

## **How IAPT manages to get outcome data on everyone who has a course of treatment**

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The English Improving Access to Psychological Therapies (IAPT) program has been remarkably successful at collecting outcome data on almost everyone who has a course of psychological therapy. Local and national analyses, and less formal scrutiny, of the outcome data has enabled the program to better understand how to deliver psychological therapies at scale (Clark, 2018; Clark et al, 2018; Gyani et al, 2013; NCCMH, 2019). As a consequence, the IAPT program now achieves in routine clinical services the excellent outcomes that have previously been largely restricted to small scale, tightly controlled research studies. In particular, around 7 in every 10 patients who have a course of treatment (defined as at least two sessions before discharge) show reliable and substantial reductions in their depression and/or anxiety. In 5 of 10 treated individuals the reductions are sufficiently large for the individuals to be coded as recovered (symptoms outside the clinical range).

Prior to the start of IAPT, a survey found that only 38% of patients who were treated in NHS counselling services had their outcomes assessed at pre-treatment and post-treatment (Clark, Fairburn & Wessely, 2008). An IAPT pilot project that ran from 2006 to 2007 demonstrated that when some post-treatment data is missing services tend to overestimate their effectiveness as patients who have improved less are over-represented in the missing data cohort (Clark et al, 2009). For this reason, when the national rollout of IAPT started in 2008 strenuous efforts were made to collect outcome data from everyone. By the end of the first year, the program had managed to collect pre and post treatment measures of depression and anxiety from 91% of treated individuals. Currently, the paired (pre-& post) data completeness rate is 99%.

Looking back at our experience with IAPT, it seems that the following features have been critical to achieving our high levels outcome data completeness.

- *Create an agreed Minimum Dataset (MDS) that comprises brief, well-validated self-report measures of symptoms and mental health related disability (see NCCMH, 2019).*
- *Collect the brief self-report measures every therapy session, once it is clear that an individual will be having a course of treatment. This ensures that if the individual*

discontinues treatment earlier than expected a post-treatment symptom score (from the last attended session) will still be available.

- *Enter the outcome data into a bespoke information technology (IT) system* that allows therapists and patients to view graphs of progress together in therapy sessions and also allows therapists and supervisors to do the same during their weekly supervision meetings. The IT system should also enable services to run detailed reports that help them identify subsets of patients who are achieving less than optimal outcomes and to explore possible reasons for this. Such exploration frequently leads to successful service innovation.
- *Train therapists in how to use the outcome measures to help guide the course of therapy on a session by session basis.* This is critical for ensuring therapist buy-in of outcome monitoring.
- *Publish the outcomes of each service to promote public transparency and encourage services to learn from each other.* In the IAPT program a government body (NHS Digital) currently receives regular extracts from each service's IT system. NHS Digital uses these extracts to generate reports that are placed in the public domain. For the first couple of years of the program, the reports were not placed in the public domain but instead were internal to the Department of Health and the IAPT services. Each service saw regular summaries of their performance and that of other services.
- *Create outcome metrics that remove any incentive to hide, or fail to collect, data from patients.* The IAPT program has two headline metrics (*recovery rate and reliable improvement rate*) that are constructed in this way. The numerator is the total number of people who had a course of treatment (two or more sessions), had paired (pre- & post) symptom scores and had improved. The denominator is all the people who had a course of treatment, irrespective of whether or not paired scores were available. So, if a service treated 100 people, got paired scores on 70 and 35 of these recovered, the recovery rate that appears in the national reports (and in the reports generated by the local IT systems) is 35%, not 50%. This practice ensured that services worked hard to get data from everyone from the very beginning of the program.

The IAPT program uses several bespoke IT systems. The systems vary in how they manage a service's data but all are required to support the IAPT minimum dataset and to comply with strict specifications that guarantee the functionality described above. Government funding for new IAPT services was initially dependent on candidate services committing to purchase an approved system and to report their paired data completeness (pre and post treatment outcome) rate every three months, along with the agreed outcome metrics. Services were told that they were expected to be able to collect pre- & post treatment measures on at least 90% of all people who have a course of treatment. Services that initially struggled to achieve that level of data completeness were provided with guidance and help from members of the national IAPT team.

## References

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