Primary Care support for Neuropsychiatric Conditions

Dr Greg Rogers
Starting point –

What is the popular view of General Practice?
More recently..?

http://vimeo.com/52378982
How do Neuropsychiatrists view GP’s

http://www.youtube.com/watch?feature=player_detailpage&v=hm_fld6bD84
ICD10 version 2010: Chapter V Mental and behavioural disorders (F00-F99)

- F00-F09 Organic, including symptomatic, mental disorders
- F10-F19 Mental and behavioural disorders due to psychoactive substance use
- F20-F29 Schizophrenia, schizotypal, and delusional disorders
- F30-F39 Mood [affective] disorders
- F40-F48 Neurotic, stress-related, and somatoform disorders
- F50-F59 Behavioural syndromes associated with physiological disturbances and symptoms due to psychoactive substance use
- F60-F69 Disorders of adult personality and behaviour
- F70-F79 Mental retardation
- F80-F89 Disorders of psychological development
- F90-F98 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence
- F99-F99 Unspecified mental disorder

"we are not afforded to say – ‘that is not my area’ – in a sense as a generalist everything is our area"
Neurocognitive disorders—dementias and mild cognitive impairment
Drug-induced movement disorders,
Tourette’s syndrome,
Psychiatric disorders associated with movement disorders such as Parkinson’s disease and dystonia,
Psychiatric disorders associated with epilepsy,
Psychiatric disorders cerebrovascular disease,
Psychiatric disorders head injury,
Chronic fatigue syndrome and other psychoneuroimmunological disorders,
Attention deficit hyperactivity disorder,
Conditions in which cognitive, behavioral, or affective disturbance results directly from brain insult.

Some neuropsychiatrists claim schizophrenia, bipolar disorder, melancholic depression, and obsessive compulsive disorder, these disorders remain the province of general psychiatrists with perhaps some input from neuropsychiatrists in the management of resistant cases with novel treatment techniques such as transcranial magnetic stimulation, vagus nerve stimulation, deep brain stimulation, leukotomy, and in the future, genetic and stem cell therapies.
What GPs currently do - QOF

<table>
<thead>
<tr>
<th>Dementia</th>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>DEM001</td>
<td>The contractor establishes and maintains a register of patients diagnosed with dementia</td>
<td>Minor wording change</td>
<td>5</td>
</tr>
<tr>
<td>DEM002</td>
<td>The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months</td>
<td>Minor wording change</td>
<td>15</td>
</tr>
<tr>
<td>DEM003</td>
<td>The percentage of patients with a new diagnosis of dementia recorded in the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12, and folate levels recorded between 6 months before or after entering on to the register</td>
<td>Minor wording change</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

http://www.eguidelines.co.uk/eguidelinesmain/external_guidelines/qof.php
## What GPs currently do - DES

### Depression

<table>
<thead>
<tr>
<th>No.</th>
<th>Indicator</th>
<th>Amendments</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEP001</td>
<td>The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have had a bio-psychosocial assessment by the point of diagnosis. The completion of the assessment is to be recorded on the same day as the diagnosis is recorded</td>
<td>Replacing DEP6</td>
<td>21</td>
</tr>
<tr>
<td>DEP002</td>
<td>The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 35 days after the date of diagnosis</td>
<td>Replacing DEP7</td>
<td>10</td>
</tr>
</tbody>
</table>

**Total points** 31

<table>
<thead>
<tr>
<th>No.</th>
<th>Indicator</th>
<th>Amendments</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH001</td>
<td>The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy</td>
<td>Minor wording change</td>
<td>4</td>
</tr>
<tr>
<td>MH002</td>
<td>The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record (in the preceding 12 months), agreed between individuals, their family and/or carers as appropriate</td>
<td>Minor wording change, Threshold change</td>
<td>6</td>
</tr>
<tr>
<td>MH003</td>
<td>The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months</td>
<td>Minor wording change, 15–12 month change</td>
<td>4</td>
</tr>
<tr>
<td>MH004</td>
<td>The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 12 months</td>
<td>Minor wording change, 15–12 month change</td>
<td>5</td>
</tr>
<tr>
<td>MH005</td>
<td>The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months</td>
<td>Minor wording change, 15–12 month change</td>
<td>5</td>
</tr>
</tbody>
</table>
### Mental Health continued

<table>
<thead>
<tr>
<th>MH006</th>
<th>The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months</th>
<th>Minor wording change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>15–12 month change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td></td>
<td><strong>Total points</strong></td>
<td><strong>40</strong></td>
</tr>
<tr>
<td>MH007</td>
<td>The percentage of patients with schizophrenia, bipolar affective disorder, and other psychoses who have a record of alcohol consumption in the preceding 12 months</td>
<td>Minor wording change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15–12 month change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>MH008</td>
<td>The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder, and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years</td>
<td>Minor wording change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15–12 month change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>MH009</td>
<td>The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months</td>
<td>No change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>MH010</td>
<td>The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the preceding 4 months</td>
<td>No change</td>
</tr>
<tr>
<td></td>
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<td>2</td>
</tr>
</tbody>
</table>

## Learning Disability

<table>
<thead>
<tr>
<th>Learning disability (LD)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator</strong></td>
</tr>
<tr>
<td>The contractor establishes and maintains a register of patients aged 18 or over with learning disabilities</td>
</tr>
<tr>
<td>The percentage of patients on the learning disability register with Down’s syndrome aged 18 or over who have a record of blood TSH in the preceding 12 months (excluding those who are on the thyroid disease register)</td>
</tr>
</tbody>
</table>

**Total points**: 7

http://www.eguidelines.co.uk/eguidelinesmain/external_guidelines/qof.php
What GPs currently do – Directed Enhanced Services

‘DES’

Learning Disability

‘This DES is designed to encourage practices to identify patients aged 18 and over with the most complex needs and offer them an annual health check. Local authority (LA) lists of people known to social services primarily because of their learning disabilities, are to be used as the basis for identifying patients to be offered the checks. The rationale is to target people with the most complex needs and therefore at highest risk from undetected health conditions (usually people with moderate to severe learning disabilities).’

‘240,000 patients fall into this category across the country’

Assessment of at-risk patients who may be showing early signs of dementia. This will be undertaken through an initial enquiry followed by a specific test. There will also be a focus on prompt diagnosis of patients with the condition so that they can be brought into the care pathway earlier. The scope of at-risk patients will be refined during the consultation to be carried out by the NHS Commissioning Board.
A risk profiling scheme to anticipate the needs of physically and mentally vulnerable patients – practices doing this work must coordinate and manage the care of frail older people and other high-risk patients (including patients with mental ill health) predicted to be at significant risk of unscheduled hospital admission. This might require regular risk profiling by practices to identify patients most at risk and have a multidisciplinary approach to case management for a proportion of patients identified. The proportion of patients supported in each practice will be agreed locally in conjunction with the clinical commissioning group.
Holistic care
What else could we do

Joint clinics with LD team

Thanet pilot

- LD DES jointly performed between LD team and GPs
- Early dementia DES joint working – DSQIID incl score sheet

From this;

Signposting clinic for social activities and employment for people with Learning Difficulties

Identifying people with fatigued/elderly carers

Identifying people hitherto not identified as having LD or aspersers' disease
GPs with Extended role

Learning Disabilities
Help manage LD Consultants large caseload – different from LD nurses [mind set of diagnosing and investigations and prescribing.]

Mental Health
Supporting memory clinics prescribing of acetylcholinesterase (AChE) inhibitors
General community clinics
Conversion Disorder F44.

- Some conversion reactions are transient, whereas others are very persistent (Ford & Folks, 1985).

- There is evidence that even chronic conversion symptoms can resolve spontaneously but resolution may be helped by insight-oriented, supportive or behavioural therapy (Lazare, 1981).
Symptoms that can occur with somatisation disorder

- Abdominal pain
- Amnesia
- Back pain
- Bloating
- Chest pain
- Diarrhoea
- Difficulty swallowing
- Pain during urination
- Shortness of breath
- Vision changes
- Non epileptic seizures
- Painful menstruation
- Pain in the legs or arms
- Palpitations
- Paralysis or muscle weakness
- Sexual activity
- Dizziness
- Headaches
- Impotence
- Joint pain
- Nausea and sometimes vomiting
- Pain during intercourse

Can Primary Care be equipped to help this group of people? If so how can it be achieved?
Epilepsy

- RCGP Clinical Priority April 2013 – 2016
- Clinical and holistic support for people with epilepsy
- Joint working with Neuropsychiatry?
  - GP level
  - At GPwSI in Epilepsy level

- Is it needed? If so how can it be promoted?
Dementia and Epilepsy

• It is estimated that the number of people aged 65 and older will double between 2010 and 2050. A fourfold increase is expected in the number of persons over the age of 85.

• Older adults with cerebrovascular disease, dementia, and traumatic brain injury appear to account for the largest percentage of cases with subsequent new-onset epilepsy.

• Epilepsy should be suspected in the elderly with loss or impairment of consciousness, episodic confusion, transient behavioral change, or unresponsiveness not associated with loss of postural control. Twitching, involuntary movement, or sensory disturbance of a limb, limbs, or face without loss of consciousness is another clue to the diagnosis of epilepsy. Frequent falls with amnesia without any head trauma should alert clinicians to the possibility that the patient has epilepsy.
Epilepsy and the effect of the age

- The incidence of a first seizure in those aged 40–59 years is 50–60 per 100,000 people, rising in those aged over 65 years to 136 per 100,000.
- The overall annual incidence of epilepsy is 85.9 per 100,000 people in those aged 65–69 years, and 135 per 100,000 people in those aged over 80yrs.
- The prevalence of active epilepsy in the elderly population is up to 1.5%, but among nursing home residents may exceed 5%.
- Stroke is the leading cause of new-onset epilepsy beyond 65 years of age, accounting for 50–75% of epilepsy cases where a cause can be identified.
- Alzheimer’s disease, other dementias and other neurodegenerative disorders may account for 10–20% of all epilepsy in older people.

- Can Primary Care help to detect and support this group?

Ann Johnson and Phil Smith Epilepsy in the elderly , Expert review of neurotherapeutics 2010 Volume: 10
Feedback

- Areas of agreement and disagreement?

- Are there any next steps?

- Any suggestions to put to the RCGP with regard to epilepsy care?