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Scottish School of Primary Care

GP Clusters

Briefing

Paper 9

Mental Health

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Collaborative Quality Improvement in General Practice Clusters

This paper is the ninth in a series that relates to areas of quality and safety on which general practice clusters could usefully focus improvement activity. Each paper summarises research, guidelines and other evidence about areas of care which can be improved, and improvement methods and interventions.

Mental Health

It is estimated that approximately 90% of mental illness, including severe mental illness, is managed in primary care. Common Mental Health Problems (CMHP) are estimated to feature in approximately one third of primary care consultations and are a common co-morbidity with long term physical conditions. The range of problems and their severity varies such that no single approach to management can be considered. Instead, the Stepped Care Approach (Figure 1) has been advocated where the most effective yet least resource intensive treatment is delivered to patients first and subsequently 'stepped up' to more intensive/ specialist services as clinically required. With common mental health problems the threshold at which medication management is required and the effectiveness of medications for mild symptoms is often a grey area. There is also recognition of the social determinants underlying many mental health problems. This paper reviews current approaches to the management of common mental health conditions in primary care, and considers those that are likely to improve patients' quality of life, and make better use of primary and other healthcare resources.

The problem

Common mental health disorders can affect up to 15-17% of the population at any one time and approximately one quarter of the UK population will experience some form of mental health disorder during their lifetime[1]. Common mental health disorders include depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder and social anxiety disorder. The most common of these, depression and anxiety disorders, have a high risk of recurrence (relapse rates of 60% within 1 year of recovery are commonly reported), with this risk increasing with each subsequent episode[2-3]. More than half of people aged 16 to 64 years who meet the diagnostic criteria for at least one common mental health disorder experience comorbid anxiety and depressive disorders[1, 4, 5]. A number of demographic and socioeconomic factors are associated with a higher risk of disorders, including gender, age, marital status, ethnicity and socio-economic deprivation[2]. The majority of these disorders are managed in primary care (estimated at 90%)[3].

The Problem of Definition

There is yet to be a universally agreed set of criteria for the diagnosis of the various common mental health disorders; and criteria that can adequately or unequivocally distinguish between severe, moderate and mild forms of these disorders. There are areas of ambiguity such as: whether depression is a categorical concept or exists on a continuum of normal functioning[6]; the relationship between depression and anxiety and whether they are co-existing conditions or a single pathological condition[7]; and the direction of the relationship between depression and co-morbid physical disease or illness[8]. Many primary care patients present with a mixture of physical, psychological/emotional and social problems, each impacting on how they experience their mental health symptoms. General practitioners often manage sub-threshold disorders which do not meet formal diagnostic criteria but which nonetheless represent significant levels of impairment. It is in this context of complexity in which GPs make their assessment of patient needs and decide how to respond to these needs. This might explain why a significant amount of common mental disorders remain undetected and untreated, especially those milder forms of illness.

Managing common mental health disorders in primary care

The range of problems and their severity varies such that no single approach to management can be considered. Instead, the Stepped Care Approach (Figure 1) has been advocated where the most effective yet least resource intensive treatment is delivered to patients first and subsequently 'stepped up' to more intensive/ specialist services as clinically required[1,9].

There have been some attempts to improve the quality of care for people with depression in the UK. The Quality and Outcomes Framework (QOF) indicators for Depression previously recommended that a biopsychosocial assessment be carried out at the same time as the diagnosis of depression was made, and that a review is conducted normally within 2 weeks of diagnosis. Additionally, for those with specific long term conditions such as Coronary Heart Disease and Diabetes Mellitus, the QOF had recommended screening for depression using 2 questions, followed by an assessment if the patient scored 1 or more on either question[10].

The QOF ceased to exist from April 2016 and is no longer a driver for quality in primary care mental health, with the danger that case finding in those with long term conditions becomes a low priority, alongside attention to a bio-psychosocial assessment of needs for those diagnosed with a common mental disorder.

In the UK, the NICE guideline [CG123] "Common mental health problems: identification and pathways to care" is the main source of evidence for directing care management of these disorders[2, 3]. This guideline has been specifically focused on primary care with the aims of: improving access to services (including primary care services themselves); improving identification and recognition of disorders; and providing advice on the principles that need to be adopted to develop

appropriate referral and local care pathways. Based on patient centred care principles, treatment and care should take into account patients' needs and preferences. People with a common mental health disorder should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. This paper outlines some of the key recommendations from this guideline, including a focus on improving access to services and the development of local care pathways which should be valuable for General Practice clusters in taking improvement in mental health forwards.

DEP indicator 001 (NICE 2012 menu NM49)

The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have had a bio-psychosocial assessment by the point of diagnosis. The completion of the assessment is to be recorded on the same day as the diagnosis is recorded.

DEP indicator 002 (NICE 2012 menu ID: NM50)

The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier that 10 days after and not later than 35 days after the date of diagnosis.

Identification

NICE [CG123] still recommends being alert to possible depression in at risk populations (such as people with a past history of depression, possible somatic symptoms of depression, or a chronic physical health problem with associated functional impairment: see Figure 2 below) and using 2 screening questions[10]:

During the past month

1. *Have you **often** been bothered by feeling down depressed or hopeless?*
2. *Have you **often** been bothered by little interest or pleasure in doing things?*

If a person answers 'yes' to either of the above questions (score of 1 or more) they recommend further assessment (see below).

Similar advice is given in relation to anxiety disorders and the need to be alert to at risk populations (such as people with a past history of an anxiety disorder, possible somatic symptoms of an anxiety disorder or in those who have experienced a recent traumatic event) and using 2 screening questions for anxiety related disorders as follows[11]:

Over the past 2 weeks, how often have you been bothered by the following problems

1. *Feeling nervous, anxious or on edge?*
2. *Being unable to stop or control worrying?*

If the person scores three or more on the GAD-2 scale (the first 2 questions of the GAD-7[11]) they should be further assessed for an anxiety disorder. If the person scores less than three on the GAD-2 scale, but still gives concern they recommend asking the following: 'Do you find yourself avoiding places or activities and does this cause you problems?'. If the person answers 'yes' to this question they should be further assessed for an anxiety disorder.

Assessment

Assessment should be conducted using a diagnostic or problem identification tool or algorithm such as a validated measure relevant to the disorder or problem being assessed. These can include, for example, PHQ -9[12], the HADS[13] or GAD-7[11] to inform the assessment, and support the evaluation of any intervention. For the most commonly used depression assessment tool in the UK, the PHQ-9, a cut-off score of 10 may be a useful indicator of depression[2].

However, there is uncertainty as to whether screening is associated with improved outcomes in primary care[14,15]. The use of such tools should bring added value to the patient and the GP, for example: in facilitating communication between doctor and patient, particularly when patients somatise symptoms; and facilitating communication between GPs and specialist services. In managing their patients, general practitioners also understand the fluctuating or transient nature of their patient's emotional state (and which can also be exacerbated by their current social circumstances) and the impact that symptoms are currently having on their day to day lives (functioning). What is required is a more holistic assessment of need which does not focus solely on diagnosis but which also takes account of functional status/disability, duration and chronicity of symptoms, and any underlying social or physical problems.

Therefore, in addition to assessing symptoms and associated functional impairment, NICE also recommends considering how the following factors may have affected the development, course and severity of a person's presenting problem: a history of any mental health disorder; a history of a chronic physical health problem; any past experience of, and response to, care of children and young people should also be assessed, and if necessary local safeguarding procedures followed[2].

Depression in particular is also associated with a higher risk for suicide and people with a common mental treatments; the quality of interpersonal relationships; living conditions and social isolation; a family history of mental illness; a history of domestic violence or sexual abuse; employment and immigration status. If appropriate, the impact of the presenting problem on the health disorder should be directly asked about suicidal ideation and intent. If there is a risk of self-harm or suicide:

- assess whether the person has adequate social support and is aware of sources of help
- arrange help appropriate to the level of risk
- advise the person to seek further help if the situation deteriorates

Interventions at Primary Care Level

Evidence supports the use of time-limited psychological interventions to address mild to moderate mental health problems in primary care, and mechanisms to

link people to non-medical sources of support. In addition, there is a growing body of evidence in support of guided self-help approaches for common mental health problems.[16,17]

Guided self-help involves the role of a 'therapist' in delivering the self-help module to the patient and normally involves monitoring the progress of the patient in using the self-help module. There are many variations of this model, depending on the type and level of qualifications of the 'therapists' delivering the self-help materials: which may include the use of non-qualified self-help workers through to clinical psychologists supporting the delivery of CBT based self-help approaches. In the national *Doing Well by People with Depression Programme* established in Scotland, many sites found it was possible to deliver evidence based psychological interventions through non-traditional roles, such as self-help workers, lifestyle coaches, primary care mental health workers and lay support people.[18] The new Link Worker roles currently being evaluated in Scotland (see http://links.alliance-scotland.org.uk/) also show promise of impacting on patient outcomes and providing additional capacity and capability to support primary care. The **National Links Worker Programme** is a Scottish Government funded programme which aims at researching how the primary care team can mitigate the impact of the social determinants of health. The programme is being delivered as a partnership between the Health and Social Care Alliance (The ALLIANCE) and General Practitioners at the Deep End (The Deep End). These roles retain the use of the therapeutic relationship which is highly valued by patients.

The Role of Self-help and Self Care

There are many different conceptualisations of self-help, and across both professional and public perceptions the boundaries between self-help, guided self-help and psychological therapies often merge or differ, depending on the context in which they are being delivered[19]. Nonetheless, there is a growing body of evidence (particularly in the field of CBT-based approaches and including computerised/on-line CBT) in support of self-help approaches for common mental health problems[19]. The internet is proving a new way to increase access to guided self-help interventions. There are examples of free online self-help resources: devised to help people develop key life skills to help them tackle common life problems, such as low mood, anxiety, disrupted sleep and unhelpful thought patterns. Courses are typically based on cognitive behavioural therapy (CBT) approaches. These include Living Life to the Full: http://www.livinglifetothefull.com and Mood Gym: http://moodgym.anu.edu.au/ .

The SIGN Guideline 114 Non-pharmaceutical management of depression in adults January 2010, provides further guidance on self-help interventions[20].

It should be noted that self-help groups are not recommended for those with post-traumatic stress disorder (PTSD).

The Role of Social Support

It is now widely understood that social, economic and environmental factors have a significant influence on the mental health and well-being of people[2]. 'Social prescribing' or 'social referral' are terms used when healthcare practitioners link patients with non-medical sources of support within the community[21,22]. These might include opportunities for arts and creativity, physical activity, learning and volunteering, mutual aid, befriending and self-help, as well as support with, for example, benefits, housing, debt, employment, legal advice or parenting. Promoting the use of community and voluntary sector based services fits well a commitment to increasing patient choice and to addressing the social and economic determinants of health.

'Building healthy communities' is an approach which takes account of the roles that other public services (e.g. schools, higher education establishments, housing and employment agencies) and voluntary agencies can play in alleviating mental distress[23,24]. It is based on the notion that "mental health is everybody's business" but also requires building the capacity of other public and voluntary services to promote mental health and support recovery. The involvement of community development workers and joint arrangements across health and local government organisations can help to achieve some of these aims.

To facilitate the role of self-help and to increase the availability and use of social supports for the management of depression, it is essential to improve GP and patient access to information and resources. ***ALISS (A Local Information System for Scotland)*** is a search and collaboration tool for Health and Wellbeing resources in Scotland. It helps signpost people to community resources and enables communities to contribute information about the resources they have to offer e.g. places, groups, activities, opportunities, events, and services (see https://www.aliss.org/).

The Role of Pharmacological Interventions

Evidence reviewed within the National Institute for Clinical Excellence in England (NICE) does not generally support the use of pharmacological treatments (antidepressants) for people suffering from mild depression because the risk-benefit ratio is poor. This should be balanced by more appropriate prescribing for those with moderate to severe depression which would require an assessment of the level of severity, such as via the PHQ or HADS. Medication management support, such as in the chronic disease model, might also be appropriate for those with moderate to severe depression in receipt of antidepressant medication.

Improving access to services

NICE [CG123] recommends that primary and secondary care clinicians, managers (and commissioners where appropriate) should collaborate to develop local care pathways that promote access to services for people with common mental health disorders by:

- supporting the integrated delivery of services across primary and secondary care

- having clear and explicit criteria for entry to the service
- focusing on entry and not exclusion criteria
- having multiple means (including self-referral) to access the service
- providing multiple points of access that facilitate links with the wider healthcare system and community in which the service is located.

Developing local care pathways

NICE [CG123] recommends that primary and secondary care clinicians, managers (and commissioners where appropriate) should work together to design local care pathways that:

Promote a stepped-care model of service delivery that:

- provides the least intrusive, most effective intervention first
- has clear and explicit criteria for the thresholds determining access to and movement between the different levels of the pathway
- does not use single criteria such as symptom severity to determine movement between steps
- monitors progress and outcomes to ensure the most effective interventions are delivered and the person moves to a higher step if needed.

Provide an integrated programme of care across both primary and secondary care services. Pathways should:

- minimise the need for transition between different services or providers
- allow services to be built around the pathway and not the pathway around the services
- establish clear links (including access and entry points) to other care pathways (including those for physical healthcare needs)
- have designated staff who are responsible for the coordination of people's engagement with the pathway.

Ensure effective communication about the functioning of the local care pathway. There should be protocols for:

- sharing and communicating information with people with common mental health disorders, and where appropriate families and carers, about their care
- sharing and communicating information about the care of service users with other professionals (including GPs)
- communicating information between the services provided within the pathway
- communicating information to services outside the pathway.

Implementation in real-life NHS practice

The variety of common mental disorders, including their severity means that no one size fits all in terms of service provision and access. A range of different types of support delivered in a variety of settings are required. A local needs assessment could help to determine the structure and distribution of services, which should typically include delivery of:

- assessment and interventions outside normal working hours
- interventions in the person's home or other residential settings
- specialist assessment and interventions in non-traditional community-based settings (for example, community centres and social centres) and where appropriate, in conjunction with staff from those settings
- both generalist and specialist assessment and intervention services in primary care settings.

New ways of engaging with patients (for example, text messages, email, telephone and computers), for the purposes of assessment, treatment and outcome monitoring can also be helpful to increase engagement for people who may find it difficult to, or choose not to, attend a specific service. These mechanisms can also improve efficiency in conducting such tasks when services have limited resources for face-to-face delivery.

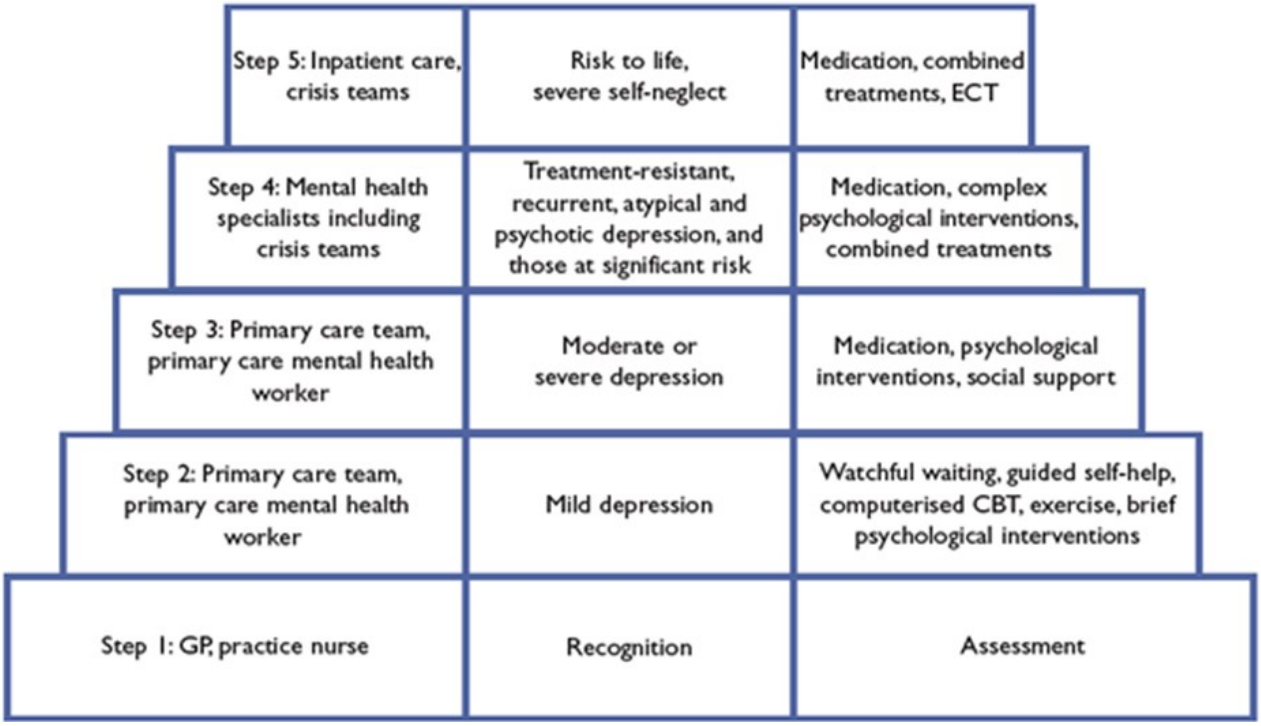
Attention also needs to be given to the diverse cultural, ethnic and religious backgrounds when working with people with common mental health disorders, to be aware of the possible variations in the presentation of these conditions including: culturally sensitive assessment; using different explanatory models of common mental health disorders; addressing cultural and ethnic differences when developing and implementing treatment plans; and working with families from diverse ethnic and cultural backgrounds.

Implication for collaborative quality improvement in general practice clusters

Common mental disorders are highly prevalent, often co-morbid with other mental disorders and/or long term physical illness and demanding on primary care services. This paper has presented some potential improvements that can be implemented in individual practices, and discussed in clusters, perhaps with a view to collaborative approaches to monitoring and evaluation.

The management of common mental disorders would be a suitable topic for early implementation of general practice clusters because it is a high volume activity for practices, especially with associated co-morbidities. It is a topic which matters to NHS Scotland, to Health Boards and to GPs caring for patients with these distressing conditions. The social determinants of many of these common mental disorders and the need to alleviate many of the life stresses which cause or exacerbate patients' physical and mental wellbeing means it is an area where primary, community and social care services should work together in developing local care pathways.

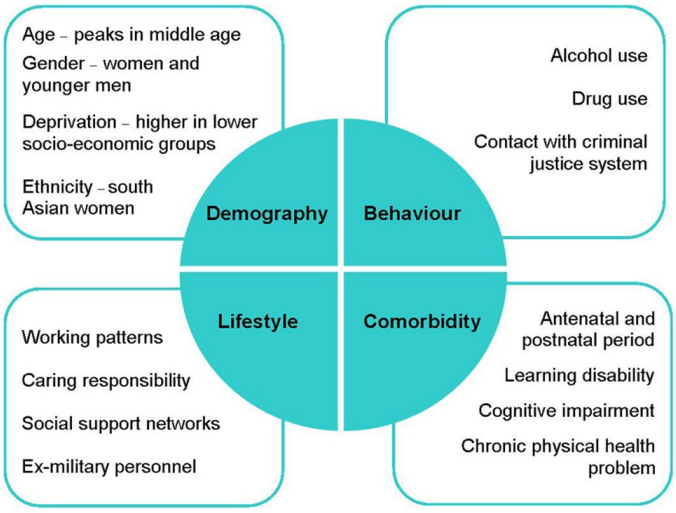
Figure 1. Stepped Care Model (NICE)



A **Step 0** can be included in some models to cover promotion and prevention or community based activity.

Figure 2. Risk Factors for Common Mental Disorders

(in https://www.nice.org.uk/guidance/CG123/resources/stepped-care-for-people-with-common-mental-health-disorders-commissioning-guide)



Further reading

- NICE guidelines [CG123], 2011. Common mental health problems: identification and pathways to care
- NICE Common mental health disorders: Evidence Update March 2013. A summary of selected new evidence relevant to NICE clinical guideline 123 'Common mental health disorders: identification and pathways to care' (2011).
- SIGN Guideline 114. Non-pharmaceutical management of depression in adults. A national clinical guideline. Jan 2010. http://www.sign.ac.uk/pdf/sign114.pdf

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