

## Addressing All Axes: Holistic Patient Assessment

Most clinicians often question how they can improve the clinical care of their patients, and many default to a search for a new medicine or a new surgical procedure. Perhaps as trained surgeons, our mindset is inclined to mechanical solutions. This editorial gives me an opportunity to share with you a recent development at my orofacial pain service at King's College London that has revolutionized my patient care.

The psychologic burden of chronic pain is recognized. Dansie and Turk (2013)<sup>1</sup> highlight that:

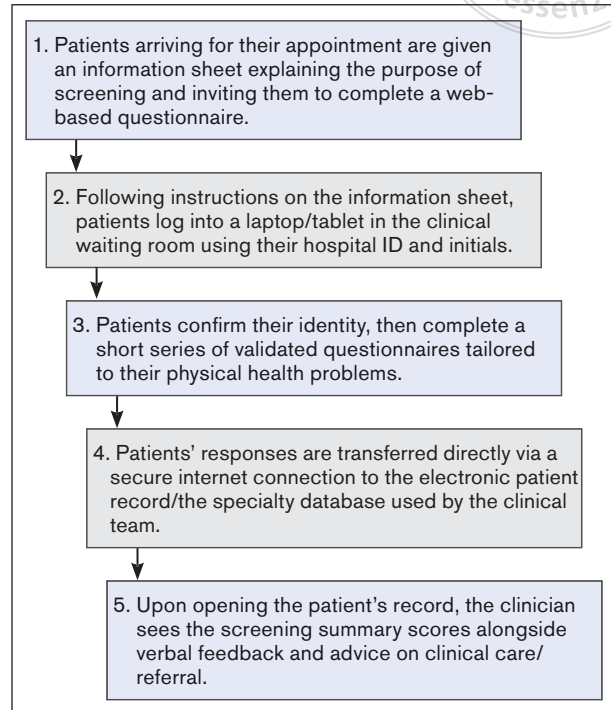
*Given the multidimensional nature of chronic pain, efficacious assessment, and treatment requires a comprehensive, multi-axial approach. Traditional biomedical approaches can be effective only as a starting point for assessment and should be accompanied by interviewing and standardized assessment tools to uncover the potential social, emotional, cognitive, environmental, and behavioural factors that shape the chronic pain experience. Successful treatment of patients with chronic pain can only be accomplished if our assessment efforts focus on the entire person, not just the organic pathology.*

In addition, many studies highlight the significant psychosocial burden of patients with chronic orofacial pain, most focusing on temporomandibular disorders<sup>2</sup> and conditions associated with neuropathic pain, such as posttraumatic trigeminal neuropathy and trigeminal neuralgia.<sup>3-6</sup>

A holistic approach to the assessment of a patient in pain is essential but often overlooked. These factors may have a bearing on the development and persistence of pain, as well as the response to treatment.<sup>7</sup> The majority of readers will be more than familiar with the holistic approach. So the question arises: How do we build Axis II assessment seamlessly into our clinical practices?

Integrating mental and physical health care research, training, and service (IMPARTS) was an initiative funded by King's Health Partners (KHP) at Guy's, St Thomas', and King's College Hospitals. The aim was to pioneer a new model of service delivery that facilitates "whole person care" and promotes research as a natural outgrowth of patient care.

A key strategic goal of KHP, where we are based, is to ensure that mental and physical health services work collaboratively to treat the whole person in order to provide high-quality psychologic care to patients presenting in medical settings. Physical illness is



**Fig 1** The Informatics System. We have developed a web-based screening interface that captures patient-reported outcomes in the course of routine clinical practice. The data collected feed into the patient's electronic health record, and issues that need to be addressed in the clinical consultation are flagged.

associated with much higher rates of depression and anxiety (15% to 40% in long-term conditions) and substance misuse and dependence (directly responsible for around 15% of accident and emergency attendances). These problems are common and lead to poorer physical health outcomes (increased disability, reduced compliance, increased mortality) and higher health services costs. Effective treatments exist, but mental health problems in medical patients are often silent and therefore missed by clinical teams. Developing better models of care for patients with comorbid mental/physical health problems is a key challenge in improving the performance of health care systems. Recent guidelines from the National Institute for Health and Care Excellence (NICE) recommend routine screening of patients with chronic physical illness alongside a strategy to provide care and follow-up to patients with probable mental disorder(s). The package has four components:

1. An informatics system that facilitates routine collection of patient-reported outcomes, with real-time feedback to guide clinical care (Fig 1)

2. Development of mental health care pathways for patients identified via the informatics system
3. Training in core mental health skills for physical health care teams alongside ongoing support and supervision from a mental health specialist
4. A portfolio of bespoke self-help materials tailored to specific patient groups

In addition, the IMPARTS informatics system is implemented alongside a care pathway to guide management of psychologic problems identified through screening. The IMPARTS team works with the physical health care team to develop a referral algorithm tailored to their specific clinical setting. Specifically, for our orofacial pain patients, we have aligned our psychologic screening with the DC/TMD to provide optimal comparisons between orofacial pain groups.

Our measurements include: the EuroQol-5D (every time); Generalized Anxiety Disorder-7 (every 2 months); Patient Health Questionnaire (PHQ)-9 (every 2 months); PHQ-15 (every 2 months); Brief Pain Inventory Orofacial (every 3 months); Impact of Event Scale-Revised (every 3 months); Smoking (every 12 months); and consent for contact (once only).

For patients with pain only, assessments include the previous measurements, as well as: Graded Chronic Pain Scale (3 months); Chronic Pain Sleep Inventory (3 months); Short-Form McGill Pain Questionnaire-2 (every 3 months); and mPAIN-DETECT (every 3 months).

All patients attending our orofacial pain clinic are given a tablet on which to complete their questionnaires, with support if required. The data are instantly uploaded to the patient's electronic patient record, and staff can screen through the Axis II results before the patient even enters the clinic. With ethical approval, anonymized data can be transferred to datasets for clinical, investigatory, and response-to-treatment factors, allowing for powerful data collection and analysis.

This system has revolutionized my patient care in that, for the first time in decades, I feel as though I am treating the whole patient. This system has also highlighted the significant Axis II issues that our patient cohort is experiencing and allows our team to provide appropriate support and care that would otherwise be overlooked.

It is my belief that this is the future for clinical teams: Axis II will be a routine part of assessment of all patients, no matter the clinical setting or specialty. I also believe that the general dentist, not just specialist clinicians, would benefit from a scaled-down version to enable practitioners to support their patients, better understand them, and identify those who may require additional support when considering complex elective care or those who need a referral.

Possible disadvantages may include additional team training and an increased need for accessible support (for example, clinical psychologists and liaison psychiatrists). However, the overall advantages of easy access for the patient and clinician to the Axis II psychosocial impact measures will benefit all and improve our patient care.

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