



Be vigilant for common mental health disorders

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Professor Tony Kendrick
MD FRCGP FRCPsych

Professor of Primary Care and Dean, Hull York Medical School



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AUTHOR
Professor Tony Kendrick

MD FRCGP FRCPsych

Professor of Primary
Care and Dean, Hull York
Medical School



How should patients be assessed?

Which screening tools are recommended?

Which patients should be referred?



COMMON MENTAL HEALTH DISORDERS AFFECT AS MANY AS ONE IN SIX PEOPLE IN THE

community. The 2007 ONS household survey of adult psychiatric morbidity in England found that 16.2% of 16–64 year olds were suffering from an anxiety or depressive disorder.¹ Of those 4.4% were diagnosed with generalised anxiety disorder (GAD); 3.0% with post-traumatic stress disorder (PTSD); 2.3% with major depression; 1.4% with

phobias; 1.1% obsessive compulsive disorder (OCD); and 1.1% with panic disorder. The conditions are not mutually exclusive and the most common problem was mixed anxiety and depression, found in 9% of patients.¹ The diagnoses were established through diagnostic psychiatric interviews with subjects screening positive in the survey.

These disorders are even more common in primary care. The New Zealand Magpie Study found that 20.7%

of people presenting to primary care had suffered a common mental health disorder over a 12-month period, compared with 14.8% in the community.²

Many patients with common mental health disorders go undetected by GPs, and can suffer disabling symptoms for years as a result, yet treatment is usually successful.

Most sufferers do not consult their GP – only 38% of people with disorders in the ONS survey had asked their doctor for help. Even when patients



SPECIAL REPORT

COMMON MENTAL HEALTH DISORDERS

Table 1
GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1 Feeling nervous, anxious or on edge	0	1	2	3
2 Not being able to stop or control worrying	0	1	2	3
3 Worrying too much about different things	0	1	2	3
4 Trouble relaxing	0	1	2	3
5 Being so restless that it is hard to sit still	0	1	2	3
6 Becoming easily annoyed or irritable	0	1	2	3
7 Feeling afraid as if something awful might happen	0	1	2	3
Total Score T	=		+	+

do present with symptoms they are often not diagnosed. As a consequence, a minority of patients get help in primary care. Only 24% of sufferers in the ONS survey were receiving treatment: 14% medication; 5% counselling or therapy; and 5% both.¹

GPs often fail to identify cases of anxiety and depression among the patients presenting to them. Kessler and colleagues screened patients attending practices to identify cases and followed them up for three years to see if, and when, they were diagnosed by their GP.³ As many as 30% of the cases of anxiety and depression remained undetected at three years' follow-up, of which 14% were severe cases significantly disabled by their problems.³

NICE has produced a range of guidelines on the management of common mental health disorders covering: depression in adults,⁴ depression with chronic physical health problems,⁵ anxiety (GAD and panic),⁶ antenatal and postnatal mental health,⁷ OCD,⁸ and PTSD.⁹

These guidelines on the individual disorders cover treatment very well, but vary in their coverage of identification, assessment, and appropriate referral. GPs have to consult several different guidelines when presented with common mental health disorders. A major driver for the development of the latest guideline *Common mental health disorders: Identification and pathways to care*, published in May 2011,¹⁰ was to bring together recommendations on identification, assessment and referral in one place, for easy reference.

IMPROVING IDENTIFICATION

The NICE depression guidelines^{4,5} recommend that GPs are alert for depression in those with a past history of depression, and in patients with a chronic physical health problem.

The two Whooley questions for depression will be familiar to GPs and practice nurses who have used them to screen patients with diabetes and

coronary heart disease for the QOF (see box 1, below):

- During the last month have you often been bothered by feeling down, depressed or hopeless?
- During the last month have you been bothered by having little interest or pleasure in doing things?

The GAD and panic guideline⁶ also recommends that practitioners look for anxiety disorders in people with chronic physical disorders, plus frequent attenders with multiple functional somatic symptoms, and in patients with excessive alcohol consumption. The new guideline recommends using a brief screening tool for anxiety disorders, the two item screen for generalised anxiety disorder, or GAD-2.¹¹ GAD-2 consists of the first two questions of GAD-7 (see table 1, above). The tool asks:

- Over the last two weeks, how often have you been bothered by the following problems?

- 1 Feeling nervous, anxious or on edge
- 2 Not being able to stop or control worrying

If the GAD-2 is positive (GAD score ≥ 3) the guideline recommends that the practitioner asks patients the other five questions of the GAD-7 tool for generalised anxiety disorder¹² (see table 1, above) to make a provisional diagnosis of a significant anxiety disorder.

If the GAD score is ≤ 2 but you still have concerns about anxiety, then ask:

- Do you find yourself avoiding places or activities and does this cause you problems?

If the response is positive, then consider an anxiety disorder.

The GAD is useful among patients with anxiety symptoms within the past two weeks, but some patients with panic, phobias, PTSD, or OCD may not come into this category if they have been avoiding the situations or cues that make them anxious. So the guideline recommends the use of the avoidance question above. If the response is positive it should lead on to further enquiry about situation-specific anxiety. For those with language difficulties, it may be preferable to use the distress

Box 1

Depression indicators (Quality and Outcomes Framework 2011/12)

Diagnosis and initial management indicators	Points
DEP1. The percentage of patients on the diabetes register and/or the CHD register for whom case finding for depression has been undertaken on one occasion during the preceding 15 months using two standard screening questions	6
DEP4. In those patients with a new diagnosis of depression, recorded between the preceding 1 April to 31 March, the percentage of patients who have had an assessment of severity at the time of diagnosis using an assessment tool validated for use in primary care NICE menu ID: NM10	17
DEP5. In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1 April to 31 March, the percentage of patients who have had a further assessment of severity 4-12 weeks (inclusive) after the initial recording of the assessment of severity. Both assessments should be completed using an assessment tool validated for use in primary care NICE menu ID: NM11	8

key points

SELECTED BY

Dr Peter Saul

GP, Wrexham and associate GP Dean for North Wales

Common mental health disorders (CMHD) affect one in six people in the community. These disorders are even more common in primary care. The New Zealand Magpie Study found that 20.7% of people presenting to primary care had suffered a common mental health disorder over a 12-month period, compared with 14.8% in the community. Many patients with common mental health disorders go undetected by GPs, and can suffer disabling symptoms for years as a result, yet treatment is usually successful. Most sufferers do not consult their GP, even when patients do present with symptoms they are often not diagnosed. Only 24% of sufferers in the ONS survey were receiving treatment: 14% medication; 5% counselling or therapy and 5% both.

The NICE guideline on identifying common mental health disorders brings together recommendations on identification, assessment and referral in one place, for easy reference. The NICE depression guidelines recommend that GPs are alert for depression in those with a past history of depression, and in patients with a chronic physical health problem. The GAD and panic guideline also recommends that practitioners look for anxiety disorders in people with chronic physical disorders, plus frequent attenders with multiple functional somatic symptoms, and in patients with excessive alcohol consumption.

The use of the depression screening and assessment questionnaires in implementing the QOF has been criticised as some practitioners have made decisions on the basis of these scores alone, without carrying out a fuller assessment. The new guideline emphasises that practitioners should go on to: characterise the patient's mental state, assess the degree to which it interferes with their daily lives and explore interpersonal and social difficulties with relationships, living conditions, money and family worries which may be causing the problem.

In considering whether referral for specialist psychological or psychiatric treatment is necessary, the guideline recommends that practitioners take into account: the patient's past experience of their disorder, including their experience of, and response to, previous treatments, the trajectory of their symptoms, their severity and duration, the degree of associated functional impairment and comorbid mental or physical disorders complicating the presentation.

Access to care for mental health problems should be possible from different settings throughout the community, through multiple means of access, including self-referral. The evidence suggests that access is reduced rather than enhanced by restricting entry to a single point of access. GP commissioning consortia should consider ensuring that a full range of treatments is available for patients, especially those with PTSD and OCD.

thermometer,¹³ an analogue scale which asks the patient to rate their distress between 0 and 100, with scores above 40 suggesting further assessment should be arranged.

THE PATIENT'S MENTAL STATE

The use of the depression screening and assessment questionnaires in implementing the QOF has been criticised as some practitioners have made decisions on the basis of these scores alone, without carrying out a fuller assessment. The new guideline emphasises that practitioners should go on to:

- characterise the patient's mental state
- assess the degree to which it interferes with their daily lives
- explore interpersonal and social difficulties with relationships, living conditions, money and family worries which may be causing the problem

It also recommends taking into account previous treatment and considering using further standardised assessments to make specific diagnoses. These would include the PHQ-9¹⁴ or HADS¹⁵ for depression, as currently recommended in the QOF.

REFERRAL

In considering whether referral for specialist psychological or psychiatric treatment is necessary, the guideline recommends that practitioners take into account:

- the patient's past experience of their disorder, including their experience of, and response to, previous treatments
- the trajectory of their symptoms, their severity and duration
- the degree of associated functional impairment
- comorbid mental or physical disorders complicating the presentation

Psychological wellbeing practitioners receiving referrals from GPs or practice nurses, or self-referrals by the patients themselves, could use the Improving Access to Psychological Therapies (IAPT) screening prompts tool¹⁶ to identify specific diagnoses when considering whether patients referred to them should be treated with brief low-intensity therapy initially, or referred straight on to clinical psychologists for high-intensity CBT-based interventions.

ACCESS TO CARE

There are significant barriers to access to both primary care and secondary care for mental health problems, which particularly affect the elderly, black and minority ethnic patients, especially if English is not their first language.

The guideline recommends that GPs and specialists agree explicit criteria for entry to the mental health service, and provide information about services in the care pathway in a range of languages and formats (visual and aural).

Access should be possible from different settings throughout the community, through multiple means of access, including self-referral. The evidence suggests that access is reduced rather than enhanced by restricting entry to a single point of access.

The guideline also recommends that mental health services should be provided in a variety of settings, including the community rather than hospital outpatients, patients' homes, and outside working hours. A healthcare professional should be designated to oversee the whole of the patient's journey through the care pathway. It also suggests that crèches, assistance with travel, and advocacy services should be provided to assist patients in accessing treatment.

Text messages, email, the telephone, and internet have all been shown to improve communication with patients, and encourage them to attend for follow-up. Translators should be readily available, and therapists should use culturally sensitive methods of assessment.

A STEPPED CARE APPROACH

The guideline recommends that treatment should follow a stepped care approach, such that patients receive the least intrusive treatments first, unless the severity of their problems, or previous non-response to low-intensity treatment, means they should be referred directly on for high-intensity treatment.

The quick reference guide (see useful information box, p32) contains an algorithm summarising the treatment recommendations for all the anxiety disorders and depression, across steps 1, 2, and 3 of the stepped care model.

It is striking that antidepressants are not usually recommended as treatment until step 3, yet in practice most patients receive antidepressants as a first response in general practice.

This algorithm might be a useful resource for practitioners in suggesting treatments they should request from their local psychological services



SPECIAL REPORT

COMMON MENTAL HEALTH DISORDERS

and, if not available already, consider commissioning through the GP consortium. These include newer treatments such as eye movement desensitisation and reprocessing for PTSD, and exposure and response prevention for OCD.

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Useful information

NICE CG123. Common mental health disorders: identification and pathways to care

Copies of the full guideline, quick reference guide and guidance for patients can be downloaded free from: www.nice.org.uk

We welcome your feedback

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A HUNDRED YEARS AGO

Extracted from a 1911 issue of *The Practitioner*

BLOOD PRESSURE

By J. CAMPBELL McCLURE, M.D.

CLINICAL ASSISTANT,

WEST END HOSPITAL FOR NERVOUS DISEASES, AND MOUNT VERNON HOSPITAL

In adults up to about the age of 40, the normal pressure may vary between 115 mm. Hg and 130 mm. Hg, and, indeed a pressure of 140 mm. Hg is so common that it can scarcely be considered as abnormal. As age advances the "normal" pressure may be higher, and a pressure as high as 150 or 160 mm. Hg is fairly common in people over 50. This "normal" increase in arterial pressure with age is probably due to the degeneration and loss of the natural elasticity of the arterial walls, and is not commonly associated with any symptoms.

If on careful observation the arterial pressure is found to be above norm, it should be regarded as a symptom of some underlying disease and not as a disease in itself. We know so little about the reason for its presence, that to attack it strongly as if it were the real disease from which the patient is suffering is wrong. It may be that, like fever, it is the result of some protective action on the part of the human organism about which we understand little or nothing, and speculation on this point is, from the view of practice, idle and unprofitable. It is enough to realise definitely that the variations in arterial pressure are symptomatic of some other condition or conditions and must be treated accordingly.

The treatment of high arterial pressure should proceed on broad lines. The patient should be put at rest as far as possible, suitably dieted, and strict attention paid to the condition of the intestines and stomach and to the function of the liver and kidneys. The dietary need not be fluid or even semi-solid, but it should contain, at least at the beginning of treatment, no animal proteid – even milk is not always well borne – and alcohol and tobacco, save perhaps in very minute quantities as a placebo, should be forbidden.

When the high pressure is due to primary renal changes it is advisable to confine the patient absolutely to bed until all urgent symptoms have disappeared, to encourage him to drink large quantities of distilled water or Imperial Drink to increase the urinary output, and the alkaline diuretics are also used. Mild purging should be induced by the use of pil. hydrarg. or calomel, with the aperient sulphates. Digestion is usually difficult

when the patient comes under observation, and frequent feeding should be avoided, so as to give the stomach a reasonable chance of emptying itself after a meal before more food is taken, except in the case of the aged or the very feeble, when only very small quantities of food can be taken at a time. Gastric or intestinal stasis, which are sometimes associated with a high arterial pressure, must be treated by special methods.

Drugs which are specially directed towards the reduction of the pressure ought to be used sparingly, if at all. Sodium nitrite, nitro-glycerine, the spirit of nitrous ether, and amyl nitrite should be employed only in times of emergency and then with a full knowledge of the risks which are being run.

I have a vivid recollection of a patient who suffered terribly from headache and had an arterial pressure of over 200 mm. Hg, whose pressure was reduced fairly rapidly by means of mercurial purges, the aperient sulphates, and sodium nitrite. When the pressure fell to 155 mm. Hg he began to give every indication of extreme cardiac failure, and, despite all efforts to check the course of events, he died two days later, his arterial pressure two hours before his death being only 70 mm. Hg.

The principles of treatment adopted in cases of renal cirrhosis should be applied also in all other cases of high arterial pressure. Rest, avoidance of surface chill, careful dieting, and attention to elimination are the means most likely to be of service in cases where high arterial pressure is due to other causes which, however, are probably toxic also; and there is no more need to employ drastic drug treatment in the one class of case than in the other.

It is only when the patient is seized with the intolerable agony of angina pectoris that nitrites should be used with any freedom.

Headache is usually more or less amenable to phenacetin in combination with caffeine.

"It is only when the patient is seized with the intolerable agony of angina pectoris that the nitrites should be used with any freedom"

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