Family doctors' role in providing non-drug interventions (NDIs) for common mental health disorders in primary care

Summary of Recommended Competencies

Be able to demonstrate active listening and clinical interpersonal skills to show warmth, interest, respect, empathy and support

- Attentive body language: facial expressions, eye contact, gestures to show engagement and interest
- Following skills: open-ended questions to facilitate the patient to tell their story, attentive silences, facilitative responses, picking up on cues
- Reflecting skills: paraphrasing, summarising or repeating back what has been said to clarify and show understanding, reflect back feelings

Be able to effectively assess a patient's psycho-social status e.g. using the BATHE technique

- **B**ackground: e.g. *"What's going on in your life?", "Tell me what has been happening?"*
- **A**ffect: e.g. *"How does that make you feel?", "How has that affected you"*
- **T**rouble: e.g. *"What troubles you about this?", "what bothers you the most about the situation?"*
- **H**andling: e.g. *"How are you handling that?", "How have you been managing this problem?"*
- **E**mpathy: Instil hope by expressing your understanding of what the patient is going through e.g. *"I imagine that could be / may be difficult", "You seem to be going through a lot"*

Be able to provide psychoeducation

- Be able to provide psychoeducation for depression, anxiety and panic attacks – pathophysiology, effect on health and treatments
- Be able to explain the sleep cycle and its effect on mental health
- Be able to provide instructions on sleep hygiene.

Be able to teach relaxation and stress management techniques

- Be able to teach slow breathing exercises
- Be able to teach progressive muscle relaxation
- Be able to promote and support patients to practice guided relaxation, meditation and/or mindfulness-based interventions

Be able to incorporate principles of behavioural activation into the management plan

- Be able to negotiate with the patient to construct a patient-centred activity plan
- Be able to encourage and motivate a patient to keep engaged in pleasurable activities and activities that can improve self-esteem and self-efficacy
- Be able to motivate patients to keep physical active by maintaining or increasing physical activity
- Be able to facilitate patients to strengthen their social supports

Be able to support patients in using internet-based psychological treatments

- Be able to facilitate and support patients using guided internet based psychological therapies such as iCBT

Be able to empower patients to become better problem solvers

- Be able to facilitate patients to identify specific life problems associated with psychological and/ or somatic symptoms
- Be able to guide patients to set specific, achievable goal/s
- Be able to assist patients to brainstorm possible solutions and weigh their pros and cons
- Be able to empower patients to decide on and implement a realistic plan of action, and to review the outcomes

WONCA WPMH Non Drug Interventions Tool Kit	
Clinical Interpersonal Skills	
Active Listening	http://www.racgp.org.au/afpbackissues/2005/200512/200512robinson.pdf
BATHE technique	http://primhe.org.uk/documents/relavent_docs/BATHE_technique.pdf
Communication skills	https://www.each.eu/teaching/resources/
Psychoeducation	
Depression	https://www.cci.health.wa.gov.au/Resources/For-Clinicians/Depression http://www.racgp.org.au/afp/2013/april/bibliotherapy-for-depression/
Panic attacks	https://www.cci.health.wa.gov.au/Resources/For-Clinicians/Anxiety
Sleep	https://sleep.org/ https://sleepfoundation.org/sleep-topics/sleep-hygiene
iCBT	http://www.racgp.org.au/afp/2013/november/cbt/ Each of the following sites offers clinician access and guidance. •**MoodGYM** (https://moodgym.anu.edu.au/welcome) is a free online training program developed by the Centre for Mental Health Research, Australian National University. It uses CBT and interpersonal therapy. MoodGYM is available in several languages. •**THIS WAY UP** clinic (https://thiswayup.org.au/clinic /) offers several courses developed by staff at the Clinical Unit of Anxiety and Depression at St Vincent's Hospital, Sydney and the University of New South Wales Faculty of Medicine. Patients require a GP referral and there is a small fee. Progress can be monitored by the referring GP. Courses available include depression, generalized anxiety disorder and mixed depression and anxiety. Clinicians have free access.
Relaxation Exercises	
Slow Breathing	https://www.cci.health.wa.gov.au/Resources/Looking-After-Yourself/Other-Resources https://www.youtube.com/watch?v=aN05yXFbwI0 (YouTube video)
Progressive Muscle Relaxation	http://www.cci.health.wa.gov.au/docs/ACF3C8D.pdf
Behavioural Activation	
Activity scheduling	https://www.cci.health.wa.gov.au/Resources/For-Clinicians/Depression http://psychologytools.com/task-planning-and-achievement-record.html
Exercise prescription	https://www.move.va.gov/docs/Resources/CHPPM_How_To_Write_And_Exercise_Prescription.pdf
Problem Solving Therapy	
	http://www.racgp.org.au/afp/2012/september/problem-solving-therapy/#16
Training manuals and guidelines	
mhGAP Intervention Guide - Version 2.0	http://www.who.int/mental_health/mhgap/mhGAP_intervention_guide_02/en/
Thinking healthy	http://www.who.int/mental_health/maternal-child/thinking_healthy/en/
Problem Management Plus (PM+)	http://www.who.int/mental_health/emergencies/problem_management_plus/en/

Interpersonal therapy	http://www.who.int/mental_health/mhgap/interpersonal_therapy/en/
Problem-solving therapy	Weel-Baumgarten, E. van, Mynors-Wallis, L., Jané-Llopis, E., & Anderson, P. (2005). A training manual for prevention of mental illness: managing emotional symptoms and problems in primary care. Nijmegen: Radboud University of Nijmegen.http://uwaims.org/files/pst/PST-PC_Manual.pdf
Collaborative Care Model	American Psychiatric Association/Academy of Psychosomatic Medicine. Dissemination of integrated care within adult primary care settings the collaborative care model 2016. https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Professional-Topics/Integrated-Care/APA-APM-Dissemination-Integrated-Care-Report.pdf
Atención a Las Personas con Malestar Emocional Relacionado con -Condicionantes Sociales en Atención Primaria de Salud (in Spanish) https://consaludmental.org/publicaciones/Atencion-personas-malestar-emocional.pdf	

Introduction

Common mental health disorders, such as depression and anxiety affect up to 15% of the population at any one time.[1] The 2010 Global Burden of Disease found that major depressive disorders accounted for 8.2% of global years lived with disability (YLD) making it the second leading cause of YLDs after cardiovascular disease.[2] To date, the most common method used to manage common mental health disorders in primary care has been with psychotropic medications[3] despite the fact that non- pharmacological treatments are often preferred by patients[1] and have been shown to be effective[4]. Referral of patients for psychological services can be difficult because of limited access to qualified therapists and patient barriers such as time and stigma.[5] Methods of providing psychological treatments that are less resource intensive, accessible, affordable and non-stigmatizing to patients is of great importance to primary care.[6 7]

The primary care setting is the point of entry for most people into the health system and family doctors are well placed to deliver mental health interventions due to the longitudinal relationship and trust they have with patients and families, their ability to respond to undifferentiated problems, the use of a bio-psycho-social model and their ability to integrate care of mental with physical conditions.[8]

Mental health presentations most frequently encountered by family doctors include generic psychosocial distress, grief, bereavement, sub-threshold mood symptoms, reactive disorders, mild-moderate unipolar depressive disorders and anxiety disorders, which can be of sufficient severity to impair daily functioning or health-related quality of life. Such presentations may account for as much as 30% of consultations in primary care.[9 10] In many primary care settings, usual care for depression and anxiety typically involves empathic listening, provision of some informal supportive counselling, prescription of psychotropic medications (usually antidepressants), a medical certificate and/or a referral to a mental health service.[11 12] Evidence from several meta-analyses have found that the effectiveness of antidepressants over placebo appears to be minimal or non-existent in mild or moderate depression, but may be more substantial in patients with very severe depression.[13-15] The risk-benefit ratio for antidepressants is therefore reasonably poor for most primary care patients who tend to have mild to moderate symptoms when weighed against the adverse drug effects associated with tolerability and withdrawal.[15 16] NICE guidelines advises avoiding drug treatment unless there is a past history of moderate or severe depression that persists after other interventions have been trialled, or sub-threshold symptoms that have been present for a long period typically at least two years.[17]

Non-drug interventions for common mental health problems can take a variety of forms ranging from supportive and empathic clinical interpersonal communication techniques and low intensity psychosocial interventions that can be delivered by any family doctor, to more intensive psychological therapies provided by trained therapists. The aim of this guidance paper is to help raise awareness of the role of non-drug interventions (NDIs) in managing common mental health disorders, and to encourage family doctors to incorporate these evidence-based treatments into their routine practice. Our WONCA work group have drawn together evidence from the literature to make recommendations on how to promote the use of NDIs with a focus on the training needs of family doctors and recommendations on service delivery models relevant to primary care.

Recommendations on the types of skills that family doctors need

1. Clinical interpersonal skills

Interpersonal skills are an important and integral part of the practice of good medicine. There is a large body of evidence supporting the value of core attributes and skills such as showing empathy[18-21], compassion [22], and being able to provide patient support. These competencies are relevant not only for reducing patient distress, but studies have also found that doctors who possess and demonstrate such skills are more effective. Patients have better faith in their doctors and are more willing to adhere to their

treatments ultimately resulting in better mental and physical wellbeing.[23] [24] Techniques such as the Cambridge-Calgary method[25] which emphasises active listening skills and the BATHE technique[26] [27] as a method for assessing a patient's psycho-social status have been shown to result in more effective GP consultations and increased patient satisfaction.[25] [28] Ideally this should be done in a calm and undisturbed environment.

Studies have found that formal training of doctors and medical students is effective.[25] An educational programme in mindful communication was found to enhance empathy and patient-centred care, and reduce burnout [29]; family physicians taking part reported enhanced ability to listen deeply to patient's concerns and develop their own adaptive reserves.[30] Empathy training modules in postgraduate medical education have been shown to significantly impact empathy scores as rated by patients.[31]

Recommended competencies

Be able to demonstrate active listening and clinical interpersonal skills to show warmth, interest, respect, empathy and non-judgmental support[28]

- Attentive body language: facial expressions, eye contact, gestures to show engagement and interest
- Following skills: open-ended questions to facilitate the patient to tell their story, attentive silences, facilitative responses, picking up on cues
- Reflecting skills: paraphrasing, summarising or repeating back what has been said to clarify and show understanding, reflect back feelings

Be able to effectively assess a patient's psycho-social status e.g. using the BATHE technique[26]

- **B**ackground: e.g. *"What's going on in your life?", "Tell me what has been happening?"*
- **A**ffect: e.g. *"How does that make you feel?", "How has that affected you?"*
- **T**rouble: e.g. *"What troubles you about this?", "what bothers you the most about the situation?"*
- **H**andling: e.g. *"How are you handling that?", "How have you been managing this problem?"*
- **E**mpathy: Instil hope by expressing your understanding of what the patient is going through e.g. *"I imagine that could be / may be difficult", "You seem to be going through a lot"*

2. Skills in delivering low intensity psychosocial interventions

Low intensity psychological interventions refer to interventions that do not rely on mental health specialists and may consist of modified, brief evidence-based therapies including guided self-help or e-mental health.[32] They tend to be trans-diagnostic (can be used for any type of common mental health disorder) with a primary focus on enhancing patients self-efficacy.[33] Evidence-based interventions include psychoeducation, stress management and relaxation techniques, behavioural activation, cognitive behavioural therapy (either in individual or group format) and problem-solving therapy. Low intensity psychosocial skills training can feasibly be incorporated into medical school curricula even when curriculum time is limited.[34]

2.1. Psychoeducation

Description

Psychoeducation refers to any educational intervention offered to individuals (and their families) to help empower them to improve their health. Psychoeducation can help to reduce stigma, self-blame and barriers to treatment. The key goals of psychoeducation are:

- Knowledge transfer (e.g. pathophysiology or the cause of the illness, education about treatments)
- Promote understanding (e.g. to understand what can make things worse or better),
- Support treatment (e.g. to enhance compliance),

- Promote self-help (e.g. what to do if a crisis occurs).

Evidence

A meta-analysis found that brief psychoeducational interventions for depression and psychological distress can reduce symptoms and are easy to implement as an initial intervention for psychological distress or depression in primary care. [35] Studies have found that psychoeducation can help to prevent and reduce the risk of relapse of depression.[35-37]

Current evidence suggests that whilst the quality of psychoeducation provided is important, the method of delivery appears to be less important (e.g. patient information leaflets, face-to-face discussion, group-based classes).[35] This means that even in a busy GP setting, doctors can provide psychoeducation by promoting individualized self-help (e.g. by referring patients to books or websites or providing patient education leaflets) or refer patients to group psychoeducation classes.

Recommended skills

- Be able to provide psychoeducation for depression, anxiety and panic attacks – pathophysiology, effect on health and treatments
- Be able to explain the sleep cycle and its effect on mental health
- Be able to provide instructions on sleep hygiene.

2.2. Stress management and relaxation techniques

Description

Stress, especially that relating to work, is a common trigger for health problems presenting to primary care.[38] There is a body of research connecting stress to physical health problems such as cardiovascular disease, metabolic syndrome, obesity, weakened immunity and infertility through disturbances of the hypothalamic-pituitary axis and increased cortisol levels, as well as to mental illnesses such as depression.[39-41] Given the negative impact of stress, it is important for family doctors to be familiar with commonly used stress management and relaxation techniques and be able to teach them to their patients.

Evidence

There are many evidence-based stress management techniques shown to be able to help reduce psychological distress. Examples include slow breathing or diaphragmatic breathing exercises, progressive muscle relaxation, guided imagery or guided meditation and Mindfulness-Based Stress Reduction (MBSR).[42] Stress management techniques are useful clinical skills for family doctors as they are applicable not only to people who are sick or under distress, but also to healthy individuals for health promotion. A review paper on stress reduction techniques found that they can improve the quality of life of patients and contribute to the reduction of physical and psychological symptoms, and that the same techniques can be therapeutic for healthcare providers and help to enhance their interactions with patients. [42] A recent Dutch pilot study of mindfulness-based stress reduction for GPs has found positive effects on dedication, mindfulness and compassion.[43] Training intensity for these techniques can range from a half-day session to 8-12 week courses.

Recommended skills

- Be able to teach slow breathing exercises
- Be able to teach progressive muscle relaxation
- Be able to promote and support patients to practice guided relaxation, meditation and/or mindfulness-based interventions

2.3. Behavioural activation

Description

Behavioural activation is a therapeutic process that emphasizes planned activities which help to increase behaviours that are likely to produce improvements in thoughts, mood, and overall quality of life.[44] The aim of behavioural activation is to structure in positive distractions and mood improving activities. These activities aim to increase pleasurable activities, enhance social interactions, promote better sleep and improve self-esteem. It helps to enhance mood by reducing mood-worsening rumination whilst promoting positive reinforcing thoughts and feelings.[44]

Evidence

Behavioural activation is targeted predominantly for patients who may be depressed, socially withdrawn or have poor self-esteem.[45] [46] This may be particularly important in the elderly who are prone to social isolation due to physical illness.[47] There is some evidence that it may also be effective for anxiety.[48] Exercise (on its own or incorporated into an activity plan) should also be promoted routinely by GPs. A Cochrane review found that exercise is moderately more effective than a control intervention for reducing symptoms of depression, and as effective as psychological or pharmacological treatments.[49] In a 2016 RCT, Hallgren found that exercise is beneficial for depression even when it is light (yoga and stretching) as opposed to moderate and vigorous and when conducted once per week.[50] Furthermore, there can be cardiovascular and metabolic benefits for patients with depression.

Incorporating an activity plan is feasible in a routine GP consultation.[51] A doctor can help guide their patient to draw up a schedule of planned activities. These activities should be negotiated using a patient-centred approach to enhance the compliance and effectiveness in alleviating mood symptoms. Activities could include day-to-day essentials (bathing, shopping, eating, and sleeping) with the incorporation of social activities (e.g. lunch with a friend), pleasurable activities (e.g. hiking, watching a movie) and activities that can promote self-esteem (e.g. gardening, volunteer work). Patients need to be encouraged to remain engaged and active even if they do not feel like doing it.

Recommended skills

- Be able to negotiate with the patient to construct a patient-centred activity plan
- Be able to encourage and motivate a patient to keep engaged in pleasurable activities and activities that can improve self-esteem and self-efficacy
- Be able to motivate patients to keep physically active
- Be able to facilitate patients to strengthen their social supports

2.4. Internet-based psychological treatments e.g. iCBT

In many countries, computer-based therapies such as internet-delivered cognitive behavioural therapy (iCBT) is gaining significant attention as a way to scale up the delivery of psychological services and been found to be as effective as traditional CBT. A 2012 review on internet-based psychological treatments found that iCBT interventions are effective and provide an important alternative to face-to-face psychological treatments, but that guided iCBT treatments (either with the GP or an allied health staff) are more effective than unguided treatments. Contact before and/or after the treatment can enhance both guided and unguided iCBT.[52]

Recommended skills

- Be able to facilitate and support patients using guided internet based psychological therapies such as iCBT

Examples of iCBT

- Mood gym: https://moodgym.anu.edu.au/welcome
- This way up: https://thiswayup.org.au/how-we-can-help/internet-delivered-cognitive-behaviour-therapy/

2.5. Problem-solving therapy (PST)

Description

Problem-solving therapy (PST) is a focused psychological intervention that helps patients to develop problem-solving skills that can be applied to life problems associated with psychological and somatic symptoms. It can be used for various psychological problems including depression, anxiety, and sleep disturbance. The aim is to empower the patient to identify and solve their own problems by guiding them through the problem solving process in a structured, sequential way.
An abbreviated version has been developed for use in primary care that can be delivered over a series of four to six 15-30 minute consultations.[53]

Evidence

PST has been shown to be as effective as antidepressant medication for major depression in improving symptoms and social functioning when provided by appropriately skilled GPs.[54]
Primary care doctors and nurses can learn to deliver PST by doing a short training programme.[55]

Recommended skills

- Be able to facilitate patients to identify specific life problems associated with psychological and/ or somatic symptoms
- Be able to guide patients to set specific, achievable goal/s
- Be able to assist patients to brainstorm possible solutions and weigh their pros and cons
- Be able to empower patients to decide on and implement a plan of action, and to review the outcomes

Recommendations on service delivery models relevant to primary care

The WHO Mental Health Gap Action Programme (mhGAP) have developed and evaluated a set of training manuals for scalable psychological interventions to help build mental health capacity. These manuals were designed for training non-specialised health workers with no prior mental health qualifications. These interventions are particularly relevant for settings where access to psychological services is limited and in great need such as in communities affected by adversity. [56] They currently include:

- ***mhGAP Intervention Guide - Version 2.0*** for mental, neurological and substance use disorders in non-specialized health settings
  http://www.who.int/mental_health/mhgap/mhGAP_intervention_guide_02/en/

- ***Thinking healthy***: a manual for psychosocial management of perinatal depression[57]
  http://www.who.int/mental_health/maternal-child/thinking_healthy/en/

- ***Problem Management Plus (PM+):*** PM+ is for adults suffering from symptoms of common mental health problems (e.g., depression, anxiety, stress or grief), as well as self-identified practical problems (e.g., unemployment, interpersonal conflict). It uses a trans-diagnostic approach that can be very useful in primary care where many present with comorbidity or no specified diagnosis. PM+ integrates problem-solving and behavioural treatment techniques with a strong emphasis on behavioural (as opposed to cognitive) techniques, as these are easier to teach and learn. [58]
  http://www.who.int/mental_health/emergencies/problem_management_plus/en/

- ***Guidance on group interpersonal therapy (IPT)**:* WHO recommends interpersonal therapy (IPT) as a first line treatment for depression. The World Health Organization (WHO) guidance on use of interpersonal therapy (IPT) uses an 8-session group protocol for use by supervised facilitators who may not have received previous training in mental health.[59]
  http://www.who.int/mental_health/mhgap/interpersonal_therapy/en/

Collaborative Care Model for delivery of mental health services in primary care

Over the past decade, the Collaborative Care Model as originally described by Katon and colleagues[60] has been shown to improve patient outcomes, save money, and reduce stigma related to mental health. Collaborative Care operationalizes the principles of Wagner's Chronic Care Model[61] to improve access to evidence based mental health treatments for primary care patients. It helps to normalize and de-stigmatize treatments for behavioural health disorders, and enhances service access for patients. In this integrated team-based, stepped care approach, patients are managed by a primary care clinician and an allied health provider who acts as the case manager. A specialist psychiatrist liaises usually via the case manager to provide advice on diagnosis and treatment when first line treatments are not effective. Training in collaborative/integrated care can help optimise the skill mix to enhance the outcomes for mental health problems in primary care.[62] The American Psychiatric Association/Academy of Psychosomatic Medicine has produced a report summarising the evidence on how to implement Collaborative Care model for mental health into primary care (see link to the document in the NDI Toolbox).

Acknowledgements

This guidance document was produced by a task group from the WONCA Working Party for Mental Health (WWPMH). The task group was led by Dr Weng Yee Chin, Department of Family Medicine and Primary Care, University of Hong Kong. The task group members were:

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- Professor Christopher Dowrick, Department of Psychological Sciences, University of Liverpool, UK.

The group received valuable comment on earlier iterations of this document from members of WWPMH and from Dr Evelyn van Weel-Baumgarten (President, International Association for Communication in Healthcare), Dr Henk Parmentier (Secretary, World Federation for Mental Health), Professor Gabriel Ivbijaro (President, World Federation for Mental Health), Professor Helen Hermann (President, World Psychiatric Association) and Dr Tarun Dua (WHO Mental Health Directorate).

The document has been approved for publication on the WONCA website by the WONCA Executive.

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