Mental Health and Sexual Health

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The most common mental health problems are anxiety and depression

- Most people will experience one or other of these over the course of their lives. Population prevalence for depression is around 5%. Anxiety conditions probably around 15%

- Health anxiety (confusingly used as a synonym for hypochondria) is extremely common

- Other conditions such as schizophrenia and bipolar disorder (0.4% prevalence) are much less common, but there are still large numbers of people in the population with them (Kirkbride et al DoH Policy research programme 2012)

- The other common problem is personality disorder, prevalence of diagnosable personality disorder is about 5%

Rates of depression and anxiety are considerably elevated in people with HIV infection

Various characteristics lead to elevated rates of anxiety and depression in people living with HIV

- The infection itself and its social stigma and physical consequences

- Men without a long term partner have higher levels of mental health problems, more gay men fall into this category and more gay men who become HIV+ in particular

- Many heterosexuals with HIV are migrants, often forced migrants

- Both gay men and migrants continue to face stigma

- Ex drug users have a higher incidence of mood disturbance (and did so before they used drugs)

Mental Health problems are common in GUM

- Osborne et al 2002
- Half of GUM attenders met diagnostic criteria for anxiety or depression
- A fifth were identified by staff
- Those identified by staff were more likely to attend follow up appointments

Mental health problems are associated with higher costs

- Seivewright et al. 2004. 8-11% of GUM attenders met criteria for hypochondria

- They used 37% more clinic time than non-hypochondriacs

- It is very common to be both ill *and* to have hypochondria. Disproportionate worry about whatever condition one has

Anxiety and depression

It is best to rely on questionnaire measures

- The alternative, a mood history is far too time-consuming for use in acute care
- Putting a number on severity is very helpful in management

Screening for anxiety and depression

- Readily available free to use scales
- Can be easily downloaded from multiple internet sites
- Available in computerised form
- GAD7 (Anxiety)
- PHQ9 (Depression)
- Take about two minutes for patient to self-complete
- Good validity and reliability
- We use them more or less routinely

The GAD and PHQ

- Like the Hospitals Anxiety and Depression Scale are well-suited to populations who are physically ill because they concentrate mainly on psychological symptoms

- The GAD, like most state anxiety scales, is poor at detecting panic disorder and phobias and so will underestimate gross prevalence of anxiety conditions

- The PHQ will sometimes miss patients with mood swings because it asks about the last two weeks

- Both sensitivity and specificity are good for the GAD and PHQ

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

A11 – PHQ-9 Total Score

If the PHQ4/GAD7 are too long for you

PHQ-4 – Anxiety and Depression Screen

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

Feeling nervous, anxious or on edge :	Not at all
Not being able to stop or control worrying :	Not at all
Little interest or pleasure in doing things :	Not at all
Feeling down, depressed or hopeless :	Not at all

That still leaves a problem

- Mood changes and people become depressed or anxious (and stop being depressed or anxious)
- There is a problem that assessing mood is not a “one off” problem
- One strategy is simply to administer the PHQ4 or the GAD/PHQ at regular intervals, perhaps quarterly
- As a minimum one should ask “how has your mood been since I (we) last saw you?”
- And use scales when:
  - The patient has had a significant adverse life event
  - There is a change in behaviour
  - Adherence becomes a problem in someone with prior good adherence

Differential diagnosis

- Where a patient's mood was good but has changed for the worse:

- Consider the possibility of neurocognitive impairment

- Changes in brain function are often accompanied by, and sometimes preceded by, changes in mood

- The symptoms of early neurocognitve impairment can be mistaken for anxiety/depression, for instance problems with concentration and memory

Other mental health problems

- After anxiety/depression and substance misuse the most common mental health issue is personality disorder

- Not really possible to screen for it in acute care and, in any case, treatment outcomes are poor and so missing the diagnosis in acute care is less problematic than for more treatable conditions like anxiety and depression (although it may complicate care)

- Eating disorders should be suspected in the patient who has a persistently low BMI in the absence of obvious physical pathology

- Bipolar disorder should show up on depression scales, at least over time.

- About 0.5% of the population have a psychotic spectrum disorder. While undiagnosed psychosis sometimes appears in acute settings most people with psychotic symptoms will already have been diagnosed by their mid-twenties (except for some post-menopausal women)

But what to do with patients once identified?

Treatment options for anxiety and depression

- Anxiolytics are a problem because the most effective group, the benzodiazepines, are addictive
- SSRIs have some effect against anxiety but would normally be considered an adjunct or a second-line treatment
- Psychological intervention is the treatment of choice for anxiety
- In trials antidepressants and psychological interventions, particularly CBT, are equivalent in effect for the treatment of depression
- Problems with adherence and reluctance to take medication are prominent problems with antidepressants in everyday practice limiting their real-life effectiveness
- Depression is a relapsing condition and there is some evidence that psychological treatments have a lower relapse rate
- Psychological treatments and antidepressants can be combined and this may be a good option in more severe depression

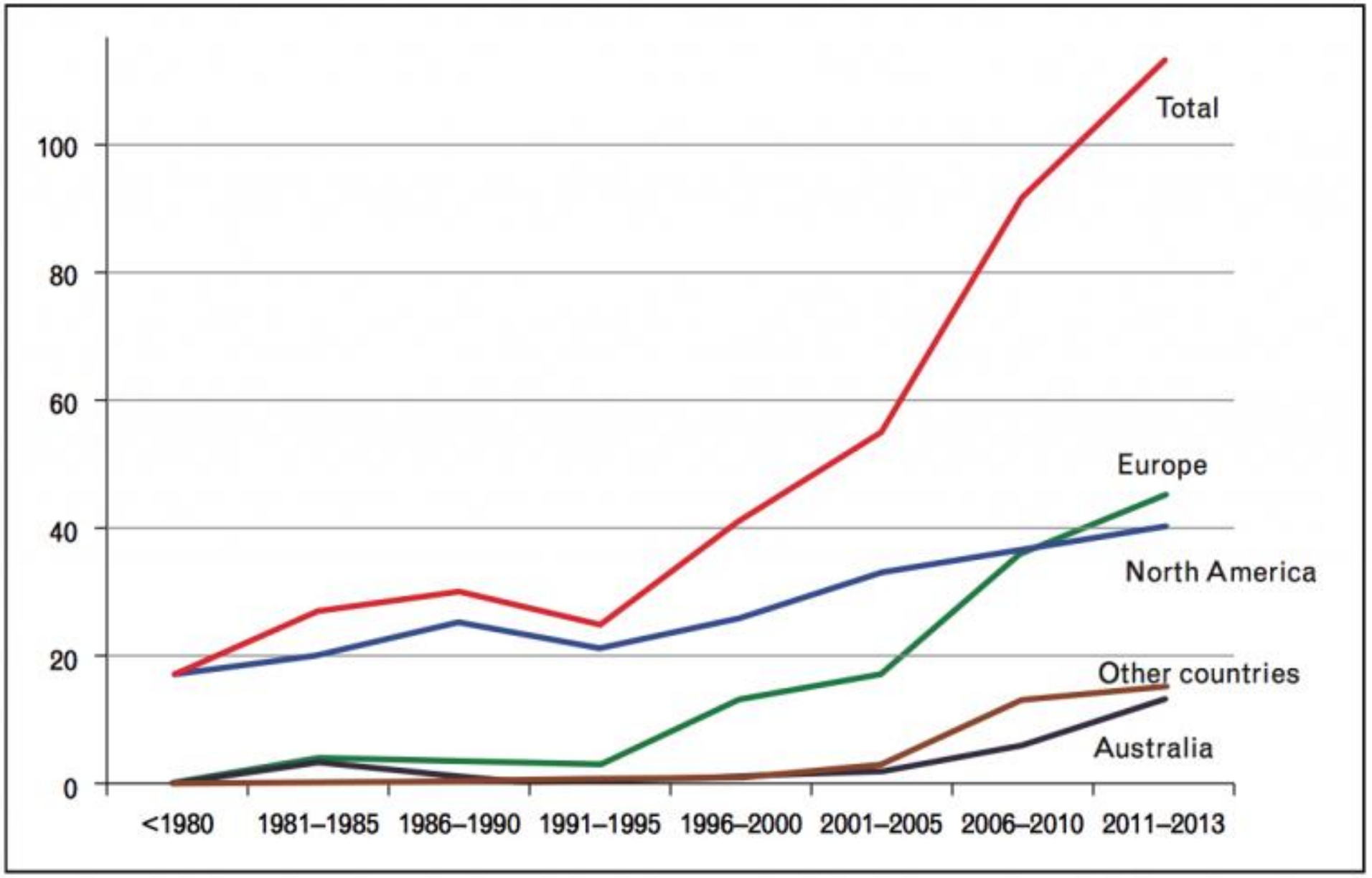

FIGURE 1. Randomized controlled trials examining the effects of psychotherapies for adult depression ($N = 400$).

The ideal

- Is to have in-house psychology and perhaps psychiatry sessions
- Mental health is best integrated into acute care rather than being an add-on
- This sort of holistic care is the preferred model across medicine
- With resources tight it is more difficult to achieve than ever

Secondary care mental health services are under particular pressure

- Mental health funding overall has probably fallen in real terms over the last decade (publication of formal figures by DoH stopped in 2013)
- Mental health services have seen funding transferred to other providers probably 25-30%
- Demand is sharply up and regulatory demands have increased particularly around risk management
- The plan is that mental health services will, like acute services, assess, stabilise and discharge to primary care
- Currently most effort in mental health is directed at psychotic spectrum disorders
- There is very little capacity for anything else - particularly so in inner city areas

The consequence

- Secondary care mental health services are narrowing down onto the most ill in the population
- Most resources go into the severely mentally ill (SMI), psychosis, bipolar, severe PD, treatment resistant depression because they are more likely to be admitted and more likely to need complex multidisciplinary care
- Risk is a major driver of mental health services, particularly risk of harm to self and others
- In theory patients are being transferred to primary care, but resources are lacking in primary care particularly in London and inner city areas and GPs are reluctant to take on care of all but the most stable

IAPT

- Increasing Access to Psychological Therapies
- National programme with a service in each CCG area
- Treats only “mild to moderate”anxiety and depression, in practice lack of alternatives leads to it treating everyone except SMI patients and the acutely suicidal
- National programme gets about 1 million referrals a year
- About two thirds of these are seen - the main reasons for not seeing them is difficulty in locating or engaging the patient or the patient not being anxious or depressed

Targets

- Unique in NHS in having a recovery target (50% of patients must no longer be anxious or depressed at end of treatment)
- About 2/3 of patients show a significant clinical improvement
- Analogous to “intention to treat”. Recovery rate includes drop-outs, deaths, those referred on to other services.
- There are also access targets set as a percentage of population morbidity (15% currently, due to rise to 21% by 2021)
- Usual wait <6 weeks.
- Patients can self-refer by phone or online as well as referral by any health professional (does not have to be via GP)

However

- Staff are trained to treat anxiety and depression only
- They do not do behaviour change, personality disorder, sexual risk behaviours, chemsex, disclosure to partners etc.
- Most staff in IAPT know little about sexual health
- Only patients who meet the diagnostic criteria for anxiety and depression can be treated.

We reviewed HIV referrals

- Straightforward cases have relatively infrequent contacts with hospital for monitoring/medication

- People with HIV accessing a wider range of health care outside specialist services

- Referrals coming into our department are either severe or very complex or both

- Often behavioural components eg risky sex, chemsex, medication non-adherence, or complex social problems

- Very few suitable for IAPT

However

If you start to screen for anxiety and depression routinely you are more likely to find mild to moderate depression cases

Patients can be referred to local IAPT service or a self-referral suggested.

- Self referral reduces need to write referral
- Leads to a quicker appointment for patient who does not have to wait for referral letter to be sent
- Has no disadvantages

The immediately suicidal

- Many people who are depressed have suicidal thoughts
- Most of those will not actually kill themselves
- Higher risk in people who misuse drugs and alcohol, those who live alone, young men, those with a history of deliberate self-harm
- However just because someone has none of these features does not mean they will not commit suicide
- There is no foolproof way of judging risk of self-harm and there is no way of totally reducing any risk there is

Assessing the patient

- The key question is whether they have any plans to do it
  - Have bought rope - urgent A&E referral, seek MH advice from MH professional or MH single point of access if available
  - Planning to buy rope this afternoon - As above
  - Often think about buying rope - referral to MH service or IAPT. Advice to access primary care or A&E if mood worsens
  - Often wish I was dead - referral to MH service or IAPT. Advice to access primary care or A&E if mood worsens
- No-one will expect you to carry out a full risk assessment in a GUM clinic. You are only trying to decide how best to help the patient

Single Point of Access

- Increasingly common in secondary care
- My own trust has one which covers all our boroughs
- Can be contacted by phone or by conventional referral methods
- Offers advice to referrers and patients and carries out rapid telephone assessments to establish need and optimal disposal of patient
- Cannot compensate for lack of resources downstream
- Simplifies the position for referrers

The future

- Further exploration is under way on whether, and how, to link psychology and IAPT in the context of GUM. Don’t expect an immediate answer because cost savings are a major driver

- IAPT is a standardised national service, but there is some variation with a few services underperforming and a few areas with long waits

- Secondary care mental health is likely to continue to suffer huge stress, further contraction of services is inevitable

- It doesn’t look good. And after Brexit you won’t even be able to go live in France to get a better funded service