

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



NHS England and NHS Improvement

Document purpose:	To provide guidance on the IAPT-LTC pathway
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Target audience:	Mental health commissioners, physical health commissioners, IAPT providers
Additional circulation list:	Clinical networks
Description:	From April 2018 all CCGs are expected to expand IAPT by commissioning IAPT services integrated into physical healthcare pathways. This document supports this expansion by setting out the treatment pathway that underpins the access and waiting time standards, which all services should seek to measure themselves against. The guidance also provides evidence on what works, as well as local case studies of service-led examples that describe how to make IAPT-LTC services a reality
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Equality and Health Inequalities Statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values.

Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in, access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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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. Aims of this document

This pathway has been developed by the National Collaborating Centre for Mental Health, following a process agreed with the National Institute for Health and Care Excellence (NICE), with support from an Expert Reference Group including experts by experience, carers, practitioners, academics, commissioners, service managers and representatives from national NHS arm's-length bodies.

For more detailed discussion, evidence, step-by-step pathways and positive practice examples for all aspects of the IAPT pathway for people with long-term physical health conditions (LTCs) and medically unexplained symptoms (MUS) see the [full implementation guidance](#), published by the National Collaborating Centre for Mental Health.

About IAPT services for people with LTCs and MUS

IAPT services are transforming the treatment of depression and anxiety disorders in England. Now established in every clinical commissioning group (CCG), IAPT services provide a course of NICE-recommended psychological therapy to over half a million people each year. A unique session-by-session monitoring system collects outcome data from almost every person. Nationally, one in two people recover and one in three show significant improvement in their mental health.

Around 40% of people with depression and anxiety disorders also have an LTC. Around 30% of people with an LTC and 70% with MUS also have mental health comorbidities. Currently, mental and physical health care are provided by separate services that are rarely coordinated. This is inconvenient for the person, costly to the NHS and likely to produce sub-optimal outcomes.

Building on IAPT's existing dedicated workforce, development of new IAPT services for people with LTCs and MUS is underway (called 'IAPT-LTC' services for short in this guidance). These services will aim to ensure that people with LTCs and MUS have the same access to NICE-recommended psychological therapies as other people. They will bring together mental and physical health providers so they can work in a coordinated way to achieve the best outcomes for all people, irrespective of their diagnosis.

1.1 This guidance sets out the policy initiatives and strategic context for the national expansion of IAPT services for adults (aged 18 years to the end of life) with LTCs and MUS. The expansion is a key priority for commissioners, providers and [Sustainability and Transformation Partnerships](#) (STPs) as it is one of the mental health objectives outlined in the [Next Steps on the NHS Five Year Forward View](#), published in March 2017.

1.2 The guidance supports this expansion by setting out the treatment pathway that underpins the [access and waiting time standards](#), which all services should seek to measure themselves against. The guidance also provides evidence on what works, as well as local case studies of service-led examples that describe how to make IAPT-LTC services a reality.

1.3 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](#). Services should be designed to meet the needs of diverse communities, be accessible to them and be able to communicate with them effectively. The [full implementation guidance](#) outlines the steps that commissioners can take to do this.

1.4 Local service design should be co-produced to meet the needs of the local population and tailored to people's personal circumstances. Services should consider culturally specific beliefs, needs and values, as well as providing support for families and carers of people with mental health needs.

2. Policy and strategic context

“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.”

The Five Year Forward View for Mental Health

2.1 [The Five Year Forward View for Mental Health](#) and the [Next Steps on the NHS Five Year Forward View](#) highlighted the disparity between mental and physical health care.

2.2 Mental and physical health are intrinsically linked, and the relationship between untreated depression and anxiety disorders and poor physical health is complex and bi-directional (see Section 2 of the [full implementation guidance](#) for further detail).

2.3 If left untreated, mental health problems can have a significant impact on the person’s physical health. This includes:

- lowering the person’s likelihood of engaging with the treatment of their physical health problem and reducing their ability to self-manage effectively
- increasing the person’s likelihood of unhealthy behaviours, such as smoking and poor diet
- worsening the person’s physical health, including premature mortality
- poorer employment outcomes, including a higher risk of absenteeism and unemployment.

2.4 Healthcare costs for those with coexisting mental and physical health problems, compared with costs for physical health problems alone, are also significantly higher (around 50%). A large proportion of this cost is accounted for by increased use of physical health services (not mental health services). This includes a higher number of primary and secondary care consultations, as well as increased rates of hospitalisation and repeat attendance.

 <p>Long-term physical health conditions</p>	<ul style="list-style-type: none"> • 16.5 million (30% of people in England) will be diagnosed with one or more LTCs, such as cardiovascular disease or chronic obstructive pulmonary disease.
 <p>Mental health problems</p>	<ul style="list-style-type: none"> • 9.35 million (17% of people in England) will have a mental health problem. Depression and anxiety disorders are the most common.
 <p>Comorbidities</p>	<ul style="list-style-type: none"> • 30% of people with an LTC will also experience a comorbid mental health problem. This is much higher than prevalence rates in the general population. • 70% of people with MUS, such as irritable bowel syndrome or chronic fatigue syndrome, will also experience comorbid depression or anxiety disorders.

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 or sleep disorder services, which may be based in either inpatient or community settings.

2.5 [The Five Year Forward View](#) and [The Five Year Forward View for Mental Health](#) set out clear objectives to ensure the greater integration of mental and physical health care. By 2020/21 it is expected that an extra 600,000 adults with depression and anxiety disorders will be able to access evidence-based (NICE-recommended) psychological therapies each year (resulting in at least 350,000 more completing treatment). A large proportion of this expansion will focus on people with LTCs and MUS, and is expected to occur in new IAPT services co-located in physical health services (IAPT-LTC services).

2.6 There is a compelling case for delivering care in an integrated way to ensure that a person’s mental and physical health needs are met together. Integrating care:

- enhances the whole team’s capability to provide **more comprehensive, accessible and holistic care**: this can reduce costs through encouraging the prompt uptake of treatment and it decreases the likelihood of people not attending appointments
- **promotes mental health awareness and faster diagnosis**: identifying and addressing a person’s needs more quickly and accurately can in turn reduce the number of frequent attenders and repeat assessments
- promotes coordination and encourages the development of **a single jointly-developed care plan**: this can lead to greater efficiencies and improved relationships within teams and services
- is **more cost effective** and can reduce a person’s use of physical health services: this can reduce the annual expenditure per person by £1,760.

Key statements: what should good IAPT-LTC care look like?

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.”

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.”

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 six 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.”

3. Delivering IAPT-LTC services

“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.”

A psychological wellbeing practitioner

3.1 IAPT-LTC services provide evidence-based psychological therapies for people with depression and anxiety disorders, who also have LTCs or MUS. The services are built on the same key principles that underpin the IAPT programme:

- **Ease of access**, including the use of self-referrals
- Offering the **most effective and least intrusive NICE-recommended psychological therapies first**, in line with a stepped-care model
- **Trained and competent clinicians**, who have regular clinical supervision that is outcome-focused and supportive
- **Meaningful choice** in treatment
- **Routine, session-by-session outcome monitoring**
- **Close links** with primary care, specialist mental health services and employment support

New principles of IAPT-LTC services

- **Mental health case recognition methods** in general health care pathways
- **Co-location** with general health care teams and primary care
- **Revised IAPT assessment protocols and workforce**, in recognition that there are likely to be more high-intensity interventions and complex assessments conducted
- **Close links** with existing IAPT services, core 24 liaison mental health services and clinical and health psychology services

3.2 Since September 2016, NHS England has put in place a targeted, geographical approach to support the delivery of IAPT-LTC services:

- ☑ **2016/17:** NHS England supported 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.

3.3 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. By 2020/21 it is expected that an additional 4,500 IAPT clinicians will be trained and deployed within IAPT services. Of these, 3,000 will be co-located in primary care. To develop the right competences, NHS England and Health Education England have developed a number of [specialist training programmes](#) for psychological wellbeing practitioners and high-intensity therapists. A [competence framework](#) is also available.

Rolling out IAPT-LTC services

Detailed case studies are available for four early implementer sites:

- [Sunderland Psychological Wellbeing service](#)
- [TalkingSpace Plus, Oxford](#)
- [Insight Nottingham Talking Therapies](#)
- [The Wellbeing Service, Hertfordshire](#)

Further information on wave 1 and wave 2 sites including the CCGs involved can be found on NHS England’s [website](#).

4. The IAPT-LTC pathway

“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!”

A commissioner of an early implementer site

4.1 The IAPT-LTC pathway and accompanying standards aim to reduce unwarranted variation in the delivery of psychological therapies for people with LTCs and MUS, while at the same time enabling local improvement and maintaining the existing [national standards for access, waiting times and recovery](#). Further detail about the pathway can be found in the [full implementation guidance](#).

Ensuring timely treatment

4.2 IAPT-LTC services will be expected to deliver the same standards of care that already exist in IAPT services. This means that at least 25% of adults with the relevant disorders will have timely access to all IAPT services, with at least 50% of those treated moving to recovery.

The following standard has been set for all IAPT services (including IAPT-LTC services):

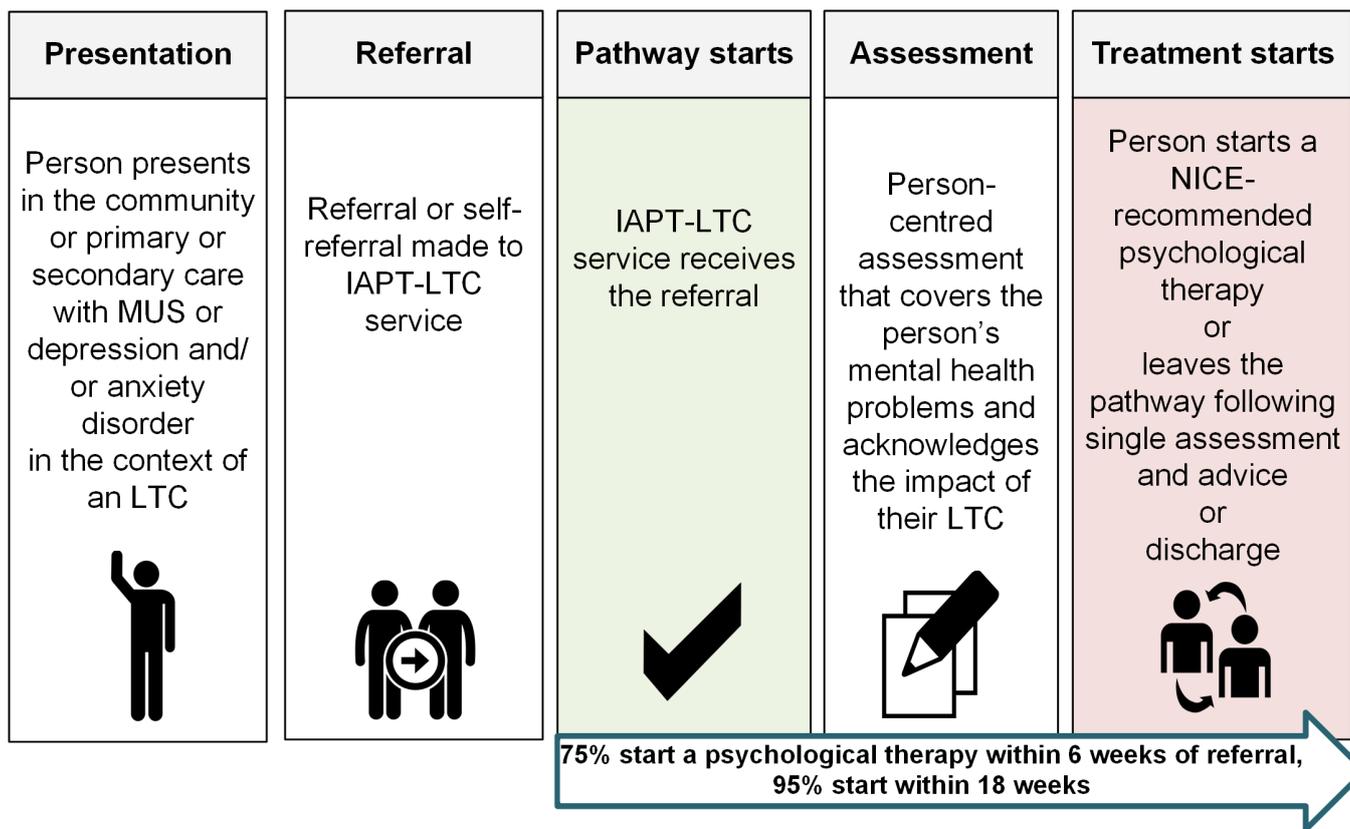
75% of the referrals that have a course of treatment should have their first treatment session within **six weeks**, and 95% within **18 weeks**.

Among other indicators, IAPT also has 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 six weeks, and 95% within 18 weeks.

4.3 Timely response is a key component of the pathway. No one should wait longer than necessary for an assessment and course of treatment. It is good practice for CCGs to ensure that the national standards are also met for subsequent courses of treatment (where the person is stepped up to a high-intensity treatment). 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).

4.4 The IAPT-LTC pathway starts when the referral or self-referral is received by the IAPT-LTC service. Following assessment, if it is decided that the person requires psychological therapy, the IAPT-LTC pathway is considered to have been completed when the person receives their first NICE-recommended treatment session. See the diagram on [page 11](#) for the pathway.

4.5 Some people may benefit from a single assessment and advice session and require no further treatment, or they are signposted to another appropriate service. If the person does not require a course of treatment in an IAPT service, they will leave the pathway. Processes should be in place to ensure that the person still receives appropriate health or social care within the wider system.



Delivering evidence-based treatment

4.6 A wide range of NICE guidance is available for the treatment of depression and anxiety disorders in the general population, LTCs and specific diagnostic groups of MUS. The guidance is more limited when depression and anxiety disorders are comorbid with an LTC or for other patterns of MUS. See Section 4 of the [full implementation guidance](#) for further detail.

4.7 An expert advisory group was convened by NHS England to review existing NICE guidance for the use of psychological therapies for the treatment of depression and anxiety disorders in the context of LTCs and the treatment of MUS (see the box on the right). It should be noted that many psychological interventions are effective alone or in combination with pharmacological interventions.

The recommendations of the expert advisory group

For the treatment of depression and anxiety disorders in the context of LTCs, the 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 in which LTCs interact with mental health problems and impact on daily functioning.

For this reason, it is 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 LTCs on people and their families and carers, or on their level of engagement with therapy
- modify the delivery of the intervention to take into account the LTC.

- 4.8** To ensure that treatment is effective:
- a stepped-care model for the delivery of NICE-recommended psychological therapies should be used, when appropriate
 - treatment choice should be guided by the person's **problem descriptor(s)**, taking account of their choice and preferences
 - it should be offered at an appropriate dose, with the majority of people offered a course of treatment.

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. Descriptors are important for identifying the appropriate NICE-recommended intervention. Services can enter multiple problem descriptors, though the primary problem descriptor should characterise the leading problem and reflect the treatment being delivered.

Ensuring suitability for IAPT-LTC services

4.9 A person's suitability for IAPT-LTC services should be decided in discussion with the treating clinical team after a thorough assessment. If a person's needs will not be best met by the IAPT-LTC service, local protocols should be in place to ensure that the person can promptly and easily access the wider health systems (including clinical and health psychology services and liaison mental health services). Further information can be found in Section 5 of the [full implementation guidance](#).

Reporting and outcomes measurement

- 4.10** A key characteristic of IAPT services is the routine collection of clinical outcome measures and monitoring of activity. IAPT-LTC services will be expected to:
- be part of the national collection system for IAPT and use the [IAPT minimum data set](#)
 - capture four domains:
 1. mental health outcomes (depression symptoms, the recommended measure for anxiety symptoms or MUS, and related disabilities)
 2. perception of physical health
 3. healthcare utilisation
 4. patient experience questionnaires
 - obtain pre- and post-treatment outcome data on at least 90% of service users.

4.11 Further information, including recommended measures and the session-by-session monitoring system, can be found in Section 5 of the [full implementation guidance](#).

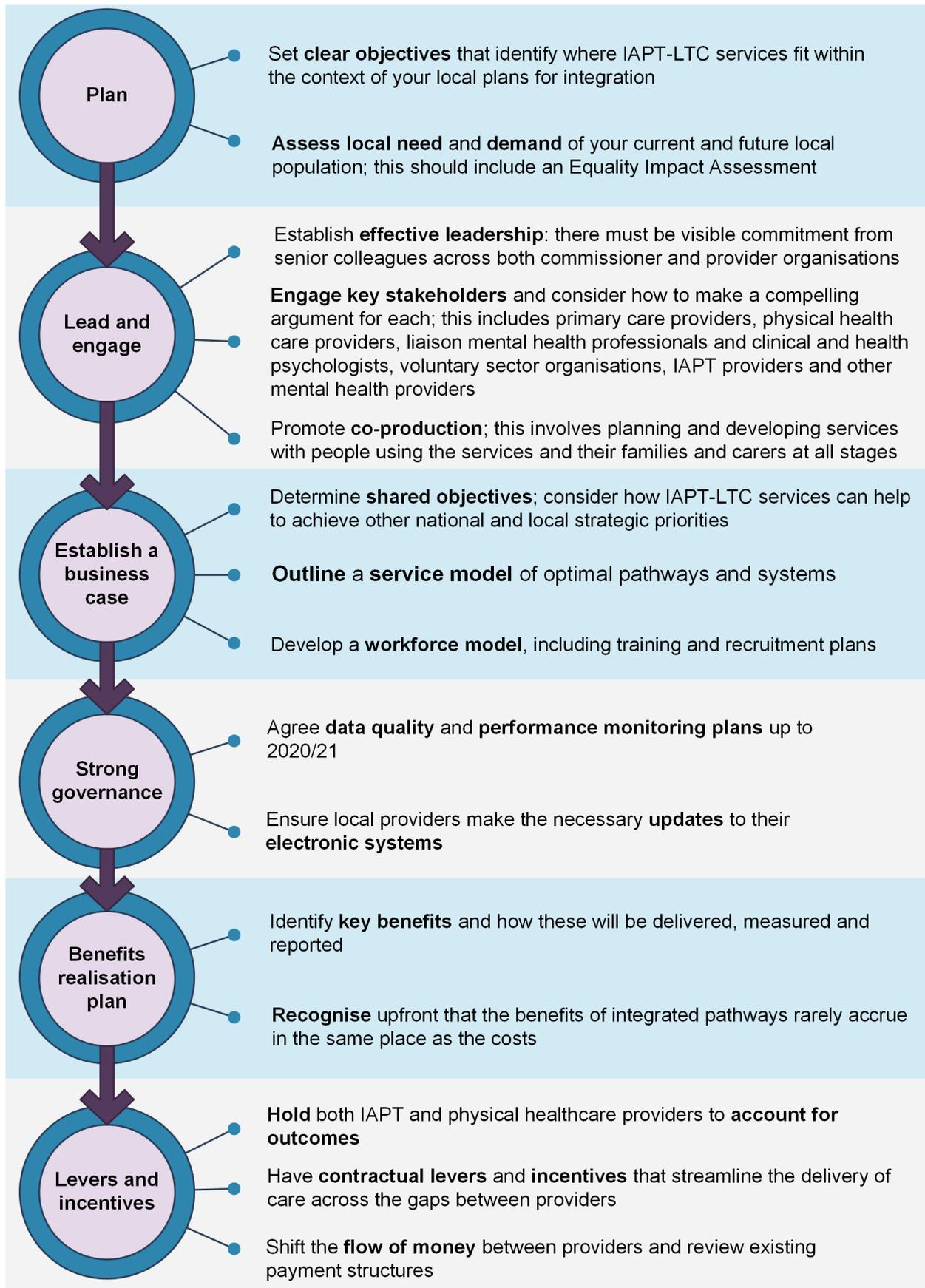
Full implementation guidance and IAPT Manual

4.12 Further detail and resources on the IAPT-LTC pathway can be found in the [full implementation guidance](#). This includes steps to commissioning services, further positive practice examples and detailed explanations of the standards set out in this guidance.

4.13 Further detail and resources on IAPT services can be found in the [IAPT Manual](#).

Key commissioning considerations can be found in the diagram on [page 13](#).

5. Key commissioning considerations





This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request.

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