Accessibility and implementation in the UK NHS services of an effective depression relapse prevention programme: learning from mindfulness-based cognitive therapy through a mixed-methods study

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Scientific summary

An effective depression relapse prevention programme

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Scientific summary

Background

Depression is one of the most common mental health problems, affecting as many as one in five people in their lifetime. It often runs a recurrent lifetime course and is associated with considerable disability, personal distress and cost to society. Mindfulness-based cognitive therapy (MBCT) was developed as a group-based psychosocial approach to help people at risk of depressive relapse learn skills to prevent depressive relapse and stay well in the long term. Its effectiveness has been demonstrated in numerous randomised controlled trials and the National Institute for Health and Care Excellence (NICE) has recommended it as one of two psychological treatments for depression relapse prevention since 2004. Numerous stakeholders, patient groups and most recently an All Party Parliamentary Group have called for it to be made more readily available in the NHS. Our literature review and feasibility work suggest that access to MBCT is very patchy, access is inequitably distributed and we have little systematic understanding about why that is the case and how best to improve the accessibility and implementation of MBCT. As such, this study fills a gap in the evidence about the implementation of an effective psychological intervention.

Objectives

The objectives of this work were to:

- scope existing provision of MBCT in the health service across England, Northern Ireland, Scotland and Wales
- develop an understanding of the perceived benefits and costs of embedding MBCT in mental health services
- explore facilitators that have enabled services to deliver MBCT
- explore barriers that have prevented MBCT being delivered in services
- articulate the critical success factors for enhanced accessibility and the routine and successful use of MBCT as recommended by NICE
- synthesise the evidence from these data sources and, in co-operation with stakeholders, develop implementation guidance and related resources that services can use to implement MBCT.

Methods

We used a two-phase qualitative, exploratory and explanatory study, which was conceptually underpinned by the Promoting Action on Research Implementation in Health Services (PARIHS) framework. In phase 1 we conducted 68 interviews with participants from 40 regions across the UK about current provision of MBCT. We sampled key stakeholders, including commissioners, managers, MBCT practitioners and teachers, and people living with depression and their carers. Normally we started with a key stakeholder within each region and then sought a pool of participants from key stakeholder groups.

In phase 2 we undertook a more in-depth study of MBCT implementation within 10 case studies. Cases were purposively sampled from across England, Northern Ireland, Scotland and Wales with attention to embeddedness (four fully embedded, four partially embedded and two scarce/no implementation) and site demographics. Across the 10 case studies, we interviewed 127 participants, observed 16 events (e.g. supervision, special interest groups, service user sessions and teacher training sessions), collected documents (e.g. strategy papers) and gathered key contextual information about sites from publicly available sources (e.g. demographics for socioeconomics, ethnicity, as well as mental health metrics).

Interviews were transcribed, observational field notes were written and documents added to the data corpus for analysis.

Typically audio-recorded semistructured interviews were conducted, with interview schedules revised to enable us to build up a rich and coherent description and explanation throughout the two phases of work.

The data were analysed using thematic analysis. An iterative and combined inductive and deductive approach was used to build a description of MBCT implementation and then progress to an explanatory account of what supported sustainable implementation of MBCT in the UK NHS. The case study analysis viewed each case as a whole first, and then looked at cross-case themes and pattern matching logic to extract themes and a framework that applied across cases as a more generalisable explanatory model.

Results

Although there appears to have been progress since our feasibility study, a picture emerges suggesting that the access and format of MBCT provision across the NHS remains variable, even within the same region and site. NHS services have typically adapted MBCT to their context. The integration of MBCT into care pathways was also highly variable.

We used the PARIHS framework, which articulates dimensions of context and evidence through which facilitation takes place. The context for implementation comprised both macro (e.g. national policies, service priorities and culture) and meso (e.g. service specifications, care pathways) levels. A supportive implementation context tended to be linked to national policies, service priorities and crucially found a way to fit MBCT into existing services. Another key contextual factor was resourcing. This included building capacity in terms of MBCT teachers, accessing financial resources, time, as well as practical resources such as space in which to offer MBCT.

Evidence was important to implementation and took different forms. The NICE depression guideline was often cited as opening the door and creating legitimacy in people's minds. Other types of evidence were audits, evaluations and first-person accounts. There were several examples of pilots being used to build a platform from which to evolve and develop services further.

In terms of facilitation, perhaps the most significant single element in our data was the central role of the MBCT implementers: dedicated individuals who 'championed' implementation, created networks and over time mobilised top-down organisational support. These individuals were generally self-designated in these roles. MBCT implementation has been described as a bottom-up grassroots movement. Our data had numerous examples of implementation that could be characterised as starting with dedicated implementers generating a grassroots groundswell. Top-down implementation typically came in later in the implementation process with organisational support being mobilised, greater alignment with organisational strategies and priorities, and securing the support of senior and key stakeholders.

The case study analysis produced a theoretically transferable account of the how and why of MBCT implementation in this framework, an implementation journey is determined over time by a potentially creative tension between grassroots facilitation from implementers' effort and work, and top-down organisational prioritisation of MBCT, through more or less strategic support and subsequent flow of resources, over time. Implementation journeys could be enabled by a degree of alignment or fit between context, appropriately targeted grassroots implementation effort, working with different forms of evidence and responses/reactions to MBCT, and top-down factors. An accumulation of factors that were aligned resulted in some shift (positive or negative) in implementation progress. We conceptualise these as *pivot points*, which have real potential for market forward shifts in implementation.

Implementation success was explained by the degree of alignment (high–low) between the intervention and the context of implementation (e.g. MBCT implementation being challenged by NHS focused on treatment more than well-being, NHS fast paced – MBCT needs appropriate time, etc.) and the degree of implementation effort required (low–high). Finally, it is notable that the potential for sustainability in service provision was evident in services that had invested in developing training pathways.

Conclusions

Although access to MBCT across the UK is improving, it remains very patchy. Moreover, its form and delivery are variable across different services. Over two phases of work, we developed themes that describe what facilitates MBCT implementation and a theoretical model of how MBCT becomes sustainably embedded within a NHS service. Implementation is a *process and a journey*. We used, and 'tested' in our dissemination workshops, the metaphor of a team embarking on a cycling journey as being an instructive way to bring the explanatory framework to life in a practical way. The next phase of work will be the development of implementation guidance that services can use to implement MBCT.

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