Tony Kendrick and Stephen Pilling

Common mental health disorders — identification and pathways to care:

NICE clinical guideline

T Kendrick, MD, FRCGP, FRCPsych, professor of primary care and dean, Hull York Medical School, Hull; and chair, Guideline Development Group.
S Pilling, PhD, professor of clinical psychology, University College London; and clinical effectiveness and director, National Collaborating Centre for Mental Health, London.
Address for correspondence
Tony Kendrick, Hertford Building, Hull York Medical School, University of Hull, Hull, HU6 7RX.
E-mail: Tony.Kendrick@hyms.ac.uk
Submitted: 29 June 2011; **final acceptance:** 7 July 2011.

DOI: 10.3399/bjgp12X616481

INTRODUCTION

NICE has developed a guideline on the identification of common mental health disorders (CMHDs) and on pathways to care for these disorders.[1] These CMHDs include:

- depression;
- generalised anxiety disorder (GAD);
- panic disorder;
- obsessive-compulsive disorder (OCD);
- post-traumatic stress disorder (PTSD); and
- simple phobias.

The prevalence of CMHDs in the community is around 15%, and even higher, around 20%, among people attending general practice. The costs of CMHDs are high. They are estimated to cause 1 in 5 days lost from work in Britain.[2] There are problems with access to care and with identification of people with CMHDs. In the 2007 household survey of adult psychiatric morbidity only 38% of people with CMHDs had asked their GP for help, and only 24% were receiving treatment (14% medication; 5% counselling; and 5% both).[3]

The aim of the NICE guideline is to improve access to services, improve the recognition and identification of CMHDs, and provide advice on developing care pathways. There is a need for greater clarity around the indications for treatment and referral of CMHDs, including severity, duration, associated disability, and other factors likely to affect responses to drug and psychological treatments. A more systematic approach to organising care pathways is needed, including the consideration of developing 'stepped care' systems and 'collaborative care' across the primary and secondary care sectors of the NHS.

The guideline also brings together in one place advice from existing NICE guidelines on referral for and treatment of the disorders. These are guidelines on depression in adults,[4] depression with chronic physical health problems,[5] GAD and panic disorder,[6] antenatal and postnatal mental health,[7] OCD,[8] and PTSD.[9] The individual guidelines already developed cover treatment, but vary in their coverage of identification, assessment, and appropriate referral.

GUIDANCE

Identification

The guideline states that practitioners should be alert for disorders particularly in those with a past history, potential somatic symptoms, or a chronic physical health problem. The identification of depression is already covered in the NICE guideline CG90[4] that recommends the two 'Whooley' questions for case-finding in depression:

- During the last month, have you often been bothered by feeling down, depressed, or hopeless?
- During the last month, have you often been bothered by having little interest or pleasure in doing things?

For case-finding in anxiety, the guideline recommends the two-item questionnaire for detecting GAD[10] (GAD-2) (Box 1). Then, just as the depression guideline suggests that practitioners consider using a longer tool such as the nine-item Patient Health Questionnaire[11] (PHQ-9) or the Hospital Anxiety and Depression Scale (HADS)[12] in the event of a positive response to the two 'Whooley' questions, so the new guideline recommends considering asking a further five questions that, together with the first two, make up the GAD-7 questionnaire[13] (Box 1).

If the person scores <3 on the GAD-2, but the health professional is still concerned they may have an anxiety disorder, the guideline recommends that healthcare professionals should ask a third, 'avoidance' question:

Box 1. Identification questions for anxiety disorders

Case identification
Ask the two questions that make up the GAD-2:
Over the last 2 weeks, how often have you been bothered by the following problems?

- Feeling nervous, anxious, or on edge?
- Being unable to stop or control worrying?

The GAD-2 is scored as follows:

Not at all: 0, Several days: 1, More than half the days: 2, Nearly every day: 3.
If a person scores ≥3 or more consider a possible anxiety disorder.

Further assessment
If the GAD-2 is positive, consider using the full GAD-7 that includes the following five questions in addition to the two above:

Over the last 2 weeks, how often have you been bothered by:

- Worrying too much about different things?
- Having trouble relaxing?
- Being so restless that it is hard to sit still?
- Becoming easily annoyed or irritable?
- Feeling afraid that something awful may happen?

All seven questions (the GAD-7) are scored with the scoring system above, and a total score >8 (for GAD-7) indicates a possible anxiety disorder.[13]

- Do you find yourself avoiding places or activities and does this cause you problems?

Where there are significant communication difficulties, practitioners should consider using the 'distress thermometer' and/or ask a family member or carer about the person's symptoms. The distress thermometer is an analogue tool ranging from 0 (no distress) to 10 (extreme distress).[14] The patient is asked to indicate their level of distress and action is suggested if the score is >4.

If these initial questions indicate the presence of a common mental health disorder, further characterisation of the specific nature of the disorder can be achieved using a diagnostic or problem identification tool or algorithm, for example, the Improving Access to Psychological Therapies (IAPT) screening prompts tool,[15] or using a validated measure relevant to the disorder or problem being assessed, for example, the PHQ-9.

The guideline recommends that staff conducting assessments should be trained and competent to determine the nature, duration, and severity of the disorder, take into account functional impairment, and identify appropriate treatment and referral options. Factors that may affect the course and development of a person's problem include their past history of mental health disorders, chronic physical health problems, their past experience in terms of response to treatments, the quality of their interpersonal relationships, and their living conditions and social isolation. Issues such as responsibility for childcare, domestic relationships, employment, and immigration status should also be assessed if appropriate.

Assessing severity

Mild disorders are those with relatively few core symptoms, a limited duration, and little impact on day-to-day functioning. The first step in care for mild disorders is usually active monitoring especially if the disorder is of recent onset and there is no history of moderate to severe problems. Moderate disorders are those with the core symptoms, other related symptoms, and have a clear impact on functioning, for which more active intervention is recommended. Severe disorders are usually of long duration, have the majority, if not all, key symptoms, and have a marked impact on functioning. Persistent sub-threshold symptoms that do not meet full diagnostic criteria but have a substantial impact on a person's life, and particularly those that are present for a significant period of time, are also indications for intervention.

Improving access to services

The guideline recommends collaboration to develop care pathways that support integrated delivery across primary and secondary care, with clear and explicit entry criteria, focusing on entry and not exclusion. The guideline recommends:

- a designated lead to develop and oversee a particular care pathway;
- multiple points of access, including self-referral, rather than constraining services with a single point of access, that may be difficult to reach and produce waiting lists;
- providing services in various settings, including patients' homes, and outside working hours;
- promotion of access to people from socially excluded groups, particularly older people and those from black and ethnic minority groups, adopting culturally sensitive assessments;
- practical help including crèches, help with travel costs, and interpreting services; and
- texting and email, as well as telephone, and online communication.

Stepped care

A stepped care model of integrated delivery

means providing the least intrusive effective intervention first, with explicit criteria for different levels of intervention.[16] Stepping up should be based on clear objective criteria, and designated staff should be responsible for coordination of care. A particular emphasis of the guideline is routine monitoring and reporting of outcomes, to the service coordinators, to GPs, and to the service users themselves.

Case management and collaborative care

Systematic literature reviews carried out for the guideline found evidence of significant benefits from interventions or systems focused on the coordination and organisation of individual care. Identified case managers and the active engagement of the patient in the planning, delivery, and monitoring of their own care, were associated with positive outcomes.[17] Effective communication was enhanced by direct contact between primary care and mental health professionals and was associated with improved patient outcomes and patient satisfaction.[18]

COMMENT

From a general practice perspective, the recommendation that the GAD-2 and GAD-7 questionnaires should be used to help identify anxiety disorders is one of the biggest proposed changes from current practice. An economic modelling exercise was carried out that suggested that this was more cost-effective than usual GP care. However, a number of assumptions had to be made to inform the modelling exercise, as there is limited research on the clinical and cost utility of questionnaires for the identification of anxiety disorders compared to routine GP assessments. The distress thermometer has not been validated in a UK primary care population.

The evidence for the benefits of case management is largely limited to depression and much less research has been done on the coordination of care for anxiety disorders.[19] Trials of collaborative care have been shown to be cost-effective particularly for patients with depression accompanying long-term physical health problems.

If fully implemented, the guidance could incur greater costs to the NHS through increased identification and referral of people with anxiety disorders in particular, together with increased costs of collaborative care or case management for depression. Some of the mechanisms recommended to promote access would also have cost implications, particularly assistance with travel, provision of translators, crèche facilities, and the development of culturally sensitive assessments.

Competing interests

The authors have declared no competing interests.

Provenance

Freely submitted; externally peer reviewed.

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