

“Right person, right time, right care with no waiting times”

Systems dynamics analysis of interim findings of the Independent Inquiry into Mental Health Services in Tayside and a group model building workshop with student practitioners

Dr. Karin Diaconu  
September 2019

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## Introduction

### The Independent Inquiry into Mental Health Services Tayside

Beginning in September 2018, the Independent Inquiry was convened to address concerns raised by the Scottish Parliament about the accessibility, safety, quality and standards of care provided by mental health services in Tayside. The Inquiry has collected both written and oral evidence (encompassing over 200 written documents and evidence from 70 oral sessions) from patients and their families, employees and other professionals active in the service and in third sector organisations in Angus, Dundee and Perth & Kinross (Interim Report 2019). The purpose of the Inquiry is to analyse all available evidence and make informed and evidence-based recommendations for improvement of the service.

### Systems dynamics study

Analyses of the evidence collected by the Inquiry is ongoing, however preliminary findings are summarized in the Inquiry's Interim Report (2019). Complementarily, the Inquiry has sought to conduct a study exploring the underlying dynamics of the mental health system in Tayside. The purpose of this systems dynamics analysis is to a) identify interactions and pathways influencing the services' function and quality of care currently and b) identify areas suitable for improvement alongside concrete recommendations for intervention.

The systems dynamics study was organized in two phases, offering the chance for triangulation of findings. In Phase 1, the Interim Report (2019) was reviewed to identify variables and pathways affecting patient access to care, patient sense of safety, quality of care, organizational learning and governance (including issues of leadership). An initial concept model capturing the pathways of action between these variables was then developed and analysed, and three sub-models focused on crisis service and community care, general practice and mental health care services (in- and out-patient) and leadership and human resource capacity were elaborated.

In Phase 2, a participatory group model building workshop with student practitioners and quality improvement managers active in the mental health service in Tayside was convened. In this workshop, participants were prompted to elaborate a concept model focused on the same five themes as above (patient access to care, patient sense of safety, quality of care, organizational learning and governance). Participants were further invited to identify areas where the service is particularly fragile and those suitable for improvement; and to additionally elaborate and prioritize intervention strategies.

### Aim

The purpose of the systems dynamics analysis was to identify the underlying dynamics affecting service function and quality of care and identify concrete recommendations for improvement of the mental health service in Tayside.

## Methods

### Systems dynamics modelling

There is increasing recognition among health practitioners, policy makers and researchers that health system performance – particularly in high income settings – has largely stagnated. Braithwaite (2018) notes that “60% of care is based on evidence or guidelines; the system wastes about 30% of all health expenditure; and some 10% of patients experience an adverse event.” While previous improvements were secured largely by the introduction of standardized and evidence-care regimens and linear quality improvement strategies, to secure further gains it is now necessary to move beyond linear thinking and identify how and where system complexity hampers system performance.

Systems dynamics methods (SDM) have originated in engineering and management science (Sterman, 2002) two disciplines where the study of feedback loops among multiple components of highly complex systems is necessary. The methods have seen increasing application in health service and systems research (Chang *et al.*, 2017), including to study care for HIV and tuberculosis (Atun *et al.*, 2007), service delivery in humanitarian crisis situations (Ager *et al.*, 2015) as well as health system readiness to offer chronic care in fragile situations (Queen Margaret University, no date). SDM encompasses both qualitative methods (including participatory methods such as group model building) as well as quantitative simulation methods (so called stock and flow simulations).

SDM seeks to identify and document system complexity, as well as offer insights into the underlying dynamics which drive systems behaviour. (Sterman, 2002) In health research, these dynamics extend beyond system hardware (i.e. expansion of physical resources of the system) to include systems software (e.g. issues of governance, information flows and cultural norms) (Sheikh *et al.*, 2011). Using a varied set of tools (including systematic reviews, group model building), causal loop models depicting the dynamics of a system are built and the leverage points (Meadows, 1999) affecting system behaviour then identified and explored as potential areas of action and system change.

### Part 1: Systems analysis of evidence summarized in Interim Report

The Interim Report (May 2019) of the Independent Inquiry into Mental Health Services in Tayside was reviewed to identify key issues and themes affecting underlying systems dynamics. Variables corresponding to each of the themes listed across the five areas of the report (patient access to care, patient sense of safety, quality of care, organizational learning and governance) were extracted and an initial concept model (i.e. a precursor to a causal loop model) capturing the pathways of action between different variables was developed.

The concept model underwent a further analysis. First, sub-areas of the model depicting different aspects of the system were identified; specifically, three sub-models corresponding to crisis service and community care, general practice and mental health care services (in- and out-patient) and leadership and human resource capacity were elaborated. Second, each model was reviewed for completion to ensure that key pathways depicted were complete. Third, feedback loops within each model were identified and documented.

## Part 2: Group model building workshop

The above concept models were used to elaborate the agenda of a group model building workshop with student practitioners, and quality improvement managers, active across the mental health services in NHS Tayside. (Appendix) Group model building is a participatory process whereby an experienced facilitator and/or team, guide participants in the development of a causal loop model via the use of discrete short exercises, otherwise known as scripts. The process is intended to generate dialogue among participants and capture a breadth of views, not necessarily to achieve consensus.

### Workshop aims

The workshop was convened on August 26<sup>th</sup> at the University of Dundee and aimed to:

- a) elaborate a concept model focused on patient access to care, patient sense of safety, quality of care, organizational learning and governance (thus enabling triangulation with findings presented in the Interim Report and Phase 1 systems analysis)
- b) identify areas where the system was fragile and/or suitable for improvement; and in association with this,
- c) elaborate a vision for an improved service, including identification and prioritization of intervention strategies.

### Participants

Student practitioners active in the delivery of mental health services in Tayside were invited via email to take part in a one-day workshop. Invitations were issued to students from Dundee and Abertay Universities. Overall 14 participants agreed to take part, approx. 50% of which were women; all participants attended the start of the workshop, however only 11 completed the whole day. The workshop was additionally joined by two quality improvement advisors for the mental health service in Tayside. Participants were split into two groups initially, however worked as one group to elaborate the causal loop model and for further exercises.

### Scripts

Scripts (i.e. process notes) corresponding to the activities used to prompt participants in the model building process are available in the Appendix. Briefly, participants started by elaborating a vision for the day and noting their expectations for what was to be achieved. This was followed by a rich picture activity where participants in the two separate groups were invited to draw the care seeking journeys of adults and children/adolescents respectively; rich pictures also captured issues affecting quality of care once contact was made with the service. Further, variables affecting the care seeking journey and quality of care were identified and compared between the two groups. Given limited differences in these variables and preceding pictures, groups then proceeded to jointly elaborate a concept model and further identified areas particularly fragile/suitable for intervention by individually casting votes. Once this was complete, a vision for the future service was elaborated, including strategies for service improvement. As a final step, participants were asked to reflect on the likely impact (on patients and the service itself) and feasibility of implementation of elaborated strategies.

### Analysis

Analyses proceeded similarly to Part 1. The elaborated concept model first underwent cleaning (i.e. variable names were clarified, arrow direction reviewed to ensure internally consistent logic) and further, feedback loops affecting health service utilization and delivery of care were identified. Fragility and intervention points highlighted by participants are noted in colour (see legend of Figures).

### Triangulation between systems dynamics studies (part 1 and 2)

Findings and models of the above workshop analysis were contrasted with those from the Interim Report analysis. Overall, models focused on access and quality of care were largely concordant, however the model focused on leadership and governance was not as well elaborated in the workshop. Given the profile of participants this is not surprising: participants had more experience of the direct care process and therefore provided more detail on this, however had less experience and/or contact with service management and leadership structures and therefore could not speak to these.

### Limitations

Three principal limitations apply to findings presented here. First, the initial concept models elaborated from data in the Interim Report were elaborated from already analysed data, rather than primary sources. Some nuance may therefore be lost. However, the purpose of systems analysis is to capture and describe core dynamics and only highlight nuance when particularly relevant, therefore we can be confident that core dynamics would be captured. Second, in relation to the group model building workshop, student practitioners were accompanied by two quality improvement advisors which may have resulted in power imbalance. The facilitator carefully observed group dynamics and as necessary intervened when more senior members appeared to dominate the discussion; overall power imbalance is therefore unlikely to affect findings. Third, elaborated models on governance and/or leadership are largely descriptive. This may be because limited evidence on these two components was submitted to the Inquiry and because no representatives at these levels were invited to the group model building workshop.

## Findings

### Findings of group model building workshop

#### Rich pictures

Participants focused on the health seeking journey of adults experiencing a mental health problem (Figure 1), and identified the GP as a first point of call. Participants noted that the GP may signpost the person to different services, however given high waiting times and likely limited availability of beds for inpatient services (attributed to limited funding for the NHS), it was likely that the GP themselves had to initiate treatment. In most cases, treatment would consist principally of medication and include follow-up if possible via a community mental health nurse. However, participants noted that the referral routes and availability of mental health nurses fluctuated across Tayside and Scotland; remote communities in particular were noted to have access to a limited pool of resources. Persons residing in these areas and other deprived communities were also noted to be less likely to seek care for mental health reasons.

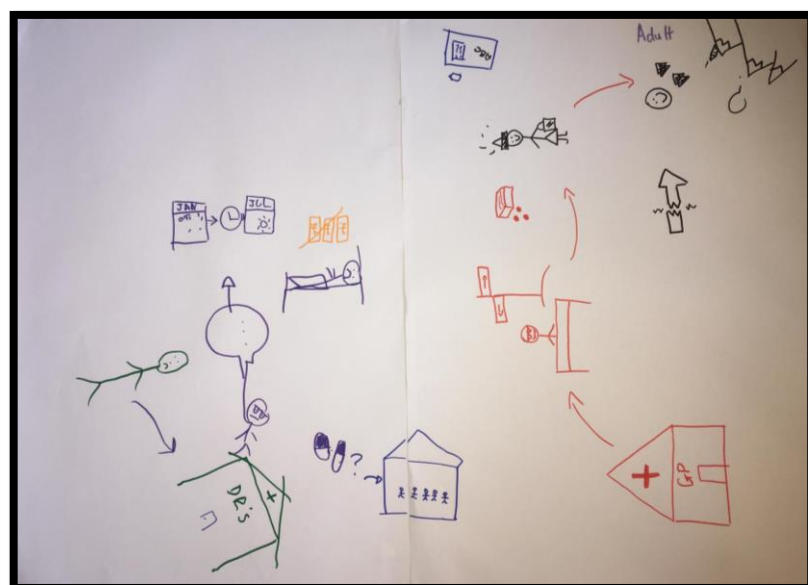


Figure 1: Rich picture: Health seeking and care delivery - adults

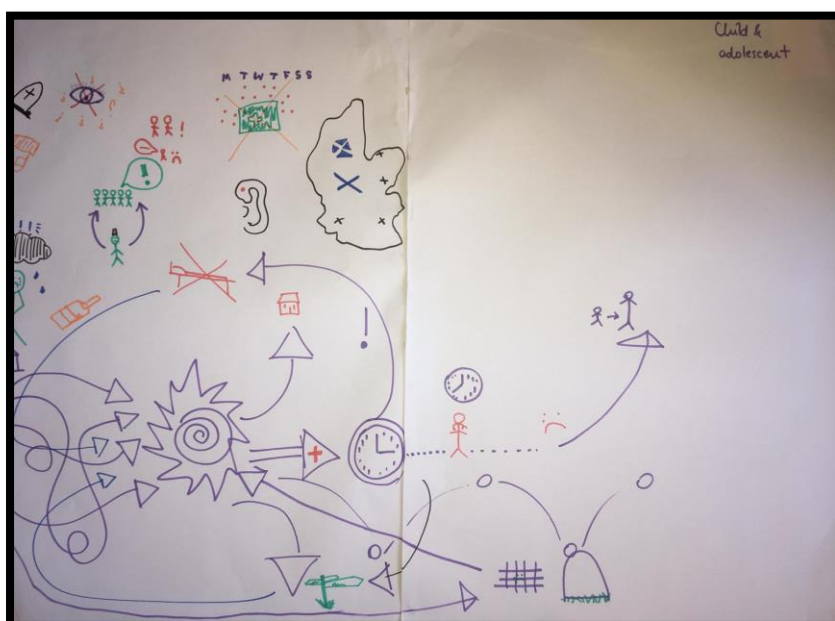


Figure 2: Rich picture: Health seeking - children and adolescents

Participants focused on elaborating the health seeking journeys of children and adolescents (Figure 2) noted that a myriad of options existed for accessing care. Given the emphasis placed on safeguarding children and adolescents in general, it was likelier for other persons (e.g. parents, teachers among others) to pick up on changes in a persons' behaviour and further signpost the family towards a relevant service.

However, participants in this group also emphasized the long waiting times that existed for

accessing services, including the challenges these presented when adolescents were first picked up as requiring care, however then transitioned to being an adult when first accessing the service. Differences in the availability and delivery of services across Scotland were also discussed, including the absence of appropriate inpatient facilities in some regions.

#### Causal loop model elaborated

Upon cleaning and refinement of the model generated by workshop participants, two smaller causal loop models could be distinguished.

Figure 3 presents a model focused on population health seeking behaviours. Participants focused largely on non-emergency related health seeking behaviours and discussed what would prompt someone to seek initial help relating to a mental health issue. The model highlights the promotive environment surrounding this initial health seeking behaviour in blue. Participants spoke about how the health service needed to create an environment whereby the communities' knowledge of health, wellbeing and a healthy life-style (and as part of that mental health), and of the health system itself and how to navigate this, was strengthened. Creating this type of environment or strengthening would both strengthen personal willingness to present with a mental health problem and also result in increased normalization of mental health and thus strengthen the availability of support structures in the community. Participants emphasised that stigma, as driven by cultural traditions and by negative historical attitudes towards mental health, continued to pose a significant barrier to health seeking, particularly among men and in deprived communities. At times, stigma was also noted to be perpetuated by health care staff and their outdated biased attitudes towards mental health.

The group also noted that trust, belief in the system (by both communities and health staff) and the health systems' reputation played a significant role in promoting health seeking in general (see orange loop). The reputation of the mental health service in Tayside was noted to be compromised – previous negative experiences of the service by patients and largely negative imbalanced portrayal of the service in the media were seen to contribute to this. Trust was seen to be strengthened by previous positive experiences within the service – for example, by smooth transitions between child/adolescent and adult services. Similarly, however, previous experiences may undermine health seeking – e.g. participants spoke about how it was difficult for patients to reconcile that general practitioners are there to also offer mental health services given their historical predominant emphasis on physical health.

Reasons for why the demand on the mental health service continue to be particularly high are identified in green. Participants placed the ability of patients to open up about their problems at the centre of the model and noted that systemic forms of rationing (e.g. via short 10-minute appointment times in primary care or via long waiting times in the specialist mental health service) compromised trust in the service and also a patients' ability to honestly relate his/her problem to a practitioner. In such conditions, the necessity for repeat appointments increases and thus results in patients taking up more space and resources than would potentially be necessary; similarly, participants noted that this cycle

of repeat appointments is unlikely to address root causes of problems and may therefore actually increase the severity of problems for patients.

Further, Figure 4 identifies the overarching dynamics and system resource constraints which impact on the systems' ability to deliver services and meet patient demand. Overall, participants identified NHS Tayside's current emphasis on medical curative care and culture of medicalization as a root cause for the challenges the service is currently facing.

Participants noted for example that community services and mental health and psychosocial supports had historically seen de-investment in favour of investments in clinical care. In the long term, this did not help prevent the levels of mental ill health that were occurring at community levels and indeed resulted in a growth of the overall burden and severity of disease that now has to be managed clinically by the service (see blue loop in Figure 4). Participants also spoke of how investments into the clinical service had failed to keep pace with increased demand: particularly in relation to human resources where a lack of speciality mix was seen as a major challenge, but also in relation to physical infrastructure (e.g. participants spoke of outdated IT systems). Given the services' current situation, participants noted that greater third sector involvement would be needed to put in place community support and also help manage demand on the NHS.

#### Areas of fragility and intervention

Areas of fragility and intervention identified by participants are listed in Table 1. Overall, participants identified areas of fragility and intervention which related to general knowledge of mental health (both of communities and staff) but also on the resource constraints of the service and challenges within the service (e.g. high pressure and workload of staff). Participants discussed how the media in particular was not helping combat stigma against mental health and instead also contributed towards undermining confidence of the population in the service. While participants acknowledged that media should highlight issues with the service (which they acknowledged existed), it was felt that media lacked a balanced view of the service as a whole.

In addition to financing and infrastructure challenges, participants also highlighted the limited availability of qualified staff for delivery of MH services. In particular, student practitioners noted that older staff often had outdated views in regards to mental health; while these views were no longer supported by evidence, students did not feel that either they or leadership in the service was challenging staff on their outdated thinking.

A high staff workload and breakdowns in communication between agencies delivering services (but also within the same service) were highlighted as major service delivery challenges. Student practitioners highlighted how the high workload would eventually erode staff's wellbeing and lead to increased absenteeism or to staff leaving the service in favour of other employers.

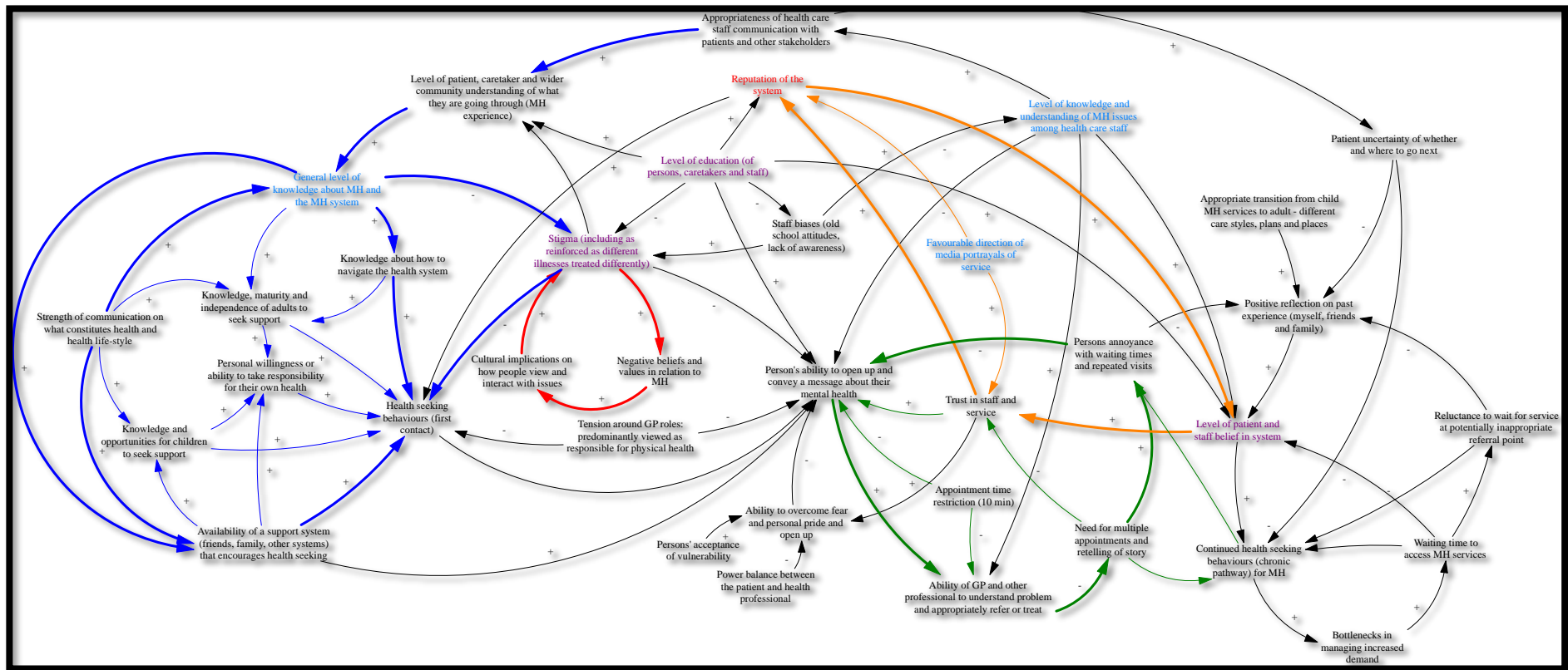


Figure 3: Causal loop model on determinants of health seeking behaviours (elaborated during group model building session)

Legend:

Variables by colour: purple – areas of fragility and potential intervention; blue – areas of intervention; red – areas of fragility.

Arrows by colour: blue – feedback loop around health seeking and strengthening wellbeing by strengthening community knowledge of MH; red – feedback loop identifying influences on stigma; orange – feedback loop around trust in system and influences on reputation and belief in the system; green – feedback loop around restrictions on appointment time and influences on repeat visits.

Client: Independent Inquiry into Mental Health Services in Tayside

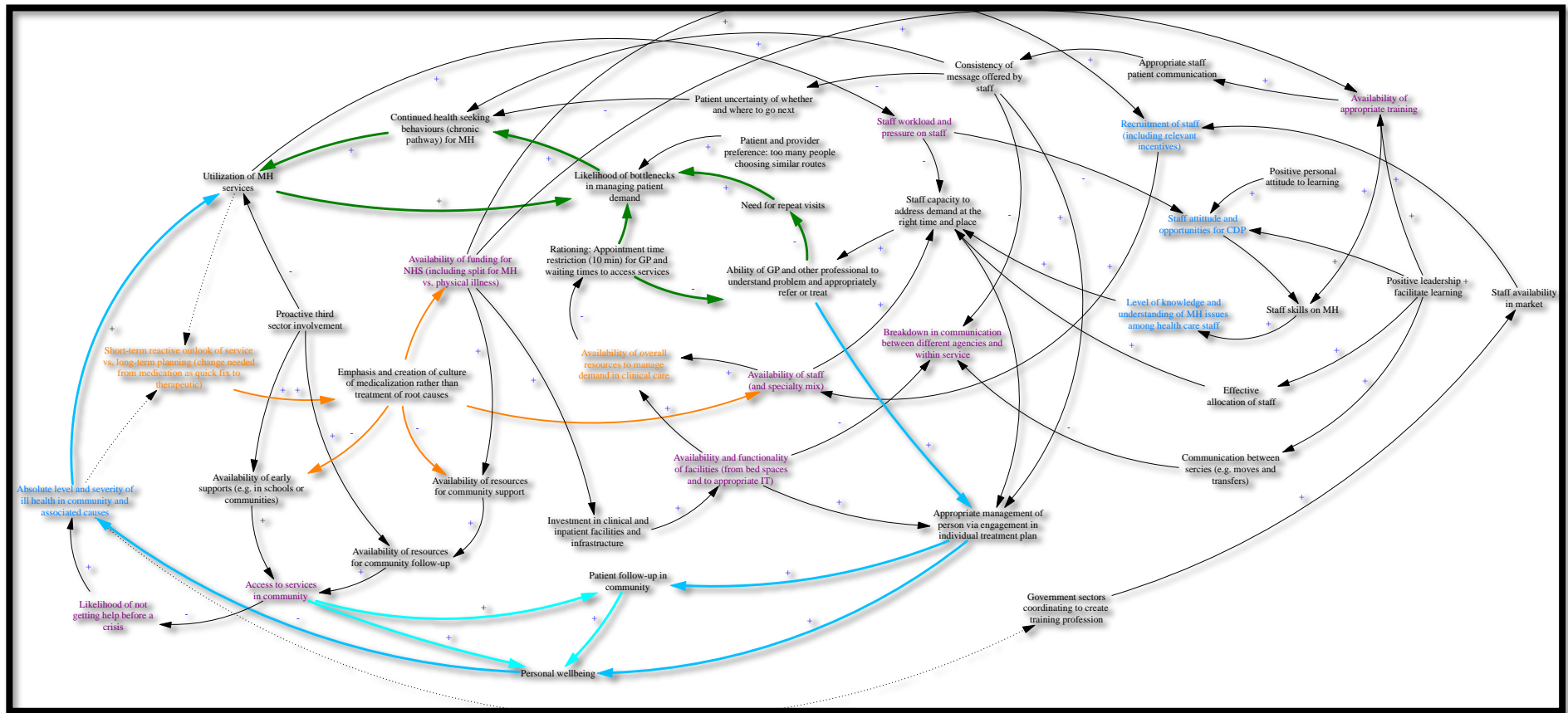


Figure 4: Systems influences on bottlenecks in management of MH service demand

Legend:

Variables by colour: purple – areas of fragility and potential intervention; blue – areas of intervention; orange – added during analysis.

Arrows by colour: blue– feedback loops around mental health service utilization for those persons already accessing care; blue – feedback loops depicting discharge into community and how availability of community services would affect overall service demand; orange – pathways flowing from central variable “Emphasis and creation of culture of medicalization rather than treatment of root causes”.

**Table 1: Areas of fragility and intervention identified by participants**

<b>Area</b>	<b>Areas of fragility and intervention (i.e. participants placed both fragility and intervention votes on area)</b>	<b>Areas of intervention (areas identified for intervention only)</b>
<b>General awareness of MH and reputation of the service</b>	Level of education of communities, persons and staff in the service	General level of knowledge about MH and the MH system
<b>MH and reputation of the service</b>	Stigma against MH in community and within the service given differential treatment of MH	Direction of media in relation to NHS
<b>MH and reputation of the service</b>	Level of patient and staff belief in system (reputation of the system identified as fragile only)	
<b>Financing, human resource and infrastructure inputs</b>	Availability of funding for the NHS in general, and also the split of funding dedicated to MH vs. physical illness	
<b>Financing, human resource and infrastructure inputs</b>	Availability of staff and appropriate training for staff to strengthen their MH skills	Level and knowledge of mental health staff, including recruitment of staff and opportunities for staff to attend CPD and environment conducive to positive attitudes towards CPD
<b>Financing, human resource and infrastructure inputs</b>	Availability of appropriate and functional infrastructure	
<b>Service availability and demand</b>	Availability of services in the community (both preventive, promotive and for follow-up)	Absolute level and severity of ill health in community and their causes
<b>Service availability and demand</b>	Likelihood of not getting help pre-crisis	
<b>Service delivery challenges</b>	Staff workload	
<b>Service delivery challenges</b>	Breakdown in communication between agencies and within the service	

## Vision for the service

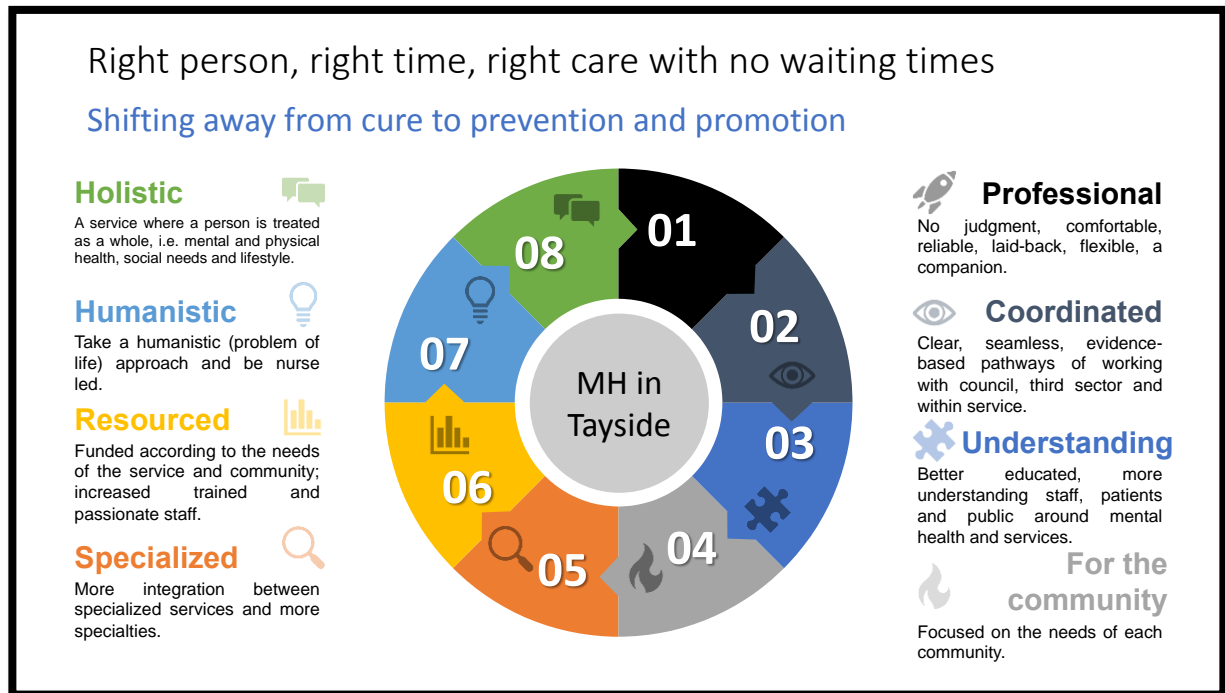


Figure 5: Vision for the Mental Health service in Tayside (© Copyright Showeet.com – Creative & Free PowerPoint Templates)

Participants jointly elaborated a vision for the Mental Health Service in Tayside (Figure 5) focused on shifting away from curative to preventive and promotive care and promising to put in place the “right person, right time, right care with no waiting times”. Overall, participants recognized their vision was similar to the current vision and ethos of the service, however improved upon this in a few critical respects:

- It promised to be holistic and humanistic and thus to treat persons as a whole, addressing both physical and mental health issues and being more approachable and focused on actual problems of life rather than clinical diagnoses.
- It promised to be nurse rather than physician led, thus shifting emphasis away from curative care to a service intended to support communities cohesively through their lifetime.
- It promised to be responsive to communities and put in place mechanisms for participatory feedback and recognize the need for specialisms and specialist support – particularly here participants noted the need to convene specialist teams to deal with ever increasing diagnoses of personality disorders.

## Priority interventions

Towards their vision, participants jointly elaborated a set of 18 interventions intended to improve on the current service.

1. Reconsider how and when diagnostic labels are used: in communication with patients, stop using diagnostic labelling and instead focus on a patient-friendly description of the issue; ensure that further access to care is not dependent upon prior diagnosis.

2. Develop a MH framework for awareness raising for schools (tailored as needed to specific ages and locations), including talks in schools on MH and associated pathways to seeking support.
3. Develop a MH media engagement framework, including reflection on how to engage with the media and ensure that the service is not afraid to let its guard down and allow the media in.
4. Develop a MH framework for awareness raising at the workplace: as the police is first aid trained, so other workplaces could follow. A workforce that is informed of the relevance of trauma, sensitive to its impacts and knew mental health first aid could be of huge benefit in signposting to appropriate care and promoting wellbeing.
5. Monitor and supervise staff in the service: ensure that there are incentives in place and monitoring opportunities (objective, blind assessments) to see how all staff perform in relation to mental health.
6. In antenatal and parenting classes, place bigger emphasis on mental health, including education on how to handle traumatic events and adverse childhood experiences.
7. All nurses to have training on mental and physical health.
8. Create a learning environment: failure will happen and ensure that the environment does not penalize this but is set up to learn; includes leadership training and joined up thinking, including acceptance that individual mistakes are systems' mistakes.
9. Allow students to choose a specialty in their final degree year.
10. Create a directory that summarizes what is available where, for whom, and under what criteria. Make this available for all NHS and third sector staff.
11. Host regular community workshops to ensure the service is identifying gaps and listening and responding to community priorities.
12. If possible, offer services for hard to reach groups at their relevant workplace or appropriate locale – e.g. men in trades need to be seen elsewhere.
13. Ensure meetings are held routinely to coordinate with the third sector.
14. Ensure appropriate balance of funding for preventive and curative care, including in outpatient and inpatient settings.
15. Ensure improved planning, including means testing where funding should be allocated and for what (staff, service, facilities).
16. Ensure more multi-disciplinary team meetings can be hosted – will help with long-term prevention.
17. Invest in a co-designed user-friendly IT infrastructure.
18. Invest in the use of electronic means of communication (conference calls) for delivery of care.

Participants were asked to prioritize interventions according to their impact and feasibility of implementation – both considered both in terms of patient responses as well as overarching systems dynamics. Priority interventions for both the system and patients are noted in Figure 6 and refer to interventions 1, 2, 5, 10, 11, 17 and 18. The interventions are consistent with the elaborated vision for the service and include strategies that could help alleviate the burden of both ill-health in the community (e.g. by raising awareness in schools), ensure coordination among mental health service providers (e.g. by creating a directory of providers) as well as improving community- health systems relations (e.g. by ensuring mechanisms for feedback are in place at all times).

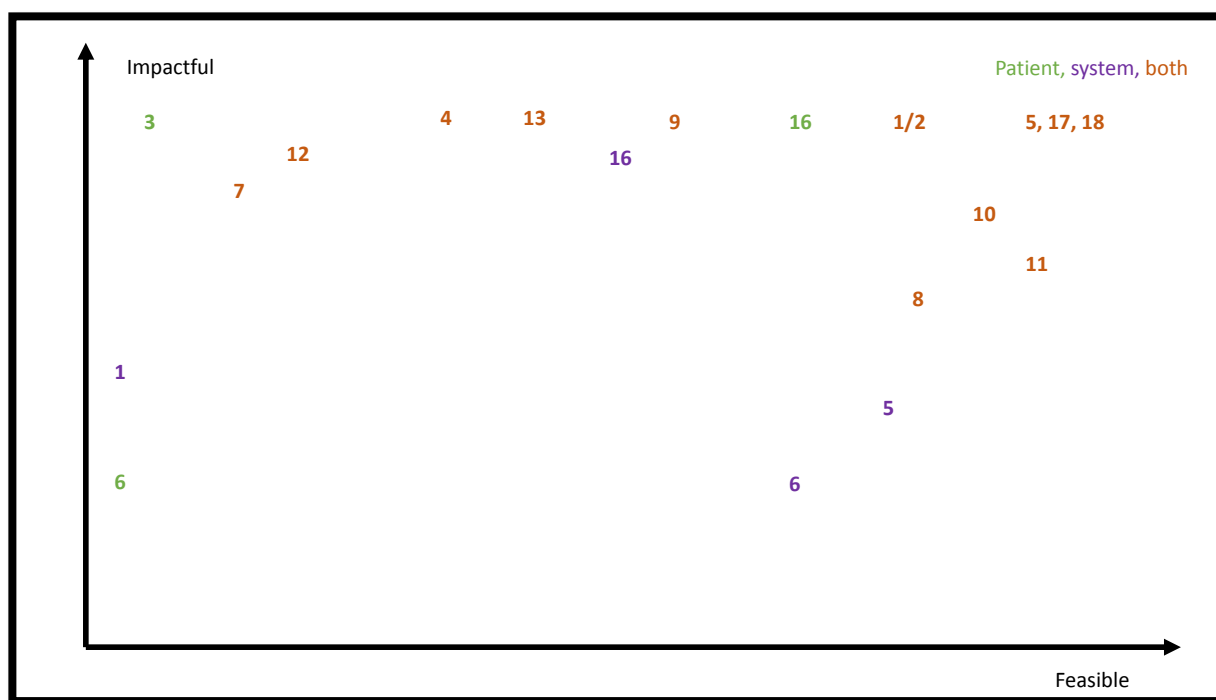


Figure 6: Prioritization of interventions (numbers refer to text)

## Concluding remarks: triangulated findings

The systems analysis of findings presented in the Interim Report of the Inquiry and the analysis of the group model building session identify three core themes which speak to the underlying dynamics of the mental health service in Tayside. First, it is clear the service is operating according to a short-term vision which places emphasis on reacting to current increases in service demand rather than reflecting on how to meet long-term trends in the burden of mental ill-health in communities. Both group model building participants and findings of the report highlight how challenges in meeting patient demand have largely driven the service to enact demand stabilizing strategies (e.g. via rationing and enacting increased waiting times) and further led to the service emphasizing a medicalized approach to care (i.e. emphasizing care for severe cases and in medical form, likely via medication). While this approach has kept the service afloat in the short term, it has also now bred resentment within communities and affected the services' reputation.

Second, both sources of evidence emphasize that coordination among different types of providers – both within the service and with the third sector – presents a challenge currently. Coordination is key to ensuring smooth patient flow, yet is now a neglected area given the high workload pressures placed on staff. Group model building workshop participants highlighted the need for coordination with specialist teams in particular; practitioners spoke of the need to have teams focused on personality disorders and the report highlighted the need for substance use specialists.

At the core of the services' difficulties, findings presented here highlight the limited availability of trained staff, and further, the lack of organizational learning and likely

associated absence of leadership that creates an environment conducive learning, including associated learning processes and practices. Further research and dialogue with service leadership in particular will be necessary to identify opportunities for system strengthening at this level.


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## Appendix

### Group model building workshop, 26<sup>th</sup> August 2019 Agenda and scripts

Time	Activity	Adaptation notes
09:30	<p><b>Welcome and introductions</b></p> <p>Introducing the inquiry, its aims and principles (Denise Jackson) Introducing the workshop, methods to be used during the day</p>	
10:00	<p><b>Expectations for the day – hopes and fears exercise</b></p> <p>Using post-its, participants will be asked to identify one hope and one fear they have relating to the workshop, including expectations. Issues will be grouped thematically and discussed, the facilitator will then introduce the principles of engagement for the day.</p>	Colour coded: red fears, green hopes.
10:15	<p><b>Rich picture</b></p> <p>On flipcharts, participants will be asked to draw rich pictures (as per soft systems' methodology) depicting:</p> <ul style="list-style-type: none"> <li>○ Journey to accessing support of an adult with a mental health need</li> <li>○ Journey to accessing support of an adolescent or child with a mental health need</li> <li>○ Issues affecting a persons' wellbeing once they have accessed the service</li> </ul> <p>Participants will be asked to reflect on issues affecting the organization and quality of care.</p>	One group focused on adults; one group on children and adolescents.
10:45	<p><b>Variable elicitation</b></p> <p>On post-its, each participant will be asked to identify the top 3 factors:</p> <ul style="list-style-type: none"> <li>- Resulting in bottlenecks in patient access to care (initial or further referral)</li> <li>- Affecting quality of care (including continuity, treatment management, communication with patients)</li> </ul>	<p>Separately done in groups, focused as above.</p> <p>Intermediate assessment: variables largely similar so proceeding to elaboration of one model is possible. (Main difference: children and adolescents receive more support, adult independence emphasized.)</p>
11:00	<p><b>Causal loop model elaboration</b></p> <p>First, participants will be asked to agree a boundary for the model to be developed: i.e. should we include community care or focus on general practice/mental health services (out and inpatient) more specifically. Using variables identified previously, we will then proceed to elaborate causal links, stepwise. The facilitator will demonstrate how this is done, however will then hand over to participants.</p>	Notes: Main focus of the model (given the participant group) is on community relations and on what affects patients' ability to open up once accessing service. Limited discussion and/or elaboration of model in area of governance and leadership.

	The facilitator will project the models developed previously based on the Inquiry's main data and ask whether and how participants' want to change their model.	
	Lunch break	
14:00	<p><b>Identifying areas of fragility and intervention</b></p> <p>Each participant will be given 5 votes to distribute as they like (i.e. all votes on one issue or splitting the votes as desired) on the developed models to identify:</p> <ul style="list-style-type: none"> <li>- Areas of fragility / weakness in the system</li> <li>- Areas that are suitable or prioritized for intervention</li> </ul> <p>The facilitator will discuss the areas in turn with participants to understand how/why votes were distributed in a specific manner.</p>	
14:15	<p><b>Vision and goal of the service</b></p> <p>On post-its, each participant will be asked to identify top 2 expectations for a future service. The facilitator will gather all post-its and with participants discuss what the vision and goal of the service should be.</p>	Notes: need for improved specialized care and/or coordination among specialized providers introduced.
14:35	<p><b>Elaborating interventions</b></p> <p>The facilitator will introduce the idea of leverage points to participants.</p> <p>Reflecting on the areas marked in the previous exercise as well as the elaborated vision for the service, each participant will be asked to note down on post-it's the top 3 interventions to change the underlying dynamics of the system.</p> <p>The facilitator will discuss all interventions in turn, elaborating their mechanism of action and categorizing them against their impact and feasibility on a diagram as below.</p> 	
16:00	<b>Close</b>	