

# Barns Medical Practice Service

## Specification Outline: Mental Health

---

**DEVELOPED March 2015**  
**NEXT REVIEW July 2019**

**REVIEW July 2017**

### **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**

The intention is that most patients presenting with mental health problems should be seen and managed by a GP rather than practice nurse or nurse practitioner.

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.

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 diagnostic code – (X)depression NOS. Change the event type to new. This will trigger the QOF requirement of a depression interim review within 10-56 days. 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.

## 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) 1-2 weeks after initial presentation and until symptoms are no longer deteriorating, monthly when stable, 3 monthly when symptoms are improving then 6 monthly when stable on medication. In occasional circumstances annual reviews appropriate. 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. Annual bloods should be taken at this time. 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<sup>1</sup>. 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 every opportunity to address and modify lifestyle should be made in these patients<sup>7</sup>.

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 the practice has a Community Link Worker, Rebecca, who can offer support and advice.

There is also a developing online Cognitive Behavioural Therapy resource which will allow 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. Patients should be advised that these SE are common and often resolve in 1-2 weeks.

Patients should also be advised that effect of antidepressants can take several weeks to become evident. They should also be warned that initiating or changing antidepressant medication can initially sometimes cause worsening symptoms but if this occurs it usually improves after a 2-4 weeks<sup>4</sup>. 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.

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. SSRI's are sometimes used as anxiety and depression often coexist but lifestyle modification should be encouraged.

### **Mood Stabilising Drugs**

Some patients are on these drugs – lithium and depakote for bipolar disorder or severe depression. The prescription is initiated on consultant advice only however we issue the prescription. Lithium has specific monitoring requirements – lithium levels need to be done 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 done every 6 months<sup>6</sup> . 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](http://www.moodjuice.scot.nhs.uk)
- Lighthouse Foundation- is an Ayrshire wide charity who works with families affected by drug and alcohol misuse. Tel- 01563521343 or email [lighthousekillie@aol.com](mailto:lighthousekillie@aol.com)
- Ayrshire Council on Alcohol – one to one counselling. Tel- 01292281238
- Community Mental Health – referral is via GP.
- Copeline-confidential emotional support, listening and information service for anyone who is concerned about their own mental health or those of a friend /relative. Tel-08000568181
- 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- 08457909090
- Alzheimer Scotland- offers support to sufferers of all forms of dementia and their carers. Tel- 01292318008. Email [SouthAyrshire@alzscot.org](mailto:SouthAyrshire@alzscot.org)
- Domestic abuse helpline- tel 08000271234
- Princess Royal Trust South Ayrshire Carers Centre- offers information , advice and support on a wide range of issues and practical support to help fill in forms. They also have a number of relaxing therapies to help manage stress. Tel-01292263000

NICE recommended resources:

- MIND — [www.mind.org.uk](http://www.mind.org.uk).
- Depression Alliance — [www.depressionalliance.org](http://www.depressionalliance.org).
- Depression UK: — [www.depressionuk.org](http://www.depressionuk.org).

- Mental Health Foundation — [www.mentalhealth.org.uk](http://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](http://www.rcpsych.ac.uk/pdf/PCCJ_Holt_FINALONLINE_JAN%5B1%5D.pdf)

## **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.

**Bio-psycho-social 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

## **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