

Developing evidence-based and acceptable stepped care systems in mental health care: an operational research project

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Executive Summary

Background

Around 16% of the adult population experience depression and anxiety in any one year, with common or 'high-prevalence' mental health problems constituting 97% of the total population prevalence. However, the majority of spending in mental health is undertaken by specialist health care providers to deliver care for people with serious mental health problems such as psychosis. Despite patient preference and recommendations in guidelines for anxiety disorders and depression, access to evidence-based psychological treatments is poor. Clinical guidelines recommend stepped care – a system of delivering and monitoring treatments so that the most effective yet least resource-intensive treatment is delivered to patients first – as the means by which resources should be husbanded towards efficient and effective service delivery. However, whilst stepped care offers the potential to make systems more efficient, the optimal configuration of system elements is unknown and although apparently of inherently good sense, there is a lack of specific empirical evidence for stepped care *per se* and the specific system configurations required.

Aims

The aims of the project were to:

- design effective and efficient stepped care systems for psychological therapies in a variety of settings through stakeholder consensus exercises, facilitated by computer modelling to forecast patient throughputs, waiting times and capacity needs;
- investigate the effect of implementing these systems on patient access, throughputs, clinical outcomes and patient choice;
- identify barriers to the implementation of stepped care;
- investigate the generalisability of the reconfiguration process including the utility of an implementation manual and computer modelling tool.

Methods

We took an overarching operational research (OR) approach to this study, using multiple methods within a broad health services research paradigm. We used a specific method of consensus development – the constituency approach – to help sites frame their problems and develop a shared picture of stepped care service designs they were going to develop.

We used data generated by these initial systems to develop a computerised modelling framework to help NHS sites estimate the number of people receiving care at each step within a stepped care system over time and the number of people leaving the service via various exit points. We developed a stand alone CDROM reconfiguration software tool and accompanying user manual in MS Excel with extensive use of Visual Basic for Application (VBA) routines.

We used qualitative interview techniques to help us understand the experiences of the first four sites to extract information on the likely barriers to stepped care reconfiguration in the NHS.

We then disseminated the CDROM stepped care reconfiguration tool and manual across additional NHS sites in England and used further interviews to investigate their use of the tool. All sites were asked to give qualitative feedback on the tool and manual and the context within which it was used.

Results

We successfully used the consensus development process to clarify the specifics of all four sites' aspirational service model and to help them move from their current situation to new stepped care structures. The service models developed were extremely diverse.

Data collected from these sites for our modelling showed that the principle driver of patient flow through stepped care systems was allocation to initial treatments. Service performance was additionally influenced by triage, resource constraints, access points and staff role. Rates of stepping patients up from low- to high-intensity treatment were consistent across three sites but lower where few high-intensity resources were available.

Barriers to change included: staff resistance to the prescriptive nature of stepped care and the degree of professional clinical scrutiny required in stepped care systems; uncertainties about the exact format of the low-intensity clinical methods; the requirement for adequate resources to be present in all steps; and managing the change process of introducing a new workforce and reassigning traditionally qualified professional workers.

Data from the four sites were incorporated into the modelling tool. Additional sites experienced great difficulty using the tool due to a rapidly changing context, principally the national Improving Access to Psychological Therapies initiative. Sites were constrained by the need to follow a centrally determined, prescriptive organisational model and the rapidity of its implementation.

Conclusions

Stepped care as implemented by different NHS sites will vary greatly in structure and design according to different site contexts. Prescriptive

national initiatives should incorporate local modelling to translate national prescriptions to specific situations.

NHS managers and clinical leaders do not find it easy to utilise stand-alone operational research modelling tools and require brief training and support for them to effectively use planning tools. In contrast, a supported consensus development method can be used to design new service configurations.

Stepped care is a 'complex intervention' with multiple clinical and organisational components which requires further investigation through the stages of the MRC's Complex Intervention Research Framework.

Disclaimer

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Addendum

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