Psychological Therapies, Annual Report on the use of IAPT services:

England– 2013/14

EXPERIMENTAL STATISTICS

Published 17 September 2014
We are the trusted national provider of high-quality information, data and IT systems for health and social care.

www.hscic.gov.uk
enquiries@hscic.gov.uk
0300 303 5678
@hscic

This product may be of interest to the Department of Health (DH), IAPT services, commissioners and members of the public interested in information about activity and outcomes regarding NHS funded IAPT services for adults in England.

Author: Community and Mental Health team, Health and Social Care Information Centre

Responsible statistician: Claire Thompson, Principal Information Analyst

Version: V1.0

Date of publication: 17 September 2014
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>4</td>
</tr>
<tr>
<td>Introduction</td>
<td>5</td>
</tr>
<tr>
<td><strong>Content of this publication</strong></td>
<td>5</td>
</tr>
<tr>
<td><strong>Background to the IAPT Programme</strong></td>
<td>5</td>
</tr>
<tr>
<td><strong>The IAPT Dataset</strong></td>
<td>6</td>
</tr>
<tr>
<td><strong>Access to Services</strong></td>
<td>7</td>
</tr>
<tr>
<td><strong>Referrals received</strong></td>
<td>8</td>
</tr>
<tr>
<td>Referrals received by Provisional Diagnosis</td>
<td>10</td>
</tr>
<tr>
<td>Entering Treatment</td>
<td>11</td>
</tr>
<tr>
<td>Entering treatment by Provisional Diagnosis</td>
<td>11</td>
</tr>
<tr>
<td>Waiting Times</td>
<td>12</td>
</tr>
<tr>
<td>Referrals which ended in the year</td>
<td>14</td>
</tr>
<tr>
<td>Finished Course of treatment by Provisional Diagnosis</td>
<td>15</td>
</tr>
<tr>
<td><strong>Appointments by method of contact for ended referrals</strong></td>
<td>15</td>
</tr>
<tr>
<td>Number of Appointments by Therapy Type provided</td>
<td>16</td>
</tr>
<tr>
<td>Number of Sessions</td>
<td>17</td>
</tr>
<tr>
<td><strong>Outcome Measures in IAPT</strong></td>
<td>20</td>
</tr>
<tr>
<td>Recovery</td>
<td>20</td>
</tr>
<tr>
<td>Recovery by Provisional Diagnosis</td>
<td>22</td>
</tr>
<tr>
<td>Reliable Improvement</td>
<td>23</td>
</tr>
<tr>
<td>Reliable Improvement by Provisional Diagnosis</td>
<td>25</td>
</tr>
<tr>
<td>The interaction of reliable improvement and recovery</td>
<td>26</td>
</tr>
<tr>
<td>Employment</td>
<td>29</td>
</tr>
<tr>
<td>Psychotropic Medication status at the start of treatment</td>
<td>30</td>
</tr>
<tr>
<td>Psychotropic Medication status at the end of treatment</td>
<td>30</td>
</tr>
<tr>
<td><strong>Person Level Analysis</strong></td>
<td>31</td>
</tr>
<tr>
<td>Analysis by Gender</td>
<td>32</td>
</tr>
<tr>
<td>Analysis by Ethnicity</td>
<td>35</td>
</tr>
<tr>
<td><strong>Appendix</strong></td>
<td>36</td>
</tr>
<tr>
<td><strong>Glossary</strong></td>
<td>37</td>
</tr>
</tbody>
</table>
Executive Summary

The experimental figures presented in this annual report provide a picture of activity in Improving Access to Psychological Therapies (IAPT) services and of the people that used them in 2013/14.

The IAPT programme is designed to provide services for those experiencing anxiety and depressive disorders and the purpose of the IAPT dataset is to support reporting on the treatment of these individuals. Locally IAPT services may have expanded to treat other psychological disorders. The information presented uses version one of the IAPT dataset, which was first reported on in quarter one of 2012/13. The report also uses the latest (mid-2013) population estimates from the Office for National Statistics.

Key Findings:

In 2013/14:

- Nearly one million (947,640) individual people were referred to IAPT services (in total they received 1,118,990 referrals) and 63% of these (596,518) were female. The highest rates of access were for people between the ages of 25 and 29, at 3,384 per 100,000 of the population (compared with 1,759 for all ages).
- Although provisional diagnosis was not recorded in all cases, diagnoses of ‘depressive disorder’ (137,124 referrals) accounted for over a quarter of new referrals with a provisional diagnosis recorded (27%).
- 61% of the referrals that entered treatment¹ in the year (709,117 including some referrals made during the previous year) had a first treatment appointment within 28 days of referral, and 89% (632,486) within 90 days. By Clinical Commissioning Group (CCG) the proportion varied from 3% to 96%.
- 3,234,981 appointments were attended and 93% of these (2,997,357) involved some form of therapy (referred to as a ‘treatment appointment’). Cognitive Behavioural Therapy (CBT) was the most common therapy type (recorded for 38% of treatment appointments).
- 919,994 referrals ended during the year, of which 40% (364,343) had ‘finished a course of treatment’ (having attended at least two treatment appointments). However, 37% (335,944) ended without being seen by the service² (and the remaining 24% (219,707) had either one attended treatment and one attended assessment appointment, or just an attended assessment appointment
- The mean average number of treatment sessions within a finished course of treatment was six sessions, although 20% of referrals that ended with a finished course of treatment had the minimum of two. This varied by provisional diagnosis; referrals for Obsessive Compulsive Disorder (OCD) had the highest average at nine sessions.
- Of the 364,343 referrals that ended having finished a course of treatment, 60% showed reliable improvement³ (217,591). 19,976 (13%) of the 159,247 referrals where the patient was prescribed and taking medication at the start of treatment were no longer taking it after their course of treatment.

¹ Referrals enter treatment at the point of their first treatment appointment.
² Referrals that were never seen by the service did not have any attended appointments (assessment or treatment) during the referral.
³ Referrals are classed as having reliable improvement if the patient shows a reliable decrease in anxiety or depression score between the first and last measurement, and the other clinical state (depression or anxiety) either also reliably decreases or shows no reliable change.
Introduction

Content of this publication

This is the second annual report produced from the IAPT dataset and is intended to give an overall picture of IAPT services during the 2013/14 reporting year (April 1st 2013 to March 31st 2014), based on key areas of activity and outcomes. This is in addition to the quarterly and monthly reports on specific measures that have been published throughout the year.

The content of this release comprises:

- this report;
- national reference data tables including organisational level breakdown for some measures at commissioning region, local area team (LAT) and clinical commissioning group (CCG) level; a background data quality report.

This release is published at: http://www.hscic.gov.uk/pubs/psycther1314

This report includes data on access to services, waiting times, the number of sessions within referrals and recovery data, as well as demographic information regarding those referred to services.

Due to the experimental nature of these statistics we welcome feedback on their utility, as well as any other comments you would like to make. If you would like to provide us with some feedback please contact us through: enquiries@hscic.gov.uk

Background to the IAPT Programme

IAPT is an NHS programme that is rolling out services across England which offers interventions approved by the National Institute for Health and Care Excellence (NICE) for treating people with depression and anxiety disorders.

The programme was created to offer patients a realistic and routine first-line treatment combined where appropriate with medication. The programme was first targeted at people of working age, but in 2010 was opened to adults of all ages.

The second phase of the programme was marked by the publication of ‘Talking therapies: a four year plan of action’ in February 2011. The plan was published with ‘No health without mental health, a cross-government mental health outcomes strategy for people of all ages’ and aims to expand the scope of the programme to children and young people, people with long-term physical conditions, medically unexplained symptoms or severe mental illness.

The IAPT programme is designed to support the NHS in delivering:

- Evidence-based psychological therapies, as approved by NICE, for people with depression and anxiety disorders;
- Access to services and treatments by people experiencing depression and anxiety disorders from all communities within the local population;
- Increased health and well-being, with at least 50% of those finishing a course of treatment moving to recovery and most experiencing a meaningful improvement in their condition;
- Patient choice, and high levels of satisfaction from people using services and their carers;
- Timely access, with people waiting no longer than locally agreed waiting times standards;

5 https://www.gov.uk/government/publications/the-mental-health-strategy-for-england
• Improved employment, benefit, and social inclusion status including help for people to retain employment, return to work, improve their vocational situation and participate in the activities of daily living.

NICE recommends that psychological therapy services for the treatment of depression and some (but not all) anxiety disorders should be organised in a system of “stepped care”, in which people with mild to moderate symptoms are initially offered low intensity interventions (such as guided self-help), with people who fail to recover with low intensity intervention being stepped up to more traditional face-to-face therapies (high intensity interventions). The recommended IAPT stepped care system is supported by the comprehensive use of patient-reported outcome measures (PROMs) to support treatment planning (including step-up/step-down decisions), clinical governance, case supervision, effective communication with patients and inter-professional communication.

IAPT has established a central principle of ‘sessional collection’ of outcome measures i.e. these are recorded at each and every contact with an IAPT worker delivering low or high-intensity therapy. This data is used by patients and IAPT workers to monitor treatment progress and by supervisors to review clinical work. It is used by managers to facilitate effective service performance and by service commissioners and others to demonstrate the direct return on the investment made in services, benchmarked against clear performance measures.

The IAPT Dataset

The IAPT dataset is a regular return of data generated by providers of IAPT services in the course of delivering these services to patients. The data also includes information from independent sector organisations who are providers of NHS funded IAPT services. It is received by the Health and Social Care Information Centre (HSCIC) as record level data from clinical systems.

From Quarter 1 2012/13 the HSCIC has published monthly data quality reports and quarterly data measures from the dataset, covering access, activity and outcomes in the service.

These reports have continued to show increases in data quality and volumes reported as the dataset has become more established, and an increasing number of providers have been able to submit data. This annual report builds on the initial analysis reported in the 2012/13 release, and provides more detail on the activity of IAPT services and their outcomes, including breakdowns by provisional diagnosis, and further detail on the duration of treatment and the breadth of therapies available.

The IAPT dataset is collected through a mandatory monthly return from providers of IAPT services. Providers of IAPT data make a ‘primary’ and an optional bulk ‘refresh’ submission one month later for each month. The data used as the data source for this analysis is labelled ‘final’ data and consists of the most recent submission (whether primary or refresh – in some cases providers do not provide a refresh submission and so the primary submission is the only one available and is then incorporated into the final set of data) for every provider for each month in the year. This ensures the most complete and latest picture for a dataset that is used. The analysis contained within this report utilises final data which has been reconciled to remove duplicates and to ensure the most recent record of a referral has been used.

In the course of 2013/14 a number of providers failed to submit an appointment table in their refresh submission, having submitted appointments in their primary submission for a given month. In agreement with these providers we have prioritised their primary submissions for these months in order to ensure the most complete data set. For more information on this please see the data quality notice that accompanies this release.

Access to Services

In order to access IAPT services, an individual requires a referral. Referrals are often provided by General Practitioners (GPs), but there are many other potential sources of a referral including self-referral by the individual. Once a referral has been received, it should follow through the recommended stepped care pathway as shown below.

Figure 1 – Recommended stepped care pathway for IAPT services

Source: Talking therapies: A four-year plan of action
Referrals received

A referral is generated when a person is referred to IAPT services for treatment. One individual may only have one referral for a given provider at any one time, but may have multiple referrals across multiple providers, or may have received more than one referral over the course of the year. A count of referrals, therefore, is not equal to a count of people.

The bulk of this publication will discuss counts of referrals, in a similar way to figures in the quarterly reports. Additionally, some person level analysis has been included later in this report, giving an impression of the numbers of individual people being referred to the service.

In 2013/14 a total of 1,118,990 referrals were received, with the most referrals being received in the North of England Commissioning Region (350,450 referrals; 31% of the national total). By way of comparison, London Commissioning Region received 162,890 referrals (15% of the total).

The proportion of all referrals received varied across the Local Area Teams from 6% for Greater Manchester Area Team (64,840 referrals), to 1% for Shropshire and Staffordshire Area Team (12,335 referrals received). This excludes London Area Team, which accounts for 15% of referrals received (162,890 referrals), but has the same geography as its Commissioning Region. Nationally, 50,100 referrals could not be assigned to a Commissioning Region or Local Area Team, accounting for 4% of the total number of referrals received.
Figure 2: New referrals received by Clinical Commissioning Group, 2013/14

Sources: Improving Access to Psychological Therapies dataset, Table 1c, ONS 2013 Clinical Commissioning Groups (England) April 2013 Boundaries.
Referrals received by Provisional Diagnosis

In 2013/14 provisional diagnosis was recorded for 46% (513,346) of new referrals received by IAPT services. It is to be expected that some referrals may not have had a diagnosis at the point of referral as the service user may not have seen a therapist at this point. Recently we undertook a consultation exercise, on IAPT reporting, which included a question on the reasons for a lack of completion of the provisional diagnosis field. A common reason reported was that clinicians may not feel adequately trained or qualified to provide a diagnosis.

ICD-10 diagnosis codes are presented at three and four character level (e.g. F32; F41.2), to show the breadth of service provision within IAPT services. It is important to note, however, that direct comparisons should not be made between three and four character classifications as four character diagnosis codes are a subset of the wider three character codes.

For those new referrals which did have a provisional diagnosis recorded, the most commonly reported was ‘depressive disorder’ accounting for 12% of all new referrals received (137,124 referrals). ‘Bipolar affective disorder’ accounted for only 0.1% of new referrals received in the year (1,171).

Figure 3: New referrals received by Provisional Diagnosis, 2013/14

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>F32 - Depressive episode</td>
<td>12.3</td>
</tr>
<tr>
<td>F41.2 - Mixed anxiety and depressive disorder</td>
<td>12.0</td>
</tr>
<tr>
<td>F41.1 - Generalized anxiety disorder</td>
<td>5.9</td>
</tr>
<tr>
<td>F99 - Mental disorder, not otherwise specified</td>
<td>4.1</td>
</tr>
<tr>
<td>Other ICD10 code</td>
<td>4.0</td>
</tr>
<tr>
<td>F33 - Recurrent depressive disorder</td>
<td>2.3</td>
</tr>
<tr>
<td>F41.0 - Panic disorders</td>
<td>1.0</td>
</tr>
<tr>
<td>F43.1 - Post-traumatic stress disorder</td>
<td>1.0</td>
</tr>
<tr>
<td>F42 - Obsessive-compulsive disorder</td>
<td>0.9</td>
</tr>
<tr>
<td>F40.1 - Social phobias</td>
<td>0.7</td>
</tr>
<tr>
<td>Z63.4 - Disappearance and death of family member</td>
<td>0.4</td>
</tr>
<tr>
<td>F40.2 - Specific (isolated) phobias</td>
<td>0.3</td>
</tr>
<tr>
<td>F45 - Somatoform disorders</td>
<td>0.3</td>
</tr>
<tr>
<td>F40.0 - Agoraphobia (with or without history of panic)</td>
<td>0.3</td>
</tr>
<tr>
<td>F50 - Eating disorders</td>
<td>0.2</td>
</tr>
<tr>
<td>F10 - Mental and behavioural disorders due to use of</td>
<td>0.1</td>
</tr>
<tr>
<td>F31 - Bipolar affective disorder</td>
<td>0.1</td>
</tr>
<tr>
<td>Other ICD10 code</td>
<td>0.1</td>
</tr>
</tbody>
</table>

Source: Improving Access to Psychological Therapies dataset, Table 11

---

7 Provisional diagnosis is recorded as an ICD-10 code. Diagnosis codes are presented at three and four character level, to show the breadth of service provision within IAPT services. It is important to note, however, that direct comparisons should not be made between three and four character classifications as four character diagnosis codes are a subset of the wider three character codes. More information about ICD-10 codes can be found at: [http://www.who.int/classifications/icd/en/](http://www.who.int/classifications/icd/en/)

8 Consultation on changes to Quarterly Improving Access to Psychological Therapies reports: [http://www.hscic.gov.uk/iaptconsult](http://www.hscic.gov.uk/iaptconsult)
**Entering Treatment**

Once an individual has been referred to IAPT services they should be assessed and then, if appropriate, enter treatment. Not all referrals enter treatment, however, as a patient may discharged, or may choose not to continue in the service for a number of different reasons. In 2013/14 370,627 (40% of all referrals that ended in the year) referrals ended before entering treatment, and most of these (91% or 335,944) didn’t attend any type of appointment in IAPT services.

In order to be classed as ‘entering treatment’ a referral must have attended at least one treatment appointment in the year. In order to be counted as a treatment appointment, at least one therapy type must be recorded as having been delivered. In 2013/14 709,117 referrals entered treatment.

Not all of the referrals who entered treatment will have been received in the year, as some referrals will have been received in 2012/13. Equally, not all referrals that are received in the year would be expected to enter treatment within 2013/14 as some may have been received at the end of the year and would therefore be expected to enter treatment in 2014/15.

**Entering treatment by Provisional Diagnosis**

Provisional diagnosis was recorded for 59% (415,110) of the referrals that entered treatment in the year, showing higher data completeness than for new referrals received in the year. The most common diagnosis for those referrals entering treatment in the year was ‘mixed anxiety and depressive disorder’ at 15% (108,489) of all referrals entering treatment in the year. ‘Bipolar affective disorder’ accounted for less than 0.1% (952) of referrals entering treatment in the year.

**Figure 4: Referrals entering treatment in the year by Provisional Diagnosis, as a proportion of all referrals entering treatment, 2013/14**

Source: Improving Access to Psychological Therapies dataset, Table 11
Waiting Times
We can currently only measure crude waiting times using the IAPT dataset, and this is done by counting the number of days between a referral being received and the first treatment appointment. Of the 709,117 referrals that entered treatment in the year, 61% (435,406) were seen within 28 days or less, while 89% (632,486 referrals) received a first treatment in 90 days or less.

Figure 5: Waiting times for all referrals with a first treatment in the year, 2013/14

Regionally, Durham, Darlington and Tees Area Team had the highest rate of referrals entering treatment within 28 days, at 86% (17,900 referrals), whilst Lancashire Area Team and Shropshire and Staffordshire Area team had the lowest rates, both having 24% of referrals entering treatment within 28 days (3,825 and 1,405 referrals respectively). Lancashire also had the highest rate of referrals waiting over 90 days to enter treatment at 34% (5,320 referrals). By CCG the proportion of referrals entering treatment within 28 days varied from 96% (NHS Barking and Dagenham CCG) to 3% (NHS Eastern Cheshire CCG).
Figure 6: Referrals entering treatment within 28 days as a proportion of all referrals entering treatment by Clinical Commissioning Group, 2013/14

Sources: Improving Access to Psychological Therapies dataset, Table 2c, ONS 2013 Clinical Commissioning Groups (England) April 2013 Boundaries.
Referrals which ended in the year

In 2013/14 919,994 referrals ended, of which 37% (335,944) had never been seen by the service. A further 4% (34,683 referrals) ended after having attended at least one appointment, but not receiving any treatment, while 20% (185,024) ended after a single treatment appointment.

If a referral receives a minimum of two treatment appointments in the course of the referral prior to discharge they are classed as ‘having a finished course of treatment’. In order for a referral to be assessed for recovery, improvement and other outcomes they must have a finished course of treatment.

During 2013/14 364,343 referrals finished a course of treatment; this is 40% of the number of referrals that ended in the year.

Figure 7: Proportion of referrals ending in the year by level of contact with the service, 2013/14

![Bar chart showing proportions of referrals ending in the year by level of contact with the service, 2013/14](chart)

Source: Improving Access to Psychological Therapies dataset, Table 7

---

Referrals that were never seen by the service did not have any attended appointments during the referral.
Finished Course of treatment by Provisional Diagnosis

In 2013/14 64% (231,667) of referrals that finished a course of treatment had a recorded provisional diagnosis. The most common diagnosis for those completing a course of treatment was ‘mixed anxiety and depressive disorder’ (59,089 referrals, or 16% of all referrals finishing a course of treatment). ‘Mental and behavioural disorders due to the use of alcohol’ accounted for less than 1% (246 referrals).

Figure 8: Proportion of referrals that finished a course of treatment in the year by provisional diagnosis, 2013/14

Appointments by method of contact[^10] for ended referrals

2,586,368 appointments were attended in the course of referrals that ended in the year; these may be for different purposes such as assessment, treatment or review. The main methods of contact for these appointments were ‘Face to Face’ (76% or 1,975,719 attended appointments) and Telephone (19%, 488,728 attended appointments), with a further 4% (110,882 attended appointments) that had an unrecognised medium. All other mediums (Email, SMS, Talktype[^11] and web camera) when combined accounted for less than 1% of attended appointments for referrals that ended in the year.

The majority (80% or 1,847,615) of attended appointments for referrals that finished a course of treatment in the year were via the medium of ‘face-to-face’ consultation. For referrals without a finished course of treatment, the proportion of ‘face-to-face’ appointments was lower at 48% of appointments (101,625) for those referrals with only a single attended treatment appointment and 39% of appointments (26,479) for

[^10]: Method of Contact is the description used during this report. This relates to the “medium” field as recorded in the dataset, which is a field containing details of how an appointment was conducted, such as face to face, by telephone or over email or text.

[^11]: Talktype is a consultation medium used for persons who are unable to communicate by speaking.
referrals with no treatment appointments (These referrals did have attended appointments, but not that were categorised as treatment appointments).

‘Telephone appointments’ were the most prevalent appointment medium for referrals with only a single attended treatment appointment at 46% of appointments (97,200). This medium only accounted for 16% (377,242) of appointment for referrals with a finished course of treatment, and 21% of appointments (14,286) for referrals without any attended treatment appointments.

Approximately two fifths (39% or 26,463) of attended appointments for referrals with no treatment appointment had no consultation medium recorded.

### Number of Appointments by Therapy Type provided

During 2013/14 there were 3,234,981 attended appointments in IAPT services, of which 93% (2,997,357) were treatment appointments. The North of England Commissioning Region carried out the most appointments, delivering 32% of the total treatment appointments for England (962,515).

It is possible for more than one therapy type to be delivered in a single appointment, with 3,062,907 instances of different therapy types being delivered in 2,997,357 treatment appointments. ‘Cognitive Behavioural Therapy’ was the most common therapy type, with 38% (1,145,957) of treatment appointments recorded as including this therapy type. ‘Guided Self Help’ and ‘Counselling’ were the next most reported therapy types, and were included in 20% (586,669) and 15% (458,435) of appointments respectively.

‘Employment support’ is the least common therapy type, included in less than 1% of appointments (3,187 appointments), closely followed by ‘Dynamic Interpersonal Therapy’ which was also included in less than 1% of appointments (4,662 appointments).

---

12 All IAPT appointments should be classified by their purpose. Currently, the presence of a valid therapy type is used as an indicator of whether treatment was provided in the course of the appointment. Once dataset v1.5 is implemented the appointment type code will be used instead. An attended appointment will be considered a Treatment Appointment if it is coded as either “02 -Treatment”, “03 - Assessment and Treatment” or “05 -Review and Treatment”.
In order for psychological treatment to be optimally effective, it needs to be delivered in an appropriate dose. NICE issues recommendations about the number of treatment sessions that should be offered for different clinical conditions and their severity. To this end it is important to look at the number of treatment sessions delivered within a referral that has finished a course of treatment.

In 2013/14 the 20% of referrals with a finished course of treatment had two sessions, the minimum needed to finish a course of treatment, (73,070 referrals). The second most common number of sessions for a referral with a finished course of treatment however was 10 or more, accounting for 16% of finished referrals (57,538 referrals). Overall the majority of referrals with a finished course of treatment had 5 or fewer appointments (56% of all completed treatments, 203,540 referrals), with the median number of sessions being 5. Regionally Midlands and East of England Commissioning Region had the lowest median number of sessions per referral at 4, whilst London Commissioning Region had the highest median number of sessions at 6.
An important factor in the number of sessions required for a person is the condition being treated. For the 231,667 referrals that finished a course of treatment with a provisional diagnosis recorded, the highest mean average number of sessions was recorded for ‘Obsessive Compulsive Disorder’ at 9 sessions, compared to the national mean of 6 sessions.
In addition it is possible to examine the mean number of sessions of a specific type that were attended during a course of treatment. On average a course of treatment that includes Interpersonal Psychotherapy (IPT) would contain 6 Interpersonal Psychotherapy (IPT) sessions, whereas a course of treatment that includes Pure Self Help would contain 2 Pure Self Help sessions. The number of sessions recommended by NICE varies based on the diagnosis and the therapy type provided. Different therapy types are recommended for different conditions. For example, depending on severity NICE recommends CBT, IPT, Behaviour Activation, Behavioural Couples Therapy, Counselling or Guided Self Help for service users who are suffering from a depressive episode, whilst the only therapy type recorded in the IAPT dataset which is recommended for any of the anxiety-related disorders (Generalised Anxiety Disorder, Panic Disorder, Social Anxiety Disorder, Agoraphobia, Specific Phobias, Post-traumatic Stress Disorder, Obsessive-Compulsive Disorder) is CBT. Nationally, the IAPT programme has assumed that NICE guidance would translate into services giving an average of 8-10 sessions of treatment, bearing in mind that some patients will recover with less than the full number of sessions recommended by NICE and others will require the full dose.

Figure 12: Mean number of sessions in a finished course of treatment by therapist type, 2013/14

Source: Improving Access to Psychological Therapies dataset, Table 6c

In addition to varying therapy types, appointments can also be administered by a variety of different therapists in IAPT. For those referrals with a finished course of treatment, Cognitive Behavioural Therapists delivered the most appointments, with a mean of 6 appointments per referral being delivered by this type of therapist. Psychological Well-being Practitioners delivered the fewest appointments, with a mean of 4 appointments per finished course of treatment being delivered by this type of therapist.
Outcome Measures in IAPT

The IAPT dataset contains a wealth of information that can be used to measure the outcomes of a course of treatment within IAPT services. This includes information such as use of prescription medication, employment status and assessment scores that allow the progress of an individual towards recovery to be monitored. These measures can then be used to measure the performance of IAPT services in improving the wellbeing of service users.

Recovery

One of the key outcome measures relating to IAPT service is the measurement of recovery. At each treatment appointment patients complete a number of well-validated questionnaires that assess the severity of their clinical condition. These are the Patient Health Questionnaire (PHQ-9), which assesses the severity of depression and a measure of anxiety (either the Generalised Anxiety Disorder scale (GAD7) or another appropriate Anxiety Disorder Specific Measure (ADSM). The ADSM is chosen according to the provisional diagnosis assigned to the patient and a full list of which ADSM is used for each provisional diagnosis can be found in the Appendix. These measures are designed to allow therapists to track progress of service users, but the start and end positions for those that finished a course of treatment can also be examined to determine whether recovery has been achieved. Higher scores on a questionnaire measure indicate a higher severity of illness.

In order to examine recovery and other outcomes, it is essential that assessment scores are recorded at both the start and end of treatment, and in the case of anxiety measures, the same measure must be recorded at start and end of treatment. In 2013/14, 96% of those referrals with a finished course of treatment had paired assessment scores that could be used to assess outcomes.

A key element of determining whether a referral can be classed as having recovered or not is whether the service user is at ‘caseness’ at the beginning and end of treatment. Each measure (PHQ9 and GAD7/ADSMs) has a caseness threshold; this is the score above which an individual is classed as being a ‘case’, as it is the point where they have a high likelihood of suffering from a disorder. For example, if an individual scores above the caseness threshold of 7 on the GAD 7 measure, they are classed as being a case as they are exhibiting clinically significant signs of anxiety. In order for a referral to show recovery over the course of their treatment they must move from being at caseness on one or both of the measures assessed, to not being at caseness on either measure.

By definition, recovery can only be assessed for referrals that finished a course of treatment (with at least two attended treatment appointments) and who were at caseness on their first recorded score. In 2013/14 319,904 referrals met these criteria and 45% (143,833 referrals) of eligible referrals recovered. Regionally, recovery rates varied between 41% for the London Commissioning Region (17,610 referrals moving to recovery) and 47% in the South of England Commissioning Region (39,380 referrals moving to recovery).

Three Local Area Teams (Arden, Herefordshire and Worcestershire; Bath, Gloucestershire Swindon and Wiltshire; and Wessex Area Teams) met the national target of a 50% recovery rate and no Area team had a recovery rate of lower than 40%.

48 CCGs were able to exceed the 50% target, with the highest recovery rate being recorded in Swindon CCG which had a 71% recovery rate (955 referrals recovered). The lowest recovery rate recorded for a CCG was NHS Bristol CCG which recorded a recovery rate of 24% (80 referrals moving to recovery).

---

13 Caseness is the term used when a referral is assessed as being a clinical case. This is determined by the scores recorded on the anxiety (ADSM/GAD7) and depression (PHQ9) measures. If patients score above the clinical/non-clinical cut-off on either anxiety, depression or both, they are classified as clinical cases.
Figure 13: Recovery rate by CCG, 2013/14

Sources: Improving Access to Psychological Therapies dataset, Table 10c, ONS 2013 Clinical Commissioning Groups (England) April 2013 Boundaries.
Recovery by Provisional Diagnosis

Recovery rate varied by provisional diagnosis; at 63% (964 referrals) the highest levels were seen for the 1,533 referrals that had a provisional diagnosis of ‘specific (isolated phobias)’ and could be assessed for outcomes.

Of the three provisional diagnoses which had the highest numbers of referrals finishing a course of treatment who were at caseness, ‘depressive disorder’ had a recovery rate of 45% (24,267 referrals moving to recovery), ‘mixed anxiety and depressive disorder’ had a recovery rate of 44% (23,652 referrals) and ‘generalised anxiety disorder’ had a recovery rate of 55% (15,779 referrals). Referrals with a provisional diagnosis of any type recorded had a combined recovery rate of 46% (95,583 referrals); this was higher than for referrals without a provisional diagnosis recorded, which had a recovery rate of 43% (48,250 referrals).

Figure 14: Recovery rate by provisional diagnosis, 2013/14

Source: Improving Access to Psychological Therapies dataset, Table 11
Reliable Improvement

The assessment of recovery by examining simply whether a referral moves below the caseness threshold has a number of drawbacks. For example there may be cases which do not move below the caseness threshold, but do still show a large improvement across their treatment as their scores decrease by a large amount. In addition, those referrals which were not above the caseness threshold at their first treatment may still have shown improvement which is not reflected when just looking at caseness. Equally, scores for referrals that were “borderline” i.e. just over the caseness threshold on entering treatment may only decrease a small amount and still be counted as having recovered but have only shown a marginal improvement.

In order to accommodate these issues, we have also looked at the number of referrals that have shown reliable improvement, regardless of whether they were above the caseness threshold at the start of treatment. A referral is deemed to show reliable improvement if it shows a decrease in one or both assessment measure scores that surpass the measurement error of the questionnaire (the amount by which a difference could be attributable to natural variance). In addition neither measure must show an increase beyond the measurement error. Equally, if an individual shows an increase in one or both scores that is more than the measurement error, they can be described as having reliable deterioration.

In 2013/14, 217,591 referrals showed reliable improvement, representing 60% of the number of referrals finishing a course of treatment in the year. The South of England Commissioning Region showed the highest rate of reliable improvement at 62% (58,290 referrals) whilst the London Commissioning Region showed the lowest reliable improvement rate at 56% (27,820 referrals).

Nationally, all but one Local Area Team achieved an improvement rate of over 50%. Essex area team had an improvement rate of 46% (5,495 referrals). The highest improvement rate was achieved by Arden, Herefordshire and Worcestershire Area Team at 67% (5,845 referrals). Overall, 88% of CCGs achieved a reliable improvement rate of over 50%, with the highest rates being achieved by Coastal West Sussex CCG (72%, based on 3,355 referrals). Recovery rates were not calculated for those CCGs where the number of referrals which finished a course of treatment or the number of referrals which recovered is less than 5.
Figure 15: Reliable Improvement rate by CCG, 2013/14

Source: Improving Access to Psychological Therapies dataset, Table 10c, ONS 2013 Clinical Commissioning Groups (England) April 2013 Boundaries.
Reliable Improvement by Provisional Diagnosis

Referrals with a provisional diagnosis of ‘somatoform disorders’ had the highest reliable improvement rate, at 69% (1,580 referrals), whilst the lowest reliable improvement rate was recorded for those referrals with a provisional diagnosis of ‘Mental and Behavioural disorders due to the use of alcohol’ at 44% (107 referrals). Looking at the three most reported provisional diagnoses for referrals having a finished course of treatment, referrals for ‘Mixed Anxiety and Depressive disorder’ had a reliable improvement rate of 63% (36,986 referrals), referrals with ‘Depressive disorder’ had a reliable improvement rate of 62% (36,700 referrals) and those with ‘Generalised Anxiety Disorder’ had a reliable improvement rate of 67% (21,969 referrals). Referrals with a finished course of treatment that did not have a provisional diagnosis recorded had a reliable improvement rate of 56% (73,616 referrals), whereas the average reliable improvement rate for those who did have a diagnosis recorded was 62% (143,975 referrals).
The interaction of reliable improvement and recovery

Reliable improvement and recovery can be combined to create an overall measure of reliable recovery – a count of those referrals that show both a change from caseness to not being at caseness during the course of the referral and which also show a reliable improvement in their scores that is more than the variance associated with the assessment measure. Combining the two measures also allows examination of the outcomes for borderline referrals, such as those which showed recovery with no improvement, or those which did not show recovery but did show improvement. In some cases it is even possible for an individual to show recovery but also deteriorate when evaluating both the PHQ9 and ADSM. A full understanding of the possible pathways a referral can take is seen below.

Figure 16: Schematic representation of the potential output pathway of a completed referral

Although unlikely, it is possible for referrals to show recovery and also deterioration, or to move from not being at caseness to being at caseness and still show improvement. This generally occurs when looking at borderline cases which may show a small change on one measure that passes the caseness threshold, while showing a larger change in another measure which does not pass the caseness threshold. This is not expected to occur in many cases but the possibility is included in this diagram for completeness.
Figure 17 Calculating Recovery, Improvement and Reliable Recovery

The table below shows that in 2013/14 there were 136,928 referrals which showed reliable recovery in the year, 43% of the number of referrals who completed treatment and were at caseness at their first
assessment. This is 2% lower than those showing just recovery, which is to be expected since reliable recovery is a more stringent measure. The same pattern was shown regionally, with all Commissioning Regions also showing a 2% decrease when comparing reliable recovery to recovery.

### Table 1: Output measures by region

<table>
<thead>
<tr>
<th>Commissioning Region</th>
<th>Recovery</th>
<th>Reliable Improvement</th>
<th>Reliable Recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>45% (143,833)</td>
<td>60% (217,591)</td>
<td>43% (136,928)</td>
</tr>
<tr>
<td>London Commissioning Region</td>
<td>41% (17,610)</td>
<td>56% (27,820)</td>
<td>39% (16,645)</td>
</tr>
<tr>
<td>Midlands and East of England Commissioning Region</td>
<td>46% (37,275)</td>
<td>60% (55,185)</td>
<td>44% (35,460)</td>
</tr>
<tr>
<td>North of England Commissioning Region</td>
<td>43% (44,205)</td>
<td>59% (68,290)</td>
<td>42% (42,365)</td>
</tr>
<tr>
<td>South of England Commissioning Region</td>
<td>47% (39,380)</td>
<td>62% (58,290)</td>
<td>45% (37,350)</td>
</tr>
<tr>
<td>Unknown</td>
<td>46% (5,360)</td>
<td>58% (8,010)</td>
<td>43% (5,105)</td>
</tr>
</tbody>
</table>

Source: Improving Access to Psychological Therapies dataset, Table 10a

1 Commissioning Region is based on GP Practice. Where the GP Practice is not recorded, or cannot be assigned to a Commissioning Region, the referral is categorised as 'Unknown'.

---

15 The denominator used in recovery and reliable recovery rates is the number of “Completed treatments” in the period, minus those who were not at caseness to begin with.

16 The denominator used to calculate reliable improvement rates is the number of “Completed treatments” in the period, regardless of whether or not they were at caseness the first time scores were taken for the individual.

17 The denominator used in recovery and reliable recovery rates is the number of “Completed treatments” in the period, minus those who were not at caseness to begin with.
Employment

One of the aims of the IAPT programme is to improve “social and economic participation, including employment for working-age people”. Employment status should be recorded at every applicable appointment and this information can then be used to look at the starting and ending employment status for all referrals where treatment was completed in the year.

Of those referrals that finished a course of treatment in the year and that had employment status recorded, 48% were for patients who were in employment at the start of treatment (176,431 referrals). A further 14% of referrals were for patients recorded as unemployed and seeking work’ (50,273 referrals) whilst 7% were for patients identified as ‘long term sick or disabled, or in receipt of benefit payments’ (25,612 referrals).

Figure 18: Employment status at start and end of treatment for referrals with completed treatment, 2013/14

The number of referrals where the patient identified as being in employment at the end of their treatment was 167,413, which is 46% of referrals with completed treatment. This decrease includes the 4,138 referrals that were recorded as ‘employed’ at the start of treatment but where the patient did not state their employment status at the end of treatment, and the additional 6,492 referrals that had a status of ‘employed’ at the start of treatment but had an invalid final employment status code. These two groups combined accounted for 6% of the number of referrals that finished a course of treatment and were employed at the start of treatment.

The number of referrals recorded for patients who were unemployed at the end of their treatment had also fallen to 12% (44,275 referrals), while the number for patients who identified themselves as being ‘long term sick or disabled, or in receipt of benefit payments’ remained at 7% (25,244 referrals) of the total number of referrals with completed treatment.
The figures suggest that 5% (1,286) of referrals for patients with an initial employment status of ‘long term sick or disabled, or in receipt of benefits’, had moved to employed when the final employment status was recorded. In addition, 11% of referrals for patients who identified as being unemployed at their first recorded employment status had a status of ‘employed’ after treatment (5,494 referrals). 14% of those with an initial status of ‘long term sick, disabled, or in receipt of benefit payments’ had moved to a status of ‘unemployed and seeking work’ (3,609 referrals). However, of the 9,920 referrals where the patient had identified as ‘not receiving benefits and not working or actively seeking work’, 21% (2,045 referrals) had moved to being classed as long term sick or disabled, or in receipt of benefits.

**Psychotropic Medication status at the start of treatment**

At each appointment the psychotropic medication status should be recorded; this describes whether a person has been prescribed and is currently taking medication. For those referrals with a finished course of treatment, 44% (159,247 referrals) were for patients who were prescribed and were taking psychotropic medication at the start of treatment, whilst 34% (122,070) were for patients not prescribed medication. 10% of referrals (37,652) did not have a valid status code, and the medication status of a further 8% was unknown or not stated (29,693 referrals).

**Psychotropic Medication status at the end of treatment**

The number of referrals with a prescription and that were taking psychotropic medication at the end of a finished course of treatment accounted for 39% of referrals (142,072 referrals), while 31% (114,525) of referrals were not prescribed medication. The number of referrals where the medication status was unknown or not stated is higher at the end of treatment, accounting for 13% (47,550 referrals) of all referrals with a finished course of treatment, while a further 13% (47,818 referrals) had an invalid code for their last psychotropic medication status indicator.

Of the 159,247 referrals for patients who were prescribed and taking psychotropic medication at the start of treatment, 13% moved to the patient no longer being prescribed medication (19,976) and a further 3% (4,509) ended treatment with the patient no longer taking their prescribed medication, whilst 72% (114,873) had the patient recorded as still ‘prescribed and taking medication’. Of the 15,681 referrals for patients who were prescribed but not taking medication at the start of treatment, 24% (3,744) recorded the patient as ‘being prescribed and taking medication’ at the end of treatment, whilst a further 33% (5,206) had a patient who had moved to not being prescribed medication. Of the 122,070 referrals for patients who were not prescribed medication at the start of treatment, 70% (84,887) had the patient recorded as still not prescribed medication at the end of treatment, whilst 15% (18,622) had changed to the patient being prescribed and taking medication.
Person Level Analysis

The majority of the experimental statistics included in this report are counts of referrals to the service, rather than counts of people, as one person may make multiple service requests across different providers. The following analysis, however, shows some limited demographic analysis using people counts for the first time, in order to show the number of people using the service over the course of 2013/14.

In total, during 2013/14, 947,640 people were referred to IAPT services, in comparison to 1,118,990 referrals received. This indicates that 171,350 referrals to the service were issued for patients who already had a referral. This may be a reflection of people being treated in multiple providers or returning to IAPT services multiple times.

In addition, IAPT services operate a stepped care model, wherein an individual may be stepped up or down between high and low intensity treatment. Where this can be done within a provider (i.e. a provider offers both high and low intensity services) then it can be recorded within the same referral. However in some cases when an individual is stepped up or down they are transferred to a new provider, generating a new referral despite the step being part of a single spell of care. Currently it is not possible to trace these individuals across providers within the IAPT dataset and so this is also likely to contribute to the issue of multiple referrals being received in the year for a single service user. A new version of the dataset has been mandated from July 2014, and this may allow us to trace this activity in the future.
Analysis by Gender

Of the 947,640 people being referred to IAPT services during 2013/14, 63% (596,518) were female and 36% (338,908) were male, whilst gender was not recorded for 1% of people (12,214). This seems to be a much more pronounced gender difference than has been seen in secondary mental health care (the 2012/13 Mental Health bulletin\(^\text{18}\) shows that 44% of people using NHS funded adult and elderly secondary mental health services were male, while 56% were female).

Figure 19: Males and females accessing IAPT services by age group, as a proportion of all people referred to IAPT services, 2013/14

The gender distribution across age bands can be seen in figure 19 and this shows that the distribution between genders remained largely static across age bands, with women accounting for around two thirds of people being referred to IAPT services during 2013/14 across most age bands. This difference becomes more pronounced for people aged 65 and over where women account for 67% of all referrals.

Additionally, as can be seen in figure 20, it is apparent that both genders had a similar pattern of referrals across age bands, with most people being referred to services between the ages of 20 and 49 (70% of people were referred in this age group) and a peak between 20 and 34 (accounting for 38% of people referred). Whilst this pattern was evident for both men and women, men did not have as pronounced a peak in referrals between 20 and 34.

Figure 20: Number of males and females accessing IAPT services by age group, 2013/14

The rate of referral to IAPT services (number of referrals per 100,000 of the population\textsuperscript{19}) was highest for people in age groups between 20 and 34, at 3,291 per 100,000 of the population (compared with 1,759 for all ages). Following a peak at 3,384 for people aged 25 to 29; a decline was seen between 5-year age bands, which became more pronounced with age. This is in direct contrast to the pattern seen in data from Secondary Mental Health services (Mental Health Bulletin, 2012/13) where the numbers accessing mental health services per 100,000 of the population shows a marked increase after the age of 65.

\textsuperscript{19} ONS mid-year estimates 2013
Figure 21: Comparison of numbers of people referred to IAPT services per 100,000 population (crude rates) compared to those using specialist mental health services

People referred to IAPT services per 100,000 population, 2013/14

People using adult specialist mental health services per 100,000 population, 2012/13

Source: Improving Access to Psychological Therapies dataset, Table 16, Mental Health Minimum dataset, Mental Health Bulletin 2012/13, Table 1.3 and ONS 2013 mid year estimates
Analysis by Ethnicity

The IAPT dataset has shown a reasonable level of data quality in ethnicity recording, with 73% of people having a valid ethnicity recorded.

The data show that during 2013/14, 89% (618,755 people) of those accessing IAPT who had a valid ethnic code recorded (696,390 people) were categorised as ‘White’, making up the majority of IAPT users. Individuals with Asian or Asian British background made up 4% of IAPT users (31,062 people) and those categorised as being from an ‘Other Ethnic Group’ accounted for 1% of those with an ethnicity recorded (10,379 people).

When compared to ONS population figures by ethnicity (based on the 2011 Census) to produce rates of access to IAPT services, people with an ethnicity of ‘Any other mixed background’ who were over the age of 18 had the highest number of people referred to IAPT per 100,000 population at 4,434. The lowest proportion of people referred to IAPT services compared to the base population for that ethnic group was for people with a Chinese ethnic group (465 people referred per 100,000 population).

Figure 22: People being referred to IAPT services per 100,000 population, by ethnic group, 2013/14

Source: Improving Access to Psychological Therapies dataset, Table 18 and ONS 2011 Census

---

20 excluding those whose ethnicity was unknown or not stated, accounts for 27% of the total number of people referred
## Appendix

### List of ADSMs to Provisional Diagnosis

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Provisional Diagnosis</th>
<th>Appropriate ADSM</th>
<th>Caseness Threshold</th>
<th>Measurement Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>F10</td>
<td>Mental and Behavioural disorders due to use of alcohol</td>
<td>GAD 7</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>F31</td>
<td>Bipolar affective disorder</td>
<td>GAD 7</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>F32-F39</td>
<td>Depressive episode</td>
<td>GAD 7</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>F33</td>
<td>Recurrent depressive disorder</td>
<td>GAD 7</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>F40.2</td>
<td>Specific (Isolated) phobias</td>
<td>GAD 7</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>F41.1</td>
<td>Generalised anxiety disorder</td>
<td>GAD 7</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>F41.2</td>
<td>Mixed anxiety and depressive disorder</td>
<td>GAD 7</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>F50</td>
<td>Eating Disorders</td>
<td>GAD 7</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>F99</td>
<td>Mental Disorder not otherwise specified</td>
<td>GAD 7</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Z63.4</td>
<td>Disappearance and death of a family member</td>
<td>GAD 7</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>F40.0**</td>
<td>Agoraphobia</td>
<td>Agoraphobia Mobility Inventory</td>
<td>60</td>
<td>19</td>
</tr>
<tr>
<td>F40.1</td>
<td>Social Phobias</td>
<td>Social Phobia Inventory</td>
<td>19</td>
<td>10</td>
</tr>
<tr>
<td>F41.0**</td>
<td>Panic Disorder</td>
<td>Panic Disorder Severity Scale</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>F42</td>
<td>Obsessive compulsive disorder</td>
<td>Obsessive Compulsive Inventory</td>
<td>40</td>
<td>32</td>
</tr>
<tr>
<td>F43.1</td>
<td>Post-traumatic stress disorder</td>
<td>Impact of Events Scale</td>
<td>33</td>
<td>9</td>
</tr>
<tr>
<td>F45.2</td>
<td>Somatoform disorder</td>
<td>Health Anxiety Inventory (Short Week)</td>
<td>18</td>
<td>4</td>
</tr>
</tbody>
</table>

21 As the IAPT dataset does not accept decimals, the Agoraphobia measure is evaluated as a cumulative score, rather than the normal average. Normal Caseness threshold on this measure is 2.3, and the measurement error is 0.73. For the evaluation of recovery from the dataset, however, the caseness threshold is 60 and the measurement error is 19, as confirmed by the toolmaker.

22 As there is currently no provided reliable change value for the Panic Disorder Severity scale, GAD7 is currently used instead as the ADSM for this diagnosis.
Glossary

**ADSM** – Anxiety Disorder Specific Measures are questionnaires that are sensitive measures of the severity of particular anxiety disorders. The IAPT Data Handbook recommends relevant ADSMs for obsessive-compulsive disorder, generalized anxiety disorder, social phobia, health anxiety, agoraphobia, panic disorder and post-traumatic stress disorder. If a patient receives a provisional diagnosis of one of these conditions, the relevant ADSM should be used to measure change in anxiety during treatment. If the relevant ADSM has not been given at least twice during a course of treatment, the GAD7 (IAPT’s generic anxiety measure) is used to assess change in anxiety.

**Caseness** – Caseness is the term used when a referral is assessed as being a clinical case. This is determined by the scores recorded on the anxiety (ADSM/GAD7) and depression (PHQ9) measures. If patients score above the clinical/non-clinical cut-off\(^\text{23}\) on either anxiety, depression or both, the referral is classified as a clinical case.

**Referral ending in the year** – A referral is considered to have ended in the year if it has a valid end date which is between 1st April 2013 and 31st March 2014 recorded.

**Finished Course of Treatment** – Patients are classified as having finished a course of treatment if they have had at least two treatment appointments and their referral has been closed (as indicated by a valid end date). Follow-up appointments do not count. All patients who have finished treatment are eligible for assessment of outcome (recovery, reliable improvement, no reliable change, reliable deterioration).

The term “finished course of treatment” should not be confused with a clinician’s judgement of whether the course of treatment finished as scheduled, or otherwise. In the IAPT dataset v1.0 clinicians can indicate that they think a course of treatment has ended as scheduled by choosing the end code “completed treatment”. To reduce confusion, in IAPT dataset v1.5 this will be indicated by the end code “completed scheduled treatment”. It is important to note that all patients who have had at least two treatment appointments are assessed for outcome, irrespective of whether their clinician judges that their treatment finished as scheduled, or otherwise.

**Entering Treatment** – In order to enter treatment a referral must have a first treatment appointment in the period.

**GAD7** – The Generalised Anxiety Disorder-7 questionnaire is IAPT’s default questionnaire for assessing the severity of anxiety. It was originally developed as a measure of Generalized Anxiety Disorder and can be used as an Anxiety Disorder Specific Measure for this clinical condition. However, it can also pick-up changes in anxiety in other anxiety disorders and, as a consequence, is used to measure change in anxiety in any other anxiety disorder if the relevant ADSM has not been given repeatedly. The GAD7 should be recorded at each appointment.

**PHQ9** – The Public Health Questionnaire-9 is IAPT’s measure of the severity of depression and should be recorded at each appointment.

**Recovery** – Patients who have completed a course of treatment are deemed to have recovered if they are classified as clinical cases when they enter treatment and are no longer classified as cases when they have completed a course of treatment. Recovery is measured in terms of the anxiety and depression scores. To be considered as recovered, a patient needs to score below the clinical threshold on BOTH at the end of treatment, to ensure that recovery is measured by looking at the welfare of the individual rather than one specific symptom.

\(^{23}\) Information on the cut off values and how they should be used can be found in the IAPT data handbook [http://www.iapt.nhs.uk/silo/files/iapt-data-handbook-v2.pdf](http://www.iapt.nhs.uk/silo/files/iapt-data-handbook-v2.pdf)
Reliable Change – all measures of symptoms are subject to error. As a consequence, small changes in questionnaire scores may not indicate a real change in clinical state. A change of scores between the beginning and end of a course of treatment is considered a reliable change if it exceeds the measurement error\(^{24}\) of the questionnaire.

Reliable Deterioration – It is possible for people to show deterioration, as well as improvement, during a course of therapy. Patients are classed as having shown reliable deterioration if they show a reliable increase in anxiety or depression score between the first and last measurement, and the other clinical state (depression or anxiety) either also reliably increases or shows no reliable change.

No Reliable Change – Patients are classed as having shown no reliable change if they fail to show reliable change on both anxiety and depression measures, or if reliable improvement is shown on one whilst reliable deterioration is shown on another.

Reliable Improvement – Patients are classed as having shown reliable improvement if they show a reliable decrease in anxiety or depression score between the first and last measurement, and the other clinical state (depression or anxiety) either also reliably decreases or shows no reliable change.

Reliable Recovery – If a patient meets the criteria for both recovery and reliable improvement when they have finished a course of treatment, they are said to have reliably recovered.

Referral – A service user can be referred to IAPT services, from a number of sources, including the GP and self-referral, and this generates a referral. One patient can only have one open referral at a provider at any given time, but could have multiple referrals across providers or multiple referrals in the same provider across the year. In most cases a count of referrals is used, rather than a count of people, when looking at activity in IAPT services, including recovery.

Treatment Appointment – All IAPT appointments should be classified by their purpose. Currently, the presence of a valid therapy type is used as an indicator of whether treatment was provided in the course of the appointment. Once dataset v1.5 is implemented the appointment type code will be used instead. An attended appointment will be considered a Treatment Appointment if it is coded as either “02 -Treatment”, 03 - Assessment and Treatment” or “05 -Review and Treatment”.

Initial Assessment Appointment – Currently the initial assessment appointment is the first attended appointment where a score is recorded. Once dataset version 1.5 is implemented this measure will instead correspond to the first appointment with an appointment type of “01 – Assessment” or “03 – Assessment and Treatment”.

Therapy Type – The type of therapy given to a patient or planned to be given to the patient during an Improving Access to Psychological Therapies Contact. The National Codes are National Institute for Health and Care Excellence (NICE) approved and/or evidence based (i.e. Employment Support is evidence based).

\[\text{http://www.datadictionary.nhs.uk/data_dictionary/attributes/t/tes/therapy_type_for_improving_access_to_psychological_therapies_de.asp?shownav=1}\]
