Barns Medical Practice Service Specification Outline: Mental Health

DEVELOPED March 2015 **REVIEW November 2018**
NEXT REVIEW November 2020

Introduction

Mental health problems are common with an estimated 1 in 6 people experiencing a mental health problem.

The most common conditions to present are anxiety/depression and are usually treated by GP's. Less common conditions such as schizophrenia, bipolar disorder, psychosis are usually treated by a psychiatrist after referral by a GP.

Diagnosis

At initial presentation the history should be taken and a biopsychosocial assessment performed (appendix 2). This should include an assessment of suicidality. An initial management plan should be formed at the presenting appointment and plans made for regular follow-up until symptoms are stable. If a patient has not been seen by a GP at initial diagnosis, it may be appropriate for an appointment to be arranged.

The social context is very important as many social stressors can affect mood and anxiety. Simply addressing these, changing them or finding different ways to help somebody cope (for example counselling) can have a marked benefit and can, in some cases, avoid the need for medication at all. Examples may include money worries, unemployment, relationship problems, domestic abuse, difficulties at work, or a history of childhood abuse. Some people find it easier to open up about these concerns if directly asked.

Many patients will present with symptoms of depression. See Appendix 3 for key symptoms and further assessment.

If there are concerns regarding worsening memory or possible dementia then some initial bloods and a memory test may be done by the practice nurse or health care assistant (see appendix 1).

Recording Depression

To record a new episode of depression use the correct diagnositic code – (X)depression NOS. Change the event type to new. When the patient returns for review the code depression interim review should be used. For a continuing episode change the event type to continuing to avoid the requirement of an interim review. A patient with a new diagnosis of depression should be reviewed between 2 and 8 weeks of their initial presentation, particularly if started on a new medication or if their antidepressant has been changed.

Regular Review

On initial assessment a treatment plan should be made and follow-up at regular intervals should be done. Review either in practice or on the telephone (depending on symptom severity)

Recommended review intervals:
Initial presentation – between 1-6 weeks depending on severity
When stable – between 6-12 weeks
When symptoms have improved – 6 monthly-1 year

If using medication, assessments should be made on a regular basis to discuss medication and try to reduce medication if this is appropriate. If symptoms deteriorate, patients should always be asked to make an urgent review.

Patients with schizophrenia, bipolar affective disorder, other psychoses and those on lithium are invited for annual review with the practice nurse. This allows an opportunity to carry out cardiovascular screening, discuss lifestyle including safe alcohol limits and smoking cessation where indicated.

The review allows time to discuss the care plan that is formulated by the community mental health team or clinicians in secondary care and ensure the patient is attending their clinic appointments. The mental health template is completed and recorded within the consultation manager data area of the patient's records. Medication management is coordinated via the GP.

Treatment Options

Lifestyle changes

Consideration to diet, caffeine, nicotine, alcohol and prescribed and unprescribed drug use should be made in patients from mild to severe mental illness. These can all lead to an increase in anxiety and low mood[1]. Spikes in sugar levels or food intolerances can lead to a person feeling unexplainably tired and drained. Some prescribed medications such as opiates and gabapentin can lead to symptoms of depression and a medication review of all medications should be done as part of initial assessment and interim review. Patients with long term severe mental illness are at high risk to cardiovascular disease and their physical health should be assessed annually but also at every consultation to opportunistically address and modify lifestyle[7] .

Exercise alone can be a beneficial treatment for mild symptoms as it helps to stimulate release of wellbeing hormones - serotonin and dopamine in your brain.

If there are financial concerns or difficulties with a social situation a Community Link worker, currently accessed via South Ayrshire Life, can offer support and advice.

There is also an online Cognitive Behavioural Therapy resource, Beating the Blues, which will allows immediate access to psychological therapy.

Antidepressants

Antidepressants are often used to treat depression however are better reserved for moderate to severe cases.

If an antidepressant is deemed necessary the recommended first line treatment is fluoxetine (SSRI), alternative sertraline. Citalopram is also commonly used but has the potential to interact with many medications (QT interval). Paroxetine is not recommended, it can be difficult stop at the end of treatment.

Side-effects – nausea, vomiting, dyspepsia, abdominal pain, constipation, diarrhoea, loss of appetite, dizziness. Patients should be advised that these are common and often resolve within 2-4 weeks.

Patients should also be advised that the effect of antidepressants can take several weeks to become evident. They should also be warned that initiating or changing antidepressant medication may initially cause worsening symptoms but if this occurs it this usually improves after 2-4 weeks[4] . Medication should be continued for at least 6 months if symptom resolution occurs to reduce the risk of relapse.

If the first chosen antidepressant does not improve symptoms options are to increase the dose of that antidepressant, to use an alternative of the same class or to change class. It is usually best, if there are no side-effects, to titrate to the highest therapeutic, tolerated dose before changing the medication. Amitriptyline and dosulepin should not be first line because of their toxicity in overdose. Mirtazapine is a sedating option. GP notebook is a helpful

resource to guide clinicians in switching antidepressant medications http://www.gpnotebook.co.uk/simplepage.cfm?ID=1637482568.

Anxiety symptoms can be treated with propranolol (B Blocker) as long as the patient does not have asthma or a recorded adverse reaction to these. It is important to consider lifestyle modification as this can be very effective in treatment of mild to moderate symptoms.

Mood Stabilising Drugs

Mood stabilisers are usually initiated on consultant advice for bipolar disorder or severe depression. Lithium has specific monitoring requirements – lithium levels need to be checked every 3 months for the first year then 6 monthly if stable (unless elderly, at risk of renal, thyroid problems or hypercalcaemia where 3 monthly checks should be continued). U+E's, bone profile and TFT's should be checked every 6 months[6] . Lithium levels should be taken 12 hours post dose.

Antipsychotic Drugs

A range of antipsychotic drugs are used by the psychiatric clinic. Most of these are prescribed by the practice after initiation on consultant advice. The exception is clozapine which is prescribed and monitored by the psychiatric clinic.

Resources for Staff and or Patients

- www.moodjuice.scot.nhs.uk
- Ayrshire Council on Alcohol – one to one counselling. Tel- 01292281238
- Community Mental Health – referral is via GP.
- Breathing Space- confidential emotional support, listening and information service for anyone who is concerned about their own mental health or those of a friend /relative. Tel- 0800838587
- Samaritans-- confidential emotional support, listening and information service for anyone who is concerned about their own mental health or those of a friend /relative. Tel- 116123
- Alzheimer Scotland- offers support to sufferers of all forms of dementia and their carers. Tel- 01292318008/08088083000. Email SouthAyrshire@alzscot.org
- Domestic abuse helpline- tel 08088023333
- South Ayrshire Carers Centre- offers information , advice and support on a wide range of issues and practical support to help fill in forms. Tel-01292263000

NICE recommended resources:

- MIND — www.mind.org.uk.
- Depression Alliance — www.depressionalliance.org.
- Depression UK: — www.depressionuk.org.
- Mental Health Foundation — www.mentalhealth.org.uk.
- Samaritans — telephone helpline: 08457 90 90 90.
- SaneLine: telephone helpline: 0845 767 8000. Open from 6pm to 11pm every day of the year.

References

1) https://www.getselfhelp.co.uk/docs/healthy%20eating%20depression.pdf
2) http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/eatingwellandmentalhealth.aspx
3) https://www.nice.org.uk/guidance/cg90/chapter/1-guidance
4) https://cks.nice.org.uk/depression#!scenariorecommendation:1
5) https://www.mentalhealth.org.uk/statistics/mental-health-statistics-most-common-mental-health-problems
6) https://www.nice.org.uk/guidance/cg185/chapter/1-Recommendations#managing-bipolar-disorder-in-adults-in-the-longer-term-in-secondary-care-2
7) http://www.rcpsych.ac.uk/pdf/PCCJ_Holt_FINALONLINE_JAN%5B1%5D.pdf

APPENDIX 1

Protocol for the New Diagnosis of Dementia

Aim

The aim is to provide an early diagnosis, and offer effective, appropriate advice, treatment and reassurance to patients.

Eligible Group

All patients who present with concerns re memory loss and wish this investigated.

Assessment

Take a detailed history. This should include:

- Onset and duration of symptom
- Any other associated symptoms
- Any concerns re. effects on daily living
- Social support and coping strategies
- Take next of kin details including contact numbers

Management

1. Complete a memory assessment eg. GPCOG, AMT or ACE III
2. Check a sample of urine
3. Bloods - FBC, Calcium, Glucose, U+Es , LFTs, Vitamin B12 and folate
4. An appointment should then be made to attend the GP to discuss, blood results if there is memory impairment and then referral to ECMHT for further investigations inc CT head should be made.
5. Following consultant diagnosis, the new diagnosis of dementia template should be completed.

APPENDIX 2

Bio-psychosocial Assessment

- Current symptoms including duration and severity
- Personal history of depression and past experience of treatment
- Family history of mental illness
- Quality of interpersonal relationships, eg. Partner, children and /or parents
- Living conditions
- Social support
- Employment and/or financial worries
- Current or previous alcohol and/or substance use
- Suicidal ideation
- Discussion of treatment options

APPENDIX 3

Key Symptoms of Depression

- **Persistent sadness or low mood; and/or**
- **Marked loss of interests or pleasure**
- **At least one of these, most days, most of the time for at least 2 weeks**

If any of above present, ask about associated symptoms:

- disturbed sleep (decreased or increased compared to usual)
- decreased or increased appetite and/or weight
- fatigue or loss of energy
- agitation or slowing of movements
- poor concentration or indecisiveness
- feelings of worthlessness or excessive or inappropriate guilt
- suicidal thoughts or acts

Factors that favour general advice and active monitoring:

- four or fewer of the above symptoms with little associated disability
- symptoms intermittent, or less than 2 weeks' duration
- recent onset with identified stressor
- no past or family history of depression
- social support available
- lack of suicidal thoughts

Factors that favour more active treatment in primary care:

- five or more symptoms with associated disability
- persistent or long-standing symptoms
- personal or family history of depression
- low social support
- occasional suicidal thoughts

Factors that favour referral to mental health professionals:

- inadequate or incomplete response to two or more interventions
- recurrent episode within 1 year of last one
- history suggestive of bipolar disorder
- the person with depression or relatives request referral
- more persistent suicidal thoughts
- self-neglect

Factors that favour urgent referral to specialist mental health services

- actively suicidal ideas or plans
- psychotic symptoms
- severe agitation accompanying severe symptoms
- severe self-neglect