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Management of common mental disorders for psychogeriatric patients in Hong Kong – a comparison of two clinics

The enhanced Common Mental Disorder Clinic (CMDC) was developed by the Hospital Authority of Hong Kong in 2015 to shorten new-case waiting time at the psychiatric specialist out-patient clinic (SOPC) for adult patients with common mental disorders (CMDs).[1] Patients with CMDs usually have to wait for a long time for their first psychiatric consultation and during that period symptoms may worsen and become more distressing. They may require a longer duration of treatment if their problems have become more complicated. CMDC aims at providing early treatment to nip the problem in the bud. It consists of two doctors, three nurses, two occupational therapists and one clinical psychologist. Each patient is under the care of a multidisciplinary team. The additional allied health input aims to reduce doctors' burden. It is hoped that after one year of treatment, a substantial number of patients can be discharged from the programme.

CMDC started its operation in the Kowloon East Cluster of Hong Kong in July 2016 – Kowloon East is one of seven clusters governed by the Hospital Authority and it serves a population size of about 1.1 million. Psychogeriatric patients are normally seen at SOPC, with waiting times of 110 weeks in 2015. We intend to include psychogeriatric patients in the new programme with a view to shorten the waiting time.

A pilot study has been conducted by recruiting 30 consecutive psychogeriatric patients, with CMDs, from CMDC and SOPC retrospectively. The difference in clinical factors between the two groups, as well as any benefit of shortening the waiting time by triaging suitable psychogeriatric patients from SOPC to CMDC, were assessed. Aims of the pilot programme were to demonstrate any benefit of extending CMDC to psychogeriatric patients and to guide future modifications needed for this group.

There was no statistically significant difference in the age and gender distribution of the two groups. The waiting time for the CMDC group (median of 89.5 days, IQR=52.8) was significantly shorter than the SOPC group (mean 425 days, s.d.=220) ($P<0.00001$). All CMDC psychogeriatric patients were referred for psychological intervention. The clinical psychologist appointment was available within 1 month after referral. Only about half of the patients attended the psychological intervention arranged for them. For the SOPC group, 8 patients (26.7%) from the SOPC group were referred for psychological intervention with a waiting time of at least 9 months. Two (25%) refused the intervention. About 60% of patients in both groups received treatment by general practitioners or private psychiatrists before being referred to us. At 6 months, 28 patients (93%) remained in CMDC, and 23 patients (76.7%) remained in SOPC.

CMDC significantly reduced waiting times for a medical consultation and psychological intervention for elderly patients with CMDs by 80%. The waiting time of psychogeriatric SOPC was also shortened to about 50 weeks after the new programme ran for 10 months. CMDs are common in the elderly population and they are suitable candidates for the clinic. Acceptance towards psychological intervention is only modest for this group of patients as the CMDC programme was not tailor-made for elderly patients. If the clinic is to be extended to psychogeriatric patients, the content of the groups will need to be more age-specific.

Primary care settings present important opportunities for the detection and management of depression in older adults.[2] Programmes in which primary care providers and mental health specialists collaborate effectively could improve patient outcomes for those with CMDs.[3] It is worthwhile involving primary care doctors in the new programme by providing care after patients are stepped down from CMDC.

Psychological intervention by nurses helps to reduce the frequency of medical consultations. Doctors' time can thus be spent on less stable patients. Nurse-led clinics were also found to present an opportunity by freeing up specialists to see more complex patients.[4]

Acceptance of psychological intervention may be related to the age group of patients; this information would be useful for guiding future services. Comparison will be performed again when the CMDC group has completed the 1-year programme. A larger number of patients are expected to be discharged from the CMDC in comparison to SOPD after 1 year. The number of doctor consultations will be compared. We hope that by studying the characteristics of patients who can be discharged successfully after completion of the programme, we can identify suitable patients to be referred to it.

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Author's reply – the cognitive therapy of depression

Although Dr Moorey and I both deprecate theoretical whimsy and while there is much that we can agree on concerning cognitive–behavioural therapy (CBT) and psychoanalysis, we profoundly disagree on several other matters including, especially, the content and remit of that paper of mine on which he commented.[1,2]

Regarding CBT, we both agree that it has the most comprehensive evidence base of all the psychological therapies

for depression and we referenced reviews of many published studies on the effectiveness of CBT. We also both agree that there is nothing like the same size evidence base concerning psychoanalytic therapy.

However, what such reviews show is that CBT for depression tends not to deliver good outcomes. I take this assessment to be scientifically uncontroversial – it is based on a straightforward examination, rather than any kind of theoretically driven interpretation, of the outcome data. What we find are: effect sizes that are rather uninteresting, true remission rates not greatly higher than for no or routine treatment, non-take-up and drop-out and relapse rates high, and success best predicted by other models or by allegiance effects. True – therapies conducted by CBT practitioners work as well as antidepressants – but, when one considers that the latter often work little better than placebos, that is really no great shakes. And to be told[1] that 40% of those primary care National Health Service patients who did not drop out of treatment were 'reliably recovered' directly after short-term CBT is unhelpful without knowing the relapse, spontaneous recovery and routine care recovery rates for this population. If, say, 53% would have remitted anyway without treatment within the year,[3] if perhaps 25% drop out,[4] and if relapse rates 1 year on for that 40% of treatment completers who are non-depressed directly after treatment may themselves be 29%,[5] the benefits of CBT over treatment as usual are not loomingly apparent. A clear danger presents itself: that we habituate to such dismal outcome data and take encouragement from treatments that merely add a few percentage recovery points to what would have happened anyway.

Maybe, as Dr Moorey implies, we should simply acquiesce in a belief that depression just 'is a relapsing condition' and do the best we can using the well-researched mainstream (largely CBT-based) treatment models. I, however, consider a more optimistic option: that depression is often relapsing only in the absence of such treatment as gets down to its pathogenic roots. After all, sometimes psychotherapy for depression, conducted by practitioners of whatever stripes, really can be truly – and, more importantly, lastingly – effective. What would be good to know is not so much which model the therapists in question use, but what the actual psychological processes are that occur in the recovering patient and which of the various therapeutic interactions foster these.

A curious feature of Dr Moorey's argument is that, although I was very explicit that I was not setting out to write an empirical critique of CBT, or provide an empirical justification for psychoanalytic therapy, my failure to do so is what nevertheless forms the target of much of his criticism. To use a rather CBT-ish metaphor, if the only tool in your critical toolkit is the hammer of 'what's the empirical evidence for that?', it is perhaps not surprising that you use it to try to whack other approaches. To try and force all meaningful questions and methods into the mould of empirical hypotheses, even when they are not about matters of fact but instead about more fundamental issues of meaning and rationale, is the crudest form of science-betraying scientism. Yet, in the absence of a better explanation, it occurs to me that precisely such a scientism may explain why Dr Moorey implies my argument to be driven by theoretical whimsy, since if one somehow thought all valid questions to be empirical in character, then manifestly non-empirical answers could hardly appear anything but whimsical.

The particular approach I chose in the paper was to use the conceit of the 'does x rest on a mistake?' question to inquire into Beck's rationale for developing – and not his evidence for – his depression treatment model. My ambition thereby was not to commit what philosophers call the 'genetic fallacy' – I did not incoherently try to show that CBT-inspired treatments for depression are ineffective because they arise from a rejection of a misunderstood model of psychopathology. That they are often relatively ineffective is already suggested loud and clear by the outcome data. My ambition was instead to reconsider the underlying psychoanalytic theory which Beck abandoned. The origins story of CBT has it that it arose when Beck tested the psychoanalytic theory of depression and to his dismay found it wanting. However, although he disconfirmed the hypotheses he derived from the theory, he was – as I showed – mistaken about the psychoanalytic theory of dreaming and depression, and so his hypotheses did not aptly reflect the theory.

If CBT-inspired treatments for depression were marvellous, the curious story of their origination in a misguided set of theoretical assumptions and experimental and clinical procedures would be merely academic. And if the origins story was to be trusted, we might be justified in thinking that despite the unpromising outcome data for CBT-inspired depression treatments, it would be ill-advised to reconsider the psychoanalytic alternative. However, my paper showed that the origins story is not to be trusted: Beck's mistake was not to be unaware of today's British psychoanalytic theory, but to misunderstand the Freudian theory of dreaming. In doing so, he became over-preoccupied by one ('retroflected hostility') strand of a diverse psychoanalytic theory of depression and overlooked the relational significance of what shows up clinically in the therapeutic situation.

Whether a psychoanalytically informed approach really does offer more promise remains to be seen. Yet, the rationale I reconstructed for it – restoring self-possession through undoing the repression of sadness, anger and fear, and making full use of what is available in the transference to potentiate such work – is at least clear and promising. Contrary to what Dr Moorey suggests, the couple of encouraging outcome studies I mentioned were not absurdly offered to somehow show the superiority of psychoanalytic therapy over CBT – for one thing, they were not even comparative studies. They were offered as further rationale for reconsidering the psychoanalytic model of depression and its treatment. The simple psychoanalytic model of depression I presented also offered a reason why treatments which aim primarily at cognitive restructuring, behavioural activation or mindful defusion, may often not have full or lasting effects, as they fail to target the hidden motivational roots of depression.

Dr Moorey misreads me as implying that the project of extirpating depleting depressive defences is not hard work for the patient – yet no-one who has resided either side of the couch could think this the case. Psychoanalytic psychotherapy aims after all for a real change of heart, a change which is rather more demanding than merely learning to manage your mind. It is one thing to accept that one's habitual thoughts are unevidenced and irrational, and to make efforts to challenge or disidentify from them as they arise. It is quite another to grasp,

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own, confess as motivated, and relinquish, an underlying defensive habit as it manifests in the emotional and ethical fabric of the therapeutic relationship. My point was not that a change of heart is easy, but rather that we do not do well to consign our patient to the easier-in-the-short-term, yet grindingly Sisyphean, labour of challenging her own unextirpated defences' dismal cognitive products.

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Corrections

Scottish independence: the view of psychiatry from Edinburgh. *BJPsych Bulletin* 2017; **41**: 234–236. Professor Eve Johnstone is the eighth generation of Scottish doctors (para 3 line 2). None of the participants of the ECT study described in the interview had intellectual disability (para 10) – the final sentence should read: 'Not shirking controversy, she then ran a placebo-controlled trial of electroconvulsive therapy (ECT), which demonstrated ECT to be effective, albeit only for about 8 weeks, particularly in those depressed patients who experienced delusions and had psychomotor retardation'. The online version of this article was amended post-publication, in deviation from print and in accordance with this correction, on 9 August 2017.

Burnout and psychiatric morbidity among doctors in the UK: a systematic literature review of prevalence and associated factors. *BJPsych Bulletin* 2017; **41**: 197–204. The paper stated erroneously (p. 202, penultimate paragraph) that 96 doctors died by suicide since 2004 while being investigated by the GMC. In fact, the source for the information that 96 doctors died while involved in GMC investigations since 2004 states: 'how many of those took their own lives was not revealed'.

Evaluation of the 13-item Hypomania Checklist and a brief 3-item manic features questionnaire in primary care. *BJPsych Bulletin* 2017; **41**: 187–191. The final sentence of paragraph two under the subheading 'ROC analyses' on p. 188 should read; 'Therefore, a threshold of 8 points was chosen to give the best balance between different statistical parameters.'

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