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National Audit of Psychological Therapies for Anxiety and Depression

National Report

Executive Summary 2011

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HQIP
Healthcare Quality Improvement Partnership

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Foreword

Around 6 million adults in England and Wales are affected by anxiety and depression. Access to appropriate, acceptable and effective psychological therapies is critical for helping individuals recover and for reducing disability and associated costs to the public purse. It is clear that professionals across services provided by NHS and third sector work hard to deliver good quality psychological therapies. What is perhaps less understood is exactly which type of services exist, where they are based and precisely what interventions they provide.

The National Audit of Psychological Therapies for Anxiety and Depression (NAPT) has provided a unique opportunity for us to begin to understand the range and quality of services and the experience of those who receive therapy. The audit findings, incorporating data from across Wales and England, derive from a spectrum of services, including those in primary and secondary care, small and large services, IAPT and non-IAPT services.

The audit has produced some very encouraging findings; for example, the majority of service users who responded to the audit reported a positive therapeutic alliance with their therapist and felt that therapy had helped them to cope with their difficulties. It is clear that good quality services can have an incredibly positive impact on an individual with anxiety and depression and there is much to be celebrated. However, within this overall positive picture there is wide variation between services. For example, whilst many services meet the standards around waiting times, for others, a sizeable proportion of service users still face unacceptably long delays. For people with anxiety or depression –especially those who need time and courage to seek help in the first place – these delays can pose real difficulties. It is therefore important that whilst we celebrate the many areas of achievement, we continue to strive for further improvement.

Central to the process of improving services is reflecting on these findings and trying to understand why such variation occurs. The audit findings allow participants to benchmark their services against other services, enabling clinicians, managers and commissioners to learn from good practice and plan positive changes. Learning from the experience of those who use psychological therapy services will be key to making improvements. We are delighted with the service user input into the audit and expect the feedback from the more than 10,000 service users who responded to the audit survey to be of immense value when planning future developments. The willingness of clinicians and service users to contribute to this national audit and their openness to reflect on areas for possible improvement has been inspiring and bodes very well for the continued development of psychological services provision in Wales and England.

Professor John Cape
Chair of the NAPT Steering Group

Catherine O'Neill
Service user and third sector lead, NAPT

Executive Summary

Background

The National Audit of Psychological Therapies for Anxiety and Depression (NAPT) was established in 2008 with funding from the Healthcare Quality Improvement Partnership (HQIP, see http://www.hqip.org.uk). The aim of this three-year project was to evaluate and improve the quality of treatment and care provided to people who suffer from anxiety and depression in England and Wales.

The key aims of the audit were to measure:

- Access
- Appropriateness
- Acceptability
- Outcomes

to/of treatment for those suffering from depression and anxiety.

Audit standards

Audit standards were developed from relevant guidance literature, including that produced by the National Institute for Health and Clinical Excellence (NICE), and in consultation with both the audit's Steering Group and Expert Advisory Group.

Method

In 2009 a pilot phase was carried out that tested different methods of collecting data for the audit. After a review and discussion with the pilot sites the questionnaires were amended and methods for data collection were chosen. The following audit tools were used to assess adherence to the audit standards:

1. Service Context Questionnaire
2. Therapist Questionnaire
3. Retrospective Audit of people who completed therapy between 1 September and 30 November 2010
4. Service User Survey 'Talking Treatment'

Data collection was carried out between May 2010 and February 2011.

In total, 357 services from 120 organisations across England and Wales participated in NAPT.

Performance against the NAPT standards

Below is a summary of performance against each of the NAPT standards, measured using the data collection tools described above. The standards relate to the aims of the audit, as follows:

Access – standards 1-3
Appropriateness – standards 4-6
Acceptability –standards 7-8
Outcomes –standards 9-10

Please note: for most standards, the data were analysed at both patient at service levels. The findings therefore include the experience of the average patient, as well as comparisons between services. The large variation in the number of returns by service means that there are important differences in these two approaches, which should be taken into account when interpreting these findings.

Standard 1a: The service routinely collects data on age, gender and ethnicity for each person referred for psychological therapy

Overall, there was 99% data completeness for age group; 99% for gender and 76% for ethnicity. At a service level, the vast majority of services had 100% or near data completeness for age and gender; however, there was much greater variability in the levels of completeness for ethnicity data.

Standard 1b: People starting treatment with psychological therapy are representative of the local population in terms of age, gender and ethnicity

There appears to be an underrepresentation of older people (65+) when compared to expected rates of common mental health problems for this age group nationally. The available ethnicity data are consistent with the Office for National Statistics (ONS) data. No ethnic groups appear to be over- or underrepresented at a national level; however, data were not mapped at a local level, and no conclusions can be drawn for those patients (24%) for whom ethnicity was incomplete.

Standard 2: A person who is assessed as requiring psychological therapy does not wait longer than 13 weeks from the time at which the initial referral is received to the time of assessment

Overall, this standard was met for 85% of patients. At a service level, the median percentage of patients meeting the standard was 80%.

Large services had the shortest waiting time to assessment, with patients in medium services waiting on average 49% longer, and patients in small services waiting on average 43% longer.

Standard 3: A person who is assessed as requiring psychological therapy does not wait longer than 18 weeks from the time at which the initial referral is received to the time that treatment starts

Overall, this standard was met for 85% of patients. At a service level, the median percentage of patients meeting the standard was 80%.

Large services had the shortest waiting times, with patients in medium-sized services waiting on average 49% longer, and patients in smaller services waiting 34% longer on average.

Standard 4: The therapy provided is in line with that recommended by the NICE guideline for the patient's condition/problem

Overall, this standard was met for 83% of patients who had a primary diagnosis of anxiety or depression covered by a NICE guideline. Patients with a primary diagnosis of OCD/body dysmorphic disorder, panic disorder/agoraphobia were most likely to receive therapy in line with NICE guidance (90% and 89% respectively) and patients with a diagnosis of PTSD were least likely to receive therapy in line with NICE guidance (75%).

At a service level, the median proportion of patients who received a NICE recommended therapy was 87%. However, there was considerable variation across services, with the top quartile providing a NICE recommended therapy for over 96% of their patients, and the bottom quartile for less than 78% of their patients.

NB: This standard has only been measured for those patients for whom a diagnosis has been made. No conclusions can be drawn for those patients whose diagnoses were not recorded.

Standard 5: Treatment for high intensity psychological therapy is continued until recovery or for at least the minimum number of sessions recommended by the NICE guideline for the patient's condition/problem

Overall, this standard was met for 54% of patients. At a service level, the median percentage of patients who received the right number of sessions or who recovered was 56%.

Number of recommended sessions
30% of patients received the minimum number of sessions recommended in the specific NICE depression or anxiety disorder guideline for the patient's condition/problem. The diagnosis most likely to receive the correct number of sessions was panic disorder/agoraphobia (62%) and the diagnosis least likely was Generalised Anxiety Disorder (GAD) (18%).

Recovery and reliable improvement rates
It was possible to calculate this for 92% of patients who met the pre-treatment caseness criteria. Of those that did not have the recommended number of sessions, 46% recovered, 13% made reliable improvement but did not recover and 41% neither recovered nor made reliable improvement.

Reasons for therapy ending
For those patients who did not receive the minimum number of sessions and neither recovered nor reliably improved, the most frequently reported reasons for ending therapy were completing treatment (49%) or dropping out/unscheduled discontinuation (44%).

Standard 6: The therapist has received training to deliver the therapy provided

All therapists surveyed had some training in at least one therapy type. This includes people who have received formal training, attended short workshops and those working with supervision.

At a service level, the median percentage of therapists who had received formal training in at least one therapy was 86%.

In relation to the provision of high intensity therapy, therapists were most likely to have completed formal training for counselling, person-centred therapy, CBT and psychodynamic therapy. For low intensity therapy, the majority of therapists had completed formal training for the provision of support with medication, psychoeducation, guided self-help and other low intensity therapies. Overall, the most frequently reported qualification was a postgraduate diploma.

Standard 7: People receiving psychological therapy experience and report a positive therapeutic relationship/helping alliance with their therapist which is comparable to that reported by people receiving treatment from other therapists/services

This standard was met for 80% of patients. At a service level, the median percentage of patients reporting a positive therapeutic alliance was 82%, while the rate for services in the top quartile exceeded 88%. It should also be noted that the response rate for the ARM-5 was 19%; the service users that responded to the questionnaire may be more favourable about their therapeutic relationship than those that did not respond.

Standard 8: Patients/clients/service users report a high level of satisfaction with the treatment that they receive

Overall, 87% of responses were positive. Quantitative data indicated slightly higher overall levels of satisfaction with outcomes of therapy when compared to access to therapy. The lowest levels of satisfaction were in relation to the waiting time for treatment to start and the number of sessions that patients were receiving. It should also be noted that the response rate for the service user questionnaire was 21%; the service users that responded to the questionnaire may be more favourable about their experience of therapy than those who did not respond.

Standard 9a: The service routinely collects outcome data in order to determine the effectiveness of the interventions provided

Eighty-one percent of patients had both a first and last score on at least one measure. At a service level, the median proportion of patients with both a first and a last score on at least one measure was 76%.

Standard 9b: The clinical outcomes of patients/clients receiving psychological therapy in the therapy service were comparable to those achieved to benchmarks from clinical trials and effectiveness studies and to those achieved by other therapy services

The mean recovery rate for participating services was 49% with the top quartile achieving recovery rates of greater than 57%.

Few participating services had effect sizes that were comparable to those found in trials data, but the outcomes are broadly similar to those reported in the practice-based literature.

Standard 10: The rate of attrition from commencing treatment to completing treatment is comparable to that of other therapy services

The attrition rate for people ending therapy within the audit period is 25%. At service level, the attrition rate ranged between 0 - 50%, with a median of 19%. Both very high and very low attrition rates could be worthy of further exploration by the services concerned.

Key findings

The following list summarises key findings emerging from the audit data.

1. **The psychological therapy services that participated in the audit vary greatly in size.**
   The smallest services in the audit (which employed fewer than eight therapists) were predominantly secondary care services and not considered part of the English IAPT programme. The largest services (which employ more than 20 therapists) were mainly based in primary care and many of these received IAPT funding. This variation is important when considering the other key findings for the audit. The largest services have much higher throughput and so account for a disproportionately high proportion of the patients (27% of services accounted for 78% of the patients).

2. **Older people are less likely to receive psychological therapy than younger people.**
   Based on what is known about the prevalence of common mental health problems, people aged between 65 and 74 are half as likely, and those aged over 75 one-third as likely, to receive therapy as people under the age of 65. Over one-third of services (36%) have a policy that excludes older people.

3. **The waiting time standard, both from referral to assessment and from referral to treatment, was met for 85% of patients for whom data were returned.** However, variation between services varied widely and long waiting times were one of the most frequently cited area of concern by service users completing the survey. Many of the comments made by service user respondents illustrated the debilitating effect that long waiting times can have on an individual's wellbeing.

4. **The analysis of clinical outcome measures showed that nearly 49% of patients with pre- and post-treatment measures had recovered at the end of therapy. The outcomes for participating services are broadly similar to those reported in other large evaluations of psychological therapy in routine clinical settings, but lower than that reported in randomised controlled trials.**
   The fact that only one-third of all services returned adequate data to be included in the analysis of outcome measures needs to be taken into account. The two approaches used for making comparisons with other studies also need to be considered when drawing any conclusions.

5. **Ninety percent of patients who returned a questionnaire reported a positive therapeutic alliance with their therapist.**
   These findings must be considered in light of the fact that the 19% of service users who completed the ARM-5 measure might be biased in favour of those who are more satisfied. It should also be noted that the views of patients who either declined or dropped out of therapy are not represented in the sample.

6. **The type of therapy provided is in line with NICE guidance for 83% of patients with a diagnosis for which there is a NICE clinical practice guideline.**
   Although this indicates that a large majority of patients received therapy in line with NICE guidance, the fact that no diagnostic information was provided for 46% of patients needs to be taken into account. No conclusions can be drawn for those patients whose diagnoses are missing. The proportion of people receiving a NICE recommended therapy varied according to diagnosis, with PTSD having the lowest level of adherence. Although it may be clinically appropriate to provide an alternative therapy, the reasons for such decision-making are unclear.

7. **Seventy percent of patients who had high intensity therapy did not receive the minimum number of treatment sessions that NICE recommends.**
   About one-half of these patients had not recovered by the time that therapy was discontinued. Concerns about the number of sessions provided were also evident in the results from the quantitative and qualitative analysis of the data from the service user survey.

8. **A number of therapists are delivering therapies for which they have received no specific training.**
   Although all therapists reported receiving training in at least one therapy modality, they had not necessarily received specific training for the therapies they reported delivering. 30% or more of therapists that deliver the following types of therapy report having undertaken no training in that therapeutic approach:

   - high-intensity therapies - interpersonal therapy, couples therapy, eye movement desensitization and reprocessing, dialectical behaviour therapy and arts psychotherapies;
   - low-intensity therapies – computerised cognitive behaviour therapy. It is noted that low-intensity therapies generally require less training.

9. **There is substantial variation between services in meeting the audit standards.**
   - For example, those in the bottom quartile for waiting time performance met the standard for waiting time from referral to treatment for 50% of patients or less, compared to services in the top quartile which achieved this for 93% of their patients;
   - the standard for delivery of a treatment recommended by NICE was met for 77% of patients or less by those in the bottom quartile, compared to 96% or more in the top quartile.
   - Those in the bottom quartile for therapeutic alliance had 13% or more patients reporting a weak therapeutic alliance, compared to those in the top quartile, which had 5% or fewer patients reporting a weak alliance.

10. **Patients from small and particularly medium services waited longer than patients from large services for both assessment and treatment.**
    There was a significant effect of service size upon waiting times, but no effect of IAPT funding and service level after adjusting for the effects of service size.

11. **The extent to which services routinely collect outcomes data is unclear.**
    The finding that for 81% of patients there was at least one outcome measure with pre and post scores needs to be considered in light of the fact that only one third of all participating services returned adequate outcome data. Furthermore, the data submitted indicated that 42 services (15%) had no outcome data for any of their patients.

12. **Some psychological therapy services are poor at recording the ethnicity and diagnosis of the patients they treat.**
    Our conclusion that people from Black and minority ethnic groups do not appear to be disadvantaged in terms of access to psychological therapies must be tempered by the finding that ethnicity was not recorded for 24% of patients. Also, because of the challenge of defining the catchment area of participating services and taking into account the differing target populations of participating services, we have compared the patient cohort to the UK population and not to the local population. It is therefore possible that differential access by certain ethnic groups has been missed. Recording of diagnosis is even poorer; 46% of patients had not been assigned a diagnosis. Differing practices in relation to assigning diagnoses may be a contributory factor.

Recommendations

Recommendation 1: Investigate reasons for sub-optimal duration of therapy

- The finding that a substantial number of patients end therapy before having received the number of treatment sessions that NICE recommends and without having recovered, should be communicated to therapists employed by participating services and service managers.
- Local services should seek to gather more specific information about why patients who have not recovered end therapy when they do and where appropriate, act on these findings.

Recommendation 2: Training of therapists

- The finding that a substantial number of therapists are delivering some therapies that they report they have not been trained in needs further exploration to consider the appropriateness of this. This issue also needs to be discussed with professional bodies and training providers.
- Service managers should consider the skill mix and training of employed therapists at both an individual and service level, taking into account the national picture. Any training or support needs should be followed up in supervision and annual appraisals.
- Attempts should be made to gather further information about the training and accreditation of therapists in future research and audit work.

Recommendation 3: Services that are outliers should consider the reasons and make action plans to address the problem

- Local reports will alert each participating team to any standards in which they are an outlier and these teams will be encouraged to take action.
- The reaudit should assess whether local action has increased the extent to which standards have been met.

Recommendation 4: Addressing service user sources of dissatisfaction

- Service user concerns need to be discussed with all relevant stakeholders in order to identify changes that need to be made. The two areas of greatest dissatisfaction (waiting time for treatment to start and the number of sessions that they were receiving) need to be given particular consideration as these were also backed up by other findings.

Recommendation 5: Action to address the poorer access to therapy services by older people

- The NHS Commissioning Board and relevant policy leads should be asked to consider whether further changes should be made to current policy and the system for commissioning, regulating and managing the performance of services that provide psychological therapy services. It is noted that the IAPT programme in England has recently pledged to improve access for older people and any lessons learnt from this in the future will need to be widely shared amongst commissioners and managers of all services.
- The local reports sent to individual participating services should highlight this issue and ask services to consider addressing it in their action plans.
- The reaudit undertaken in 2012 should attempt to gather data to further understand the reasons for services providing differential access by age.

Recommendation 6: Improving the recording of ethnicity and diagnostic data

Obstacles to recording ethnicity and diagnostic data need to be further explored with a view to identifying effective strategies for attaining high completion rates. Examples of good practice should be shared across services.

Recommendation 7: Investigate reasons for non-adherence to NICE guidelines

The reason why adherence to NICE recommended therapy varies according to diagnosis should be further explored. The local reports and NAPT action planning tool kit will prompt participants to consider whether this is an issue for them. Where appropriate, services will be encouraged to take action. The NAPT reaudit should seek to gather further information on why such variation occurs.

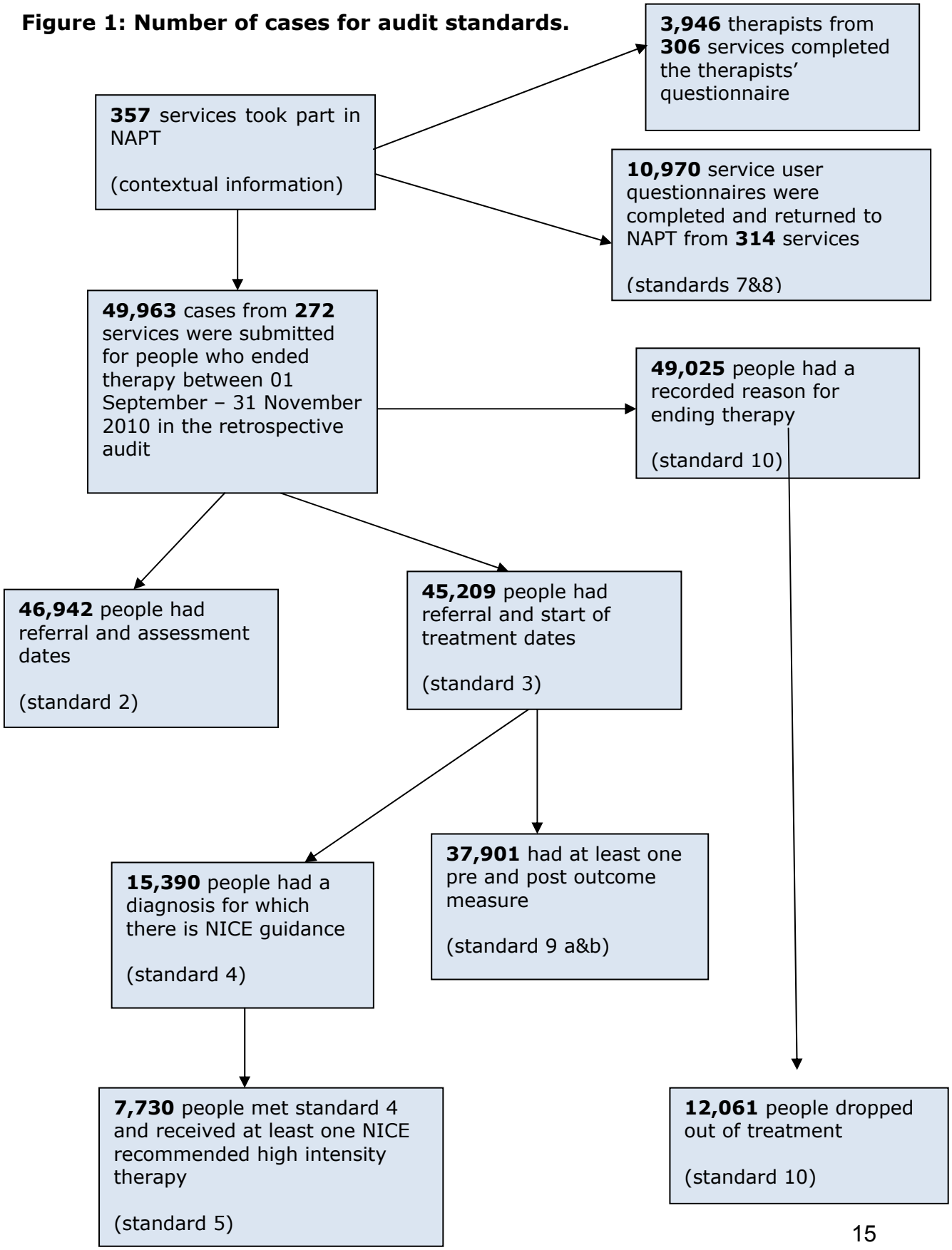
Recommendation 8: Improve routine outcome monitoring

Services need to improve the ways that they collect outcome data. This should be addressed in local action plans, as well as discussed further at a national level. It is noted that the IAPT programme expects services to achieve at least 90% data completeness by utilising session by session outcome monitoring. It is also noted that data from IAPT services dominated the sample included in the analysis of outcomes. This will need further consideration when designing the reaudit in 2012.

Response rates

Figure 1 illustrates the number of cases collected and how this relates to the audit standards.

Figure 1: Number of cases for audit standards.



The future of NAPT

In June 2011, the National Audit of Psychological Therapies secured funding from the Healthcare Quality Improvement Partnership (HQIP) for a further two years from November 2011.

For more information on NAPT, please visit
www.rcpsych.ac.uk/napt