

Review Article

The Benefits of Syndication of Mental Health Nurses within Rheumatology Out-Patient Departments: A Narrative Discussion

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Abstract

Rheumatology deals with the investigation, diagnosis and management of patients with musculoskeletal conditions. It is a multidisciplinary complex specialty incorporating over 200 disorders affecting joints, bones, muscles and soft tissues, including inflammatory arthritis and systemic autoimmune disorders.

Musculoskeletal conditions can be debilitating and socio-economic consequences severe: 20% of people with chronic physical health problems have depression known to be associated with poor treatment adherence and diagnostic overshadowing, adversely affecting treatment and health status. Diseases are often treated in isolation but there is increasing recognition of the complex relationships between diseases and treatments in patients with multiple chronic diseases, and growing evidence of the detrimental effect poor mental health can have on physical health outcomes.

There is little formal acknowledgement of the impact of mental health on those with musculoskeletal conditions. With the management of arthritides largely based in secondary care, the rheumatology team could be best positioned to provide psychological support for those with mental health issues as co-morbidities. The European League against Rheumatism (EULAR) recommends that the role of the rheumatology practitioners should include provision of psychosocial and self-management support for patients with inflammatory arthritis (IA). This discussion advocates syndication of a registered mental health nurse (RMN) embedded within the Rheumatology outpatient department (OPD). This will require the support of clinical leaders and policy makers but could bring significant patient benefit.

ABBREVIATIONS

IA: Inflammatory Arthritis; RMN: Registered Mental Nurse; OPD: Out Patient Department; RA: Rheumatoid Arthritis; LH: Learned Helplessness; SLE: Systemic Lupus erythematosus; NRAS: National Rheumatoid Arthritis Society; RN: Registered Nurse

INTRODUCTION

Conditions commonly seen and managed within the rheumatology OPD encompass a wide range of inflammatory and non-inflammatory rheumatic diseases, many of which are long

term and progressive, and can have significant mental health implications. These problems are illustrated in three diseases commonly seen in rheumatology clinics: rheumatoid arthritis, systemic lupus arthritis and fibromyalgia.

Rheumatoid arthritis (RA)

RA is the most common of the inflammatory conditions seen in the OPD. It is a systemic, chronic inflammatory disease with complex pathogenesis causing joint pain, swelling, stiffness and fatigue [1,2]. RA is estimated to cost the United Kingdom economy £8 billion per year [3] and around 80% of RA patients will have one or more co-morbidity associated with adverse health

outcome and delaying care pathways. These co-morbidities can increase the patient's overall disability, significantly detracting from physical and psychological health and the wider economy [4].

The prevalence of depression in patients with RA is almost three times higher than in the general population [5]. Patients with RA often feel fatigued and distressed whilst coping with pain and disease activity. Currently it is rare for clinicians to carry out a formal evaluation of mood in busy OPD settings. Evidence suggests physicians may not recognise depression in 72% of their patients [5]. Mental health symptoms may be wrongly ascribed to disease activity: rheumatologists may wrongly escalate medical treatment when the underlying problem is psychological. Alternatively, they may tell the patient no more can be done.

Many RA patients may have a dysthymic disorder, minor depressive symptoms which persist over a period of time but do not meet criteria for clinical depression [5]. As many as 65% of patients with RA can be identified as having psychological distress without fulfilling diagnostic criteria for anxiety and depression. Additionally, patients with rheumatologic diseases have a higher risk of psychopathology than the general population, exhibited most frequently as neuroses and anxiety [6]. Psychological distress often persists even after active disease is treated and joint pain subsides [7].

'Sadness' and 'learned helplessness' (LH) are specific symptoms of depression that can be sufficiently extreme to interfere with daily functioning. LH describes low feelings of control and increasing passiveness which is associated with poorer health outcomes [8]. LH can accurately predict disease outcome in RA, and is a potentially modifiable factor which should be addressed by clinicians.

Systemic lupus erythematosus (SLE)

SLE is a chronic auto-immune disorder resulting from genetic, environmental and hormonal factors and can involve multiple organ systems. The heterogeneity of disease presentation and variability in severity are recognised as making diagnosis and assessment difficult [9]. Anxiety and suicide ideation is found to be higher in patients with SLE than in the general population [10]. The management of SLE ideally should combine an assessment of disease activity, quality of life and a psychological evaluation. As with RA, formal psychological evaluation is often overlooked in the OPD setting. Fatigue and depression are two of the most salient in the patient's experience of the disease and it is likely that subsequent poor mental health could be averted if attention was directed at managing these symptoms in particular.

Fibromyalgia/persistent chronic widespread pain

Fibromyalgia is characterised by widespread musculoskeletal pain, sleep disturbance and fatigue, frequently associated with psychological distress and impaired cognition. Fibromyalgia may lead to high levels of disability and unemployment, even greater than those experienced by patients with RA [11]. Pain and depression frequently co-exist (30%-50%) with an adverse cumulative effect on health outcomes and treatment responsiveness. The combination of chronic pain and depression is associated with worse clinical outcomes than either condition

alone [12], consistent with a bio-psychosocial aetiology [13], suggesting the need to consider cognition around health and pain beliefs in management.

Many rheumatologists are uncomfortable dealing with chronic pain where the cause is unclear, the therapeutic response disappointing and high levels of patient distress are present [14]. Once diagnosed, patients with fibromyalgia may be excluded from further treatment options.

Current management of psychological aspects of rheumatological conditions

Many of the characteristic psychological features of rheumatic disease including fatigue, anxiety, and depression appear subjective and may not be recognised by clinicians or patients. Depression, distress and psychosocial symptoms can overshadow patients' medical history and presentation thus complicating diagnosis, treatment adherence, and clinical decision-making resulting in poorer treatment outcomes [15]. Failure to recognise psychological morbidity has been estimated to increase the total

Table 1: Summary of Evidence of Health & Economic implications.

Evidence	Source
People with long term conditions have become the biggest users of health and social care accounting for 70% of the NHS budget	NHS Five Year Forward View (2014)
Between 12% and 18% of all NHS expenditure on long-term conditions is estimated to be linked to mental health problems.	Naylor <i>et al.</i> , (2012)
It is estimated that each patient with co-morbidity depression costs health services between 30% and 140% more than equivalent patients without depression	Melek & Norris (2008)
Depression can increase financial costs to the healthcare system through repeated consultations, reduced treatment adherence and poorer treatment outcomes	Bruce (2008)
Summary of the evidence base linking long-term conditions and mental health suggested that co-morbidity mental health problems raise total health care costs by at least 45% per person.	Naylor <i>et al.</i> , (2012)
Enhanced care for depression was equally or more cost-effective than treatment of the patient's chronic medical illness.	Kroenke <i>et al.</i> , (2009)

Summary of role

- To establish a structured validated position of an RMN/Rheumatology Specialist Nurse post with the aim to succession-plan for mental health in secondary care rheumatology.
- To establish identified clinics where an RMN/Rheumatology Specialist Nurse can assist in reducing onward referrals and improve patient equity and accessibility to mental health care.
- To ensure OPDs can deliver a structured pathway for the training of an RMN/Rheumatology Specialist Nurse with appropriate clinical supervision, supporting academia, assessment, revalidation, accreditation and clinical governance.

Table 2: Benefits identification and realization of this post.

Health Economic Benefit	Re-allocation of resources of clinician's time	Fewer onward referrals to psychology/other agencies for mental health issues
Economic Benefit	Reduced time spent on mental health consultations	Fewer repeat appointments where mental health is underlying issue, releases clinician time
Quantifiable	Economically difficult to quantify in the short term	Improved mental health outcomes Reduced waiting list times
Non-Quantifiable	Qualitative benefits	Improved staff skill-mix Improved patient mental health outcomes

health care cost of managing these conditions by at least 45% per person [16,17].

Clinicians often feel ill equipped to address psychological issues. A survey of nurses and allied health care professionals by NRAS [18] found that most felt “out of their depth” and lacked training to adequately address patients’ issues around the effects of RA concerning emotions, relationships and sexuality. There is a tendency to concentrate on information-focused ‘biomedical’ consultation styles [19]. A lack of confidence and competence in providing psychological support has been noted in rheumatology staff that lack formal training in specific approaches. Some clinicians expressing a need for additional support to utilise any previous training [20].

Patients with mental health issues feel stigmatised and fear being judged [21]; the inadequacy of health professionals’ training acting as a barrier to exploring patient emotions [22]. Many patients with mental health distress are seen by primary or secondary care clinicians rather than psychiatrists. It is especially important rheumatology staff have the knowledge and skill-mix to recognise important and severe symptoms such as those associated with suicidal ideation [23]. Patients who may still be assimilating diagnosis and complicated information, having seen numerous clinicians, may feel anxious seeing health professionals un-skilled in mental health, rendering them reluctant to communicate suicidal thoughts, especially if past experience has been unsatisfactory [24].

A survey of psychological support provision in rheumatology departments in England reveals psychologists are employed in only 8% of OPDs, in 73% the psychological support provision was rated as inadequate [20]. NRAS [25] asked patients whether the “emotional effects of RA were as significant as the physical effects of RA”; respondents overwhelmingly agreed. An NRAS [26] *Non-pharmacological interventions* workshop for patients with RA identified depression and anxiety as important areas for research. As far back as 1994, [27] the question was posed “who is looking after the proven psychological needs of the patient”? Unfortunately the answer remains that in many cases, no-one is.

At present institutional bias exists against treating mental health. *The Kings Fund* [28] highlights a longstanding criticism: people with mental health problems often fail to receive the same access to services or quality of care as people with physical illness.

New paradigms must identify how to recognise and respond to mental health presentations, improve practice, and allow prompt access care.

National strategy

The Mental Health Taskforce [29] explored variation in access and quality of mental health services across England. The importance of parity of access to mental and physical health services was first outlined in the public health strategy ‘*Healthy lives, healthy people*’ [30] and was developed further in the mental health outcomes strategy ‘*No health without mental health*’ [31]. The *Musculoskeletal Framework* [32] advocates expanding capacity within secondary care services.

These political initiatives aim to stimulate health improvements and enable local health changes, whilst providing strategic leadership and raising expectations. The *Five Year Forward Policy* [33] re-emphasised the need to develop novel services, and development of rheumatology skills-mix clinics. The Keogh [34] report identified that best therapy is delivered by those clinicians engaged in innovation. *The NHS Confederation* [35] reported 60-70% excess mortality among people with mental illness is due to physical ill health.

A key factor in reducing the divide between best practice and common practice has been identified as the ability of health care providers and organisations to spread innovations and novel ideas rapidly [36]. Pockets of excellence exist but knowledge of good practice often remains isolated. Historically the NHS has difficulties converting aspirational designs for better mental health services into reality.

Syndication proposal

Better integration with mental health services is needed to transform care for patients with musculoskeletal disease. The OPD should move towards ‘whole-person’ care and commissioning, and explicitly include a mental health care focus. Syndication would improve the co-ordination and reduce excess morbidity. Much of the OPD workload involves complex long-term condition management and many nurses work in extended roles. Successful nurse-led education and escalation clinics for newly-diagnosed rheumatology patients have already demonstrated innovation and cost-benefits, offering a model for improved physical outcomes. Clinical nurse specialists are both valued by patients and cost-effective [37,38]. This model could be extended to psychological care.

While a range of health professionals might be equipped to provide aspects of this care, RMNs are best suited to this role. An RMN syndication service would be subtle and nuanced, promoting a cultural re-evaluation prioritising mental health prevention and education allowing time to talk with patients about difficult emotions. Registered nurses (RNs) have a professional nursing value base which encompasses an ethical responsibility to deliver high quality, safe services to improve the health, wellbeing and independence of patients whilst recognising and responding compassionately when people are anxious or in distress [39,40].

Boundary issues may be anticipated with an RMN carrying out aspects of a role traditionally held by RNs. However, all

nurses in this role would have a responsibility to ensure that they have undertaken the relevant education and training in musculoskeletal disease to gain the necessary skills and knowledge to perform their role safely and effectively, demonstrating understanding of the duty of care needed by patients [40]. The Health and Care Professionals' Council recognises that it is common for physiotherapists' and occupational therapists' scope of practice to change or expand over time and that this may include encompassing services traditionally performed by another registered profession [41]. Determining a parity of status for RMNs could facilitate transformation of services and help in developing this new model of care. The planned outcome of this innovation is to provide a robust pathway for mental health trained nurses to develop into RMN/Rheumatology specialist nurse roles.

CONCLUSIONS

With no specific mental health provision or clear pathway of referral, vulnerable patients may achieve neither optimum pharmacological treatment effect, nor good mental health. This novel service could provide a model for other chronic disease/mental health management strategies, extending cost savings to other services and would deliver Public Health England's priority for 'local action that will drive sustainable change in public health' [42]. The potential value of this can be demonstrated to service users, Trust management and commissioners. The RMN/Rheumatology specialist nurse role although visionary will become integral to meet future demand for service. It has the potential to support the current and future NHS agenda, and contribute to OPDs achieving this objective by providing necessary mental health support to patients.

It is a traditionally held view that with limited and prescriptive appointment times, many aspects of emotional and psychological care prove difficult to service presently within the department. The discussion here disputes this. Addressing deficiencies in mental health recognition by the syndication of an RMN will result in holistic patient benefit. This will also support recognition of the changing role of nursing to meet future challenges, focusing upon prevention of further ill-health through personalisation of patient care and education.

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