



A Service Evaluation of the Assessment Process in a Step4 Psychological Therapies Service

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A Service Evaluation of the Assessment Process in a Step4 Psychological Therapies

Service

Purpose: To improve the efficiency of the assessment process within a Step4 Psychological Therapies Service by identifying factors related to assessment non-attendance and service suitability for referred clients.

Design/Methodology/Approach: Referral and assessment information was accessed between October 2019–March 2020 from Step4 routine service data electronic client records where necessary and Step4 staff self-report questionnaires.

Findings: All clients offered an assessment during this time attended. Findings indicated several factors could influence service suitability in meeting client need. These included individual differences such as readiness to change, which was not necessarily identified at referral or prior to assessment, and potential systemic factors, such as the opt-in procedure, which possibly impeded access. Though the necessity for assessment in clarifying client needs and treatment was indicated, an assessment (from referral to assessment appointment) that led to discharge could take an excess of one working day of service time, associated with considerable opportunity cost to other clients awaiting assessment. Recommendations are made for improving assessment efficiency.

Originality/value: With a high prevalence of poor mental health in the UK, efforts must be made to identify and reduce additional demand upon service time and resources within mental health services to effectively meet people's needs. Recommendations to improve assessment process efficiency include the use of a standardised referral form, offer of follow-up support procedures, increased client involvement, a streamlined opt-in battery and ongoing monitoring to ensure shared practice between clinicians. These are transferable to other mental health services, with implications for subsequent quality and timeliness of care.

Keywords: Service evaluation; referrals; psychological assessment; Step4; mental health

Background

Each year in the UK, approximately one in four people experience a mental health difficulty (McManus et al., 2009; Evans et al., 2015). The Department of Health estimates that mental health difficulties cost the UK economy between £70 billion and £100 billion per year (Davies, 2013). With a high prevalence of poor mental health in the UK, mental health services can often be overstretched and insufficiently funded (Dehghan et al., 2017). The associated level of work for practitioners can also mean that services are at risk of acquiring long waiting lists (Marzillier & Hall, 1999). Hence, resource allocation is vital to ensure care is provided in the most appropriate setting and that there are efficient pathways to specialist care for those who need it (Dehghan et al., 2017).

In 2008, the Improving Access to Psychological Therapies (IAPT) programme was established with the aim of enabling access to a range of evidence-based psychological therapies recommended by the National Institute for Health and Care Excellence (NICE). IAPT uses a stepped-care approach to manage the provision of services for people with mental health difficulties, 'stepping down' when a less intensive treatment is more appropriate or 'stepping up' to more intensive treatments (NHS England, 2021). The stepped-care approach consists of Step 1 (all common mental health difficulties), Step 2 (persistent mild to moderate depression or anxiety) and Step 3 (mild to moderate depression or anxiety disorders that have not responded to lower-intensity interventions; NICE, 2011). Step 4 services offer specialist psychological assessment and intervention to people with a higher chronicity and severity of mental health difficulty or functional impairment which may include risk of self-neglect or harm, complex social factors, or multiple diagnoses. A reported advantage of the stepped care model is that it can maximise treatment effectiveness by improving resource allocation, making it an economically viable and useful treatment option

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3 (Ho et al., 2016). However, due to differences in the availability of resources across diverse
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5 settings, it can be difficult to standardise the stepped model nationally, thus it may be argued
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7 that flexibility within stepped care is needed to adequately respond to these differences (Ho et
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9 al., 2016).
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14 ***Step4 Psychological Therapies Service***

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16 A local NHS Step4 Psychological Therapies Service covers four geographical areas with a
17
18 total population of approximately 476,900 people (Office for National Statistics, 2019). This
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20 service consists of one Consultant Clinical Psychologist/Service Lead, five Clinical
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22 Psychologists and Counselling Psychologists, two Trainee Clinical Psychologists on
23
24 placement, and one Assistant Psychologist, supported by a small team of administrative staff.
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26 Step4 assessments are offered within a timeframe of eight weeks, with a considerably longer
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28 wait for any psychological intervention. Treatments include a range of evidence-based
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30 therapeutic approaches such as cognitive behavioural therapy (CBT), cognitive analytic
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32 therapy (CAT), and psychodynamic therapy. According to NICE (2011), there should be
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34 sufficient capacity within Step 4 services to increase the amount of people who are identified,
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36 assessed, and offered treatment. However, to date, there is no equivalent benchmark to
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38 compare against when considering staffing, referrals, or assessments in Step 4 services in
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40 other localities. Within this service, annual reports for commissioners contain comparison
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42 data from primary care (General Practice) and IAPT services but there is acknowledgement
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44 that Step4 is a 'higher' level service with relatively fewer clients with greater mental health
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46 chronicity and complexity in comparison to Steps 2 and 3 (Mental Health Matters, 2018) and
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48 may therefore make for a poor comparison. For example, according to differences in service
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50 level agreements, IAPT is based on a Payment by Results model, whereby funding of the
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52 service is reflective of the number of people who access (and are assessed by) IAPT each
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3 month. In comparison, Step4's contract has no monthly assessment targets (although does
4 have the eight-week target for assessment), hence, its emphasis is on the numbers offered
5 treatment. Unlike IAPT, Step4 can provide up to 30 sessions of therapy and can offer more in
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10 10% of cases where clinically indicated.

11 12 13 14 15 ***Psychological Assessment in Step4***

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17 According to NICE (2011), assessment in Step4 should be a fundamental part of the stepped-
18 care pathway for mental health difficulties. This Step4 service, like many, uses an 'opt-in'
19 model whereby, following a referral, the client is contacted to complete and return a battery
20 of opt-in questionnaires within two weeks. Opt-ins are reportedly an effective way to manage
21 referrals, limit 'Did Not Attends' (DNAs) and effectively utilise staff time (NHS England,
22 2015). However, opt-ins may also act as a type of effort test based on an assumption that
23 clients will complete them if distressed enough to do so. Thus, to support client engagement,
24 it has been recommended that there should be no over-complicated referral process or opt-in
25 system (The National Collaborating Centre for Mental Health, 2018). In this service, clients
26 are asked to complete a personal history questionnaire to collect demographic information
27 and a description of their difficulties in their own words, as well as the University of Rhode
28 Island Change Assessment (URICA; McConaughy, 1981) as a measure of readiness for
29 therapeutic change. This information is reviewed before the client is invited to assessment.
30 Clients are then asked to complete the Clinical Outcomes in Routine Evaluation Outcome
31 Measure- 34-item (CORE-34; Evans et al., 2000), as a measure of psychological distress,
32 which is reviewed by the clinician at assessment. Whilst the opt-in procedure can inform the
33 assessment and reduce non-attendance at first appointment (Houghton et al., 2010), it may
34 also act as a barrier to accessing services, specifically discriminating against those with the
35 most common mental health difficulties, such as anxiety disorders and depression (Houghton
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3 et al., 2010), people from lower socio-economic backgrounds, and those with literacy
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5 difficulties, which could further compound health inequalities (Hawker, 2007). In Step4, if
6
7 literacy difficulties are known at referral, the Assistant Psychologist would contact the client
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9 to support with completion of the opt-in battery over the phone. Similarly, the CORE-34
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11 (Evans et al., 2000) may be completed and reviewed at the assessment appointment.
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13 However, if literacy difficulties are not identified, there is an expectation that clients make
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15 contact to request formal support with completion, which could arguably serve to disparege
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17 some with pursuing help. Although the opt-in need not be completed in its entirety (rather,
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19 offering demographic information alone may indicate that the client is actively seeking
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21 therapy), efforts to further increase accessibility may improve engagement in mental health
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23 services, as well as ensuring clients feel listened to and are not stigmatised as part of seeking
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25 help (Lawn et al., 2021).
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33 Assessment involves identifying the presenting problem, establishing service suitability and,
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35 in considering how therapy may be helpful (Sweeney et al., 2019), determining the most
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37 suitable NICE-recommended treatment (The National Collaborating Centre for Mental
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39 Health, 2018). Assessments conducted by a mental health professional reportedly lead to
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41 more accurate identification of difficulties and appropriate treatment in comparison to
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43 primary care but is likely to involve greater cost and longer waiting times for treatments,
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45 which can have a negative impact on care (NICE, 2011).
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51 *Service unsuitability at referral*

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53 Step4 provides referral guidelines which outline service and exclusion criteria. For example,
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55 Step4 is not appropriate for people who misuse substances, pose a forensic risk, experience
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57 psychosis or are participating in another therapy. Although there is suggestion that referral
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3 guidelines are helpful, they may not be consistently adhered to, though the reasons for this
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5 are ambiguous (Hartveit, et al., 2013; Rogers et al., 2013). The content and quality of
6
7 referrals can also vary which can lead to delayed treatment and impact the efficacy of
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9 services (Allwood et al., 2019). A lack of necessary information in the referral may affect
10
11 whether people reach the most appropriate destination first time and the service's ability to
12
13 pre-empt appropriateness for therapy prior to assessment (Dehghan, 2017). Greater
14
15 understanding of the referral process by clients and referrers is vital to the clients' overall
16
17 healthcare experience, with rejected referrals and adjusted timescales a regular cause of client
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19 apprehension and uncertainty (Dehghan, 2017).
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26 *Service unsuitability following assessment*

27 Presumably, those who do not meet service criteria or meet any exclusion criteria would not
28
29 be accepted for assessment. Step4 service criteria states that clients should be ready, willing,
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31 and able to engage in talking therapy, therefore, assessment of a client's motivation for
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33 therapy is deemed important in influencing the likelihood of becoming meaningfully and
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35 actively involved in therapy (Ogrodniczuk et al., 2018). The URICA (McConaughy, 1981),
36
37 underpinned by the Transtheoretical Model of Behaviour Change using the stages of
38
39 precontemplation, contemplation, preparation, action, maintenance, and termination
40
41 (Prochaska & Velicer, 1997), has shown excellent reliability, prediction of treatment
42
43 retention and attrition and modest utility for predicting treatment outcome (Dozois et al.,
44
45 2004). However, it may be criticised for its arbitrary dividing lines between the stages which
46
47 may, misleadingly, be perceived as time-specific and sequential (West, 2005). Hence,
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49 URICA scores may be used alongside clinical judgement to consider suitability. Those for
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51 whom Step4 is deemed inappropriate following assessment are referred back to the care of
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53 their General Practitioner (GP) or signposted to other services.
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Non-attendance at assessment

According to Step4 policy, DNAs refer only to non-attendance without reason. DNAs can lead to reduced productivity, increased costs (Binnie & Boden, 2016), deterioration in therapeutic working relationships (Lee et al., 2019), and cause further delay for other individuals waiting to be seen (Phillips et al., 2017). Thus, services with high non-attendance often retain longer waiting lists (Trusler et al., 2006). Clients who do not attend their initial Step4 assessment appointment without reason or contact with the service are discharged. In any other instance, for example, DNAs for secondary assessment or therapy appointments, a follow-up letter is sent to the client to request they contact the service within two weeks to rearrange the appointment. If there is no contact, they are subsequently discharged.

Research has indicated major predictors of first appointment non-attendance can include clients with a lower non-risk score on the CORE-34 (Evans et al., 2000), regular thoughts of 'being better off dead' (as indicated on the CORE-34; Evans et al.), or recent onset of a mental health difficulty (one month or less) or long-term condition (more than two years; Di Bona et al., 2014). Clients from lower socioeconomic backgrounds and those with multiple co-morbidities are also reportedly more likely to miss appointments, often citing forgetfulness, transportation difficulties and family commitments (Wilson & Winnard, 2022). Conversely, clients found to most likely attend their first appointment included those who self-referred and those with fewer previous referrals (Davis et al., 2020).

Despite individual characteristics, there are also external factors that can impact non-attendance. Long waiting times between referral and first appointment can lead to poor therapeutic engagement and increased attrition (Grunebaum et al., 1996; Foreman & Hanna,

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3 2000). Non-attendance may also be related to inefficiencies in appointment booking systems
4
5 and inconvenient appointment times (Wilson & Winnard). For example, some evidence
6
7 suggests that the day of the week can affect attendance rates, where DNAs are reportedly
8
9 highest on Mondays and lowest on Fridays. The decline in DNAs over the week has been
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11 shown in both males and females across all age groups (Ellis & Jenkins, 2012). Therefore,
12
13 although psychological difficulties may be viewed as located within the individual, services
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15 sit in a context of a relationship between itself and the community it serves. Hence,
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17 consideration must also be given to systemic facilitators and barriers and the service's role in
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19 providing access, opportunity and reducing attrition.
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26 **The Present Study**

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28 Though mental healthcare quality and delivery is at the forefront of the modernisation agenda
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30 of the NHS (Trusler et al., 2006), the NHS continues to operate within a context of
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32 organisational change, with increased demand for mental health services and minimal growth
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34 in funding. Hence, efforts must be made to identify and reduce the misapplication of valuable
35
36 service time and protect resources to effectively meet people's needs. This is in line with the
37
38 local NHS Trust's commitment to targeting and reducing unwarranted variation in service
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40 efficiency to maximise productivity and ensure clients have a positive experience. It is hoped
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42 that this service evaluation will help to identify factors related to assessment non-attendance
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44 and service unsuitability to inform recommendations in improving the efficiency of the
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46 assessment process and subsequent quality and timeliness of care for the people who use this
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48 Step4 service.
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Aims

The service evaluation aims to examine individual and service level outcomes between October 2019–March 2020 to address the following research questions:

1. Pre-assessment;
 - a. how many opt-in referrals did not attend for assessment;
 - b. could non-attendance have been predicted in any way and;
 - c. how much service time is taken with non-attendance at assessment?
2. Post-assessment;
 - a. how many people were discharged following assessment;
 - b. could service suitability have been identified at referral and;
 - c. how much service time is taken to assess people who are then not offered treatment?

Methodology

Setting

The service evaluation was conducted in a Step4 Psychological Therapies Service and, in August 2020, was authorised by governance procedures via the local NHS Learning and Development Team for ethical approval of data use.

Materials

Referral and assessment information was accessed from routine service data, detailing CORE-34 (Evans et al., 2000) and URICA (McConaughy, 1981) scores, and demographic information. Clients were informed via their invitation to assessment that their data may be used by the service to produce reports to enable service improvement. Returning their opt-in questionnaires confirmed that they consented to this. Though the service data contained some identifiable information (date of birth and electronic record numbers), data was referred to as

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2
3 a collective, hence, no identifiable information was used in the evaluation. Clients' electronic
4 records, referral letters, and previous contact and correspondence with services were
5 reviewed where necessary. Data collected from staff self-report questionnaires were also
6 reviewed.
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14 *Procedure*

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16 In response to questions 1a and 2a, referral and assessment service data was reviewed for
17 numbers of assessment non-attenders and number of discharges following assessment in the
18 6-month period of October 2019–March 2020. Data after March 2020 was excluded as it was
19 deemed unlikely to be representative of routine service data due to the impact of the
20 Coronavirus (COVID-19) on service procedures.
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31 To address all remaining research questions regarding predictors of or factors related to non-
32 attendance and service suitability, a combination of methods was used. This included:
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- 34 • Reviewing CORE-34 (Evans et al., 2000) scores at assessment, as part of service-
35 collected data (where available), to gauge clients' level of distress, risk, and overall
36 wellbeing.
37
- 38 • Reviewing URICA (McConaughy, 1981) scores at assessment, as part of service-
39 collected data (where available), to assess readiness for therapeutic change.
40
- 41 • Reviewing clients' electronic clinical notes, referral letters, and previous contact with
42 services to gather more information about the reason for referral, the nature and
43 severity of the mental health difficulty, the level of risk, any previous engagement
44 with services, and overall appropriateness of Step4 to meet the clients' needs.
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- 46 • Consulting the service's DNA policy.
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3 Furthermore, two electronic, self-report questionnaires (one for administration staff and one
4 for clinicians) were circulated to Step4 staff via NHS encrypted email to request an estimate
5 of the time taken for assessment-related tasks. Examples of tasks included the time taken to
6 prepare for assessment appointments (reading notes and referrals), to conduct assessment
7 appointments, to send new appointment or DNA letters where necessary, to complete
8 administration post-assessment (clinical notes, care planning, risk assessments, onward
9 referrals, and so on). Completed questionnaires were returned via email to the first author. By
10 completing the questionnaires, staff consented to taking part in the service evaluation.
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24 Consideration of compromised data integrity due to missing service data was deemed
25 inconsequential since the data set was small and did not undergo statistical analysis. With
26 regards to questionnaire data, there may have been potential response bias, thus the first
27 author selected permanent staff to complete the questionnaires (excluding Trainees and bank
28 staff) who arguably had greater knowledge, experience of and familiarity with the service to
29 avoid inconclusive or incorrect insights and increase the reliability and validity of the results.
30 Separate questionnaires were developed for clinicians and administrative staff to enable
31 question context and clarity. Though questionnaires were anonymous, to address social
32 desirability or self-presentational bias, in this case, staff possibly recording shortened activity
33 times to convey competence, the first author reassured that data would be viewed collectively
34 to help inform recommendations.
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51 **Findings**

52 *Appropriateness of referral*

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54 According to routine service data, the service received 185 referrals between October 2019–
55 March 2020. Of these, 60 (32%) were not accepted to the service, with repeated instances of
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3 clients meeting exclusion criteria, for example, in cases of high risk, where psychiatric
4 assessment was required, or those who had recently engaged in therapy. There was also
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6 indication that some clients required a 'lower step' service for stabilisation work. Of the 185
7
8 referrals, 125 were sent opt-in questionnaires, however, over one quarter (34) were not
9
10 returned and subsequently discharged. In instances where opt-ins are not returned within the
11
12 two-week period, clients are sent discharge letters, based on the assumption they no longer
13
14 require the service. Sometimes the discharge letter can act as a prompt for clients to return
15
16 their opt-in questionnaires, request help with completion, request they are re-sent or request
17
18 an extension period for returning them. However, there is no formal follow-up should opt-ins
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20 fail to be returned. Hence, in these 34 cases, the reasons for not returning the opt-in
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22 questionnaires remain unknown.
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31 *Attendance at assessment*

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33 At the time of the evaluation, of the 91 who returned their opt-in questionnaires, 51 referrals
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35 were not invited to assessment. Due to COVID-19, it may be that assessment and auditing
36
37 processes were disrupted, resulting in delayed invites to assessment and missing service data.
38
39 Thus, the outcome of these 51 referrals is unclear. The remaining 40 clients were invited to
40
41 assessment and all 40 attended. As there were no assessment non-attenders during this review
42
43 period, no conclusions could be made about possible predicting factors of non-attendance.
44
45 However, questionnaire data from Step4 staff provided an estimate of service time taken for
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47 DNAs. The questionnaires asked staff to give an estimate of the average time taken in
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49 minutes for each step in the assessment process. For example, beginning with attendance at
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51 referral meetings to discuss suitability and reviewing returned opt-in questionnaires. For
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53 clinicians, specifically, this also included the time taken for preparatory administration such
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55 as reviewing client referrals and notes and liaising with administrative staff regarding next
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3 steps to either discharge or rearrange the appointment following DNAs. Between the five
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5 clinicians, this averaged at 89 minutes (1 hour 29 minutes) of clinician time per assessment
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7 non-attendance. For administrative staff, each assessment non-attendance could take
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9 approximately 139 minutes (2 hours 19 minutes) of service time, which included initial
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11 processing of the referral, attending referral meetings, electronically accepting or rejecting
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13 the referral, processing returned opt-ins, sending assessment appointment letters and
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15 discharging or rearranging client appointments as requested by the clinician.
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21 *Appropriateness following assessment*

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23 Of the 40 people assessed, 36 were accepted to the service. An assessment audit form,
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25 completed by assessing clinicians, was used to consider readiness for therapy. From routine
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27 service data, data was available for 38 of the 40.
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32 Data indicated that 34 clients (89.5%) were viewed by clinicians as ‘very appropriate’ or
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34 ‘appropriate’ for the service, with 29 clients (76.3%) having either ‘good’ or ‘very good’
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36 psychological insight into their difficulties. Most clients (92.1%) were ready for therapy to
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38 some degree, and all were viewed as being motivated and having potential for improvement.
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42 In addition to the assessor-rated scores, URICA data (as part of routine service data, available
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44 for 35 of the 40 assessed) was used to further assess readiness to change, as shown in Figure
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52 Data showed that URICA scores from 21 clients (60%) fell within the ‘Contemplation’ stage,
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54 eight (22.9%) within the ‘Action’ stage and six (17.1%) clients within the ‘Pre-
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56 Contemplation’ stage. One client at the ‘Action’ stage and one client at the ‘Contemplation’
57
58 stage were discharged. Of the six people who were not deemed ready for change (‘Pre-
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3 contemplation'), one was discharged, and one referred on. Thus, in total, Step4 was deemed
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5 unsuitable for four of the 40 clients (10%) and therefore readiness appeared to be a major
6
7 predictor of service appropriateness.
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12 In consideration of whether these four clients could have been identified at referral, their
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14 referrals, URICA (McConaughy, 1981) and CORE-34 (Evans et al., 2000) scores, and
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16 clinical notes were reviewed for any commonalities, including demographic information such
17
18 as gender, age, socioeconomic status according to their postcode and employment status. All
19
20 four clients lived in the same county. Two were single parents and two lived with their
21
22 parents or partner. Three were unemployed and all received disability and sickness benefit.
23
24 More information, including the outcome of their Step4 assessment, is provided below.
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30 31 *Client 1*

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33 Client 1 was a White British female in her 50s. Client 1 was referred by her GP to Step4.
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35 Though there was no cover letter, the GP had forwarded a letter received from an A&E
36
37 Mental Health Liaison Nurse detailing Client 1's mental health needs. At assessment, Client
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39 1's CORE-34 score was 2.30 (above the cut-off of 1), which may have indicated a 'moderate-
40
41 severe' (Mellor-Clark, 2006) clinically significant level of psychological distress. Her
42
43 URICA scores placed her within the Contemplation stage, however, the assessing clinician
44
45 felt that she was not ready to make changes or improve her own coping skills. Client 1 was
46
47 discharged back to her GP.
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52 53 *Client 2*

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55 Client 2 was a White British female in her 30s. Client 2 had been referred by a psychiatrist
56
57 for trauma work in the context of Emotionally Unstable Personality Disorder (EUPD). Client
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3 2's CORE-34 score was 2.41 which suggested a 'moderate-severe' (Mellor-Clark, 2006)
4
5 level of psychological distress. Her URICA scores indicated she was at the Action stage of
6
7 change, however at assessment, the clinician considered Client 2 was not ready for trauma
8
9 work due to her ongoing dissociation and lack of adaptive coping strategies should therapy
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11 trigger overwhelming emotions. She was referred on to a service for people with personality
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13 difficulties for specialist assessment and treatment.
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19 *Client 3*

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21 Client 3 was a White British male in his 20s. Client 3 was referred for assessment by a
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23 council re-enablement service due to anxiety and depression in the context of childhood
24
25 trauma and ongoing physical health difficulties. Though the opt-in battery was returned, no
26
27 CORE-34 data was available for Client 3. His URICA scores fell within the Precontemplation
28
29 stage, which may have indicated his readiness for therapy. Client 3 stated he was managing
30
31 well and that his priority was to regain his driving licence. As there was no mental health role
32
33 for Step4 in this case, Client 3 was discharged.
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40 *Client 4*

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42 Client 4 was a White British female in her 30s. Client 4 was referred by IAPT for trauma
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44 work as she had requested Eye Movement Desensitisation Reprocessing (EMDR) which was
45
46 not offered within local Step 3 services. Client 4's CORE-34 scores were missing from the
47
48 service data. Her URICA scores indicated that she was at the Precontemplation stage. She
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50 was referred on to a Step 3 therapist for CBT for depression, which was assessed as a priority
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52 over the trauma work, and according to client preference. Client 4 was also referred to the
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54 Local Mental Health Team (LMHT) for support with activity scheduling and self-care.
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3 Questionnaire data offered an estimate of the average service time taken to assess clients for
4 whom Step4 was then deemed unsuitable to meet their needs. For clinicians, this was
5 approximately 458 minutes (7 hours 38 minutes) per person, which included time spent on
6 administration prior to assessment, two, up to 90-minute appointment slots with the client,
7 administration following assessment including notes, care plans, risk assessments, service
8 audit data and assessment letter with psychological formulation and care plan. There were
9 also additional time costs to clinicians between areas, such as attending local referral
10 meetings, liaising with colleagues within and outside of Step4 about service eligibility,
11 sending resources to clients between assessment appointments and attending to any
12 safeguarding or risk issues raised at assessment. This could add an additional, on average, 42
13 minutes to clinician time. For administrative staff, each assessment that resulted in discharge
14 could cost approximately 33 minutes, including sending discharge letters and closing the
15 client referrals to the service.
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35 Discussion

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37 The aim of the service evaluation was to identify any factors related to assessment non-
38 attendance and service suitability for clients referred to this Step4 service. Between October
39 2019–March 2020, the service received 185 referrals, 125 of which were sent opt-in
40 questionnaires but over a quarter were not returned. Though the reasons for this are unknown,
41 it could be argued that the opt-in model effectively managed referrals (NHS England, 2015)
42 and streamlined the service. Alternatively, it may be that the opt-in questionnaires served as a
43 barrier to client engagement and access. It would have been interesting to further investigate
44 any pertinent demographic information of the 34 who did not return their opt-in battery to
45 elucidate whether there was a disproportionate cut-off, for example, considering gender, age,
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3 socioeconomic status, or education and literacy abilities to ensure a larger number of people
4 were identified, assessed, and offered treatment (NICE, 2011).
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10 Though not anticipated, every client who was offered an assessment attended. It is unclear
11 whether this was due to an efficient screening process at referral, or whether clients with
12 higher levels of distress were met with greater challenges in accessing the service. Therefore,
13 it was not possible to examine potential predictors of or factors related to non-attendance,
14 such as those indicated by Di Bona et al. (2014). The total estimated service time for each
15 assessment non-attendance equated to approximately 3 hours 48 minutes. If an average
16 working day is 7.5 hours, one assessment non-attendance could take over half a day of
17 service time. However, data in the 6-month review period was narrow and featured only a
18 small slice of service activity. Hence, should the typical number of DNAs be
19 underrepresented in this data, it would be useful to review a larger period to calculate an
20 average number of assessments not attended and provide more precise indication of the
21 implication upon time and health outcomes.
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40 The service evaluation revealed that, following assessment, Step4 was unsuitable for 10% of
41 clients who were then discharged. This figure provides a service level average, therefore, if
42 some clinicians are discharging more than 10% of their clients following assessment, it would
43 be worth further enquiry. Each assessment that resulted in discharge required, on average, 8
44 hours 11 minutes of service time, in excess of one working day. This finding has relevance
45 for service quality and efficiency, considering Step4 should preserve sufficient capacity for
46 assessment and intervention (NICE, 2011). However, more importantly, consideration should
47 be given to the cost to the clients' time and expectations. Though it is recognised that the
48 service needs strict criteria, reasons for determining that Step4 is not appropriate in meeting
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3 some clients' needs should be explored with curiosity and compassion, considering systemic
4 factors in facilitating or hindering access and opportunity. Although client motivation is often
5 deemed important in influencing the likelihood of becoming meaningfully involved in
6 therapy (Ogrodniczuk et al., 2018), it seemed that URICA scores alone were not a predictor
7 of service appropriateness. For example, Client 2's scores fell within the 'Action' stage but
8 was discharged following assessment. This may emphasise the importance of assessment by
9 mental health professionals to judge suitability and more accurately identify problems and
10 treatment (NICE, 2011). Alternatively, Client 2's EUPD diagnosis, which Step4 is not
11 commissioned to work with, may have acted as a barrier. Moreover, Client 1's referral
12 appeared to lack necessary information which may have impeded her reaching the most
13 appropriate destination first time and hence reduced the service's ability to pre-empt its
14 appropriateness prior to assessment (Dehghan, 2017).

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33 There were commonalities between Clients 1-4 including their nationality, ethnicity, receipt
34 of government financial support, trauma and objective levels of psychological distress as
35 measured using the CORE-34 (Evans et al., 2000). However, only tentative links can be made
36 between individual traits, circumstance and service suitability which seems reductionistic,
37 risks oversimplifying human complexities, and fails to recognise other factors such as
38 variation between assessing clinicians. Larger scaled data would be needed to identify crude
39 demographic factors and potential inequalities, hence the commonalities highlighted here are
40 likely coincidental.

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54 With regards to methodological shortcomings, though there was a strength in triangulating
55 information from different sources, a weakness was in the completeness and accuracy of data.
56 For example, when staff were asked to broadly quantify service time, it may have been that
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3 this did not correspond with actual time (Zakay, 2012) since individual retrospection can vary
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5 when compared with timestamped activity data and group consensus (Fine & Vajsbahe,
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7 2013). Though questionnaire data was collectively combined to estimate average service
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9 time, timings provided by clinicians were highly variable which questions standards of
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11 uniformity, shared practice, and consequent quality of experience for clients. Thus,
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13 uncertainty remains about whether clinician timings were heterogenous, reflective of
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15 assessing clients of differing complexities, variability in how clinicians recorded their activity
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17 timings or, due to small scale data, generated by chance distribution.
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24 A further criticism is that the service evaluation involved only a single service with no
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26 comparison to other Step 4 services, hence, findings may be less applicable to other localities.
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28 Instead, via informal benchmarking, consideration was given to how data fit with other
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30 services. Though Step4 treats a relatively smaller minority of people in comparison to 'lower'
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32 level services (Mental Health Matters, 2018), the number of people discharged following
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34 assessment seemed comparable to the third-sector organisation Mind, for example, who
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36 found that one in 10 people following assessment were not offered therapy (Mind, 2013).
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38 Likewise, in 2019-2020, Step4 received a similar percentage of referrals (32%) to IAPT
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40 (31%), whose needs could not be met and who did not enter therapy (NHS Digital, 2020),
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42 including those who declined initial appointments (NHS Digital).
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49 *Recommendations*

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51 The implementation of the below recommendations may help to optimise this Step4 service's
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53 assessment process, however, may require further consideration due to possible changes in
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55 current working practices following COVID-19:
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- To better identify appropriateness at referral, though not strongly supported here, a standardised referral form may provide a reminder of exclusion criteria and request necessary information from referrers, if doing so would not further complicate the referral process (The National Collaborating Centre for Mental Health, 2018).
- Continue to consider client engagement to maintain current assessment attendance and comparable working with other mental healthcare providers. For example, a telephone prompt to the client may provide additional opportunity to discuss and return opt-ins, identify any barriers to completion and offer support where necessary. Similarly, access may be increased by encouraging client involvement via a follow-up phone call to those who do not attend initial assessment appointments or offering a choice of appointment times at the point of opt-in.
- Though they provide indication of distress, risk and motivation, psychometric scores and referral information alone cannot predict service suitability. URICA (McConaughy, 1981) scores were not consistently used in predicting service appropriateness, with no apparent relationship between scores and invitation to assessment. Therefore, the service may wish to consider streamlining the opt-in battery.
- Since group consensus is reportedly accurate (Fine & Vajsbaher, 2013), clinician idiosyncrasies and timings may be more precisely quantified via collective staff discussion and ongoing monitoring and evaluation to ensure standardised, shared practice, reduced variation, increased productivity and positive client experience. For example, considering a 'crib sheet' for clinicians to standardise the assessment appointment. Quality standards and adherence to a structured assessment could be further explored in a service audit.

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3 To identify possible themes and recommendations to improve access, suggestions for future
4 research include exploration of client attitudes towards the opt-in battery, specifically those
5 who did not return them. Moreover, further investigation may be warranted into clinicians'
6 experiences of assessment, especially in relation to the impact of change in the NHS and
7 during COVID-19, to consider and address any systemic factors affecting service processes
8 and efficiencies.
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21 **Data Availability Statement**

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23 The data that supports the findings of this study is available from the corresponding author
24 upon reasonable request.
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32 **Funding Source Declaration**

33
34 There have been no funding or research grants received in the course of the study, research or
35 assembly of the manuscript.
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43 **Declaration of Conflicts of Interest**

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45 None.
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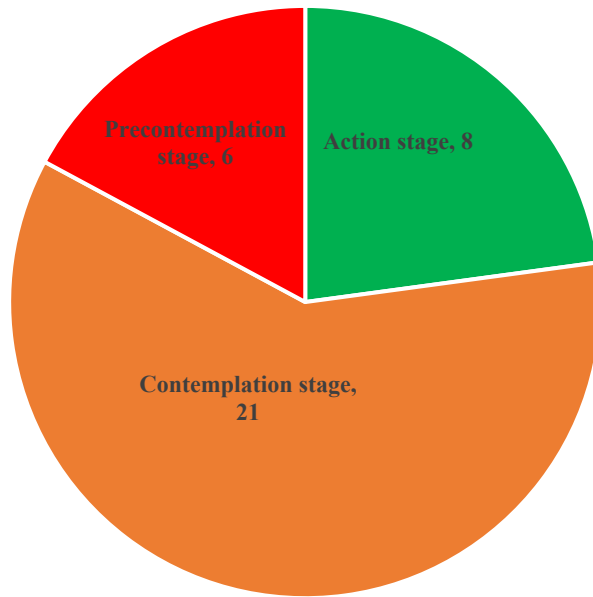
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Figure 1. Indication of Clients' Readiness to Change using URICA scores



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