



## Resource Pack

**Promoting mental health, cultivating social inclusion  
and managing mental health problems in primary care**

**A guide to developing integrated services  
in line with the national service frameworks for mental health**

*A river, though,  
has SO many things to say  
that it is hard to know  
what it says to each of us*

*Norman Maclean, A River Runs Through It*

**Appendices, Acknowledgements,  
References and Further Reading**



## Information for PCO senior managers, mental health, clinical governance and education leads and PEC board members

Short-term interventions which aim to improve care only in the acute phase of mental disorder do not produce long-term benefit.

This is because most common mental disorders are relapsing, chronic conditions for most primary care patients. Interventions need to be designed to improve care over the long term and be sustained or repeated.

### The two most frequently used methods to improve primary mental health care in the UK are:

- Developing guidelines and protocols.
- Providing training to GPs, nurses and others in the primary care team.

There is excellent evidence that, while these are necessary and can improve skills, by themselves they are not sufficient to improve outcomes for patients (Lin & Katon 1998).

#### For example:

**A randomised controlled trial of 60 primary care practices in an English health district showed that an educational intervention designed to convey the current consensus on best practice for the care of depression, though well received, did not result in improvements in recovery from depression for patients (Thompson, Kinmoth et al 2000).**

Funding staff (for example a clinical governance co-ordinator) to develop and agree protocols and arrange training for primary care teams will not be sufficient to improve outcomes for patients.

So what does work?

### Education and guidelines/protocols that are linked to changes in service organisation and delivery can deliver improved outcomes for patients.

There is little point educating a practice team about the management of depression, if you do not attend to the practice processes and procedures that will allow active follow-up and structured, long-term management - similar to the primary care approach to asthma (see Action Plans) (Lin 1999).

### Examples of organisational change in primary care that have delivered improvements in patient outcome include:

- Follow up by a nurse of patients with depression at 2 and 8 weeks, using a written protocol. Sessions included assessment of daily routine and lifestyle, attitudes to treatment, education about depression and related problems, self help, local resources for social problems, drug treatment and side effects and their management. Nurses had general training and primary care experience only. Significant clinical benefit was shown in patients with major depressive disorder prescribed therapeutic doses of medication (Peveler, George et al 1999).
- A programme of systematic follow-up of patients on antidepressant treatment, that consisted of an introductory 5 minute telephone call from a nurse-manager, followed by two 10-15 minute telephone assessments at 8 and 16 weeks after the initial prescription, resulted in improved outcomes for patients (Simon et al 2000).

### The elements of a structured approach to common mental disorders are:

**Support of the individual (eg medication, individual therapy).**

+

**Support of the individual in his/her family monitored over time (eg home assessment by health visitors; relationship counselling).**

+

**Support of the individual in his/her community (eg signpost to help with debt, housing, employment, social support).**

### Key levers for improving outcomes for patients

The service changes needed to improve outcomes for patients require a different use of staff time and staff roles, which education and communication systems then need to support.

#### This means either:

- Reconfiguration of existing budgets.

or

- Use of new money.

### Important opportunities to provide incentives for organisational change include:

- PMS and other practice-based contract negotiations.
- Practice Development Plans, prioritising the provision of a structured approach to common mental disorders supported by:
  - Section 36 or GP development scheme monies.
  - Primary care development monies.
  - Mental health modernisation fund.
  - NSF mental health funds.
- Ensuring related training is included in Personal Development Plans.
- Use of protected learning time where possible.
- Links to local Health Improvement Programmes/Local Delivery plans
- Commissioning related training via Consortia or their successor organisations.
- Commissioning of Services by PCOs as this develops.
- Information from Clinical Effectiveness Bulletins etc.

Whilst all practice populations have significant mental health needs; some have considerably more than the average.

### Factors associated with higher than average levels of mental ill health:

#### Locality factors:

- Social deprivation.
- Homelessness - especially numbers of street homeless.
- Numbers of refugees.

### Individual practice factors:

(May result in increased number of patients with severe mental illness).

- Near to group homes for people with mental illness or shelters for people who are homeless or bail hostels.
- Near to a major rail terminus.
- One of more partner known to have an interest in psychiatry.

### NB: For information on how to assess health needs for mental health problems, see:

Improving Quality in Primary Health Care: a practical guide to the National Service Framework for Mental Health

L Gask, A Rogers, M Roland and D Morris.

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Murray C J L and Lopez A D (eds), 1996, "The Global Burden of Disease: a comprehensive assessment of mortality and disability from diseases, injuries and risk factors in 1990 and projected to 2020" Published by The Harvard School of Public Health on behalf of the WHO and the World Bank.

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## What is severe mental illness?

There have been a variety of definitions proposed over the years. Severe mental illness is defined in the National Service Framework as:

Presence of a mental disorder as designated by a mental health professional (psychiatrist, mental health nurse, clinical psychologist, occupational therapist or mental health social worker and either).

A score of 4 (very severe problem) on at least one, or a score of 3 (moderately severe problem) on at least two, of the HoNOS items 1-10 (excluding item 5 'physical illness or disability problems') during the previous 6 months or

There must have been significant level of service usage over the past five years as shown by:

- A total of six months in a psychiatric ward or day hospital or
- Three admissions to hospital or day hospital or
- Six months of psychiatric community care involving more than one worker or the perceived need for such care if unavailable or refused.

An appropriate definition of SMI, acceptable to all groups, needs to be agreed locally between professionals, users and carers.

HoNOS - the Health of the Nation Outcome Scale -

<http://www.rcpsych.ac.uk/cru/honoscales/index.htm>

may also be available from your local Community Mental Health Team.

## Key facts about Mental Health in Primary Care

**The mental health problems that are most common in primary care are:**

### Prevalence of mental disorders in primary care settings

Depression	10.4%
Anxiety disorders	10.1%
Sleep problems	6.5%
Alcohol misuse	6.0%
Chronic tiredness	5.4%
Unexplained physical symptoms	2.7%
Any mental disorder	24.0%
Two or more mental disorders	9.5%
Subthreshold problems	9.0%

These disorders have one thing in common - they cause suffering and can be harmful and disruptive to family life, social life and work. They often coexist with each other and with physical problems (Ustun et al 1998).

**Mental ill health is a major part of the workload of primary care** (Goldberg & Bridges 1987, Goldberg & Huxley 1992).

**“One quarter of routine GP consultations are for people with a mental health problem. Around 90% of mental health care is provided solely by primary care.”** (National Service Framework for Mental Health).

**Common mental health problems are associated with levels of disability similar to those associated with respiratory and cardiovascular disorders.**

Disability days/month is a measure of the number of days in the previous month the individuals were unable to carry out their usual activities, such as personal care, moving around, managing daily tasks, work and social relations (Murray & Lopez 1996, Investing in health, Oxford 1993, Ustun et al 1998).

## People with common mental health problems consult frequently.

A study that followed 100 people with depression and anxiety in general practice for eleven years found that:

- Mean consultation rates were 10.8 a year for the eleven years.
- Some patients consulted weekly for eleven years (Lloyd et al 1996).

Estimates from the US suggest that over 50% of people who attend their family physician frequently have a common mental health problem (Bowers, 1993).

## But it is not straight forward to identify them

Most patients with a well-defined mental disorder\*, present to primary care with a complaint usually associated with a physical condition (such as back pain, shortness of breath or dizziness).

**Frequency of reasons given by patient for visiting primary care surgery:**

Various types of physical pain	29.3%
Physical complaints	32.8%
Sleep/fatigue	6.9%
Psychological problems	5.3%
Other reasons (eg routine check-ups)	25.7%

\*Well defined mental disorders have been taken to include the following ICD10 conditions: alcohol dependence, harmful use of alcohol, depression, dysthymia, agoraphobia, generalised anxiety disorder, somatization disorder, neurasthenia and hypochondriasis (Ustun et al 1998).

**Where practitioners lack the interest, time or motivation to deal with mental health problems, it is usually possible for them to side-step mental health and focus on the accompanying physical problems.**

Assessing and managing mental health problems takes time. Time is in short supply in primary care and there are currently no incentives in the system for clinicians to spend extra time with patients.

**However, when the mental health needs of patients with “hidden psychiatric problems” are recognised and treated, health care expenditure may be reduced.**

**One recent UK study showed that, when GPs changed their way of dealing with patients who consulted them repeatedly with physical symptoms with no physical basis, there was:**

- **A 33% reduction in the cost of referrals outside the primary care team.**
- **A 29% reduction in the number of referrals outside the primary care team.**
- **A 15% reduction in health costs overall for the patients in the study.**
- **Improved social and physical functioning for patients.**
- **No change in patient satisfaction.**

The reduction in costs was caused by a reduction in referrals for investigations and treatment for possible physical disorders (Morriss et al 1998).

### QUESTIONNAIRES AND SCREENING TOOLS

A number of psychiatric questionnaires have been validated for use in general practice and can be used to screen patients for depression and anxiety and to assess severity. They also can be used to monitor response to treatment. In addition, it is possible to use some questionnaires as part of an audit process. The most widely used are the Goldberg General Health Questionnaire (GHQ) which comes in several versions, the Hospital Anxiety and Depression Scale (HAD Scale), the Edinburgh Postnatal Depression Scale (EPDS) and the Geriatric Depression Scale (GDS).

For information about the **HAD** and the **GHQ**, which are copyright, and to purchase copies in bulk, contact:

NFER-Nelson Publishing Co. Ltd, Darville House,  
2 Oxford Road East, Windsor, Berks SL4 1BU.

The **Edinburgh Postnatal Depression Scale (EPDS)** may be copied with appropriate acknowledgements. Please see:

Cox, J. and Holden, J. (1994) Perinatal Psychiatry: use and misuse of the Edinburgh Postnatal Depression Scale. London. Gaskell.

The **Geriatric Depression Scale (GDS)** is recommended by the Royal College of General Practitioners for use as part of the over-75 health check. It is reproduced in the Primary Mental Health Care Toolkit (Department of Health 1997). See also: Katona C, Freeling P, Hinchcliffe K et al (1995) Recognition and management of depression in late life in general practice: consensus statement. Primary Care Psychiatry. 1. 107-113.

The **Beck Depression Inventory** provides a means of assessing the severity of a depressive illness, and allows for measurement of change over time. It is mainly used by specialists. Information on its use in general practice is in:

France, R & Robson, M. (1986) Behaviour Therapy in Primary Care. Croom Helm. Kent.

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<http://www.radcliffe-oxford.com>

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Chambers R, Boath E & Wakely G (2001) *Mental Health Matters in Primary Care*. Abingdon. Radcliffe Medical Press.

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### Materials and resources from:

Depression Alliance:

<http://www.depressionalliance.org/Contents/amazon.htm>

Mental Health Foundation:

<http://www.mentalhealth.org.uk/page.cfm?pagecode=PBAL>

Mental Health Media: <http://www.mhmedia.com/about.html>

MIND: <http://www.mind.org.uk/shopping/shopping.asp>

mindOUT: [http://www.mindout.net/mo\\_sitemap.asp](http://www.mindout.net/mo_sitemap.asp)

Sainsbury Centre for Mental Health:

<http://www.scmh.org.uk/wbm23.ns4/WebLaunch/LaunchMe>

*Journal of Primary Care Mental Health*: Primhe's official organ.

Primary Care Mental Health and Education. [www.primhe.org](http://www.primhe.org)

*Journal of Child and Adolescent Mental Health in Primary Care* - Primhe.

*Journal of Mental Health Promotion* published by Pavilion.

[www.pavpub.com](http://www.pavpub.com)

Primary Care Mental Health is a new, peer-reviewed journal on research, education, development and delivery of mental health in primary care. The journal will publish the results of original research, innovative techniques and best practice, providing a multidisciplinary forum for professionals in health, social and voluntary care.

[http://www.radcliffe-oxford.com/journals/J14\\_Primary\\_Care\\_Mental\\_Health/default.htm](http://www.radcliffe-oxford.com/journals/J14_Primary_Care_Mental_Health/default.htm)

### Fiction, Autobiography and Films:

Anton Chekhov, 'The Black Monk', in *The Tales of Chekhov Vol 3: The Lady with the Dog and other stories*, Ecco, 1984 (first published in 1894)

William Shakespeare, *King Lear*, ca. 1605

Andrew Soloman, *The Noonday Demon: an atlas of depression*, Touchstone Books, 2002

Anne Deveson, *Tell me I'm here*, Penguin, 1998

Kay Redfield Jamieson, *Night Falls fast: Understanding Suicide*, Vintage Books, 2000  
Kay Redfield Jamieson, *An Unquiet Mind: a memoir of moods and madness*, Random House, 1997

Kay Redfield Jamieson, *Touched with Fire: manic depressive illness and the artistic temperament*, Touchstone Books, 1996

Janet Frame, *An Angel at my Table*, The Women's Press, 2002

C.P. Snow, *The Light and the Dark*, Scribner, 1961

William Styron, *Darkness Visible: a memoir of madness*, Vintage, 1990

William Carlos Williams, 'The Mental Hospital Garden', in ed. Robert Penn Warren, *Sixty Years of American Poetry*, Abram, 1996 (first published 1954)

Sylvia Plath, *The Bell Jar*, Bantam, 1981 (first published 1963)

### Films:

Girl, Interrupted (James Mangold, 1999)

A Beautiful Mind (Ron Howard, 2001)

Shine (Scott Hicks, 1997)

Vertigo (Alfred Hitchcock, 1958)

The Piano (Jane Campion, 1993)

Spellbound (Alfred Hitchcock, 1945)

As Good as it gets (James L. Brooks, 1997)

The Three Faces of Eve (Nunally Johnson, 1957)

The Hours (Stephen Daldry, 2002)

Frances (Graham Clifford, 1982)

The Madness of George 3rd (Nicholas Hytner, 1994)

Ordinary People (Robert Redford, 1980)

Groundhog Day (Harold Ramis, 1993)

Iris (Richard Eyre, 2001)

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