

Sub-threshold mental health syndromes:

Finding an alternative to the medication of unhappiness

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ABSTRACT

Sub-threshold anxiety and depression are common presentations in primary care. They carry a significant disability burden along with the risk of developing a frank disorder. Intervention options are limited, although there is some evidence that ultra brief interventions may be effective with this patient group. We argue that there is a need for a systematic but ultra brief, minimal contact intervention, that can be delivered by GPs or practice nurses. Such an intervention would be a form of facilitated self-management, a step up from self-help, from which people could be referred on to more intensive treatment or medication if required.

MeSH keywords: Primary health care, mental health, psychotherapy, mental disorders

Introduction

Just over one quarter (26.5%) of primary care patients in NZ and overseas^{1,2} are considered by GPs to have sub-threshold mental health syndromes. These are combinations of signs and symptoms that do not meet the threshold for disorder in standard diagnostic systems such as DSM-IV.³ Unlike secondary mental health service populations, the primary care mental health population includes people with a broad spectrum of undifferentiated syndromes ranging from few, mild or transient symptoms to symptom combinations and severity that meet diagnostic criteria. Often these arise in the context of social problems such as family or economic stress. In a NZ primary care sample, functional impairment was found not to differ significantly between diagnosed disorder and sub-threshold syndromes.⁷ Furthermore, a subset of those with sub-threshold syndromes are at increased risk for development of clinical depression⁴ or eventual suicide.⁵ Sub-threshold mental health syndromes therefore represent an important morbidity and disability burden to the community,⁶ in terms of work and role impairment as well as distress.^{7,8} It has been suggested that intervention may be warranted for up to 80% of those affected.^{9,10}

Despite the extent of morbidity burden, in New Zealand only 22% of these people receive an intervention of any kind, most commonly supportive discussion and non-specific counselling.¹⁰ Access to interventions for sub-threshold syndromes is likely to be even less equitably

distributed than access to treatment for diagnosed disorders. The evaluation of Ministry of Health-funded NZ demonstration projects for primary care services for common mental disorders and sub-threshold syndromes shows a high degree of perceived unmet need for treatment and substantial variability in what is offered for sub-threshold syndromes.¹¹

Given this information, the key questions are, firstly, should people with such syndromes receive an intervention and, secondly, if so, what should the intervention be? These questions can be answered by considering the nature of contemporary primary care practice, the availability of interventions, the existing evidence about interventions, the policy context, and primary care sector workforce development.

Nature of primary care practice

GPs face a number of challenges in the management of sub-threshold syndromes: The primary care environment is complex and chaotic, with dynamic treatment plans that change to meet the changing need of the patient, competing illness priorities and difficult socio-economic problems. The current classification of psychiatric illness does not apply well to undifferentiated psychosocial problems in primary care. Sub-threshold syndromes do not always conform to the boundaries of less severe forms of DSM-IV defined entities.^{7,12-15} In practice, GPs tend to make pragmatic management decisions based as much on functioning

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as on whether or not syndromes exceed a diagnostic threshold.^{16,17} In this context, management of sub-threshold syndromes is inevitable, as GPs are balancing a focused and pragmatic response to competing presenting problems.¹⁸ Common non-specific GP management strategies include giving advice and/or reassurance, sometimes in extended consultations.¹⁹

Availability of interventions

Other options for sub-threshold mental health syndromes are limited. Secondary care services are not appropriate for this group, even if they were available and patients wished to use them. GPs can refer patients for generic counselling or specific psychotherapies but, despite recent policy initiatives,²⁰ cost may still be an important barrier. The need for referral out of the practice is a barrier for both patients (due to waiting and uncertainty about eligibility for treatment) and some practitioners (due to administration and supply of trusted providers to refer to).^{11,17,20} Furthermore, the notion of on-referral to a 'specialist' or 'expert' is a secondary care model which may not be appropriate for the majority of these problems. The Internet offers the possibility of direct patient access to self-management information. The HRC has funded a clinical trial of Internet treatment for clinical depression (RID,ⁱ PI Dr S Nada-Raja, University of Otago), which is also available to those with sub-threshold syndromes.

Evidence for interventions

Treatments used in primary care RCTs are commonly described generically using terms such as 'counselling',²¹ and they are being conducted with varied clinical groups (e.g. sub-threshold depression,²² major depression, or sub-

threshold syndromes,²³ meaning trials cannot be readily compared or replicated. There is some limited evidence supporting the use of ultra brief interventions for sub-threshold depression in primary care, using cognitive behavioural and interpersonal-dynamic principles²⁴ and interpersonal psychotherapy.²⁵ A smaller evidence base is developing in relation to self-help for sub-threshold syndromes.⁸ The evidence to date indicates that the treatments best supported by evidence include exercise and relaxation training, bibliotherapy based on CBT^{26,27} and web-based psycho-education.²⁶

Many brief treatments, including self-help, appear to be condensed versions of interventions developed to treat discrete disorders over many months.²⁸ Some of these interventions may be too densely packed with therapeutic elements to actually be feasible over a short period. The Primary Care Initiatives Evaluation therapist survey revealed that counsellors and therapists generally considered that six sessions were too few.²⁰ While severity of the conditions being treated may explain some of this, several therapists also described difficulties in choosing the 'right' approach in such a short space of time. The underlying assumption that the nature of the psychopathology is the same as for full (especially severe) disorders may be flawed,^{29,30} and this may partly explain the smaller effect sizes commonly seen for more established treatments such as CBT in primary care settings, although lower distress at baseline and the effectiveness of 'usual GP care' may also contribute.²¹ In their seminal review of psychotherapy research, leading UK psychotherapists Roth and Fonagy called for further development work on the management of sub-threshold syndromes in primary care.²⁸

Policy context

The Primary Health Care Strategy³¹ prompted a new direction for NZ primary health care, within an overarching public health framework. The vehicle for achieving the changes was Primary Health Organisations (PHOs), which have evolved from a range of other provider entities, resulting in diversity in philosophical approaches, capacities and rates of development, and different expectations with respect to infrastructure and workforce.²⁰ These structures and the revision of funding mechanisms made it possible for mental health services to be developed as an integral part of PHOs and these are now embedded as a core part of funded primary care activity. The expectation is that primary care will manage mental disorders of 'mild' to 'moderate' severity and also be proactive in mental health promotion (with a possible hope that this will reduce incident cases of frank disorder). Clearly in this policy context there is an intention to address sub-threshold syndromes given their position in this spectrum.

Primary care sector workforce development

The evaluation of the Primary Mental Health Initiatives showed that there was great diversity among clinicians providing psychological interventions, in terms of professional and theoretical backgrounds. There will need to be considerable primary mental health workforce expansion and skill enhancement in order to meet the extent of unmet need. Existing staff working in this area have particularly emphasised the need for skill development in brief interventions.²⁰ Substantial work will be required in relation to this, as most

ⁱ <http://www.otago.ac.nz/rid/>

training for psychological treatments is time-consuming, whether it is delivered intensively or intermittently.

Should people with sub-threshold mental health syndromes receive intervention and, if so, what?

We suggest that the evidence supports intervention on the grounds of relief of suffering and the restoration of functioning. However, the over-riding argument is that the nature of primary care practice means that people with these syndromes are *already* receiving interventions of various kinds. On the whole these are likely to be pragmatic approaches to common and complex presentations, of the kind that GPs have been delivering for many decades, variably infused with evidence as it comes to hand. In light of this, and the need to be thoughtful about the use of scarce health resources, the focus needs to be on the most effective way of delivering this care.

A useful framework for considering the problem of provision of treatment for mental health problems in the face of scarce resources is that proposed by Jorm.²⁶ The model suggests that a range of responses is available for subpopulations with varying levels of symptoms and impairment. As symptoms and impairment increase from a low base due to stresses in everyday life,^{32,33} so the interventions called into play move from the first 'wave' of self-help using everyday strategies such as exercise and talking to family or friends, through a second 'wave' of facilitated self-help. The next 'wave' is professional help-seeking, with, finally, provision of specific treatments once severity is at the disorder threshold. This approach is consistent with the 'stepped care' model now commonly accepted as a structure for funding mental health services.

In this framework, presentation or detection in primary care represents part of the first wave of professional help-seeking. Primary care practitioners need a range of management options to call on at this level, and there have been calls for investment in research to establish whether the use of 'minimal' interventions are an efficient method of delivering psychological treatments.³⁴ We have been fortunate to receive Health Research Council funding to develop an ultra-brief intervention that can be delivered by a trained but non-mental health-specialist primary care practitioner (e.g. practice nurse or GP). This will involve a pragmatic two-three contact intervention to reduce the disability associated with sub-threshold mental health syndromes, as a step up from self help in the 'wave' framework. The intervention will require minimal additional training; and we hope it will reduce the need for referral on, thus maintaining patient links with the primary care team; and will reinforce the patient's existing self-help strategies, consistent with the strengths-based approaches now being emphasised in NZ mental health practice. Following development we hope to take the intervention to pragmatic clinical trial in the NZ primary care setting.

Novel intervention research such as this is central to meeting demand in primary care mental health in NZ and it will contribute to the national and international evidence base for the management of this common and burdensome problem. We acknowledge that secondary care mental health clinicians may be doubtful about the idea of an ultra brief intervention that can be used by people with a minimum of training: 'Where are the formulations? The risk assessments? The highly trained mental health clinicians?' However, current mental health funding policy in New Zealand provides access to sophisticated, expensive treatment, which is in relatively short supply,

and is aimed at diagnosable disorders. Most primary care patients cannot jump this high threshold for access to services, and this is probably appropriate. However, below this threshold there a large group of people with, at best, (and only recently) partly-met need. We aim to help meet this need.

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Mind over matter—implications for general practice

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For centuries, it has been recognised that the mind has power over the body, and experience of external stimuli is subjective and variable. This paper will explore some of the evidence for this, and seek to apply the phenomenon to a health care setting.

In the New Zealand (NZ) primary care environment where patients are increasingly critical of the service they receive, where retention of capitation base is important, and recruitment of appropriate new patients is desirable and, most importantly, where efficient delivery of quality health care is paramount, a good understanding of the relationship between expectations and experience is vital.¹

Patients in primary care are increasingly mobile, and many will seek provision of their health care from various sources, depending on the specific problem. This may be due to a desire for confidentiality, an opportunity to seek specialised care, or merely a geographical or temporal convenience. The fourth reason for patient movement is dissatisfaction with care provision, from phone to reception to nursing and doctor involvement. The advent of fully capitated general practice funding in NZ is encouraging patients to seek all their primary care needs from the one provider, as subsidy is enrolment-specific to one practice.

If general practitioners and primary care business owners are able to understand and cooperate with patient expectations, they will have better opportunity to manage patient movement and financial risk, as well as provide improved health outcomes.

Many studies have been undertaken to demonstrate the psychological relationship between the brain's expectation of a sensory input, and the actual report of that experience.^{2–7} Most famous are the experiments involving wine tasting and pain stimulation. In these various blinded experiments, different subjects reported variable experiences despite identical sensory challenges. Being told that you are drinking an expensive wine, or about to receive a reduced pain impulse, results in tasting a fine wine or feeling less pain, despite the wine being poor or pain level unchanged, respectively. The conclusions are that the pre-frontal cortex modulates the actual sensory assessment to fit with a pre-determined expectation. Indeed, Magnetic

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