Improving Access to Psychological Therapies (IAPT) Programme: Setting Key Performance Indicators in a More Robust Context: A New Perspective

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Abstract

The key performance indicators (KPIs) for the Improving Access to Psychological Therapies (IAPT) programme as published by the Department of Health (DH) use patients "completing treatment" as a denominator for calculating rates of "moving to recovery". The implications of applying different denominators to the indicator "moving to recovery" were explored. The IAPT-adopted KPI for patients "moving to recovery" as a proportion of those completing treatment, as published by the DH, is forty-four per cent. Using those starting therapy as a denominator, the rate falls to twenty-two per cent. Using as the denominator all patients "referred" to the IAPT programme, this figure is still lower, at twelve per cent. Commissioners of psychological therapies in primary care will want to exercise their own judgement as to which of these figures offers transparency to support analysis of outcomes. Recognition and understanding of the needs and experience of the high proportion of patients who have one or fewer contacts with therapists should be a high priority in the development of commissioning for psychological therapy.

Key words: Improving Access to Psychological Therapies (IAPT), mental health, commissioning, recovery, primary care, benchmarking.

The Journal of Psychological Therapies in Primary Care, Vol. 2, November 2013: pp. 133–141.

Introduction

One of the most significant recent developments in mental health service delivery has been the introduction and full rollout from 2008 of the Improving Access to Psychological Programmes (IAPT) programme originally proposed by Layard and colleagues (2006). The IAPT programme is a key element in the implementation of the DH mental health strategy, *No Health Without Mental Health* (DH, 2011).

The IAPT programme offers therapeutic help for adults with common mental health problems using a stepped care model, from low to high intensity care. The core therapeutic modality is cognitive behavioural therapy (CBT). IAPT therapists work in teams, have routine supervision, and collect patient-rated outcome measures at each contact, including the Patient Health Questionnaire-9 and the Generalised Anxiety Disorder Assessment-7.

Recovery rates and outcomes

Commissioners have data from the IAPT programme through monitoring of patients' progress at every point of contact with an IAPT worker. Patient-reported outcome measures (PROMs) are used to inform a judgement of whether a patient is above or below clinical "caseness", or in other words, considered to be suffering from a mental illness (IAPT, 2012). When a patient is considered to have moved below clinical "caseness" they are determined to be "moving to recovery". There is a minimum required response rate per patient of ninety per cent of required monitoring according to the IAPT Data Handbook v2.0.1. IAPT collects key performance indicators (KPIs) on each service as an agreed mechanism for measuring progress (Table 1).

In 2011, the IAPT National Team reported an average recovery rate of forty-three per cent, but with considerable variability between sites (from twenty-seven to fifty-eight per cent) (IAPT, 2011).

Methods

Data collection

For this project, key performance indicator (KPI) data were collected via the open access website through the NHS

Table 1: An adapted list of KPIs and their definitions used within the IAPT service

Key Performance Indicator	*Definition*
1	Number of people who have depression and/or anxiety disorders
2	*No longer collected*
3a	Number of people who have been referred for psychological therapies
3b	Number of active referrals who have waited more than twenty-eight days from referral to first treatment/first therapeutic session (at the end of the reporting quarter)
4	Number of people who have entered (i.e., received) psychological therapies during the reporting quarter
5	Number of people who have completed treatment during the reporting quarter
6a	Number of people who are "moving to recovery" of those who have completed treatment, in the reporting quarter
6b	Number of people who have completed treatment not at clinical caseness at treatment commencement
7	Number of people moving off sick pay or ill-health related benefit

Source: IAPT, 2012

Information Centre: Specialist Mental Health Service (NHS IC, 2012). KPIs used for IAPT are presented with brief definition in Table 1.

Results

As a means to support rigorous outcome analysis by commissioners, three separate methods of presenting outcomes were explored. They are presented here as Benchmarks A, B, and C.

Benchmark A: "moving to recovery" as a proportion of those who completed treatment

This is the favoured IAPT measure for "moving to recovery":

those "moving to recovery" (IAPT Key Performance Indicator (KPI 6a) as a proportion of those who completed treatment (KPI 5), minus the number of people who have completed treatment who are not at clinical caseness at treatment commencement (KPI 6b).

"Completed treatment" is $\frac{A = KPI\ 6a}{KPI\ 5 - KPI\ 6b} \times 100$ defined as:

a count of all those who have left treatment within the reporting quarter, having attended at least two treatment contacts, for any reason including: planned completion; deceased; declined treatment; dropped out (unscheduled discontinuation); or unknown.

Using this measure, the proportion of patients completing treatment who are "moving to recovery" is forty-four per cent.

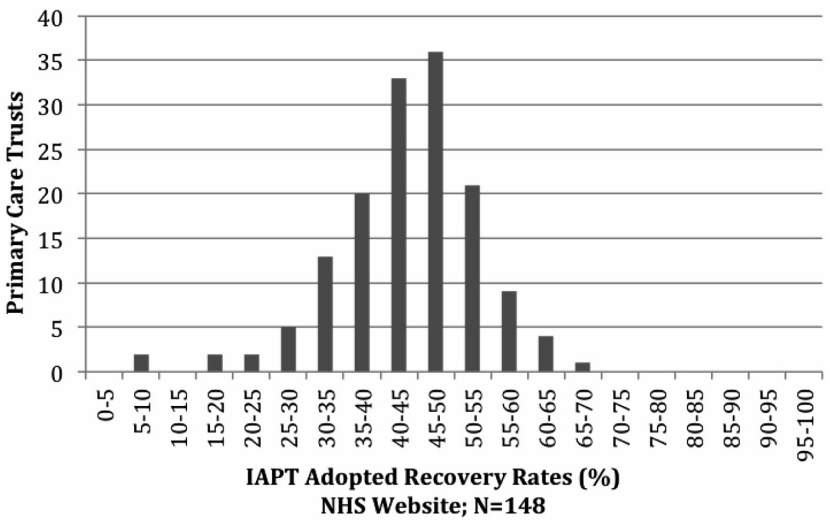

Figure 1: Primary care trust (PCT) distribution histogram: IAPT-defined recovery rates: all IAPT compliant PCTs, 2011–2012

Source: NHS open access data website. West Essex PCT, with a 97.93% recovery rate, has been removed as an outlier.

Benchmark B: "moving to recovery" as a proportion of those who have entered psychological therapy

A more robust and transparent measure of the intervention's effectiveness may entail use of the larger denominator of all those who entered therapy rather than only those who completed it. This is posited as Benchmark B:

patients categorised as "moving to recovery" (KPI 6a) as a proportion of those who entered psychological therapy (KPI 4).

$$B = \frac{KPI\ 6a}{KPI\ 4} \times 100$$

This will include those who left without completing the therapy (although there is no clear KPI which is defined as "leaving the programme during the quarter" within the IAPT dataset).

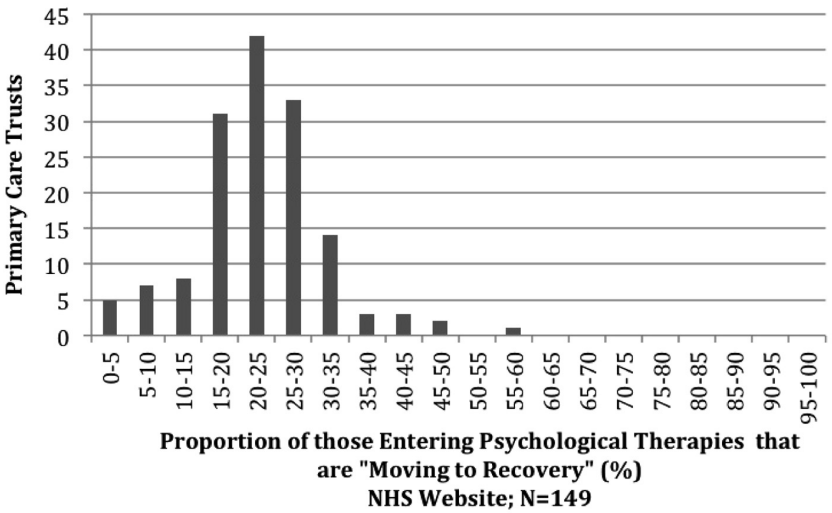

Figure 2: PCT distribution histogram: patients who were "moving to recovery" as a proportion of those "entering psychological therapy": all IAPT compliant PCTs, 2011–2012

Source: NHS open access data website from 149 PCTs that were IAPT compliant.

"Entered psychological therapies" is defined as:

> attending first therapeutic session, which may be during the same appointment as initial assessment.

Using this measure, twenty-four per cent of those entering psychological therapy are found to be moving to recovery.

Benchmark C: "moving to recovery" as a proportion of patients referred

A third way of assessing outcomes is to identify those who are "moving to recovery" as a proportion of those who have been referred to the IAPT programme:

> patients categorised as "moving to recovery" (KPI 6a) as a proportion of those who have been referred for psychological therapies (KPI 3a).

$$C = \frac{KPI\ 6a}{KPI\ 3} \times 100$$

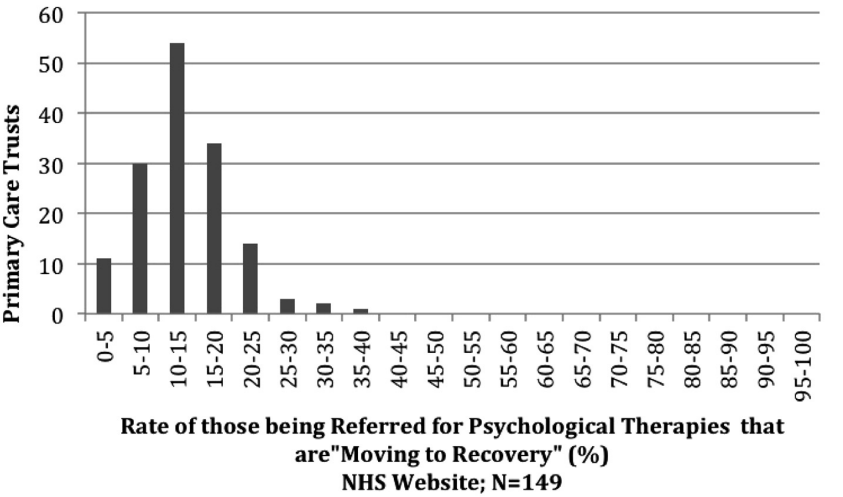

Figure 3: PCT distribution histogram: patients who were "moving to recovery" as a proportion of those "referred for psychological therapies": all IAPT compliant PCTs, 2011–2012

Source: NHS open access data website from 149 PCTs that were IAPT compliant

Table 2: Comparison of the three alternative denominators for "moving to recovery" data

	Benchmark A % of those who completed treatment	*Benchmark B % of those who entered psychological therapy*	*Benchmark C % of patients referred*
Total	43.72	23.90	11.86
Lowest quarter	38.64	18.41	9.73
Median	44.66	21.90	13.10
Highest quarter	49.64	27.30	17.62

The proportion of patients "moving to recovery" by this measure is twelve per cent, with services ranging anywhere between zero and thirty-five per cent (IQR: ten to eighteen per cent).

Discussion: the need for further analysis to enable scrutiny to inform commissioning

Similar concerns to those raised here about the adequacy of IAPT recovery measures available to commissioners have been raised in a recent report by the Centre for Social Justice (Callan & Fry, 2012). The authors argue that the evidence base claimed for recovery rates for IAPT is flawed. "IAPT figures claim recovery as over 40 per cent . . . but from the point of view of commissioners and referring GPs, 86 per cent are not being helped by the IAPT service."

An earlier study of progress made by sites in the first rollout year of the programme (2008–2009) suggests that fifty-three per cent of referrals had one or fewer contacts with the programme, including forty-two per cent who were not assessed (Glover, Webb, & Evison, 2010). Recognition and understanding of the needs and experience of these patients is as important as measuring the outcomes of those who completed more than one treatment session.

The DH is committed to spending an additional £400 million in the four years to 2014–2015 to support the rollout of IAPT. Given this level of investment, coupled with the introduction of any qualified provider (AQP) to psychological

therapies in primary care, including IAPT, it is imperative that outcome data should be widely available in a form that:

(a) that helps commissioners to understand the nature of the patient journey through IAPT from referral, and
(b) enables accurate cost-benefit analyses.

Conclusion

This study's key finding is that the proportion of patients "moving to recovery" depends on which of the three calculations is used. The difference between the method favoured by the IAPT programme (43.72%) and the proportion of all referrals (11.86%) is too large to be ignored.

Commissioners of psychological therapies in primary care will want to exercise their own judgement as to which of these figures offers transparency to support analysis of outcomes. Recognition and understanding of the needs and experience of the high proportion of patients who have one or fewer contacts with therapists should be a high priority in the development of commissioning for psychological therapy.

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