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Common Mental Health Conditions in Primary Care

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ABSTRACT

Common mental health problems particularly depression and anxiety are frequently found in primary care settings. Depression can range from mild to severe but even in less severe cases can cause problems with normal functioning. Anxiety regularly manifests itself with depression but anxiety disorders, of which there are several, are also likely to disrupt normal life. There are several treatments for these conditions both pharmacological and psychological. Severe mental illness (SMI), generally bipolar disorder and schizophrenia, is also managed by primary care health professionals therefore it is essential these professionals are aware of how these conditions may present and the current treatments available. Bipolar disorder, a serious mood disorder, is often under-diagnosed in primary care that has implications for the individual's care and treatment. People with schizophrenia are often monitored by primary care health professionals although liaison and referral to secondary services is recommended for both these SMIs. A holistic recovery focused approach to care is recommended.

Key Words: primary care; psychiatry; mental health nursing

Common Mental Health Problems in Primary Care

Common mental health problems (CMHPs) have been described 'as extreme forms of 'normal' emotional experiences such as depression and anxiety[1]. Depression, anxiety disorders and mixed anxiety and depression are widespread with a huge burden on society in terms of emotional, social and economic hardship[2,3]. NICE [4] discusses that although CMHPs will differ in how people are affected, the risk of chronic ill health is possible. It has been found that 90% of common mental health problems are managed in primary care with between 25 and 30% of consultations to GPs related to CMHP[5-8]. Depression has been predicted by the WHO to be the second highest cause of morbidity worldwide by 2020 [3].

Depression

Depression is a mood disorder which although is a common mental health problem can be severe enough to endanger life. However, even in less serious cases it is likely to have an impact on all areas of the individual's functioning. It is estimated that 1,250,000 people living in Scotland will experience depression and that 500,000 Scots are currently enduring

varying symptoms of depression[9]. Depression is likely to occur in people across the lifespan from children to older adults. It is generally accepted that to diagnose depression, the symptoms are classified according to either Diagnostic and Statistical Manual of Mental Health Disorders (DSM) issue IV [10] or International Classification of Diseases (ICD) issue 10 [11] (Table 1).

Table 1: Making a Diagnosis of Depression in Primary Care

DSM IV	ICD10
• 5 or more of following symptoms present nearly every day for same 2 week period • At least 1 of the symptoms is either depressed mood, or loss of interest or pleasure • Weight loss/weight gain • Insomnia/hypersomnia • Fatigue/loss of energy • Feelings of worthlessness • Reduced concentration • Recurrent suicidal ideation • Psychomotor agitation/retardation	• Individual usually suffers from depressed mood, loss of interest and enjoyment, reduced energy Other common symptoms – • reduced concentration • reduced self confidence • ideas of guilt/unworthiness • pessimistic views of future • disturbed sleep • reduced appetite • ideas/acts of self-harm or suicide

Although the cause of depression is unclear, several theories have been put forward[12]. These can be classed as biological influences – genetics, neurotransmitters, endocrine factors and immune system deficits and non biological considerations – early life experiences, current life events, social isolation, gender and socioeconomic factors. Generally a combination of factors will contribute to someone becoming depressed. Frequently depression and anxiety will be experienced together and even in mild depression anxiety is often present[13].

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Anxiety and Anxiety Disorders

Anxiety is common to all human beings and can be seen to be an understandable reaction to stressful life events. At normal levels it has a protective and invigorating function. However it can become severe enough to disrupt normal functioning and at this point can be classified as a disorder[14]. McManus, Shafran, & Cooper [15] claim that 'anxiety disorders have a profoundly negative impact on quality of life and are the most economically costly of all psychiatric disorders'. Although anxiety itself is a generic term, it can be classified into several disorders (Table 2).

Table 2; Disorders within the spectrum of an anxiety diagnosis

The main conditions are:
• generalised anxiety disorder (GAD)
• panic disorder (PD)
• obsessive compulsive disorder (OCD)
• post-traumatic stress disorder (PTSD)
• social anxiety disorder
• specific or simple phobia

Research has shown that suffering from these disorders will adversely affect an individual's quality of life[16]. In the general population it has been suggested that one in four people will meet the criteria for an anxiety disorder throughout their lives[17]. Several theories have been put forward to explain the development of anxiety disorders. These purport to be biological or genetic, cognitive- behavioural or that anxiety is a learned behaviour. It has been claimed that anxiety is 'one of the most common treatable mental disorders' [18] and there are specific interventions which can be employed to deal with this.

Mixed Depression and Anxiety

It is clear that both depression and anxiety have a range of symptoms that are overlapping. Watson et.al [19] would argue that although it has proved difficult to separate the two conditions, both depression and anxiety have distinctly different manifestations. It has been found that within the general population that comorbid depression and anxiety occur in over half those who report symptoms [17] Psychological therapies are being recommended as first line treatment of depression and anxiety [20,4,21]

NICE [4] advocates a Stepped Care Model so that people with CMHPs receive the most effective treatment. In this model people will be offered the most appropriate therapy for their problem from low intensity interventions for example psychoeducation or guided self help based on (Cognitive Behavioural Therapy) CBT principles to high intensity one to one psychotherapy. Currently both CBT and Interpersonal Therapy (IPT) are recommended for the treatment of depression [4,21]. Depending on the severity of the depression this can be in conjunction with antidepressant medication[9]. Anxiety disorders are generally treated with CBT, applied relaxation and/or antidepressant medication depending on the specific condition [4].

Severe Mental Illness in Primary Care

Sadler [22] discusses that health professionals working in primary care should be as aware of early warning signs of mental ill-health as they are of signs of chronic physical health problems. As well as CMHPs a significant number of people with severe mental illness (SMI) will be supported within a primary care setting. Both bipolar disorder and schizophrenia are deemed to be SMIs and it is essential that health professionals working in primary care are aware of how these can present and current treatment. Despite SMIs being relatively common in community settings there is a lack of awareness by staff including GPs regarding bipolar disorder [23].

Bipolar Disorder

As with depression, bipolar disorder is a mood disorder. It is a serious mental health problem which is distinguished by periods of mania and depression. However in those with bipolar disorder although 90% will have experienced a major depressive episode this does not have to be present to warrant diagnosis to be made [24]. According to DSMIV bipolar disorder is classified into types I and II [10]. Type I is characterised by having experienced one or more manic episodes (lasting at least a week). Although having a depressive episode is not required for the diagnosis of type I bipolar disorder, the majority of people will experience both depressive and manic episodes. People can experience multiple episodes of disturbed mood. The lifetime prevalence of bipolar I is estimated at 1% of the adult population.

The majority of people with bipolar disorder type I will experience episodes of major depression and episodes of mania. Mania is characterised by specific symptoms (Table 3). Mixed episodes where an individual experiences symptoms of irritability and sadness with elation are not uncommon. Misdiagnosis of bipolar disorder in primary care is common as individuals are likely to present with a depressive episode. There is evidence that people with bipolar disorder can have more than one episode of depression before the onset of mania [25]. Diagnosis of type II is made if an individual experiences at least one hypomanic episode (not severe enough to be classed as mania however) and one depressive episode [24]. Normally symptoms of bipolar disorder will develop between the ages of 15 and 24 years.

Establishing the correct diagnosis is important as treatment must be specific to bipolar disorder. There is a risk of inducing a manic episode or causing the person to experience rapid cycling of mood by treating the depression with antidepressants only [23]. Smith et.al [26] found that bipolar disorder was under recognised in primary care settings. It has been discussed that the complex nature of bipolar disorder has implications for management of people in primary care [27].

When people experience severe mood swings there is likely to be disruption to relationships, employment and subsequent financial difficulties. Substance misuse is common [23]. People with bipolar disorder are at higher risk of physical health problems and of suicide [28]. The management of bipolar disorder is twofold as people may need treatment for both acute symptoms and longer term therapy to maintain their mood at an optimal level. Acute symptoms of mania will commonly be treated with antipsychotic medication

and short term benzodiazepines for agitation. Pharmacological management in the longer term is generally with mood stabilisers - Lithium; antipsychotics – Olanzapine; or anticonvulsants – Valproate [29] These may be used in combination depending on the severity of the illness and would normally be continued for 2-5 years.

As well as pharmacological treatment for bipolar disorder NICE [29] recommends that health professionals advise people with bipolar disorder about self management particularly of early warning signs and lifestyle strategies. There is evidence that psychological therapies (CBT & IPT) and psychoeducation have a part to play in helping people manage bipolar disorder[30]. NICE [29] makes specific recommendations for primary care health professionals to consider liaison with and referral to secondary services for people with bipolar disorder. Another SMI is schizophrenia, which can present in primary care but is often treated in secondary care.

Table 3 : Core diagnostic features in Bipolar Disorder

Emotional	Physical
Mood swings such as euphoria/elation to anger/irritability	Increased energy/always on the go
Immediate gratification of wishes	Decreased need for sleep
Cognitive	Appetite changes
Racing thoughts, pressure of speech	Lack of attention to personal hygiene/general health
Distractible	
Flight of ideas	Psychotic symptoms in mania
Impaired judgement	Delusions – generally mood congruent. Grandiose in nature – beliefs about being royalty or having special powers but can be persecutory
Behavioural	
Intrusive/demanding/aggressive	
Impulsive	Hallucinations –most commonly auditory, don't tend to be unpleasant
Sexually disinhibited, increased libido	

Schizophrenia

Schizophrenia is a serious mental illness that features a cluster of conditions including positive and negative symptoms and schizophrenic thinking. Hallucinations are a positive symptom that are most commonly auditory, but can also be visual, tactile or olfactory related. Negative symptoms are often a lowering of mood, lack of motivation, becoming socially withdrawn and unemotional [31].Schizophrenic thinking refers to a disturbance of normal thought, such as delusions or thought insertion or withdrawal [11]. It should be acknowledged that every individual will have different combinations of symptoms unique to them [20](Table 4).

Table 4: Core diagnostic features in Schizophrenia

Positive Symptoms	Negative Symptoms
Schizophrenic thinking	Lower mood
Delusions	Loss of interest
Hallucinations	Social withdrawal

There is no definitive cause but it appears to be related to stress vulnerability. Zubin & Spring [32] explain this as people with low tolerance to stress, perhaps due to genetic loading or environmental factors such as childhood trauma, are more likely to develop symptoms. About 1% of the population develop schizophrenia [20]. According to DSM-IV [33], it affects males and females equally and different populations equally worldwide. It often first appears in early adulthood.

According to ICD-10 [11] classification, there can be a prodromal period of time where loss of interest, self-isolation and problems with mood appear, most often in young people. However, there is insufficient evidence to conclude that prodromal symptoms should be included in the diagnostic criteria for schizophrenia. Substance misuse should be ruled out before diagnosis as this can cause psychotic symptoms to occur [10]. It is also true that people with schizophrenia misuse substances more frequently than the rest of the population, making it difficult to make an accurate assessment.

NICE [20] recommends that oral anti-psychotic medication is prescribed. This is in order to decrease the positive symptoms. Although modern atypical anti-psychotics don't carry the same risk of extrapyramidal side effects that typical medication does, they still have unpleasant side effects, such as weight gain, cardio-vascular problems and, with clozapine in particular, agranulocytosis [20]. Clozapine should be offered to people who have not successfully been treated with at least two other anti-psychotic medications. Any serious side effects may affect compliance with the medication.

Where there is difficulty with daily medication compliance, intra-muscular depot injections may be offered. Some people prefer this, as oral medication will need to be taken every day however depots can be given less frequently. People experiencing distressing hallucinations and delusions may be treated in an acute psychiatric ward in hospital in order to stabilise their symptoms with medication before discharging back to the community.

Living in the community can be successful with the help of carers [11]. Many people with schizophrenia will be looked after in the community by Community Psychiatric Nurses. They may visit to give depot injections, provide emotional support and signpost to voluntary organisations which may run support groups. Having a diagnosis of schizophrenia carries with it a stigma, perhaps due to a lack of understanding by family, friends and the general public. This can mean it is difficult to maintain work or study and relationships may breakdown. The first few years after the person develops schizophrenia can be very difficult, meaning that there can be an increased risk of suicide [20]. NICE [20] also recommends that professionals involved should work in a recovery focused manner, conveying hope and optimism. A holistic care approach should be given, including yearly physical health checks to monitor cardio-vascular disease in particular. SIGN [34] advises that education on the illness and effects of medication is provided to the service user and carer by an experienced professional. A Family Intervention Programme should be offered to address any relationship difficulties and CBT should be offered to help with distressing symptoms. NICE [20] also suggest art therapies to help with negative symptoms.

Psychosis can appear in severe depression and in bipolar disorder as well as in schizophrenia. People with SMIs often are admitted to secondary care during acute episodes of mania or psychosis, more so than depression and anxiety. Community Mental Health Teams (CMHTs) are required to make decisions on when to admit someone to hospital; usually if there are concerns about a person's safety or others' safety. However, once the acute phase has settled, people can be discharged back to the community with increased support from CMHTs if necessary. There is evidence that crisis intervention teams can provide care in the home that is more acceptable to both the person and their carers. It has also been seen to reduce repeated admissions to hospital [35].

Conclusion

Depression and anxiety are very common mental health problems that are mostly treated in primary care. They have a huge impact on society with people having extended periods of sickness absence from work and can negatively affect relationships. Although they are individual conditions, frequently they are diagnosed together and many of the symptoms overlap, however vulnerability factors may be different. More SMI problems such as bipolar disorder and schizophrenia may be diagnosed in primary care, but acute manic or psychotic episodes are often treated in secondary care. CMHTs help support people diagnosed with these conditions in the community but if people experience acute mania or psychosis they may need to arrange admission to hospital or referral to a crisis intervention team in order to stabilise their symptoms. It has been acknowledged that increased awareness of the symptoms of mental ill-health is required by health professionals in primary care to maximise appropriate diagnosis and treatment.

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