

Common mental health problems

Clinical case scenarios for primary care

Support for education and learning

May 2012



These clinical case scenarios accompany the clinical guideline: 'Common mental health disorders: identification and pathways to care' (available at www.nice.org.uk/guidance/CG123). Issued May 2011.

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Contents

Introduction.....	4
NICE clinical case scenarios.....	4
Common mental health problems	5
Learning objectives	7
Clinical case scenarios for primary care	8
Case scenario 1: effective local pathways; Shubha.....	8
Case scenario 2: identification (comorbidities); James	14
Case scenario 3: identification (multi-morbidities); Barbara	19
Case scenario 4: identification (longstanding anxiety); Fred.....	23
Case scenario 5: Identification and assessment (comorbidities); Paul	30
Case scenario 6: Assessment (criminal justice system); Dan.....	38
Case scenario 7: psychoeducation and active monitoring; Jerome	49
Case scenario 8: Review (social care); Violet.....	54
Related NICE recommendations	58
Stepped care: step 2 treatment interventions table	65
Stepped care: step 3 treatment interventions table	68
Tools to support diagnosis	71
Glossary	74
Quality and Outcomes Framework (QOF) indicators.....	76
Appendix: Personal accounts of generalised anxiety disorder	77
Other implementation tools.....	84
Acknowledgements	84

Introduction

NICE clinical case scenarios

Clinical case scenarios are an educational resource that can be used for individual or group learning. Each question should be considered by the individual or group before referring to the answers.

These eight clinical case scenarios have been developed to improve the identification, assessment and treatment of common mental health problems within primary care. They illustrate how the recommendations from 'Common mental health disorders: identification and pathways to care' ([NICE clinical guideline 123](#)) can be applied to the care of people presenting in primary care. Each scenario has been written by a different contributor with experience in this field, so each chapter reflects the different contributors' styles.

The clinical case scenarios are available in two formats: this PDF version, which can be used for individual learning, and a slide set that can be used for groups. Slides from the clinical case scenario slide set can be added to the [standard NICE slide set](#) produced for this guideline.

You will need to refer to the NICE clinical guideline to help you decide what steps you would need to follow to diagnose and manage each case, so make sure that users have access to a copy (either online at www.nice.org.uk/guidance/CG123 or as a printout). You may also want to refer to the NICE pathways for [depression](#), [anxiety](#), [panic disorder](#) and [post-traumatic stress disorder \(PTSD\)](#) and the NHS Evidence topic pages on [depression](#) and [anxiety](#).

Each scenario includes details of the person's initial presentation, their case history and their GP's summary of the situation after consultation. Decisions about diagnosis and management are then examined using a question and answer approach. Hyperlinks to the relevant recommendations from the NICE guideline are included after the answer, with corresponding recommendation numbers. An excerpt from personal accounts of people who currently have or

have had symptoms of generalised anxiety disorder (GAD) is also included to provide some insight into their experiences.

Common mental health problems

Common mental health problems such as depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder and social phobia may affect up to 15% of the population at any one time. The severity of symptoms experiences will vary considerably, but all of these conditions can be associated with significant long-term disability. For example, depression is estimated to be the second greatest contributor to disability-adjusted life years throughout the developed world. Many anxiety disorders, particularly once established tend to have a chronic course. The majority of people diagnosed with depression or anxiety disorders (up to 90%) are treated in primary care. However, many individuals do not seek treatment, and both anxiety and depression often go undiagnosed. It is likely that only 30% of people presenting in the community have their condition recognised and treated. Although under-recognition is generally more common in mild rather than severe cases, people with mild disorders are often distressed and this can lead to significant morbidity.

Recognition of anxiety disorders by GPs has been variable, and in some cases particularly poor, and only a small minority of people who experience anxiety disorders ever receive treatment. In part this may stem from GPs' difficulties in recognising the disorder, but it may also be caused by worries about stigma which may make people more reluctant to disclose their symptoms.

Core principles

Good communication skills including active listening are key components for building a trusting relationship with patients, for example through demonstrating empathy, by making eye contact and explaining and talking through diagnoses, symptom profiles and possible treatment options. The evidence base shows that adopting a collaborative approach with patients can help facilitate a greater engagement from them in any resulting treatments.

The longstanding relationship that GPs often have with patients can help to optimise the quality of an assessment and in establishing the characterisation of their problems. Validated tools such as PHQ-9 and GAD-7 can help support the formulation of a diagnosis and establish the severity of a patient's symptoms, but a comprehensive assessment that does not rely on a symptom count alone is recommended. In addition, assessment of risk is vital. A more rounded assessment can be achieved by exploring lifestyle factors. These can include a person's accommodation status or living conditions, social isolation, family challenges, cultural issues, financial problems, or any other pressures that they may have. Also there may be protective factors that can be taken into consideration, such as social support or a person's spirituality.

A key ability for GPs is to be able to detect emotional distress and it has been found that where practitioners used skills to enable patients to disclose their distress during a session, this enhanced the opportunity for it to be detected and managed¹. When a patient initiates a discussion regarding their mental health with their GP or healthcare provider, this may create additional anxiety for them. By being mindful of your approach, for example through a measured tone of voice or through the use of sensitive questioning, this may help the person to engage better within the consultation. Sometimes people will experience distress or anxiety in response to challenging life events, as a result of workplace pressures or job insecurity. In such cases the communication skills and clinical judgement of their GP, in the discussion with the patient, will be crucial in ensuring that this distress is not medicalised².

GPs should approach any discussions regarding management and treatment options with hope and optimism, underlined by the premise that recovery is possible. Where treatment and care is provided it should take into account a patient's individual needs and preferences, and the patient should be supported

¹ Goldberg, D. P. & Bridges, K. (1988), Somatic presentations of psychiatric illness in primary care settings. *Journal of Psychosomatic Research*, 32, 137–144; Goldberg, D. P., Jenkins, L., Millar, T., et al. (1993), The ability of trainee general practitioners to identify psychological distress among their patients. *Psychological Medicine*, 23, 185–193

² [NICE Into practice shared learning example: De-medicalising long term sickness absence, human solutions to 'stress' and common mental health problems](#)

by their GP to reach informed decisions about their care. Core components of the doctor-patient relationship, such as respecting a patient's confidentiality, privacy and dignity will also help to consolidate the relationship and an effective consultation to occur.

Learning objectives

After working through the case scenarios, participants should be able to describe and demonstrate:

- the factors, signs and symptoms to prompt investigations for a common mental health problem
- key points to consider when providing care for, and engaging people from a minority ethnic cultural background
- principles of stepped care and be able to describe examples of this applied to practice
- insights from practice of effective approaches for engaging people who are experiencing distress in a collaborative consultation
- evidence based approaches that support investigations for common mental health problems with people within their care
- how the principles of psychoeducation and active monitoring can be applied in practice
- the importance of review and continuity of care for people with common mental health problems, and the pivotal role that a GP can have in this
- and effective approaches for multi-disciplinary working or for establishing local treatment and referral pathways.

Clinical case scenarios for primary care

Case scenario 1: effective local pathways; Shubha

Presentation

Shubha is a 26-year-old woman who has been referred to you by the local mother and baby clinic. You are a GP for Shubha's husband and members of his extended family are registered at your practice, but this is the first time that you have met her. Shubha emigrated from Bangladesh to the UK three years ago with her husband and his family, and gave birth to a baby girl one month ago. She has had an arranged marriage and the family have struggled with financial pressures since the move. Her husband is very close to his mother, who advises him on all issues related to the baby.

Shubha can speak limited English. She is unhappy about the appointment with the GP as she feels this will bring shame to the family. She sees you – a white male GP – with her husband, who acts as an interpreter. Her husband says that Shubha seems unhappy and does not want to do anything. She is reluctant to get out of bed or to look after the baby, and complains of pain in her stomach constantly. He discloses that his mother thinks she is lazy because she is unwilling to do household chores.

Medical history

Her husband says Shubha did not disclose any past medical history to him, so her past psychiatric history is unknown.

On examination

An initial physical examination does not reveal anything abnormal. A blood sample for full blood count and testing for vitamin D deficiency are taken.

1.1 Question

- a) After receiving the referral from the baby clinic, how may you need to tailor your approach within this consultation?

- b) Should the content of your assessment also be changed?

1.1 Answer

a) You should be respectful of, and sensitive to, diverse cultural, ethnic and religious backgrounds when working with people with common mental health problems, and be aware of the possible variations in the presentations of these conditions. [Relevant recommendations (1.1.1.3) to (1.1.1.5) see pg 58].

You should ensure that you are competent in:

- culturally sensitive assessment³
- using different models to explain common mental health problems
- addressing cultural and ethnic differences when developing and implementing treatment plans
- working with families from diverse ethnic and cultural backgrounds.

b) To enable an effective consultation it is important that you are aware of and able to address any factors outlined in answer 'a' above. If you use a validated tool to support your diagnosis, such as PHQ-9 you should not significantly vary the content or structure of the tool to address specific cultural or ethnic factors (beyond it being translated into another language) as there is little evidence to support significant variations to the content and structure of these tools.

Supporting information

Gender can be a significant issue for patients from some cultural backgrounds.

Shubha may prefer to be assessed by a female health professional, especially if a physical examination is required.

Health professionals should be aware that patients from some cultural backgrounds may be reluctant to shake hands or to make eye contact and therefore that this may not be a symptom. Some patients may have a louder tone of voice and use hand gestures, but this does not always mean that they are being aggressive.

Next steps for diagnosis

1.2 Question

You suspect Shubha may have postnatal depression. How do you confirm this?

³ [Royal College of Psychiatrists: Building a culturally capable workforce — an educational approach to delivering equitable mental health services](#)

1.2 Answer

a) You should be aware that people from some cultural backgrounds may not always be forthcoming during the consultation. A full assessment will be required with Shubha which may take longer than normal and possibly more than one appointment to complete. It may be helpful to offer Shubha the option of using an independent translation service - and a female translator if available - to assist her during any subsequent appointments.

b) Start by asking questions about Shubha's physical health and the health and wellbeing of her baby so she can feel that she is being listened to. Once you have established a rapport with Shubha, symptoms of mental distress can then be investigated. Perceptions of shame and stigma regarding mental health problems in some communities means Shubha may feel reluctant to acknowledge any symptoms of depression that she has, and she may present with somatic symptoms.

c) You should then ask Shubha the following two case-finding questions⁴:

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

d) If Shubha answers yes to either of the questions then a depression screening questionnaire should be used. For example, the 9-item Patient Health Questionnaire (PHQ-9) or the Improving Access to Psychological Therapies (IAPT) screening prompts tool⁵ could be used. You should check that Shubha is able to complete the form herself, and if not, to offer either a version translated into her language (if available) or to run through the questions with her.

⁴These questions are also known as the 'Whooley questions'. Whooley MA, Avins AL, et al (1997) Case-finding instruments for depression: two questions are as good as many. J Gen Intern Med. 1997 Jul;12(7):439-45

⁵ Located within Chapter C of the IAPT Data Handbook Appendices version 2.0.1 June 2011 <http://www.iapt.nhs.uk/silo/files/iapt-data-handbook-appendices-v2-word-version.doc>

[Relevant recommendations include: (1.3.1.1), recommendations for assessment (section 1.3.2): (1.3.2.1), (1.3.2.2), (1.3.2.3), (1.3.2.4), (1.3.2.5), (1.3.2.6). In addition, recommendations on arranging help appropriate to the level of risk (see section 1.3.3) (1.3.2.9)].

Next steps for diagnosis

On further probing, it transpires that Shubha feels that it will be better for her baby if she was dead. She believes that she is worthless and that her husband's family do not like her. She reveals that this has also started to affect how she feels about spending time with her baby. She tells you that she is sometimes reluctant to feed the baby, she often misses meals, and has found she does not have the energy to look after herself as well as she used to.

1.3 Question

What factors should you consider in Shubha's risk assessment and monitoring?

1.3 Answer

a) You should consider whether any of the following factors may have affected the development of Shubha's symptoms:

- a history of any mental health problem
- a history of a chronic physical health problem
- the quality of Shubha's interpersonal relationships
- living conditions and social isolation
- any family history of mental health problems
- any history of domestic violence or sexual abuse
- her employment and immigration status.

b) To assess the risk Shubha's symptoms may pose to her you should ask her directly about suicidal ideation and intent. If you think there is a risk of self-harm or suicide then you should:

- assess whether Shubha has adequate social support and find out if she is aware of sources of help
- assess whether there are any protective factors that can help Shubha
- arrange help appropriate to the level of risk
- advise Shubha to seek further help if the situation deteriorates
- monitor Shubha's physical health during any subsequent consultations⁶

Next steps for management

Your assessment indicates that Shubha presents a high risk of potential harm both to her baby, as she has been refusing to feed her, and also risk to herself through self-neglect. Shubha should therefore be referred urgently to specialist services. [Relevant recommendations include: (1.3.3.1) to (1.3.3.3)].

1.4 Question

How could your subsequent risk assessment and monitoring of Shubha be effectively conducted?

⁶ Management of self-harm and coordination of care in primary care [Self-harm: longer-term management](#). NICE clinical guideline 133 (2011)

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1.4 Answer

Further risk assessment and monitoring needs handling in a sensitive manner. Engagement of Shubha's family is also crucial. Recognising and acknowledging the hierarchies that may exist within Shubha's family will be important because Shubha may be reluctant to provide this information. Her family may not be supportive of the process, and could isolate her or put pressure on her to disengage from services. The health visitor or any other health professionals in contact with Shubha should be actively encouraged to engage with her at this point in time.

In light of Shubha's symptoms, a referral to specialist perinatal services should be considered immediately. As a priority, the welfare and care of the baby should be investigated further. You should schedule a follow up appointment with Shubha, ideally for a week's time (dependent on whether she is admitted to specialist care).

[Relevant recommendations include section 1.4: Steps 2 and 3; Treatment and referral for treatment, and specifically (1.4.1.9) and (1.4.1.3)].

Supporting information

Families may sometimes expect a 'quick cure' following the appointment and if this is not achieved may contact traditional healers or priests. It is worth noting that some patients from minority cultures may expect their health professionals to have a paternalistic rather than collaborative approach when advising them about their care.

Case scenario 2: identification (comorbidities); James

Presentation

James is a longstanding patient at your surgery, he is 47-years-old and was diagnosed two years ago with stage 5 chronic kidney disease due to accelerated hypertension. He also has asthma and is Hepatitis C positive. You have not seen James for around six months, and he is now attending a routine appointment with you.

James had been an IT consultant but is not currently working because of his medical problems. He has been separated from his wife since 2003.

Because of his renal impairment, he is seen in an advanced chronic kidney disease clinic and he has recently decided to have haemodialysis as his renal replacement therapy.

On direct questioning, James reports feeling very tired to the point of weariness, he says that his memory has been affected recently, he has also had a lack of interest for his hobbies and is finding it difficult to be able to enjoy everyday activities such as watching the television or sharing a meal with his family.

On examination

James speaks in short sentences and rarely makes eye contact. Most of his replies are 'yes' and 'no' and he frequently needs direct questions to prompt answers. James shows signs of poor hygiene and self care.

Establishing a diagnosis

2.1 Question

What questions can help you to establish if depression is the cause of James' symptoms?

2.1 Answer

You need to ask James whether during the last month, if he has felt down, depressed or hopeless. You need to explore the biological symptoms of depression and assess risk. You need to also ask James about any alcohol use.

Supporting information

In people with chronic diseases it can be hard to differentiate the symptoms caused by the chronic disease from depression. Two useful questions⁷ to help with establishing a fuller diagnosis are:

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

Next steps for management

James discloses that he has been feeling low for quite for a long period of time. He explains that he had begun to feel down from around the age of 15, and that he had experienced frequent periods of physical and emotional abuse as a teenager. He states that at times he just didn't feel good enough and often struggled with trying to fit in with the social groups at his school and this left him often feeling quite isolated.

You suspect that James' experiences during his adolescence could be a significant factor for his current emotional problems.

2.2 Question

What is the best course of action to suggest to James?

⁷ These questions are also known as the 'Whooley questions' and can help in case identification. Clinical case scenarios: Common mental health disorders in primary care (May 2012)

2.2 Answer

a) You discuss options with James and give him some written information about depression, and agree to refer James to the psychology department attached to the advanced chronic kidney disease clinic⁸ where he is being treated, for a full psychological assessment.

b) The psychology team carry out a full assessment of James which establishes that he has severe depression⁹. A psychologist from the team confirms with you, as James' GP, that the treatment plan agreed with him is for a 10-session course of psychological therapy using cognitive behavioural therapy (CBT) to help James counter his negative thoughts and his self-critical beliefs.

c) At this point you schedule a follow up appointment with James to discuss - due to his diagnosis of severe depression - the benefits of combining his psychological therapy with an antidepressant.

[Relevant recommendation: (1.5.1.2)]

d) During the consultation, you then explain and explore with James:

- any likely side effects there may be for him from taking an SSRI, as well as any potential interactions with his existing medication, his hypertension, his asthma and his other physical health problems
- his thoughts on the proposed medication and its likely benefits for his condition. You reassure James that this medication is not addictive
- any possible initial side effects and the importance of James taking the medication as prescribed, the length of time it may take for the full antidepressant effect to develop, and you emphasise that James will need to continue the course of tablets beyond the point where he feels his symptoms have begun to diminish.

⁸ If this option were not available locally, then James' GP would need to refer him to the single point of assessment provided within the local primary care mental health team.

⁹ A PHQ9 would have been used by the psychology team to establish the severity of James' symptoms. Clinical case scenarios: Common mental health disorders in primary care (May 2012)

e) After this discussion with you, James agrees to begin taking antidepressants, and sertraline¹⁰ is prescribed, with a initial 14 day supply.

You advise the renal clinic and their psychology team of this additional treatment.

Next steps for management

2.3 Question

What further action could you take?

¹⁰ Where an SSRI is being considered for a person with a chronic physical health problem, citalopram or sertraline should be considered as they have a lower propensity for interactions.

2.3 Answer

a) At the end of the consultation when you prescribed sertraline you offered James a follow-up appointment for two weeks time. At the follow-up appointment you are able to discuss James' experience so far of taking the sertraline, any side-effects that he has had and you can answer any further questions that James may have about his treatment. This appointment enables you to be able to monitor James' symptoms closely, especially regarding any side effects from the medication.

b) At the end of the consultation, you then agree a subsequent appointment for James for four weeks time and issue a further prescription. During this next appointment you are able to follow up with James regarding his experiences of his medication, as well as to hear about his progress from the early stages of his CBT therapy, which he has recently started.

c) You then schedule a further four weekly follow-up appointment with James. As his medicine seems to be effective, monthly appointments are scheduled for the next six months to enable further monitoring and review of his progress with the treatment. At the end of this period, the need for sertraline can be reviewed.

[For an overview of the relevant recommendations for James' treatment please view the NICE Depression Pathway].

Case scenario 3: identification (multi-morbidities); Barbara

Presentation

Barbara is 42-year-old woman presenting at your surgery for a routine appointment. Three years ago she was diagnosed with early stage (stage 3a) chronic kidney disease associated with hypertension. Her kidney disease and hypertension are managed by a combination of drugs that includes an ACE inhibitor, and dietary restrictions. Barbara is complaining of 'these heads of mine' that she says make her feel poorly, and a discomfort in her back and abdomen.

Medical history

Her notes show that a previous doctor has prescribed Barbara benzodiazepines for nervous complaints. You have treated her mother in the past for depression.

On examination

Barbara describes her symptoms in a flat, monotonous voice and looks anxious and ill at ease. You find that she uses vague phrases such as "these heads of mine" without properly describing them. During the consultation she attributes her symptoms to her chronic kidney disease. Further exploration reveals that Barbara is describing headaches which she attributes to her kidney problems.

Establishing a diagnosis

3.1 Question

What else might you look for to help with establishing a diagnosis?

3.1 Answer

a) Non-verbal cues may be helpful, for example, Barbara may fidget and may have restless movements. She might avoid eye contact, and her posture might be collapsed. A person's voice - in this case Barbara's monotonous and uninflected tone - could also provide another cue to help you as a GP in establishing a fuller picture of a person's situation.

b) Picking up on Barbara's earlier mention of her feelings could be useful, for example: 'You mentioned earlier that your headaches make you feel poorly. What do you mean by that?' Also, try asking Barbara how things are at work and at home.

c) When you obtain an accurate description of Barbara's head pains she describes bilateral mild to moderate pain, which feels like a tightening or pressing (but not throbbing) and you establish that is not aggravated by routine activities of daily living. The headaches happen about twice a week and based on this description¹¹ you diagnose this as an episodic tension-type headache. You ask Barbara to keep a headache diary should further management be needed.

Next steps for diagnosis

3.2 Question

What else could help you to establish a diagnosis?

¹¹ For further information please see the NICE clinical guideline: Headaches: diagnosis and management of headaches in young people and adults (in development at time of publication).
Clinical case scenarios: Common mental health disorders in primary care (May 2012)

3.2 Answer

Ask the questions below.

In view of Barbara's worry and restless movements (using the GAD-7):

- a) Have you recently been feeling nervous, anxious or on edge?
- b) Have you not been able to control worrying?

In view of her flat monotonous voice (using the PHQ-9):

- c) Have you recently felt down or depressed for most of the time?
- d) Have you recently experienced much less interest or pleasure than is usual for you?

If there are **any** positive replies, you will need to investigate further.

Supporting information

Barbara's chronic kidney disease may be responsible for some of her symptoms, and in such cases it is better to avoid making a diagnosis solely on neurovegetative¹² symptoms such as poor appetite and loss of weight. It is helpful to ask about symptoms that are unlikely to be caused by a physical illness, for example asking if she is:

- feeling worthless?
- feeling inferior to others?
- blaming herself for how she feels?
- having guilty feelings?
- feeling completely hopeless?
 - (if yes) having thoughts of ending her life?
 - ◇ (if yes) making plans for ending her life?
 - ◇ (and) what stops her from harming herself?

Next steps for management

3.3 Question

If Barbara's replies lead you to suspect depression, what should you do next?

¹² Neurovegetative signs of depression are the symptoms that affect the patient's functioning: for example, sleep, appetite and concentration. In order to make a diagnosis of major depression, a clinician will check for these neurovegetative symptoms, as well as a depressed mood.

3.3 Answer

Ask Barbara how she is feeling, and if she is affected at all by her symptoms, for example:

- have these problems prevented you from doing any of your usual activities?
 - (if yes) has this been more than one activity?
 - (if no) have you been able to carry on with your usual activities, but only with increased effort?

This additional questioning will help you to establish the severity of Barbara's depression, and to help with formulating a diagnosis – which will then be based both on the number of depressive symptoms and the extent of any associated impairment.

Refer to the [NICE pathway for Depression in adults](#) for advice on next steps, treatment options and management for adults with a chronic physical health problem.

[Relevant recommendations are included within: from the NICE Guideline on depression (diagnostic criteria); NICE Guideline on Common mental health disorders (for core principles, identification and assessment); and the NICE Guideline on Depression in adults with chronic physical health problems (for chronic minor depression in chronic physical illness)].

Case scenario 4: identification (longstanding anxiety); Fred

Presentation

Fred, aged 45, is a locksmith. He has longstanding and persistent worries that he has not done his job properly and that someone might get burgled as a result. He worries he might have given customers the wrong change whenever they have paid him in cash. Fred informs you that he worries about many things in his life, and his most common thought is 'what if'? He often imagines the worst happening and states that when he worries, he often feels sick, has headaches, feels butterflies in his stomach and is aware of his heart pounding. Fred often gets hot and sweaty and says his anxiety makes it difficult to concentrate and do his job or play with his children. He is very distressed by his constant worrying and feelings of anxiety, and regards it as a sign of weakness. At the beginning of the consultation with his GP, Fred states he is attending because of problems with sleeping. But after questioning about how things have been for him recently, Fred discloses to his GP that he is feeling under considerable stress.

Medical history

Fred has no medical history of note.

On examination

On examination, no physical problem can be found. Fred looks distressed and is clearly sweating despite the fact that it is not warm in the GP surgery. The GP asks Fred how things are for him at work and at home, and Fred mentions that he has found work a bit difficult recently. He tells the doctor he fears his levels of stress and anxiety will cause him to make a mistake at work and someone will get burgled. He says that he worries his stress levels will make him go mad.

Diagnosis

4.1 Question

How should you approach Fred's case and what should your first step be?

4.1 Answer

a) The GP asks Fred:

“Over the past two weeks, how often have you been bothered by **either** feeling nervous, anxious, on edge **or** have you been unable to stop or control your worrying?”

Fred replies that he feels anxious and on edge all of the time, every single day.

b) In response, the GP then asks Fred:

“Please could you tell me a bit more about the difficulties your anxiety is causing for you in terms of how you are functioning in your daily life at work and at home?”

Fred appears hesitant in answering the GPs question, has clasped his hands together and is looking uncomfortable. The GP attempts to reassure Fred by telling him it is okay to take his time and that the GP is here to help.

Fred then replies:

“I can’t tell you how terrible it is to wake up in the morning feeling as though your head is going to explode and your heart will jump out of your chest. My mind and body are just overwhelmed with fear and I feel so scared. I can’t work properly and I can’t play with the children. I worry I will make a mistake at work because of this and someone will get burgled. I keep asking my wife if I am going to go mad with all this stress and worry and it’s driving her mad! I am slow at work and people are beginning to notice.”

Next steps for diagnosis

4.2 Question

As Fred’s GP, what should your next course of action be?

4.2 Answer

a) The GP asks Fred to complete a GAD-7, introducing it with:

“Please could you complete this form so I can get a bit more information on the nature of your worries? It won’t take very long, there are only seven questions and it will help me to work out how best to help you.”

Fred completes the GAD-7 questionnaire.

b) The GP then also asks Fred how long he has had these symptoms for.

Fred replies that he has always been a bit of a worrier, but that he feels in the past year, since the recession really hit, it has got a lot worse.

c) To establish a fuller picture, the GP then asks Fred:

“Is there anything else that is relevant that I should know about? For example, you have just mentioned the recession, are there any particular worries for your firm at the moment? Do you have any particular money or other worries?”¹³

The GP then follows this up with:

“Have you had any other periods of worry or any mental health problems in the past?”

The GP also asks: “I can see from your records you haven’t got a history of physical health problems. Have you ever had any help for your anxiety? Has anyone else in your family ever been a worrier like you? You mentioned some problems with your wife – are you finding it tough to get along with people more generally?”

Fred replies:

“I haven’t really suffered from any other problems like this or had any mental health problems in the past. I have never had any help – I am too ashamed. It’s

¹³ Employment support services are provided by IAPT in many regions. Contact your local IAPT lead for details of local provision.

not very 'manly' to worry is it? My mum was a terrible worrier – I wasn't allowed out of the house after dark in case I got lost or a stranger took me. I wasn't allowed on the bus by myself until I was 16! My wife is very tolerant and so are the children and I can hide the worry from most people so I guess everyone would think I was fine. I'm getting along with people okay on the outside. It is the inside that is a problem, and that can be really stressful.”

Next steps for diagnosis and management

4.3 Question

Fred's GAD-7 score and his background information point to a diagnosis of generalised anxiety disorder (GAD). With this in mind:

- a) When should this be communicated to Fred?
- b) What would be the best approach for communicating this to Fred?

4.3 Answer

a) The GP should explain the diagnosis of GAD to Fred and it should be done straight away, to help Fred begin to understand the disorder. The GP should then offer effective treatment promptly.

b) In addition, the GP should provide information and education about the nature of GAD and the options for treatment, including the '[Understanding NICE guidance](#)' booklet that is available for GAD. Information and education should be provided verbally and in writing, but if written materials are not available during the consultation then directing Fred to appropriate websites or other sources of information and support would be advisable.

Supporting information

NICE has produced a summary of GAD called '[Understanding NICE guidance](#)' for patients and carers.

NICE has also produced a '[Guide to self-help resources for generalised anxiety disorder](#)'.

Next steps for management

4.4 Question

What should your next steps be?

4.4 Answer

a) The GP should agree an arrangement with Fred that enables the monitoring of his symptoms and functioning (known as active monitoring) through either follow-up appointments or telephone consultations.

This is because education and active monitoring may improve less severe presentations of GAD and avoid the need for further interventions.

b) The GP should provide Fred with some information about anxiety.

c) As Fred has a diagnosis of GAD, his GP should also discuss with him the use of any over-the-counter medications and preparations, as some of these could increase his symptoms of anxiety.

Supporting information

Refer to recommendations 1.1.1 to 1.1.6 in 'Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: management in primary, secondary and community care' (NICE clinical guideline 113) for details of information and support that should be provided for all people presenting with GAD, their families and carers.

4.5 Question

During a follow-up appointment, four weeks later, Fred tells you that his symptoms are not improving. What action should you take?

4.5 Answer

If Fred's symptoms do not improve after four weeks of education and active monitoring, the GP should move to consider step 2 interventions (see appendix) and discuss the options available with Fred. Specifically, the GP should offer one or more of the following as a first-line intervention, guided by Fred's preference:

- individual non-facilitated self-help
- individual guided self-help
- psychoeducational groups

[Relevant recommendations for this case scenario include: section 1.3: Step 1: Identification and assessment of the Common mental health disorders guideline and recommendations (1.2.12) to (1.2.15) of the Generalised anxiety disorders guideline].

Further information on the specific treatment and interventions recommended by NICE can be found on the [Generalised anxiety disorders Pathway](#).

Case scenario 5: Identification and assessment (comorbidities);

Paul

Presentation

Paul is a 52-year-old self-employed builder who has diabetes. He presents to his GP complaining that he has been feeling increasingly tired for the last 4 months. His sleep is poor and he says he can't be bothered to shave in the morning. He says that the practice nurse was unhappy with his diabetic control and his wife has now insisted that he see a doctor.

Medical history

Paul smokes around twelve cigarettes a day, mostly at work, with his mates. He has hypertension and has been receiving an antihypertensive drug for the last five years. He takes an oral statin to lower his cholesterol and an oral antidiabetic drug for his diabetes. He also takes an ACE inhibitor for treatment of hypertension and prevention of diabetic complications, and aspirin for the prevention of cerebrovascular events. Paul does not regularly use alcohol, and reports drinking a couple of pints maximum, if he is out with his mates, after a football match.

On examination

Paul looks overweight and has a body mass index of 32. When last seen by the practice nurse his HbA_{1c} had increased from 8% to 9.2% and his cholesterol level is 5.8mmol/l. His current blood pressure is 145/85 mm/Hg. He appears low in mood, is avoiding eye contact and has lost his usual jocular manner. He is speaking quietly and describes his mood as 'fed up'. He is blaming himself for not being able to 'pull himself together'.

Establishing a diagnosis

5.1 Question

As Paul's GP, what should your next steps be?

5.1 Answer

The GP should ask Paul about his appetite and his sleep patterns over the past month, as this will help to reveal symptoms of any depressive disorders.

Paul informs the GP that he has lost his appetite, and he is finding his eating is 'all over the place'. He is usually in bed by 10pm, and has no problems with getting off to sleep but has begun to recently experience sleep disturbance as he wakes once or twice at night to use the toilet. Paul reports that he has also recently begun to wake about an hour earlier than usual (at 5am) feeling stressed, and finds he cannot get back to sleep. The GP then asks Paul if he felt refreshed on waking in the morning, and he replies that he "feels tired and finds it hard to get out of bed".

5.2 Question

How could you build up a full picture of the impacts on Paul, including those affecting his psychological functioning?

5.2 Answer

a) The GP asks Paul how his concentration has been over the last month or so, and for example, whether he is able to concentrate on reading a newspaper (these questions will help to test Paul's psychological functioning).

Paul feels his concentration is okay, and he is able to read the headlines of the newspaper, but doesn't read much more because he feels there is too much bad news in the papers.

b) The GP then asks Paul if he can test his concentration, by asking him to name today's date, and his own date of birth. Paul is able to correctly name his date of birth and the month for today's date, but appears to be struggling to identify the actual date within the month.

5.3 Question

What risk factors should you consider with Paul?

5.3 Answer

a) The GP asks Paul if he has had any suicidal thoughts, for example, has he ever wished when he went to bed at night that he would never wake up. The GP also asks Paul directly about whether he has ever thought of harming or killing himself. Paul is adamant that he loves his wife and children too much to do that to them, and confirms that he has never had any ideas or plans to harm himself.

b) The GP also asks Paul if there have been any problems with his diabetes medication, as he has noticed his diabetes is not as well controlled as usual. Paul states that he is still taking his medication, but that he has been a bit forgetful regarding taking it over the past six weeks, and has ended up skipping some doses as a result.

c) The GP also asks Paul if he is still smoking, and Paul confirms he is still smoking about twelve cigarettes a day, but he feels too stressed to stop at the moment.

[Relevant recommendations: this scenario is based on recommendations from the following NICE guidelines: Depression: the treatment and management of depression in adults. NICE clinical guideline 90 (2009); and Depression in adults with a chronic physical health problem: treatment and management. NICE clinical guidance 91 (2009), Type Two Diabetes: clinical guideline for the management in primary and secondary care (update). These recommendations are featured within the NICE Pathways for Depression, and for Diabetes treatment and management].

Next steps for diagnosis and management

5.4 Question

What would your next steps be in establishing a diagnosis for Paul?

5.4 Answer

The GP asks Paul some further questions about the management of his diabetes and whether - apart from the practice nurse - he has seen anyone else about it.

Paul confirms he has had appointments with the diabetic nurse at the surgery every six months and thinks he last saw her three months ago and that he has a target of 7.5% for his HbA_{1c}.

The GP probes further, to try and discover why Paul thinks his HbA_{1c} has risen to 9.2%. Paul confirms that over the past month he has often forgotten to take his medicine during the day. He then admits that he has also struggled with keeping to his diet plan and has had a few days in a row where he has been for all-day breakfasts with the lads from the building site at lunchtime.

The GP explains that because of Paul's current weight, his HbA_{1c} and the level of his cholesterol that if he met with the practice nurse at this point it may trigger an intensification of his treatment.

The GP thinks that an escalation in Paul's diabetes treatment could potentially risk denting his self-esteem at this point in time, and it could also introduce further medicines whereas behaviour change support may actually help Paul to get his diabetes management back on track.

As Paul had managed his diet previously, his GP encourages him to set some realistic goals for his diet for the next fortnight, for example by trying to avoid the café for at least a couple of days a week, and if he does go to try and opt for a healthier option. He also asks Paul to keep a food diary.

5.5 Question

What else could you ask, as Paul's GP to help establish a clearer picture of his psychological functioning?

5.5 Answer

a) The GP asks Paul if he has ever suffered from depression, but Paul doesn't think that he has. The GP says to Paul that he wonders if he is experiencing symptoms of depression, and asks him what he thinks about this. Paul states that his wife had suspected this, and that is why she had encouraged him to visit the GP.

b) The GP asks Paul if his work has been affected since he has been feeling this way and Paul confirms that although he is still working – he is a builder, and he says that work is becoming scarce - he is often feeling really tired at work¹⁴.

c) The GP asks Paul about his home life, and whether the way he has been feeling recently may have affected things at all. Paul discloses that his wife has seemed annoyed with him at times, as he is often sitting around and she says it is like he is moping all the time and he can't even be bothered to go to watch the football with his friends anymore.

Next steps for diagnosis and management

Question 5.6

As Paul's GP, how should you negotiate the diagnosis with him?

¹⁴ Employment support services are provided by many local IAPT services. Contact your local IAPT lead for detail of any services provided within your area.

Answer 5.6

a) The GP informs Paul that from what he has mentioned so far, it appears that Paul is moderately depressed, that it seems to be beginning to affect his work and how he feels at home, and that this could also be having a knock-on effect on his diabetic control. He asks Paul what he thinks about this diagnosis and Paul replies that he feels okay to take any actions the GP recommends, especially as he can see that the depression is now affecting his relationship with his wife.

b) The GP gives Paul some leaflets on depression so that he can understand it better, and asks Paul if he would like to be referred for counselling from a therapist who can see him at the surgery. Paul agrees to this referral, and says he thinks it would be good to start to try and tackle his symptoms.

c) The GP also asks if Paul would like to attend a follow-up appointment with his wife, so that they can together explain Paul's issues and his planned treatment. Paul agrees to this course of action.

Next steps for treatment

Question 5.7

What would the best approach be for both the management of Paul's diabetes and the treatment of his depression?

Answer 5.7

a) The GP makes a follow-up appointment to see Paul and his wife together in two weeks' time so that they can explain to her what is happening with Paul, his plans for treatment and can answer any questions she may have.

b) The GP also asks Paul to complete a PHQ-9 questionnaire – explaining that it is so Paul's progress with his depression symptoms can be monitored. Paul's PHQ-9 score is 14 which equates to moderate depression. His GP explains to him that this score, along with the other factors they have discussed today indicates that he is moderately depressed.

c) Towards the end of the consultation the GP makes a referral for Paul to the surgery's IAPT therapist and reminds him of his follow-up appointment with the GP in two weeks' time.

d) The GP also asks Paul to let him know if things get any worse, and to come back and see him straight away if they do.

At the end of the consultation Paul asks the GP whether he thinks he needs tablets for his symptoms of depression. The GP asks Paul why he suggested this and they discuss his symptoms again and how to manage them. They agree that Paul will continue to see the GP regularly in order to monitor things.

[Relevant recommendations: please refer to the stepped care model in the appendix of this document for details of recommended treatments].

Supporting information

National Institute for Health and Clinical Excellence (2011) [Commissioning stepped care for people with common mental health disorders](#). NICE commissioning guide 41. London: NICE.

Case scenario 6: Assessment (criminal justice system); Dan

Presentation

Dan is a 32-year-old man presenting with shoulder pain. He has not been seen in the surgery for a couple of years and in passing mentions poor sleep, annoyance about his benefits, and dissatisfaction with his accommodation. It quickly becomes clear that the main problem affecting Dan is mental health related, and that his shoulder pain is related to a minor injury he sustained two or three weeks ago which is already resolving itself. A brief history shows that he has symptoms which fulfil the criteria for both anxiety disorder and depression. When asked how he had been in previous months he seems a little uncertain how to answer, and then admits that he has been in prison. On further questioning, Dan informs you that he was convicted for assault with ABH (actual bodily harm) and resisting arrest.

Medical history

Dan was last seen in the surgery two years ago for a couple of minor complaints and his computer records go no further back. He sees himself as always having been well, but admits that he did see some kind of counsellor or psychologist at the age of about 10 years old.

On examination

Dan presents as reasonably smartly dressed with new casual clothes and is cleanly shaven. He is alert but seems wary.

Next steps for diagnosis

6.1 Question

How can you balance the need to get a more detailed history with a busy surgery schedule and a concern that Dan may not return?

6.1 Answer

a) You may not be able to conduct a full assessment within a routine ten minute consultation, but as much as possible must be done to ensure that Dan engages. Distrust is likely to be a significant issue for Dan, and he may not want to admit that he has a mental health problem, so initiating discussion about his mental health could be difficult. It is likely though that people in Dan's position may want to talk and discuss their problems, even if it may be difficult to accept a potential mental health diagnosis. Your initial questioning shows that Dan may be experiencing symptoms that could point to depression, anxiety and a number of other mental health problems. It is important to talk with Dan about alcohol and drugs.

b) It will be critical to overcome issues of distrust by showing that you have listened, that you care and that you would be willing to see Dan again. Even if as a practitioner you feel limited in the help you can provide, just showing that you can take time is an important first step. It is also important to set up a further, possibly extended, appointment within the next couple of weeks.

Supporting information

It would be worth also asking Dan where he is living, if he is in stable accommodation and if he is happy to give you a phone number for him. This can help to show your interest and concern for Dan's welfare, and it also allows you to contact Dan if he does not return for the following appointment.

Next steps for management

6.2 Question

It is clear that there are likely to be a number of other diagnoses underlying the initial presentation. How can you prioritise your investigations?

6.2 Answer

Dan mentions a difficult childhood which included witnessing physical violence from his father towards his mother, and a resulting placement in residential care. He later had a stable foster placement, and was then able to settle more in school. There are likely to be a number of significant background factors for Dan that may include trauma and abandonment from his childhood, and current problems such as social isolation, or problems linked to relationships, issues with obtaining employment/training as well as insecure accommodation.

Firstly, using validated screening questions to look for other comorbidities such as post-traumatic stress disorder (PTSD), eating disorders, obsessive compulsive disorder (OCD), and to rule out psychosis or previous manic episodes will be helpful. Explore any aligned areas, such as whether hazardous or harmful drug and alcohol use is used as a coping mechanism. Although substance misuse is considered as a separate entity within the DSM¹⁵, evidence suggests that ongoing hazardous or harmful drug and or alcohol use can be used as a form of self-medication for underlying mental health problems. Comorbidity between these can be very common. Therefore a current and past drug and alcohol history will be useful, with a particular emphasis on exploring the rationale for any ongoing drug and alcohol use in terms of symptom management.

Secondly, an assessment of personality dysfunction is important. Underlying traits to look for include dependence, being avoidant, and potential antisocial factors such as a lack of empathy. Consider also traits of borderline personality disorder such as chronic feelings of emptiness, rapid mood changes in response to minor situations and repeated difficulties with close relationships.

¹⁵ Diagnostic and Statistical Manual of Mental Disorders http://www.psyweb.com/DSM_IV/jsp/dsm_iv.jsp
Clinical case scenarios: Common mental health disorders in primary care (May 2012)

Next steps for management

6.3 Question

How can you resolve the issue of comorbidity and decide which issue to address first?

6.3 Answer

- a) Use sensitive questioning to investigate Dan's past history, to discover the extent of both his depression and anxiety, including the types of anxiety he has experienced, in order to work out whether anxiety follows the depression or vice versa.

- b) Consider whether Dan's problems could be primarily related to a personality disorder, and if so whether he might meet the criteria for support from a local specialist team for people with personality disorders.

- c) Consider whether any substance misuse is likely to prevent engagement in treatment or make medication problematic.

- d) Although you may schedule several appointments with Dan, it is worth considering that he may expect some form of action at the end of the first consultation.

Next steps for management

6.4 Question

How can you ensure consideration of Dan's social goals is met, whilst you are establishing a symptom profile and diagnosis?

6.4 Answer

a) This is a key issue when identifying or treating psychological issues. Although the evidence is limited for this approach, it could be helpful to consider Dan's mental health problems as being a culmination of his social problems, any biochemical abnormalities he may have and his symptom clusters. It may not be helpful to separate these out for him, as he is clearly experiencing anxiety.

Considering the multiple factors that may be impacting on Dan's emotional and physical wellbeing such as any psychological symptoms, social situation factors, diagnosis and Dan's individual personal and social goals and his strengths may help to develop a more coherent treatment plan. A full assessment may need to take place over a number of consultations, and while Dan's diagnosis is a key part of this, it will not be the sole factor that will help inform any decisions about his agreed plan of treatment.

Next steps for management

b) Further questioning reveals that Dan is using alcohol to manage his anxiety, low mood and sleep problems. He feels that his anxiety is linked to meeting people, who he sees as often looking down on him. During the consultation it becomes clear that Dan is aware that alcohol has not helped his mood, but he still reports drinking significantly for two or three evenings each week in the last fortnight in order to reduce anxiety and the intolerable suicidal thoughts that he had.

c) As Dan has mentioned having suicidal thoughts, you ask him directly about these, to try and establish the level of risk that they may pose for him and also about any protective factors. You then:

- ask Dan about sources of social support he currently has in his life, and if he is aware of sources of help that are available

- you telephone the local mental health crisis team to make an urgent referral for Dan (you do this at the end of the consultation, whilst Dan is still in the consultation room with you)
- you provide Dan with details of local and national sources of help including crisis telephone numbers, such as the Samaritans
- you encourage Dan to get back in contact with you at the surgery if he feels that his situation deteriorates any further
- you monitor Dan's physical health during any subsequent consultations¹⁶

d) Dan appears to also have low-level symptoms of PTSD as he has recounted feelings of irritability, difficulties with his concentration and regular sleep disturbance. He also mentions problems with several close relationships which – combined with the other factors above - could point you to consider a personality disorder.

e) Having spent an 18-month period in prison, Dan is under the supervision of the probation service and is getting support from a probation officer whom he says he likes and he has a good relationship with, partly because he makes a point of 'checking in' with Dan prior to making any decisions on his case. Dan's main concerns are to get back in touch with his children and to find a job. He has trained as a plumber and had previously served in the army, so there were times in his life when he had proved to himself that he can achieve things.

6.5 Question

How can you approach the issue of information sharing across agencies with Dan?

¹⁶ Management of self-harm and coordination of care in primary care [Self-harm: longer-term management](#). NICE clinical guideline 133 (2011)
Clinical case scenarios: Common mental health disorders in primary care (May 2012)

6.5 Answer

Most people, including people who have been in prison, will agree to information on them being shared if the reasons for it are fully explained and they are told who will be involved in the information exchange.

Putting this into practice will require sensitive handling, for example by asking Dan if he is happy for medical issues to be discussed with specific agencies such as the probation service, and for this to be documented in his medical records. You can then ask the other agency involved, for example, the probation service, to set up similar arrangements for you.

Next steps for management

6.6 Question

How can you best manage a referral for Dan to an anxiety support service, given both his anxiety and his use of alcohol?

6.6 Answer

Dan's referral will depend on what local services are available, and their protocols. Given that alcohol is not being used by Dan on a daily basis and is primarily used for relieving his symptoms of anxiety, there may be a good argument for treating his anxiety first and to incorporate simple measures regarding alcohol consumption within an overall management plan for anxiety. As Dan's GP you could be in a challenging situation, as he may be excluded from a local anxiety support service if his alcohol use is considered to be a significant problem.

A strong case may have to be made for Dan to access a local anxiety support service, based on the fact that he meets the criteria for support, it is the main problem he wants to address, and it is preventing him from achieving his goals.

You may also find a similar problem when attempting to refer Dan to specialist services, if he is identified as having a personality disorder¹⁷.

Supporting information

It would be helpful if you could also offer Dan basic advice about alcohol. Raising the issue as Dan's GP can also help to increase his feeling of support and/or your interest in his care. NICE pathway on [alcohol-use disorders](#)

6.7 Question

Should you also attempt to address Dan's PTSD?

¹⁷ NICE has produced guidance on [antisocial personality disorder](#) and [borderline personality disorder](#)

6.7 Answer

Your actions will depend on the severity of Dan's PTSD symptoms, how much they are affecting him, the extent of his alcohol use¹⁸ and whether he could tolerate the therapy directed at his traumatic memories at this point in time¹⁹. To establish a clearer picture²⁰, you ask Dan if he thinks any of his symptoms, such as his sleep disturbance, are linked to any specific events from the past. You then ask Dan if he has ever experienced a traumatic event, for example, during his time in the army.

Supporting information – the NICE PTSD guideline recommends:

GPs should take responsibility for the initial assessment and coordination of care of people with PTSD in primary care and determine the need for emergency medical or psychiatric assessment.

Ensure that assessment is comprehensive, includes risk assessment, asks about any re-experiencing (including flashbacks and nightmares) or hyperarousal (including exaggerated startle response or sleep disturbance) and addresses a person's physical, psychological and social needs.

People with PTSD should be provided with information on effective treatments and support services and their preferences for treatment should be taken into account.

Because of Dan's comorbidities it is likely that he will need an assessment from an experienced mental health practitioner to evaluate the relative importance and impact of his anxiety, depressive and PTSD symptoms.

6.8 Question

How can you try to ensure continuity and follow-up care for Dan?

¹⁸ Significant drug or alcohol problems should be treated prior to commencing treatment for PTSD.

¹⁹ Only provide trauma-focused psychological treatment when the patient considers it safe to proceed.

²⁰ The NICE [PTSD Pathway](#) covers the assessment, treatment and management of PTSD symptoms. Clinical case scenarios: Common mental health disorders in primary care (May 2012)

6.8 Answer

- a) As Dan's GP, gaining his trust will be essential and you may have to avoid the use of mental health language or labels that may imply a stigma, as well as demonstrating that you take his opinions seriously. Dan's GP record will provide a useful coordinating point and as his GP you should ensure that all reports, referrals or progress are included.
- b) You agree and book a series of appointments with Dan, initially running on a weekly, then fortnightly basis for the first few weeks which will provide an opportunity for you to monitor Dan's mood, his progress and any suicidal feelings he may have. You explain that this will provide an opportunity for you to monitor his progress, and for him to ask any questions that may arise once his treatment plan has been established.
- c) An agreement regarding information sharing between the different teams working with Dan will be needed, including the non-medical teams. People particularly don't like to retell their story repeatedly, so establishing agreement (ideally written) outlining the goals agreed with Dan and providing clarity on the responsibilities for care and monitoring for each of the agencies involved will be important. As Dan is likely to need support from more than one agency, it is important that services work together around Dan's needs and wishes and don't need him to negotiate the barriers and boundaries between them.

Supporting information

At times there can be issues with access to services for people that have problems across a number of diagnostic domains and who may not reach the diagnostic threshold in any one particular area, but could still be experiencing major problems. In such cases, it is helpful if specialist services are able to make decisions based on a holistic assessment and approach for the person, rather than relying on diagnostic criteria alone.

Patient resources - PTSD

[Royal College of Psychiatrists: Post-traumatic Stress Disorder leaflet](#)

[Mind: Understanding post-traumatic stress disorder](#)

[NHS Choices: Post traumatic stress disorder](#)

Case scenario 7: psychoeducation and active monitoring;

Jerome

Presentation

Jerome is a 35-year-old welder who lives with his partner and two children aged 3 and 5 years. Jerome has come to see you at your surgery as he is feeling tired all the time.

Medical history

Jerome has a history of anxiety and depression. He joined your surgery 5 years ago, at which time he was taking sertraline for moderately severe depression and associated panic attacks. This was prescribed by his previous GP. The sertraline was effective and Jerome stopped taking the medication after 6 months of treatment. He has not returned to the surgery since that time.

Jerome is otherwise physically fit and well and is not prescribed any medication.

On examination

Jerome describes a lack of drive and energy for the past six weeks. He feels stressed at having to face his job but is still going to work. Jerome admits trying to cope with disrupted sleep patterns by drinking more alcohol than usual during the past fortnight. He is now drinking 3 pints of beer every night instead of only twice per week as he used to. His physical examination is normal but he appears in low mood.

Next steps for diagnosis

7.1 Question

You suspect depression. What would you do to investigate this?

7.1 Answer

a) You should ask Jerome the following questions:

- During the last month, have you often been bothered by feeling down, depressed or hopeless?
- During the last month, have you often been bothered by having little interest or pleasure in doing things?²¹

b) If Jerome answers yes to **either** question then this should be followed up using a validated scale and the 9-item Patient Health questionnaire (PHQ-9) or Hospital Anxiety and Depression scale would be appropriate.

c) As part of the consultation you should explore possible life triggers for Jerome's depressive feelings and the functional impact that these are having on Jerome's life, as well as the risk of self-harm or suicide.

d) You should compare Jerome's current presentation with any record on his notes of his previous presentation (when he had been diagnosed with moderately severe depression).

[Relevant recommendations include: (1.3.2.1, (1.3.2.2), (1.3.2.3) and (1.3.2.9)].

Next steps for management

Jerome scores 11/27 on the PHQ-9 and he has no thoughts of self-harm and is still functioning at work and home with his family.

As a result you diagnose a mild depressive episode. However, there is also associated anxiety and excess alcohol use.

7.2 Question

What should your next step be?

²¹ These questions are also known as the 'Whooley questions.'
Clinical case scenarios: Common mental health disorders in primary care (May 2012)
Page 50 of 85

7.2 Answer

- a) You should use the step 1 interventions [[NICE stepped care model](#)] of active monitoring and psychoeducation, providing information and leaflets or weblinks on depression and discuss some effective approaches for Jerome to use to manage his depressive feelings. In addition, you should provide information about both depression and the role that excess alcohol use has in exacerbating a depressed mood, as well as its contribution to poor sleep. Written information and web links could be used to supplement the information that you provide to Jerome.
- b) You should advise and collaboratively agree with Jerome that he reduces his alcohol intake to below 21 units weekly, or to cut alcohol out completely²².
- c) Jerome should be asked to come back in two weeks so that you can reassess the effect on his mood.

[Relevant recommendations include: (1.3.2.8, (1.4.1.5) and (1.4.1.6)].

Supporting information

Leaflets on depression and alcohol use are available from the [Royal College of Psychiatrists website](#)

Next steps for management

Jerome returns to see you after 2 weeks. He reports that with support from his partner, he has significantly reduced his alcohol use to around four units per week. However, he has found that his mood is no better.

7.3 question

What should you now advise?

²² [NICE Pathway Alcohol use disorders](#)

7.3 Answer

a) Follow the step 2 interventions (step 2 and 3 tables included in appendix).

b) Discuss Jerome's use of alcohol, and advise him to try and continue to reduce his alcohol use – aiming to reach abstinence from alcohol.

c) Discuss the treatment options with Jerome, taking into account his preferences and previous response to treatment. These include:

- individual facilitated self-help based on the principles of cognitive behavioural therapy (CBT)
- computerised CBT
- a structured group physical activity programme
- antidepressants

d) As this is a recurrence of depression and Jerome previously had a good response to sertraline, he could restart medication and continue for 6 months after recovery (alone or in conjunction with the treatment options above).

e) You should outline the principles of CBT and offer an information leaflet/web link on CBT.

Next steps for management

Jerome chooses individual facilitated self-help using CBT, and agrees to return to see you to reconsider talking sertraline if non-drug approaches are not effective.

7.4 Question

Who should you now refer Jerome to for his treatment?

7.4 Answer

You should refer him (depending on local services) to either:

- A primary care mental health worker providing services to your practice
- A psychological well-being practitioner who offers low-intensity interventions as part of the local IAPT service.

[Relevant recommendations: (1.4.1.1) to (1.4.1.4), (1.4.2.1), (1.4.2.3)].

Supporting information

Guided self-help at step 2 (and above) can make use of a mixture of face-to-face professional input, information leaflets, CBT computer programmes and books.

- [The Royal College of Psychiatrists information leaflet on CBT:](#)
- [Get the best from your medicines: your wellbeing in mind, from Norfolk and Suffolk Foundation Trust](#) a web resource using a question and answer approach to provide information on over 110 medicines used in mental health treatments.
- Free web-based CBT self-help programmes for depression and anxiety:
www.livinglifetothefull.com and http://moodgym.anu.edu.au
- Popular self help books for depression that use CBT Principles:
Greenberger, D and Padesky, C A (1995), Mind over mood. New York: Guilford
Williams, C (2001) Overcoming Depression: a Five Areas Approach. London: Arnold

Further management

a) Over the next 2 months, Jerome receives a mixture of face-to-face and phone consultations as part of his low-intensity treatment plan. This also means he does not have to miss work.

b) Jerome's treatment includes the following interventions: explanation; monitoring of risk and alcohol consumption; activity scheduling and goal setting; challenging of unhelpful and extreme thinking; and written 'homework' diaries.

c) Over time, Jerome's depression and associated anxiety resolves. He also creates a written Staying Well (relapse prevention) plan with his mental health worker for the future.

Case scenario 8: Review (social care); Violet

Presentation

Violet is 84 years old. She has been in a residential home for four months following time in hospital with a fractured femur after a fall. She is a widow and her only visitor has been her younger brother, who suffered a stroke six weeks ago and has not been able to visit her since. Violet has become increasingly quiet and withdrawn. The care staff report that she is not eating and is staying in her room much of the time. The GP is asked to visit Violet because her weight has dropped by 4 lb in 1 month.

Medical history

Violet has Type 2 diabetes and hypertension which have been reasonably well controlled. She is partially sighted because of macular degeneration and has widespread joint pains from osteoarthritis.

On examination

The GP finds Violet to be alert and oriented. She looks sad and gets tearful when discussing her feelings with the GP. She admits she is very lonely since her brother stopped coming to see her and is worried that he may never be fit enough to come again. She says that she is sleeping poorly, has lost her appetite and 'can't be bothered' to sit with other people in the care home – she says 'they all get on my nerves'. She denies being anxious or panicky and says she has never drunk alcohol. Importantly, Violet says she does not feel like harming herself, but that she does wish that she will "just not wake up one morning". The GP conducts a PHQ-9 with Violet, and her score is 20. A physical examination (including chest and abdomen) is normal, her BP is 146/82 and a dipstick urine test is negative.

Next steps for diagnosis and management

8.1 Question

What should your next steps be?

8.1 Answer

- a) The GP should suggest to Violet that she might be depressed and that her symptoms do indicate this, they should also explain that it happens to many older people and ask what she feels about that. The GP should discuss possible treatment options and explore her views about talking treatments and/or antidepressants.
- b) Depending on Violet's wishes, the GP should either refer her to the primary care mental health team²³, or offer an appropriate antidepressant. Another appointment should be offered to Violet by the GP for about two weeks' time.
- c) The GP should discuss with a member of staff in charge at the care home (with Violet's consent) what the problems are and how the staff could help to encourage Violet to participate in activities in the care home. The GP should also try to obtain a collateral history from the care home staff.
- d) The GP needs to be aware of the local referral pathways for primary care mental health services. In addition, they should be aware that Violet's low mood might be the result of poor control of her diabetes, or another medical condition particularly as she has recently lost weight. The GP should take blood for glucose, HbA1C, urea and electrolytes, full blood count, and thyroid function tests.

[Relevant recommendations include: (1.3.2.3), (1.3.2.6), (1.3.2.8), (1.3.2.9), (1.4.1), (1.4.1.2), (1.4.1.3)].

²³ Primary care mental health teams will often provide assessment and a range of short-term psychological treatments, interventions and support. These services may be delivered as part of the national Improving Access to Psychological Therapies (IAPT) programme.
Clinical case scenarios: Common mental health disorders in primary care (May 2012)

Supporting information

'Let's respect' toolkit for care homes

<http://www.nmhdu.org.uk/news/lets-respect-toolkit-for-care-homes-published/>

Age UK: Depression in later life: Down but not out (web page)

<http://www.ageuk.org.uk/get-involved/campaign/depression-in-later-life-down-but-not-out/>

Age UK: Depression in later life, Resources

A series of downloadable leaflets that includes spotting the signs of and advice on coping with depression <http://www.ageuk.org.uk/get-involved/campaign/depression-in-later-life-down-but-not-out/resources/>

Feeling Blue, an interactive workbook for older people with depression to support them discussing their symptoms with their GP

<http://www.ageuk.org.uk/Global/Campaigns/Feeling%20Blue%20DBNO%20Booklet.pdf>

RCGP: Mental Health in Older People

online module <http://elearning.rcgp.org.uk/mod/forum/discuss.php?d=36>

Management of depression in older people: why this is important in primary care (February 2011) a factsheet from the Royal College of General Practitioners, Royal College of Psychiatrists, and others

http://www.rcgp.org.uk/pdf/NMH_10095_OPMH%20%20depression%20%20Feb%202011.pdf

Next steps for management

8.2 Question

As Violet's GP, what should you do at the review visit in two weeks?

8.2 Answer

- a) The GP should ask Violet how she is and get an update on her collateral history from the care home staff. The PHQ-9 questionnaire should be repeated.
- b) If Violet has agreed to try antidepressants, then a discussion regarding the period of time it will take for the medication to become fully effective, the likely duration of treatment any side effects is important. Agreement should be tried to be reached with Violet that she will take the tablets for at least six months.
- c) If Violet had previously declined antidepressants, and her PHQ-9 score is still high, then the GP should discuss whether antidepressants would now be appropriate and acceptable.
- d) If Violet was referred for a talking treatment, the GP needs to ensure that this referral was received by the primary care mental health service and give Violet and the staff at the care home an indication of when she can be expected to be seen.
- e) The GP should also discuss with staff at the care home and with Violet how positive support can be given to her within the home, for example enabling her to phone her brother.

[Relevant recommendations include: (1.4.1) and (1.5)].

Related NICE recommendations

CG 123 Common mental health disorders: identification and pathways to care

1.1 Improving access to services

1.1.1.1 Primary and secondary care clinicians, managers and commissioners should collaborate to develop local care pathways (see also section 1.5) that promote access to services for people with common mental health disorders by:

- supporting the integrated delivery of services across primary and secondary care
- having clear and explicit criteria for entry to the service
- focusing on entry and not exclusion criteria
- having multiple means (including self-referral) to access the service
- providing multiple points of access that facilitate links with the wider healthcare system and community in which the service is located.

1.1.1.2 Provide information about the services and interventions that constitute the local care pathway, including the:

- range and nature of the interventions provided
- settings in which services are delivered
- processes by which a person moves through the pathway
- means by which progress and outcomes are assessed
- delivery of care in related health and social care services.

1.1.1.3 When providing information about local care pathways to people with common mental health disorders and their families and carers all healthcare professionals should:

- take into account the person's knowledge and understanding of mental health disorders and their treatment
- ensure that such information is appropriate to the communities using the pathway.

1.1.1.4 Provide all information about services in a range of languages and formats (visual, verbal and aural) and ensure that it is available from a range of settings throughout the whole community to which the service is responsible.

1.1.1.5 Primary and secondary care clinicians, managers and commissioners should collaborate to develop local care pathways (see also section 1.5) that promote access to services for people with common mental health disorders from a range of socially excluded groups including:

- black and minority ethnic groups
- older people
- those in prison or in contact with the criminal justice system
- ex-service personnel.

Identification

1.3.1.1 Be alert to possible depression (particularly in people with a past history of depression, possible somatic symptoms of depression or a chronic physical health problem with associated functional impairment) and consider asking people who may have depression two questions, specifically:

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

If a person answers 'yes' to either of the above questions consider depression and follow the recommendations for assessment (see section 1.3.2).

1.3.1.2 Be alert to possible anxiety disorders (particularly in people with a past history of an anxiety disorder, possible somatic symptoms of an anxiety disorder or in those who have experienced a recent traumatic event). Consider asking the person about their feelings of anxiety and their ability to stop or control worry, using the 2-item Generalized Anxiety Disorder scale (GAD-2; see appendix D).

- If the person scores three or more on the GAD-2 scale, consider an anxiety disorder and follow the recommendations for assessment (see section 1.3.2).
- If the person scores less than three on the GAD-2 scale, but you are still concerned they may have an anxiety disorder, ask the following: 'Do you find yourself avoiding places or activities and does this cause you problems?'. If the person answers 'yes' to this question consider an anxiety disorder and follow the recommendations for assessment (see section 1.3.2).

1.3.1.3 For people with significant language or communication difficulties, for example people with sensory impairments or a learning disability, consider using the Distress Thermometer²⁴ and/or asking a family member or carer about the person's symptoms to identify a possible common mental health disorder. If a significant level of distress is identified, offer further assessment or seek the advice of a specialist²⁵.

Assessment

1.3.2.1 If the identification questions (see section 1.3.1) indicate a possible common mental health disorder, but the practitioner is not competent to perform a mental health assessment, refer the person to an appropriate healthcare professional. If this professional is not the person's GP, inform the GP of the referral.

²⁴ The Distress Thermometer is a single-item question screen that will identify distress coming from any source. The person places a mark on the scale answering: 'How distressed have you been during the past week on a scale of 0 to 10?' Scores of 4 or more indicate a significant level of distress that should be investigated further. (Roth AJ, Kornblith, Batel-Copel L, et al. (1998) Rapid screening for psychological distress in men with prostate carcinoma: a pilot study. *Cancer* 82: 1904–8.)

²⁵ Adapted from '[Depression](#)' ([NICE clinical guideline 90](#)).

1.3.2.2 If the identification questions (see section 1.3.1) indicate a possible common mental health disorder, a practitioner who is competent to perform a mental health assessment should review the person's mental state and associated functional, interpersonal and social difficulties.

1.3.2.3 When assessing a person with a suspected common mental health disorder, consider using:

- a diagnostic or problem identification tool or algorithm, for example, the Improving Access to Psychological Therapies (IAPT) screening prompts tool²⁶
- a validated measure relevant to the disorder or problem being assessed, for example, the 9-item Patient Health Questionnaire (PHQ-9), the Hospital Anxiety and Depression Scale (HADS) or the 7-item Generalized Anxiety Disorder scale (GAD-7) to inform the assessment and support the evaluation of any intervention.

1.3.2.4 All staff carrying out the assessment of suspected common mental health disorders should be competent to perform an assessment of the presenting problem in line with the service setting in which they work, and be able to:

- determine the nature, duration and severity of the presenting disorder
- take into account not only symptom severity but also the associated functional impairment
- identify appropriate treatment and referral options in line with relevant NICE guidance.

1.3.2.5 All staff carrying out the assessment of common mental health disorders should be competent in:

- relevant verbal and non-verbal communication skills, including the ability to elicit problems, the perception of the problem(s) and their impact,

²⁶ For further information see ['The IAPT Data Handbook' Appendix C: IAPT Provisional Diagnosis Screening Prompts.](#)

tailoring information, supporting participation in decision-making and discussing treatment options

- the use of formal assessment measures and routine outcome measures in a variety of settings and environments.

1.3.2.6 In addition to assessing symptoms and associated functional impairment, consider how the following factors may have affected the development, course and severity of a person's presenting problem:

- a history of any mental health disorder
- a history of a chronic physical health problem
- any past experience of, and response to, treatments
- the quality of interpersonal relationships
- living conditions and social isolation
- a family history of mental illness
- a history of domestic violence or sexual abuse
- employment and immigration status.

If appropriate, the impact of the presenting problem on the care of children and young people should also be assessed, and if necessary local safeguarding procedures followed.

1.3.2.7 When assessing a person with a suspected common mental health disorder, be aware of any learning disabilities or acquired cognitive impairments, and if necessary consider consulting with a relevant specialist when developing treatment plans and strategies.

1.3.2.8 If the presentation and history of a common mental health disorder suggest that it may be mild and self-limiting (that is, symptoms are improving) and the disorder is of recent onset, consider providing psychoeducation and active monitoring before offering or referring for further assessment or treatment. These approaches may improve less severe presentations and avoid the need for further interventions.

1.3.2.9 Always ask people with a common mental health disorder directly about suicidal ideation and intent. If there is a risk of self-harm or suicide:

- assess whether the person has adequate social support and is aware of sources of help
- arrange help appropriate to the level of risk (see section 1.3.3)
- advise the person to seek further help if the situation deteriorates.

Antenatal and postnatal mental health

1.3.2.10 During pregnancy or the postnatal period, women requiring psychological interventions should be seen for treatment normally within 1 month of initial assessment, and no longer than 3 months afterwards. This is because of the lower threshold for access to psychological interventions during pregnancy and the postnatal period arising from the changing risk–benefit ratio for psychotropic medication at this time²⁷.

1.3.2.11 When considering drug treatments for common mental health disorders in women who are pregnant, breastfeeding or planning a pregnancy, consult 'Antenatal and postnatal mental health' ([NICE clinical guideline 45](#)) for advice on prescribing.

Risk assessment and monitoring

1.3.3.1 If a person with a common mental health disorder presents a high risk of suicide or potential harm to others, a risk of significant self-neglect, or severe functional impairment, assess and manage the immediate problem first and then refer to specialist services. Where appropriate inform families and carers.

1.3.3.2 If a person with a common mental health disorder presents considerable and immediate risk to themselves or others, refer them urgently to the emergency services or specialist mental health services.

1.3.3.3 If a person with a common mental health disorder, in particular depression, is assessed to be at risk of suicide:

- take into account toxicity in overdose, if a drug is prescribed, and potential interaction with other prescribed medication; if necessary, limit the amount of drug(s) available

²⁷ Adapted from 'Antenatal and postnatal mental health' ([NICE clinical guideline 45](#)).
Clinical case scenarios: Common mental health disorders in primary care (May 2012)

- consider increasing the level of support, such as more frequent direct or telephone contacts
- consider referral to specialist mental health services.

Stepped care: step 2 treatment interventions table

Step 2 Treatment and referral advice			
Subthreshold symptoms and mild to moderate common mental health disorders			
Disorder	Psychological interventions	Pharmacological interventions	Psychosocial interventions
Depression – persistent subthreshold symptoms, or mild to moderate depression	<p>Offer or refer for low-intensity interventions:</p> <ul style="list-style-type: none"> individual facilitated self-help based on principles of CBT (cognitive behavioural therapy) computerised CBT a structured group physical activity programme a group-based peer support (self-help) programme (for those who also have a chronic physical health problem) non-directive counselling delivered at home (listening visits (for women during pregnancy or the postnatal period)^{a, b, c}. 	<p>Do not routinely offer antidepressants routinely, but consider them, or refer for an assessment, for:</p> <ul style="list-style-type: none"> initial presentation of (long-term) subthreshold depressive symptoms (typically at least 2 years) subthreshold depressive symptoms or mild depression persist(s) after other interventions a past history of moderate or severe depression mild depression that complicates care of a physical health problem^{a, b}. 	<p>Consider:</p> <ul style="list-style-type: none"> informing people about self-help groups, support groups and other local and national resources; educational and employment support services^a.
Generalised anxiety disorder	Offer or refer for one of the following low-intensity interventions:	N/A	

(GAD) – that has not improved after active monitoring and psychoeducation	<ul style="list-style-type: none"> • individual non-facilitated self-help • individual facilitated self-help • psychoeducational groups^d. 		
Panic disorder – mild to moderate	Offer or refer for one of the following low-intensity interventions: <ul style="list-style-type: none"> • individual non-facilitated self-help • individual facilitated self-help 	N/A	
Obsessive-compulsive disorder (OCD) – mild to moderate	Offer or refer for individual CBT including ERP (exposure and response prevention) (typically up to 10 hours), which could be provided using self-help materials or by telephone or Refer for group CBT (including ERP) ^{e, f} .	N/A	
Post-traumatic stress disorder (PTSD) – including mild to moderate	Refer for a formal psychological intervention (trauma-focused CBT or eye movement desensitisation and reprocessing [EMDR]) ^g .	N/A	
All disorders – women planning, during or post pregnancy who have subthreshold symptoms that	For women who have had a previous episode of depression or anxiety, consider providing or referring for individual brief psychological treatment (4–6 sessions), such as IPT, or CBT ^c .	When considering drug treatments for women who are pregnant, breastfeeding or planning a pregnancy, consult 'Antenatal and postnatal mental health' (NICE clinical guideline 45)	For women who have not had a previous episode of depression or anxiety, consider providing or referring for social support during pregnancy and the

significantly interfere with personal or social functioning	Women requiring psychological interventions during pregnancy or the postnatal period should be seen for treatment within 1 month (and no longer than 3 months) from initial assessment ^c .	for advice on prescribing.	postnatal period. This may consist of regular informal individual or group-based support ^c .
<p>^a Adapted from 'Depression in adults: the treatment and management of depression in adults' (NICE clinical guideline 90).</p> <p>^b Adapted from 'Depression in adults with a chronic physical health problem: treatment and management' (NICE clinical guideline 91).</p> <p>^c Adapted from 'Antenatal and postnatal mental health: Clinical management and service guidance' (NICE clinical guideline 45).</p> <p>^d Adapted from 'Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: management in primary, secondary and community care' (NICE clinical guideline 113).</p> <p>^e Adapted from 'Obsessive-compulsive disorder: Core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder' (NICE clinical guideline 31).</p> <p>^f Group formats may deliver more than 10 hours of therapy.</p> <p>^g Adapted from 'Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care' (NICE clinical guideline 26)</p>			

Stepped care: step 3 treatment interventions table

Step 3 treatment and referral advice			
Disorder	Psychological or pharmacological interventions	Combined and complex interventions	Psychosocial interventions
Depression – persistent subthreshold depressive symptoms or mild to moderate depression that has not responded to a low-intensity intervention	<p>Offer or refer for:</p> <ul style="list-style-type: none"> antidepressant medication or a psychological intervention (CBT, IPT, behavioural activation or behavioural couples therapy)^a. <p>For people who decline the interventions above consider providing or referring for:</p> <ul style="list-style-type: none"> counselling for people with persistent subthreshold depressive symptoms or mild to moderate depression short-term psychodynamic psychotherapy for people with mild to moderate depression^a. <p>Discuss with the person the uncertainty of the effectiveness of counselling and psychodynamic psychotherapy in treating depression^a.</p>	N/A	<p>Consider:</p> <ul style="list-style-type: none"> informing people about self-help groups, support groups and other local and national resources befriending or a rehabilitation programme for people with long-standing moderate or severe disorders educational and employment support services^a.
Depression – moderate or severe (first	See combined and complex interventions column	Offer or refer for a psychological intervention	

presentation)		(cognitive behavioural therapy [CBT] or interpersonal therapy [IPT]) in combination with an antidepressant ^a .	
Depression – moderate to severe depression and a chronic physical health problem	See combined and complex interventions column	For people with no, or only a limited, response to psychological or drug treatment alone or combined in the current or in a past episode, consider referral to collaborative care ^b .	
Generalised anxiety disorder (GAD) – with marked functional impairment or non-response to a low-intensity intervention	Offer or refer for one of the following: <ul style="list-style-type: none"> • CBT or • applied relaxation or • if the person prefers, drug treatment^c. 	N/A	
Panic disorder – moderate to severe (with or without agoraphobia)	Consider referral for: <ul style="list-style-type: none"> • CBT or • an antidepressant if the disorder is long-standing or the person has not benefitted from or has declined psychological interventions^c. 	N/A	Consider: <ul style="list-style-type: none"> • informing people about self-help groups, support groups and other local and national resources • befriending or a rehabilitation programme for people with long-standing moderate or severe disorders • educational and employment support services^a.
Obsessive-compulsive disorder (OCD) – moderate or severe functional impairment, and in particular where	For moderate impairment, offer or refer for CBT (including exposure and response prevention [ERP]) or antidepressant medication ^e .	For severe impairment, offer or refer for: CBT (including ERP) combined with antidepressant	

there is significant comorbidity with other common mental health disorders ^d		medication and case management ^{e, f} .	
	Offer home-based treatment where the person is unable or reluctant to attend a clinic or has specific problems (for example, hoarding) ^e .		
Post-traumatic stress disorder (PTSD)	Offer or refer for a psychological intervention (trauma-focused CBT or eye movement desensitisation and reprocessing [EMDR]). Do not delay the intervention or referral, particularly for people with severe and escalating symptoms in the first month after the traumatic event ^g . Offer or refer for drug treatment only if a person declines an offer of a psychological intervention or expresses a preference for drug treatment ^g .	N/A	Consider: <ul style="list-style-type: none"> • informing people about support groups and other local and national resources • befriending or a rehabilitation programme for people with long-standing moderate or severe disorders • educational and employment support services^a.

^a Adapted from '[Depression in adults: the treatment and management of depression in adults](#)' (NICE clinical guideline 90).^b Adapted from '[Depression in adults with a chronic physical health problem: treatment and management](#)' (NICE clinical guideline 91).

^c Adapted from '[Generalised anxiety disorder and panic disorder \(with or without agoraphobia\) in adults: management in primary, secondary and community care](#)' (NICE clinical guideline 113).

^d For people with long-standing OCD or with symptoms that are severely disabling and restrict their life, consider referral to a specialist mental health service.

^e Adapted from '[Obsessive-compulsive disorder: Core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder](#)' (NICE clinical guideline 31).

^f For people with OCD who have not benefitted from two courses of CBT (including ERP) combined with antidepressant medication, refer to a service with specialist expertise in OCD.

^g Adapted from '[Post-traumatic stress disorder \(PTSD\): The management of PTSD in adults and children in primary and secondary care](#)' (NICE clinical guideline 26)

Tools to support diagnosis

A number of tools including GAD-2 (and the fuller GAD-7) and the PHQ-9 have been found to be effective in helping to establish a diagnosis of generalised anxiety disorder (GAD-2 and GAD-7) and depression (PHQ-9). It should be noted that these tools are not a substitute for the judgement and clinical opinion of a GP, especially if a GP has a longstanding relationship with a person.

In addition to assessing a person's symptoms and associated functional impairment, consideration should be given to how the following factors may have affected the development, course and severity of the person's presenting problem:

- a history of any mental health problem
- a history of a chronic physical health problem
- any past experience of, and response to, treatments
- the quality of interpersonal relationships
- living conditions and social isolation
- family history of mental illness
- a history of domestic violence or sexual abuse.

The Distress Thermometer

For use where there are significant language or communication difficulties.

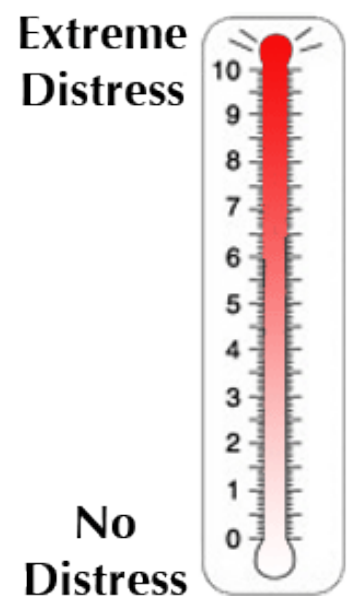
If a significant level of distress is identified, offer further assessment or seek the advice of a specialist.

Using the Distress Thermometer

The person places a mark on the scale in response to the question:

'How distressed have you been during the past week on a scale of 0 to 10?'

Scores of 4 or more indicate a significant level of distress that should be investigated further.



Roth AJ, Kornblith AB, Batel-Copel L, et al. (1998) Rapid screening for psychologic distress in men with prostate carcinoma: a pilot study. *Cancer* 82: 1904–8.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + + +
=Total Score:

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult
at all

Somewhat
difficult

Very
difficult

Extremely
difficult

Developed by Drs. Robert L Spitzer, Janet B W Williams, Kurt Kroenke and colleagues.

Using PHQ-9

This self-administered patient questionnaire can be used to monitor the severity of depression and response to treatment. The questionnaire is designed to assess a person's mood over the last 2 weeks.

Each of the 9 DSM-IV criteria is included and 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.

A person's score will be out of 27.

Scores of 5, 10, 15, and 20 represent the boundaries for mild, moderate, moderately severe and severe depression, respectively.

GAD-7

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

(Use "✓" to indicate your answer)

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

(For office coding: Total Score T_____ = _____ + _____ + _____)

GAD-7 Developed by Drs. Robert L Spitzer, Janet B W Williams, Kurt Kroenke and colleagues.

Using GAD-7

This self-administered patient questionnaire can be used to support diagnosis, and for establishing a severity measure for generalised anxiety disorder.

For each of the seven 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 represent: 0–5 mild anxiety, 6–10 moderate anxiety, 11–15 moderately severe anxiety, 15–21 severe anxiety.

Glossary

Definitions are given below of some commonly used terms within this document, based on definitions from related NICE guidelines. This list is not intended to be exhaustive, and a full glossary can be accessed via [this link](#).

Active monitoring

An active process of assessment, monitoring symptoms and functioning, advice and support for people with mild common mental health problems, that may spontaneously remit. It involves discussing the presenting problem(s) and any concerns that the person may have about them, providing information about the nature and course of the disorder, arranging a further assessment, normally within 2 weeks, and making contact if the person does not attend follow-up appointments. This was described as 'watchful waiting' in the NICE 2004 depression guideline.

Facilitated self-help

In the context of this document, facilitated self-help (also known as guided self-help or bibliotherapy) is defined as a self-administered intervention, which makes use of a range of books or other self-help manuals, and electronic materials based on the principles of CBT and of an appropriate reading age. A trained practitioner typically facilitates the use of this material by introducing it, and reviewing progress and outcomes. The intervention consists of up to six to eight sessions (face-to-face and via telephone) normally taking place over 9 to 12 weeks, including follow-up.

Low-intensity interventions

Brief psychological interventions with reduced contact with a trained practitioner, where the focus is on a shared definition of the presenting problem, and the practitioner facilitates and supports the use of a range of self-help materials. The role adopted by the practitioner is one of coach or facilitator. Examples include: facilitated and non-facilitated self-help, computerised CBT, physical activity programmes, group-based peer support (self-help) programmes, and psychoeducational groups.

Assessing severity of common mental health problems: definitions

Assessing the severity of common mental health problems is determined by three factors: symptom severity, duration of symptoms and associated functional impairment (for example, impairment of vocational, educational, social or other functioning).

Mild generally refers to relatively few core symptoms (although sufficient to achieve a diagnosis), a limited duration and little impact on day-to-day functioning.

Moderate refers to the presence of all core symptoms of the disorder plus several other related symptoms, duration beyond that required by minimum diagnostic criteria, and a clear impact on functioning.

Severe refers to the presence of most or all symptoms of the disorder, often of long duration and with very marked impact on functioning (for example, an inability to participate in work-related activities and withdrawal from interpersonal activities).

Persistent subthreshold refers to symptoms and associated functional impairment which do not meet full diagnostic criteria but have a substantial impact on a person's life, and which are present for a significant period of time (usually no less than 6 months and up to several years).

See the glossary on the [NICE website](#) for terms not defined above.

Quality and Outcomes Framework (QOF) indicators

Relevant QOF indicators for 2012-13:

DEP1. The percentage of patients on the diabetes register and/or the CHD register for whom case finding for depression has been undertaken on 1 occasion during the preceding 15 months using two standard screening questions.

DEP6. In those patients with a new diagnosis of depression, recorded between the preceding 1 April to 31 March, the percentage of patients who have had an assessment of severity at the time of diagnosis using an assessment tool validated for use in primary care.

DEP7. In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1 April to 31 March, the percentage of patients who have had a further assessment of severity 2 - 12 weeks (inclusive) after the initial recording of the assessment of severity. Both assessments should be completed using an assessment tool validated for use in primary care.

Appendix: Personal accounts of generalised anxiety disorder

Patient and carer personal accounts, reproduced from the NICE Generalised anxiety disorder (GAD) full guideline. A sample of personal accounts from people with generalised anxiety disorder and their carers are featured here, to illustrate some of the experiences, challenges and learning that each person has undergone in their path to seek treatment and better management for either their condition, or that of a loved one who they provide care for. The full suite of personal accounts can be downloaded from the NICE website, or accessed via the link in the box below:

Please note, this extract is featured as part of a support tool to help those who are implementing the NICE guidance on Common mental health problems, it is not NICE guidance. We recommend that you also read the following source guidance: 'Common mental health disorders Identification and pathways to care' (available at www.nice.org.uk/guidance/CG123) 'Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: management in primary, secondary and community care' (available online at: www.nice.org.uk/guidance/CG113).

Each contributor signed a consent form allowing their personal account to be reproduced in the full NICE GAD guideline.

Findings

The majority of individuals who provided an account experienced long-standing anxiety symptoms and often a delay in obtaining a diagnosis of GAD (which may have been compounded by co-existing mental health problems or misrecognition of their anxiety symptoms). However, once diagnosed most expressed a sense of relief. Most individuals also reported adverse impacts on many areas of their lives, particularly on relationships, self-esteem, social interaction, employment and education. Limitations placed on life choices were also commonly experienced, particularly when choosing careers and friendships. The individuals detailed a range of helpful approaches to managing their anxiety, including both NHS and non-NHS prescribed treatments

(psychological and pharmacological) and personal coping strategies (exercise, managing diet, relaxation, talking to people who share common experiences and receiving non-judgmental support). Unhelpful factors included stigma and general unsupportive attitudes from healthcare professionals, family members, friends or colleagues (for example, being told to 'pull yourself together'). Individuals were dissatisfied with the lack of treatment options: antidepressants were frequently offered first, leaving people to seek psychological therapy independently and/or privately. People felt that it was important for them that the right treatment should be offered at the right time.

Personal account A

I was diagnosed with GAD in 2004 aged 39. My husband and I had recently moved so that my husband could take up a new job that would significantly develop his career. I had recently accepted voluntary redundancy from my job, so it was the right time for us to move. We moved into a small flat whilst we sold our house. We had no garden and only one car. I had no job and no friends in the area and as a result of the change and my newfound isolation I had a bad bout of anxiety which resulted in me seeing my new GP. My anxiety symptoms included insomnia, excessive worrying about my health (constantly checking my body for new symptoms and worrying that minor symptoms were indicative of a more serious illness), panic attacks, feeling tense and unable to relax, and being easily startled and upset. On an intellectual level I knew the feelings were not rational and that the reality was quite different, but I couldn't control the anxious response and it made me feel powerless and trapped in my anxious feelings. Fortunately for me my new GP had a special interest in anxiety and depression so he was very understanding.

Despite only receiving a diagnosis in 2004, I have been suffering from symptoms of anxiety all my life – it just wasn't recognised as such. From the age of 17 I have also suffered intermittently with panic attacks. It was a huge relief to get a proper diagnosis. Instead of being labelled unsympathetically by family and my GPs as a 'highly strung, nervous child', a 'stressed out, panicky teenager' and a 'jumpy, angst ridden university student', I could finally say that I had 'generalised anxiety disorder' and 'panic disorder', which were medical

conditions that could be treated and controlled. For many years prior to the diagnosis, the main advice I had received from my GP was to 'learn to relax more' and from my parents to 'snap out of it'. Labelling a person with a disease or condition sometimes isn't helpful for recovery, but it helped me by making my anxiety seem real and authentic, rather than a stupid flight of fancy.

In 2004 my GP offered me antidepressants, which I refused, and attendance at a NHS-run stress-management course which I accepted. The course was useful in expanding my repertoire of coping strategies and it helped to shorten the bout of anxiety that I was experiencing. Prior to the course I used to manage my anxiety via rest, healthy eating and regular exercise. The course provided me with additional skills, such as assertiveness training, time management skills and relaxation exercises. I have since been offered antidepressants by two other GPs, but I still refuse them. In my experience, antidepressants are always the first treatment option offered by GPs.

For me, they mask the symptoms and don't help me get to the root cause of the anxiety.

I have never been offered counselling by any GP, but I have paid for counselling myself. When I asked several GPs about counselling they told me that there was a waiting list and I could be waiting up to 6 months to see someone. I am currently seeing a counsellor who uses CBT and I am finding it very helpful, so much so that my anxiety has been reduced to much lower levels.

Both my grandmother and my mother displayed anxiety symptoms as I was growing up. My grandmother lived with us all her life and she was a very anxious person.

She took Valium for over 25 years and had bouts of deep anxiety. It is possible therefore that I learned to be anxious, but GAD could have been inherited. As well as having GAD and panic attacks, I suffer from anxiety about my health and about illness in general. This has only been a serious problem in the last 5 years or so but I think it started as a child. Both my mother and my father had serious illnesses when I was growing up and neither of them coped particularly

well with them. There was always a lot of anxiety in the air at these times and I think I learned to fear illness of any kind.

Over the years my anxiety symptoms have changed. I get far fewer panic attacks now, but I still get attacks of unspecific anxiety that come out of the blue. As mentioned before, I have started to get more anxious about my health too, which has resulted in me seeing my GP more often because of concerns that mild symptoms of illness are actually symptoms of something much more sinister, like cancer. I also worry and fret about the health of my family and friends and I am terrified of them dying.

I try to eat healthily and I exercise regularly, which involves walking for 30 minutes every day and taking more vigorous exercise three times per week. When I have an attack of anxiety it can be quite crippling; but I try to slow down the pace, exercise, get as much sleep as possible and increase the amount of relaxation exercises I do. Unfortunately I comfort eat during really anxious times, which doesn't help me manage my weight (I am overweight as a result), but the amount of comfort eating I do has reduced a bit over the years. I no longer feel guilty about cutting back on social invitations when I am unwell; to be really busy socially when I am anxious makes me exhausted.

Having GAD has changed my life in many ways. I cannot burn the candle at both ends. I have to limit alcohol and travel, both of which aggravate my anxiety. I get fatigued easily and must get enough sleep. My husband is very supportive and understanding, although the anxiety has put a strain on our marriage. I can be very clingy, needy and antisocial when I am in a bad bout and we can argue quite a bit at these times. The arguing fuels the anxiety so it is a vicious cycle. My parents do not accept that I am ill; they think I am highly strung and self-indulgent and that I should pull myself together, so they do not support me much. On a positive note, having GAD and panic attacks has made me take care of myself and I have learned to nurture myself a bit more. In some ways the anxiety pushed me to achieve standards of excellence in school and college and in my career by pushing me to work harder and be smarter.

I now regard anxiety like an old friend who has been with me for over 40 years.

My anxiety is part of me and I have learned through counselling to work with the anxiety, not to ignore it. In that way I get better more quickly.

Personal account B

I was diagnosed with generalised anxiety disorder in November 2008 when I was 22, although I believe I suffered from it for around 3 years prior to being officially diagnosed. It's difficult to pinpoint precisely when it began, although I have a vague idea. After spending a gap year working between 2004 and 2005, I moved to London to pursue a degree. It was a huge change – from earning a wage, I was now relying on my parents and by going to what is considered a prestigious university, I felt that I needed to justify my place there. Coming from a comprehensive school and a working-class family, it was as if I had to prove I was somehow better than students from more privileged backgrounds.

While in London, my mental state began to deteriorate quickly; I spent large periods not interacting with people because I was tied to my work and naturally suspicious, and every element of my day was dictated by the feeling that university work came first before anything else. This meant that while I was doing something enjoyable, whether in a pub, watching television or listening to music, I would be in a constant anxious state. Over the course of my year in London my anxiety worsened to the point that during exams I broke down entirely. I passed my exams and did attempt to return to London, but because of my anxiety and concerns around finances, I decided not to. This led to the breakdown of my relationship with my then girlfriend who was moving to London to pursue a postgraduate course. This only exacerbated my anxiety further and led to a prolonged period of being single, as I was afraid to approach women and believed that my anxiety prevented me from entering relationships.

Months later I started a fresh degree course at another university and now I felt I had to prove my change of course was the right decision. This meant work could take a lot longer compared with other students and resulted in me being given a week's extension to use if necessary.

My anxiety began to affect my social life more widely; because I was suspicious of people I had met in London, I now found social interaction with new people difficult and frustrating. This meant I spent large parts of my university life alone and relied on the friendship base that I've had for several years through secondary school and sixth-form college.

As I entered my final year of university, I had had enough. The anxiety was preventing me from pursuing personal writing projects and fulfilling my ambition to be a journalist. I had previously visited my GP practice on two occasions and got nonchalant responses; firstly I was given self-help sheets and another time was ignored altogether: the disorder was not diagnosed.

It was not until I visited my GP for a third time in October 2008 and explicitly told the practice I did not want to see those previous two GPs that things began to improve. I was seen by a trainee GP who was well aware of the services offered and was empathetic about my condition and fully understanding. Importantly, she finally diagnosed my GAD.

While suffering from anxiety I was also diagnosed with depression. I vowed to never take antidepressants as I did not want my parents to find them and consequently find out about my GAD, and I was uncertain about the possible side effects. Yet eventually through discussion with my new GP I decided it was time to pursue the option and was prescribed citalopram. I found the antidepressants the most difficult out of all therapies to keep up with; the initial side effects left me feeling highly nauseous and shaky, and almost left me housebound for a small period.

I began talking about my GAD and depression to a tutor of mine, who explained his problems with depression. I realised two things: firstly, there was no need to feel there was a stigma attached to anxiety and depression; and secondly, it made me determined to keep up with the medication and find a long-term solution.

From there I made every effort to combine medication with additional longer-term therapies. Fortunately I gained access to my university's counselling service and was also offered CCBT through my GP and local PCT within a few

weeks of beginning antidepressants. I was pleasantly surprised by this, yet somewhat guilty; patients on the NHS occasionally have to wait months to access either service, while I managed to access both quickly.

Since the beginning of this year, I have noticed a real improvement in my condition. The CCBT allowed me to recognise and control thinking errors, meaning I can distinguish between my own thoughts and ones that are triggered by the anxiety. The counselling also let me speak to someone confidentially and to work out an organised plan of action since my GAD meant I had trouble planning and organising.

I also began talking to my family about my problems with anxiety and depression, which was particularly difficult at first. They were concerned about why I hadn't raised this sooner and why I was not able to confide in them. I explained that I felt this was something I had to deal with on my own because of stigma and because I wanted to gain independence on my own instead of relying on the help of others. In the end my family understood my point of view, yet I also felt rather stupid: family are there to help you in whichever way they can and whatever situation you are in. I now feel I can be more open with my family and get support when I need it most.

I now feel more comfortable in social circumstances, can balance work and my social life better and feel much more confident in pursuing my writing and journalistic ambitions. I am now off antidepressants and, thanks to therapy, I can manage independently and confidently. Importantly, I feel gaining treatment at the beginning of my final year of university helped me secure a first-class honours degree and employment. I am also in a relationship and have been for almost 6 months. There is the odd period of anxiety and depression, but these are far less common and less debilitating than previously. I feel so much better.

Other implementation tools

NICE has developed tools to help organisations implement the clinical guideline on Common mental health disorders (listed below). These are available on the NICE website (www.nice.org.uk/guidance/CG123).

- Baseline assessment tool
- Costing report
- Commissioning guide
- Costing template
- Podcast
- Slide set²⁸
- Clinical case scenarios: slide set version for group learning

A practical guide to implementation, 'How to put NICE guidance into practice: a guide to implementation for organisations' is also available (www.nice.org.uk/usingguidance/implementationtools).

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²⁸ A PowerPoint version of these clinical scenarios is also available for group learning. It can be added to presenter slides that accompany the Common mental health disorders guideline, for a more detailed learning session.

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