outcome for IAPT therapy and will be used to calculate key IAPT indices such as recovery, reliable improvement and reliable recovery (see Section 6).
- **Perception of physical health:** it is important to measure service users' perceptions of their LTC as the therapy progresses in order to ensure that treatment focuses on the whole person. For some people, treatment of mental health problems may directly improve physical health; for others, the negative impact of LTCs on their lives may be reduced
- **Disability:** the main measure of disability is the Work and Social Adjustment Scale (WSAS),[48] which assesses the extent to which a person's mental health problem interferes with their functioning at work, at home, at leisure, socially and with their family. Although disability often decreases as symptoms improve, that is not always the case. For this reason, clinicians need to carefully monitor WSAS scores as well as symptom scores to ensure that people have reduced disability once treatment is finished
- **Healthcare utilisation**: it is expected that the treatment of mental health problems will, in general, reduce a person's use of other health service resources. Documenting this effect will be important for sustaining IAPT-LTC services. The Client Service Receipt Inventory is appropriate for this purpose. In the longer term, this self-report measure will be replaced by linking the national IAPT database with other national NHS datasets (such as the Hospital Episode Statistics). In the interim, IAPT-LTC services are encouraged to explore linkage at the local level
- **Patient-reported experience measures (PREMs):** It is important to measure the quality of a person's experience of the service. PREMs should be collected at the end of the last assessment contact (Assessment Patient Experience Questionnaire) and at the end of or after the last planned treatment appointment (Treatment Patient Experience Questionnaire).

Further information, including a copy of the measures listed in Table 6), and session-by-session monitoring system, can be found in Section 3 of the helpful resources.

Table 6: Outcome measures by problem descriptor for IAPT-LTC services

Main mental health problem (primary problem descriptor)	Depression symptom measure	Recommended measure for anxiety symptoms or MUS	Further option, only used if 'recommended measure for anxiety symptoms or MUS' is missing	Measure of disability
Depression	**PHQ-9**	**GAD-7**	-	WSAS
Generalised anxiety disorder	**PHQ-9**	**GAD-7**	-	WSAS
Mixed anxiety/depression	**PHQ-9**	**GAD-7**	-	WSAS
No problem descriptor	**PHQ-9**	**GAD-7**	-	WSAS
Social anxiety	**PHQ-9**	**Social Phobia Inventory (SPIN)**	GAD-7	WSAS
Post-traumatic stress disorder	**PHQ-9**	**Impact of Events Scale-Revised (IES-R)**	GAD-7	WSAS
Agoraphobia	**PHQ-9**	**Mobility Inventory (MI)**	GAD-7	WSAS
Obsessive-compulsive disorder	**PHQ-9**	**Obsessive-Compulsive Inventory (OCI)**	GAD-7	WSAS
Panic disorder	**PHQ-9**	**Panic Disorder Severity Scale (PDSS)**	GAD-7	WSAS
Body dysmorphic disorder	**PHQ-9**	To be agreed by IAPT's Education and Training Committee	GAD-7	WSAS
Irritable bowel syndrome*	**PHQ-9**	**Francis IBS scale**	GAD-7	WSAS
Chronic fatigue syndrome*	**PHQ-9**	**Chalder Fatigue Questionnaire**	GAD-7	WSAS
Chronic pain (in the context of depression/anxiety disorders)*	**PHQ-9**	**GAD-7**	-	WSAS
MUS not otherwise specified*	**PHQ-9**	**PHQ-15**	GAD-7	WSAS

Notes: *Recovery, reliable improvement and reliable deterioration rate calculations should be based on the pair measures highlighted in* ***bold****. When the measure in bold in the middle column is missing, the recovery calculation is based on the combination of PHQ-9 and GAD-7, if this is different.*

** Denotes a mental health problem that is new to the IAPT programme as it is being introduced in the context of IAPT-LTC services.*

Key and cut-off scores: Patient Health Questionnaire - 9 items (PHQ-9) – 10 and above; Generalised Anxiety Disorder scale – 7 items (GAD-7) – 8 and above; Obsessive-Compulsive Inventory (OCI) – 40 and above; Social Phobia Inventory (SPIN) – 19 and above; Agoraphobia-Mobility Inventory (MI) – above an item average of 2.3; Impact of Events Scale - Revised (IES-R) – 33 and above; Panic Disorder Severity Scale (PDSS) – 8 and above.

6 Key commissioning considerations and service development

> ***"Patients repeatedly ask for services to be 'more joined up' to support both their mental wellbeing as well as physical needs. This new way of delivering services is very accessible ... as well as making it much easier for GPs, nurses and other health care professionals to refer or signpost to [mental health] interventions that really make a difference to people's lives and can reduce the need for onward healthcare. We are delighted with this new way of working!"***
>
> Source: A commissioner of an early implementer site

The following section is a practical guide that can be used by commissioners to implement the IAPT-LTC pathway. It should be read in conjunction with the 'Key messages for commissioners' in the IAPT Manual, as well as other documents on integrating mental and physical health services more widely for people with LTCs and MUS.[1 6 49] A summary of the key steps of this section is provided in Figure 7. Examples of good practice that are occurring across the country can also be found in the helpful resources.

6.1 Clear objectives

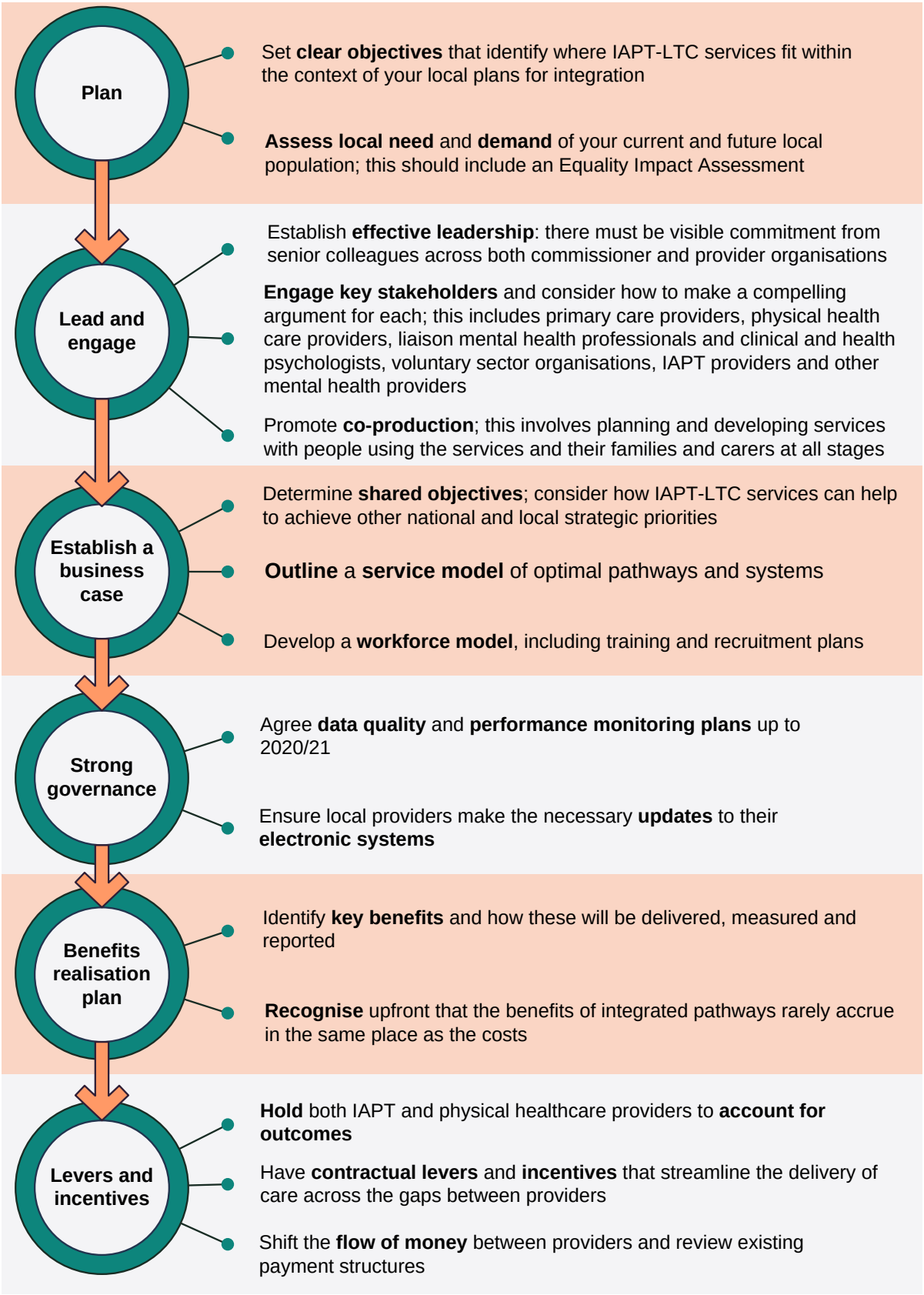
As a first step, CCGs should clearly identify and understand where the IAPT-LTC service fits within the context of local plans for integration. This will help to formulate a set of clear, outcome-focused and strategic priorities and investment plans that highlight the short, medium and long-term goals linked to delivering IAPT-LTC services. These goals are likely to vary considerably across local areas. Some are likely to be simple, while others will focus on more innovative approaches involving wider system redesign or transformative commissioning and contracting decisions.

6.2 Assessing local need and demand

To support the roll out of IAPT-LTC services at scale and pace, commissioners should have a thorough understanding of the current and future mental and physical health needs of the local population. Commissioners should:

- **Estimate the local overall incidence rates** of people with LTCs and depression or anxiety disorders, and MUS
- **Understand current pathways and local referral rates** and build a realistic understanding of how many people are referred, and when and how they are referred. This should include collaborating with mental and physical health care providers, people who use the services, as well as their carers and their health and social care team, and the public (see Box 2)
- **Understand potential savings if benefits are realised,** including estimates of the amount spent locally and a quantification of the potential 'savings' resulting from delivering IAPT-LTC services

Figure 7: Key commissioning considerations



- **Understand the local demographic profile and variance in incidence and referral rates.** Incidence and referral rates will vary across, for example, age, gender and ethnicity. An Equality Impact Assessment should be conducted, to highlight the needs of and solutions for specific groups at risk of inequality. This should consider, but not be limited to:
  - people with protected characteristics
  - people who are housebound
  - older adults
  - students
  - people who are homeless
  - people who misuse substances
- **Arrive at a local estimate** by combining the factors above.

6.2.1 Equality-focused services

Addressing inequalities in access and experience of mental health services was set out as a priority in The Five Year Forward View for Mental Health. Local commissioners should be able to demonstrate the way they meet the duties placed on them under the Equality Act 2010 and the Health and Social Care Act 2012. IAPT-LTC services should be designed to meet the needs of diverse communities, be accessible to them and be able to effectively communicate with them.

Further information (including positive practice examples) on how commissioners can promote equality in terms of access and outcomes, can be found in the IAPT Manual.

6.3 Effective leadership

Effective leadership is critical, especially if transformation and whole service redesign is behind local plans for delivery of IAPT-LTC services. There must be visible commitment from senior colleagues across both commissioner and provider organisations and across both physical and mental health settings. This includes encouraging collaboration, as well as influencing changes in organisational behaviour and ways of working.

> ***"It is so important that leaders across health reach out to their colleagues… to break down organisational barriers so that collectively, they can ensure people's needs are always put first."***
>
> Source: The Five Year Forward View

6.4 Engagement and relationships with people who use the services and other key stakeholders

Once CCGs have established a clear and convincing vision, commissioners should identify the key stakeholders involved in the successful delivery of IAPT-LTC pathways. Consideration should be given as to how to engage with each group and how to make a compelling argument for the new pathways.

Commissioners should ensure that pathways are developed and implemented collaboratively with the people who use the services and their families/carers.

> ***"Co-production is not just a word, it's not just a concept, it is a meeting of minds coming together to find a shared solution. In practice, it involves people who use services being consulted, included and working together from the start to the end of any project that affects them."***
>
> Source: SCIE co-production network

Other key stakeholders may include primary care providers, physical health care providers, liaison mental health professionals, clinical and health psychologists, psychiatrists, medical psychotherapy, specialist persistent physical symptom services (such as chronic fatigue services), voluntary sector organisations, IAPT providers and other mental health providers.

6.5 Establishing a business case

Commissioners should work with providers and wider stakeholders to determine shared objectives and develop service models that support the delivery of integrated pathways. Proposed models should be driven by evidential data and best practice, as detailed in NICE guidelines and NICE quality standards (see Section 4).

Where plans to roll out IAPT-LTC services require additional investment, commissioners should use a logic model to demonstrate a robust business case. This should illustrate how IAPT-LTC pathways can help to achieve other national and local strategic priorities, including:

- Sustainability and Transformation Partnerships
- Health and Wellbeing Strategies
- Integrated Personal Commissioning Programmes
- New care models
- Better Care Fund strategies
- Quality, Innovation, Productivity and Prevention (QIPP)
- Joint Strategic Needs Assessments
- CCG Improvement and Assessment Framework.

6.5.1 Outline a service model of the optimal pathway and systems (mapping)

This should include protocols for referral, diagnosis and access to psychological therapies for people with LTCs or MUS, and a mapping exercise of who does what, when they do it, how it is done, the outcomes that are achieved and what resources are required (see Section 3.2). As part of this, commissioners should:

- **Compile a list of existing services**, consulting with stakeholders to ensure the list is comprehensive
- **Ensure that protocols and guidance are in place so that the pathway provides equal access.** These should make it clear who should be referred and when. As part of this, efforts should be made to ensure that people who are currently receiving treatment for LTCs in an existing general health care pathway can self-refer to IAPT-LTC services
- **Ensure that shared-care arrangements include robust plans for communication and clear delineation of responsibilities for different aspects of the IAPT-LTC pathway**
- **Promote the use of technology**, such as tele-care, video conferencing and online solutions
- **Develop preventative programmes to address social and wider determinants of health,** Public Health England has published a wider range of resources to support commissioners to do this
- **Encourage and support local research opportunities**
- **Promote better recognition of mental health problems** with the use of case recognition tools.

6.5.2 Develop a workforce model

The successful delivery of IAPT-LTC services depends on having the right workforce, which is appropriately trained and has the right capacity and skills mix. Commissioners should work with providers and Health Education England to:

- **Understand the existing workforce** including numbers, skills and locations
- **Identify the new workforce** required to implement the pathway and the gap between this and the existing workforce

- **Agree recruitment plans with providers,** including how they will address any specific demographic issues. For example, in culturally and ethnically diverse areas, providers should actively try to ensure that the workforce reflects this same diversity
- **Agree training plans and associated costs with providers**, engaging local education and training boards as necessary, and ensuring that there are sufficient numbers of people trained. Training should also recognise the need for upskilling and a cultural shift towards a more integrated way of working (see Section 3.2).
- **Agree plans for successful workforce integration**. Some overarching principles to consider are:
  - The driver for successful workforce integration is a clear focus on delivering better outcomes
  - To achieve genuine workforce integration, people need to acknowledge and overcome resistance to change and transition. There needs to be an acknowledgement of how integration will affect people's roles and professional identities
  - A confident, engaged, motivated, knowledgeable and properly skilled workforce is at the heart of workforce integration
  - Successful workforce integration creates new relationships, networks and ways of working.

6.6 Strong governance arrangements

6.6.1 Data quality and performance monitoring plans

Generating accurate and up-to-date information is essential to help identify local issues, understand the extent of the performance gap and will allow baselining of the current position and the measurement of the impact of any subsequent changes. CCGs should have a clear vision of what plans IAPT-LTC services are seeking to achieve, against which success can be measured. This includes improvements in quality, better patient experience and the delivery of more cost-effective care. Commissioners should:

- **Define clear lines of accountability from the start.** Commissioners need to establish governance arrangements to drive the IAPT-LTC programme forward, and review progress in delivering against plans.
- **Agree a schedule for performance reporting**, which may be worked into existing performance reporting and management arrangements. These should be planned until 2020/21.

6.6.2 Electronic care records and information systems

Innovations in integrating mental and physical health care should be underpinned by a commitment to improving information flow across the continuum of care and enhancing communication. The IAPT Minimum Data Set will support the monitoring of the IAPT-LTC pathway in this guidance. Commissioners should ensure that local providers have made the necessary updates to their electronic care record system to ensure IAPT services can enter the data required to monitor performance against the IAPT-LTC pathways.

"We have a double opportunity: to narrow the gap between the best and the worst, whilst raising the bar higher for everyone… we can do more by measuring what matters, requiring comprehensive transparency of performance data and ensuring this data increasingly informs payment mechanisms and commissioning decisions."

Source: The Five Year Forward View

The electronic care record system should enable collection and submission of data in three key areas:

- **waiting times** (see Section 5)
- **performance against the requirement that the care accessed is in line with NICE recommendations** (see Section 4)
- **routine measurement of outcomes** (see Section 5.5).

6.7 Benefits realisation plan

Generally, the benefits of integrating mental and physical health pathways rarely accrue in the same place as the costs. This needs to be recognised and understood upfront. A benefits realisation plan should be drawn up that identifies key benefits and sets out how they will be delivered, measured and reported.

Key benefits of providing psychological therapies for people with depression and anxiety disorders in the context of LTCs and MUS include:

- improved patient experience and service user satisfaction
- greater efficiencies through reducing duplication and the need for multiple assessments
- improved clinical outcomes
- reduced use of physical health care services, including acute and emergency care.

6.8 Introduce appropriate levers and incentives (commissioning and contracting)

CCGs may need to review the commissioning and contracting tools required to drive sustainable service integration through IAPT-LTC services. Contracts can act as the 'scaffolding' for an integrated model and the contract terms act as a lever for collaboration.

Considerations include:

- **Holding both IAPT and physical health care providers to account for outcomes:** outcome-based contracting shifts greater responsibility onto providers to deliver care pathways that achieve specified outcomes. CCGs can link outcomes to incentive payments and outcomes can be weighted, depending on their likely impact on the overarching ambition of the transformation or their 'value'.
- **Having contractual levers/incentives that streamline delivery of patient care across the gaps between service providers:** there is much that providers can do to work together within a traditional contracting environment. However, such efforts are often reliant on goodwill and isolated individual relationships. In order to maximise impact and sustainability of these efforts, contracts should focus on holding providers to account for streamlining the delivery of care across these gaps for the population in question.
- **Shifting the flow of money between providers:** transformational change in service delivery may require transformational change in the flow of money. Commissioners must consider the challenges this will present and how it will be addressed. Plans for IAPT-LTC services should consider how money will flow across providers to support greater service integration. Sustainable change is likely to involve the reallocation or redistribution of money across the system.
- **Reviewing existing payment systems:** payment systems should incentivise providers to deliver IAPT-LTC services. Local systems should enable swift access, high-quality care and good outcomes. Consideration should also be given to payment models that inadvertently create perverse incentives and prevent delivery of IAPT-LTC services.

Definitions of terms and abbreviations

Definitions

Term	Definition
Core 24	A liaison mental health service model provided 24 hours, 7 days a week; it is commonly provided across urgent and emergency care pathways.
IAPT	The Improving Access to Psychological Therapies (IAPT) programme was established in 2008 to improve access to psychological therapies for the treatment of depression and anxiety disorders in adults. Further information on IAPT can be found on NHS England's website. The NHS now plans to develop new IAPT services that will ensure people with LTCs who also have depression and anxiety disorders, or who have MUS, receive joined-up health care (see below).
IAPT-LTC	A term used in this guidance to refer to IAPT services embedded in general health care pathways for people with LTCs or MUS. Such services may be located within primary care or secondary care services, such as diabetes, cardiac or respiratory care pathways.
Liaison mental health service	Liaison mental health services provide the interface between mental and physical health care for people attending general hospitals, whether they attend outpatient clinics, emergency departments or are admitted to inpatient wards. The primary purpose of a liaison mental health team is to support physical health services in the treatment and management of mental and physical health problems, including LTCs and MUS. Also commonly known as 'liaison psychiatry' or 'psychological medicine', the term 'liaison mental health' is used in this guidance to reflect the multidisciplinary nature of liaison teams.
Long-term physical health conditions (LTCs)	A range of long-term physical health conditions such as cardiovascular disease, chronic obstructive pulmonary disease, diabetes and musculoskeletal disorders.
Medically unexplained symptoms (MUS)	Persistent and distressing bodily symptoms characterised by functional disability that cannot wholly be explained by a known physical pathological cause; psychological processes are often involved in the presentation of MUS. Examples include: chronic fatigue syndrome, chronic pain and irritable bowel syndrome.
Problem descriptor	A way of describing a person's presenting mental health problems as assessed by an IAPT service. The descriptor corresponds with ICD-10 codes and should be based on the nature, severity and duration of symptoms, and their impact on functionality. Problem descriptors are important as NICE-recommendations for interventions vary in accordance to the problem descriptor. Services can enter several problem descriptors though the primary descriptor should characterise the leading problem and reflect the treatment being delivered.
Recovery	A national standard that 50% of eligible referrals should move to recovery has been set for IAPT services. A person moves to recovery if their symptoms were considered a clinical case at the start of their treatment (that is, their symptoms exceed a defined threshold as measured by scoring tools) and not a clinical case at the end of their treatment.
Reliable improvement	A person has shown reliable improvement if there is a significant improvement[j] in their condition following a course of treatment, measured by the difference in their first and last score.
Reliable recovery	A person has 'reliably recovered' if they meet the criteria for both recovery and reliable improvement.

[j] As such, the difference in scores is not attributed to chance.

Abbreviations

Abbreviation	Full term
CBT	cognitive behavioural therapy
CCG	clinical commissioning group
COPD	chronic obstructive pulmonary disease
ETG	Education and Training Group
GP	general practitioner
IAPT	Improving Access to Psychological Therapies
IAPT-LTC	IAPT services for people with long-term physical health conditions and medically unexplained symptoms
LTC	Long-term physical health condition
MUS	Medically unexplained symptoms
NCCMH	National Collaborating Centre for Mental Health
NICE	National Institute for Health and Care Excellence
PEQ	Patient Experience Questionnaire
PHQ	Patient Heath Questionnaire
PREM	patient-reported experience measure
PWP	psychological wellbeing practitioner
UCL	University College London
WSAS	Work and Social Adjustment Scale

References

[1] Mental Health Taskforce. Five Year Foward View for Mental Health - One Year On. London: NHS England; 2017.

[2] NHS England. Implementing the Five Year Forward View For Mental Health. London: NHS England; 2016.

[3] NHS England. Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21. London: NHS England; 2015.

[4] NHS England. CCG Improvement and Assessment Framework 2016/17. London: NHS England; 2016.

[5] Department of Health. Closing the Gap: Priorities for Essential Change in Mental Health. London: Department of Health; 2014.

[6] Mental Health Taskforce. The Five Year Forward View For Mental Health. London: NHS England; 2016.

[7] NHS England. Next steps on the NHS Five Year Forward View. London: NHS England; 2017.

[8] NHS England and Department of Health. Achieving Better Access to Mental Health Services by 2020. London: Crown; 2014.

[9] NHS England and NHS Improvement. NHS Operational Planning and Contracting Guidance 2017-2019. London: NHS England and NHS Improvement.

[10] HMSO. Equality Act. London: The Stationery Office; 2010.

[11] HMSO. Health and Social Care Act. London: The Stationery Office; 2012.

[12] NHS England. Guidance for NHS Commissioners on Equality and Health Inequalities Legal Duties. London: NHS England; 2015.

[13] Naylor C, Parsonage M, McDaid D, Knapp M, Fossey M, Galea A. Long-Term Conditions and Mental Health. The Cost of Co-morbidities. London: The King's Fund; 2012.

[14] NICE. Depression in Adults with a Chronic Physical Health Problem: Recognition and Management. NICE clinical guideline 91. London: NICE; 2009.

[15] NICE. Common Mental Health Problems: Identification and Pathways to Care. NICE clinical guideline 123. London: NICE 2011.

[16] McManus S, Bebbington P, Jenkins R, Brugha T. Mental Health and Wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital; 2016.

[17] Department of Health. Long-Term Conditions Compendium of Information: 3rd edition. London: Crown; 2012.

[18] Gunn J, Ayton, DR, Densley, K, Pallant, JF, Chondros, P, Herrman HE et al. The association between chronic illness, multimorbidity and depressive symptoms in an Australian primary care cohort. Social Psychiatry and Psychiatric Epidemiology. 2010;47:175–84.

[19] Vamos E, Mucsi I, Keszei A, Kopp M, Novak M. Comorbid depression is associated with increased healthcare utilization and lost productivity in persons with diabetes: a large nationally representative Hungarian population survey. Psychosomatic Medicine. 2009;71:501–7.

[20] Livermore N, Sharpe L, McKenzie D. Panic attacks and panic disorder in chronic obstructive pulmonary disease: a cognitive behavioral perspective. Respiratory Medicine. 2010;104:1246–53.

[21] Sale J, Gignac M, Hawker G. The relationship between disease symptoms, life events, coping and treatment, and depression among older adults with osteoarthritis. Journal of Rheumatology. 2008;35:335–42.

[22] Simon G, Vonkorff M. Somatization and psychiatric disorder in the NIMH Epidemiologic Catchment Area study. The American Journal of Psychiatry. 1991;148:1494-500.

[23] Nimnuan C, Hotopf M, Wessely S. Medically unexplained symptoms. An epidemiological study in seven specialities. Journal of Psychosomatic Research. 2001;51:361-67.

[24] Layard R, Clark D. Thrive: The Power of Evidence-based Psychological Therapies. London: Penguin; 2014.

[25] Mercer S, Watt G. The inverse care law: clinical primary care encounters in deprived and affluent areas of Scotland. Annals of Family Medicine. 2007;5:503–10.

[26] NICE. Multimorbidity: Clinical Assessment and Management. NICE guideline 56 London: NICE; 2016.

[27] Molosankwe I, Patel A, Gagliardino JJ, Knapp M, McDaid D. Economic aspects of the association between diabetes and depression: a systematic review. Journal of Affective Disorders. 2012;142:42-55.

[28] World Health Organization. Mental Health Action Plan 2013-2020. Geneva: World Health Organization; 2013.

[29] Community and Mental Health Team. Psychological Therapies: Annual report on the use of IAPT services. England 2015-16 (revised 2017). London: NHS Digital; 2016.

[30] O'Connor DW, Rosewarne R, Bruce A. Depression in primary care: elderly patients' disclosure of depressive symptoms to their doctors. International Psychogeriatrics. 2001 13:359-65.

[31] Goldman L, Nielsen N, Champion H. Awareness, diagnosis, and treatment of depression. Journal of General Internal Medicine. 1999:569-80.

[32] Naylor C, Das P, Ross S, Honeyman M, Thompson J, Gilburt H. Bringing Together Physical and Mental Health. London: King's Fund; 2016.

[33] Cepoiu M, McCusker J, Cole M, Sewitch M, Belzile E, Ciampi A. Recognition of depression by non-psychiatric physicians: a systematic literature review and meta-analysis Journal of General International Medicine. 2008;23:25-36.

[34] DiMatteo M, Lepper H, Croghan T. Depression is a risk factor for noncompliance with medical treatment: meta-analysis of the effects of anxiety and depression on patient adherence. Archives of Internal Medicine. 2000;160:2101-7.

[35] Laurin C, Labrecque M, Dupuis G, Bacon S, Cartier A, Lavoie K. Chronic obstructive pulmonary disease patients with psychiatric disorders are at greater risk of exacerbations. Psychosomatic Medicine. 2009;6:667-74.

[36] Carney R, Freedland K. Depression and coronary heart disease. Nature Reviews Cardiology. 2016;14:145-55.

[37] Burton C, McGorm K, Richardson G, Weller D, Sharpe M. Healthcare costs incurred by patients repeatedly referred to secondary medical care with medically unexplained symptoms: a cost of illness study. Journal of Psychosomatic Research. 2012;72:242-47.

[38] Pooler A, Beech R. Examining the relationship between anxiety and depression and exacerbations of COPD which result in hospital admission: a systematic review. International Journal of Chronic Obstructive Pulmonary Disease. 2014;9:315-30.

[39] Laurin C, Moullec G, Bacon SL, Lavoie KL. Impact of anxiety and depression on chronic obstructive pulmonary disease exacerbation risk American Journal of Respiratory and Critical Care Medicine. 2012;185:5.

[40] Konnopka A, Kaufmann C, König H, Heider D, Wild B, Szecsenyi J, et al. Association of costs with somatic symptom severity in patients with medically unexplained symptoms. Journal of Psychosomatic Research. 2013:370-75.

[41] Nimnuan T, Hotopf M, Wessely S. Medically unexplained symptoms: an epidemiological study in seven specialties. Journal of Psychosomatic Research. 2001;51:361-67.

[42] Knapp M, McDaid D, Parsonage M. Mental Health Promotion and Mental

Illness Prevention: the Economic Case. London: Department of Health; 2011.

[43] Allen L, Woolfolk R, Escobar J, Gara M, Hamer R. Cognitive-behavioral therapy for somatization disorder. A randomized controlled trial. Archives of Internal Medicine. 2006;166:1512-8.

[44] Howard C, Dupont S, Haselden B, Lynch J, Wills P. The effectiveness of a group cognitive behavioural breathlessness intervention on health status, mood and hospital admissions in elderly patients with chronic obstructive pulmonary disease. Psychology, Health and Medicine. 2010;15:371-85.

[45] Lemmens L, Molema C, Versnel N, Baan C, de Bruin S. Integrated care programs for patients with psychological comorbidity: a systematic review and meta-analysis. Journal of Psychosomatic Research. 2015;79:580-94.

[46] Department of Health. Improving the Health and Well-being of People with Long-term Conditions. World Class Services for People with Long-Term Conditions: Information Tool for Commissioners. London: Department of Health; 2010.

[47] Roth A, Pilling S. A Competence Framework for Psychological Interventions with People with Persistent Physical Health Conditions. London: UCL; 2016.

[48] Mundt JC, Marks IM, Shear MK, Greist JM. The Work and Social Adjustment Scale: a simple measure of impairment in functioning. The British Journal of Psychiatry. 2002;180:461-64.

[49] Joint Commissioning Panel for Mental Health. Guidance for Commissioners of Services for People with Medically Unexplained Symptoms London: Joint Commissioning Panel for Mental Health; 2017.

Expert Reference Group members

NCCMH technical team

Steve Pilling (Facilitator), Director, NCCMH; Director, CORE (Centre for Outcomes Research and Effectiveness), University College London

Saiqa Akhtar, Research Assistant, NCCMH (until March 2017)

Tom Ayers, Senior Associate Director, NCCMH

Katherine Biddulph, Commissioning Manager, Mental Health, NHS Nottingham City Clinical Commissioning Group

Judith Chapman, Clinical Director, Berkshire Healthcare NHS Foundation Trust

David Clark, Professor and Chair of Experimental Psychology, University of Oxford

Rebecca Gate, Lead Researcher and Developer, NCCMH

Helen Greenwood, Research Assistant, NCCMH (from March 2017)

Lucy Heard, Expert by Experience

Maryla Moulin, Senior Project Manager, NCCMH (until February 2017)

Clare Taylor, Associate Director – Quality and Research Development, NCCMH

Conor Whelan, Project Manager, NCCMH (from February 2017)

Expert Reference Group

Shane DeGaris, **Chair**, Chief Executive Officer, Hillingdon Hospitals NHS Foundation Trust

Claire Braithwaite, Divisional Director of Operations, Imperial College Healthcare NHS Trust

Sarah Eales, Senior Lecturer in Mental Health Nursing, Bournemouth University

John Hague, GP and CCG Governing Body member, Ipswich

Rob Hardy, Health Education England

John Levy, Interim Mental Health Commissioner Horsham and Mid Sussex, Coastal and West Sussex CCG, Crawley CCG

Clare Lyons-Collins, Head of Mental Health Policy, NHS Improvement

Vincent Mak, Consultant Physician, Imperial College Healthcare Trust

Rona Moss-Morris, Professor of Psychology as Applied to Medicine Head of Health Psychology Section, Institute of Psychiatry, Psychology and Neuroscience, Kings College London

Pam Myles, Director of Clinical Studies, University of Reading

John Pimm, Clinical Lead, Oxford Health NHS Foundation Trust

Amrit Sachar,Consultant Liaison Psychiatrist in Hammersmith and Fulham West London Mental Health Trust

Heather Salt, Consultant Clinical Psychologist, Oxford Health NHS Trust

Prisha Shah, Expert by Experience

Michael Sharpe, Professor of Psychological Medicine, University of Oxford

Chiryeal St John Jack, Expert by Experience

Abigail Wroe, Clinical Health Psychologist, Berkshire Healthcare NHS Foundation Trust

NHS England

Felicity Dormon, IAPT Programme Lead, NHS England

Els Drewek, Head of Intensive Support, NHS England

Ursula James, IAPT Programme Manager, NHS England

Kevin Mullins, Head of Mental Health, NHS England

Xanthe Townend, Programme Lead – IAPT and Dementia, NHS England

Special advisers

Peter Aitken, Faculty of Liaison Psychiatry of the Royal College of Psychiatrists