Improving Access to Psychological Therapies (IAPT) is a large-scale government-funded programme that has dramatically changed the face of psychological care in England since its inception in 2008. Its defining features include the provision of evidence-based psychological treatments informed by clinical guidelines, the delivery of interventions in a stepped-care model and the routine application of validated patient-reported outcome measures (PROMs) to monitor and evaluate treatment. Currently around 147 IAPT services provide treatment across 212 clinical commissioning group (CCG) localities. Consistent with UK government policy, mental health services are expected to attain measurable outcomes for equitable access to care, waiting times, clinical improvement and satisfaction. Current policy rhetoric emphasises the notion of ‘recovery’ from common mental disorders. Informed by outcomes observed in an initial pilot study, the clinical performance of IAPT services is assessed based on whether at least 50% of treated cases recover according to data derived from PROMs. Available data appear to show very wide variations in recovery rates across CCG areas, ranging between 8.2 and 86.6%. At face value this may indicate marked variations in recovery rates across CCG areas, ranging from 8.2 to 86.6%. However, adjusting other factors (such as socioeconomic deprivation) may increase recovery rates by 43.1% in areas with less deprivation (72.5%). After adjusting benchmarks for socioeconomic context, the predictors entered into the regression model included IMD and a dummy variable to assess the influence of outlier cases. Finally, we used chi-square and kappa (κ) statistics to compare the classification of CCG areas with suboptimal outcomes according to (a) the current 50% benchmark and (b) the lower 95% confidence interval for the IMD-adjusted benchmarks. Ethical approval was not required for these analyses, since they relied on information available in the public domain that does not contain any personally identifiable patient data. Associations were examined in four steps. First, we calculated rank correlations between IMD, number of referrals and case-load sizes per CCG area. Second, we calculated rank correlations between IMD and recovery rates. A sensitivity analysis excluding extreme outliers was carried out to assess whether CCG areas with unusually large or small recovery rates overly influenced associations between the variables of interest. Next, we used weighted least squares regression to assess the proportion of variance in recovery rates attributable to IMD, and to estimate adjusted recovery rates. We estimated 95% confidence intervals weighted by sample size to account for measurement error, and based on the rationale that services should be expected to perform at least as well as the ‘average’ IAPT site working within a similar socioeconomic context. The predictors entered into the regression model included IMD and a dummy variable to assess the influence of outlier cases. Finally, we used chi-square and kappa (κ) statistics to compare the classification of CCG areas with suboptimal outcomes according to (a) the current 50% benchmark and (b) the lower 95% confidence interval for the IMD-adjusted benchmarks. Ethical approval was not required for these analyses, since they relied on information available in the public domain that does not contain any personally identifiable patient data. Associations were examined in four steps. First, we calculated rank correlations between IMD, number of referrals and case-load sizes per CCG area. Second, we calculated rank correlations between IMD and recovery rates. A sensitivity analysis excluding extreme outliers was carried out to assess whether CCG areas with unusually large or small recovery rates overly influenced associations between the variables of interest. Next, we used weighted least squares regression to assess the proportion of variance in recovery rates attributable to IMD, and to estimate adjusted recovery rates. We estimated 95% confidence intervals weighted by sample size to account for measurement error, and based on the rationale that services should be expected to perform at least as well as the ‘average’ IAPT site working within a similar socioeconomic context. The predictors entered into the regression model included IMD and a dummy variable to assess the influence of outlier cases. Finally, we used chi-square and kappa (κ) statistics to compare the classification of CCG areas with suboptimal outcomes according to (a) the current 50% benchmark and (b) the lower 95% confidence interval for the IMD-adjusted benchmarks. Ethical approval was not required for these analyses, since they relied on information available in the public domain that does not contain any personally identifiable patient data. 

Results

We observed a statistically significant and negative correlation between IMD rank and the number of new referrals per CCG (r = -0.27, P < 0.001), but IMD was not correlated with case-load sizes (r = -0.07, P = 0.33). Online Fig. DS1 displays a scatterplot of...
recovery rates and IMD rank per each CCG area. Rank correlations were statistically significant (r = 0.39, P < 0.001) and excluding extreme outliers had a negligible influence on the correlation coefficient (r = 0.38, P < 0.001). Similarly, outlier cases did not significantly lever age regression slopes (P = 0.54), so the dummy variable was removed to attain a parsimonious regression equation including IMD rank as a single independent variable that predicted 15.3% of variance in outcome (F = 37.76, d.f. = 1, P < 0.001). Agreement between the benchmarking methods was low (k = 0.45). The 50% benchmark classified a significantly greater proportion (72.5%) of CCG areas as ‘underperforming’ by comparison with the IMD-adjusted benchmark (43.1%; \( \chi^2 = 60.66, \) d.f. = 1, P < 0.001). The mean IMD-adjusted recovery rate for the whole sample was 45.2% (s.d. = 30.0, 95% CI 40.1–50.5).

**Discussion**

Consistent with the wider literature on psychiatric morbidity,\(^7\) higher numbers of referrals for psychological care were moderately associated with greater deprivation of local areas. However, no such relationship was found for deprivation and case-load sizes, which suggests that the ‘inverse care law’ applies in this context. This could be explained by the detrimental influence of deprivation on the likelihood of starting therapy after being referred,\(^5\) insufficient healthcare resources in services working in poor areas, or a combination of both. Furthermore, we found evidence of statistically significant associations between socioeconomic deprivation and psychological therapy outcomes. Poorer areas had lower average recovery rates. These associations were moderate in strength at an aggregate population level. Given that more detailed data were not accessible at the time of analysis,\(^3\) it is unclear whether these associations would remain significant after controlling for patient-level variables. A range of other factors including employment status,\(^14\) baseline symptom severity, functional impairment and variability between therapists are likely to influence clinical outcomes in psychological care.\(^15\)

We found that the current 50% recovery target is classifying a significantly larger number of CCG areas as underperforming (an additional 29.4%) by comparison with the IMD-adjusted benchmark. It seems improbable that over 70% of IAPT services are attaining these standards’ for some services and not others. A related and perhaps more palatable consideration is whether services working in more deprived areas should receive increased funding, commensurate with the increased psychiatric morbidity and disadvantages of their local populations. Overall, we caution against the wholesale application of unadjusted performance targets, and argue for population-matched and risk-adjusted metrics such as those advanced in other areas of healthcare.\(^18\)

**References**


Data supplement

Fig. DS1 Relationship between population deprivation and Improving Access to Psychological Therapies (IAPT) recovery indices.

Data from 211 clinical commissioning groups (CCGs). Rank correlations: $r=0.39$, $P<0.001$, full sample; $r=0.38$, $P<0.001$, excluding outliers.
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