
EXPERIMENTAL STATISTICS

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Foreword

The Improving Access to Psychological Therapies (IAPT) programme and the dataset that supports it are a high priority, as part of the Department of Health’s continuing commitment to parity of care between Mental Health and other Health services.

The national IAPT programme started in 2008, following pioneering pilot work on Doncaster and Newham. From the start, the programme placed a strong emphasis on data collection. A sophisticated minimum dataset was developed and a unique session by session outcome monitoring system ensured, for the first time, that clinical services could report clinical outcomes on 90% or more of people who received a course of therapy (irrespective of whether they completed or dropped out). Local commissioners collected the outcome data, and average national recovery rates were published. These reports, which were later published by the Health and Social Care Information Centre (HSCIC), allowed the benchmarking of services against each other and provided public transparency about the outcomes of IAPT services. National analyses also identified organizational characteristics of the services that achieved particularly good outcomes.

The learning that has come from locally collated IAPT outcome data has been very important for improving the quality of the services. However, the requirement for local commissioners to collate the data has meant that reports have had to be restricted to a few simple indices and have not realised the full potential of the IAPT dataset, which includes detailed information about patient characteristics, clinical conditions, types of interventions and multiple indices of improvement. To address this problem, it was decided in 2011 that IAPT services would move to a new data processing system in which individual patient level data would flow to the HSCIC, which would then calculate the indices previously reported by commissioners and would also provide much more detailed reports of service performance. The patient level data flow was first mandated in April 2012, and has been reported on in quarterly reports throughout the year.

The dataset will be an invaluable tool in monitoring the progress of the IAPT initiative, allowing the identification of successes, as well as areas for improvement. An important element of the dataset will be the ability to measure access and recovery by different patient groups, clinical conditions and interventions. This capability is an exciting tool in mental health data. In addition to recording clinical outcomes, the dataset also allows the recording of factors such as employment status, and whether a patient is being prescribed medication, to be tracked throughout the course of treatment, which helps to give a more comprehensive picture of the effect IAPT services are having on patients.

The ability to quantify outcomes, in a standard, centralised way, is key when tracking performance against the aims of the IAPT programme, such as providing equity of access for all groups, having 50% of those who receive a course of therapy moving to recovery, and most patients experiencing a meaningful improvement in their condition. By using one centralised method to process the IAPT dataset, it will be possible to make comparisons on the same basis across services for the first time.

As the first annual report based on the new way of processing the IAPT dataset, this paper represents a first look at how the database can be used to measure performance against our obligations under the IAPT programme, and is an exciting step forward in the move to using patient level data to produce national statistics regarding IAPT.
Work is on-going, to continue to explore the possibilities of the dataset, as well as efforts to address data quality and completeness issues, which might be expected in moving from local to national data processing. It has been recognised that there was under reporting in this initial year of IAPT dataset collection, and this particularly applied to the number of people who had a course of treatment and the number who recovered. However there have been marked improvements in the quality of data uploaded by local services throughout the year, and it is expected that this will continue in the year ahead. This report skims the surface of the rich data source that is now available, and the possibility for new and more detailed reporting in the future is a truly exciting prospect.

Prof Lord Richard Layard
Executive Summary

The experimental figures presented in this first annual report provide a picture of activity in Improving Access to Psychological Therapies (IAPT) services and the people that use them in 2012/13. Throughout the year Key Performance Indicator figures were also collected that provide an authoritative picture of levels of IAPT activity during this period. The KPI data is available separately on the HSCIC website.

The IAPT programme is designed to provide services for those suffering from anxiety and depression disorders and the purpose of the IAPT dataset is to support reporting on the treatment of these individuals, although locally IAPT services may also 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 population figures from the Office for National Statistics 2011 Census.

As 2012/13 is the first year of reporting from this dataset, statistics are only reported for those referrals that were received in the year. It is recognised that there is some under counting of figures as may be expected when moving to a new dataset, particularly in the first half of the year. However, there has been marked improvement throughout the year as the quality and completeness of data provided by services has increased. Referrals that started before April 2012 are excluded.

Key Findings from the dataset for 2012/13 include:

- A total of 883,968 new referrals were received by IAPT service nationally, representing 761,848 people.
- 434,247 referrals entered treatment\(^1\), accounting for 49% of the number of referrals received.
- Of those referrals that received treatment in the year, 274,975 referrals (63%) were seen within 28 days or less, while 92% (400,786 referrals) received a first treatment appointment in 90 days or less.
- 54,430 referrals nationally were able to achieve recovery\(^2\) in 2012/13. This represents 43% of those records that were eligible for outcome assessment and were at caseness\(^3\) at the beginning of treatment (127,060 referrals). Three Local Area teams met the national target, having 50% of referrals (which were eligible for assessment and who were at caseness) moving to recovery.
- 534,721 referrals ended in the year, with 50% of ended referrals attributed to patients either declining or dropping out of treatment (268,998 referrals).
- In the year 144,210 referrals closed, having received at least two treatment appointments, rendering them as eligible for outcome assessment\(^4\). This represents 16% of the referrals which began in the year and 27% of all referrals that ended in the year.
- In 2012/13, 82,910 referrals showed reliable improvement\(^5\), representing 57% of the number of referrals eligible for assessment in the year. 51,900 referrals showed reliable recovery\(^6\). This equates to 41% of those referrals eligible for assessment which were at caseness at the start of treatment.

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1. In order to enter treatment a referral must have a first treatment appointment in the period. Being referred to IAPT services does not necessarily mean an individual will enter treatment, as they may be referred elsewhere, be discharged or decline treatment for a number of reasons before treatment is provided.

2. In order for a referral to exhibit recovery they must have a score that is less than the caseness threshold on both the PHQ9 and ADSM measures used at their last score taken.

3. In order to be classed as at “caseness” a referral must have either a PHQ9 or ADSM score which is above the threshold required to be classed as a case. Please see the Appendix for more details on threshold scores for each measure.

4. This is also referred to as “Completed Treatment” in this report and in Quarterly reports.

5. In order to show reliable improvement, a referral must show a positive change in scores which is greater than the measurement error of the questionnaire used, for either the PHQ9 or ADSM (or both), without showing deterioration on the other measure used.
Of the 761,848\textsuperscript{7} people being referred to IAPT services in the year 36\% (274,409) were male and 62\% (474,963) were female (gender was not recorded in 2\% of cases), with most people being referred to services between the ages of 20 and 49 (71\% of people were referred in this age group).

The data show that in 2012/13 84\% of those accessing IAPT, excluding those whose ethnicity was unknown or not stated (which account for 30\% of the total number of people referred), were categorised as “White British”, making up the majority of IAPT users. The number of people categorised as having ‘Mixed’ ethnicity was the highest in proportion to the number of people in the general population with the same ethnic status. The ethnic category with the next highest proportion was ‘Black or Black British’.

\textsuperscript{6} A referral is classed as having reliable recovery if it has met the conditions for both recovery and reliable improvement.

\textsuperscript{7} One individual may have multiple referrals across providers or at different times throughout the year, and so there are more referrals received than distinct people referred to IAPT services.
Introduction

Content of this publication

This is the first Annual report produced from the IAPT dataset and is intended to give an overall picture of the IAPT services, based on key areas of activity and outcomes. This is in addition to the Quarterly reports on specific measures that have been reported throughout the year.

The content of this release comprises:

- This report on the analysis
- National reference data tables
- Organisational level breakdown for some measures at Commissioning Region, Local Area Team and Clinical Commissioning Group level
- A background data quality report

This can be found at: [http://www.hscic.gov.uk/psycther1213](http://www.hscic.gov.uk/psycther1213)

The intention of this release is to provide some insight into activity within IAPT services, including numbers of referrals received by services and how many of these entered and completed treatment. This report will also provide experimental statistics on recovery rates and changes in employment status over the course of treatment. In addition, the report will include some limited analysis on the numbers and demographic breakdown of the people using IAPT services, analysis which is carried out for the first time as previous reports have only been concerned with numbers of referrals.

Due to the experimental nature of the statistics we are very keen to receive 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 rolling out services across England offering interventions approved by the National Institute of Health and Clinical Excellence (NICE) for treating people with depression and anxiety disorders.

It was created to offer patients a realistic and routine first-line treatment combined where appropriate, with medication which traditionally had been the only treatment available. 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’[^8] 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’[^9] 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 completing 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;
- 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.

To achieve this, a skilled IAPT workforce is being assembled in order to ensure the continued development of effective multi-disciplinary teams, capable of offering the full range of NICE-approved therapies with a choice of time, venue, mode, practitioner and appropriate treatment, which is personal to the individual patient.

NICE recommends that psychological therapy services for the treatment of depression and some (but not all) anxiety disorders are organised in a system of “stepped care”, where treatments received by patients should be the least restrictive possible, whilst achieving the required outcomes. The recommended IAPT stepped care system is supported by the comprehensive use of patient-reported outcome measures (PROMs) to enable 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. 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 provide tangible evidence of treatment progression 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 also providers of NHS funded IAPT services.

The IAPT dataset is received by the 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, aiming to produce data that can be used to replicate existing measures of performance and activity.

Throughout the year these reports have shown 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. Data quality improvements were such that we were able to report on recovery for the first time at provider level in the Quarter 4 publication. This annual report builds on this initial analysis, providing data on annual recovery rates at a national, regional and Clinical Commissioning Group (CCG) level, as well as analysis of employment status at the start and end of treatment.

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) 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 ensure the most recent record of a referral has been used.

Data Completeness

When reviewing the content of this report, it is important to note that the report draws from the first year of data recorded and as such there are known issues with data completeness. The dataset only contains information on those referrals that were received after the 1st of April 2012 and so we do not report on activity pertaining to referrals that were already in IAPT services prior to this point. This is particularly relevant when looking at activity that occurs after the referral is received, such as receiving first appointments, closing referrals, and assessment of outcome measures. As a result of this, counts of activity are likely to be lower than the full count of activity occurring in services, particularly towards the start of the year.

In addition to this, not all services were able to provide data to the IAPT dataset at the start of the year. The number of services providing data has steadily increased throughout the year, but this lack of data also means that activity figures in this report will be under counted as not all activity could be recorded in the dataset. As can be seen in Figure 1 below, the number of referrals received throughout the year has shown a steady increase, which is encouraging for future years of reporting.

**Figure 1: New referrals received by quarter 2012/13**

![Graph showing new referrals received by quarter 2012/13](image)

Source: Improving Access to Psychological Therapies dataset (Quarterly Reports)

Throughout the year aggregate KPI figures were also routinely collected alongside the IAPT dataset and these can be used as a benchmark for the figures obtained from the dataset throughout the year. Two key KPI measures are the numbers entering treatment and completing treatment. Figure 2 shows how the dataset figures have compared to these throughout the year\(^\text{11}\). Again, this shows that there has been a substantial increase in the volume of figures and comparability to KPI figures, but it is also clear that the

\(^{11}\) Please note that methodological changes were made in the calculation of numbers entering and completing treatment in quarters 3 and 4, which may have impacted the volume of figures. In addition please note that there are some methodological differences between the KPI measures and the equivalent measures calculated from the dataset. For more detail please see the data quality statements which accompany the IAPT dataset quarterly reports.
dataset still appears to show some under counting, and this must be taken into consideration when considering the annual picture shown by the data set.

**Figure 2: IAPT dataset measures as a percentage of the comparable KPI measure, by quarter, 2012/13**

![Graph showing IAPT dataset measures as a percentage of the comparable KPI measure, by quarter, 2012/13]

Source: Improving Access to Psychological Therapies data set (Quarterly Reports) and Improving Access to Psychological Therapies Key Performance Indicator reports

Work is on-going to investigate the difference between the two data sources and a key element of this is data completeness, which continues to improve. It is also important to note that there are some methodological differences between the KPI measures and those produced by the IAPT dataset, as well as local inconsistencies regarding how KPI figures were calculated. Further information regarding this is available in the data quality statement that accompanies this report.

The HSCIC is currently in the process of engaging with users, stakeholders and providers of data to continue to improve the quality of the data produced from the IAPT dataset, and we are keen to continue this process. If you would like to find out more about this process or engagement events that we have organised please contact us at: enquiries@hscic.gov.uk.
In order to access IAPT services, an individual requires a referral. Commonly, these are provided by the individual's GP, but there are many other potential sources of a referral including secondary care and judicial systems, as well as self-referral. Once a referral has been received, it should follow through the recommended stepped care pathway as shown below.

Figure 3 – Recommended stepped care pathway for IAPT services

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

The main measurement used in quarterly publications through 2012/13 is a count of service requests. A service request is a referral for an individual, generated when they are referred to IAPT services for treatment. One individual may only have a single service request for a given provider at one time, but may have multiple service requests across multiple providers, or may have received more than one referral over the course of the year. Furthermore, an individual who is stepped up or down in their level of care may generate an additional referral, as the dataset does not currently have the ability to track referrals across providers. A count of service requests, 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 people being referred to the service for the first time from the dataset. The IAPT dataset records service request ID, and a referral request is a subset of this. The report uses the term referral throughout to describe a service request in the interests of accessibility.

In 2012/13 a total of 883,968 referrals were received, with the most referrals being received in the North of England Commissioning Region (291,914 referrals received 33% of the national total). Comparatively, London Commissioning Region received the least referrals with only 135,488 referrals being received, which equals 15% of the total.

Overall, the proportion of all referrals received fluctuates across the Local Area Teams (LATs) within each of the 4 NHS England Commissioning Regions, from 5% of England’s referrals being received by Cumbria, Northumberland Tyne and Wear Area Team (47,510 referrals received), to 1% being received by Shropshire and Staffordshire Area Team (9,771 referrals received). Other areas with a large share of the number of national referrals are Birmingham and the Black Country Area Team and Greater Manchester Area Team, both also receiving 5% of the total referrals (43,538 and 43,992 referrals received respectively). This excludes London Area Team, which accounts for a much higher 15% of the national total of referrals received, the same number as the London Commissioning Region (135,488 referrals). Nationally, 41,424 referrals could not be assigned to a Commissioning Region or Local Area Team, accounting for 5% of the total number of referrals received.
Figure 4: New referrals received by Local Area Team, 2012/13

Source: Improving Access to Psychological Therapies dataset. Table 1b
Entering Treatment

Being referred to IAPT services does not necessarily mean an individual will enter treatment, as they may be referred elsewhere or decline treatment (for a number of reasons) before or instead of treatment being provided. Additionally, in many cases it may be that the patient does not require treatment and the best course of action is for them to be given guidance and advice rather than a full course of treatment. Therefore, another key measure of access to services is to examine the number of referrals which enter treatment.

In order to be classed as ‘entering treatment’ a referral must have had at least one treatment appointment in the year. A treatment appointment is an appointment where treatment constituted some part of the appointment. In 2012/13 434,247 referrals entered treatment, accounting for 49% of the number of referrals received.

The numbers entering treatment during 2012/13 were quite consistent across Commissioning Regions, with the Midlands and East of England Commissioning Region having 47% of referrals entering treatment (102,581 referrals) and London Commissioning Region and the North of England Commissioning Region showing 48% entering treatment (64,617 and 138,949 respectively. The region with the highest proportion entering treatment was the South of England Commissioning Region at 56% (111,551 referrals).

Across Area Teams a wider spread was apparent, with North Yorkshire and Humber Area Team showing the lowest percentage of referrals entering treatment at 33% (5,714 referrals) whilst the highest percentage entering treatment was recorded by Lancashire Area Team at 70% (14,220 referrals). Overall the highest volume of referrals moving to treatment (outside of London Area Team which recorded 15% of the national total moving to treatment) was recorded by Wessex Area Team with 25,973 referrals entering treatment, 6% of the national total.

Figure 5: Referrals to IAPT services received and entering treatment, by Commissioning Region, 2012/13

Source: Improving Access to Psychological Therapies dataset. Table 1a
Waiting Times

The IAPT dataset is only currently able to show crude waiting times, counting the number of days between a referral being received and the first treatment appointment. In future versions of the dataset, it is hoped that waiting times calculations will be able to control for legitimate reasons for a first appointment being delayed, such as the patient requesting a later appointment. As discussed, 49% of referrals received in the year received a first treatment appointment. Of these, 274,975 referrals were seen within 28 days or less, accounting for 63% of all referrals receiving treatment, while 92% (400,786 referrals) received a first treatment in 90 days or less. Of the 449,721 referrals who did not receive a first treatment in the year, 166,458 (37%) were waiting for treatment at the end of the year. This number, however, may include referrals which were only received at the end of the year (such as in March 2013), and so had not yet received treatment. 84,442 referrals still waiting for treatment at the end of the year had been waiting for over 90 days, making up 51% of those still waiting for treatment.

Figure 6: Waiting times for all referrals with a first treatment in the year, 2012/13

![Waiting times chart](source)

Source: Improving Access to Psychological Therapies dataset. Table 2a

The remaining 283,263 referrals that were received but did not enter treatment in the year and who were not still waiting for treatment at the end of the year had been closed prior to entering treatment. This may be for a number of reasons, including the patient being referred onto other services, or not being suitable for IAPT services.
Therapy Type

There are a number of different treatments which are available through IAPT services and patients can have up to four treatments in a session. The treatment provided is determined through consultation of the NICE12 guidance, according to an assessment of the patient’s needs and the intensity of treatment required.

In total, there were 1,750,369 attended appointments in the England in the year, of which 1,449,164 were classed as treatment appointments by virtue of having at least one therapy type recorded. Services in the North of England Commissioning region had the most attended appointments (583,097 appointments), of which 80% (466,574) were treatment appointments. This area represented 33% of the total number of attended appointments nationally and 32% of treatment appointments. Conversely London Commissioning Region had the lowest amount of attended appointments (243,114), contributing to 14% of the national total. Overall the South of England Commissioning Region had the highest percentage of attended appointments which were deemed to be treatment appointments (92%), whereas nationally 83% of attended appointments were treatment appointments.

In the year, Cognitive Behaviour Therapy (CBT) was the most prevalent treatment provided with 33% (476,245) of all 1,449,164 attended treatment appointments including CBT treatment type as part of the appointment. Guided Self Help was the second most prevalent therapy, being provided in 350,712 attended treatment appointments (24%). Dynamic interpersonal therapy, Employment support, Collaborative care and Behavioural couples therapy were the least prevalent therapy types, all of which being delivered in fewer than 1% of treatment appointments. CBT was the most prevalent treatment in all but one Commissioning Region. The exception to this being the North of England Commissioning Region, wherein Guided Self Help was the most common therapy type, being provided in 31% of appointments (145,533 appointments).

The high use of CBT and Guided Self Help is likely to be a reflection of NICE guidance which recommends the use of these for Generalised Anxiety Disorder13 and Depression14. One of the key aims of the IAPT programme is to complete “the nationwide roll-out of IAPT services for adults of all ages who have depression or anxiety disorders”15. The IAPT dataset is primarily designed to assist in the recording of data regarding the treatment of these disorders and services are tailored to deliver this, although some services may have a wider scope depending on local need. It is, therefore, unsurprising that two of the most prevalent treatment methods are those that are recommended for these disorders.

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14 [http://publications.nice.org.uk/depression-in-adults-cg90/key-priorities-for-implementation](http://publications.nice.org.uk/depression-in-adults-cg90/key-priorities-for-implementation)
In order to examine the outcomes of the IAPT programme, it is important to identify service requests that have closed in the year, in order to compare start and end positions on measures of improvement. It is again important to note that this report only gives information on those referrals that started in the year, meaning that it is likely to be an under report of true activity in the year. This will particularly be the case for the early part of the year, as most referrals ending at this point will predate the first of April 2012, and so will not be counted in this report.

In 2012/13, 534,721 referrals ended, with 50% of referrals ending as a result of the patient declining or dropping out of treatment. 26% of ended referrals were as a result of the patient dropping out of treatment unexpectedly (137,500 referrals), with the second most common reason being patients declining treatment (25%). Patients completing treatment then accounted for 23% of ended referrals. In addition, 9% of referrals ended as the patient wasn’t considered suitable for the IAPT service, while 8% were referred on to another service for treatment.

Across Local Area Teams, there is some degree of regional variation in the reasons for the end of referrals. Some of this variance will be due to data quality issues, and variations in how the ends of referrals are recorded locally. 6 out of 25 Local Area Teams recorded patients completing treatment as their most common reason for the end of a referral, with Bath, Gloucestershire, Swindon and Wiltshire Area Team reporting the highest proportion completing a course of treatment at 37%.

In order to have an end code of “completed treatment”, the therapist has determined that the patient has had the full course of treatment they require. This should not be confused with the term “completed treatment” previously used in quarterly reports and this annual report to denote closed referrals with at least two treatment appointments. A patient may have an end code of “completed treatment” but have only had one

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16 The end reason “Completed treatment” is used when a patient is discharged as a result of the clinician deeming their treatment to be at an end. This is not the same as the number of patients deemed to have completed treatment and who are therefore eligible for outcomes assessment, when calculating recovery measures and other outcomes, as this only requires attendance at two treatment appointments before the end of the referral in order to have completed treatment.
appointment (as this is all that is required) so they cannot be assessed for Recover and other outcomes as this requires at least two appointments.

Shropshire and Staffordshire Area Team showed the lowest percentage of ended referrals that had completed a course of treatment at less than 1% but this is likely to be due to 63% of ended referrals for the Area Team having no end reason recorded. This may be due to data quality issues as a result of the relative immaturity of the dataset. For further information on data quality issues associated with the dataset, please see the data quality statement that accompanies this report.\(^{17}\)

Bristol, North Somerset, Somerset and South Gloucestershire Area Team recorded the highest dropout rate, with 54% (7,423) of ended referrals being attributed to this reason. Meanwhile, Arden, Herefordshire and Worcestershire Area Team had the highest proportion of referrals which ended as a result of declined treatment at 45% (6,543). Conversely, Cheshire Warrington and Wirral, and Durham Darlington and Tees Area Teams, had the lowest percentage of referrals where the referral was ended by the patient dropping out or declining treatment (both at 38%; 7,710 and 5,281 referrals respectively). This excludes North Yorkshire and Humber Area Team (19%; 1,474 referrals) and Shropshire and Staffordshire Area Team (37%; 2,388 referrals) as they both had high numbers of referrals where the end code was not recorded (49%; 3,760 referrals, and 63%; 4,068 referrals respectively), indicating poor data quality on this data field for those Area Teams.

Figure 8: Ended treatments by end reason\(^{18}\), 2012/13

Not all referrals that have ended are eligible to be assessed on outcome measures such as recovery. It is possible for patients to exit the service, or be referred elsewhere, before entering treatment, or without having the required number of appointments to determine the impact of IAPT services. As a result of this, in order to be eligible for assessment a referral must end with at least two treatment appointments, allowing any changes between those two (or more) appointments to be calculated. This is known as “completed treatment”, but may not be the same figure as the number of referrals with an end reason of completed treatment, as the method allows all referrals with the requisite amount of treatment appointments to be assessed (even if the end reason is that the patient dropped out or declined treatment).

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\(^{17}\) The data quality statement can be found on the main webpage for this report, accessed here: http://www.hscic.gov.uk/pubs/psycther1213

\(^{18}\) The classification of other includes those records recorded as “Not Known”, “Invalid”, “No Code Recorded” or “Deceased”
In 2012/13, 144,210 referrals that were eligible for assessment “completed treatment” representing 16% of the referrals that began in the year\(^{19}\). The highest number of completed treatments was recorded for the North of England Commissioning Region with 30% of the national total (43,385 completed referrals) while the London Commissioning Region had the lowest number of referrals with completed treatment at 13% of the national total (18,105 completed referrals). When taking the number of referrals with completed treatment in the region as a percentage of the number received, however, the South of England Commissioning Region showed the highest proportion, with 21% of the referrals received in the region being eligible for outcomes assessment.

Across Area Teams, the percentage of referrals received in the year which had completed treatment varied from the 25% recorded by Devon, Cornwall, and Isles of Scilly Area Team (9,083 referrals) to the 8% recorded by North Yorkshire and Humber Area Team (1,458 referrals).

\(^{19}\) As this is the first year of reporting, only referrals which began in the year are counted, and so the number completing treatment excludes any referrals which began before the 1st April 2012.
Figure 9: Completed treatments by Local Area Team, 2012/13

Source: Improving Outcomes to Psychological Therapies dataset. Table 1b
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 scores on measures of recovery, which should be recorded at every applicable appointment, allowing the impact of IAPT services on an individual’s wellbeing to be measured. Reporting on these measures is still at experimental stage and some measures are affected by issues of data quality and completeness. Additionally, the measures used may be affected by factors outside the IAPT programme, such as other government initiatives and an individual’s personal circumstances. It is expected, however, that as the dataset continues to mature, the data available will allow the development of a rich understanding on the impact of IAPT services.

As with data on referrals ending in the year, this analysis will also be limited by the fact that only referrals that started after April 2012 can be counted therefore outcomes can only be assessed for these records, excluding all referrals which predate this point. This will have had a particularly pronounced effect at the start of the year when a large portion of the referrals ending could be expected to have started prior to April.

Recovery

One of the key outcome measures relating to IAPT service is the measurement of recovery. At each treatment appointment a patient should be asked to complete a number of measures relating to their disorder. These measures are the Patient Health Questionnaire (PHQ-9) and an appropriate Anxiety Disorder Specific Measure (ADSM). The ADSM is chosen according to the provisional diagnosis assigned to the patient. The most common of these is the Generalised Anxiety Disorder assessment (GAD 7), which is also used as a default when there is no recorded diagnosis, but a full list of which ADSM is used for each provisional diagnosis can be found in the Appendix.

A key element of determining whether a referral can be classed as having recovered or not is whether the person to whom the referral relates is at “caseness” at the beginning and end of treatment. Each measure (PHQ9 and ADSMs) have a caseness threshold; this is the score at 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 8 on the GAD 7 measure, they are classed as being a case as they are exhibiting 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.

Although recovery calculations have been included in the IAPT Key Performance Indicators for some time, these have always been calculated locally and submitted as an aggregate measure. Reporting on recovery from the dataset represents the first time that this calculation has been carried out centrally. It is possible that prior to this point there will have been local variation in how guidance on recovery has been implemented and it is expected that the transition to the new method of centralised calculation may create some variance, which is not reflective of the performance of services, whilst IAPT providers adjust to the new dataset submissions and methods of reporting. Therefore, all outcome measures reported on in this report should be viewed in the light of this and the experimental nature of these statistics.

54,430 referrals nationally were able to achieve recovery in 2012/13. This represents 43% of those referrals that had completed treatment and were at caseness at their first assessment (127,060 referrals). Regionally, recovery rates vary between 38% for the London Commissioning Region (5,920 referrals moving to recovery) and 46% in the South of England Commissioning Region (17,280 referrals moving to recovery).

Three Local Area Teams (Arden, Herefordshire and Worcestershire) met the national target of over 50% of referrals with completed treatment and who were at caseness moving to recovery with 1,798 referrals moving to recovery. Bath, Gloucestershire, Swindon and Wiltshire had 1,240 referrals moving to recovery.
and North Yorkshire and Humber had 624 referrals moving to recovery. Essex Area Team had the lowest recovery rate, at 24% (841 referrals moving to recovery).

Figure 10: Recovery rate by Local Area Team, 2012/13

<table>
<thead>
<tr>
<th>Area Team Code</th>
<th>Area Team Name</th>
<th>Area Team Code</th>
<th>Area Team Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q44</td>
<td>Cheshire, Warrington and Wirral</td>
<td>Q57</td>
<td>Essex</td>
</tr>
<tr>
<td>Q45</td>
<td>Durham, Darlington and Tees</td>
<td>Q58</td>
<td>Hertfordshire and the South Midlands</td>
</tr>
<tr>
<td>Q46</td>
<td>Greater Manchester</td>
<td>Q59</td>
<td>Leicestershire and Lincolnshire</td>
</tr>
<tr>
<td>Q47</td>
<td>Lancashire</td>
<td>Q60</td>
<td>Shropshire and Staffordshire</td>
</tr>
<tr>
<td>Q48</td>
<td>Merseyside</td>
<td>Q64</td>
<td>Bath, Gloucestershire, Swindon and Wiltshire</td>
</tr>
<tr>
<td>Q49</td>
<td>Cumbria, Northumberland, Tyne and Wear</td>
<td>Q65</td>
<td>Bristol, North Somerset, Somerset and South Gloucestershire</td>
</tr>
<tr>
<td>Q50</td>
<td>North Yorkshire and Humber</td>
<td>Q66</td>
<td>Devon, Cornwall and Isles of Scilly</td>
</tr>
<tr>
<td>Q51</td>
<td>South Yorkshire and Bassetlaw</td>
<td>Q67</td>
<td>Kent and Medway</td>
</tr>
<tr>
<td>Q52</td>
<td>West Yorkshire</td>
<td>Q68</td>
<td>Surrey and Sussex</td>
</tr>
<tr>
<td>Q53</td>
<td>Arden, Herefordshire and Worcestershire</td>
<td>Q69</td>
<td>Thames Valley</td>
</tr>
<tr>
<td>Q54</td>
<td>Birmingham and the Black Country</td>
<td>Q70</td>
<td>Wessex</td>
</tr>
<tr>
<td>Q55</td>
<td>Derbyshire and Nottinghamshire</td>
<td>Q71</td>
<td>London</td>
</tr>
<tr>
<td>Q56</td>
<td>East Anglia</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Improving Access to Psychological Therapies dataset. Table 5b
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, records that were “borderline” i.e. just over the caseness threshold, may 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 crossed the caseness threshold. A referral can show reliable improvement if it shows a decrease (higher scores indicate higher severity) in scores that surpasses the measurement error of the questionnaire (the amount by which a difference could be attributable to natural variance). The decrease must be shown on either the PHQ9 or the ADSM (or both) and the other score must not have shown an increase beyond the measurement error. Equally, if an individual shows an increase in score that is more than the measurement error, they can be described as having reliable deterioration.

In 2012/13, 82,910 referrals showed reliable improvement, representing 57% of the number of referrals completing treatment in the year. Recovery rates and improvement rates should not be directly compared, as recovery rates use the number of completed treatments minus those not at caseness as the denominator, whereas improvement rates just use the number of completed treatments as a denominator. This is because a referral can show improvement without being classed as being “at caseness” at the beginning of treatment, but “caseness” is required to calculate recovery. As with recovery rates, however, the South of England Commissioning Region showed the highest rate of improvement with 60% of those referrals completing treatment in the year showing reliable improvement (25,390 referrals). In comparison, the London Commissioning Region showed the lowest improvement rate at 53% (9,630 referrals showing improvement) in all commissioning regions, over 50% of completed treatments showed reliable improvement. This is an encouraging figure when considering that one of the IAPT programme’s aims is for the majority of patients completing treatment to show a “meaningful improvement”.

Nationally, all but one Local Area Team achieved an improvement rate of over 50% with the exception of Essex area team which had an improvement rate of 31% (1,238 referrals). The highest improvement rates were achieved by two Area Teams, Arden, Herefordshire and Worcestershire Area Team which had an improvement rate of 65% (2,532 referrals), and Wessex Area Team which also had an improvement rate of 65% (6,364 referrals).
Figure 11 Reliable Improvement rates by Local Area Team, 2012/13

Source: Improving Access to Psychological Therapies dataset. Table 5b
How reliable improvement interacts with 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 who also show a reliable improvement in their scores that is more than the variance of the measure. Combining the two measures also allows examination of the outcomes for borderline patients, such as those who recovered with no improvement, or those who did not recover but showed 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 12: Schematic representation of the potential output pathway of a completed referral**

If a referral does not have paired scores then it cannot be assessed for improvement or recovery as these outcomes require the change between two scores to be examined.
Figure 13 Calculating Recovery, Improvement and Reliable Recovery

ADSM (e.g. GAD7)  
Caseness Threshold

PHQ9

Scores:  
Higher scores = higher severity of condition

First ADSM = Below the threshold   
NOT AT CASENESS

First PHQ9 = Above Threshold   
AT CASENESS

Definition of caseness= either the PHQ9 or ADSM must be above the caseness threshold on the first score. Therefore this record is AT CASENESS

Last ADSM = Below the threshold   
NOT AT CASENESS

Last PHQ9 = Below the threshold   
NOT AT CASENESS

Definition of recovery = both scores must be below the threshold at the last score, after having been at caseness at first score. Therefore this record shows RECOVERY

Change between first and last = less than measurement error of ADSM   
NO RELIABLE CHANGE

Definition of improvement = Reliable improvement on at least one score, while the other has not deteriorated. Therefore this record shows RELIABLE IMPROVEMENT

Definition of Reliable Recovery = Record must show Reliable Improvement and Recovery Therefore this record shows RELIABLE RECOVERY
As can be seen in the table below, in 2012/13 there were 51,900 referrals showing reliable recovery, which was 41% 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. Two Area Teams showed a drop of 1%: Essex (819 referrals with reliable recovery) and Merseyside (1,677 referrals with reliable recovery) (see Table 5b of the reference data tables).

### Table 1: Output measures by region

<table>
<thead>
<tr>
<th>Region</th>
<th>Recovery</th>
<th>Reliable Improvement</th>
<th>Reliable Recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>43% (54,430)</td>
<td>57% (82,910)</td>
<td>41% (51,900)</td>
</tr>
<tr>
<td>London Commissioning Region</td>
<td>38% (5,920)</td>
<td>53% (9,630)</td>
<td>36% (5,590)</td>
</tr>
<tr>
<td>Midlands and East of England Commissioning Region</td>
<td>42% (13,180)</td>
<td>57% (19,930)</td>
<td>41% (12,610)</td>
</tr>
<tr>
<td>North of England Commissioning Regions</td>
<td>41% (15,840)</td>
<td>57% (24,660)</td>
<td>39% (15,160)</td>
</tr>
<tr>
<td>South of England Commissioning Region</td>
<td>46% (17,280)</td>
<td>60% (25,390)</td>
<td>44% (17,280)</td>
</tr>
<tr>
<td>Unknown</td>
<td>46% (2,208)</td>
<td>59% (3,304)</td>
<td>43% (2,097)</td>
</tr>
</tbody>
</table>

Source: Improving Access to Psychological Therapies dataset. Table 5a

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20 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.

21 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.

22 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 for “improved social and economic participation, including employment for working-age people”. Employment status should be recorded at every applicable appointment therefore it is possible to look at the starting and ending employment status for all referrals where treatment was completed in the year.

The majority of people who had employment status recorded at the start of their treatment were in employment, accounting for 50% of referrals with completed treatment (72,188 referrals). The second most likely employment status at the start of treatment was unemployed and seeking work (14%, 20,345 referrals) whilst 6% of those referrals who completed treatment in the year were identified as “long term sick or disabled, or in receipt of benefit payments” (8,245 referrals).

**Figure 14: Employment status at start and end of treatment for referrals with completed treatment, 2012/13**

As can be seen in Figure 14, the number of referrals where the patient identified as being in employment at the end of their treatment is 47% (68,339 referrals). This drop may be partly explained by the 1,338 referrals that were recorded as employed at the start of treatment but did not state their employment status at the end of treatment (2% of the number employed at the start of their treatment). The numbers recorded as unemployed at the end of their treatment had also fallen to 13%(18,433 referrals), while the number who identified themselves as being long term sick or disabled, or in receipt of benefit payments remained at 6% (8,029 referrals) of the total number of completed treatments.

It is also possible to check how the employment status associated with a referral changed between the first and last recorded status, over the course of their referral. The figures show that 4% (357 referrals) of the total number of people who registered as long term sick or disabled, or in receipt of benefits as their first recorded status, had moved to being employed when their final employment status was recorded. In addition, 10% of those who identified as being unemployed at their first recorded employment status had
transitioned to employment by their last recorded employment status (2,039 referrals). 15% of those who originally identified as being long term sick, disabled, or in receipt of benefit payments had moved to being unemployed and seeking work (1,228 referrals). Of the 4,379 referrals where the patient had identified as not receiving benefits and not working or actively seeking work, however, 19% (819 referrals) had moved to being classed as long term sick or disabled, or in receipt of benefits.

Person Level Analysis

The IAPT dataset is in its infancy, having only been reported on for one year and so 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. All previous quarterly reports have also reported by numbers of referrals (sometimes known as “service requests”). 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 2012/13.

In total, during 2012/13, 761,848 people were referred to IAPT services, in comparison to 883,968 referrals received. This indicates that 122,120 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 service multiple times. It is very likely that a large proportion of these multiple referrals will be due to individuals being stepped up or down to a different level of care within a provider; however, at present it is not possible to track these movements except as a second referral.

Analysis by Gender

Of the 761,848 people being referred to IAPT services during 2012/13, 36% (274,409) were male and 62% (474,963) were female, whilst 2% of people (12,476) did not specify their gender. 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 shows that 44% of people using NHS funded adult and elderly secondary mental health services were male, while 56% were female).

Figure 15: Percentage of males and females accessing IAPT services by age group

Source: Improving Access to Psychological Therapies dataset. Table 7

The gender distribution across age bands can be seen in figure 15. From this it can be seen 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 2012/13. Additionally, 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 (71% 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, although men do not show a peak in referrals with the numbers referred remaining stable between the ages of 20 and 49 (fluctuating between 13% and 11% across the period).

The number of people (per 100,000 of the population) being referred to IAPT services decreased with age, especially beyond the age of 65. 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.
Figure 16: 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

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

Source: Improving Access to Psychological Therapies dataset, Table 7 and Mental Health Minimum dataset, Mental Health Bulletin table 1.3
Analysis by Ethnicity

The IAPT dataset has shown a reasonable level of data quality in ethnicity recording, with 70% of people having a valid ethnicity. This is sufficient to provide some limited analysis by ethnic group.

The data shows that during 2012/13 89% of those accessing IAPT (excluding those whose ethnicity was unknown or not stated, accounts for 30% of the total number of people referred), were categorised as white, making up the majority of IAPT users. Following this, individuals with Asian or Asian British background made up the next largest percentage of IAPT users (4%). The smallest proportion of the number of people with a referral to IAPT services were categorised as Other Ethnic Group, or Mixed Ethnic group, both showing 2% each (8,196 and 11,057 people respectively).

In general, across ethnicities a similar pattern in gender distribution among service users was observed as was seen nationally. The most pronounced gender split was found in those who identified as Black or Black British, with 68% of people with a referral being female, compared to 31% being male (11,703 people compared to 5,365 respectively).

When compared to ONS population figures (based on the 2011 Census) to produce rates of access to IAPT services, a different pattern was observed. People with an ethnicity of Other Mixed who were over the age of 18 had the highest number of people referred to IAPT per 100,000 population at 2,951, followed by those of Other Black Background (1,818 per 100,000 population), and White and Black Caribbean (1,774 per 100,000 population). 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 (380 people referred per 100,000 population).

Figure 17 People being referred to IAPT services per 100,000 population, by ethnic group, 2012/13

Source: Improving Access to Psychological Therapies dataset, Table 9
## 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&lt;sup&gt;24&lt;/sup&gt;</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&lt;sup&gt;25&lt;/sup&gt;</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>Hypochondriacal disorder</td>
<td>Health Anxiety Inventory (Short Week)</td>
<td>18</td>
<td>4</td>
</tr>
</tbody>
</table>

24 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.

25 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 the measures used to assess the severity of a patient’s condition. The ADSM is chosen according to the provisional diagnosis recorded, although in most cases the ADSM used is GAD7 (see Appendix). GAD7 is also the ADSM used in the absence of a Provisional Diagnosis. The ADSM is assessed in conjunction with the PHQ9 to determine measures of recovery and improvement. An ADSM should be recorded at each appointment.

**Caseness** – Caseness is the term used when a referral is assessed as being a case. This is determined by the scores recorded on the ADSM and PHQ9 – as long as one or both scores is above a given threshold for the measure then it is classed as a case.

**Completed Treatment** – Completed Treatment is a term used for those referrals that have closed in the period and are eligible for assessment of outcome measures. A referral has completed treatment if it has ended in the period and has at least two treatment appointments, neither of which can be coded as a “follow up”. This should not be confused with those referrals that had an end reason of Completed Treatment, indicating that the course of treatment was completed.

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

**PHQ9** – The Public Health Questionnaire is used to assess the severity of the patient’s condition, and is assessed in conjunction with the ADSM recorded for the referral in order to determine measures of recovery and improvement. The PHQ9 should be recorded at each appointment.

**Recovery** – If a referral was at caseness on one or both of the first scores taken and is no longer at caseness on either score by the time the last scores are taken, then the referral is said to have moved to recovery.

**Referral** – A patient can be referred to IAPT services, from a number of sources, including the GP and self-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. For this reason, in most cases a count of referrals is used, rather than a count of people when looking at activity in IAPT services.

**Reliable Deterioration** - If a referral has shown an increase in scores between the first and last score on a measure, beyond the measurement error of the questionnaire used, and the other score tested either shows no change or also shows an increase, then a referral can be said to be showing reliable improvement.

**Reliable Improvement** – If a referral has shown a decrease in scores between the first and last score on a measure, beyond the measurement error of the questionnaire used, and the other score tested either shows no change or also shows a decrease, then a referral can be said to be showing reliable improvement

**Reliable Recovery** – If a referral meets the criteria for both recovery and reliable improvement it can be said to have reliably recovered.

**Treatment Appointment** – A treatment appointment is any appointment with a therapy type recorded. The presence of a therapy type is used as an indicator of whether a treatment was provided in the course of the appointment, rather than just an assessment appointment.