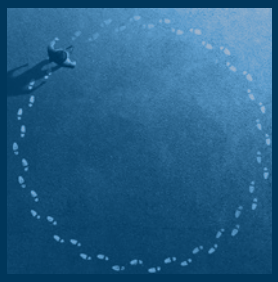
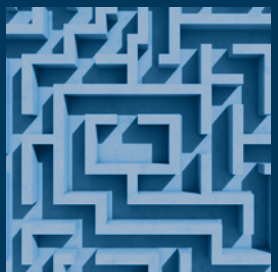


# Common mental health problems

## Handout

To be studied alongside the training film



Supported by

NHS England South East

# Introduction

Common mental health problemsare described by the National Institute for Health and Care Excellence (NICE 2011), as depression, generalised anxiety disorder (GAD), social anxiety disorder, panic disorder, obsessional compulsive disorder (OCD), and post-traumatic stress disorder (PTSD). The definitions and treatments of each disorder are explained, and the responsibilities of healthcare professionals looking after people with common mental health problemsin primary care are clarified.

Every seven years in England, the Adult Psychiatric Morbidity Survey (APMS) is carried out. It reports the trends and prevalence of many different mental health problems and treatments (though it does not include PTSD). At the time of writing, the survey was last carried out in 2014 (Stansfeld et al 2016). The authors found that nearly half (43.4%) of adults thought that they had had a diagnosable mental health condition at some point in their life (35.2% of men and 51.2% of women); but only a fifth of men (19.5%) and a third of women (33.7%) had been given the diagnoses by a healthcare professional. A national survey of wellbeing (Evans et al 2016) showed that in 2014, 19.7% of people in the United Kingdom (UK) over the age of 16 years had symptoms of anxiety or depression; this percentage was higher among females (22.5%) than males (16.8%).

# Depression

According to a systematic review in 2013 (Vos et al 2013), depression was the second leading cause of disability globally, with lower back pain being the first. Depression can negatively affect how a person feels, thinks, and behaves. They may feel sad and/or experience a loss of interest in activities they once enjoyed. It can lead to a variety of emotional and physical problems and reduce a person's ability to operate both at work and at home. The symptoms and experience of depression vary in every person.

| Physical symptoms | Psychological symptoms |
|---|---|
| • Change in appetite<br>• Change in bowel function<br>• Dry mouth<br>• Palpitations<br>• Indigestion<br>• Feel slowed down<br>• Looks unkempt<br>• Loss of libido<br>• Amenorrhoea<br>• Sleep disturbance<br>• Headaches, giddiness, tight band round chest and head, skin-picking, handwringing, general aches and pains. | • Thinking slow and difficult<br>• Poor concentration<br>• Preoccupation with morbid thoughts (death/suicide) and/or physical symptoms<br>• Feel sad, low, or flat<br>• Fed up, indecisive<br>• Indifference, denial, or lack of awareness of symptoms<br>• Loss of interest in life<br>• Speech; slow, monotonous, monosyllabic answers. Incessant negative talk |

Outcomes are influenced by their personality, resilience, family history, premorbid difficulties (for example, trauma, sexual abuse), relationships and social problems. The National Institute for Health and Care Excellence guidelines for depression (NICE 2009a – reviewed 2013 with update due in 2022) employ the Diagnostic and Statistical Manual (DSM) to define the condition. This is published by the American Psychiatric Association and offers a common language and standard criteria for the classification of mental disorders. The version described by NICE is the DSM-IV though it has since updated to DSM-V (American Psychiatric Association 2013).

**There are nine criteria for diagnosis:**

1. Depressed mood most of the day, nearly every day.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
3. Significant weight loss when not dieting, or weight gain.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day.
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day.
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation.

## Types of depression

There are different types of depression which include subthreshold depression, mild depression, moderate depression, major depressive disorder, persistent depressive disorder, seasonal affective disorder and bipolar disorder. Bipolar disorder is classified as a severe mental illness.

- **Subthreshold depression:** fewer than five of the diagnostic criteria.
- **Mild depression:** five or more of the diagnostic criteria and the symptoms result in minor functional impairment.
- **Moderate depression:** five or more of the diagnostic criteria and between mild and severe functional impairment.
- **Major depressive disorder (MDD):** also referred to as severe depression, most of the diagnostic criteria, and the symptoms markedly interfere with functioning (this can occur with or without psychotic symptoms).
- **Persistent depressive disorder:** the person experiences low mood that has lasted for at least two years but may not have reached the intensity of major depression. Often the person can function day to day but feels low or joyless much of the time. They may experience some depressive symptoms, such as appetite and sleep changes, low energy, low self-esteem, or hopelessness.

- Seasonal affective disorder (SAD): this arises when the days get shorter in the autumn and winter. It is thought that the lack of sunlight might affect the hypothalamus and cause it to produce higher levels of melatonin (a hormone associated with sleep) and lower levels of serotonin (a hormone which affects mood, appetite and sleep). The lack of sunlight can also affect the body's circadian rhythm (body clock).

## Depression types exclusive to women, trans-men and non-binary people

Women have a higher rate of general depression than men (Stansfeld et al 2016). Men are at increased risk of mental health problems during the perinatal period but there is limited research to support this at present (Wong et al 2016). Additionally, there are two depression types that are influenced by female reproductive hormones, perinatal depression and premenstrual dysphoric disorder (PMDD).

- **Perinatal depression:** this includes major and minor depressive episodes that occur during pregnancy or in the first 12 months after delivery (also known as postpartum depression).
- **Premenstrual dysphoric disorder (PMDD):** this is a severe form of premenstrual syndrome (PMS). The symptoms usually begin in the late luteal phase of the menstrual cycle (shortly after ovulation) and end once menstruation starts.

# Anxiety

Fear is the normal emotion to feel in response to a danger or threat. When a person experiences fear they trigger their fight or flight response, that is the body adapts psychologically and physically enabling the person to either run away or fight to their maximum ability. Anxiety disorders occur when the fight/flight response is triggered inappropriately, so a normal reaction to an abnormal stimulus. This stimulus is often the thought of a threat or something going wrong in the future, but it could be a due to the circumstances they are in at the time. It can lead to avoidance of the situation that makes them anxious. The physical consequences of the fight/flight response (tachycardia, rapid breathing, muscle tension, nausea, trembling) are sometimes viewed by the person as being caused by a physical illness.

The severity of anxiety disorders varies but all have been associated with significant long-term disability. There may be a lifelong course of relapse and remission, and other problems such as depression or substance misuse can also be present.

In 2013, there were 8.2 million known cases of anxiety in the United Kingdom (Finberg et al 2013). Most anxiety disorders have a relatively early age of onset, with symptoms and syndromes likely to have started in childhood or adolescence (NICE 2014). The authors of the NICE quality standard for anxiety (NICE 2014) explain that most anxiety disorders go unrecognised and those that are diagnosed are treated in primary care. Even when anxiety disorders coexist with depression, and the depressive episode is recognised, the underlying and more persistent anxiety disorder is often not detected.

## Types of anxiety

The types of anxiety include generalised anxiety disorder (GAD), social anxiety disorder, panic disorder, obsessional compulsive disorder (OCD), and post-traumatic stress disorder (PTSD).

- **Generalised anxiety disorder** is characterised by excessive worry about different events, associated with heightened tension. Symptoms include irritability, restlessness, tiredness, tense muscles, poor concentration, sleeping problems. For the disorder to be diagnosed, symptoms should be present for at least six months and should cause clinically significant distress or impairment in social, occupational or other important areas of functioning (American Psychiatric Association 2013). In 2014, 5.9% of the population in England reported they had this disorder (Stansfeld et al 2016).

- **Social anxiety disorder** is a persistent fear of, or anxiety about, one or more social situations that is out of proportion to the actual threat from them. A social situation is one that involves interaction, observation, and performance. There are no UK epidemiological surveys that specifically report data on social anxiety disorder in adults, but lifetime prevalence rates of up to 12% have been described in American studies (NICE 2013).

- **Panic disorder** is categorised by recurring unforeseen panic attacks followed by at least one month of persistent worry about having another panic attack. The symptoms of a panic attack include: heart pounding or racing; dizziness; nausea; chest pain; abdominal pain; difficulty in breathing or choking sensation; feeling very hot or very cold; sweating, trembling or shaking. There may also be concern about the consequences of a panic attack, or a significant change in behaviour related to the attacks. For a diagnosis, at least two unexpected panic attacks should have occurred that have not been caused by the use of a substance, a general medical condition or another psychological problem (American Psychiatric Association 2013). In 2014, the APMS found that 0.6% of the population in England had panic disorder (Stansfeld et al 2016) and lifetime prevalence rates of 5% have been described in American studies (NICE 2013).

- **Obsessive-compulsive disorder (OCD)** is characterised by the presence of obsessions and/or compulsions. An obsession is an unwanted intrusive thought, image or urge that repeatedly enters the person's mind. A Compulsion is a repetitive behaviour carried out because the person has an overwhelming feeling that they must do it. The symptoms often cause substantial functional impairment and distress. The APMS reported that 1.3% of England's population had OCD (Stansfeld et al 2016).

- **Post-traumatic stress disorder** can develop after a stressful event or situation of an exceptionally threatening or catastrophic nature that is likely to cause pervasive distress in almost anyone (NICE 2018). People might develop the disorder in response to one or more traumatic events such serious accidents; physical and sexual assault; abuse, including childhood or domestic abuse; work-related exposure to trauma, including remote exposure; trauma related to serious health problems or childbirth experiences (for example, intensive care admission or neonatal death);war and conflict; and torture. The person may present with a range of symptoms including re-experiencing, avoidance, hyperarousal (including hypervigilance, anger and irritability); negative alterations in mood and thinking; emotional numbing; dissociation; emotional dysregulation; interpersonal difficulties or problems in relationships; and negative self-perception (including feeling diminished, defeated or worthless).

## The responsibility of primary care

Most people with a mental illness in England are dealt with in primary care (Gask et al. 2018, Department of Health 2012) yet mental illness is unrecognised in two thirds of those attending (Mitchell et al 2009). MIND (2016) published a report for Clinical Commissioning Groups. In it they explain that patients may visit a healthcare professional in primary care and discuss other concerns that are impacting on or are related to their mental health. It may be a physical health issue or a social matter such as relationship problems, unemployment or work-related issues, welfare benefits, financial worries, and social isolation. They may attend frequently before their underlying mental health needs are addressed.

National guidance for common mental health problems advocates that healthcare professionals working in primary care have a responsibility to identify common mental health problems, assess the severity, provide relevant information, and consider any special needs (NICE 2011). They should also offer the correct treatment options for those with mild to moderate problems and make an appropriate referral for those who have a moderate to severe common mental health problems. The National Confidential Inquiry (2018) assert there should be a mechanism in place to ensure that people who present with major physical health issues are assessed and monitored for depression and risk of suicide. This is because they are two to three times likely to have depression than those with good physical health (NICE 2009b, Katon 2011).

## Recognising common mental health problems

People with underlying psychological distress may present with a physical health problem such as increased tiredness, bowel problems, difficulties with sleep, headaches or change in appetite. They may also report an increase in smoking, alcohol, or drug consumption. Depression and anxiety are common in people with long-term physical conditions. These people may attend to discuss a problem with their long-term condition without realising the cause is psychological, for example: a person with diabetes may attend because their blood glucose readings are raised. This is because they have stopped eating healthily and exercising because they are feeling low.

To ascertain whether someone has depression and/or anxiety there are screening questions available. Two for depression (Whooley *et al*. 1997) and two for anxiety (Kroenke *et al*. 2001). The person simply answers "yes" or "no"; if they answer yes to either question the healthcare professional should explore whether this is something they want help with and consider further assessment of the mood symptoms they are experiencing. Some primary care practitioners argue that the use of these standardised questions is unnecessary. If they are not used, it has been reported that up to seven out of ten cases of depression will go undetected (Arroll et al. 2005). As the questions are not written in most people's natural style of conversation, printing the questions on a laminated sheet and asking the person to read them can have a number of benefits: the questions get asked correctly; they have time to think and prepare their response; and they have the option of putting up a barrier between themselves and the healthcare professional while they are thinking. The questions are:

**Depression questions**

- *'During the last month have you often been bothered by feeling down, depressed, or hopeless?'* Yes/No
- *'During the last month have you often been bothered by having little interest or pleasure in doing things?'* Yes/No

**Anxiety questions**

- *'Do you feel nervous, anxious or on edge?'* Yes/No
- *'Do you feel unable to stop worrying?'* Yes/No

**Help question**

- *'Is this something with which you would like help?'* No/Yes, but not today/Yes

An answer of 'No' to the first four questions indicates that the person is unlikely to have depression or anxiety. The help question improves the specificity of diagnosis; this means if the person answers yes to one of the screening questions and then declines help, this is usually because they do not have an underlying depression or anxiety. They should be given the option of coming back to see a healthcare professional should they change their mind. An answer of 'Yes' to any of the questions should trigger a more detailed assessment, using the Patient Health Questionnaire (PHQ-9) and Generalised Anxiety Disorder assessment (GAD-7). If a person attends and reports they are feeling down, depressed or anxious, they can be assessed with the PHQ-9 and GAD-7 (i.e. there is no need to use the screening questions).

When a person screens positively for anxiety or depression,

## Eliminating physical causes of depression and/or anxiety

Investigations are not indicated routinely when a person presents with depression but may be necessary to exclude other causes of symptoms. In someone with predominant fatigue it is useful to carry out a full blood count to exclude anaemia, a thyroid function test to exclude hypothyroidism, and vitamin D to exclude deficiency. There are some drugs which may cause depressed mood, though this is uncommon; these include:

- Centrally acting antihypertensives (e.g. methyldopa).
- Lipid-soluble beta-blockers (e.g. propranolol).
- Benzodiazepines or other central nervous system depressants.
- Opioid analgesics.

## Measuring the severity of depression and anxiety

Both the PHQ-9 and the GAD-7 tools have been validated for use in primary care.

The PHQ-9 comprises of nine questions to score the severity of a person's depression. It is designed to assess their mood over the last 2 weeks.

## PHQ-9 questions

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

1. Little interest or pleasure in doing things?
2. Feeling down, depressed, or hopeless?
3. Trouble falling or staying asleep, or sleeping too much?
4. Feeling tired or having little energy?
5. Poor appetite or overeating?
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down?
7. Trouble concentrating on things, such as reading the newspaper or watching television?
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?
9. Thoughts that you would be better off dead, or of hurting yourself in some way?

For each of the nine tested criteria there are four possible answers:

- **Not at all** = 0 points
- **Several days** = 1 point
- **More than half the days** = 2 points
- **Nearly every day** = 3 points

The scores are added up and the depression severity is graded based on this:

- **0-4** None
- **5-9** Mild
- **10-14** Moderate
- **15-19** Moderately severe
- **20-27** Severe

The GAD-7 contains seven questions to score the severity of a person's anxiety.

## GAD-7 questions

**Over the last 2 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
3. Worrying too much about different things
4. Trouble relaxing
5. Being so restless that it is hard to sit still
6. Becoming easily annoyed or irritable
7. Feeling afraid as if something awful might happen

Each question is scored between 0-3 in the same way as the PHQ-9. A total score of between 1-9 indicates mild anxiety, 10-14 is moderate and 15-21 is severe. The GAD-7 is only validated to measure the severity of generalised anxiety disorder, i.e. not social anxiety, panic disorder, OCD or PTSD.

Using both the PHQ-9 and GAD-7 provides only probable diagnoses, therefore further clinical evaluation is required. The PHQ9 and GAD7 can be used at regular intervals to monitor progress.

Studying the PHQ-9 and GAD-7 questions given a higher score, guides the practitioner to choose the most appropriate therapy. The table below provides some examples.

| | |
|---|---|
| **PHQ9 -1** | Low level activity planning (Behavioural Activation – BA) |
| **PHQ9 -2** | Assess suicide risk, consider antidepressant |
| **PHQ9 -3** | Sleep hygiene |
| **PHQ9 -4** | Dietary changes / thyroid function test |
| **PHQ9 -5** | Diarying and diet advice |
| **PHQ9 -6** | CBT self-help techniques |
| **PHQ9- 7** | Assigned worry time, BA |
| **PHQ9 -8** | Consider antidepressant |
| **PHQ9 -9** | Assess suicide risk |

| | |
|---|---|
| **GAD7 -1** | Relaxation/7-11 breathing |
| **GAD7 -2** | Assigned Worry Time |
| **GAD7 -3** | Books e.g. – 'How to stop worrying' and cCBT |
| **GAD7 -4** | Relaxation and morning exercise |
| **GAD7 -5** | Morning exercise |
| **GAD7 -6** | Diarying for precipitants and challenging critical thinking |
| **GAD7 -7** | CBT self-help techniques |

The distress thermometer described in Chapter 1 can be beneficial for use in people with long-term conditions such as stroke (Gillespie and Cadden, 2013) and those with significant language or communication difficulties, for example people with sensory impairments or a learning disability (NICE 2012).

## Carrying out a biopsychosocial assessment

Mental health and well-being are influenced not only by a person's individual attributes, but also by the social circumstances in which they find themselves and the environment in which they live. Therefore, it is important to consider biological, psychological and social factors. The list below is a guide to gaining helpful information.

- What are their current symptoms including duration and severity?
- Have they had depression before? Is this episode the same as before?
- Have they got a family history of mental illness? If so, what have they observed and what do they understand?
- What is the quality of their relationships with the people close to them? This may affect their outcome.
- Are they receiving any social support? (The encouragement given by family, friends, colleagues, and others. It can be emotional, instrumental, informational, or appraisal).
- What are their living conditions? Is this part of the problem?
- Do they have employment and/or financial worries?
- Is there any current or previous alcohol and substance use?
- Do they have any suicidal ideation?
- What treatment options are they aware of?
- Have they had any experience of, and response to, treatments? If something has worked in the past, then it is sensible to use again.

## Suicide

The Office for National Statistics' bulletin released in 2019 regarding suicide in the UK in 2018, states that there were 6,507 suicides registered in the UK, the first increase since 2013. Three quarters (4,903) of these deaths were among men. The highest age-specific suicide rate was for those aged 45 to 49 years (27.1 deaths per 100,000 males and 9.2 deaths per 100,000 females). They report that despite having a low number of deaths overall, rates among the under 25s have generally increased in recent years, particularly in females aged 10 to 24 years where the rate has increased significantly since 2012 to its highest level with 3.3 deaths per 100,000 females. The most common method of suicide in the UK was hanging, accounting for 59.4% of all suicides among males and 45.0% of all suicides among females.

Suicide is defined by the American Psychiatric Association (2019) as the act of killing yourself, most often because of depression or other mental illness, though this has been disputed (Oquendo and Baca-Garcia 2014). Only half of those who die by suicide have previously been referred to mental health services (National Confidential Inquiry 2013) and one study found that 37% of primary care patients who die by suicide had never received a diagnosis (National Confidential Inquiry 2014). Suicides can occur impulsively in times of crisis when the person is unable to cope with stress (World Health Organisation 2019). Causes of stress may include monetary problems, relationship issues and chronic pain and illness. Other high rates of suicide are prevalent in people who:

- Have experienced conflict (disaster, violence, abuse, loss and a sense of isolation)
- Are discriminated against (refugees and migrants; indigenous peoples; lesbian, gay, bisexual, transgender, intersex [LGBTI] persons; and prisoners).
- Have a family history
- Made a previous attempt
- Have had initiation of or changes to antidepressant medication
- Have a long-term physical condition (or pain)
- Are male
- Are middle-aged
- Abuse alcohol or drugs
- Are under extreme distress
- Self-harm
- Are homeless

**When a person presents with a possible COMMON MENTAL HEALTH PROBLEMS, they should always be asked directly about suicidal ideation and intent (NICE 2011):**

1. **Have you made a suicide attempt in the past?**
   *A positive answer should cause you concern.*

2. **Do you think that life is not worth living?**
   *Many people who are not suicidal think this – it is useful to share with patients that this is a common thought amongst people who are depressed*.

3. **Do you think about harming or killing yourself**?
   *This is a common thought. A positive response should prompt the next questions.*

4. **Have you got a plan to kill yourself? How would you do it?**
   *If they have no plan there is no need to continue with the questions. If they do, then ask the next question.*

5. **Do you aim to carry out this plan?**
   *If yes, this person is actively suicidal.*

6. **Have you got access to the necessary tools to carry out the plan?**
   *Having the tools means the patient has prepared themselves.*

7. **What would stop (or is stopping) you from carrying out your plan?**
   *Often patients choose not to attempt suicide because of commitments to family or friends or faith.*

# Actions for healthcare professionals

## No suicidal ideation

The healthcare professional should make a record that an assessment of suicide risk has been made and the person has no suicidal thoughts.

## Suicidal ideation but no plan

The healthcare professional should make a record that an assessment of suicide risk has been made and the person has suicidal thoughts but no current intent. Any advice and action should also be recorded. The person (and those involved in caring for them) should be advised:

- To immediately seek help (GP, Out of Hours service) if they start to think about making a plan, are concerned, or if their situation deteriorates.
- Of sources of help, for example:
  - **Staying safe: www.stayingsafe.net/home**
  - **The Samaritans: www.samaritans.org**
    Telephone **116 123** (24 hours a day, 7 days a week)
  - **Shout: www.giveusashout.org** Text **Shout** to **85258**
- To be watchful for changes in mood, negativity and hopelessness, and suicidal intent, particularly during high-risk periods such as initiation of or changes to antidepressant medication or at times of increased stress.

## Suicidal ideation with intent to carry out a plan

The healthcare professional needs to arrange immediate referral to mental health services following their local procedure. The way this works will vary in different areas of the country and might depend on the person's circumstances. If the suicidal person is accompanied by a friend or family member, they may be asked by the mental health service team to attend one of their locations. Often the team will come to the practice but there may be a delay. In this situation it is helpful if there is a quiet room in the practice where the person can wait. They should not be left unaccompanied, so having a person within the practice designated for this role (such as an administrator who has been trained to do this) allows the healthcare practitioner to continue with their clinic.

# Treatment

Treatment for mild to moderate common mental health problems can be offered in the primary care setting. More specialist treatment will require a referral.

## Treatment delivered in primary care

The treatments for people with common mental health problems that can be provided by healthcare professionals working in primary care are active monitoring; support to aid physical, psychological, and social wellbeing; psychoeducation; and antidepressants.

### Active monitoring

Active monitoring or watchful waiting is a decision between the clinician and the patient to not treat the condition, and to intermittently reassess its status along some rational time course in follow-up (Hegel *et al* 2006). NICE guidance for depression (NICE 2009a) recommends that this should be within two weeks.

### Support to aid physical, psychological, and social wellbeing

The healthcare professional can help a person with mild to moderate depression to keep well by providing advice, encouragement, and support.

- **Physical** – sleep hygiene, the benefits of following a regular exercise programme and eating a healthy diet, reducing caffeine and alcohol intake if appropriate, taking medication as prescribed and adequate rest and relaxation.
- **Psychological** – structured problem solving, sharing worries with others, books that can help, listing and estimating, assigning worry time, activity planning, distraction techniques, mindfulness, and self-monitoring diaries.
- **Social** – adult education, meeting up with friends, visiting the library, catching up with relatives, walks in the park and going to the pub for a drink with friends.

### Psychoeducation

The aim of psychoeducation is for the person to:

- Learn about their condition and its treatment
- Express how they feel about their condition and its treatment
- Be supported to comply with medication or other treatment
- Recognize their symptoms, crisis situations and know what to do.

Providing a relevant leaflet is a good start, for example:

- **Anxiety – www.nhs.uk/conditions/generalised-anxiety-disorder**
- **Depression – www.nhs.uk/conditions/clinical-depression**

## Antidepressant medication

Antidepressant medications are an effective treatment for people with moderate to severe depression. Response to treatment usually occurs within two weeks. Antidepressant medication does not usually work for people with mild depression, so should not normally be prescribed. In moderate to severe depression, patients will usually need medication to improve their concentration and lift their energy levels before they are able to engage in psychological treatments. People, who are newly prescribed antidepressants or have a change in dose or type, should be reviewed two weeks later to assess the effect. Some of the antidepressant medication is licensed for anxiety. When it is a first episode of depression, the medication is usually prescribed for at least six months AFTER the person reports that they feel better to prevent relapse. This period may be extended for subsequent episodes.

Selective Serotonin Reuptake Inhibitors (SSRIs) are the most frequently used medicines for the treatment of depression. These include **fluoxetine**, **citalopram**, **paroxetine** and **sertraline**. Serotonin (along with noradrenaline and dopamine) is one of the main neurotransmitters in mood disorders, it is hypothesised that depression is associated with a lack of serotonin. Antidepressant drugs exert their effect by boosting serotonin levels in the brain. SSRIs do this by inhibiting the reuptake of serotonin into the neurone effectively fooling the brain into producing more of the neurotransmitter. It is recommended that healthcare professionals prescribe these first. If there is no response, then a different SSRI should be used before trying another type of antidepressant. In the patients that fail to respond to SSRIs about half will improve with either with a different SSRI or class of antidepressant. The alternative classes of antidepressants include:

- Serotonin and Noradrenalin Reuptake Inhibitors (SNRIs).
- Noradrenergic and Specific Serotonergic Antidepressants (NaSSA).
- Tricyclic antidepressants (TCA).

## Treatment delivered by other agencies

For the person to benefit from treatment delivered by another agency, the healthcare professional will need to make a referral. They need to ensure the referral is appropriate by

taking account of patient preference and referring for the least intrusive, most effective intervention first (NICE 2011). If harmful drinking or alcohol dependence is also present, this should be treated first as it may lead to significant improvement in depressive or anxiety symptoms.

### Support or self-help groups

Members of a self-help group share a similar health problem. Their mutual goal is to help each other to manage this problem. Support or self-help groups are often provided by charitable organisations.

### Educational and employment support services

Unemployment is linked with poor mental health and being off sick with stress or depression can lead to unemployment (NHS Confederation 2010). A report by Depression Alliance (2016) advocates that local and national health services across the UK must play a greater role in supporting people to find or keep a job, with expanded access to psychological support, an increased number of placement support programmes and further investments in health-led interventions that are proven to work for people with mental health problems. One such initiative, the Mindful Employer is aimed at increasing awareness of mental health at work and providing support for businesses in recruiting and retaining staff. It is led and supported by employers, more information is available at **www.mindfulemployer.net**

### Individual or group cognitive behavioural therapy

Cognitive (thoughts) behavioural (actions) therapy (CBT) is a psychological intervention where the person works collaboratively with the therapist to learn how their thoughts, beliefs and attitudes affect their feelings and behaviour. They are also taught coping skills for dealing with different problems.

### Individual self-help

Self-help can be facilitated or done alone. It involves the patient using a range of books, manuals and electronic materials based on the principles of CBT.

- **Individual facilitated self-help** – patients are guided by a trained practitioner who introduces the material and reviews their progress and outcomes. The intervention usually consists of six to eight sessions which may be face-to-face and/or by telephone.

- **Non-facilitated self-help** – involves minimal contact with a practitioner (an occasional short telephone call) and includes instructions for the patient to work systematically through the materials over a period of at least 6 weeks.

### Computerised cognitive behavioural therapy

Computerised cognitive behavioural therapy (cCBT) is a form of cognitive behavioural therapy that is delivered through a stand-alone computer-based or web-based programme over a period of nine to 12 weeks. It works best when the patient is facilitated by a trained practitioner who reviews their progress and outcome.

### Structured physical activity

There is research to show that moderate intensity physical activity interventions, aerobic activity, and if supervised by exercise professionals, can have a positive effect on major depressive disorders (Stanton and Reaburn 2014). Physical activity programmes are defined as structured and group-based (with support from a competent practitioner) and usually comprise of three sessions (24-60 minutes) per week for 12 weeks (NICE 2011).

### Group-based peer support (self-help) programmes

Peer support can be defined as the process of giving and receiving non-professional, non-clinical assistance from individuals with similar conditions or circumstances (Tracy and Wallace 2016). Some mental health providers commission structured programmes but they are not available everywhere in the country.

### Exposure and response prevention

Exposure and response prevention (ERP) is a psychological intervention used for OCD. It aims to help patients overcome their need to engage in obsessional and compulsive behaviours. They are exposed to the feared situation with the support of a practitioner and taught ways of coping with their anxiety, distress or fear. The process is repeated until the person no longer feels this way.

### Trauma-focused CBT or eye movement desensitisation and reprocessing

Trauma-focused CBT or eye movement desensitisation and reprocessing (EMDR) is a psychological intervention for PTSD. The patient is asked to concentrate on an image connected to the traumatic event and the related negative emotions, sensations and thoughts while watching the therapist's fingers moving from side to side in front of their eyes. After each set of eye movements (about 20 seconds), they are asked to discuss the images and emotions they felt during the eye movements with the therapist. This process is repeated with an emphasis on problematic and persevering memories. When the distress about the image has lessened, they are asked to concentrate on it while having a positive thought relating to it. Treatment should be regular and continuous.

## Interpersonal therapy

Interpersonal therapy (IPT) is an intervention that focuses on the patient's interactions. The patient works with the therapist to identify social conflicts, role transitions, grief and loss, and social skills, and their effects on existing symptoms, feelings, and problems. They are taught how to cope with or resolve such problems or conflicts. IPT usually consists of 16 to 20 sessions over three to four months.

## Behavioural activation

Behavioural activation (BA) is a psychological treatment that aims to reduce symptoms and problematic behaviours through behavioural tasks related to reducing avoidance, activity scheduling, and enhancing positively reinforced behaviours.

## Behavioural couples therapy

Behavioural couples therapy aims to help people understand the effects of their interactions with each other as influences in the development and maintenance of symptoms and problems. The therapy involves working to change the nature of the interactions so that the mental health problems improve.

## Counselling

Counselling is a supportive approach which helps patients to explore their feelings and problems and make appropriate changes in their lives and relationships.

## Short-term psychodynamic psychotherapy

In short-term psychodynamic psychotherapy the therapist and patient explore and gain understanding into conflicts and how these are represented in current situations and relationships. The therapy is non-directive and recipients are not taught specific skills.

## Combined interventions

Combined interventions are the use of more than one treatment.

## Collaborative care

Collaborative care is a coordinated approach to mental and physical healthcare involving case management, close teamwork between primary and secondary physical health services and specialist mental health services, a range of psychological interventions, and long-term coordination of care and follow-up.

## Applied relaxation

Applied relaxation is the application of muscular relaxation in situations and occasions where the patient is or might be anxious.

# Agencies who deliver treatment

## Counselling services

Counselling services can be accessed through:

- **The workplace** – some organisations have telephone or face to face provision for their employees
- **Charities** – counselling may be offered for free, for a donation or for a fixed sum
- **Private counsellors** – these should be registered with the British Association for Counselling and Psychotherapy (BACP).

## Improving Access to Psychological Therapies (IAPT) programme

This service was created to offer patients with mild, moderate, and moderate to severe symptoms of anxiety or depression a realistic and routine first-line treatment, combined where appropriate with medication. The services that they may offer include CBT, IPT, self-help, psychodynamic psychotherapy, EMDR, BA and relaxation. The local IAPT service can be located via the NHS website **www.nhs.uk/service-search/other-services/Psychological%20therapy%20(NHS%20IAPT)/LocationSearch/396**

## Third sector organisations

Third sector organisations are nongovernmental organisations (also known as the voluntary sector, community sector or "not-for-profit" sector). They are called the third sector, in reference to the public sector (providing basic government services) and the private sector (run by individual groups for profit). Many of these voluntary organisations provide invaluable services for people with mental health problems.

## Secondary care mental health services

Secondary care refers to services provided by health professionals who generally do not have the first contact with a person and a GP referral is required.

The roles and functions of people in the mental health team are described below.

## Psychiatrist

A psychiatrist is a medical doctor with specialist training in diagnosing and treating mental illnesses and emotional problems. Each team has a consultant who has completed their professional training. If the patient in contact with specialist mental health services needs to take medication, psychiatrists are usually responsible for prescribing this (although in some services, nurse prescribers take this responsibility too). There may also be an associate specialist, who will have trained in psychiatry but who has not become a consultant.

## Community mental health nurse

Community mental health nurses (CMHNs) work outside hospitals and visit people in their own homes, out-patient departments, or GP surgeries. They can help people to talk through problems and give practical advice and support. They can also give medicines and review their effects. Nurse therapists have had extra training in particular problems and treatments, such as eating disorders or behaviour therapy.

## Social worker

Social workers help people to talk through their problems, give them practical advice and emotional support and provide some psychological treatments. They give expert practical help with money, housing problems and other entitlements.

## Occupational therapist

Occupational therapists (OTs) help people to get back to undertaking the tasks of everyday life. This can be through doing practical things or talking with other people in groups.

## Clinical psychologist

Clinical psychologists will usually meet regularly with a person for a number of sessions to talk through how they are feeling, thinking and behaving. They may use cognitive behavioural therapy, psychodynamic or behavioural psychotherapies. They also advise other members of the team.

## The team manager

The team manager will usually be a senior nurse or social worker.

## Approved mental health professional

The approved mental health professional (AMHP) will usually be a social worker but can be any member of the community mental health team. They have had further training in operating the Mental Health Act and have a central role in assessing and determining if there are grounds to compulsorily admit and detain someone in hospital under the Act.

## The care coordinator

A person receiving help from secondary care would usually be allocated a care coordinator who is often a social worker or a nurse.

## Specialist community-based teams

Some areas in the United Kingdom may have specialist teams, these include:

- Home treatment
- Crisis intervention
- Early onset psychosis
- First episode psychosis
- Assessment and brief treatment (ABT)
- Continuing care
- Recovery
- Assertive outreach
- Forensic
- Child and adolescent mental health

Healthcare professionals should have an up to date record of the contact details of the services they may refer to.

| Local Service | Contact details |
|---|---|
| Counselling services | |
| IAPT service | |
| Third sector agencies | |
| Secondary care services | |
| Other (e.g. social services, debt counselling) | |

## Choice in mental health services – patients' rights

In April 2014 people with mental health conditions in England were given the same legal right to choose their health care provider as those with physical health conditions. The relevant NHS contract for the services referred into needs to be present and the referral needs to be clinically appropriate. Healthcare professionals referring patients to mental health services need to advise them about this choice and signpost them to the NHS website **www.nhs.uk** for more information.

## Summary

Healthcare professionals in primary care have a responsibility to recognize common mental health problems, provide information about the treatment options and to make appropriate referrals. They can also help people with common mental health problems to improve their physical, psychological, and social wellbeing.

## Vignette

*Janet is 43 years old and has attended the practice for her annual diabetes review. She has put on 10 kilograms since last year and her blood glucose is raised. Janet normally exercises regularly and eats a healthy diet. She reports that she is comfort eating and cannot be bothered to exercise or prepare food. She is avoiding eye contact and her reactions appear slow.*

**How should the healthcare professional approach the consultation?**

## Reflective Questions

- Think about the last time you were feeling low for a couple of days. How did this affect you physically and mentally?
- What local third sector agencies are available for people with common mental health problems and how can they be accessed?
- What psychological therapies are offered by your local IAPT service? How long do people have to wait before they gain access to this treatment and what support do they receive while they are waiting?

# References


- American Psychiatric Association. (2019) *Suicide*. **www.apa.org/topics/suicide**
- American Psychiatric Association (APA) (2013). The Diagnostic and Statistical Manual of Mental Disorders. 5th edition. Arlington (VA): APA.
- Arroll B, Goodyear-Smith F, Kerse N, Fishman T, Gunn J. (2005) Effect of the addition of a 'help' question to two screening questions on specificity for diagnosis of depression in general practice: diagnostic validity study. *British Medical Journal*. **331** (7521) 884.
- Department of Health. (2012) *Preventing suicide in England: a cross-government outcomes strategy to save lives*. London: Department of Health.
- Evans J, Macrory I and Randall C. (2016) *Measuring national well-being: Life in the UK*, (2016). ONS. **www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/measuringnationalwellbeing/2016#how-good-is-our-health**
- Gask L, Kendrick T, Peveler et al. (2018) *Primary care mental health*. 2nd ed. London: Royal College of Psychiatrists.
- Gillespie D and Cadden A. (2013) The Distress Management System for Stroke (DMSS): an approach for screening and initial intervention for post-stroke psychological distress. *Journal of Nursing Education and Practice*. **3** (10) 150-158.
- Hardy S. (2015) Mindfulness: Enhancing physical and mental health wellbeing. *Practice Nursing*. **26** (9) 450-453.
- Hegel M, Oxman T, Hull J et al. (2006) Watchful waiting for minor depression in primary care: remission rates and predictors of improvement. *Gen Hosp Psychiatry*. **28** 205-12.
- Katon W. (2011) Epidemiology and treatment of depression in patients with chronic medical illness. Dialogues Clin Neurosci. **13** 7-23.
- Kroenke K, Spitzer R, Williams J. (2001) The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine*. **16** (9) 606-613.
- McManus S, Meltzer H, Brugha T et al. (2009) *Adult psychiatric morbidity in England, 2007: results of a household survey*. NHS Information Centre for Health and Social Care: Leeds.
- Mitchell A, Vaze A, Rao S. (2009) Clinical diagnosis of depression in primary care: a meta-analysis. *Lancet*. **374** 609-619.
- National Confidential Inquiry. (2018) *Safer services: a toolkit for specialist mental health services and primary care*. Available at: **www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/suicide-prevention/safer-services_a-toolkit-for-specialist-mental-health-services_updated-nov-2018.pdf?sfvrsn=f6620787_2**
- National Confidential Inquiry. (2014) *National Confidential Inquiry into suicide and homicide by people with mental illness: suicide in primary Care in England: 2002-2011*. Manchester: University of Manchester.
- National Confidential Inquiry. (2013) *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Annual Report, England, Northern Ireland, Scotland and Wales*. Manchester: University of Manchester.
- National Institute for Health and Care Excellence. (2018) Post-traumatic stress disorder. **www.nice.org.uk/guidance/ng116/chapter/Recommendations**
- National Institute for Health and Care Excellence. (2014) Anxiety disorders Quality standard (QS53). **www.nice.org.uk/guidance/qs53**

- National Institute for Health and Care Excellence. (2013) Social anxiety disorder. The NICE guideline on recognition, assessment and treatment. **www.nice.org.uk/guidance/cg159/evidence/full-guideline-189895069**
- National Institute for Health and Care Excellence. (2011) *Common mental health disorders: Guidance and guidelines*. **www.nice.org.uk/guidance/cg123**
- National Institute for Health and Clinical Excellence. (2009a) *CG90 Depression in adults – full guidance*. **www.nice.org.uk/guidance/cg90**
- National Institute for Health and Care Excellence. (2009b) *Depression in adults with a chronic physical health problem: treatment and management, CG91*. **www.nice.org.uk/guidance/CG91**
- NHS Confederation. (2010) *Working it out: employment for people with a mental health condition*. **www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/Mental_health_briefing_200mar10.pdf**
- Office for National Statistics. (2019) *Suicides in the UK: 2018 registrations*. **www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2018registrations**
- Oquendo M and Baca-Garcia E. (2014) Suicidal behavior disorder as a diagnostic entity in the DSM-5 classification system: advantages outweigh limitations. *World Psychiatry*. **13** (2) 128-130.
- Smiley E. (2005) Epidemiology of mental health problems in adults with learning disability: an update. *Advances in Psychiatric Treatment*. **11** 214-22.
- Stansfeld S, Clark C, Bebbington P et al. (2016) Chapter 2: Common mental health problemss. In S. McManus, P. Bebbington, R. Jenkins, & T. Brugha (Eds.), Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital.
- Stanton R and Reaburn P. (2014) Exercise and the treatment of depression: a review of the exercise program variables. *Journal of Science and Medicine in Sport*. **17** (2) 177-182.
- Tracy K and Wallace S. (2016) Benefits of peer support groups in the treatment of addiction. *Substance Abuse and Rehabilitation*. **7** 143-154.
- Vos T, Barber R, Bell B et al. (2013). Global, regional, and national incidence, prevalence, and years lived with disability for 301 acute and chronic diseases and injuries in 188 countries, 1990-2013: A
- Whooley M, Avins A, Miranda J, Browner W. (1997) Case-finding instruments for depression. Two questions are as good as many. *Journal of General Internal Medicine*. **12** (7) 439-445.
- Wolf J. (2018) *The Patient Experience Consumer Study 2018*. Nashville: The Beryl Institute.
- Wong O, Nguyen T, Thomas N et al. (2016 Perinatal mental health: Fathers – the (mostly) forgotten parent. Asia Pac Psychiatry. **8** (4) 247-255.
- World Health Organization. (2019) Suicide. **www.who.int/news-room/fact-sheets/detail/suicide**