The use of diagnoses in mental health service eligibility and exclusion criteria

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Abstract
Background: Diagnoses are controversial but ubiquitous in mental health; however, whether they are essential features of service entry has not been analysed.
Aim: To investigate the use of diagnosis in the service entry criteria of UK NHS adult mental health services.
Methods: Freedom of Information requests were made to 17 NHS adult mental health Trusts; responses were analysed thematically.
Results: Four service types were identified: broadly diagnostic, problem-specific, supporting specific life circumstances and needs-led. Diagnoses were used frequently but not universally. Non-diagnostic factors were central to service entry criteria.
Conclusions: Diagnoses were neither necessary nor sufficient in-service entry criteria. Broad clusters of difficulties were used rather than specific diagnoses. Extensive exceptions revealed diagnoses as inefficient proxies for risk, severity and need. Differences across criteria appeared largely driven by professional competencies. Implications for innovative care pathways include preventative services and working with psychosocial factors.

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Mental health services; service eligibility criteria; psychiatric diagnosis; innovative services

Introduction

Psychiatric diagnosis arguably facilitates communication between individuals and professionals (Craddock & Mynors-Wallis, 2014), provides clarity around identification of difficulties, and treatment options for those difficulties (Callard, Bracken, David, & Sartorius, 2013). Even critics of psychiatric diagnosis recognise it as central to the planning and organisation of mental health services (Harper, 2013). Kendell and Jablensky (2003) discuss the poor validity of current diagnostic categories, but nevertheless, argue that many diagnoses remain invaluable due to their clinical utility. However, they emphasise that, "statements about utility must always be related to context, including who is using the diagnosis, in what circumstances, and for what purposes" (p. 11). This paper considers the utility of psychiatric diagnoses within the context of the gatekeeping role performed by service entry criteria.

Methodology

Freedom of Information (FOI) requests and responses

Services' entry and eligibility criteria are locally decided, and information is not held centrally within the NHS. Freedom of Information requests were therefore submitted to each of the 17 NHS mental health Trusts in the North of England. Each asked: "What are the service entry criteria for each of the adult mental health services (community & specialist) within the Trust? I.e. on what information is a decision based when accepting an individual to each service (e.g. the service entry criteria for CMHTs, early intervention, eating disorders services and so forth)".

Eleven Trusts responded with a breakdown of entry criteria for different services. Of these, seven gave detailed responses representing all services within the Trust, and four gave information for six or fewer services. The services described in these incomplete responses were analysed as part of the findings below. A further two Trusts signposted to websites where some or all of the information was publicly available. The majority of information from Trusts included descriptions of the purpose of services, as well as lists of their entry criteria. This information was included within data analysis. Two Trusts offered only a brief response giving an overview of the process of referrals to services and will, therefore, be excluded for the purposes of this paper. Two Trusts declined to respond on the basis that the request would exceed FOI guidance on the time required to gather this information (Wanless, 2014).

Analysis

Information about each service type was examined carefully to ensure appropriate comparison with other services, and services with different names were checked for similarities; for example, a "clinical treatment team" (Trust G) was identified as an electroconvulsive therapy (ECT) service, and categorised accordingly. Detailed data for each service were organised using nVivo software. Thematic analysis (Braun & Clarke, 2006) was used to analyse the data, in order to identify and analyse patterns or themes in the data, and to give a map or outline of these themes across the dataset. This process produced a framework of four service types: (1) broadly diagnostic services; (2) problem-specific but non-diagnostic services; (3) services supporting specific life circumstances; and (4) needs-led services providing specialist or particular services. A further theme related to the frequent use of diagnoses in exclusion criteria.

Ethical approval

Information gained through FOI requests is available in the public domain, and does not contain any personal or identifying information (Savage & Hyde, 2014); therefore, ethical approval was not sought for this study. The Trusts to whom the requests were made have been anonymised throughout.

Findings

Broadly diagnostic services

The majority of services within this theme performed a specialist role (Table 1). Diagnoses were rarely used in a form that would equate to specific ICD or DSM diagnostic criteria. Two service types were for the specific assessment and intervention of a particular diagnosis (ADHD, gender identity difficulties). For example, "To provide assessment and/or follow up for people with symptoms of ADHD graduating from CAMHS, those adults with a previous diagnosis of ADHD not in Service and those adults with a suspected diagnosis of ADHD" (Trust A). The majority of services, however, identified broad bands of diagnoses, such as learning difficulties (LDs), and "personality disorders". These represented a broad range of experiences and diagnoses rather than a specific ICD or DSM diagnostic category.

These findings suggest that the rationale for "broadly diagnostic" services was one of the competency-based teams working together because they had specialist skillsets necessary to work with particular difficulties, and perhaps a particular ethos, but not because diagnostic criteria were vital per se.

Table 1. Number of Trusts reporting service entry criteria for broadly diagnostic services.

Number of Trusts	Service
7	Memory/cognitive assessment + dementia service for younger people
3	Learning disabilities (LD)
3	Attention deficit hyperactivity disorder (ADHD)
3	Eating disorders
3	Personality disorders
1	Gender identity difficulties

Some services identified several diagnoses; “Individuals suffering depression and/or anxiety and/or stress or an anxiety disorder, or living with a long term physical health condition that has a psychological impact” (Trust K), and others gave lists of a dozen different diagnoses with a statement that treatment was “primarily provided for the following psychological problems only” (e.g. Trust F and Trust J). However, these diagnoses were also associated with a particular level of need, at a specific severity of difficulties.

Specialist services, such as “personality disorder” and “eating disorder” services were largely diagnostic, but criteria also explicitly required complex needs and significant risk associated with the diagnosis that necessitated such a specialist service, such as “moderate to severe Anorexia Nervosa…severe Bulimia Nervosa” (Trust M). These criteria indicated a particular level of severity, with an expectation that mild to moderate eating difficulties are seen in primary care, or other non-specialist services. The provision of services for particular diagnoses, therefore, shows diagnostic labels being used as a proxy for a particular severity of difficulties. Some services required additional tools to corroborate this information by using formal rating scales to measure functioning (IAPT, Trust F; mental health access team, Trust J).

Problem-specific services

Problem-specific services provided interventions for collections of similar difficulties, to organise and access specialist care, but did not use formal diagnostic categories (Table 2).

These included early intervention in psychosis (EIP) services (reported by eight Trusts), services for psychosexual problems (reported by two Trusts), traumatic stress, and alcohol and substance misuse problems. Although each of these could be associated with ICD or DSM diagnosis (for instance, substance misuse disorder diagnoses), the criteria for these services instead used descriptions of difficulties, for example, “[a]ll adults (individuals and couples) who are experiencing relationship difficulties or sexual dysfunction with likely psychosexual components” (Trust K). A traumatic stress service (Trust G) used a checklist tool to determine severity as it is, “a specialist service and is provided for patients who are assessed as experiencing severe or extreme symptoms. It is assumed that local teams will have the skills and capacity to provide assessment and treatment for patients who present with mild to moderate symptoms of trauma” (Trust G). For many EIP services, the emphasis was explicitly on symptoms not diagnosis; “Acceptance will be based on symptom presentation rather than diagnostic criteria” (Trust D); “acceptance is irrespective of potential diagnosis” (Trust N). Trust N defined psychosis as “distressing hallucinations or delusional beliefs of sufficient intensity and frequency”, a much looser definition than any psychosis-related diagnostic criteria.

Table 2. Number of Trusts reporting service entry criteria for problem-specific services.

Number of Trusts	Service
8	Early intervention in psychosis (EIP)
2	Psychosexual
1	Traumatic stress
1	Alcohol and substance misuse

Two Trusts specifically highlighted working with “diagnostic uncertainty” (Trust F and Trust N), whereby the teams assess and work with people’s psychotic experiences even where a diagnosis appears unclear. These services offer an example of teams working together with specialist skills, but also indicative of how NHS trusts can design, commission and manage services without necessarily relying on diagnoses.

Needs-led services

The largest group of services was categorised as needs-led; services are outlined in Table 3.

Criteria for these services often highlighted their mental health focus, but without using specific diagnoses; for example, “patients who present with significant disability due to mental illness” (assertive outreach service, Trust D), or have difficulties “only in the context of a serious mental disorder” (psychiatric intensive care unit, PICU, Trust A). IAPT services were typically described as “for those individuals experiencing mild to moderate anxiety and depression” (Trust O), who

"experience mild or moderate social and/or functional impairment" (Trust F). IAPT services frequently listed examples of specific diagnoses that fall within anxiety and depression-related difficulties, and one highlighted a "categorical (diagnostic) model" (Trust F); however, the remit of "mild to moderate" difficulties was central to all IAPT services' eligibility criteria, thus their inclusion in the needs-led services. Similarly, some CMHTs gave examples of diagnoses, but as with the specialist services these were used to indicate a particular level of severity or need, which was also indicated by additional qualifiers: CMHTs outlined qualifiers such as: "Individuals accessing secondary care services are most likely to be: Services users with severe and persistent mental illness, such as schizophrenia, severe depression or bipolar disorder" (Trust I); "Psychotic disorders that cannot be managed within primary care services due to severity or because of complex and enduring need…Severe types of obsessive/compulsive disorder, phobia, anxiety disorders that significantly impair social functioning" (Trust P).

Table 3. Number of Trusts reporting service entry criteria for needs-led services.

Number of Trusts	Service
16	Community mental health team (CMHT)
7	Home treatment team (HTT)
6	Improving Access to Psychological Therapies (IAPT)
6	Inpatients
6	Liaison psychiatry
6	Psychological therapies
5	Crisis services
5	Assertive outreach
5	Single point of access & other access teams
4	Psychiatric intensive care units (PICU)
4	Rehabilitation
3	Secure services
3	Recovery services
2	Community services (psychosis)
2	Community services (non-psychosis)
2	Electroconvulsive therapy (ECT)
1	Acute day service
1	Complex needs
1	Primary care (not IAPT)
1	Respite care
1	Liaison and diversion (offence-related)
1	Psychological medicine
1	Community mental health nursing service

The level of support required was also used to override diagnostic inclusion criteria, for example, although typically accepted diagnoses might be schizophrenia or bipolar disorder, two CMHTs stated that they would also accept "Any disorder where there is significant risk of self-harm or harm to others (e.g. acute depression, anorexia, high levels of anxiety) where the level of support exceeds that which the primary care team can offer" (Trust I and Trust M).

The majority of criteria for CMHTs were non-diagnostic. As well as geographical criteria, these focused on the level of input services could provide: "People who have substantial and complex mental health needs which cannot be met by primary care, the IAPT Service or other community services" (Trust A and Trust K), or that require a "skilled or intensive treatment, multi-agency approach" (Trust F). Frequent non-diagnostic factors were: risk ("Complex presentations with a significant risk of self-harm, harm to others, risk of harm from others or serious self-neglect", Trust A), or impaired functioning and other disability ("Suffer substantial disability as a result of their illness, such as an inability to care for themselves independently, sustain relationships or employment", Trust D). Two trusts (Trust N and Trust P) divided their CMHTs into two pathways, "psychosis" and "non-psychosis", akin to the wide-ranging diagnostic, or quasi-diagnostic, use of "common mental disorder" in IAPT. This distinction between the two intervention pathways reflected the different needs of the two groups. The psychosis pathway (Trust P), for example, emphasised "proactive interventions" to help with "poor treatment adherence".

Other services emphasised the level of care needed by individuals; "…assessment will always be based on clinical need. Patients will only be admitted if they display a level of risk aggression [sic] that presents as risk to self, others and property" (PICU, Trust H). Home treatment teams are

designed as a last port of call of intensive intervention, aimed at avoiding inpatient admission. Criteria reflected this high level of care; “Crisis likely to necessitate psychiatric inpatient admission; Imminent risk of harm to self or others by a service user experiencing mental health problems; Early intervention is required to prevent relapse…” (Trust J).
One Trust noted, “Decisions on whether someone should be accepted for services are based on their health and social care needs as a whole and not on Diagnosis alone” (CMHT, Trust I), and this balance between assessing the experiences of an individual alongside their needs and what a given service could provide was a common thread throughout the needs-led service criteria. These services acknowledged different levels of support; however, they do not formally recognise other needs that are highlighted by the literature (Allsopp & Kinderman, 2017), such as financial and income

Table 4. Number of Trusts reporting services supporting specific life circumstances.

Number of Trusts	Service
2	Military veterans
1	Homeless and traveller team
1	Perinatal mental health

needs, home, family and social support, and specific interventions such as trauma therapy. Services supporting specific life circumstances Four services had pragmatic, needs-led, criteria that worked with individuals experiencing particular life circumstances; two military veterans services, a homeless and traveller team, and a perinatal mental health service (Table 4). The veterans’ services, for example, described a clear need for flexible provisions for a group that may not always be best served by traditional mental health services; “The whole ethos of the service is to be more responsive and accessible to this hard to reach cohort” (Trust P). Similarly, the homeless and traveller service (Trust K) made adaptations to meet the needs of an itinerant or insecurely housed population, and offered support to; “Homeless families in temporary accommodation and refuges; Young people (16–19 years), pregnant women and adults in temporary accommodation and hostels; Gypsies and Travellers.”

Exclusion criteria

It was notable, however, that psychiatric diagnoses tended to be used as exclusion, not inclusion, criteria. The most commonly cited diagnoses in exclusion criteria were drug or alcohol misuse and dependency, organic or degenerative conditions, such as dementia, and LD or autistic spectrum diagnoses, followed by “severe and enduring mental illness”, with examples given of personality disorder, schizophrenia and bipolar disorder diagnoses.
The use of diagnoses as exclusion criteria implied their use as proxies for exclusion on the basis of a person’s needs being (a) too low; (b) too high; and (c) the service being inappropriate. Exclusion on the basis of low need was sometimes described by higher support services, for example, mild to moderate difficulties would not usually be seen in a CMHT. However, as mentioned earlier, these decisions can be overruled by clinical need, for example, within the exclusion criteria for a specialist psychological therapies service, “People who have mild to moderate mental health needs unless other interventions and treatments have failed…People whose assessed needs are classed as moderate to low unless specialist intervention is necessary to prevent an imminent risk of deterioration” (Trust I). Exclusion on the basis of high need was frequently noted in lower level services, particularly within primary care. For example, “Severe and enduring mental illness or in need of complex care package” (Trust N, Primary care), which is listed within the context of other exclusions such as high risk. As a consequence, frequently excluded diagnoses may be more vulnerable to being “gamed”. Clinicians may be reluctant to make a diagnosis such as “personality disorder” because it would then prevent their client from accessing a particular service, or, conversely, diagnosis may be (inappropriately) used as a means of refusing unwanted referrals, for instance in the case of oversubscribed or under-resourced services.
Where excluded diagnoses indicated that a service is inappropriate for particular difficulties, these tended to be alcohol or substance misuse or dependency, organic problems or learning disabilities. These labels indicated a need for particular intervention or skills that are available in specialist

services. Nevertheless, these terms, although suggestive of diagnoses, are so broad as to be descriptive.

Some Trusts' responses were more explicit about why particular diagnoses were excluded. These descriptions give an indication of what these diagnoses represent, such as specific difficulties or levels of need that cannot be appropriately managed within these particular services. For example: "clear evidence of diagnosable antisocial personality disorder which infers significant risk" (Trust N, EIP) and "…repeat suicide attempts, deliberate self-harm, other impulsive self-injurious behaviours likely to indicate personality problems requiring interventions around emotion regulation" (Trust H, IAPT). The same service stated: Individuals with a current diagnosis of a personality disorder or PD traits which prevents them from engaging effectively in short term therapy e.g. patients for whom low mood or anxiety is a co-morbid feature of a personality disorder which require intervention in themselves. (Trust H, IAPT).

Non-diagnostic exclusion criteria included descriptive information to the same effect; for example, exclusion criteria for one psychosexual service were based on difficulties outside of the remit of the support offered: We are not able to offer the service to patients whose sexual difficulties or behaviour have brought, or are at risk of bringing, them into conflict with the law; patients with advanced sexual or other addictions; patients who pose high risk of harm to self or others…. (Trust A). Such descriptions represent a more nuanced clinical rationale, applicable to inclusion and exclusion criteria, rather than black and white inclusion or exclusion based on diagnosis. These descriptions are also more appropriate given the now well-established NHS policy that personality disorder is no longer a diagnosis of exclusion (NIMHE, 2003), despite its frequent occurrence in Trusts' exclusion criteria in this dataset.

Discussion

Clinical implications

Diagnoses are inefficient proxies for individuals' needs, demonstrated by the requirement for extensive caveats and exceptions within service entry criteria. For each of the four service types identified, differences across service provision were driven more by professional competencies in specific teams than by diagnosis. Given the history of mental health services, diagnosis may be less a necessity for service entry criteria so much as a historical artefact.

The use of broad pseudo-diagnostic categories (such as "severe and enduring mental illness", or groups of diagnoses such as "personality disorders") for important gatekeeping functions of service entry criteria reflect the common pragmatic or heuristic uses of diagnostic categories (Kendell & Jablensky, 2003). However, such categories are very different to the "rational, careful, respectful, diagnosis" (Callard et al., 2013, p. 2) advocated by diagnostic classification, and are at odds with the ICD and DSM models, new versions of which seek to increasingly define diagnoses in more precise ways (Kupfer, First, & Regier, 2002). Formal diagnostic classification places emphasis on specificity and detail, especially where commentators wish to draw distinctions between "normal" and "disordered" (Frances, 2014). However, in practice, mental health services and legal systems use much broader, more flexible definitions. The use of broad pseudodiagnostic categories (such as "severe and enduring mental illness", "personality disorders" or "eating disorders") may reflect pragmatic decisions within broadly medical mental health services, but represent significant conceptual divergence from the formal diagnostic manuals.

The 2007 amendments to the Mental Health Act (MHA), for example, defined "mental disorder" as "any disorder or disability of the mind; and 'mentally disordered' shall be construed accordingly…" (Mental Health Act, 2007, p. 1). The MHA, therefore, does not require a specific psychiatric diagnosis to be decided upon by an assessing clinician prior to admission. These references to "mental disorder" hint towards but do not require the use of diagnoses, and are far from the precise application recommended by the ICD or DSM. The MHA and the Equality Act (2010) can be utilised by clinicians to work in the best interest of their clients, without using specific diagnostic labels. There are certain special circumstances related to substance misuse and intellectual disability; ensuring that these diagnoses alone cannot serve as sufficient criteria for detention, again requiring qualifying behavioural criteria such as "abnormally aggressive or seriously irresponsible conduct". This again highlights the role of diagnoses as exclusion rather than inclusion criteria.

To adopt innovative practices, including non-diagnostic approaches to service delivery, it is necessary to dispel myths; including the myth that ICD and DSM diagnoses are necessary for service planning and delivery. Alternatives to diagnostic approaches are already embedded within some NHS mental health services. Furthermore, specific psychological difficulties, such as depressed mood, voice-hearing and non-suicidal self-injury, are now contained within the new ICD-11 (World Health Organization, 2018), which may represent a way forward for capturing data on phenomenological but non-diagnostic difficulties on which to organise services and to be reflected within staff competencies (Kinderman & Allsopp, 2018). Heterogeneity across services can encourage innovation, through which Trusts can learn from each other. This flexibility can be capitalised upon in order to better meet clients' needs and more accurately identify client populations. Services could also work to better support other life factors, such as social, financial and trauma-related difficulties; these types of support appeared lacking within the services analysed. These needs are concurrent with mental distress but not captured within psychiatric diagnostic criteria. Both the ICD-10 and ICD-11 list over 80 individual codes (such as homelessness, poverty, discrimination and negative life events in childhood, including trauma; codes Z55-Z65), which provide an existing means for mental health services to formally capture information about the psychosocial context of mental health difficulties (Allsopp & Kinderman, 2017). Together with the phenomenological codes, these developments in the ICD could improve clinical practice by facilitating the development of care pathways that target particular trajectories of distress following specific adversities (Kinderman & Allsopp, 2018).
These findings have important clinical implications for psychiatrists; supporting approaches to developing innovative services that work with specific symptoms, life circumstances or demographic groups, rather than diagnoses. These implications are especially important for early intervention services and care pathways for secondary or targeted prevention of mental health difficulties (Costello, 2016), for individuals who are presenting with symptoms or a clear risk factor, such as the psychosocial factors identified above, but who would not yet meet the full criteria for a psychiatric diagnosis. Such pathways must necessarily be nondiagnostic in order to intervene to halt progression of distress into psychiatric disorders for the simple reason that diagnosis cannot, logically, follow successful prevention (McGorry, Ratheesh, & O'Donoghue, 2018). It is also worth noting that many diagnoses, especially for more serious problems, require prolonged periods of identifiable difficulties (in some cases as long as six months), which are incompatible with referral timelines, particularly for early intervention. As well as in the field of psychosis (McGorry, 2015), early intervention is also gaining momentum in the treatment of bipolar (Vieta et al., 2018) and in child and adolescent mental health services (Malla et al., 2016).

Limitations

These data cannot identify whether or not more diagnostic services better meet clients' needs, but it is evident that diagnosis does not play an essential role in differentiating between services. The sample represents approximately 29% of NHS Mental Health Trusts in England, therefore may not be representative of all Trusts. In addition, some NHS Trusts declined to respond, some only gave brief overview of services, and therefore some data may have been incomplete.

Future research

In light of these limitations, future research exploring these implications could usefully subject the alternatives, including diagnosis-led approaches, to empirical tests, in order to compare whether individuals would have better access to services and receive better care if services use diagnostic versus non-diagnostic entry criteria. From a clinical service perspective, research should aim to establish in which context, for which type of problems, non-diagnostic versus diagnostic models would be best, as well as further exploring whether the use of broad descriptive categories are more effective, flexible ways of signposting appropriate services than specific diagnoses. Research could also evaluate innovative ways of supporting individuals with multiple needs, to avoid unnecessary exclusion from services due to particular diagnoses such as personality disorder.
Wider functions of psychiatric diagnosis should be acknowledged, and for non-diagnostic approaches to extend across the field of mental health, further development will be required. For example, pharmaceutical companies are required to develop drugs on the basis of specific indications, currently diagnoses, and specific, non-diagnostic descriptions such as low mood may not suffice. The

psychiatric pharmaceutical industry, however, is one already in flux, in part due to the difficulty of using heterogeneous diagnostic categories that lack biomarkers (Hyman, 2013).
Furthermore, in practice, clinicians at times use psychiatric drugs "off label" for non-identified diagnoses, and tend to rely on clients' specific symptom presentations rather than diagnostic labels. In fact, it has been argued that psychiatric classification "has little or no relevance to psychotropic drug action and as a consequence an accurate diagnosis is not required for optimal prescribing" (Taylor, 2016, p. 224).
Higher level, systems use of psychiatric diagnosis also requires careful thought, such as the use of diagnostic categories for healthcare providers remuneration, at both the level of individual insurance claims and of national health services. In the UK, for example, NHS Payment by Results (PbR) processes use "care clusters" (NHS England/NHS Improvement, 2019), such as "common mental health problems (low severity)" and "Non-psychotic chaotic and challenging disorders", which, consistent with the findings of this paper, utilise broad descriptors of distress, severity and need, alongside pseudo-diagnostic distinctions including "psychotic", "non-psychotic" and "cognitive impairment".
Finally, there will be other legal or regulatory barriers across which implementation questions must be negotiated, such as the MHA, and other laws that invoke psychiatric diagnoses.

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