

Discussion paper

Quality improvement in primary care mental health practice. A case for political intervention?

Hugh Middleton MA MRCP MRCPsych MD

Associate Professor, School of Sociology and Social Policy, University of Nottingham, UK

ABSTRACT

Improving the quality and consistency of detecting and providing for so-called common mental health problems in primary care settings is a contemporary issue. Such conditions are common and they are now recognised as a significant burden upon the economy. Though energetically pursued for much of the last half century, a medical approach based upon syndromal diagnosis and treatment has not provided a clear, evidence-based approach to their management that can form the basis of an educational intervention. Where that has been attempted and evaluated, it has been found wanting. A more politically driven imperative has stimulated ‘top-

down’ and firmly managed processes of change, encouraged by fresh investment. Improving Access to Psychological Therapies will not be the first programme to influence mental health services in this way. Experience of other programmes of deliberately managed change suggests that this approach can be effective and productive, particularly in a context which mental health exemplifies, where there are relatively few clinical certainties and a multitude of opinions.

Keywords: health policy, mental health, organisational innovation, primary health care, psychology

How this fits in with quality in primary care

What do we know?

Mental health problems are an important cause of disability with a high cost to individuals and society. Despite initial hopes that educational interventions directed at practitioners would improve mental health practice, they have been shown to have little impact on patient outcomes. This has been due to a number of factors including problems of definition of mental illness, difficulty identifying those affected, heterogeneity of conditions and the lack of effective therapies.

What does this paper add?

Many large-scale organisational interventions for mental health problems have been introduced based on policy imperatives rather than scientific evidence of their effectiveness. The policy directives are driven by public expectation, government need and changing clinical perspectives. The programme of Increasing Access to Psychological Therapies (IAPT) represents another such development which is likely to have considerable effect on primary care practice. It is argued that such interventions can be justified as a means of bringing about radical whole-system change in mental health practice.

The challenge of quality improvement in primary care mental health practice

Providing consistent, high-quality, evidence-based services for common mental health problems as they are managed in primary care is a considerable challenge. Some estimates suggest that they make up to 50% of all consultations,¹ although a more recent census found that general practitioners (GPs) rated 7.0% of consultations to be primarily for psychological problems and 8.1% to be for more complex combinations of psychological and physical problems.² Disability due to mental ill-health is a large and growing contribution to the economic, social and personal burden of disease. Mental illness has been targeted as one of the 'biggest causes of misery in our society... . Posing heavy costs on the economy, some 2% of Gross Domestic Product (GDP) and on the Exchequer (again 2% of GDP)'.³ The World Health Organization (WHO) has estimated that 'depression' is the largest non-fatal cause of disability worldwide.⁴ Surveys have demonstrated that nearly 25% of UK, USA and Australian populations are suffering from a mental disorder at any one time.⁵⁻⁷ Despite this high prevalence, the same surveys reveal that only about one-third seek help.⁸⁻¹⁰

When individuals do seek help with emotional or psychological difficulties from primary care, the results are variable. Despite encouragement to limit drug treatment, prescriptions for antidepressant medication have continued to rise over recent years,¹¹ even though pouring antidepressants into the population in ever-increasing quantities has not prevented rates of certification for mental health difficulties continuing to rise until it has now become the single most common ground for incapacity benefit.¹²

It has long been understood that the GP's role in relation to psychological or emotional difficulties is a complicated one. Historically, very few such cases presenting in primary care would be cases of clear mental illness demanding the services of the psychiatrist or even the asylum, and the GP would be expected to muddle through providing counsel, wisdom and sedatives as he or she thought fit.¹³ As the psychiatric establishment clarified its diagnostic criteria during the 1980s, many more conditions and forms of psychological distress came to be considered cases of mental illness that were not receiving the care they deserved.¹⁴

Educating the practitioner

Following the success of a study in Gotland, in which a whole community took part in an educational

programme designed to alter approaches to depression,¹⁵ the Royal College of Psychiatrists and the Royal College of General Practitioners jointly launched their Defeat Depression campaign.¹⁶ This was based upon the understandable assumption that there was a strong need for improved case detection and the provision of treatment for an illness that was, it was thought at the time, poorly detected and imperfectly treated. Since then there have been three formal investigations of enhanced training for targeted GPs. None resulted in significant improvements in outcome or a reduction in the burden of disease. In the first, GPs from a representative sample of English practices were provided with an educational package designed to improve their detection and treatment of depression.¹⁷ It was well received, and 80% of participants felt it would improve their ability to detect and manage depression. Unfortunately there were no significant differences in detection rate or changes in the Hamilton Anxiety and Depression rating scale between practices that had received the intervention, and those that had not. In the second, GPs were provided a four-and-a-half-day course of instruction in recognising depression and using cognitive behaviour therapy (CBT) to treat it.¹⁸ The intervention made no difference to GPs' ratings of their understanding of the condition, or to changes in patients' Beck Depression rating scale. The third,¹⁹ investigated the use of practice guidelines based upon The International Classification of Diseases (ICD)-10 WHO primary care guidelines for the diagnosis and management of mental disorders.²⁰ Guidelines were adapted for local relevance and made available to intervention practices, who were encouraged to make use of them. There were no significant differences between intervention practices and controls in their abilities to detect cases or in patients' General Health Questionnaire (GHQ) scores at follow-up.

A problem too complex for medicine alone?

It is clear that there are important limits to the utility of a medical approach to common mental health difficulties managed in primary care.²¹ The validity with which mild to moderate depression, mixed anxiety and depressive disorder, generalised anxiety disorder and unwise alcohol consumption can be distinguished from adaptive responses to difficult circumstances or problematic behaviours is widely questioned.^{22,23} Neither drug nor specific psychological therapies are definitively effective in the treatment of depression unless it is at least moderately severe in intensity.^{24,25} As far as the anxiety disorders are concerned, sedative drug treatment is only ever palliative, and CBT is only of

proven efficacy in the treatment of panic disorder, obsessive compulsive disorder and phobias.²⁶ Thus, some three-quarters of the conditions from which '25% [of the] population suffer mental illness' are neither clearly distinguishable as a morbid state from more understandable vagaries of human experience, nor responsive to 'treatment' in a way that passes muster when a strict definition of evidence-based practice is the benchmark.

This reality puts the GP in a difficult position, and quite possibly accounts for the negative outcomes of trials attempting to alter practice and outcomes. Folklore, persuasive psycho-pharmaceutical marketing, the published views of experts, a medical background and frame of reference, and the understandable need to 'do something' when confronted by a distressed patient all conspire to encourage attempts to provide 'treatment' when it might not be helpful or appropriate to do so. In contrast, when such approaches do not prove effective, and referrals are made to specialised services, letters of referral tend to be couched in more holistic, social terms, making reference to patients' difficulties of living rather than more clearly identified features of 'illness',²⁷ and the recipients of such referrals often refer to them as 'inappropriate'.²⁸ A critical hindrance to the development of consistent, high-quality, evidence-based services for common mental health problems is that they have been hard to define in ways that all concerned, whether the public, academics, or primary or secondary care practitioners, can agree upon.

A political intervention

Concerns about the high prevalence of mental health difficulties and their economic cost have stimulated NHS policy development.²⁹ The 2007 Government Comprehensive Spending Review committed £173 million to 2010/2011 in order to support the establishment of services that will improve access to psychological therapies (IAPT). The programme is based upon the premise that cognitive behaviour therapy (CBT) can be effective in a variety of conditions, and so it is intended to make CBT much more widely available. The programme recognises that a large proportion of those loosely defined as suffering 'mental disorder' may recover without need for professional input, and it also recognises the potential value of self-help groups, bibliotherapy and computer-administered forms of CBT. Nevertheless, the IAPT programme is strictly specified around a defined service model. Each commissioned and commissioning primary care trust (PCT) is expected to provide services across a range of intensities and complexities that mirror previously published National

Institute for Health and Clinical Excellence (NICE) guidelines for the management of depression and for the management of anxiety disorders. These are described as 'stepped care', in which Step 1 is described as 'recognition of the problem and watchful waiting', Step 2 comprises self-help and computerised CBT, and Step 3 is CBT conducted by skilled and appropriately trained professionals.³⁰ Commissioning guidance encourages a mixed economy in which commissioners are expected to consider tenders from commercial and voluntary sector organisations as well as NHS service providers, and the development and its oversight are to be performance managed by strategic health authorities.³¹

IAPT is very much a pragmatic solution to a pressing problem. There is widespread concern about the lack of provision for many considered to be suffering common forms of mental health difficulty, and related disability is an economic burden. At a detailed clinical level, the conditions contributing to the problem are heterogeneous and therefore defy a conventional clinical (detect, diagnose, treat) model. Not all the applications of CBT that it recommends are endorsed by clinical trial evidence of randomised controlled clinical trial quality, but some are, and there is sufficient consensus to encourage investment in those that are not. The programme has been designed with considerable flexibility and in line with published NICE guidelines. This means that it is acceptable to advocates of evidence-based practice and also able to accommodate the vagaries of real-world practice. Furthermore, it provides a substantial investment of new money, which at the same time makes it attractive to practitioners, and justifies tight performance management.

In all of these respects, IAPT resembles several other major developments in mental health practice. Closure of the asylums in favour of treatment in district general hospital-based units during the 1960s and 1970s was as much an act of public policy as it was a response to meticulously conducted clinical research. Contributing factors included changing public attitudes to the practice of incarcerating vulnerable or threatening individuals, promises of therapeutic breakthrough from academics and the pharmaceutical industry, and the economics of maintaining some 150 000 long-term institutional placements in ageing buildings, often set in prime locations.

Formalising the process of 'care in the community' in the form of case management and the Care Programme Approach in the 1990s was a response to concerns for public safety arising from high-profile incidents such as the killing of Jonathon Zito by Christopher Clunis in 1992.³²

In 1999 the Department of Health published a National Service Framework for Mental Health (NSF).³³ This was prescriptive guidance on standards and services across the full range of mental health service activities, and formed part of wider, politically

driven NHS reforms. In 2001, the NSF was followed by explicit policy implementation guidance specifying how community mental health services should be configured around a set of teams each providing for one of five sets of clients.³⁴ Over the intervening years, these service developments have been directly encouraged, supported and managed by the Department of Health. Encouragement has been in the form of significant sums of new money, support has been in the form of eight regional development teams and central co-ordination that was originally NIMHE, the National Institute for Mental Health (England), and more recently CSIP, the Care Services Improvement Partnership. Introduction of the new teams and assurance that they conformed to policy guidance has been managed by the strategic health authorities (SHAs).

One of the more radical innovations initiated by the NSF and policy guidance has been the introduction of crisis resolution/home treatment (CRHT) teams, and the provenance and process of this development might illustrate how the introduction of IAPT could progress. There was a perceived need to change; many instances of admission to an acute psychiatric ward were considered to be an unsatisfactory way of dealing with acute social breakdown. There was charismatic support for managing such problems by providing intensive support at home, which made intuitive sense even though clear randomised controlled clinical trial data derived from a UK setting did not exist. Economic advantages in the form of reductions in inpatient bed numbers were anticipated. These forces supported an explicit plan to establish comprehensive crisis team cover across England; each SHA was given a target number of teams based upon capitation amounting to a total of 343 teams. There was an expectation that these would be in place by the end of 2004, and this process was closely monitored. During 2006 the CRHT teams were surveyed.^{35,36} A large proportion had been put in place during the second half of 2004. Composition varied; most narrowly conformed to policy guidelines, some were more generously endowed with staff, and some less so. In some areas, in particular metropolitan districts, providers had made their own arrangements, amalgamating prescribed teams into a smaller number of larger ones to better suit local need. Most were fulfilling service model expectations of availability and the provision of alternatives to admission, but only about half were doing this to full specification. Where teams had been in place for two or more years, there was a discernable effect upon bed usage.³⁷ Service user satisfaction was beginning to register appreciation.³⁸ Some but not all professional groups were accommodating changes in their practice and interprofessional relations; medical staff were among the more reluctant to change.³⁹

Conclusions

Quality improvement in primary care mental health practice cannot escape the fact that it has to happen in a context of clinical uncertainty and heterogeneity of context. Thus, there are no critical key skills to learn or practices to follow. This was the lesson learned by the unsuccessful Defeat Depression Campaign. There have been enormous changes in mental health services over the last half century, although these have had only indirect effects upon primary care mental health practice. These changes have all been the result of a series of complex interactions between public expectations, government, and changing clinical perspectives, and on the whole they have been orchestrated by direct, 'top-down', firmly managed policy directives. IAPT represents another such development which will have considerable effect on primary care practice, and it is set to be as firmly managed as its predecessors. Mental health services are an area of practice where clinical authority and public policy are particularly closely bound. Providing for the 'mad' has always and inescapably included a statutory dimension, and possibly for that reason mental health service providers and practitioners may be more able to accept externally imposed directives than their colleagues from other specialties. Changes over the last 50 years have not been without their critics or pockets of resistance, and IAPT will undoubtedly provoke both. There is already controversy over the validity of so wholly embracing CBT as a therapeutic model.⁴⁰ Established practitioners will have to acquire new ways of working with one another and with unestablished, and quite possibly unqualified, personnel working beyond conventional NHS boundaries.⁴¹ There will inevitably be objections to the tight performance management that the process is expected to adopt. Nevertheless, there is good evidence that such an approach can be successful in achieving radical whole-system change in other areas of mental health practice, and it may be that this will be another example of a successful 'top-down' policy-driven approach. It is attempting to do nothing more than implement common sense where clinical authority might choose to lead, but cannot, for lack of clinical evidence.

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PEER REVIEW

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CONFLICTS OF INTEREST

None.

ADDRESS FOR CORRESPONDENCE

Dr Hugh Middleton, Associate Professor, School of Sociology and Social Policy, University of Nottingham, University Park, Nottingham NG7 2RD, UK. Tel: +44 (0)115 846 7612; fax: +44 (0)115 951 5232; email: hugh.middleton@nottingham.ac.uk

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