Screening for anxiety and depression in patients with chronic pain in the North East of Scotland

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Background

Patients with chronic pain often have symptoms of anxiety and depression, which can impact on pain perception, level of function, quality of life and utilisation of heath care resources. The presence of these symptoms in patients with chronic pain thought to be high, but the prevalence in the North East of Scotland population is unknown. Appropriate assessment and treatment of affective symptoms has been shown to improve outcomes in chronic pain, and may require input from a specialist mental health practitioner.

Methods

One hundred new attenders to the Aberdeen chronic pain clinic were assessed using the Hospital Anxiety and Depression Scale (HADS), a questionnaire that assesses self-reported symptoms of anxiety (HADS-A) and depression (HADS-D) (Figure 1)$^2$.

Each question is rated 0-3 and a score out of 21 in each is generated. A score ≥8 is predictive of anxiety and depression$^5$ (Table 1) and the absolute score allows grading of the severity of the symptoms$^6$ (Table 2). Clinical notes were reviewed to assess previous or current mental health diagnoses and treatment.

Table 1

<table>
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<tr>
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<th>Sensitivity</th>
<th>Specificity</th>
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<tbody>
<tr>
<td>HADS-A</td>
<td>78%</td>
<td>90%</td>
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<tr>
<td>HADS-D</td>
<td>79%</td>
<td>83%</td>
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Results

83 patients met criteria for anxiety or depression, 54 of whom fulfilled both criteria (Figure 2). The median age was 55. The female to male ratio was approximately 2:1 and median HADS score was 10 (Figure 3). 73 met anxiety and 64 depression criteria. 17 met criteria for severe anxiety or depression (Figure 4). 30 patients had a previous history of anxiety and/or depression and were on treatment. 53 patients had no previous psychiatric history and were on no treatment (Figure 5). No patients were referred from the clinic to their general practitioner or mental health practitioner for consideration of therapy.

Discussion

The majority of patients met HADS criteria, with the rate in this population appearing higher than that reported by the National Pain Audit$^7$. However, HADS is not a diagnostic tool$^7$ and symptoms of affective disorders can overlap with other conditions, for example personality disorders, or be secondary to other stressors.

Given the potential numbers involved, it would seem impractical to refer all HADS positive patients to primary care or secondary care mental health services, and indeed some patients may reject a psychiatric cause for their symptoms.

Hence, treatment of affective symptoms is likely to be most effective when embedded within the chronic pain service$^3$ with pragmatic psychological interventions tailored to chronic pain, delivered by a mental health practitioner who can refer onwards as necessary. HADS may be a useful tool in identifying who would benefit from this approach$^7$, but it would require adequate resource allocation to the chronic pain team and increased multidisciplinary working.

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