University of BRISTOL

MB ChB Programme

Low mood block

GP teacher guide,
Effective Consulting, Year 2

Academic Year 2018-2019

Introduction and link to course and teaching information
Clinical Contact, Primary Care in Teaching Block Two, Year 2 2018-19

Dear GP tutor,

Thank you for teaching Year 2 students in 2018-19 and welcome to this session guide for the Low Mood block.

All the main information on the course is available in the year 2 18-19 GP handbook so please refer to this for information on how key dates, how the course is structured including assessment, your role, expectations of your students and teaching tips such as giving feedback. This is available here:

https://www.bristol.ac.uk/media-library/sites/primaryhealthcare/documents/teaching/handbooks/Year%202%20Effective%20Consulting%20Primary%20Care%20Teacher%20Guide%202018-19.pdf

This also contains information on the support that is available for students, however I am always happy to discuss any student you have concerns about.

This session guide outlines the learning outcomes for the students' time with you, key information about teaching history and examination, and a menu of options for other activities you can do with your students. Students will come to you during the *second* week of their Case Based Learning cycles. Students alternate between clinical contact in Primary Care with sessions in Secondary care for each Case Based block, so if they are with you for the Low Mood block, they will be in the hospital setting for Joint and Back pain (the next case). A table of dates with the topic for the session is on page 4.

Please bring in 2 patients with conditions relevant to the symptoms the students are learning about to help students learn how to talk with and examine patients to find out what is wrong with them, apply their understanding of anatomy and physiology, and practice making diagnoses. There is no physical examination in the Low Mood block but please talk to your students about observation of patients' mood through their appearance and affect. Communication, history and examination skills will be assessed by an OSCE examination in May 2019.

If you have 6 students, you may find it easier to divide the group with 3 students each with a different patient and the GP going between groups. The groups can share their learning when they come back together.

Discussing psychological symptoms may raise issues for your students, if they speak to you about this please remind them of the support available at the University. The homepage of "Blackboard" has a link to "Your health and wellbeing" (this link takes you to Blackboard. On the top right-hand corner in the black banner click on the word 'Wellbeing' on the far right), and there are Faculty Student Advisors in the medical school who can signpost students to relevant help and support.

I am always happy to be contacted if you wish to discuss any aspect of the course and welcome your comments, feedback and suggestions. With all best wishes for teaching in the year ahead.

Dr Jessica Buchan

GMC Outcomes for Graduates

The GMC have updated guidance on what they expect newly qualified doctors to be able to know and do. The outcomes have been aligned to Good medical practice and are categorised as professional values and behaviours, including professional and ethical responsibilities and patient safety; professional skills including communication and interpersonal skills and diagnosis; and professional knowledge. Please be familiar with this document:

https://www.gmc-uk.org/-/media/documents/dc11326-outcomes-for-graduates-2018_pdf-75040796.pdf

The outcomes of particular relevance to teaching in Clinical Contact in Year 2 are; 2d, e, j & u. 5a, b & d. 6a. 7b & h. 10a. 11a, b, c & d. 12. 13. 14a, b, c & d. 20. 22b & c. 23a, c, d, &e. 24d &e. 25a

Structure of the Effective Consulting Day and Key Dates

The ILOs for each EC day covered in this session plan cover the whole EC day, which is delivered to varying degrees by lecture, EC lab and clinical contact. If the students are with you for the morning, they will have a lecture and practice specific consulting skills in a tutorial group with actors in the afternoon, if you have students in the afternoon, they will have already had a lecture and practised consultation skills. This means that if you have afternoon students you may notice that they are better prepared, but if you have morning students, they benefit from having their learning "primed" by meeting real patients prior to their small group tutorial in the afternoon.

Clinical contact alternates for each student in each CBL "case" between primary and secondary care. We try and align the teaching across settings much as possible.

In both primary and secondary care students should:

- Have a brief tutorial (to orientate the students to the task)
- Meet patients to practise focused gathering of information from history and consider clinical reasoning.
- Present back the patients they've met
- Be helped to consider the patient perspective, impact of the illness or problem on patient lives, and to consider what support and future needs patients have.
- Be starting to consider variations in presentation, differential diagnosis and what they might do next.
- Get feedback on any observed history and examination, and on their clinical reasoning and presentation skills
- Debrief in the group (usually without the patient present) to ask questions and consolidate learning.

Dates	Case Based learning symptom	Key learning goals in clinical contact	Types of patients
Thursday **14th March** 2019	Low mood	Assessing mood in clinical practice	2 patients with history of mood disorder—depression or anxiety or other mental health presentation e.g. OCD, eating disorder, previous psychosis or addiction.
Thursday **28th March** 2019	Joint pain including back pain	Clinical presentation and assessment of joint pain (including back pain)	Patients with arthritis, or joint pathology or replacement, chronic back pain. Patient suitable for examination.
Thursday **9th May** 2019	Urinary symptoms and thirst	Clinical presentation and assessment of diabetes and renal pathology	Patients with diabetes, chronic renal disease, dialysis.
Thursday **23rd May** 2019	Headache	Clinical presentation and assessment of patients with headaches. Cranial nerve examination.	Patients with recurrent headaches e.g. migraines or previous significant headache e.g. Temporal arteritis, Subarachnoid haemorrhage, stroke/raised ICP. Any patient for examination or patient with abnormality of cranial nerves.
May 29th/30th	OSCE EXAM		
Thursday **13th June** 2019	Collapse	Assessment of patient with history of collapse. Neurological examination	Ideally patient with previous collapse (fit or faint) from any cause including seizure.

Framing teaching the medical history and examination in the "Clerking Consultation" & COGConnect

Medical students do not yet "consult" with patients as such, as they are still learning how to. Instead, on the Effective Consulting course we talk about the "*clerking consultation*" they "*clerk*" patients for training purposes in part to learn about medicine from the patient's narrative—what happened, what symptoms the patient experienced and what the outcome was. In this way student doctors build up a bank of illness scripts. We know the more exposure student doctors get to patients, the more experience they build up, so we are very grateful you help provide this experience. They also practice speaking to patients to learn *how* to talk to patients and assess problems—in other words they are learning *how* to consult. Therefore, here in Bristol we call the process the *clerking consultation*, as we want to emphasise the active hands on practice students get in consulting. You can help this process by spending some time directly observing the students speaking to patients, and by listening to them presenting summaries back to you. Where you have observed, please give feedback not only on the content of the clerking, but on the process. It's also particularly helpful to students learning if you get them to commit to what they think is going on and what they might want to do next—to start student "*thinking like a doctor*".

In MB21 in Bristol we have taught the medical students to think about all aspects of consulting with patients, we call this systematic approach COGConnect. This describes the different stages of consulting with patients that we want students to consider whenever they meet patients. We would be grateful if you could highlight these stages in your feedback.

Preparation: It has been emphasised to students that any clinical encounter begins with preparation. A doctor will prepare to see their next patient by reading the notes, a referral letter, perhaps looking at the medication screen. Doctors also prepare themselves to see the next patient perhaps they have just had a difficult consultation or need to finish a task before calling in the next person.

You can help students think about this stage when they prepare to see the patient you are bringing in.

Example questions to discuss with students to consider preparation:
As a GP, when you find out the next person on the telephone or waiting to see you has got abdominal pain...how do you prepare? What do you need to do or know before you phone the patient or call them in? What information is particularly useful and why?

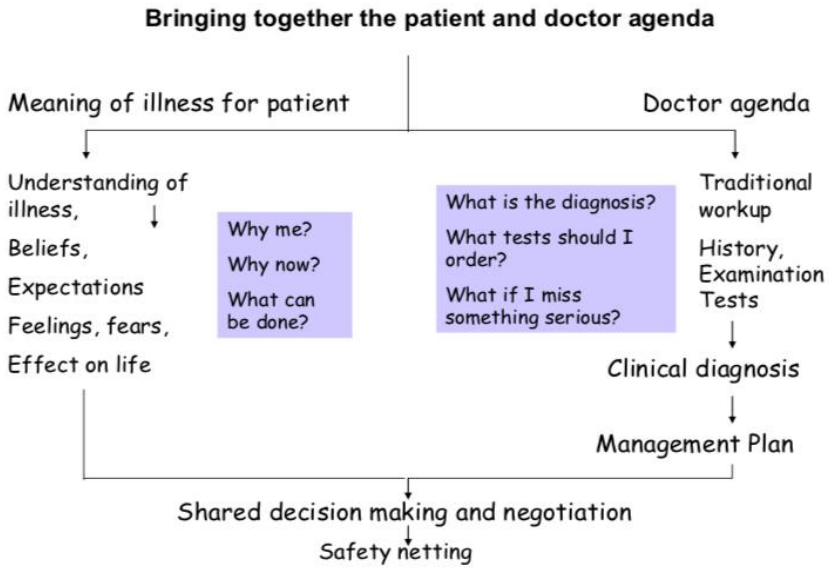
Preparing the students for meeting the patients today: Discuss any brief information you want the students to know before they see the patient. Briefly recap assessment of mood disorders, what information will they want to find out from the patient? Do they have any questions?

Preparing the patient: Please prime the patient as to where to start their story and what to focus on. For example, if the patients have multiple problems you may need to tell the patient that the students are particularly interested in how episodes of depression have affected them. You may also want to say how much information to give, for example "Please don't tell them straight away that you were diagnosed with Bipolar disorder, just start by saying what symptoms you had and how you felt. They will ask you some questions and try and work out what might have happened to you."

Opening: All the students should be familiar with introducing themselves to the patient, checking the patients details and asking permission to talk to/examine the patient. Remind them to do so if they do not do this automatically. They should make sure the patient is comfortable, knows what is going to happen e.g. how long it should take, and start with open questions and attentive listening.

Gathering: We teach students to "*gather information*" around a presenting problem. The medical history is an essential, structured *part* of gathering information that students need to learn and learn how to adapt for different situations. We emphasise that the medical history is one part of broader assessment of patients' problems including information from the notes, observation of the patient's presentation and non-verbal communication, examination findings, and results from investigations, and where appropriate, from third parties. We also want to emphasise that gathering is partly about *how* to find out information (the *process* which includes listening skills and how to phrase questions) as well *what* they find out (the *content*—which is forms the medical history).

Patients often come with a problem or problem list (which is not necessarily a symptom) and we want students to be able to form a holistic assessment of the situation. The GMC's outcomes for graduates does require that newly qualified doctors can "elicit and accurately record a patient's medical history, including family and social history (Outcome 11a)" but of note is that graduates should be able to "work collaboratively with patients, their relatives, carers or other advocates to make clinical judgements and decisions *based on a holistic assessment of the patient and their needs, priorities and concerns, and appreciating the importance of the links between pathophysiological, psychological, spiritual, religious, social and cultural factors for each individual (Outcome 14)"*



When students learn to gather a comprehensive assessment of the patient through systematic history and examination, they need to continue to consider the patients understanding, beliefs, fears, expectation and impact of the problem on their lives. Sometimes as they learn a "list" of questions to ask they can start to be so focused on remembering *what* to ask, they forget to respond to patient cues, for example a patient might respond to a question about smoking with the information that their Dad died from smoking related disease and the student ignores that to move on to asking about alcohol intake. Remind them to acknowledge what they are hearing and seeing. This is where you can help by spending some of the time observing the students talking to patients and giving feedback and helping the other students observe and give effective feedback to their peers.

Key consultation skills to practice

- Attentive listening, picking up cues
- Open and closed questions
  - Open questions tend to begin with 'What, where, when and how?'
  - Closed questions tend to start with 'Have you, did you, could you?...'
  - Questions starting with 'Why' are difficult for patients, better to say; 'What made you think that?' rather than 'Why did you think that?'
- Jargon free language
- ICEIE – ideas, concerns, expectations, impact of the problem, and emotions. It is very important to understand where the patient is coming from, what they are worried about, what they need, and how the problem is affecting them.
- Clarification - what did the patient mean by saying 'couldn't breathe'?
- Summarising – This helps you to review the information you have already gathered, and the patient can tell you whether you understood correctly and what information is still missing.
- Acknowledgement: *'I am sorry to hear that', 'That must have been difficult for you'*

Formulating: What do I think so far, and what next?

Students may find it helpful to keep these questions in mind while talking to patients, and systematically consider them when they feel they have come to the end of the information gathering stage. You can ask your students:

- **Can you summarise what you have been told so far?**
- **Does it tell a story from beginning to end?**
- **Is the story unique to the individual and their situation?**
- **Can you tell what the probable diagnosis is (main problem)?**
- **And what is less likely (differential diagnosis)?**
- **What you must not miss, red flags? --In mood disorders this is a risk assessment of the possibility of harm to themselves or others**
- **Do you know what the patient thinks is wrong? And what they worry about?**

Explaining

Are they any elements that the students could practise explaining to a patient or each other e.g. common side effects of SSRIs?

Activating

The students have been introduced to activating patients. By activation we mean empowering and motivating people to manage their own health. Different people need different interventions to feel more able to manage their health & wellbeing. You can read more here:

https://www.kingsfund.org.uk/publications/supporting-people-manage-their-health

When students meet patients with you, you can help them think about this by discussing areas of the patient's lifestyle or how they manage their condition that are ripe for intervention e.g. reducing alcohol intake.

Planning

Try asking the students "If you had met this patient when they had first presented with this symptom (e.g. anxiety) what would you do next?" Help them consider a wide range of options e.g. self-help advice and monitoring, medication, referral...

Doing

Some consultations have a procedure as part of them. In Primary care this might be a minor surgical procedure, or doing a joint injection, also taking a smear, doing an ECG, giving a flu jab. Over their training students will learn an increasing number of practical procedures.

Closing

Closing a clinical encounter needs specific skills. Students should be encouraged to help the patient summarise, ask any further questions, and make sure the patient is clear on what will happen next including follow up, getting results, hearing about a referral. They can practise safety netting for example in a patient with stable angina.

Integrating

This is the stage after the patient has left the room. Both doctors and patients "integrate". For the doctor this is where they write up the notes, make a call to a colleague or write a referral letter, or look something up. Students can be helped to assess their learning needs at the end of the session.

Low mood session guide for Thursday 14th March 2019
Primary Care Clinical Contact, Year Two 2018-19

Intended Learning Outcomes:

- Describe the difference between mental illness and normal responses to stress and life events including transition and bereavement
- Describe the broad range of ways a person with a mood disorder may present
- Describe how gather a well-rounded impression of patient's psychological health
- Describe what may constitute risk to self, including self-harm, suicide, risk taking
- behaviour and neglect, and risk to others
- Discuss how to formulate a differential diagnosis of a patient presenting with low mood with an appreciation of social, physical and psychological factors
- Discuss, in broad terms, how mood disorders may impact on the provision of medical care in practice

Resources:

Hippocrates, the Bristol Medical School website, has section on psychiatry, it is aimed at students in later years but there is useful learning material herex accessed 15.12.18.

Suitable patients for the low mood block:

- Patients with chronic or recurrent depression or anxiety
- Also, patients with a previous episode of mental health disorder e.g. psychotic episode
- Patients with other mental health presentations that may co-exist with or be part of a mood disorder e.g. substance abuse or addiction, eating disorder or OCD

Low mood session activities:

Introductory tutorial (30 minutes)

1. Assess learning needs; discuss the students' learning during their low mood CBL case and what they feel confident in and what they want to practise.
2. Prepare for the session; discuss how mental health disorders present in practice, and how to assess.
3. Recap an overview of a history in mental health presentations, what is important to find out? The history is no different from any other clinical history but with more emphasis on the personal history including developmental, educational and forensic history, and relationships, and on past and family psychiatric history.
4. Brief students on the first patient.

Patient one (30 minutes)

5. Patient One Arrives. Brief information on the patient you are going to see together. Allocate one student to practice gathering information (you might want to allocate one student to take over 1⁄2 way so that 2 students get a turn). The other students should be given observation tasks. One could look at content of the history (anything missed?), one could look at body language and non-verbal communication, and one could look at process e.g. active listening, building rapport with the patient. When the student/s have finished talking to the patient help them summarise what they have heard—can they tell the patients story?

BREAK—offer students a snack and drink and toilet break. (10 minutes)

Patient two (30 minutes)

6. Patient Two Arrives. Repeat as above with Patient One.
7. Debrief, questions and identify further learning needs and resources.

Other options:

- Show them a PHQ-9 and if and how you use it
- Talk about your own experiences of patients presenting with mood disorders, how you decide what is going on and how to manage?
- How do you approach "assessing risk" in consultations e.g. Harm to self and others?
- Discuss what options are available to you as a GP in managing patients with mood disorders?

Tutorial notes (available to students via OneNote) Please note these are designed to be quick reference notes so are brief and **do not** replace core textbooks.

Assessing mood

In the UK, around 2.3 million people suffer from depression at any time[1]. The female to male ratio is 2:1[2]. It is estimated that 30-50% of all depression goes undiagnosed; much is likely to be mild and resolve spontaneously. Patients may be embarrassed, fear stigma or doubt the medical professions ability to respond. First presentation of depression may be with vague non-specific physical symptoms. Not all depressive symptoms are depression; dementia, hypothyroidism, substance abuse and normal reactions to life events such as bereavement produce depressive symptoms. Conversely, patients with depression may be missed because they present with somatic symptoms e.g. tiredness or lack of energy, loss of appetite, or general aches and pains (commoner in older patients). Patients with chronic physical illness are more at risk of depression, and the relationship is complex as many of the symptoms can be attributed either to mood or the underlying condition –for example tiredness in COPD. Sometimes the mood disorder is missed if the physical presentations appear more pressing. Then not all patients or cultures view their symptoms in the same way. What is important is not the exact meaning of symptoms but the doctor's sensitivity to the needs of the individual patient and their ability to understand distress and meaning in the patient's cultural context.

In depression or anxiety symptoms are significant if they are severe and/or persistent enough to be disabling e.g. cause significant distress or functional impairment.

Who is at risk of depression?[3]

- *Social problems* – e.g. recent unemployment or other significant life event.
- *Other psychiatric problems including substance misuse*.

- *Physical disorders* – e.g. diabetes, coronary heart disease.
- *Drugs that can cause symptoms of depression* – e.g. β blockers.

Screening questions

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

If the answer to either of these questions is yes, then a more detailed history is needed, and you also need to enquire if the patient wants help.

Assessment of depression

Preparing and Opening: It is worth thinking about the *process* as well as the *content.* How you introduce yourself, position your seats, and gain rapport will help you ask about *feelings* as well as *facts*.

Gathering information: Content: Get a chronological account from patient. Precipitating events? Past history of psychiatric problems/chronic disease? Alcohol and/or substance misuse? Family history of psychiatric problems? Social problems? Level of support from friends/family/work/community?

Symptoms
Core Symptoms (one of these must be present for a diagnosis of depression)

1. Persistent low mood
2. Loss of interest/pleasure

If at least one of the core symptoms has been present most days for at least 2 weeks and is affecting the patient's life, then assess severity by asking about other associated symptoms:

3. Disturbed sleep
4. Fatigue
5. Change in appetite
6. Feelings of worthlessness/guilt/self-blame
7. Poor concentration
8. Psychomotor agitation/retardation
9. Suicidal thoughts/plans/acts

Atypical depression may present with reactive mood, weight gain, increased appetite and excessive sleepiness. In some cultures, there is no exact equivalent term for depression - they may present with unexplained/vague physical symptoms (somatisation).

Examination

You will learn a formal mental state examination in Psychiatry teaching. The patient's mental state is assessed by a systematic assessment of appearance, affect and behaviour and other domains as listed below. A GP will be observing these throughout the consultation:

- Appearance
- Attitude/rapport
- Behaviour
- Mood and affect. Mood is described using the patient's own words. Affect is described by labelling the apparent emotion conveyed by the person's nonverbal behaviours

- Speech
- Thought process
- Thought content/Perceptions
- Cognition
- Insight and judgment

For example, patients may display thought distortions such as exaggeration/catastrophising where everything seems difficult and difficulties turn into a disaster. Saying something that upset a friend is perceived as the friendship being over and ending up with no friends. Or overgeneralisations where broad statements that emphasise the negative "no-one likes me." Ignoring the positive, jumping to conclusions, all or nothing thinking (if it's not perfect it's a failure). Labelling e.g. I'm a bad mother, and personalising—assuming responsibility for things that aren't under their control.

Assessing severity

- DSM IV assesses the number of symptoms as listed above so that sub threshold depression has fewer than 5 symptoms. If these symptoms persist NICE guidelines[4] recognise the distress this can cause and recommend treatment. Severe depression has most of the 9 symptoms (including one of the core symptoms) where the symptoms markedly interfere with functioning. Severe depression can occur with or without psychotic symptoms. Depressive symptoms lasting 2 years or more is chronic depression.
- In the UK, a self-completed questionnaire can be used to assess severity, the **PHQ-9**[5]
- If a diagnosis of depression is made, GPs may record a **biopsychosocial** assessment at the time of diagnosis.

Biopsychosocial assessment
This includes: Current symptoms including duration and severity Personal history of depression Family history of mental illness. The quality of interpersonal relationships with, for example, partner, children and/or parents. Social aspects including living conditions, social support, employment and/or financial worries Current or previous alcohol and substance use Suicidal thoughts and risk of self-harm –past, current. Past experience of, and response to, treatments

Assessing risk

Risk to self and others, or from others can take many forms but is important to explore. You will learn more about risk from others later in the course but open questions about the home situation or relationships may raise this issue. Risk to self can be self-neglect, substance abuse or active physical harm to the self.

- It can be daunting to ask about suicidal ideas and plans but most people with depression feel relieved to talk about them. We can normalise and start with open, general questions then focus in; "People who feel like you do sometimes experience thoughts of harming themselves or ending their life, have you ever felt like that?" or start by asking about past

thoughts, plans or actions before asking about current ideation. Has anything happened recently to make them feel like this? Are these feelings ongoing?

If self-harm or concern about risk to self or others, assess and escalate appropriately. Most areas have a "crisis team" that can assess patients urgently or A&E.

We don't expect Year 2 students to be able to do a comprehensive risk assessment at this stage in their training, but they should be aware of what to ask, practice phrasing questions and when to escalate concerns. Risk is increased by clear and detailed plans, and social isolation or lack of protective factors, and risk factors: male, increasing age, divorced>widowed>never married>married, profession (vets, pharmacists, farmers, doctors), admission/recent discharge from psychiatric hospital, social isolation, history of DSH, depression, substance misuse, personality disorder, schizophrenia, serious medical illness (e.g. cancer). Also, psychiatric state increases risk of suicide: hopelessness, concrete thinking in depression, agitation, early schizophrenia with retained insight (especially young patients), delusions of control/poverty/guilt.

Management of depression: Stepped-care model

In Year Two you do not need to know details of managing depression but it usual to be aware of the range of options for treatment, and the existence of the "stepped care model". This means that in all known and suspected presentations of depression (Step one) patients should be assessed, and offered support, psycho- education, active monitoring plus or minus referral for further assessment and interventions, then the treatment is "stepped up" tailored to the severity of depression.

Non-drug treatments

- *Counselling* – In isolation, this is not a NICE approved intervention but, is the most easily available resource in primary care. Local access varies and some practices have in house services. Involves reflective listening, encouraging the patient to think about and then try to resolve their own difficulties. Usually brief/time-limited. Specific services may be appropriate e.g. RELATE (relationship difficulties) or CRUSE (bereavement).
- GP's can advise lifestyle change tailored to individuals for example establishing routines, eating well, exercise, and sleep hygiene: establishing regular sleep and wake times, avoiding excess eating, smoking or drinking alcohol before sleep, creating a proper environment for sleep, taking regular physical exercise. Some schemes exist that GP's can refer patients for e.g. exercise on prescription.
- *Problem solving*–Can be effective for mild to moderate depression. Write a list of problems (can be therapeutic). Rank the problems in order of importance and think about solutions for the most important problems first.
- *Therapies:* There is a range of different therapeutic approaches, not covered here. Easily accessible on the NHS with a good evidence base for mild to moderate depression is *Cognitive behavioural therapy* which looks at the way a person thinks and reacts. This may involve systematic desensitisation (behavioural method) or focussing on people's thoughts and reasoning to challenge assumptions and address negative thoughts. Self-help programmes in books, online (e.g. Beating the Blues) or over the phone are available. Can be accessed through the NHS via community mental health providers e.g. "Bristol Wellbeing service".

Questioning negative thoughts: a process and technique that can be learned.
Questions patients might find helpful:

What is the evidence that my thought is true?
Is there an alternative explanation for what happened?
What's the worst that could happen, and how could I handle it?
What would I tell a friend in my position?
What is the effect of my believing this negative thought? How would I think about it more realistically?
What should I do now?

Drug treatments

Several different antidepressants exist. Commonly used (in most circumstances the first line) are Selective Serotonin Reuptake Inhibitors, SSRI's (See BNF). Drugs will not solve all the patient's problems but recommended for those with severe depression or in mild to moderate depression not responding to initial interventions, patient preference and those with persistent "sub threshold depression." Patients should be advised that it is likely to be a few weeks before they feel any benefit and advised about side effects. Some adverse effects such as gastrointestinal upset or increase in anxiety are often temporary, an increase in symptoms such as anxiety and even suicidal ideation can occur initially and patients should be warned about this and seeking help. Medication can, and often is, used alongside therapy.

Anxiety

There are several anxiety disorders including panic disorder, social phobia and agoraphobia, the most prevalent is Generalised Anxiety Disorder (GAD) which may occur with or without episodes of panic. In Autism or Obsessive-Compulsive Disorder anxiety may be a key presenting feature.
DSM5 definition of generalised anxiety disorder

- Excessive anxiety and worry occurring more than not for at least 6 months and in different situations e.g. work or school performance.
- The person finds it difficult to control the worry
- Associated with three or more of the following six symptoms (more days than not for 6 months)
    - Restlessness or feeling keyed up or on edge
    - Easily fatigued
    - Difficulty concentrating or mind going blank
    - Irritability
    - Muscle tension
    - Sleep disturbance
- The anxiety, worry or physical symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning
- The disturbance is not due to the direct physiological effects of a substance or medical condition e.g. hyperthyroidism

Combined depression and anxiety

Combinations of anxiety and depression are common. This can lead to increased functional impairment and often becomes more chronic with poorer response to treatments. The general rule is to treat the predominating feature, but therapy such as CBT and medication such as SSRIs are

indicated for both. The Hospital Anxiety and Depression score (HADs) can be used to help decide on the prominent feature.

When do you refer to secondary care?

- Routine – Poor or incomplete response to 2 interventions, recurrent episode within a year, patient or relative request, self-neglect.
- Urgent – Suicidal thoughts but with protective factors, diagnosis not clear? Mild psychotic or manic features.
- Same day – Actively suicidal ideas and plans, psychotic symptoms, severe agitation accompanying severe symptoms, severe self-neglect.

In reality, when to refer comes from experience. It is mainly based around risk assessment and what services there are available to refer to. Safety netting is key, with a clear care plan, appropriate contact numbers and contract agreed with the patient.

References:

1. Simon C, Everitt H, van Dorp F, Burkes M. **Oxford Handbook of General Practice. 4rd Ed.** Oxford: Oxford University Press; 2014.
2. Blythe A, Buchan J. **Essential Primary Care**: John Wiley & Sons Ltd; 2017
3. NICE: Depression in adults with a chronic physical problem: recognition and management. https://www.nice.org.uk/guidance/CG91 (Accessed Feb 2019).
4. NICE: Depression in adults: recognition and management of depression in adults www.nice.org.uk/CG90 (Accessed Feb 2019)
5. PHQ – 9 www.patient.co.uk/doctor/Patient-Health-Questionnaire-(PHQ-9).htm

Patient resources

http://www.nhs.uk/conditions/online-mental-health-services/Pages/introduction.aspx - NHS online resources for supporting patients with mental health problems
www.beatingtheblues.co.uk – online CBT programme (payment required)
www.samaritans.org – patient support (24 hours) and information
www.sane.org.uk – leading UK mental health charity
www.rcpsych.ac.uk/mentalhealthinfoforall/problems/depression/depression.aspx
www.moodgym.anu.edu.au – online CBT - need to register to use
www.llttf.com (living life to the full) – online CBT- need to register to use
https://www.moodjuice.scot.nhs.uk/sleepproblems.asp self-help for sleep problems:
https://www.sleepcouncil.org.uk/wp-content/uploads/2013/01/Get-a-Good-Nights-Sleep.pdf the sleep councils' downloadable booklet

Case Based Learning overview for Low Mood Year Two: FYI ONLY.

Case-Based Learning Cases in Low Mood

A third-year veterinary student who feels tired, "stressed out" and low in mood. Anxious about exams in 2 weeks and struggling to study as she feels tired and unhappy which makes it difficult to get motivated. She has some panic symptoms. Her symptoms have gradually worsened over the past month. She has not harmed herself or had suicidal thoughts.

She isn't as hungry as usual and so doesn't eat as much, but she is not aware of any change in weight. This is not something she measures regularly. Olivia often stays up until 2am studying and then still sometimes has difficulty getting to sleep. She wakes at 7.30am. She has started drinking a small glass of wine before bed as she thinks it will help her sleep. She has not noticed any change in bowel habit and she has regular periods.
She takes the combined oral contraceptive pill. She drinks around 14 units per week. She does not use illegal drugs and is a non-smoker. She lives with three other students, who she gets on well with. She is not in a relationship. Olivia's family live in London. Her parents are supportive, and she gets on with her elder sister but feels a lot of pressure to do as well as her sister.
Olivia has a family history of bowel cancer (mother), thyroid disease (mother and aunt) and depression (father). She has an uncle with OCD. Her grandfather, to whom she was very close, died following an MI last year at the age of 78. There is no other family history of note.
Olivia believes she may have hypothyroidism and is also worried that she may have cancer. She has been taking multi vitamin supplements as she thought they may boost her thyroid function. She started taking St John's Wort one week ago and is on the oral contraceptive pill.
Olivia is keen to get help with her symptoms. She is looking forward to getting back to normal and is very keen to continue her studies.
Four weeks later. She has passed her exams and yet feels worse in her mood and energy levels. Olivia feels low every day, particularly in the mornings and she often doesn't want to get up, despite now waking much earlier than usual (4am). Having woken she lies in bed ruminating about all the bad things in her life. PHQ-9 is 19. GP discusses diagnosis of depression and treatment options including:

- SSRI treatment, intended benefits and side effects.
- CBT for depression

Olivia seems uncertain about receiving treatment for depression and what impact a diagnosis of depression might have on her ability to practice as a Vet. She decides to take SSRI and see the mental health nurse at the practice. She speaks to her family and discovers that her father had an episode of severe depression and had previously taken an overdose, he was discharged to the crisis team then treated by the community mental health team with antidepressants and CBT.
Facilitator questions:

- ***What are the possible diagnoses?***
- ***Is her worry normal?***
- ***How do we differentiate between normal and pathological anxiety?***
- ***What symptoms would allow you to rule in / out these diagnoses?***
- ***What investigations would you like to do, why?***
- ***What is the difference between normal sadness and depression?***
- ***How do you seek help for mental health problems?***
- ***What should you do if you are concerned about a friend's mental health?***

- ***Do mental illnesses have a genetic component?***
- ***What predisposes to anxiety or depression?***
- ***What is the relationship between mental and physical ill health?***
- ***What are the physiological effects of stress?***
- ***What impact does stress have on working memory?***
- ***What is the neuroscientific basis of sadness?***
- ***What self - care strategies are there to promote wellbeing?***
- ***What is the relationship between sleep and mood?***
- ***What impact does alcohol have on sleep and mood?***
- ***What are the diagnostic signs and symptoms associated with depression?***
- ***What is a serotonin selective reuptake inhibitor and how does it work?***
- ***What is CBT and how does it work?***
- ***What is the neurobiology of depression?***
- ***What signs might you expect Olivia to show on mental state exam?***
- ***What is the impact of stigma on people experiencing mental illness?***
- ***Why might Olivia be concerned about seeing help?***
- ***What impact to early life experiences have on future mental health?***
- ***Why do people engage in behaviour which results in harm to themselves?***
- ***What are the expectations upon professional students with regards to managing their mental and physical health?***
- ***What professionals did you meet who are involved in the treatment of people with mental health problems? What were their roles? How did this compare between primary and secondary mental health care?***
- ***What non-statutory services are available for people with depression?***
- ***What factors might determine whether someone is treated in primary or secondary care?***
- ***What can you do if you are concerned about someone's mental state, but they do not want to seek help? As a friend? As a professional?***

Lectures and practicals:

- Setting the scene: Introduction to mental illness
- What are thoughts and feelings made of?
- The mind/brain/body conundrum.
- Symptoms and diagnosis
- What makes you, you? Personality and personality disorder
- Sleep and self-care
- Psychopharmacology in depression
- Psychotherapy in depression
- The inter-relationships between physical and mental illness
- Guest lecture: Not all in the mind: the contribution of basic science to modern psychiatry
- Cross-disciplinary session. Mental Capacity Act, Mental Health Act and Ethics
- Cross-disciplinary session 2: Enhancing health
- Applied anatomy and Imaging: Functional Neuroanatomy
- Mental state, risk and rating scales small group work
- Attachment and bias workshop