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Editorial

PBC for mental health – a reality now?

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In March 2006, the Government published a White Paper, called *Our Health, Our Care, Our Say*.[1] While there was much detail in there on a wide range of issues, there was particular mention made of practice-based commissioning (PBC). PBC is a priority of the Government as it is intended to deliver commissioning to the front-line staff, and move care from the hospital to the community. Commissioning mental health services is complex, but there are areas that can be undertaken early.

Consider somatisation disorder. Patients present to their general practitioner (GP) with symptoms. It is our job to organise that presentation into some form of diagnosis or formulation, and to negotiate with the patient what that diagnosis may be. To quote the late Emeritus Professor of General Practice, Paul Freeling, the job of the GP '… is to organise the chaos of the first presentation'. Frequently there is a difference of opinion as to the possible cause for a set of symptoms, and it may take several consultations before alternative diagnoses are considered. There may also be a need to exclude a physical diagnosis before considering a more psychosomatic-orientated complaint. A patient may also request a second opinion, which in most cases the GP will accede to, as we have learnt that to refuse, is often a cause for complaint. The consequence is that patients are often referred to a specialist acute outpatient department with medically unexplained symptoms. It is not that the referral is inappropriate, far from it, but medically unexplained symptoms can account for 50–60% of all referrals to some clinics. Nimnuan *et al* reviewed sequential outpatient attenders at Kings College Hospital and found that the prevalence was significant (Table 1).[2]

The identification of people with somatisation disorder is not easy. There are a number of questionnaires developed by psychologists in academic settings that have some value. The questionnaires are usually designed as research tools, but some have been developed with the requirement that they work in primary care. However, while a questionnaire might be validated and tested for use in primary care, it may be an entirely different matter for the questionnaire to be used on a regular basis by a GP or practice nurse. Experience suggests that GPs, and less so practice nurses, are unwilling to use questionnaires regularly. The Patient Health Questionnaire (PHQ-2) recommended as part of the depression Quality and Outcomes Framework (QOF) may be the first questionnaire that will be used widely in primary care mental health.[3,4]

There are some questionnaires that may be of value in screening for somatoform disorder.

The Patient Health Questionnaire is a questionnaire designed to identify people in general practice who may have any of the common mental health conditions encountered in primary care. As such it has different elements, designed to elicit the characteristic criteria that make up the International Classification of Disease (ICD 10) diagnosis. Thus PHQ-9 is designed to diagnose people with depression, and the Generalised Anxiety Disorder questionnaire (GAD-7) is designed to diagnose people with generalised anxiety disorders. The PHQ-15 is designed to diagnose the presence of somatoform disorders, and as the name suggests is a 15-item self-complete questionnaire. Thirteen items relate to concerns about physical health and two questions relate to mood.

Table 1 Prevalence of medically unexplained symptoms in the outpatients department of a London acute trust

Clinic	Prevalence of unexplained symptoms (%)
Chest	59
Cardiology	56
Gastroenterology	60
Rheumatology	58
Neurology	55
Gynaecology	57

Other questionnaires include The Very Short Health Anxiety Inventory, developed by Salkovskis, the Health Attitude Survey developed by Noyes *et al*, a screening index commissioned by Schwartz and colleagues, the Othmer and de Souza Test, The SPHERE questionnaire from Australia, and the 7- or 14-item Whitely scale.[5–7]

Using clinical acumen together with one of the questionnaires above, may provide a more effective way of identifying and managing people with somatisation disorder. What is possible, and seems to be acceptable and practical practice, is to use the IT systems in place within the practice to identify those who have been referred more than twice in 12 months, and have had no cause found for their symptoms. This provides a practice list or register (similar to many other electronic registers in primary care) of people at risk.

The notes are flagged (electronically or otherwise) so that when a further referral is being considered, as part of the process of assessment, a screening tool is used to assess for the presence of somatoform disorder. Those few individuals who have been referred several times, who have had no cause found for their symptoms, and who have scored positively on a validated screening questionnaire, are offered two interventions:

- referral to an experienced therapist who can discuss with them what they feel about their symptoms, what they think their symptoms represent, what they think might be happening to their body, etc. For those for whom it is appropriate, the individual is either offered a cognitive-behavioural therapy (CBT) course of treatment appropriate to managing their somatic symptoms, or CBT tailored to an underlying depressive or anxiety disorder
- the GP undertakes to see the patient on a regular basis to monitor the progress of their physical symptoms. This provides reassurance that the physical symptoms are being taken seriously, and allows referral to an acute outpatient department if the symptom complex changes.

The management of people with somatisation disorder is well established, with good evidence that re-attribution training for primary care staff, and CBT are both effective.[5,8,9–11]

The use of PBC to commission a service for this group of people seems a reality. People with somatisation disorder can be identified, and there exists an effective intervention. If CBT is needed, it can be commissioned by the practice, at a significant saving to the practice, and leading to reduced waiting times at acute trusts. The following example shows the sort of calculation that practices may wish to consider:

- the costs of a full-time professional able to deliver CBT safely is about £40k (including on-costs)
- such an individual, working for 46 weeks a year, five days per week, and providing four clinical sessions each day (allowing the remaining time in the day for other professional activities) would provide a course of 10 sessions of CBT to just under 100 people
- using pre-national tariff figures, the potential savings in avoided referrals to acute trusts would be around £100 000
- other benefits would be reduced waiting times at acute trusts. There are also potential savings in reduction of GP prescribing of psychotropic medication, and analgesic medication, although there is little evidence at present to know the quantum of that saving
- what this would deliver, would be improved access to CBT, something that we all wish to see, without the need to extract money from the mental health trust. The resource comes from the acute trust, in reduced activity at the outpatient department; it also avoids the perennial and unhelpful debate of severe mental illness versus common mental illness – which should get the limited resource? More importantly it also delivers a better standard of care for patients who would otherwise end up in the cycle of more and more investigations and referrals to other specialists in an attempt to explain physical symptoms without addressing their mental health needs.

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