Primary care mental health

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Aims and objectives
• Describe the role of the GP in recognising and managing mental health conditions
• Understand the approaches used by GP’s to assess common mental health conditions and assess risk
• Outline management options for depression, anxiety and substance misuse in primary care

What mental health problems do GP’s see?
The full spectrum but...
• Mood disorders & anxiety form a core part of GP workload
• Substance misuse usually managed entirely in community setting

When mental health disorders go undercover:

1) Hidden problem:
• The patient doesn’t realise they are depressed
• Stigma/shame/lack of confidence. The patient presents with a more "legitimate" reason

2) Somatisation
• A physical expression of distress.
• Medically unexplained symptoms often linked to depression/anxiety

3) Co-morbidities
• The physical illness is given priority

When mental health issues may be missed

The patient experience
The GP’s role in mental health issues

The GP’s role

- Recognition—likelihood, MSE, case finding: screening
- Diagnosis (history Bio-psychosocial profile, MSE, validated assessment tools e.g. PHQ-9/GAD)
- Risk assessment—patient and others
- Managing mental health issues:
  - Put illness in context of patient’s life
  - Support, advocacy, advice
  - Prescribing or altering treatment
  - Signposting to other forms of support
  - Referral for assessment, advice, treatment
- Follow up and monitoring

Case study 1

- Mr Jack Jones, aged 64
- Family business—car mechanic
- 6 weeks ago had anterolateral myocardial infarction
- Come for review with the GP who sent him in

What should the GP cover?

- Review discharge notes, letters and tasks
- Current symptoms—post MI physical complications e.g. LVF
- Mood—post MI depression is common and needs action
- Medication and adherence
- Patient concerns and expectations and questions
- Examination
- Monitoring e.g. renal function especially if newly prescribed ACE inhibitor
- Review ongoing management plan and follow up
- Safety net. What happens if? 999

Case study 1: Cues

- The patient says “My wife is getting really fed up with me moping round the house all day.”
- What else do you want to know about here?

Case finding

- Alert to cues
- ASK:
  - During the last month, have you often been bothered by feeling down, depressed or hopeless?
  - During the last month, have you often been bothered by having little interest or pleasure in doing things?
  - Mental state examination (MSE)
Case study 1

“Yes I feel low sometimes. Just can’t be bothered. I haven’t any interest in anything, except food—I’ve always liked my food. I worry about not being at work and my son being left to run the garage but then I think it’s the stress of work that led to this. A warning. So I’m not sure I can go back.”

They say that I’m lucky to be here, that I got another chance… but I wake up at night thinking about it happening again, I don’t like to leave the house if I’m honest.”

Case study 1: How to assess depression

- When we gather information what do we want to find out?
  - Symptoms—somatic? severity, duration
  - Impact
  - Biopsychosocial history looks at context—symptoms and past history but also interpersonal relationships/finances/support
  - Think about
    - Pre-disposing
    - Precipitating
    - Perpetuating
- Risks—self and others intentional or neglect
- Criteria e.g. DSM 5
- Validated assessment tools exist e.g. PHQ9 in primary care

Case study 1: MSE

- Appearance
- Attitude
- Behaviour
- Mood and affect
- Speech
- Thought process
- Judgment
- Thought content
- Perceptions
- Cognition
- Insight

Assessment

1. Depressed mood/irritable (subjective or objective)
2. Decreased interest or pleasure in most activities, most of each day
3. Significant weight change (5%) or change in appetite
4. Change in sleep: Insomnia/hypersomnia
5. Change in activity: Psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Guilt/worthlessness or excessive or inappropriate guilt
8. Diminished ability to think or concentrate or indecisiveness
9. Thoughts of death or suicide, or has suicide plan

Risk assessment

- Thoughts of harm to self or others—drill down
  - Plans? Intent?
  - Severity of presentation e.g. worthlessness, hopelessness, persistent suicidal ideation, concrete thinking evident
  - Male, young <30, advanced age, social isolation, concurrent physical illness, recently started AD’s.
  - Complex presentations e.g. psychosis, bipolar, substance misuse
  - Past history and behaviours
  - Patient resilience and support systems

What questions can we ask about suicidal thinking?

- Do you ever feel that life is not worth living?
- Do you ever think about hurting yourself or ending your life?
- Have you ever harmed yourself?
- Have you ever tried to end your life?
- Have you thought about how you would end your life?
- Do you have the means for doing this available to you?
- What has kept you from acting on these thoughts?
- Get specific, concrete answers… beware of ‘not really’
Case study 1

- PHQ9 score: 16
- Lack of interest and motivation every day.
- Tiredness, insomnia and thoughts of low self worth more than half of the time.
- No thoughts of self harm and glad his MI was not fatal.
- Takes medication but is not motivated to attend cardiac rehabilitation

Case study 1: Explanations

- Need to have explored the patient’s perceptions.
  Jack hadn’t thought he might be depressed. Friends and family keep telling him he’s just had a big life change. He is worried about taking medication and doesn’t want to be labelled as mentally ill. He thinks he should “just pull myself together”. On the other hand he feels irritable and isolated and is worried that this will never improve.
- Explain common, not his fault
  An illness like any other and improvement expected over time
- Recovery more likely with treatment. 50% and 65% (AD) & 25 - 30% (placebo) much improved after 3 months

Overview of management options

- Address perpetuating factors e.g. lifestyle/work/relationship or financial issues—practical solutions
- Symptom management e.g. sleep hygiene/activity planning
- Address co-morbidities e.g. alcohol abuse 1st
- Self help: Reading/web based/games
- Homework e.g. action plan and follow up
- Counselling
- Psychological therapy e.g. LIFT
- Medication
- Refer—safeguarding, crisis team, eating disorders, psychosis or severe symptoms and severe impact on functioning.

Stepped care model

- Mild or subthreshold—info/advice and active monitoring
- Persistent—low intensity psychological therapies or group CBT
- Moderate to severe depression—high intensity psychological therapy and an antidepressant.

Case study 1: Management

Which of the management options might be appropriate for Mr Jones?

Starting antidepressants

- Time to work—2-4 weeks
- Side effects and may increase anxiety symptoms—worst first 2 weeks
- Take for 6 months after remission of symptoms (to prevent relapse), if recurrent depression use for 2 years.
- Not addictive but discontinuation side effects can occur so wean off (don’t stop suddenly)
- Driving do not drive if sedative side effects
- Also consider toxicity in O.D. (think about what and how you prescribe)
- Choice most MI. Most safety data for sertraline. Not Venlafaxine or TCA
Anxiety

• GAD – generalised anxiety disorder
• Worry
• Physiological e.g. muscle tension
• Function impaired
• Panic disorder

GAD is defined in the DSM5 as follows:
A. Excessive anxiety and worry occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
B. The person finds it difficult to control the worry.
C. The anxiety and worry are associated with three (or more) of the following symptoms (with at least some symptoms present for more days than not for the past 6 months):
   - 1) restlessness or feeling keyed up or on edge
   - 2) being easily fatigued
   - 3) difficulty concentrating or mind going blank
   - 4) irritability
   - 5) muscle tension
   - 6) sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)
D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
E. The disturbance is not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. hyperthyroidism).

GP Management GAD

• Information
• Review medication
• Avoid caffeine, nicotine & alcohol
• Sleep hygiene
• Self help resources / guided self help
• Exercise as part of good general health

Not improving marked functional impairment:
• Psychological therapy. CBT NICE 1st
• Drug therapy: SSRI 4-8 week trial

GP Management: Panic disorder

• Diagnosis and good information on what is happening is crucial
• Breathing techniques
• Problem solving
• Bibliotherapy
• CBT
• SSRI 12 wks (2nd line TCA)

Presentations of alcohol and substance misuse in primary care

• Actively seeking help
• Coincidental:
  - Tracks.
  - Abnormal bloods.
• Psychological issues:
  - Depression, psychosis, O.D.
• Medical problems:
  - Alcohol: BP, GORD, injuries, withdrawal.
  - Drugs: Acute use, complications or withdrawal effects.

Assessment

• Type of use:
  experimental/recreational/problematic/dependent?
• Which drugs, which route?
• Impact? Physical, psychological and social problems that may be attributable to use
GP management

- Assess harm to self and others
- Brief interventions to give advice on risks and reduce harm
- Assess patient’s motivation: ICE re problems and concerns about own use

Assessing alcohol use

- NICE recommend Audit
  - AUDIT
    - www.cks.nice.org.uk
  - AUDIT-C
    - How often...
    - How many (on a typical day when you are drinking)
    - How often do you have 6 or more (standard alcoholic) drinks on one occasion?

Sources of info & support

- www.smmgp.co.uk
- www.bdp.org.uk
- www.talktofrank.com
- www.addictionrecovery.org.uk
- Bristol drugs project
- Alcoholics anonymous

Referral

Aims of referral

- Stabilise use
- Reduce harms
- Prescribe & make sure used safely
- Encourage positive change
- Support moves to become drug or alcohol free

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