



## Embedding integrated mental health assessment and management in general hospital settings: feasibility, acceptability and the prevalence of common mental disorder



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### ABSTRACT

**Objective:** To assess the feasibility and acceptability of routine web-based screening in general hospital settings, and describe the level of common mental disorder.

**Method:** A service development platform to integrate mental and physical healthcare was implemented in six specialties (rheumatology, limb reconstruction, hepatitis C, psoriasis, adult congenital heart disease (ACHD), chronic pain) across three general hospitals in London, UK. Under service conditions, patients completed a web-based questionnaire comprising mental and physical patient-reported outcome measures, whilst waiting for their appointment. Feasibility was quantified as the proportion of patients who completed the questionnaire. Acceptability was quantified as the proportion of patients declining screening, and the proportion requiring assistance completing the questionnaire. The prevalence of probable depression and anxiety was expressed as the percentage of cases determined by the Patient Health Questionnaire-9 and Generalised Anxiety Disorder Questionnaire-7.

**Results:** The proportion of patients screened varied widely across specialties (40.1–98.2%). The decline rate was low (0.6–9.7%) and the minority required assistance (11.7–40.4%). The prevalence of probable depression ranged from 60.9% in chronic pain to 6.6% in ACHD. The prevalence of probable anxiety ranged from 25.1% in rheumatology to 11.4% in ACHD.

**Conclusion:** Web-based screening is acceptable to patients and can be effectively embedded in routine practice. General hospital patients are at increased risk of common mental disorder, and routine screening may help identify need, inform care and monitor outcomes.

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## 1. Background

The relationship between mental and physical illness is complex and bidirectional. Poor mental health is associated with increased risk of physical illness, and poor physical health confers an elevated risk of mental illness, most commonly depression and anxiety. Approximately 30% of the UK population have a long-term condition, and of those, around 30% have a concomitant mental disorder [1,2]. The overlap of mental and physical illness makes the management of both more complicated and costly. Physically ill patients with comorbid mental health problems experience elevated symptom burden [3], lower adherence to treatment [4], impaired quality of life [5], poorer

prognosis [6,7] and increased mortality [8,9]. They also use outpatient services more frequently, and experience more hospital admissions and primary care consultations [10–12]. In the UK, treatment of physically ill patients with co-morbid mental health problems adds an estimated £8–13 billion to the annual National Health Service (NHS) expenditure on long-term conditions [13].

There is good evidence that common mental disorders can be effectively treated in people with a physical health condition. Recent meta-analyses of pharmacological and psychological interventions for depression in physical illness have yielded effect sizes similar to those seen in people without physical illness [14,15]. There is also evidence that integrated mental healthcare positively impacts physical health outcomes [16], reducing service use and healthcare costs [17,18]. However, psychological care is often absent in physical healthcare settings, and mental disorders frequently go undetected and untreated [19–21]. In the care of long-term conditions, physical

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health outcomes are typically prioritised over mental wellbeing and quality of life [22]. Stigma attached to mental illness may inhibit patients from spontaneously disclosing psychological distress, and clinicians report feeling less comfortable enquiring about emotional concerns [23]. A lack of confidence, time or resources may contribute to clinicians' reticence to probe patients' psychological problems. Even when problems are identified, physical healthcare teams are often ill-equipped to provide effective care, having received little or no training in mental healthcare.

The case for mainstream mental health assessment and support for people with long-term conditions has been put forth in numerous recent policy reports [13,24–29]. These emphasise the need for training in basic mental health skills for physical healthcare professionals, increased investment in liaison psychiatry services, and routine outcome measurement to capture the value of mental healthcare and inform commissioning. The UK National Institute for Health and Clinical Excellence recommends routine screening to improve identification of mental disorders in chronic illness, alongside a management strategy to provide care and follow-up [30]. Yet, despite guideline recommendations and a growing body of supporting evidence [16,31], implementation of integrated care approaches has been slow and patchy.

This paper describes the design and implementation of a novel integrated care initiative introduced by King's Health Partners (KHP) in 2011. KHP is an Academic Health Science Centre in London, UK, comprising a leading research and teaching university (King's College London), two NHS Acute Hospital Trusts (Guy's and St Thomas' NHS Foundation Trust (GSTFT), King's College Hospital NHS Foundation Trust (KCH) and an NHS Mental Health Trust (South London and Maudsley NHS Foundation Trust). *Integrating Mental & Physical healthcare: Research Training and Services (IMPARTS)* [32] is a service development platform designed to support clinical teams in providing timely, tailored, evidence-based care to patients with long-term conditions. The aim is to develop a model of service delivery that facilitates integrated care, whilst simultaneously promoting research.

The IMPARTS programme has five core components:

1) *Web-based screening:*

IMPARTS has developed a web-based screening interface, which enables routine measurement of mental and physical health outcomes, with real-time feedback to guide clinical care. Screening patients electronically before their consultation results in more productive use of waiting room time, more efficient assessment, improved recognition of patient concerns, and more actions being taken in relation to these concerns [33,34]. Computerised screening has been shown to be acceptable to patients and clinicians [35,36], and studies suggest that regular screening with feedback of results may improve patient outcomes [16,34,36]. However, evidence that routine screening can be successfully implemented under true service conditions is scarce. Most studies have relied on researchers to administer screening and cannot therefore comment on the feasibility of routine implementation [34,37,38]. IMPARTS aims to translate research findings and guideline recommendations into real-world clinical practice. To be sustainable, outcome measurement must be embedded within existing infrastructure and “owned” by practitioners rather than researchers.

2) *Care pathway development:*

IMPARTS develops robust care pathways to guide management of mental health problems identified through screening. Gilbody et al. showed that depression screening in non-mental health settings was associated with increased identification of depression, but had no impact on patient outcomes [39]. However, screening was

evaluated as a stand-alone action without a care pathway or management plan. To impact health outcomes, evidence indicates that enhanced management and follow-up is needed [16,30,40]. The IMPARTS system is designed to support management and follow-up of common mental disorder. IMPARTS devises tailored mental health care pathways to ensure patients identified through screening receive appropriate care. These provide recommendations on interpreting screening output, making referrals and assessing suicide risk. Screening occurs at regular intervals so that changes in symptoms and functioning can be captured and care plans adjusted accordingly.

3) *Training in core mental health skills:*

Successful mental health screening and signposting depends on clinicians being confident in interpreting outcome measures, and engaging patients in discussion about psychological problems. Scant provision of liaison psychiatry and clinical/health psychology services means that responsibility for detecting and managing mental health problems often falls upon non-specialists. Given that approximately one in three people with chronic illness will have a probable mental disorder, it is critical that generalists are equipped with core skills in psychological care [24]. Even brief training interventions have been shown to increase clinicians' confidence in dealing with mental health problems [41]. IMPARTS has developed a mental health skills training package for physical healthcare teams. Popular topics include: eliciting concerns and discussing distress; how and when to refer to a mental health specialist; encouraging adherence; assessing risk; and problem-solving. Training is delivered in flexible, interactive sessions scheduled to accommodate the entire team, from consultant physicians to healthcare assistants.

4) *Bespoke self-help materials*

Although there are many self-help materials available for depression and anxiety [42,43] and some excellent resources for people with specific long-term conditions [44], few bridge the gap between mental and physical health. If self-help interventions do not resonate with patients' experiences, their efficacy and acceptability may be diminished. IMPARTS has developed a portfolio of bespoke self-help materials which address patients' psychological needs in the context of their illness. These materials are developed with patient and clinician input, produced in a written format and use a theoretical model. They are tailored to the nuances of the particular physical condition and designed to be used by non-specialists to supplement discussions about psychological issues and identify coping strategies. Studies have shown that self-help interventions are more effective if provided with guidance from a healthcare professional [45]. Thus, clinicians participating in the IMPARTS programme are taught how to engage patients in discussion about the key concepts.

5) *Research infrastructure*

Routine outcome measurement enables collection of data for audit and research. IMPARTS has developed a pseudonymised research database combining patient-reported outcomes from screening, with clinical and demographic data from the hospital electronic patient record (EPR). This database enables audit of clinical practice against national standards of care, and evaluation of patterns of need and service usage to inform commissioning. It also provides a rich resource for hypothesis-driven observational research investigating the prevalence,

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