Measurement-Based Care in Mental Health: Key Themes from the Education Series, Session 1 — The Why

Our first webinar, held on January 21, 2021, asked why should Ontario apply measurement-based care in mental health and addictions services? Through an example from NHS England, we aimed to demonstrate the system-level value of incorporating and standardizing measurement-based care into clinical practice.

Keynote presentation by David M Clark[1]: How data helped IAPT realize the mass public benefit of psychological therapies

The Improving Access to Psychological Therapies program (IAPT)[2] is a stepped-care program in the UK, created to improve access to psychotherapy for common depression and anxiety disorders. People strongly prefer psychotherapy over medication, but wait times were long and less than 5% of people seeking care received a NICE-recommended therapy program. IAPT launched in 2009 with major government support and ambitious but evidence-based goals – and, today, impressive results. Average waits to start treatment are now 20 days, down from 18 months; 68% of people show substantial improvement; and 52% of people recover. The idea behind stepped care is that most people with mild to moderate conditions will respond to low-intensity psychotherapy, and those who need more can be "stepped up" to more intensive treatment.

Measurement-based care is a key feature of IAPT. Before each session, patients answer a few brief questions, allowing the program to capture validated self-report measures of depression and anxiety. The data are recorded in a common (across services, nationwide) outcome monitoring system. As a result, IAPT has outcomes data for 98% to 99% of patients, with local-level service summaries available publicly and updated monthly.

David Clark, the program's clinical and informatics advisor, offered a roadmap for their approach and these key learnings for Ontario:

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[1] NHS England's Clinical and Informatics Advisor for IAPT and Professor of Psychology, University of Oxford, UK

[2] Delivers psychological therapies recommended by the National Institute for Health and Clinical Care Excellence (NICE) for depression and anxiety disorders to more than 537,000 patients in the UK each year. Detail available in: Clark et al, Transparency about the outcomes of mental health services (IAPT approach): an analysis of public data, The Lancet, 2017 Dec 17, http://dx.doi.org/10.1016/S0140-6736(17)32133-5

Outcomes-Oriented Learnings

- **There's huge value in having systematic data.** Analysis of service-level data (on program implementation and outcomes) provides great insight into what helps or hinders better outcomes for patients. How long people wait to start treatment turned out to be crucial: practices with shorter wait times had significantly higher rates of "reliable improvement" among patients. The number of sessions per patient also made a difference, among other factors.
- **Attention to quality of care can mitigate the impacts of inequity.** In the UK as in Ontario, social deprivation is linked to poorer outcomes. But, thanks to its systematic data collection, IAPT has shown that a high-quality local service can achieve similarly large improvements for patients in both high- and low-SES neighbourhoods, despite large social differences.
- **Measuring long-term recovery continues to be a challenge** because, by its nature, IAPT delivers relatively short-term therapy and that's what gets measured. But it's important to know whether people have developed resilience and learned skills that help prevent relapse in the longer term. To address this knowledge gap, strategies such as phone-outs to people at 1 year are in the works.
- **Responding to the pandemic has been challenging and informative.** In March, IAPT quickly moved to 95% remote services (phone or video) and rich data are available to monitor outcomes in this new reality. After a dip in March/April, patient outcomes have rebounded, stayed steady, and even improved further for some measures. Why? One reason may be that the average number of sessions has increased, perhaps because no one needs to travel. Free training resources for therapists on remote working are available at oxcadatresources.com (COVID-19 page).

Process-Related Best Practices

- **Getting complete data is vital.** "We're simply deluding ourselves about how good our mental health services are if we don't get data on everyone," says David Clark, "because we're systematically losing data on the people who do less well." By comparing outcomes from IAPT services (with their every-session commitment to data collection) and those from other services (with conventional pre-post data only), Clark and colleagues found that patients with no post-treatment data were not randomly distributed. As a group, those with missing post-treatment data improved less than half as much as those with complete pre–post data (< 40% improvement vs. > 80%). In the absence of measurement, we can be blissfully unaware of how we're doing and how to do better.
- **Also essential: therapists and patients use the data in every session.** The data can and should be useful for therapy. They are a tool to help relate last week's session to this week's responses. Patients can see their progress and challenges over time through an objective lens (graphs), helping them understand and engage actively in their care. Patients should be enabled to answer the questions just before each session (electronically, ideally) and their responses should come up on the therapist's screen automatically, so as not to take away therapy time. This adds immediate value and motivates providers and patients to keep the data collection ongoing.
- **Make it easy to collect and use the data.** Start with a minimum data set and allow practices to build on it locally, to avoid "perfection being the enemy of good." IAPT uses a slimmed-down, purpose-built IT system – with a low cost of about $4 CAN per patient – rather than trying to modify the much

larger NHS system, which would have cost millions more. Services can run individual- and practice-level reports, and the system automatically transmits data for national or regional-level processing.

Cultivating Change

- **Adopting IAPT was never mandated.** It was offered, with additional funding, as an add-on with the advantage of new training, supervision, and the requirement to collect and publish data as part of the program delivery. This created "a coalition of the willing." To produce a more accurate picture of outcomes, data are reported using "Smart Metrics" where the denominator is all patients seeking treatment, not just those with complete pre–post data.
- **The quality of clinical leadership matters.** To engage staff and make the most of the data, it's important that clinical leaders be people who nurture a supportive environment. This work requires a spirit of innovation, not a punitive response, when the data show opportunities for improvement.
- **Workforce support needs to be built into the program.** IAPT puts a lot of emphasis on weekly supervision (at least 1 hour one-on-one per week is required, and there's usually group supervision as well), along with other professional development and well-being initiatives. Services currently vary on how well they address these needs, and the program has data to monitor this, showing that paying attention to these goals does affect a service's patient outcomes.
- **Transparency and public reporting can drive behaviour change.** At the service level, IAPT builds in a weekly review of data by the therapist and a supervisor to monitor patients' improvement at the individual and practice levels; among other benefits, this routine review can help to improve how quickly patients who are not responding well are offered stepped-up care. The decision to publicly report aggregate data early in the life of the program (starting about year 2) was controversial but, as hoped, did motivate more practices and organizations to come on board.

Next up: Session 2, The How — How is measurement-based care being implemented in clinical practices in Ontario?

Join us **March 17, 2021,** for the second session in a three-part series. We will demonstrate how organizations in Ontario have set up measurement-based care in practice. Presenters will discuss the planning and implementation considerations for hospital and community care settings.

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