Care for common mental health problems: applying evidence beyond RCTs

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The evidence for effective interventions for common mental health problems such as anxiety and depression is becoming increasingly complex as new therapeutic and organizational approaches are developed. I will use this piece to argue that we, as family physicians, need to consider three key theoretical issues, in addition to the traditional evidence of effectiveness in managing mental health problems. These influence both our initial formulation of mental health problems and the systems of care we work within. The challenge is to produce a system that allows individuals to overcome reservations about disclosing and express emotions; encourages individuals to admit to problems and yet identifies their inner strengths; identifies individualized outcomes, often social, which are the focus of management and facilitates family doctors and therapists to work together. This does not mean abandoning or ignoring hard-won evidence but incorporating it into a systems approach that considers population as well as individual outcomes.

The primacy of trials for disorders

Mood disorders, anxiety disorders, somatoform disorders and alcohol abuse make up the majority of mental health need in primary care,[1,2] personality disorder complicates the picture further. Although the limits of trials are well described,[3] randomized control trials (RCTs) based on these diagnoses continue to provide the main basis for guidance to clinicians. Within mental health, primary care is often seen as a location for implementing individual evidence-based interventions rather than as a wider system into which they can be incorporated; this was exemplified by the 'detect and treat' model advocated by the defeat depression campaign.[4]

This trial-focussed system for accruing evidence of intervention effectiveness does not usually relate directly to the context of the individual and practitioner in which it is used. In mental health in particular, both the diagnostic system and the way we think about interventions is at least partially flawed. Firstly, unlike cancer classification, our mental health diagnostic classification systems are not only socially constructed but also based on symptoms and behaviour rather than observation of brain tissue. Patients experiencing distress may have 'symptoms' which fit none of the diagnoses set out in the DSM-IV or ICD-10 diagnostic classificatory systems, or may have many, constituting significant co-morbidity and individuals' symptoms and diagnoses can also shift over time. Secondly, we have a tendency to conceive of interventions as technical fixes, directed at faulty parts. Complex psycho-social interventions of proven effectiveness may, however, require specific 'capacities' (manifest or hidden attributes) within the individual, family or practitioners involved; these may not be replicated or even exist within the particular culture, health system or patients who make up the local population where the intervention is being replicated.[5] These two flaws make the job of the practitioner an interpreter rather than a follower of guidelines. Current guidance such as that issued by the UK National Institute of Clinical Excellence (NICE)[6,7] now recognizes the complexity of the clinical context, stigma and the need for patient choice but I assert these factors should be central to the practitioner's formulation of treatment for common mental health problems in primary care. Might patients benefit from a more fluid and socially orientated evidence-informed system of care?

Three key influences on care for common mental health problems

Three factors complement this diagnosis focused evidence base: the social origins of mental health problems, stigma and individuals' strengths and resilience. They each influence how we as primary care practitioners position ourselves in the complex world of working with individuals with mental distress.

Firstly, the complex bilateral relationship between social and psychological facets of illness and well-being has implications for clinical assessment and treatment and for how we carry out our research.[8] The origins of distress are partially organic but in many cases are

primarily social and can result from events within our environment particularly episodes of trauma,[9] disorganized attachment[10] and on-going social exclusion.[11] Mental health problems also lead to on-going social marginalization and conflicts in relationships. Further domains such as happiness, quality of life and social inclusion add to the complexity of the illness experience. There is no absolute reason for prioritizing symptoms over these additional social and psychological domains, both as the primary outcome in trials and as goals to attain in clinical practice. There is a strong rationale for seeing all interventions as contributing to social outcomes such as improved relationships, housing, training and employment as well as to emotional well-being.

Secondly, the problem of stigma can shape care for individuals in distress.[12] Initial access may be delayed or resisted altogether, and stigma has a complex relationship with social networks for hard to reach groups.[13] Our consultations consist of delicate dances with patients who are uncertain as to whether they want to disclose an emotional weakness. Some value the mental health label, though this can be for secondary gain as well as the comfort of naming the problem; others are ashamed and may not receive help from any quarter as a result of stigma. Stigma also pervades individuals' lives well beyond the consultation, affecting interaction with colleagues, family and the way they see themselves.

Thirdly, our deficit-focussed model of illness should ideally be used alongside one that takes into account individuals', families' and communities' strengths, resources and resilience.[14–16] This is both a matter of respect and expediency. Acknowledging how individuals have coped and used their own resources to get themselves better in the past might encourage them to do so again; it is economically wasteful not to try and harness these resources as a part of any support that is agreed. Furthermore, these individual resources can be seen as similar to the 'capacities' identifies by Cartwright[5] and others proposing a 'generative' view of causation in which interactions between interventions and individual context are critical.[16,17]

Formulation

It is accepted that formulation of mental health problems should not be based on symptoms alone.[6] It is possible to incorporate evidence related to stigma, strengths and the social domain, along with the body of evidence about diagnosis and treatment efficacy into a unified model for formulation.[18] Such a model draws on the best of 'generalism'[19] and of mental health practice.[20] The formulation can be conducted over time and several consultations, in collaboration with our patients, examining not only family history of mental health problems but also, when individuals are willing to talk about them, past traumas, difficult relationships and on-going social difficulties. A balanced formulation will describe not only psychiatric diagnoses based on symptomatology but also the most important psychological problems, such as rumination or 'black and white thinking', and the key issues in the social world of the individual. Co-morbidities can be made explicit and specific diagnoses (with particular treatment options associated) can be considered alongside an assessment of strengths. Making the latter explicit not only helps plan self-care but can also bolster an individual's belief in his or her ability to recover. An individual's concerns and expectations[21] can be discussed along with the evidence for specific treatments and also past individual patterns of recovery, to develop a treatment plan based on informed choice. Such a formulation also constitutes an on-going 'continuity of assessment' embedded both in clinical records and the individual's and practitioners' minds.

Interventions

While the search for evidence-based treatments has focussed mainly on medication and therapy applied to individuals with specific diagnoses and often excluding those with co-morbidity, the range of interventions has now broadened to include: autonomous and supported self-care using a variety of media, such as computers and books;[22,23] structured exercise programmes;[24,25] and social interventions, such as befriending[26] and Time banks.[27] These activities may be particularly acceptable for those who feel the stigma of mental illness or whose social situation due to commitments at work, social isolation or language differences make conventional treatments unacceptable. Making the most of all these opportunities requires knowledge of local services as well as medication and a willingness to see mental health problems simultaneously as biochemical imbalances, specific diagnoses and social troubles.

Most interventions mentioned in guidelines require prescription or onward referral, and the contribution of the consultation with primary care practitioners also needs to be included in any analysis of interventions for common mental health problems. NICE guidance now recognizes the potential benefits of active consultations,[6] but there is no conclusive evidence that listening skills and advice are effective. Problem solving has mixed evidence[28,29] but trials of 'micro-therapy' are probably not feasible. However, we know patients appreciate being listened to[29], and there is other indirect evidence about the benefits of 'good clinical care',[30] so we need to consider how to develop these skills as a part of our individual repertoires. I am not suggesting the use of therapy but the application of

certain skills and behaviours that sit at the lay-therapist interface, such as a skilled friend might use. General guidance for 'structured clinical care', such as that used in control arms of clinical trials,[31] might be one means for guiding practitioners towards best practice without the constraints of protocols. Whatever shape this training and information takes, it will have to account for practitioners' individual 'mindlines',[32] which based on past experience, peer and other influences are often more influential than top-down guidance.

Systems of care

So what system of care should be developed to encompass this broader formulation and the developing range of interventions? The evidence base for organizing primary care mental health services is in its infancy. The systems we act within have a profound effect on how patients behave and how we work. Patients still generally see primary care as a place for obtaining help for physical problems. Health services often have multiple organizations and teams, each with boundaries between them; financial and other incentives as well as governance systems[33] also strongly influence practitioners' behaviour.

It is important for services, particularly those working with marginalized populations, to demonstrate that they can respond to emotional problems as experienced by individuals: access arrangements should relate to how people see their problems and be non-stigmatizing and easy for all groups to navigate;[13] and initial engagement needs to build or renew trust and align conversations with individuals' social goals and concerns. Screening individuals who are attending primary care has not been shown to consistently improve outcomes[34] but has been built into consultations with at risk groups such as those with physical problems[35] and is used in other settings such as prison induction and the pre- and post-natal period. Even in these high-risk groups, the evidence for effectiveness is limited.[36]

Perhaps the most promising evidence about organizational design is for collaborative care:[37,38] joint work between mental health specialists and primary care practitioners, provision of therapy, supporting self-care and proactively following individuals up are likely to be the key components. Collaborative care also has the potential to provide expert support to enhance individual's strengths and capacities in a less stigmatizing setting. Stepped and stratified care, offering lower intensity treatment to those with less complex problems, and reserving higher intensity treatment for those not improving or with more complex presentations, has less evidence regarding outcomes,[39] but from a public health perspective, it can help large numbers of individuals to gain access to treatment.[40]

Stepped care has now been implemented within the Improving Access to Psychological Therapy (IAPT) programme in the UK;[41] however, its role as a vehicle for delivering NICE guidance evidence related to RCTs of specific treatments for specific diagnoses has been privileged over our understanding of stigma, social goals and co-morbidity. Furthermore, it has separate management and health records systems from the general practices where most referrals come from.

A number of problems arise when the emerging primary care mental health service becomes more like a separate secondary care mental health system: individuals and certain groups might not access care[42] because it is stigmatizing or does not appear to address their concerns;[13] screening and selection of patients to ensure they all have a 'disorder' and excluding particular co-morbidities, has a high administrative cost and means that many with significant emotional distress cannot access care[43] and focussing treatment on symptom- and disorder-based outcome measures marginalizes the importance of social goals. It also means that the work of family physicians and mental health specialists are separated, so that true collaboration is not feasible. The question arises as to whether a more complex subtle approach informed by wider range sociological evidence would achieve better outcomes.

Achieving outcomes

Measures of outcome are seen as the key to some large-scale programmes; they have been resisted by primary care practitioners, while being generally liked by patients,[44] but most importantly, their use can be associated with better outcomes[45] if part of a wider improvement system. While there is concern that they disrupt conversations and are often too focused on disorders, it is possible to integrate them skilfully into consultations or ensure they are collected through the Internet or before consultations. Symptom measures may well not be prioritized by patients, and as yet a comprehensive outcome set for common mental health problems has not been developed. Use of brief social functioning measures[46] and ideographic measures, such as PSYCHLOPS,[47] where the outcome of interest is selected by the patient, may have a role in improving the acceptability and ensuring a balanced approach. By considering the outcome of most concern as part of the formulation, the patient and practitioners can work collaboratively and select appropriate interventions likely to have an impact on the outcome of most concern. In this way, the routine collection of outcome data can both drive the direction of individual care and be aggregated to provide intelligence about the system as a whole.

Non-attendance at follow-up appointments has been passively accepted both by family doctors and

therapists, and yet assertive follow-up (case management within the collaborative care model) is associated with improved outcomes.[48] While it is important not to see all distress as pathological, or even requiring support, some individuals fail to continue accessing help because of both social and psychological problems.[49] Proactive telephone, text or written follow-up by 'case managing' therapists can create continuity of care by encouraging individuals to re-attend if they wish or are still unwell at the end of therapy. Continuity, in this instance, may not be with one practitioner, but how an individual's health care is connected over time.[50]

Sharing care and responsibility

Perhaps the greatest challenge for the integration of new collaborative and stepped care systems within primary care is the reconciliation between protocolled therapy for specific conditions and on-going care over time for individuals attending family doctors with undifferentiated distress. How do we deliver evidence-based therapy when the start and end of care is not clearly defined? And how do we allocate therapy to those who do not quite fit the inclusion criteria used in clinical trials? In our recent practice-based research evaluation of the new IAPT services in the South West of the UK, one service achieved high levels of access with low waiting times and only minimally lower outcomes by having multiples points of access, allowing individuals to choose the mode of therapy before a (diagnostic) assessment, not having preset treatment lengths and not discharging people.[51] Intriguingly, many of these design factors are advocated in the recent NICE guidance;[7] however, in contrast to the guidance, this service relies on patient choice more than practitioner assessment and also uses a range of groups, developed iteratively over years from theory and practice, alongside trial proven cognitive behavioural therapy. This system not only addresses the problems caused by purely diagnosis driven care but also goes some way towards family physicians and therapists sharing on-going responsibility for the registered population. The evaluation also showed the utility of multi-modal practice-based research[52] for examining implementation of evidence-based care within whole systems.

Shared care, in which therapist case managers and more experienced mental health practitioners, also share clinical records and regular case discussions with family physicians provides a number of further advantages beyond improved continuity. Perhaps the most important aspect is the support for primary care physicians: in making formulations and treatment decisions; contributing to teams taking a bio-psycho-social perspective and contributing to peer supervision and emotional support.

This is particularly important for family physicians who often struggle to cope with complex cases such as individuals with substance misuse, personality disorder[53,54] or medically unexplained symptoms.[55]

Put together, this new way of working would be more like a network with permeable connections facilitating individuals from treatment opportunity to well-being opportunity, ensuring outcomes are improved through light touch follow-up and letting go with the insurance that support can be regained when required.

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Declaration

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