Education Series on Measurement-Based Care in Mental Health

JANUARY 21, 2021

This session begins at 4:00 p.m. (EST)

The Why: Why should Ontario apply measurement-based care in mental health and addiction services?

AGENDA:

- Opening remarks
- Presentation
- Q&A – send questions through the **Q&A box**
- Closing remarks

Technical support:
If your computer lags, or the sound is off, please refresh your browser.
If the problem is not resolved, email MHACoE@ontariohealth.ca for help.

Ontario Health
Mental Health and Addictions Centre of Excellence

Measurement-Based Care Webinar

PAUL KURDYAK, MD, PHD

CLINICAL LEAD

MENTAL HEALTH AND ADDICTIONS CENTRE OF EXCELLENCE

ONTARIO HEALTH

JANUARY 21ST 2021

Ontario Health
Mental Health and Addictions
Centre of Excellence

What is Measurement-Based Care?

- Routine, systematic use of validated measures integrated into routine clinical practice to inform treatment decision-making
- Standard in non-mental health care
  - Diabetes
  - Hypertension
  - Cancer
  - Cardiac

Why Should MBC be Considered for Mental Health and Addictions Care?

- Outperforms treatment as usual
- Allows BOTH provider and patient/client to monitor response to treatment and to work collaboratively
- Patients/clients can use information to more meaningfully self-manage
- For providers, supports clinical judgement and ensures objective monitoring of treatment response

Why is MBC important for organizations?

- Organizations are investing in EHRs
  - Integration of MBC will help improve quality of care
- Provides real-world understanding of effectiveness of programming
- Supports targeted and iterative quality improvement
- Helps with progress towards integration and a systems approach

Why is MBC important for Mental Health Systems?

- Currently, we have little data to help us understand the mental health system
- What data we do have typically describes numbers of individuals, diagnostic categories, and types of treatments
- Monitoring outcomes (response to treatment) facilitates an understanding of performance currently unavailable

If the evidence is so overwhelmingly favourable . . .

How data helped IAPT realize the mass public benefit of psychological therapies

David M Clark

NHS England's Clinical and Informatics Advisor for IAPT

Professor of Psychology, University of Oxford, UK

e-mail: david.clark@psy.ox.ac.uk

What was the problem?

- NICE recommended evidence-based psychological therapies as first line interventions for depression and all the anxiety disorders

- Surveys showed the public prefers psychological therapies to medication in 3:1 ratio

- BUT it was not getting what it wanted. Less than 5% of people received a NICE recommended psychological therapy. Waits over a year

The IAPT Solution

- Train a large number (currently 8,000) of psychological therapists using National evidence-based curricula
- Deploy in stepped care services for depression and anxiety disorders
- Measure and report clinical outcomes for ALL patients who receive a course of treatment (*unique public transparency*)
- *"We will build a ground-breaking psychological therapy service in England.. 50% of people will recover….. Waits will come down from current 18months to a few weeks "* Alan Johnson MP, Secretary of State for Health 2008

The IAPT Arguments

- Untreated anxiety and depression depress GDP by 4% (presenteeism and absenteeism).
- Can train therapists in routine services to deliver treatments effectively
- Can monitor outcomes in everyone to demonstrate treatments are working (new session by session system)
- Minimal net cost (savings to NHS and exchequer exceed delivery cost)

PERGAMON

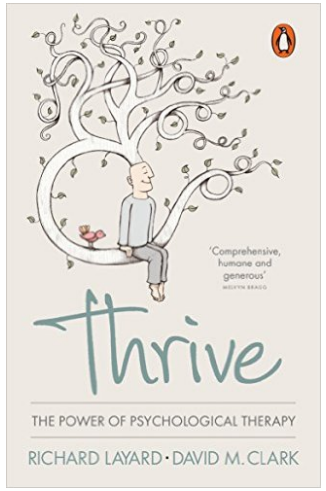
Behaviour Research and Therapy 40 (2002) 345–357

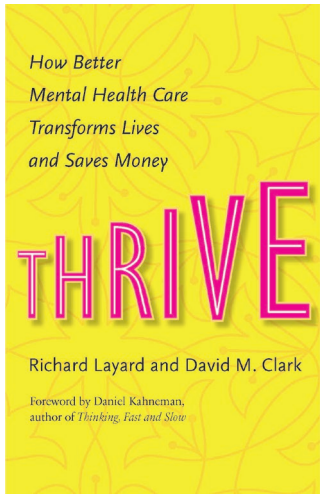
BEHAVIOUR RESEARCH AND THERAPY

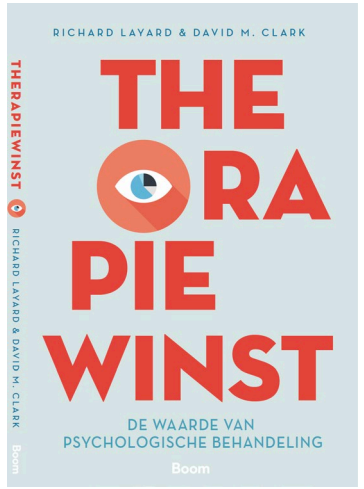
www.elsevier.com/locate/brat

Community based cognitive therapy in the treatment of post-traumatic stress disorder following the Omagh bomb

Kate Gillespie [a,*], Michael Duffy [a], Ann Hackmann [b], David M. Clark [c]







IAPT So Far (2020)

(for overview see Clark, 2018, Ann Rev Clin Psych, 14:159-83)

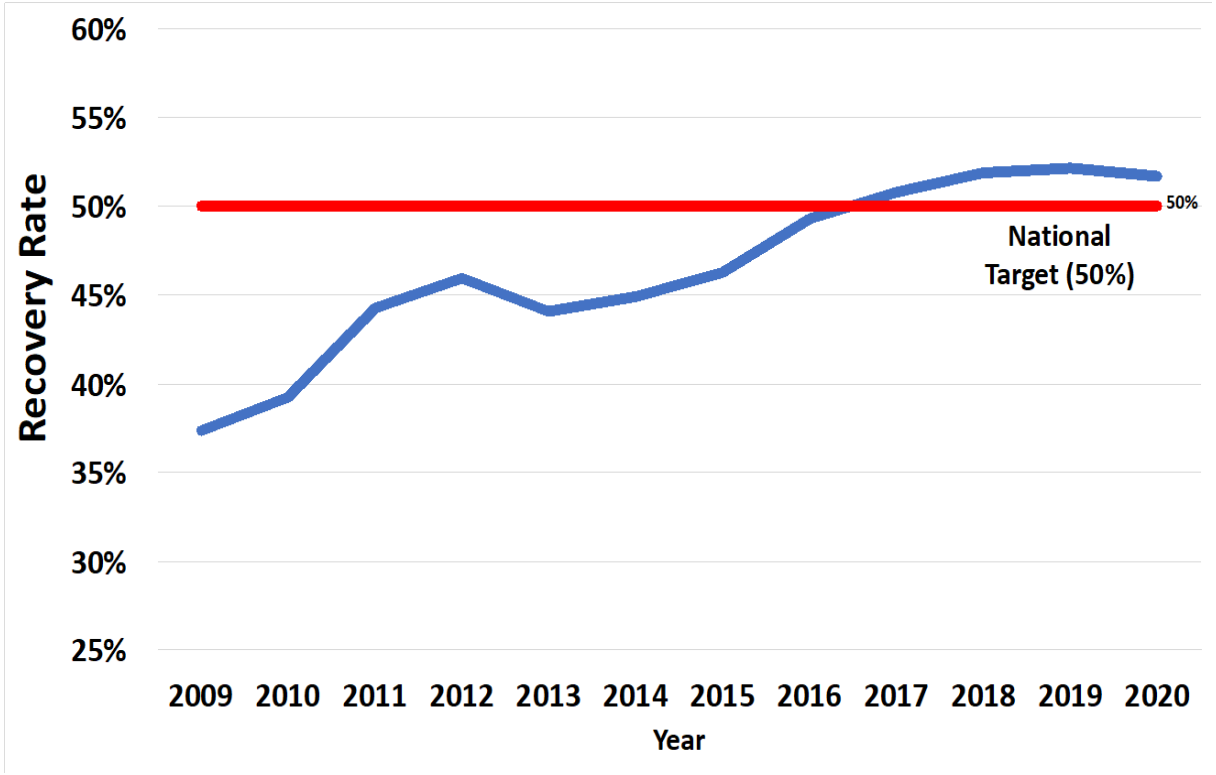
- IAPT service in every health area (CCG)
- Around 1.1 million seen each year
  - Some advice and/or signposting
  - Others (606,000) offered a course of treatment
- Stepped Care Model
- CBT for Anxiety Disorders
- Choice of Therapies for Depression
- Average wait to treat 20 days

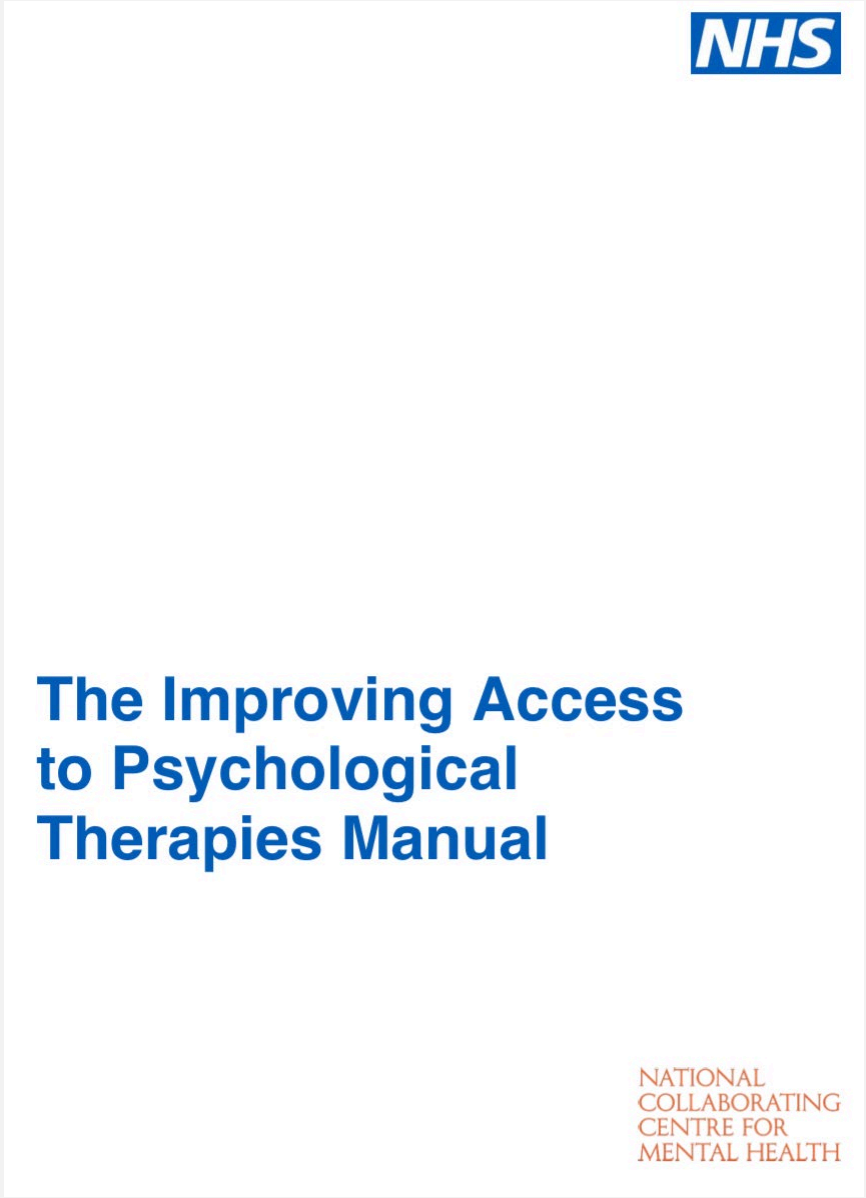
IAPT So Far (2020)

(for overview see Clark, 2018, Ann Rev Clin Psych, 14:159-83)

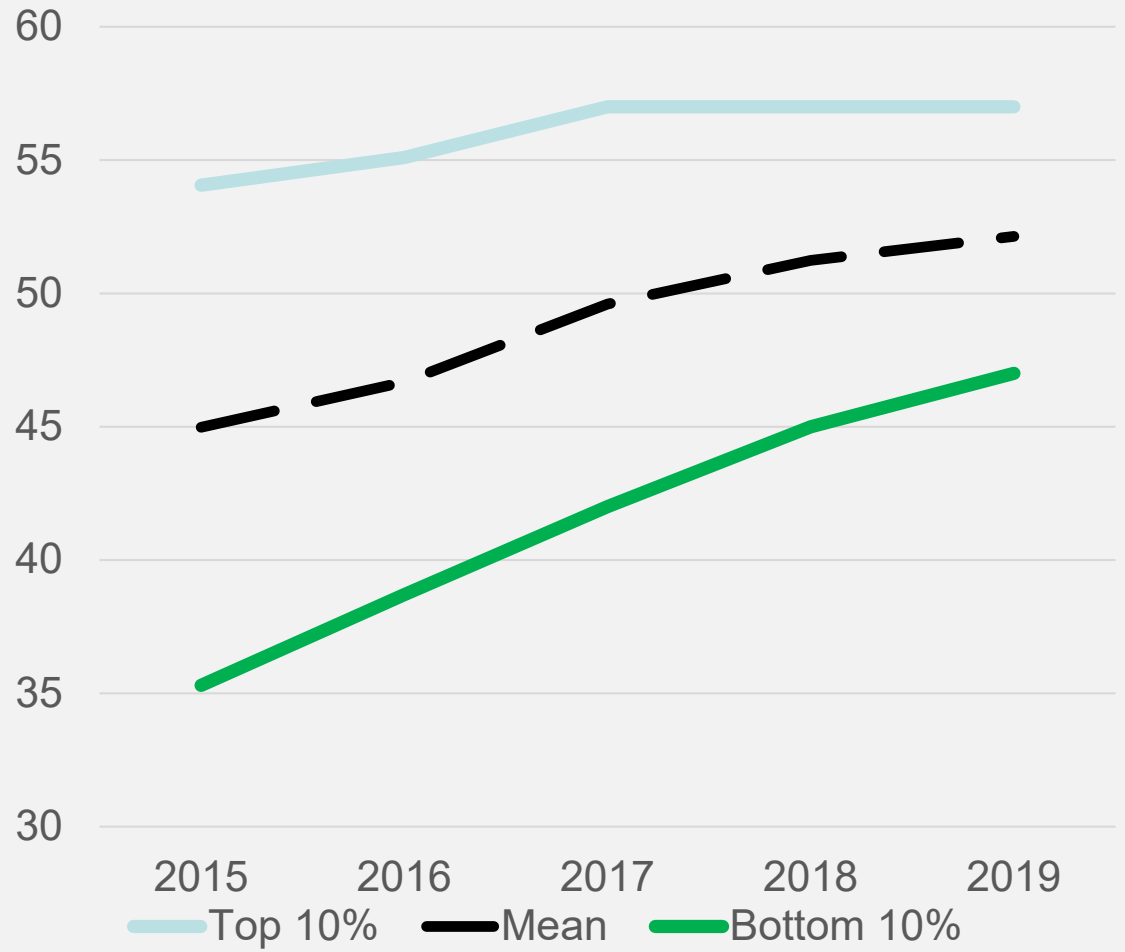
Outcomes

- recorded in 99% of cases *(38% pre-IAPT)*
- 7 in every 10 (68%) show substantial reductions in anxiety & depression (reliable improvement)
- 5 in every 10 (52%) recover





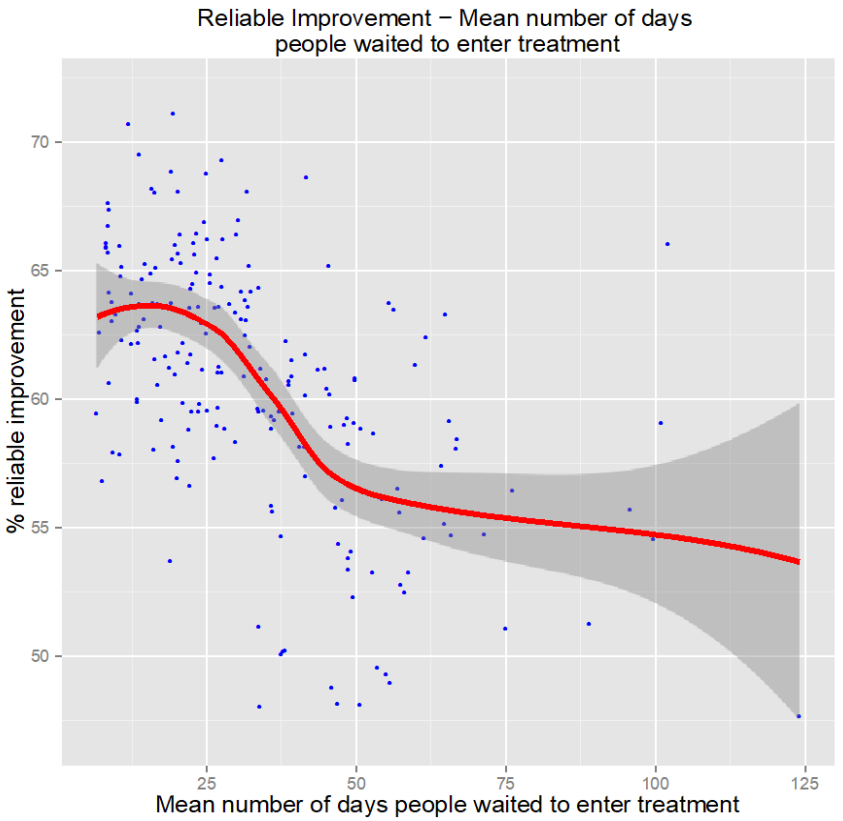
IAPT recovery rates (%) across time (CCG mean, plus top and bottom deciles)



Predictors of reliable recovery and improvement rates in IAPT services

Predictor
Problem descriptor completeness (%)
Average number of sessions
Average wait time
DNA rate (% of sessions)
Step-Up Rate
Percent of patients who get a course of treatment
Social deprivation of CCG (but attenuated by above)

Average Waiting Time



Source, Clark et al (2018) *Lancet,* 391:679-86

Can the *Lancet* organization model explain improvement in the outcomes of IAPT services between 2016 to 2019?

Factor	2016	2019	
Recovery (%)	46.3	52.1	P<.001
Reliable Improvement (%)	62.2	67.4	P<.001
Problem descriptor completeness (%)	75.1	94.2	p <.001
Average number of sessions	6.4	6.9	p <.001
Average wait (days)	31.1	20.1	p <.001
DNA (%)	11.8	10.6	P <.001
Step-Up rate (%)	50.2	54.0	P <.001

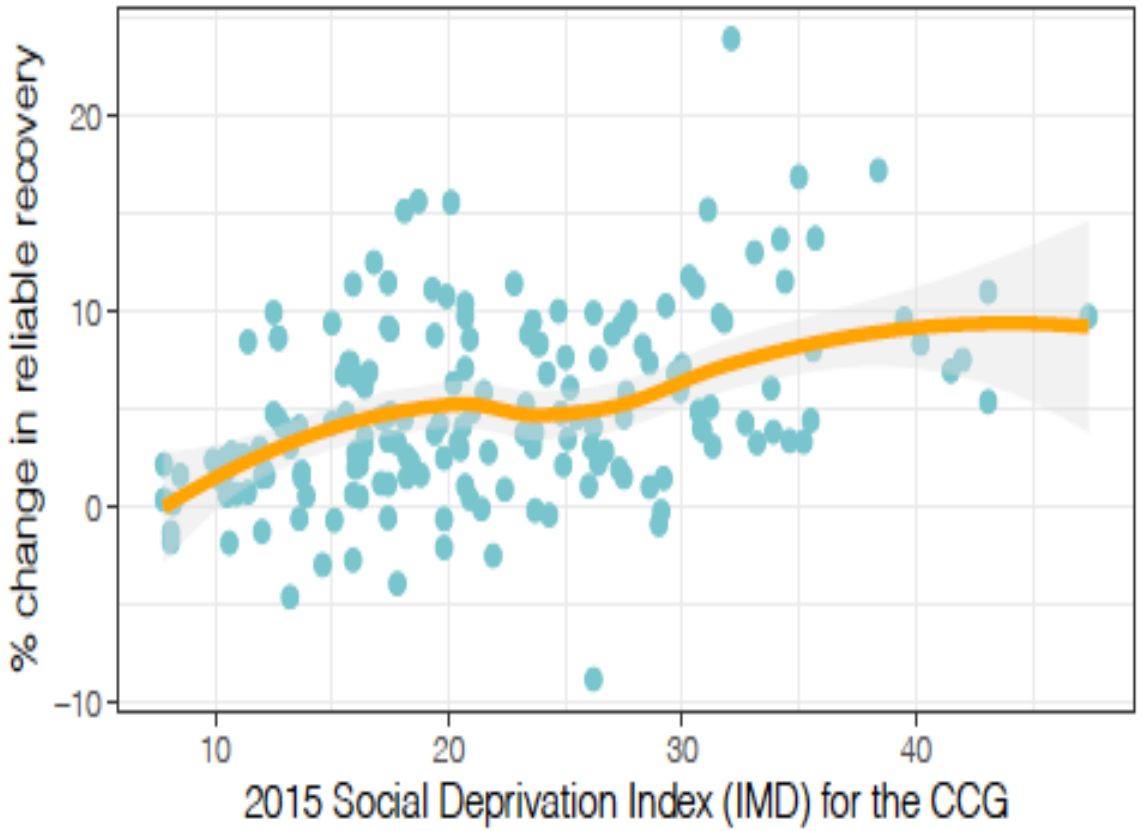
R^2 = .53 for reliable improvement & .55 for recovery

Finessing the adverse effects of social deprivation

CCG	Recover (%)	Improve (%)
Windsor	56.1	70.0
Slough	58.2	72.0

Social Deprivation (IMD)

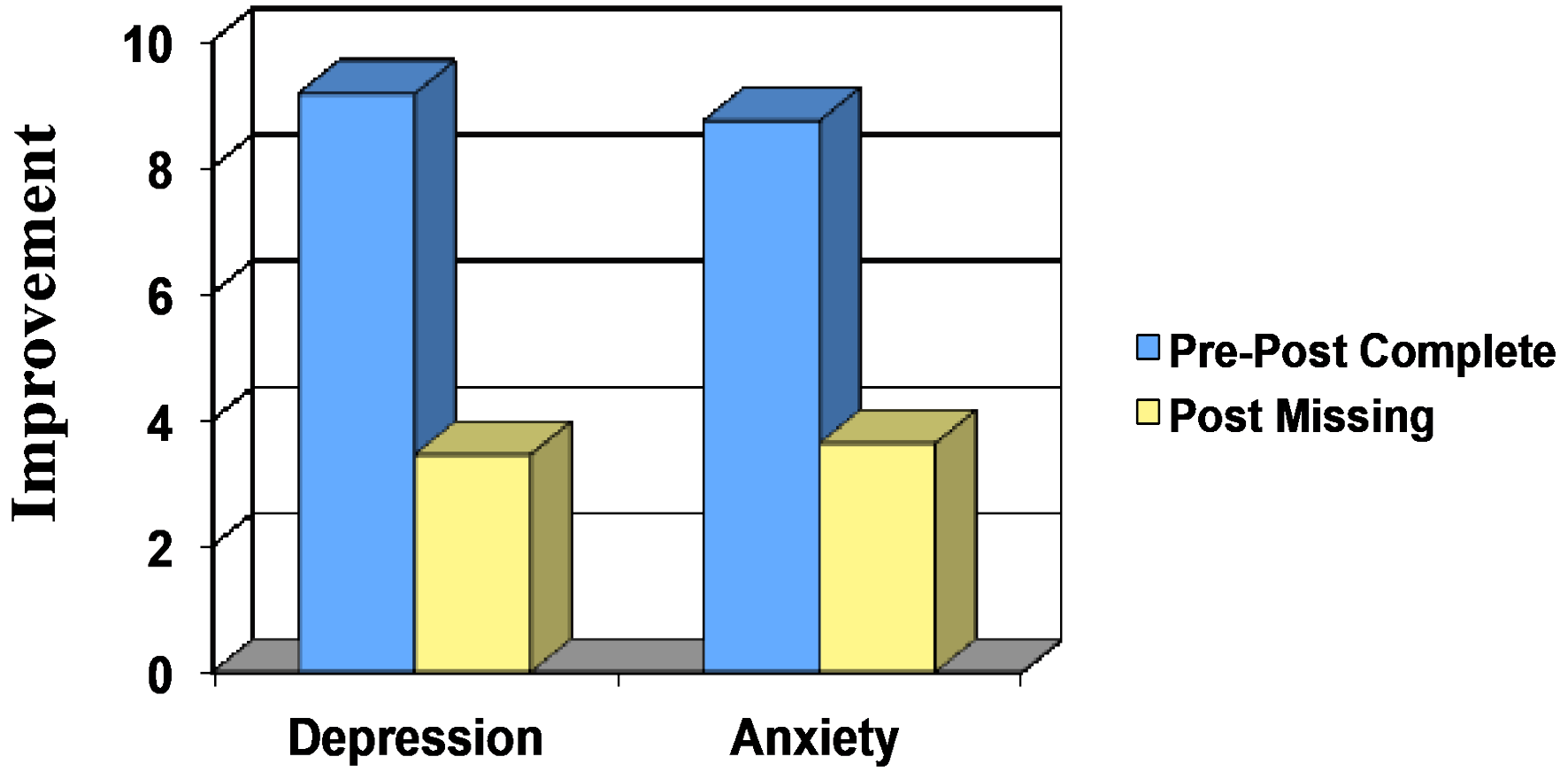
- Windsor 4th percentile
- Slough 68th Percentile
- Both served by a single high quality IAPT service



Improvement in IAPT service outcomes 2016-2019 as a function of local social deprivation

Why getting complete data matters.

(Clark, Layard, Smithies, Richards, Suckling & Wright, 2009, Behav. Res.Ther)



How to get complete outcome data (1)

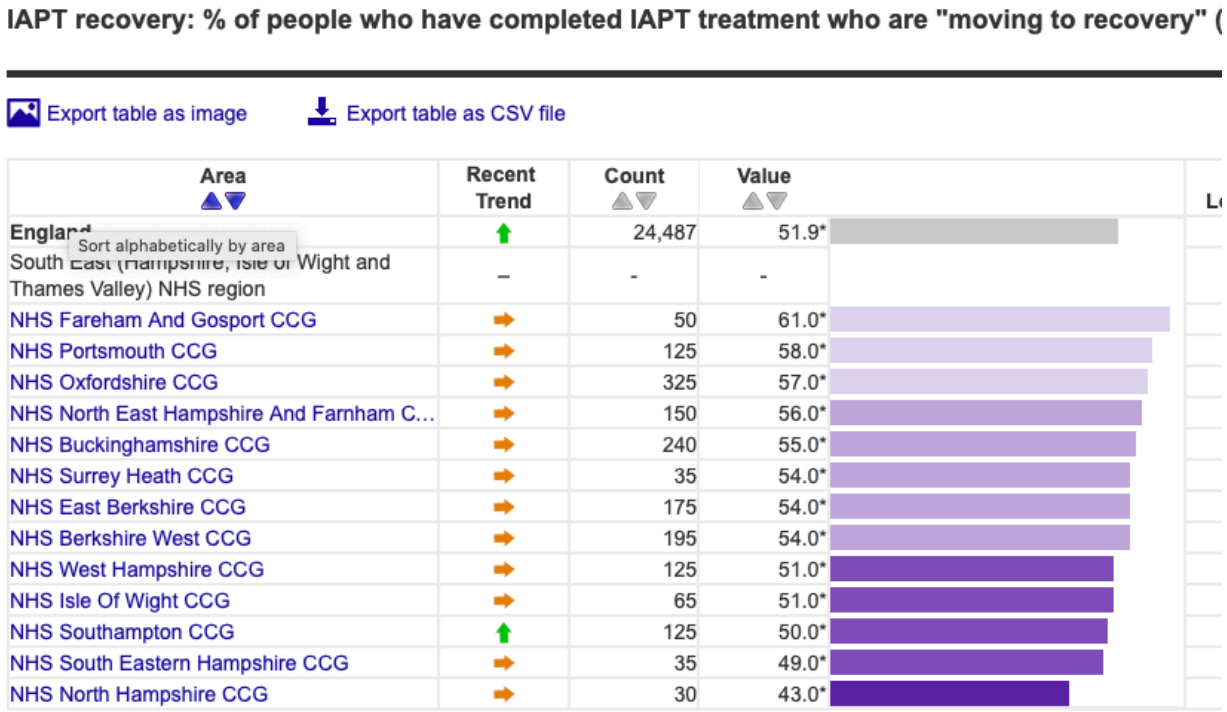
- Session by session collection

- Publish outcomes early in the program

- Use Smart metrics

	Routine	Smart
Patients treated	1,000	1,000
Pre-post scores	500	500
Recorded recoveries	250	250
Recovery metric	50%	25%

(Google:
“common mental health disorders profiles tool”)



How to get complete data (2)

Demonstrate value

Therapists

- Train how to use session by session measures to guide therapy.
- Review in *every* supervision session.

Patients

- See graphs of progress
- Therapists show they are interested in and using the measures

Make it easy to collect and view

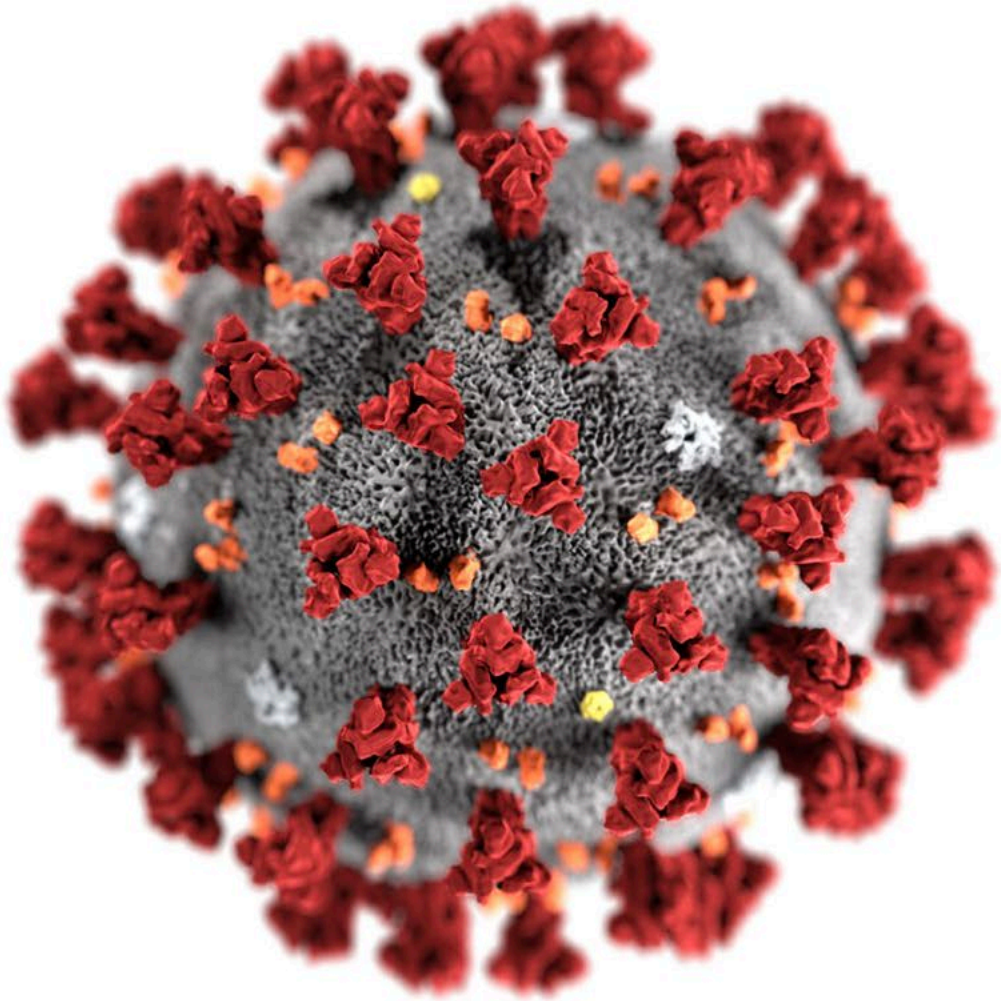
- **IT system that scores and displays measures,** supports supervision, allow services to run reports, automatically transmits data for national/ provincial level processing
- **IT system is modest cost** (UK system approx. CAN $ 4 per patient)
- **Easy data entry.**
  - Paper and pencil (initially)
  - Online portal (e-mail)
  - Online portal SMS
  - SMS much higher response rate and faster (9 min vs 90 mins).

Making data work for you

- Clinical leadership & an innovation, rather than punitive environment.
- Multiple measures to prevent an official metric dominating activity (wait to start treatment, recovery rate)
- Collaborative networks and local research projects.

Examples *(from Oxford Region)*

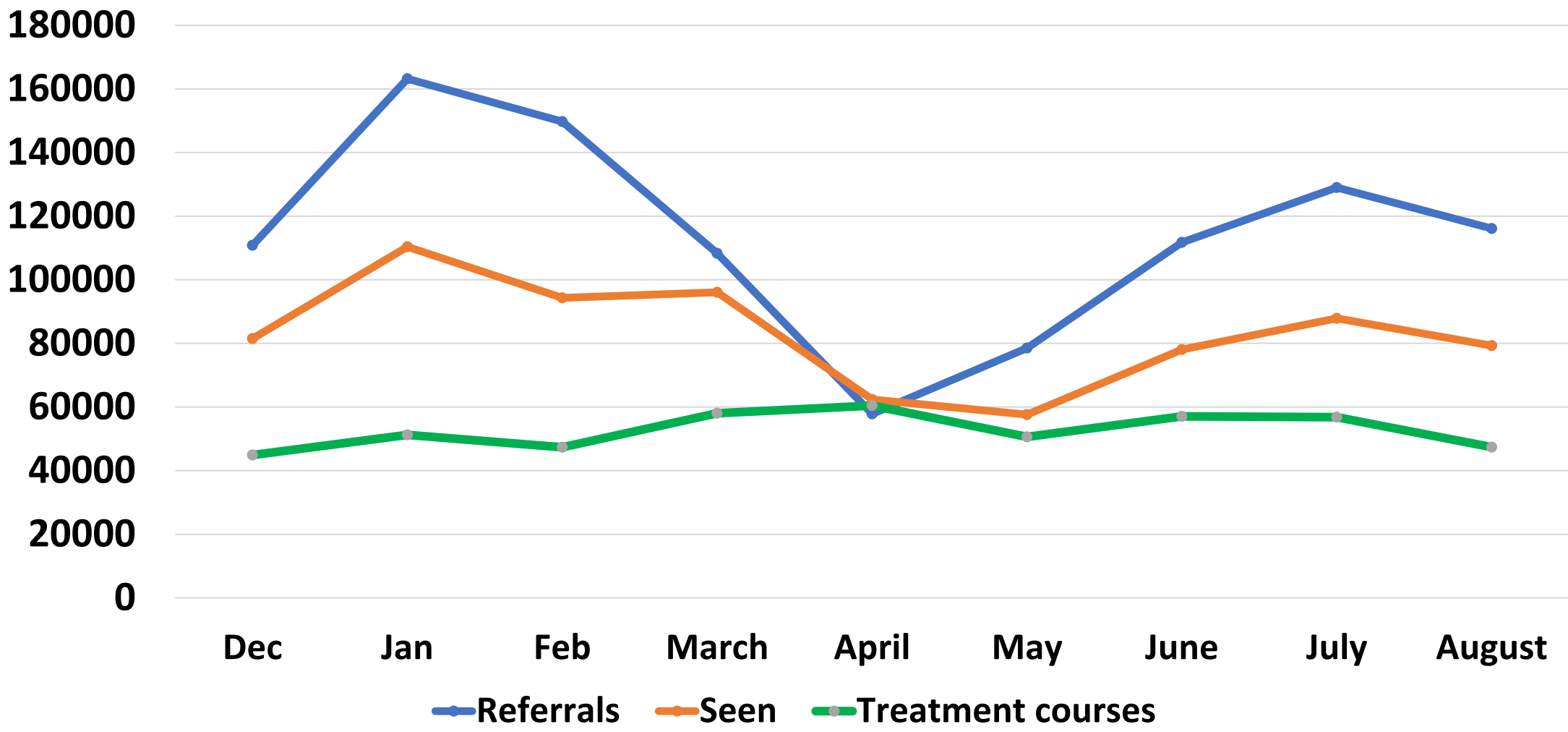
- PTSD specific measures (quarterly review of use)
  - 26%. (2017) 84% (2020)
- Stepped wedge roll-out of IAPT-Long-term conditions services with data linkage to hospital and GP data
  - Demonstrated large savings in physical healthcare



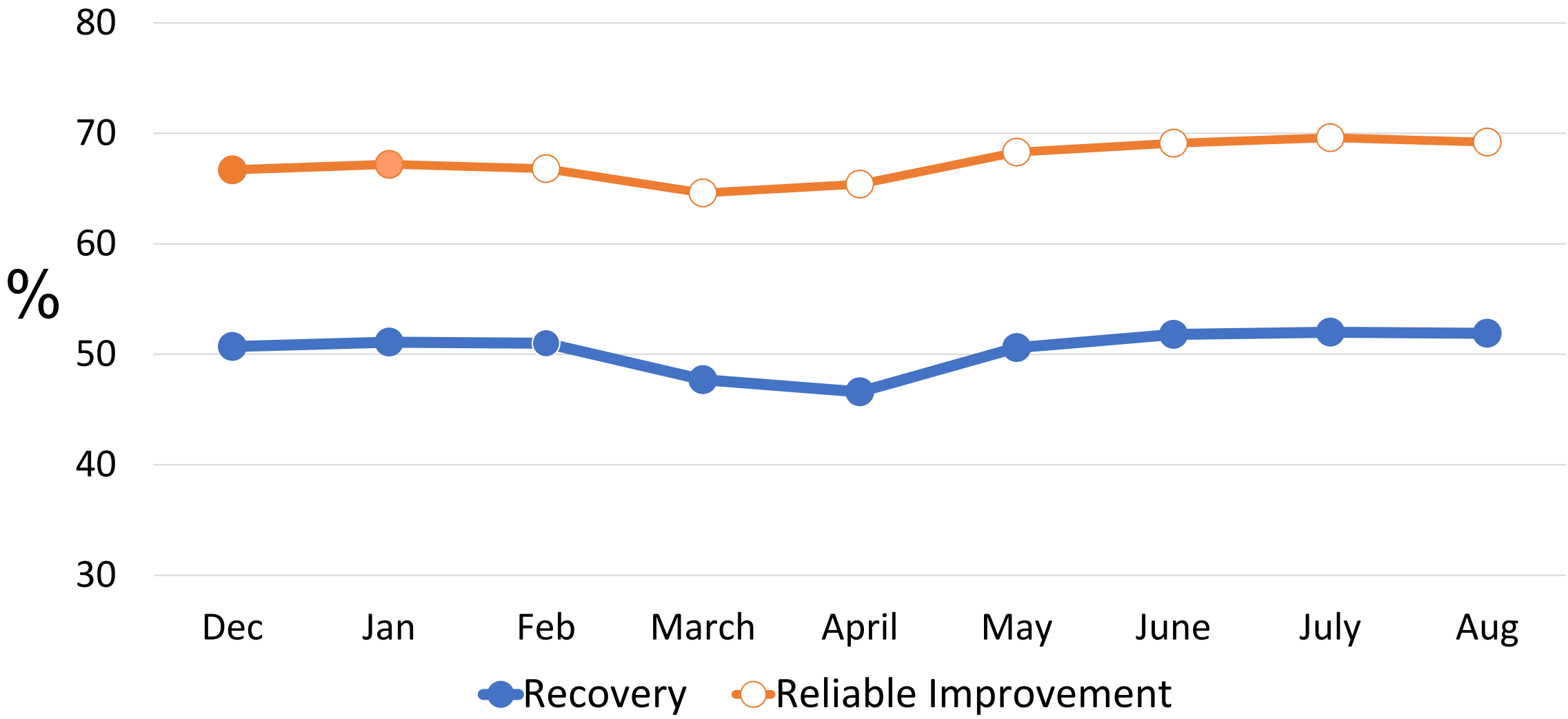
IAPT Response to COVID (1)

- IAPT not included in any pandemic plans
- BUT services quickly moved to 95% remote delivery. Video increased by 1,600%
- Uncharted territory but the rich data set allowed us to learn and should help us benefit from a few silver linings in the future

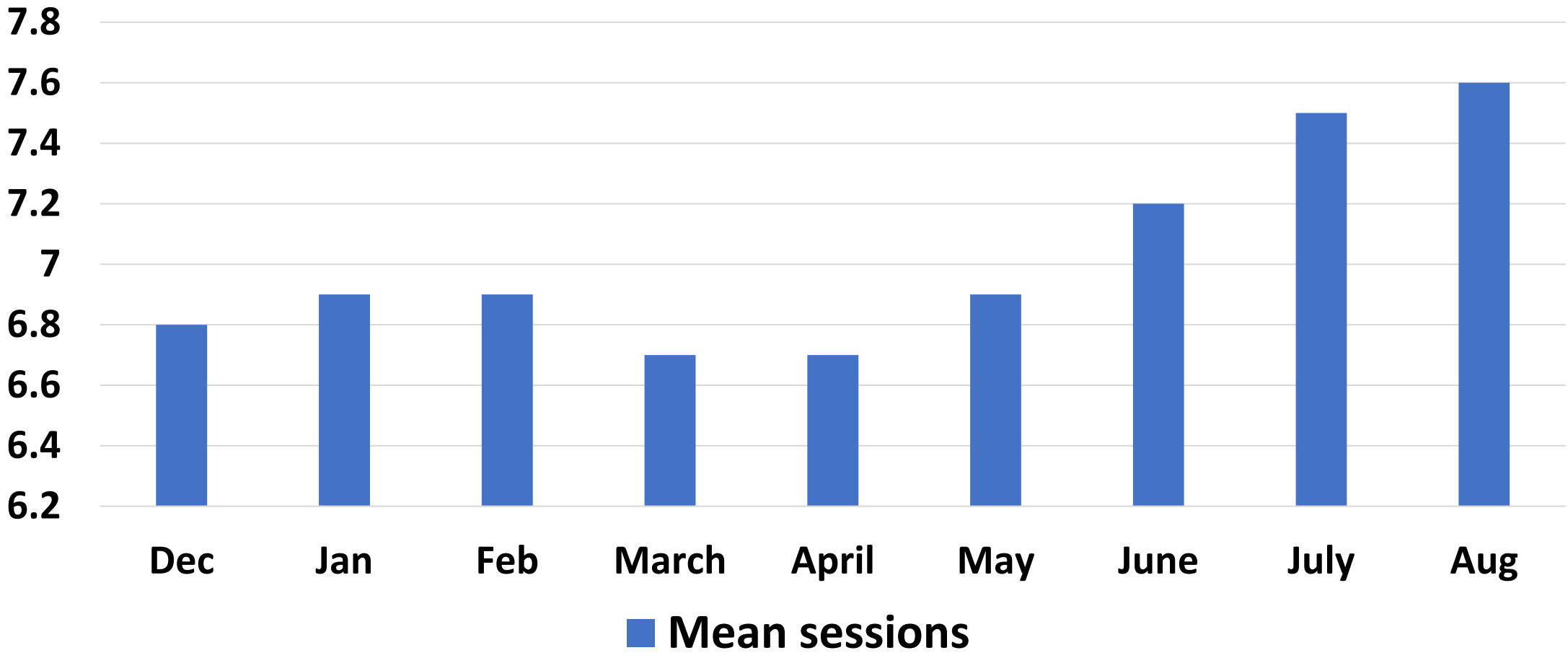
IAPT Activity before and during COVID



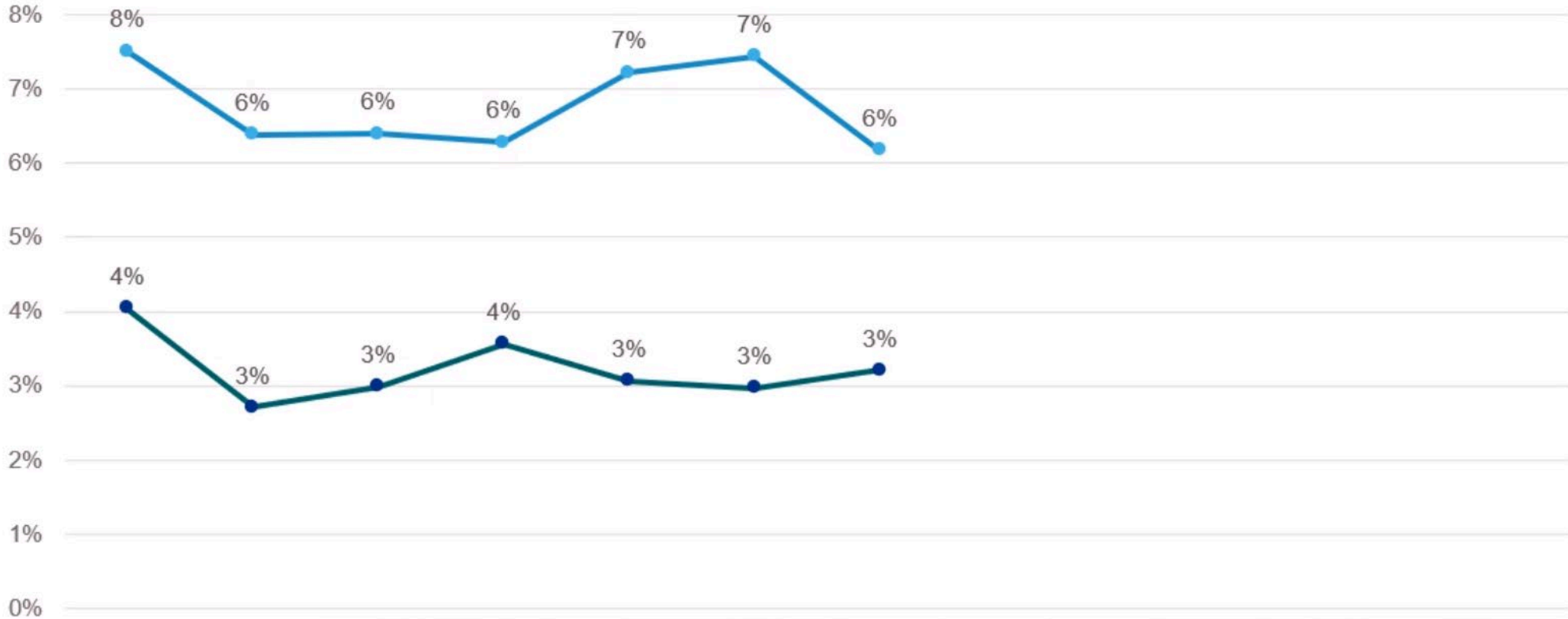
IAPT Outcomes before and during COVID



Mean number of treatment sessions before and during COVID



DNA Rate - Video vs Telephone



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Video DNA Rate	4%	3%	3%	4%	3%	3%	3%					
Telephone DNA Rate	8%	6%	6%	6%	7%	7%	6%					

Remote (video) delivery resources

www.oxcadatresources.com

Covid-19 page

Webinars on remote treatment of:

- PTSD
- Traumatic bereavement
- Social Anxiety Disorder

Written Guides on

- PTSD following ICU
- Panic disorder
- Social Anxiety

Video clips

Acknowledgments

- The Extraordinary IAPT workforce

assisted by 4 government bodies:

- NHS England
- Health Education England
- NHS Digital
- Public Health England

Questions and Answers

Open the Q&A window and type your question for the speakers. Click Send.

Note: Check Send Anonymously if you do not want your name attached to your question in the Q&A.