



CENTRE FOR
CHANGE & INNOVATION



DOING WELL BY PEOPLE WITH DEPRESSION

A GUIDE TO WHOLE SYSTEMS CHANGE IN THE
MANAGEMENT OF DEPRESSION IN PRIMARY CARE



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DOING WELL BY PEOPLE WITH DEPRESSION

EVIDENCE TO PRACTICE – A GUIDE TO HELP DEVELOP
SERVICES FOR THE MANAGEMENT OF DEPRESSION

PREPARED BY THE DOING WELL BY PEOPLE WITH
DEPRESSION NATIONAL EVALUATION TEAM

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Introduction

“Transforming research into practice is a demanding task requiring intellectual rigour and discipline as well as creativity, clinical judgement and skill, organizational savvy and endurance” (Horsley et al, 1983)

Background

Depression is now one of the most common conditions recorded at general practice consultations in Scotland and it is estimated that 95% of patients with clinical depression are dealt with in primary care. However, it is also acknowledged that a large proportion, estimated as up to 50%, of people with depression remain with their condition unrecognised and untreated. Of those who are treated, evidence indicates that up to 40% fail to respond to first line antidepressant drug treatment.

The capacity for existing health systems to deliver the full range of services required to meet the needs of those experiencing depression is currently limited. There is a need to build capacity through multi-partner and multidisciplinary networks of care. In order to use existing resources more effectively and efficiently (e.g. tailoring the existing range of skills and expertise to the appropriate level of need) there needs to be appropriate responses at all service tiers and effective communication across all levels of service. Hence the strategy that is required is not merely about the input of more resources but how these are utilised and managed, and how service components communicate and share information.

The Doing Well by People with Depression Programme

The Doing Well by People With Depression (‘Doing Well’) programme is one of the first national programmes to be established by the Centre for Change and Innovation (CCI) and was set up in 2003. The programme has funding of £4.5 million over three years and is due to conclude in March 2006.

The programme aims to:

- Improve mental well-being for people with depressive disorders
- Improve access to interventions which have an appropriate evidence base

Activities have been agreed upon that aim to have a positive impact on people who suffer from mild to moderate depression. These are:

- Build capacity for self help to meet the needs of those with mild to moderate depressive disorders and provide support through the pathway of care
- Build capacity for psychological interventions in primary care to reduce pressures on secondary services
- Improve assessment of symptoms and associated problems to ensure an agreed understanding of user need and the most effective sequences of treatments and/or support
- Improve access to a range of community based services and support

In order to share learning across the 'Doing Well' sites and to all other health systems in Scotland, a national development network has been established and a national evaluation of the implementation of the programme is also being undertaken and will be published in July 2006.

Seven health board areas across Scotland were selected as the first 'Doing Well' sites, these are: Argyll and Clyde, Ayrshire and Arran, Borders, Dumfries and Galloway, Glasgow, Grampian, and Lanarkshire. A further set of projects have joined the project in April 2005 and they are located in NHS Highland, Fife and West Lothian.

Evidence to Practice Document

This document is intended as a guide to help service leaders such as clinicians and managers in the Doing Well sites and beyond to reflect on their current strategies, in the context of the lessons that have already been learned from previous service developments and innovations in the management of depression.

This document has been compiled by drawing together many of the current reviews and briefing papers that have been produced across the UK from organisations, for example, the National Institute for Clinical Excellence (NICE), the National Institute for Mental Health in England (NIMHE), Primary Care Mental Health and Education (PRIMHE), Department of Health (DoH), the NHS R&D Health Technology Assessment programme, the Cochrane Collaboration, NHS Centre for Reviews and Dissemination, and the Sainsbury Centre for Mental Health.

Evidence based change: creating footprints in an emerging field

Types of Research Evidence

What constitutes evidence, and how this is measured, is a complex and on-going debate, resulting in the development of hierarchies of evidence with systematic reviews being accorded highest status, down to professional or service user and carer opinion (see Fig 1). However, developing and implementing the evidence base requires a more critical and reflective approach. This involves thinking beyond medically driven definitions of effectiveness, and engaging and valuing both practitioner experience, and the experiences and values of service users and carers. The development of innovative and pioneering work should also be encouraged, with an emphasis being placed on evaluation and dissemination to ensure that they, in turn, contribute to the growing evidence base.

Figure 1 Hierarchy of evidence

	Description
Type I	Evidence represents at least one good systematic review, including at least one randomised controlled trial
Type II	Evidence represents at least one good randomised controlled trial
Type III	Evidence represents at least one well-designed intervention study without randomisation
Type IV	Evidence represents at least one well-designed observational study
Type V	Evidence represents expert opinion, including the opinion of service users and carers

The evidence base arising from systematic reviews tells us very little about the context in which the interventions are delivered. The assessment of efficacy based on randomised controlled trials will not provide the transferable knowledge to assess the impact of the same intervention in a different context. Therefore, there are considerations surrounding the practical implementation of such evidence which has to be taken into account.

Evidence based approaches are not always implemented 'in practice', primarily because the format of the approach fails to acknowledge the impact of the ways in which practitioners work and how they interact with patients. Therefore 'evidence based interventions' must also be applied within the local context, which requires a more dynamic approach to implementing interventions rather than a controlled approach which forms the basis of much of the evidence in the field. The evidence base for interventions must not be viewed too narrowly because it is likely that what is implemented or required locally will vary to some degree from those described in the literature.

Different types of research evidence are needed to answer different types of research questions. What is important for implementation is that both quantitative and qualitative evidence are considered, and that change is informed by different scientific, professional and service user perspectives. What is required is a systematic approach that goes beyond questions of ‘effectiveness’: to consider needs; intervention design and development; acceptability (to service users and those involved in their delivery); and local feasibility.

A key component of improving service delivery is ensuring that services delivered are more in line with existing best evidence on effectiveness. At one level, this concerns the delivery in a timely manner of specific interventions to individual clients (a tailored response contingent on client needs and preferences). However, truly evidence-based services are ones that also take into account best evidence on service design and delivery configurations, i.e. services that have responded *organisationally* to evidence as well as at the individual professional level.

Models of Service Delivery

This document focuses on models of service design and delivery and comments on the evidence base surrounding the various models described. However, the evidence base surrounding new innovations can be relatively undeveloped. Therefore, while it is important to learn from what has gone on before, service developments can also aim to be innovative and to create new pathways for delivering information and services. Hence, in this document the Doing Well initiative is placed within the context of existing and emerging evidence, with an understanding that the relationship between evidence and practice is never straightforward or linear. This is particularly the case in an initiative like ‘Doing Well’, where new and emerging models of service delivery are being tried and tested. The challenge for ‘Doing Well’ is to create new footprints and contribute to the evidence base surrounding new methods of delivering information and services for people with depression by sharing the learning, which is developed in each project and across the programme as a whole.

Models of embedding research in organisational settings

Until recently the use of research-based evidence in directing health care professionals’ efforts has been seen to be an individual professional matter. More recent reviews however (7) highlight a greater diversity of models for embedding research in organisational settings:

- **The research-based practitioner model:** This traditional model sees it as the role and responsibility of the individual practitioner to keep up to date with research and to apply this knowledge into practice. It tends to view the ‘research into practice’ process as a relatively linear, logical and rational process that can be fostered by professional education and training, and facilitated through effective dissemination. The evidence suggests that this is a poor model – at best incomplete – in both description and prescription. Nonetheless, research-based individual practice will no doubt continue to be a mainstay of professional practice and thus cannot be neglected as one part of developing evidence-informed services.

Implications for managers: in this model the key role for managers is to facilitate the

development of staff skills in using evidence, for example critical appraisal skills and to provide a means of access to research resources such as library services and internet facilities.

- **The embedded research model:** this view sees research-informed practice being fostered by embedding the results of research in the systems and processes of care, for example by embodying best practice recommendations in standards, policies, pathways, benchmarks, procedures and local tools. In this view, the responsibility for ensuring research-informed practice lies more with managers and service designers than with front-line caregivers. Again the ‘research into practice’ process is viewed as a relatively uncomplicated and uncontested linear and rational process, yet research evidence on implementation processes would suggest that this is not always the case.

Implications for managers: as indicated, managers play a much more central role in the embedded research model. It becomes a key managerial task to translate research evidence into usable tools as well as to provide support for the implementation of these tools.

- **The organisational excellence model:** here the key to successful research use is seen to lie with developing a research-minded culture within the organisation. Moving research into practice is not seen as simple and uncontested; rather it is expected that there will be local adaptation and experimentation in the light of external research findings sometimes referred to as ‘tinkering’. Such approaches emphasise the reflexivity of local practitioners and the need to develop partnership working and ‘sustained interactivity’ with sources of research-based knowledge. In view of the experimental nature of Doing Well, this model has high relevance.

Implications for managers: in this model managerial action encompasses the formation and management of combined research/practice teams, as well as the development of initiatives to encourage ‘research mindedness’ and cultures of research engagement.

While none of these models enjoys unqualified support from the research literature, there is growing awareness that more complex representations of the research/practice nexus may be more helpful in thinking through approaches to improving the use of research. This is especially true in those areas of health care where the nature of ‘appropriate care’ is less clear-cut, more contested and heavily client contingent. In addition, the models outlined above may be more or less appropriate depending on key aspects of context. For example, the research-based practitioner model requires a highly skilled and largely autonomous workforce capable of developing the necessary additional skills, such as literature searching and appraisal when key staff groups are largely non-professional as is the case, in many aspects of social care, the embedded research model may be more appropriate. In all cases elements of the organisational excellence model may help to underpin both of these approaches.

Using service users in bringing about change

An important and underestimated area for consideration by managers and professionals is the ways in which service users can more fully contribute to change objectives and processes. A recent review sponsored by the SDO provides considerable guidance in this respect. The full report and associated briefing paper can be downloaded from the SDO website (8), but the conclusions drawn from this thorough literature review are as follows:

- Have a clear idea about the aim of involving service users before inviting them to get involved.
- Be honest with service users about the potential for change, particularly if the options are limited.
- It is not difficult to find out what people want; the difficulty is in achieving change.
- One of the main obstacles to involving users can be the reluctance of health professionals such as doctors and nurses to embrace the changes suggested by service users.
- Front-line staff need training to help them appreciate why and how service users are involved, and to carry them along with the process.
- If service users are helping to make decisions about complicated and highly technical services, they will need extra time, information and support.
- User involvement does not stop when users' views have been obtained; this process must be followed by continuing work to change services based on users' views.
- Users may need training to enable them to undertake some user involvement activities.
- When involving users, managers need to be sensitive to staff's perceptions of their own status, and their status differential with their clients.
- The onus is on managers to present information for service users in a way that the users can understand.
- In mental health, user groups that are funded need longer contracts so that they do not have to spend all their time trying to get funding for the following year.
- User involvement is not a bolt-on extra. It is a way of changing the philosophy of an organisation and all the roles within it.

Service user views are an under-recognised and under-utilised resource for service redesign programmes. A systematic, comprehensive and coherent process of user engagement can offer significantly new and challenging perspectives – so much so that a key pitfall lies in soliciting user views but then being insufficiently able to respond in terms of the radical nature of the redesign suggested by these perspectives. Raising unrealistic expectations among both staff and client groups can significantly hamper change efforts, inducing change fatigue and cynicism.

The context of innovations: evidence-based local adaptation of research findings

The 'Doing Well' innovations have been described as variations of a common theme in terms of models of primary care mental health service delivery. The main component is realignment of specialist versus generalist roles and services spanning different sectors, in order to provide a service to people with mild to moderate depression, a group hitherto poorly served. In order to address this remit local projects are adapting principles from different models of service delivery to the local realities within each site, and have to keep an eye to the local context as well as the evidence pertaining to the services they want to deliver. External factors also play a part: these innovations are also the product of other influences that must be taken into account in documenting their development, implementation and in evaluating their impact. They have emerged, and some more directly than others, as a response to national political and economic pressures for example to address the rise in anti-depressants, waiting lists for specialist services, and the lack of availability of psychological services in most areas. They are also the product of local history and service configurations which may influence their connectedness to other service systems and their longer term sustainability. Doing Well By people with Depression is itself a key catalyst of these trends, and the ways in which the initiative as a whole is managed, will impact on development of local projects. The Doing Well projects are also set in the context of an evidence base which is emerging but yet incomplete and therefore whilst they may draw upon some evidence to guide their work, at other times they are also concerned with documenting and sharing learning across projects and to those outwith the Doing Well initiative.

This review of the literature aims to facilitate this process. It sets out:

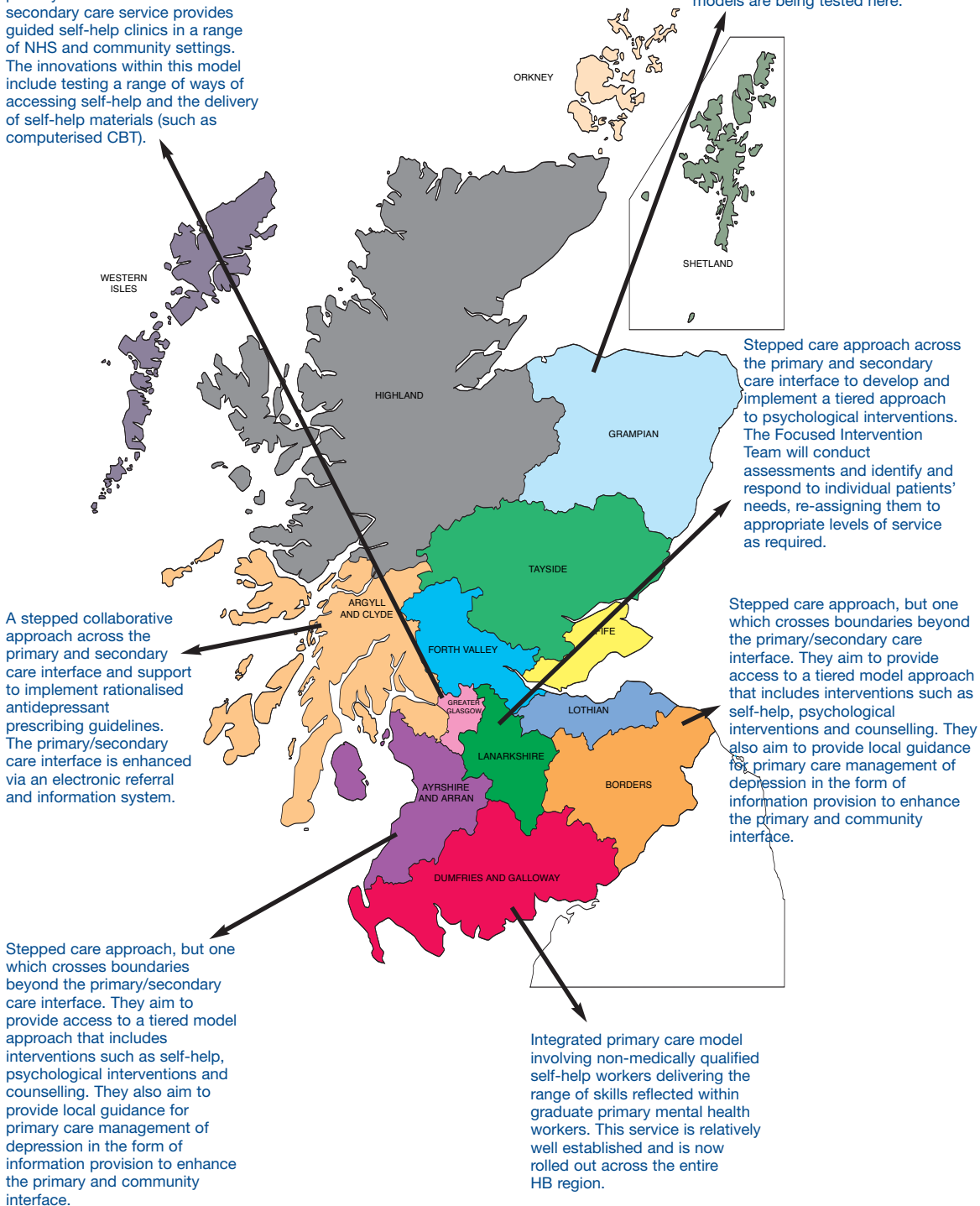
- a) Lessons learned from the evidence of the effectiveness of models of service delivery
- b) Lessons learned from the evidence of change management in projects of this kind
- c) What is known about the project management as a way of underpinning change management
- d) What we know about how to spread from pilot projects to mainstream service provision.

From this, we will draw up a 'checklist' of key points for local projects like the Doing Well projects to note and learn from.

Models of service delivery within the 'Doing Well' sites

Working at the primary and secondary care interface but reflecting elements of integrated primary care models in that the secondary care service provides guided self-help clinics in a range of NHS and community settings. The innovations within this model include testing a range of ways of accessing self-help and the delivery of self-help materials (such as computerised CBT).

Integrated primary care model involving Primary Care Medical Health Workers. Different types of workers (with different backgrounds and skills) will be implemented in different local authority areas of Grampian. Hence within the model of integrated primary care newer models are being tested here.



Models of service delivery relevant to Doing Well by People with Depression

Traditionally, models of service delivery have placed the mental health specialist in a pivotal position in terms of their skills and knowledge. Within the primary and secondary care interface, there are four well-known models of service delivery; namely replacement, community mental health team, consultation-liaison, and outreach clinics. While traditionally, these models were relatively distinct in their operation, the boundaries of their work have become increasingly blurred in the development of newer collaborative care models where specialist roles are more varied. Doing Well by People with Depression projects reflect variations of this general theme. The next section will look at traditional and newer and emergent models of service delivery.

1. Traditional Models

The information below summarises the key types of traditional models

- **Replacement/referral models** *The primary care practitioner is replaced by a mental health specialist (usually a counsellor or psychologist) as the main provider of interventions to the patient. [2-7]*
- **Education and Training** *Interventions aimed at primary care clinicians ranging from dissemination of information and guidelines or more intensive practice-based education. [43]*
- **Consultation-liaison (C-L)** *Primary care teams are provided with advice and skills from specialist mental health services (typically a psychiatrist). Differs from education/training interventions in that it involves support in caring for individual patients. [2,8,13]*
- **Shifted out-patient** *Visiting psychiatrists operate clinics within health centres and hold consultations for both new referral and follow-up patients. [8]*
- **Community mental health teams/CPNs** *The main role played by the CPN or CMHT is in providing increased liaison and crisis intervention. [25,26,27]*

2. From traditional to complex models of service delivery

At the risk of over simplification, a key difference between traditional and complex models of service delivery is that the latter involves multi-faceted interventions. In this model, the role of the specialist is less clear and can be replaced by generalists, eg. practice nurses trained in mental health interventions. [2] Taking the example of the Consultation-Liaison model, Bower et al (2002) summarise the key differences between the traditional and complex model as follows [13]:

C-L model	Types of interventions	Potential mechanisms for change
Traditional C-L model	PC teams are provided with advice and skills from specialist mental health services, usually a psychiatrist.	Relationship based, i.e. educational/use of meetings between professionals around discussions of individual cases.
Complex C-L models	'multi-faceted model', can involve practitioner and patient education; case management, telephone follow-up by nurses, interventions by mental health professionals.	Systems based, i.e. changes to structures and processes of care required.

Complex models of C-L

More recently, and particularly in the United States, the C-L model has gained complexity and is based on population approaches to care such as chronic disease models and collaborative care [9]).

Definitions of terms

Chronic disease management

Depression is managed as a chronic disease, along similar principles as the management of diabetes and coronary heart disease through the use of collaborative care and stepped care (see terms below). The CDM approach focuses on the need to change the organisation and delivery of care, and promote self care in order to meet the needs of patients with a chronic illness. [10]

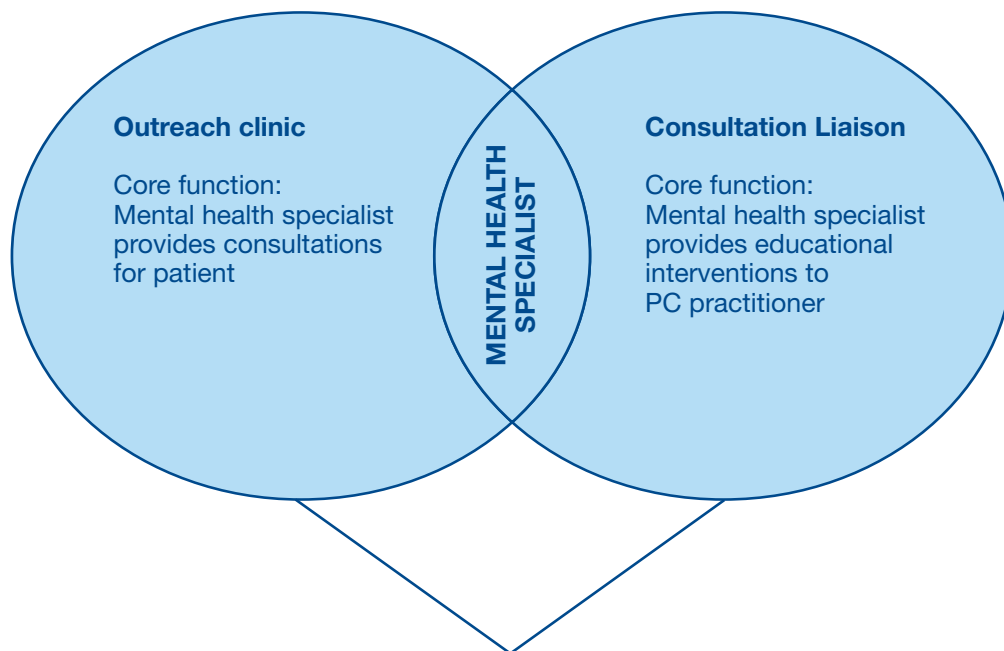
Collaborative care models

These are population-based approaches in which the multidisciplinary team assist the primary care provider in delivering evidence-based treatment. Based on a chronic illness model and includes patient, provider and system level components, see example, [11]

Stepped care

Professional care is 'stepped' in intensity, beginning with limited professional input including systematic routine assessment and preventive maintenance through to specialist care. [12]

Figure 2: Overlap between consultation-liaison and outreach model



Complex collaborative care models

Overlap between traditional models of care (i.e. studies considered for systematic reviews for both outreach clinic and consultation-liaison)

Multi-faceted interventions used

Role of specialist mental health professional less clearly defined

The narrow focus of research studies and the broader and more complex concept of ‘models’ of service delivery mean that research does not readily map to any precise model and does not capture the complex ways in which models of delivery are implemented in different local contexts. Adding to this complexity, the Doing Well sites (in many cases) are working with different models across different sectors. For example, a whole systems approach would advocate working across primary, secondary, social and community sectors. This might then involve implementing several different models at the same time, such as elements of Integrated Primary Care and Stepped or Collaborative approaches. On this basis, the evidence surrounding models of care and interventions can act as a general guide but not a blueprint for service development.

Evaluation of the evidence relating to different models

It is unlikely that one model of service provision will be equally useful to all areas therefore services need to be developed that can meet and respond to local needs. The following sections summarise the main points of learning that have emerged in relation to the impact of the models described above. These points include some of the clinical evidence around the common types of interventions within the various models. However, the contextual knowledge surrounding the evaluation of interventions and models of care provision is scarce. The emphasis on clinical effectiveness and the reporting of evidence, based on systematic reviews, means that much of the learning about the change management techniques which underpinned the studies does not exist. The next section in this document includes a few examples of **descriptive studies** which can address this knowledge gap.

3. Newer and emergent models

i Primary and Secondary Care Interface

The newer and emergent models included will be discussed below and they include:

- i Primary and Secondary Care Interface*
- ii Health and Social Care Interface*
- iii Integrated Primary Care*
- iv Primary and Community Interface*

- **Complex models of Consultation-liaison:** ‘multi-faceted model’, can involve practitioner and patient education; case management, telephone follow-up by nurses, interventions by mental health professionals. [9]
- **Chronic disease management:** focuses on the need to change the organisation and delivery of care, and promote self care in order to meet the needs of patients with a chronic illness. [10]
- **Collaborative care models:** based on a chronic illness model and includes patient, provider and system level components (e.g. IT developments. Can involve training and C-L but also quasi specialists to work with patients and liaise with PC and MH specialists. [11]
- **Stepped care:** professional care is ‘stepped’ in intensity, beginning with limited professional input (systematic routine assessment and preventive maintenance) through to specialist care. [12]

Impact of replacement/referral models

Most reviews of replacement/referral models involve several different psychological therapies delivered by a range of professionals.[70] They generally conclude that replacement/referral models are clinically effective in the short term.

Although reviews tend to consider counselling’s effectiveness in relation to the type of intervention carried out, the success of counselling and indeed other replacement model workers in general, is also dependent upon factors external to the actual therapeutic intervention. These might include:

- Availability and accessibility of psychological therapies, i.e. waiting times and availability of other referral options [6]
- Primary care practitioner perceptions of the efficacy of psychological therapies [6]
- Psychological awareness of general practitioner [6]
- Inequalities in access (for black and minority ethnic communities) [7]

Impact of Education and Training

Most types of education/training are not shown to be effective in improving outcomes for patients. Guideline implementation strategies aiming to improve the recognition and management of depression were only effective when education and organisational interventions, including nurse management, collaborative care, or intensive quality improvement were combined. [14, 43].

Impact of the C-L model

The increased complexity and loosening definition of C-L models that often involve a number of interventions or different type of professional for example from a psychiatrist to a trained generalist, make it difficult pinpoint how this model can be effective.

An early review [8] suggests that the impact of the traditional C-L model might involve:

- i. a reduction in referrals to specialist services or more selective referrals
- ii. an enhancement of GP skills in the detection and management of mental health problems

Two additional reviews [2,13] conclude that there is limited and inconsistent evidence to suggest that the traditional model facilitates a significant impact on patient care or practitioner behaviour. Evidence highlights that simple interventions such as 'practitioner education' alone are ineffective and require multi-faceted approaches to support implementation. [14]

Impact on prescribing

In the complex C-L model, the most significant impact reported is upon prescribing and adherence to medication. [2;15;16] The studies that improve adherence levels are based upon collaborative care and use multi-faceted interventions, i.e. involving education to practitioners and patients, patient-based consultation and re-organisation of services.

Consultation and referral levels

Evidence suggests that both the traditional and complex models of C-L neither significantly increases nor decreases consultation rates or shows no significant differences in rates of referral to external mental health and non-mental health resources. [2]

Contextual features

The success of collaborative care and multi-faceted approaches in studies may be linked to the presence of a research team who is able to facilitate change in study sites. This means that complex or time consuming interventions may not be sustainable after the conclusion of the research period. [17]

A recent study has tried to overcome this shortfall by linking the model of care to existing quality improving resources in the local sites. [18] The key elements of the approach taken in the study was telephone follow-up of patients by a care manager, supervision of the care manager and the clinician by a psychiatrist, and increased attention to patient education by the clinician. The study sites included a variety of settings across the US to assess generalisability of the model. The study demonstrated modest impact upon outcomes for depression but is considered more sustainable because it was an initiative grounded in the participating organisations rather than an intervention by external researchers. [18]

One study reporting the implementation of a shared care register between primary and secondary care sectors (a model of consultation-liaison) found that only the primary care staff directly involved perceived any benefit, and half of the GPs consulted did not want direct involvement in the registers. [69] The success of the strategy is highly dependent on getting 'buy in' from the professionals involved.

Impact of outpatient clinics

The approach is most operable within larger practices where the numbers of referrals make the model viable. The apparent impact of this model includes:

- Ease of access in rural and urban non-advantaged areas. [16;19] However, there is little evidence to demonstrate additional benefits within urban advantaged areas, where access to services is less problematic. [20]
- A reduction in patient non-attendance through the reduction of stigma attached to psychiatric hospitals. The model makes it easier for patients who have lost contact with services to regain contact with the system. [20]
- Clinics are also apparently associated with a reduction in psychiatric hospital admissions.
- Outreach may improve informal working relationships between the GP and psychiatrist. [8;21]

Impact of CMHT/CPN

Systematic reviews have concentrated on the management of the CMHT's role in the management of severe mental health problems. [25]

It is suggested that information and communication can help facilitate improved links between primary care and community mental health teams. A recent study showed that shared working and routine communication may be enhanced by the use of evidence-based dissemination and implementation strategies. [26]

It is commonly recognised that the development of a CMHT often results in a major increase in new patients referred from primary care. These referrals can include patients with common mental health problems, who could have been managed in primary care alone. [1;8]

A further study showed that although closer links between primary care and CPNs improved working relations, this in turn increased the demand for mental health services. Clear referral guidelines and shared care protocols were necessary to avoid services becoming swamped by referrals. [27]

Interface between primary care/specialist mental health services: Summary

- The mental health specialist as the centre of the model does not significantly improve outcomes although the location of mental health specialists in primary care may help improve working relations.
- The presence of multi-faceted interventions, involving changes to the process of care, proves more effective, i.e. case conferences, joint consultations, seminars and education sessions.
- More work is required to identify exactly which parts of the complex models generate effectiveness or if it is a combination of interventions and contextual factors.
- The impact of contextual features for example location of the model within systems in different countries and populations requires examination.

ii Health and Social Care Interface

The key features include:

- ***Partnership working*** *partnerships come in many different shapes and forms. For example, partnerships can operate at a vertical or horizontal level, both strategically and operationally. [29,30]*
- ***Integrated care pathways*** *a tool to achieving closer integrated working between agencies and in ensuring that the care process is better monitored for different patients with the same conditions. [33-36].*
- ***Case management*** *a means of co-ordinating the care of the severely mentally ill between agencies within the community. [42]*

Partnership working

Some relevant points in developing local partnerships within local health and social care systems can be taken from the literature:

Recognition of a wider system of care

Partnership working demands that often diverse organisations recognise themselves to be one part of a larger whole system of care. This requires a change from individual organisational identities and priorities to those encompassing the whole system. [29]

Need for a shared goal

Different organisations must find a shared goal for successful partnerships that are appropriate to the local circumstance. [30]

Involvement of service users and carers

Users and carers must be involved in defining outcomes and in participating in decisions about change. [30;32]

No quick fix solutions

There is no one sure-fire method that promotes joint working between agencies and the drivers for local partnerships will vary according to local circumstance and context. [30]

Impact of Integrated Care Pathways

The evidence for developing pathways for mental health at a primary-community level is not extensive. [37] There are well documented difficulties in implementing ICPs within complex areas of care such as mental illness, where outcomes and definitions are hard to predict. [38]

ICPs can operate as a tool to improve working practice: for example, to support clinical governance by strengthening service integration, helping to develop the evidence base, and in improving clinical outcomes and patient satisfaction. [39] However, evidence also suggests that integrated care pathways have little effect upon interprofessional working practices. [40]

There is some evidence (though not based on research evidence) that ICPs are used to facilitate whole systems co-ordination and linkages between different parts of the patients' journey. [41]

ICPs have been adapted and shaped around commonalities of service experiences for patients for example admission to hospital or assessments rather than specific mental health diagnoses. In acute mental health settings, mental health integrated care pathways have had some impact upon documentation procedures. [35]

Impact of case management

A systematic review of case management approaches for the severely mentally ill indicated that the approach helps clients to remain in contact with psychiatric services. However, there is no evidence to suggest that case management is effective in improving outcomes for patients. [42]

There is some evidence that nurse case management in non-specialist setting is effective in relation to adherence to medication and through psychosocial support and education to patients [43] Cases for Change (2002) highlights that while there is potential for increasing the involvement and role of practice nurses in integrated primary care, the current evidence remains limited. [1]

Interface between health and social care: Summary

- It is well recognized that joint working and partnership is a tool for integration between agencies, and that there are common drivers for success. However, partnerships and joint approaches may operate differently within different settings and are affected by individual priorities and local features of service delivery.
- Structured approaches to care are less developed in primary care-community interface models, and may be too rigid for the complex and ill-defined nature of primary care mental health. Structured approaches may be used to improve the process of care, or elements of the care process.
- Partnership approaches require agencies to operate as part of a wider system rather than operating autonomously.

iii Integrated primary care

Key features include:

- **Primary care mental health teams/workers** *Workers such as CPNs are employed by primary care rather than attached from specialist services. [46-48]*
- **Graduate primary mental health workers** *Offering a range of individual client work (brief interventions and self-help), practice team work and work in the wider community. [49-51]*
- **Social workers in primary care** *A social work service based in primary care (GP practices) with an overarching 'social' model of provision. Here there have been examples of 'attachment' schemes of social workers seconded by Social Services departments, and other models of social workers operating independently from local authorities. [52-54]*
- **Self help** *Can be delivered by primary care mental health services or by existing members of the primary care team such as health visitors. [62-68]*

While there is a lack of evidence to provide an extensive assessment of Integrated Primary Care's impact and effectiveness, there are characteristics which promote successful integrated primary care working, of which communication and the development of integrated education are key features.

Factors facilitating success [1;44]

- Development of services is a whole systems approach and not dependent upon one 'local champion'
- Good communication across services, i.e. criteria for referral and discharge and guidelines
- Commitment from primary care practitioners to mental health
- Ability of specialists to work with primary care, rather than exercise control over service delivery
- Specialists are valued and are comfortable working in a primary care led environment
- Development of a culture that can develop a local structure in responses to local needs (i.e. morbidity and resources)
- Underpinned by the delivery of inter-professional education that encourages joint working and a culture of mutual collaboration and understanding

Impact of the Primary Mental Health Worker

Although national guidance about the role of primary mental health workers has been issued [49], early research highlights some degree of ambiguity about the role of the primary mental health worker within local settings.

In a study of a pilot of primary mental health workers, Bower et al, (2004) [51] found that the functions of the workers' roles went beyond those identified within the original national guidance.

It is also clear that the successes of the new posts are dependent upon contextual factors surrounding the posts; these contextual factors might include:

Factors likely to impact on PCMHW role [50;51]

- Understanding and expectations of role by managers and clinical staff
- Issues of authority due to relatively junior position of role
- Organisation of local service infrastructure (i.e. information systems, care pathways)
- Availability of local services and existing staff skills mix
- Scepticism among primary care professionals towards roles
- Attitudes of GPs to mental health care
- Previous experience of staff employed as PMH workers

Brief psychological treatments

Underpinning many of the Integrated Primary Care models is the use of brief psychological interventions. PCMHWs (and other types of staff involved in providing mental health support roles in primary care such as self-help workers) will normally be trained in providing brief psychological interventions. The following section summarises the evidence in relation to the types of psychological interventions most likely to be provided within this model of care, including the emerging evidence surrounding computerised CBT.

Brief psychotherapy has emerged as the dominant format in practice and research [B1]. Regardless of what kind of variant of psychotherapy patients receive, their prospects of improving are greater than those receiving treatment-as-usual. Following brief psychotherapy, patients tend to no longer be considered clinically depressed, they show significantly fewer symptoms post-treatment, and experience increased symptom reduction from baseline [B2, B3]. A further systematic review is currently being conducted [B4].

While some authors report that different approaches perform better for individual patients and disorders [B1], others argue that cognitive-behavioural approaches are superior to other forms [B2]. A further systematic review is currently being conducted [B5].

Evidence suggests that cognitive-behavioural and psychodynamic therapies are equally effective in the short-term, while psychodynamic forms may require more treatment sessions than CB to maintain patient outcomes in depression [B1]. Specific, short-term psychotherapies are effective treatments in the acute stages of a depressive disorder [B6].

Problem-solving therapy

Generally, problem-solving therapy is regarded as being a potentially effective treatment for depression. More specifically, strong evidence suggests that problem-solving treatment by general practitioners is effective for major depression. For people with mild and moderate depression it should be considered as a treatment over 6-8 sessions over 10-12 weeks [B7].

Cognitive-Behavioural Therapy

Strong evidence suggests that cognitive-behavioural psychotherapy in primary care is effective in the treatment of people with mild to major depression [B8-B10, B2, B11, B12-14]. Evidence also supports the use of guided self-help based on cognitive-behavioural therapy for patients with mild depression [B7, B15].

The best results for primary care patients with chronic major depression are achieved by a combination of pharmacotherapy and CBT [B16]. A further systematic review is currently being conducted [B17]. More specifically, brief CBT should be considered as a treatment in people with mild and moderate depression over 6-8 sessions over 10-12 weeks [B7].

Evidence suggests that cognitive-behavioural therapy (CBT) affects negative thinking and mood and consequently leads to changes in vegetative and motivational symptoms [105]. It is also worth pointing out that cognitive changes, as promoted by cognitive-behaviour therapy, occur in most psychological forms of treatment [B11].

CBT is effective in preventing depression and in preventing relapse in patients with depression. The relapse rate for patients treated either with CBT alone or in combination with antidepressants is 26% versus 64% for those treated with antidepressants alone [B14]. Evidence from an economic evaluation suggests that CBT as an adjunct to pharmacotherapy and clinical management is more costly but also more effective than antidepressants and clinical management alone [B14]. A combination of antidepressants and CBT should be considered for patients whose depression is refractory [B7]. CBT should also be considered for patients 'with recurrent depression who have relapsed despite antidepressant treatment, or who express a preference for psychological intervention' [B7, B10].

Technology-aided interventions

The rising importance of technology-aided interventions goes hand in hand with the rise of consumerism, escalating levels of technological change and increasing demand for better dissemination of psychological treatments [B18]. Currently, evidence suggests that computerised self-help is not yet widely distributed among clinicians [B19].

The evidence base for the effectiveness and cost-effectiveness of computer-based interventions for the management of depression by health professionals [B20] and patients [B15] is growing but not yet convincing. A systematic review of the efficacy of computer assisted self-help materials in improving depressive disorders in both in-patient and out-patient settings is currently being conducted [B21].

A survey of frequently accessed websites about depression reported that the sites contain useful information [B22]. However, generally the quality of the sites was poor in terms of information about best practice, information about important treatment and management issues, and in providing scientific evidence for their arguments [B22]. Sites that were owned by organisations or had an editorial board provided higher quality information [B22]. A recent randomised control trial (RCT) reported that CBT and psycho-education delivered via the internet were both successful in reducing symptoms of depression [B23].

Evidence from a controlled study suggests that a specific preventive programme was not found to be more efficacious than providing general information about depression such as is already available on the internet [B24].

Telephone case management systems run by nurses, which include patients with mild, moderate, and major depression, are operated at relatively low cost (circa £50 per patient) and improve the number of patients receiving appropriate medication and depression outcome [B25, B26].

Computer-aided cognitive-behavioural therapy (CCBT)

Computer-aided cognitive-behavioural therapy is a generic term embracing a variety of methods of delivering CBT with minimal or no input from health professionals via a personal computer, over the Internet or via the telephone using interactive voice response (IVR) systems [B8, B18, B27].

CCBT provides patients with depression a flexible and confidential form of treatment and improves access to services despite limited availability of health professionals and services or other barriers to face-to-face consultations [B8, B28]. CCBT is used as a stand alone service or adjunct to face-to-face interventions but requires a certain level of literacy from the patients [B8].

Several CCBT packages are currently available for the treatment of depression in the UK. They include COPE (ST Solutions Ltd), Calipso Overcoming Depression Self-Help Materials (University of Leeds Innovations Ltd), Beating the Blues (Ultrasis plc), and Restoring the Balance (Mental Health Foundation) [B8]. Evidence suggests that the Beating the Blues programme is effective and cost-effective [B8, B28], but there is a lack of reliable information to compare the effectiveness of different packages for the treatment of depression [B8].

Evidence suggests that CCBT is as effective for minor and major depression as therapist-led CBT or bibliotherapy and more effective than treatment-as-usual and waiting list control groups [B8, B18, B28, B29]. Evidence also suggests that CCBT is a suitable form of treatment in primary care for patients from mild to severe depression [B18, B27]. One study reported that CCBT plus initial access to a health professional in primary care enabled them to treat many more patients per hour more cost-effectively than is possible without CCBT while not sacrificing the effectiveness of the care provided [B30, B31].

CCBT could potentially be more cost-effective than therapist-led CBT [B8, B28], pharmacotherapy [B28], or treatment-as-usual [B8, B18, B28, B29, B32]. However, NICE and HTA argue that the cost-effectiveness of CCBT has so far not been systematically assessed [B8, B28]. The acquisition costs of the individual packages vary from £350 to £10,000. The price depends on the content, duration, and service location of the computer treatment and on whether the package includes a dedicated computer system, technical support, training and clinical support [B8, B29].

Social workers

Firth [53,54] describes the development of a team of mental health social workers employed by a PCT which supports 12 GP practice populations across an inner-city area. The team is supported by the presence of a CPN, OT and service user representative at weekly team meetings. The team is geared towards supporting a clientele with enduring needs. The clients do not necessarily require specialist mental health service interventions but are experiencing complex social needs and often non-attendance at services is high. Social workers are trained in CBT interventions and assessment/support is geared towards meeting the client's direct needs, i.e. addressing personal and therapeutic issues and their indirect needs for example linking to other agencies such as housing, providing advice and guidance, and supporting client to attend services.

Self-help

Self-help incorporates such diverse interventions as medicines, vitamins, physical treatments, lifestyle choices, dietary changes, exercise, and 'psycho-educational' interventions. Evidence suggests that some forms of self-help are as effective as face-to-face therapy and more effective than no treatment. However, few self-help publications are tested for efficacy.

There is little evidence on the effectiveness of self-help groups [B6]. Self-help is promoted independently and as an adjunct to professional-led interventions but does not suit every individual [B33, B34, B19, B35]. Self-help treatments could potentially increase the cost-effectiveness of mental health service provision [B36].

Self regulation embraces three interdependent processes: self-monitoring, self-reflection, and self-reinforcement. Most self-regulation approaches use a cognitive-behavioural-therapy approach [B19, B35]. Evidence suggests that self-monitoring, and especially self-monitoring

in combination with self-reflection and/or self-reinforcement, is more effective than no treatment [B33, B37].

The choice of intervention should be aligned to the existing, social, work, and domestic context of each patient as well as their beliefs and practices [B33]. In primary care, self-help approaches further benefit the patient if suggested as adjuncts to other interventions [B33]. Unsupported self-help treatments with no or minimal contact with a health professional tend to be as effective as supported self-help treatments [B19, B35].

Self-regulation activities incorporating multimedia support such as audio, video, internet, telephone and/or contact with a health professional are more effective than self-administered interventions alone [B34, B38].

There is currently no convincing evidence to support the effectiveness of aromatherapy, mediation, contact with pets, and engaging in pleasant activities (without any other accompanying intervention) for depression [B39]. The evidence base for the efficacy of relaxation therapies for depression is growing but not yet convincing [B39].

Exercise

Exercise includes running, walking, dance and movement as well as other aerobic and nonaerobic activities [B39, B40]. In light of the evidence presented in all reviews it is suggested that exercise significantly reduces symptoms of depression and is more effective than no treatment or patient education [B39-B41, B8]. Exercise is as effective as other behavioural interventions [B39-B41] but less time and cost intensive, and provides additional health benefits [B40]. Evidence also suggests that exercise is beneficial as an adjunct to more traditional forms of therapy [B40, B42]. The level of depression at the start of the exercise programme and the environment in which exercise takes place might influence its effectiveness on alleviating depression [B40].

Bibliotherapy

Bibliotherapy consists of the patient using a standardized treatment at home, either in book form or computer-based. The patient works with the material more or less independently and has either no contact or minimal contact with professionals whose role is to be supportive or facilitative [B43]. Bibliotherapy approaches are usually based on either cognitive or behavioural therapy techniques. Evidence suggests that both approaches are equally effective, and more effective than no intervention [B48, B56]. The strongest evidence suggests that bibliotherapy is as effective as individual and group psychotherapy [B34, B38, B43]. Evidence also suggests that combining antidepressants and bibliotherapy does not increase the effectiveness of either treatment [B34, B38]. Bibliotherapy might be beneficial as a cost-effective and high quality intervention for people with depression who cannot be reached with traditional forms of therapy [B43].

Integrated primary care: Summary

- Evidence remains up and coming but integrated primary care is promoted by national guidance as an integral approach in current and future models of service delivery for primary care mental health.
- Emerging research evidence suggests in relation to new models of primary care workers that the impact and role of workers will be shaped more by local contexts and attitudes rather than national guidance or guidelines.
- Integrated primary care represents integration between all agencies (not only mental health and health services) and acceptance of the value that each professional contributes to the wider system of care.

iv Primary and Community Interface

Key features include:

- ***Social prescribing/social referral schemes*** a means for linking patients in primary care with non-medical sources of support within the community. [56-58]
- ***Voluntary referral facilitators*** a means to meeting the psychosocial needs of vulnerable groups of primary care patients. [59,60]

Impact of social prescribing

Social prescribing is perceived to have a number of positive outcomes for people experiencing mild to moderate mental health problems. These outcomes include:

- enhanced self-esteem and reduced low mood
- opportunities for social contact
- increased self-efficacy
- transferable skills
- greater confidence

It is also recognised that exercise is particularly beneficial in reducing symptoms of depression. [58] Social prescribing schemes generally involve activities that are community-wide, rather than tailor-made for individuals experiencing mental health problems. [56] This can be helpful in reducing the stigma attached to participation in activities provided by specific diagnosis groups such as mental health support groups.

Although the evidence base for social prescribing is emerging, there is not strong evidence to highlight the exact impact of social prescribing and in which context it is most useful. It is potentially helpful as an alternative for individuals to medication/psychological interventions or as methods of supporting the psycho-social needs of vulnerable populations.

Impact of voluntary facilitators

The perceived benefits include:

- allowing the patient to be managed more holistically
- time to allow patients to talk and explore their problems
- provision of information and facilitate referral to community service
- help in the detection and prevention of a crisis
- responding to local needs, particularly needs of ethnic minority groups

Grant's evaluated study aimed to improve patients' quality of life and decrease time spent by healthcare professionals in dealing with psychosocial problems. Although the study showed positive effects on patients' wellbeing (patients were deemed to feel more positive overall about life and their health), the cost overall of the scheme was higher than routine care and was not time saving for primary healthcare workers [60].

The success of schemes that work with voluntary organisations and workers is to an extent dependent upon the environment in which they are working. It is commonly understood that barriers to joint working and referrals between GPs and voluntary sectors exist. The main hurdles are highlighted as a lack of understanding of each other's role and responsibility, difference in professional language; lack of trust and knowledge of less well-known locally based voluntary or community groups by GPs [57;61].

Interface between primary care and the community: summary

- Evidence is up and coming but there is growing support to show that non-medical or psychological approaches can improve outcomes in mental health and impact on people's wellbeing.
- Psycho-social needs and social inclusion can be better met by access to community and voluntary resources, and facilitated through models of service delivery between primary care and the community.
- Appropriate voluntary and community resources should be available and accessible in local areas and improved links and joint working are needed between health and voluntary sector services.

Lessons from change management in service development: learning from case studies

Learning from the implementation of the newer models of service provision and the change management techniques which underpinned them is scarce. This requires a research base that offers a descriptive account of the implementation process. Unfortunately, descriptive and hypothesis generating studies that can inform policy and service development are rare. The Doing Well evaluation has taken such an approach which will ultimately enhance its ability to roll out successful strategies and facilitate mainstreaming of project ideas.

The following case studies represent some of the few studies that have generated such learning. The first case study reflects a whole systems approach within an integrated primary care model and details some of the main drivers for successful implementation of the model. The second example focuses on another area within the Doing Well initiative, namely the implementation of primary care mental health workers.

A case study of an NHS Beacon site for both mental healthcare and primary care. [71]

The Chester City Mental Health Project set out to address the problems of poor access to a range of treatments, fragmentation of services and poor communication between different agencies. It set out to reconfigure the provision of mental health services for patients with common mental health problems and commissioned and developed a multi-disciplinary mental health team in primary care. In addition to providing a broad range of interventions, the team is also responsible for increasing both the capacity and capability in primary care to manage mental health problems, by:

- Expanding the role of the primary healthcare team to treat and manage mental health problems by providing clinical supervision, shadowing opportunities and mentorship
- Providing skill-based learning programmes
- Utilising a case study approach in practices and protected learning time to improve the appropriateness and effectiveness of referrals and treatment
- Supporting the lead mental health GP in each practice
- Liaising with local statutory and non-statutory organisations in the locality and developing a resource directory
- Enabling a 'signposting' function into a range of statutory organisations
- Developing and evaluating new roles in primary care including the primary care mental health worker and support worker functions

The model is organised around four clusters of practices each covering a population of approximately 25,000 patients. This has required a considerable programme of organisational development for primary care as it challenged the traditional model of practices working in isolation. It has involved practices sharing resources, working more formally in partnership with a range of mental health providers, developing shared plans for service improvements and jointly reviewing performance. This has required action in a number of domains:

- Changes in culture and ways of working
- Training and development of the primary health care trust as a whole
- A review of communications systems within and between the constituent practices and key partner organisations

Central to the delivery of the model has been on-going monitoring and service evaluation. Early analysis of a qualitative exploration of benefits and barriers to working together suggests that both GPs and the Primary Health Care Trust recognise the benefits of the new service. The role of the GP mental health lead in each practice has been essential in terms of facilitating communication, disseminating good practice and sustaining the momentum of change. This role has succeeded without the provision of protected time or additional resource and appears to reflect high levels of commitment amongst the practices. The PCMHT has also operated with a highly flexible approach, including developing shared care approaches with district nursing teams and health visitors.

A case study of the implementation of Primary Care Mental Health Workers (PCMHWs) in Birmingham [72]

This project constituted a qualitative evaluation of the implementation of seven PCMHWs in a Birmingham Primary Care Trust. The key issues surrounding implementation were:

- Different views between the Primary Care Trust (PCT), Primary Health Care Teams (PHCT) and PCMHWs on the implementation of the policy
- Lack of clarity of workers' roles
- Difficulties around communication
- 'Hero innovators' (a supportive member of the practice) were instrumental in more successful integration of PCMHWs

The approach taken was seen as 'top-down' and therefore the PHCT felt excluded from discussions surrounding the potential roles of the new workers. This resulted in a lack of knowledge surrounding their potential roles. The PHCT were not involved in their appointment, and felt they had no control over their conduct. This resulted in PCMHWs feeling excluded from the team. The PCMHWs had to compensate by being assertive and confident in dealing with GPs. They also thought their ability to shape their roles made them more adaptable and more responsive to client needs.

The barriers created by the implementation approach were addressed through PCMHW and PHCT meeting half way: with the PCMHW making attempts to integrate and the practice being more accommodating and welcoming. Problems were more easily overcome when a 'hero innovator' was in place.

A case study of the implementation of PCMHWs in Selby and York PCT [73]

The management approach in this initiative was to have the PCMHWs shadow primary care staff prior to their placement so that the workers' configuration reflected the primary care

culture. This would also ensure that they tailored educational packages to reflect primary care presentations/issues/needs. Ringfencing of development time for individual surgeries and one day a week for the whole PCT has also enhanced the development of the project.

The successful approach of the first case study in Chester was heavily dependent on the GP mental health leads in each practice. This may not be achievable in every local context and therefore other mechanisms may need to be found to achieve the same outcomes. Equally, the 'top-down' approach caused problems in the second case study and the grass roots or 'bottom-up' approach in the third case would appear to make sense. However, that is not to say one approach is better than the other, nor would it be in all circumstances. Organisational and managerial, i.e. top-down support for change is often essential, and particularly for sustainability of projects, as was evident in the ringfencing of development time in the third case study. The lack of documented evidence surrounding change management in mental health service evaluation means we have to look to more general guidance on models of the change process.

Further lessons from innovations in primary mental health care can be found at <http://www.innovate.org.uk/Innovations/ProjectDetail.asp?ID=333>

1. The practical advice for managing change from a sample of these projects was:
 - It takes longer than you think
 - Get help from anyone you can, particularly sharing resources
 - The pace is different from secondary care, more initial assessments, so more pressure on staff
 - Support initially required by workers will be time consuming (and may also be time consuming for GPs and other practice staff)
 - Jointly producing a treatment and support pathway, referral and monitoring forms and patient information leaflets will be time consuming but can also be beneficial in allowing primary care practitioners to feel some ownership of the service
 - Good supervision is essential
 - Staff need links with peers and need informal supports
 - Little things such as phones, a base and access to computers help flow and may cause out of proportion disruption if not addressed
 - Recognise that a new service will have lots of teething problems and perhaps a high turnover of staff

2. The advice regarding plans to sustain the developments was:
 - Primary Care Trust commitment to develop mental health services in primary care
 - Be as clear as possible regarding responsibility for long-term funding, or identify early on who needs to be brought on board to achieve this
 - Continue attempts to access mainstream funding

- Continue to keep a high profile with all local statutory and non-statutory organisations and continue to innovate
- Project report and evaluation will provide a basis for decisions on future funding of the pilot

Adapting models of change management to local realities

To extend the learning from the evidence base surrounding the models of service delivery described above it is important to assess not just the effectiveness of interventions but to gain understanding of the process change in complex organisations. Unfortunately, few studies include such details. Nor do they include any knowledge about the personal skills and attributes, which influence the effectiveness of individuals involved in changing behaviour.

However, a vast literature exists, which documents models of the change process that may be useful for those seeking to understand and manage organisational change in health care settings. Primarily, this literature highlights different ways of thinking about change as well as strategies for the active management of change. It does not, in general, offer very strong guidance as to what is most effective – the evidence here is largely weak and inconclusive, and the influence of the local specifics of change and its associated context are so pervasive that this militates against the delivery of strong normative guidance. Moreover, in practice, aspects of several models will be appropriate to the specifics of change management issues in any one setting and the most effective strategy will have to be worked out locally through reflection and monitoring of different change management techniques. All ‘cognitive models of change’ (perspectives, frameworks, models, etc.) require significant levels of engagement, modification and reflexive application if their benefits are to be unlocked.

Implementation strategies thus need to be tailored to the local context; no single approach will have universal applicability. In order to identify the models and ideas which are best suited to the particular change programme in question, a range of factors need to be considered including the organisational, educational, economic and community environments of different health professionals. These will determine whether the change will be compatible with current beliefs or working practices. Even the initial task of getting agreement on a particular topic or area of need can depend on several factors, for example:

- Whether the issue is perceived as a significant problem by those who have to change
- Whether there are key individuals or organisations who are opposed to the change
- The nature of vested interests either in the proposed change or the status quo
- The resource implication of change
- The gap between what people say publicly about the change and what they are actually prepared to do

Finally and most importantly, close attention will have to be paid to who will make decisions about the changes, the extent to which these decisions will carry weight and be carried through, and ways in which this decision-making will be joined across the relevant organisations or services.

Change Management: Key Principles

A bibliography on organisational change and models of embedding research in organisational settings is included in the reference section to this document. Here are some key principles on change management drawn from this literature:

- One of the greatest barriers comes from getting the right groups and individuals to work together. There may be multiple reasons for this difficulty, including lack of time and resources, geography, or fear of loss of professional status or territory.
- The key players likely to be involved (in whatever capacity) in any change should be given the opportunity to influence the way in which any change programme is to be implemented.
- Managers who understand why change is resisted or not adopted may be better to deal with it constructively.
- Change models suggest that implementation programmes can be successful if they use interventions and activities that reduce restraining forces such as: increased workload, lack of time, poor communication, traditional working practices, and individual and organisational resistance to change.
- Conversely, incentives for change can include: financial reward, resource reallocation, education and training, performance feedback and empowerment.
- Many change programmes involve the cooperation or participation of several organisations. Such changes require the support of a strong coalition of key players. People who volunteer out of interest or belief in a programme are more likely to remain committed to the programme than someone who has been told or volunteered by their manager to take part.
- The success of any implementation or change is often dependent on effective communication of what, why and how the change is to be achieved. The communication of this across individuals and agencies may require that messages are tailored to suit the audience, focusing on issues that are most relevant to the particular audiences, using appropriate media that they will understand and communication channels with which they are familiar or most easily accessed (e.g. a single side of A4 is often best for communicating main messages to GPs).
- Resource implications must not be underestimated. Consideration needs to be given to the service and resource consequences of any proposed change. Change can be expensive requiring significant resources and time, and even some initial 'funding' is unlikely to cover the full costs of any change.
- Strategic change requires good information systems and access to routine data which provides appropriate feed-back.

The key characteristics of an environment receptive to evidence based change are:

- Clearly defined boundaries
- Clarity about decision making processes
- Clarity about patterns of power and authority
- Resources, information and feedback systems: the use of research
- Active management of competing “force fields” that are never static (i.e. driving forces *for* change versus restraining forces impeding change)
- Systems in place that enable dynamic processes of change and continuous development

(Rycroft-Malone et al, 2002)

It is unlikely that all these features will be in place for a programme of change to implement projects such as those included in *Doing Well By People With Depression*. However, by giving due consideration to the factors outlined above, local projects will contribute to the development of an environment receptive to change.

Project management and its role in organisational change

Change programmes require sound project management, with carefully developed objectives and a realistic timetable. A wide variety of tools are available to ensure that a clear eye is kept on objectives, costs and timescales. The bibliography includes a source of this information (6).

Project management is also a vital part of an approach to research based change which is particularly appropriate to the *Doing Well By People With Depression* projects. In the ‘Organisational Excellence Model’ outlined earlier, managerial action encompasses the formation and management of combined research/practice teams, as well as the development of initiatives to encourage ‘research mindedness’ and cultures of research engagement. This is vital for local projects to foster a culture of evidence-based ‘tinkering’ with models of practice and evidence from elsewhere to adapt these to local circumstances.

Activities to support and manage change cannot be underestimated. There would be little benefit from a computerised information system in an organisation where there is little management support for allowing access to these systems or for providing adequate training in their use. Training opportunities that take account of pressures on clinicians and local services.

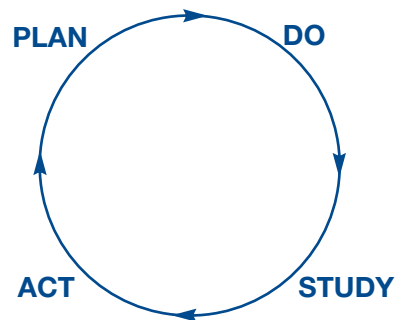
Projects will of necessity, be driven by factors other than the evidence base and local needs. Ideally, any attempt to implement change should use a systematic approach and involve strategic planning. The first step would be to conduct an ‘information and diagnostic analysis’, such an analysis might include:

1. identification of all groups involved in, affected by or influencing the proposed change(s) in practice

2. assessment of the characteristics of the proposed change that might influence its adoption
3. assessment of the preparedness of the health professionals to change and other potentially relevant internal factors within the target group
4. identification of potential external barriers to change
5. identification of likely enabling factors, including resources and skills

This analysis can then be used to inform the proposed change. The choice of intervention or change should also be guided by knowledge of relevant research. However, such systematic and strategic planning is rare, but that is not to say that an 'information and diagnostic analysis' cannot be carried out during the implementation phase.

Plan Do Study Act (PDSA) is another mechanism for change management.



This advocates that when undertaking an improvement to a system there are four essential steps which are repeated until the desired outcome is achieved:

Study

Study the system or process where improvement is needed.

Evaluate the available information.

Understand what the information is telling you.

If there is a particular problem what are its symptoms and causes.

Act

Decide what change (action) is needed.

Decide the scope of the change, e.g. on a small scale initially.

Predict the outcome of the change and decide what information is required to assess its success.

Plan

Who will do the work and when?

What equipment or training do they need?

How will information for assessing success be collected and recorded? When will progress be reviewed?

Do

Do the work according to the plan.

Study

Study the information gathered.

Was the desired outcome achieved? If not what actually happened?

Act

Decide what action is needed, e.g.

- adopt the change permanently;
- abandon the change;
- make some adjustments and go round the cycle again.

Plan

...

PDSA builds in recognition that with systems it is unrealistic to expect change to produce the right result every time because there are often complex interactions and dependencies that can be disturbed in unexpected ways. It is always necessary to check that the predicted improvement has actually happened. The 'study' step is vital.

From project to mainstream: how to get evidence into practice

Pilot projects such as Doing Well By People with Depression abound in the NHS. Although change can be achieved within small projects of this kind, the far trickier question remains of how to make sure that this change is a sustainable part of mainstream organisation of care. This question can be considered at two interrelated levels: the individual level and the organisational level.

The Individual levels: Changing professional behaviour

Some communication of knowledge will result in increasing 'awareness' in a specific field whereas other types of communication will be more intent on driving changes in behaviour or on 'implementation' activities. Generally, the dissemination of educational materials will not result in any specific improvements in practice but may be useful for raising awareness of research messages.

Educational outreach is a more promising approach for modifying professional behaviour, especially prescribing. This model is particularly effective when combined with Social Marketing (a framework for identifying factors that drive change: success is viewed as likely only when the needs, perceptions and requirements of the target group are determined and satisfied through the design and implementation of appropriate interventions). However, we are still awaiting evidence surrounding the effectiveness of this approach in the UK.

Reminder systems are generally effective for a range of behaviours.

Audit and feedback, use of opinion leaders and other interventions show mixed effects and should be used selectively.

Most common interventions, e.g. dissemination of educational materials, educational outreach, using local opinion leaders, audit and feedback, and reminders are effective under some circumstances but none is effective under all circumstances. Therefore there are no 'magic bullets' that will change practice in all circumstances and settings.

Organisational level: underpinning changes in professional behaviour

Individual behaviour is not only a matter of individual motivation and volition, but also of the environment within which professionals work. Interventions based on assessment of potential barriers to behaviour change are therefore more likely to be effective, and multi-faceted interventions targeting different barriers to change are more likely to be effective than single interventions.

Barriers to individual change are often found in the complexity of the organisational environment and the many and sometimes competing demands and policies which impinge on one person's behaviour. Therefore, the principles which describe an environment receptive to change above also describe the environment which sustains this change.

Checklist for Doing Well by People with Depression

The following general points should be noted in relation to developing services:

1. Organisationally

Primary care mental health services should be tailored to the unique characteristics of the primary care environment, which includes attention to: accessibility; high volume; quick response; provision of information; and complexity (see below).

Whole systems – services will be more effective where smooth pathways across service sectors have been established. Each model of service delivery will interface with other sectors at some point and some will span several sectors or service tiers.

Projects should also consider how other mental health services, and particularly other local primary care mental health services, will fit with their own developments and how staff can benefit from working alongside others.

Complex problems – people presenting in primary care have complex problems and services will have to be aware of their capacity to respond.

Role definition – learning from existing projects and comparability with other projects will be enhanced if there are clear definitions of the roles of those involved in service delivery (see skills development below).

Support for provision of information from self-help resources, statutory services, community groups, etc. is required in addition to providing client contact time.

2. Operationally

Development of managed care processes:

- Clear case management protocols. This is particularly important when implementing a service based on non-mental health professionals.
- Strategies for appropriate assessment of needs.
- Clear referral pathways, tailored to meet the needs of all potential referrers, e.g. GPs, other members of the primary care team, voluntary sector agencies.
- Inform primary health care teams of the roles of staff involved in new initiatives and the teamwork requirements if they are to link effectively with these services.
- Professionals in other services and systems may also need to be informed or involved if they are to link with the new developments; especially if this involves changes to the ways they work and the system as a whole.
- Formal strategies for support and supervision. This should be given careful consideration bearing in mind the placement of services and their interface with other care sectors. Clinical supervision may be organised separately from management supervision.
- Databases or toolkits of mental health, social and voluntary services to inform and support the initiative.

3. Skills development [74]

A rough hierarchy of complexity of skills relating to different models and interventions is described below. Each site should ensure that appropriate skills are tailored to the service being delivered.

- Referral facilitation is mainly focused on provision of information to patients, and requires the core skills of assessment, interpersonal and organisational skills
- Group psycho-education requires the ability to teach and encourage the use of therapeutic skills, and group facilitation skills
- Guided self help requires the ability to teach and encourage the use of therapeutic skills, and also requires the ability to develop a therapeutic alliance with an individual patient
- Case management requires provision of information, support and motivational skills.

All workers should be trained in the systematic evaluation and recording of the outcomes of mental health interventions.

4. Development of Partnerships

Involvement of service users by:

- Encouraging patient forums or discussions regarding services
- Developing links with local service user groups (but bearing in mind the need to enlist primary care service users)
- Using feedback questionnaires/interviews with people using mental health services to continually review the service
- Auditing work and practice-based needs assessment work

Partnership with primary care:

- Encourage practice teams to have ownership of the project
- Enlist the support of a 'hero innovator' in each practice or LHCC/CHP

Engagement with the voluntary sector:

- Make appropriate links with voluntary agencies
- Develop ways of sustaining contact and involvement, e.g. joint development of a directory or information toolkit

5. To enhance the transition from project to mainstream service

Make plans for sustainability of funding: linking with overall mental health strategy within the Health Board, making links with primary care development managers and Community Health Partnership management and planning structures.

Leadership arrangements or steering group mechanisms can be used to support and sustain developments.

Develop and sustain links with primary care and non-statutory organisations: cultivate local champions within these sectors and maintain a high profile for the project throughout.

Information and local evidence will be crucial to decisions of roll-out and mainstreaming of services and a proportion of project resources should be set aside to ensure this is achieved, and to rigorous standards.

Practice-based evidence is 'evidence' in itself and projects should disseminate their findings, including lessons learned from implementation and project management to as broad an audience as possible. This can be enhanced with publication of descriptive studies in professional and health service journals.

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