

## **Case Identification and Referral for Common Mental Health Disorders**

### **Stakeholder workshop breakout session notes**

2<sup>nd</sup> September 2009, 1pm-4pm, NCCMH offices Mansell Street, London

#### **Group A**

##### **Title**

- The current title is confusing. It is unclear what is meant by case identification. Recognition and assessment might be more appropriate terms. The purpose should be to identify what condition the patient has and what care pathway they should follow.
- Would adding in the term diagnosis be useful?

##### **Content of Scope**

- 4.1.1 a) people who have suffered as a result of violence or abuse should also be included.
- 4.1.2 a) people with drug and alcohol problems should not be excluded.
- 4.1.2 c) An age range of 13-18yr olds was also discussed but there would be a need to include school settings.
- 4.3.1 will the scope include monitoring and reviews, collaborative care was looked at in the depression guidelines will this be looked at in this guideline for people with anxiety disorders?
- 4.3.1 a) This should not just be symptom based it is important to look at the impact on a person's life - a social dimension is missing.
- 4.3.1 b) A review of tools used to identify anxiety disorders would be helpful Self identification tools could also be included. A review of evidence regarding the training and competencies required for case identification would be helpful.
- 4.3.1 d) The aim should not be to produce one single care pathway but to identify good features of a care pathway. eg referral mechanisms
- Algorithms would be useful.
- 4.2 a) The definition of primary care should be broad and not just GP.
- 4.2 b) There is literature on engaging prison officers with regards to case identification. Should police and forensic settings be included?
- General – there was concern about the number of people who under present to primary care. This could be put forward as a topic for the public health team at NICE to consider.
- General – There is not going to be a lot of RCT evidence for this guideline. Other forms of evidence may need to be considered.
- General – If referrals are increased significantly the cost impact would be huge.

##### **GDG recruitment**

- Voluntary sector involvement is important
- The GDG should include low intensity workers and psychotherapists
- There should be more than one GP

- Include a clinical lead of an IAPT service and a clinical lead for other psychotherapies
- A specialist mental health commissioner and a long term conditions specialist should be included. Service manager/director from NHS may also be suitable.
- There are different types of nurses.. There should be at least two nurses.
- A physician with referral liaison service experience would be helpful.

## Group B

### Title

- Try to make less 'medical', while retaining flavour of *clinical* guideline and recognising you can't please all the people all the time!
- 'Case' identification seems to de-personalise the topic, and 'disorders' focuses on pathologies, maybe reinforcing people's reluctance to come forward
- Consider: identification and effective management of common mental health disorders in primary care'
- One person favoured the concept of 'distress' rather than 'disorder'
- Suggested that this debate over terminology could play a useful part in the guideline itself – how does terminology affect people's perceptions, both in coming forward and in considering options for management?

### Content of Scope

- 4.3.1(a): Q: there is no NICE guideline on social phobias, how will that be brought in? A: this is important – there is a gap here, important point.
- 4.3.1 (b): important to aim guidance on identification tools at a wide range of practitioners. Also consider: classification/diagnostic codes are moving to *lumping* rather than *splitting* – there is commonality across diagnostic terms for management and treatment. An 'integrated tool' could be good but complex.
- 4.3.1 (c): essential here to consider criteria for referral to 3<sup>rd</sup> sector, where skills and quality vary widely – but also an important component of choice for service users?
- 4.3.1 (d): does this mean local protocols? Or *within* primary care practices? Or both? There are locally very different mixes of people – not clear how far this can go.
- 4.3.1(e): would like to see different models – self help; 3<sup>rd</sup> sector; different approaches to treatment *options* (suggest substitute 'options' for 'interventions' in this sub-para)
- General point that 'primary care' includes social things like housing and debt; occupational medicine might play a role – would they be included in, for instance, (b) and (c)?
- 4.1.1: Q: 'agoraphobia' isn't listed – will this be included? A: yes, all the anxiety disorders
- 4.1.1: Equalities groups (NB: this should be covered in a separate sub-para in 4.1.1): deaf people; older people; people from Indian sub-

continent – known stigma (but also known stigma in many minority ethnic groups)

- 4.1.2: What about people with psychosis that is in remission, who may, for instance, have a problem with anxiety – should there be some way of covering this?
- 4.4 (b) Suggest add: 'More appropriate and effective treatment *options* for common mental disorders' – this would highlight the importance of choice for service users
- Different evidence pathways for different conditions. Want to look at holistic approaches, may have to look outside published literature. There is evidence, for instance, about importance of social networks, but how do you access this therapeutically. Needs much broader approach than 'medical'. (Mention of Lord Layard's material on happiness and wellbeing...) One person noted importance of looking at *distress* in social and psychological wellbeing.

### **GDG recruitment**

None given

### **Group C**

#### **Title**

- 'Case' as a term is an issue.
- Include 'assessment'.
- 'Care Pathway' is a possible word as it integrates 'assessment' into its meaning.

### **Content of Scope**

- 4.3.1 Specific groups: young people, drugs and alcohol, need to be considered to see how they link/are referred to in the guideline.
- 4.3.1 Comorbidity is an issue perhaps best dealt with through more through advice on assessment, especially for the primary condition.
- 4.2 Settings: voluntary, community and primary care settings should be stated individually.
- 4.4 Better uptake and outcome is preferred term rather than 'more effective'.
- There is limited evidence relating to care pathways.

### **GDG recruitment**

GDG composition should also include:

- Nurses – from mental health backgrounds in primary care as well as practise nurses
- People with methodological and psychometric scale knowledge
- Public health, health promotion, inequalities perspective
- Should focus on specification of role as much as "profession"