RC
GP Royal College of
General Practitioners

Care of People with Mental Health Problems

One in a series of curriculum statements produced by the Royal College of General Practitioners:

Contents

Acknowledgements

Key messages

- Depression is common in general practice:
    - general practitioners should be able to recognise depression and assess its severity
    - all depressed patients should be screened for suicidal intent.
- People with severe mental illness have a high prevalence of physical co-morbidity that should be looked for and treated by general practitioners.
- The skills to both recognise and manage somatisation will lead to considerable savings in patient suffering and healthcare costs.
- All physical illness has a psychological component; this should be taken into account in management plans.
- The continuous improvement of communication skills and patient-centred practice is likely to be the single most important factor in improving recognition and effective management of mental health problems.

Introduction

Mental health and mental health problems

Good mental health is important to everybody's daily functioning and relevant to patients' ability to be involved in the care provided by general practitioners (GPs). It is hard to define, but is more than the absence of mental illness and includes concepts such as self-efficacy, self-worth and empowerment.

The statement incorporates elements of mental health promotion of relevance to many consultations in general practice.

Rationale for this curriculum statement

Mental health problems in primary care are common. The range of mental health problems encountered by a GP is large, and includes for example: adjustment reactions (normal responses to external circumstances); short- or longer-term disability associated with symptoms of depression and anxiety (which can be defined psychiatrically with diagnoses such as depression, but can also be seen as socially constructed); and schizophrenia and bipolar disorder (with a clearer biological basis, more easily defined from symptoms, but also with significant social meaning and consequences). These can coexist with each other, and also with problems related to consumption of alcohol or drugs, and with problems resulting from difficult traits and personality types.

If we decide to take an approach to mental health problems based on conventional psychiatric classification, then the diagnostic patterns seen in Table 1 are likely to emerge in a typical general practice:

Table 1: Prevalence of psychiatric disorders seen in a typical general practice

Problem	Weekly prevalence per 1000 adults aged 16–64	Number of patients on GP list of 2000
Psychotic illness	4	5
Mixed anxiety and depression	92	116
Generalised anxiety	47	59
Depressive episode	28	35
All phobias	19	24
Obsessive compulsive disorder	12	15
Panic disorder	7	9
All neuroses	173	218
Drug dependence	42	53
Alcohol dependence	81	102

* Assuming 63% of GP list is aged 16–64

These figures represent the number of adults of working age in an 'average' practice that will have a mental health problem – however, it fails to represent the impact that it has on GP workload:

- 80% of all contacts in the NHS take place in primary care, which receives 20% of NHS resources
- 90% of people with mental health problems are cared for entirely within primary care, but use less than 10% of the total expenditure spent on mental health
- Around 30% of people who see their GP have a mental health component to their illness[1]
- It is estimated that the costs of this care is £898m and the cost of psychotropic drugs prescribed by primary care are calculated to be a further £754m.

Co-morbidity

The association between mental illness and physical ill-health is clear. Indeed many in the field would argue that making a distinction between physical ill-health and mental ill-health causes more problems than it solves. Much of a GP's work is concerned with mind-in-bodies – the psychological consequences of cancer, the neurobiological connections between depression and the immune system or the cardiovascular system, the nature of the simple headache.

Both schizophrenia and bipolar disorder are associated with a range of significant physical health disorders; standardised mortality rates for cardiovascular and respiratory disease are considerably raised, diabetes mellitus is about five times as common and alcohol and substance misuse is increased. These illnesses are the responsibility of primary care, which has an important role in reducing lifestyle-related risk factors. They form the evidence base of the Quality and Outcome Framework on mental health.

There are well-known associations between depression and particular physical health disorders; for this reason the National Institute for Health and Clinical Excellence (NICE) guidance[2] recommends screening specific groups of people with physical health disorders.[i]

Disability and social exclusion

The effect of mental illness on disability and social exclusion is also great:

- Three in 10 working-age people have sick leave in any one year due to mental illness amounting to 91 million lost working days
- About one million people claim sickness and disability benefits for mental health conditions[3]
    - less than 10% are in contact with specialist mental health services
    - the proportion returning to employment, after having been on Incapacity Benefit for 12 months or more, is less than 5%.

Providing care for people with mental health problems is therefore integral to the work of the GP, represents a significant workload and has implications for the public health of his or her practice population.

UK health priorities

Providing care for people with mental health problems and promoting mental health is a priority for the NHS in each of the four countries of the UK. A range of ideas has been influential in determining policy and practice.

The *National Service Framework for Mental Health*,[4] published in 1999 by the Department of Health, outlined the care that should be provided. It has formed the basis for most mental healthcare developments since then and made clear that the priority within mental health services should be the care provided for people with a severe and enduring mental illness.

Primary care is charged with providing care for 'common mental health problems' and contributing to health promotion, but there is a lack of clarity about who should lead on the care of those with chronic, complex and disabling non-psychotic problems. GPs require a good understanding of the healthcare needs of all these groups.

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[i] the evidence behind this recommendation is insubstantial at best

Other government bodies continue to influence the agenda. Guidelines on schizophrenia, depression, anxiety and deliberate self-harm from NICE are relevant to GPs (see Web resources section). Increasingly the evidence points to the relatively limited impact of medication and the need for a range of non-pharmaceutical interventions. The amendments to the 1983 Mental Health Act are also likely to significantly affect the way that GPs work in England and Wales, and how care for the most severely mentally ill is provided in the community. At the time of the writing this curriculum it is not yet clear whether the amendments will be enacted by Parliament. GPs in Scotland are subject to working according to the 2002 Mental Health (Scotland) Bill. All GPs need therefore to be aware that there may be significant differences in application of issues such as compulsion and risk management in relation to patients, their carers and families transitioning across the nations of the UK.

The Social Exclusion Unit's report on mental health[5] emphasises the role of discrimination, low expectations, unemployment and lack of community engagement as both cause and consequence of mental illness. It explores new ways of working with those in marginalised groups.

Others have cautioned against the exclusive use of psychiatric models and emphasised the potential harms as well as benefits both diagnosis and treatment can bring.[6] There is however a general consensus that mental ill-health can best be tackled by a full exchange of information, shared decision-making and valuing individuals' resilience, and by drawing upon the resources within individuals (self-help) and local communities, as well as health and social care. The RCGP has endorsed a position statement on mental health and inequalities that incorporates many of these ideas.[7]

The NHS Plan (2000)[8] introduced the concept of a new worker in primary care – the graduate mental health worker;[9] in addition many general practices now have input from a variety of specialists such as counsellors, mental health practitioners and psychologists. The core competences of the mental health workforce (see Appendix 2) include a section for primary care staff.[10] The framework of *The Ten Essential Shared Capabilities*[11] is based on:

- Ethical practice
- Knowledge of mental health and mental health services
- The process of care
- The application of care
- Specific interventions.

These capabilities are now used as the framework for mental health training of all members of the mental health workforce. These have helped inform the learning outcomes documented below.

More recently the new General Medical Services contract of 2004 introduced an aspect of the Quality and Outcome Framework related specifically to care for people with a severe and enduring mental illness.

In November 2004 the government started a pre-legislation scrutiny of the *Draft Mental Health Bill*.[12]

In December 2004 NICE published guidelines for the management of depression[2] and the management of anxiety[13] in primary and secondary care.

In Scotland, the Scottish Executive's Health Department launched *The National Programme for Improving Mental Health and Well-being* in October 2001. Working nationally and locally, it is described as a vital part of the Scottish Executive's commitment to improving health and achieving social justice. The National Programme works alongside other Scottish Executive departments and policies. These include those on health improvement, social justice and social inclusion, education and young people, arts and culture, enterprise, and life-long learning.

Its vision is 'to improve the mental health and wellbeing of everyone living in Scotland and to improve the quality of life and social inclusion of people who experience mental health problems'.[14] It takes the lead on positive mental health and wellbeing improvement by shaping, funding and supporting a series of key initiatives and support partnerships that are focused on different aspects of improving Scotland's mental health. It is informed by four key aims:

- Raising awareness and promoting mental health and wellbeing
- Eliminating stigma and discrimination around mental ill-health

- Preventing suicide and supporting people bereaved by suicide
- Promoting and supporting recovery from mental health problems.

And six priority areas:
- Improving infant mental health (the early years)
- Improving the mental health of children and young people
- Improving mental health and wellbeing in employment and working life
- Improving mental health and wellbeing in later life
- Improving community mental health and wellbeing
- Improving the ability of public services to act in support of the promotion of mental health and the prevention of mental illness.

A review of mental health and learning disability was carried out in *Northern Ireland* in 2003. A number of important principles were outlined in this; partnership with users and carers, providing equity of access and provision of services, promotion of independence and self-esteem, and delivering continuity of care and support are some of these. As part of the development of *Investing for Health* a five-year strategy for promoting mental health was published in 2003.[15] The strategy's aims are to be met by an integrated partnership approach with the statutory, voluntary, community and business sector of Northern Ireland society, and are to:

- Improve people's mental health and emotional wellbeing, in particular that of people at risk or who are vulnerable, and people with identified mental health problems, their carers and families
- Prevent, or reduce the incidence of, mental and emotional distress, anxiety, mental health and suicide
- Raise awareness of the determinants of mental and emotional health at public, professional and policy-making levels, and reduce discrimination against people with mental health problems
- Ensure that all those with a contribution to make are knowledgeable, skilled and aware of effective practice in mental and emotional health promotion.

In *Wales* mental health has been made one of the Welsh Assembly Government's top three priorities. *The National Service Framework (NSF) for Working Adults* was published in May 2002, setting out the service standards for Wales.[16] The principal aim of the NSF was to drive up quality and reduce unacceptable variations in health and social services provision. It establishes the practical guidelines that will ensure consistent and comprehensive implementation of the strategy's vision across Wales. In June 2003, the Director of Mental Health, Phillip Chick, was asked to conduct a review on the adult Mental Health NSF. *The Revised Adult Mental Heath National Service Framework (NSF) and an Action Plan for Wales*[17] was published on World Mental Health Day, 10 October 2005. The key actions relate to the eight NSF standards that are:

Standard 1 – Social inclusion, health promotion and tackling stigma

Standard 2 – Service user and carer empowerment

Standard 3 – Promotion of opportunities for a normal pattern of daily life

Standard 4 – Providing equitable and accessible services

Standard 5 – Commissioning effective, comprehensive and responsive services

Standard 6 – Delivering effective, comprehensive and responsive services

Standard 7 – Effective client assessment and care pathways

Standard 8 – Ensuring a well-staffed, skilled and supported workforce.

The NSF focuses on adults of working age and covers public health challenges, health promotion and social inclusion, the needs of service users and carers, access to services and provision of comprehensive assessment and treatment. The document further includes a report on progressing the standards since the original NSF was published, a timetabled Mental Health Action Plan for Wales, national learning points arising from homicide external reviews and the review of medium secure provision and closes with an action plan timetable for the introduction of the Mental Health Bill.

Learning Outcomes

The following learning objectives relate specifically to mental health. This RCGP curriculum statement should be used in conjunction with the other curriculum statements, especially the *core* curriculum statement 1, *Being a General Practitioner*, and those covering *Care of People with Learning Disabilities* and *Clinical Management: drug and alcohol problems*.

There is a wide variety of different mental health problems that a GP is expected to treat; nevertheless there are some underlying principles of knowledge that a specialty registrar (GP) should be aware of for each of those conditions. In order to demonstrate the core competences in the area of mental health, the GP will require knowledge and skills and appropriate attitudes in the following areas:

Primary care management

- Manage people experiencing mental health problems in primary care, bearing in mind that several interventions may be effective for each mental health condition, including different forms of talking therapy, medication and self-help

- Describe specific interventions and guidelines for individual conditions, using where appropriate best practice as described in the Scottish Intercollegiate Guidelines Network (SIGN) or NICE guidelines.

- Describe the need to check for psychological illness whilst avoiding the habit of checking extensively for physical illness:
    - ideas about the physical, psychological and social should be integrated in both consultation and investigation of illness.

- Demonstrate how to screen, and diagnose, people experiencing mental health problems, using effective and reliable instruments where they are available.

- Describe the varied ways that young people who are developing a first episode of psychosis present.

- Describe how to access health and social care organisations, both voluntary and statutory, that are an essential component of managing people with mental health problems.

- Describe when it is appropriate to refer to and collaborate with the specialist mental health services (see Appendix 6).

- Describe early indicators of difficulty in the psychological wellbeing of children and young people
    - respond quickly to concerns raised by parents, family members, early-years workers, teachers and others who are in close contact with the child or young person
    - understand their responsibilities for supporting children in difficulty and know how to access support and advice from specialist Child and Adolescent Mental Health Services (CAMHS) and CAMH workers in primary care.

Person-centred care

- Describe how to engage with people experiencing mental health problems to be able to elicit a person's unedited story.
- Describe how to enable people experiencing mental health problems to fully engage in delineating their difficulties and deciding on appropriate interventions.
- Describe the special challenges of rapport-building with patients with mental health problems.[18]
- Describe the concept of concordance that is particularly important in mental health care:
  - be able to present individuals with choices as to which intervention may work best for themselves
  - understand that this ability to choose improves the effectiveness of the intervention.
- Describe the importance of continuity of care for people with mental health problems.
- Demonstrate gender-specific communication skills.

Specific problem-solving skills

- Describe the prevalence of mental health problems and needs amongst the practice population:
  - this may include the use of valid instruments, and the use of practice registers for specific conditions in association with recording data as part of the new General Medical Services contract.
- Describe how to screen and diagnose people experiencing mental health problems, using effective and reliable instruments where they are available:
  - have an awareness of people at risk for mental health problems (see Appendix 7)
  - be able to understand and appreciate the difference between depression and emotional distress
  - be able to identify mental health problems that are covert or somatised
  - be able to assess risk/suicidal ideation
  - be aware of issues about the effectiveness of screening, early identification, watchful waiting and stepped models of intervention.
- Describe how to deal with uncertainty that certain patients produce:
  - frequent attenders, patients who demand drugs, chronic suicidicity in borderline personality disorder.

A comprehensive approach

- Describe how to deal with the associated physical health problems of people with mental health problems.
- Describe how to screen and diagnose people with physical illness at risk of mental health problems.
- Describe the principles of mental health promotion (see Appendix 5).

Community orientation

- Describe the extent and implications of stigma and social exclusion.
- Describe how to challenge inequality.
- Demonstrate how to work in partnership with other agencies to secure appropriate social interventions for individuals.
- Describe how to work in partnership with other agencies to secure wider public health of the local population.
- Demonstrate the ability to contribute to the health improvement programme that reflects the perspective of the local population.
- Describe the importance of avoiding medicalising some mental distresses.
- Describe the ethical dilemma of the use of psychotropic drugs to sedate people for social reasons.

A holistic approach

- Describe the impact that social circumstances can have on mental illness and that recovery is contingent on the effective management of those social circumstances:

  - an understanding of the concept of recovery and the principles of promoting recovery (see Appendix 8).

- Understand that a model of mental illness that creates an artificial separation between mind and body is often unhelpful – particularly in understanding psychosomatic complaints, psychological consequences of physical illness and somatisation.

- Demonstrate an understanding that mental illness is culturally determined and depends on assumptions that may not be universal.

- Demonstrate cultural sensitivity.

Contextual aspects

- Demonstrate sufficient knowledge of the current Mental Health Act[ii] to undertake the responsibilities that this requires of GPs.

Attitudinal aspects

- Understand the major part that drug companies play in promoting use of psychotropic drugs.
- Understand that their own attitudes and feelings are important determinants of how they react to:

  - people who self-harm
  - people who misuse drugs or alcohol
  - people who know more about their illnesses than their doctors do
  - people who engender strong emotions in us for many reasons.

- Describe the importance of self-awareness issues for the doctor such as family of origin issues and personal prejudices.

- Understand the need for GPs to have personal management plans for how they manage their own mental health.

- Understand the need for reflective practice.

Scientific aspects

- Adopt a critical and research-based approach to practice; this is particularly important in mental health where evidence on effective treatment is often of poor quality.

- Recognise the use of value judgements in psychiatric diagnosis and understand the concept of a values-based approach to mental health.[19,20]

Psychomotor skills

- Mental state assessment.
- Suicide risk assessment.

The knowledge base

Symptoms:

- Tired all the time, insomnia, anxiety, depression, multiple somatic complaints, dizziness, palpitations, paraesthesiae, abdominal pain (children), early signs of possible psychotic illness.

[ii] a new bill is being scrutinised by parliament, and if enacted will place new responsibilities on GPs

Common and/or important conditions:

- The most common primary care mental health problems are depression, eating disorders and anxiety disorders. ADHD, post-traumatic stress disorder. Alcohol and drug misuse. (For a fuller list see Appendix 3.)

Investigation:

- Use of depression rating scales, and other aids in the evaluation of possible diagnosis and severity.

Treatment:

- Pharmacology, cognitive behavioural therapy (CBT) and simple behavioural techniques, problem-solving therapy and basis of systemic and strength-focused therapies, self-administered therapy.

Emergency care:

- Threatened or attempted suicide, delirium, psychosis, panic, aggressive or violent patients, drug overdose and alcohol withdrawal.

Resources:

- The family of the patient
- Members of the primary healthcare team, receptionist, counsellor, Citizens' Advice Bureau (CAB) worker
- Specialist mental health services and non-medical agencies (non-professional, lay or voluntary resources).
- When and how the Mental Health Act is used.

Prevention

- Mental health promotion, especially children, families and adolescents
- Screening of all language-delayed children for autism[iii]
- Early intervention in psychosis.

[iii] consider screening all language-delayed children for autism using the CHAT

Promoting Learning about Mental Health Problems

Work-based learning – in primary care

Primary care both inside and outside the practice is the ideal environment to learn about the care of people with mental health problems. Specialty registrars (GP) should take the opportunity to gain a better understanding of the practice's patients that are looked after in partnership with the specialist team. Attending clinic appointments with their patients will help the specialty registrar gain a better understanding of the patient's journey.

The specialty registrar should learn from patients and carers by offering health reviews and participating in their training practices' mental health activities They should take the opportunity to learn how to adopt a shared-care approach to primary care mental health with their community mental health teams and intermediate care mental health teams.

Teamwork learning resource

There is a toolkit specifically designed for primary care teams to evaluate the extent to which they and their practices promote mental health. It is available from d.p.c.tomson@ncl.ac.uk or maryanne.freer @pcpartners.org, or from NIMHE (www.nimhe.org.uk).

Work-based learning – in secondary care

Learn from community mental health teams about which patients are receiving shared care, and understanding their physical health needs. There should also be opportunities to learn from graduate mental health workers (and other primary care mental health service providers) which resources are available locally and how to create a local practice resource directory.

Teaching and Learning Resources

Examples of relevant texts and resources

ADDINGTON J, EL-GUEBALY N, CAMPBELL W, HODGINS DC, ADDINGTON D. Smoking cessation treatment for patients with schizophrenia *Am J Psychiatry* 1998; 155: 974–6

BRACELAND FJ, MEDUNA LJ, VAICHULIS JA. Delayed action of insulin on schizophrenia *Am J Psychiatry* 1945; 102: 108–10

BROWN S, BIRTWISTLE J, ROE L, THOMPSON C. The unhealthy lifestyle of people with schizophrenia *Psychol Med* 1999; 29: 697–701

BURNS T AND COHEN A. Item of service payments for general practitioner care of severely mentally ill patients: does the money matter? *Brit J Gen Pract* 1998; 48: 1415–16

CIVIDINI A, PISTORIO A, REGAZZETTI A, *et al.* Hepatitis C virus infection amongst institutionalized psychiatric patients: a regression analysis of risk *J Hepatol* 1997; 27: 455–63

COURNOS F AND MCKINNON K. HIV seroprevalence amongst people with severe mental illness in the United States: a critical review *Clin Psychol Rev* 1997; 17: 259–69

DAVIES T AND CRAIG T. *ABC of Mental Health (2nd edn)* London: BMJ Books, 2006

DOWRICK C. *Beyond Depression* Oxford: Oxford University Press, 2004

HARRIS EC AND BARRACLOUGH B. Excess mortality of mental disorder *Br J Psychiatry* 1998; 173: 11–53

HENDERSON DC. Atypical anti-psychotic induced diabetes mellitus: how strong is the evidence? *CNS Drugs* 2001; 16: 1–13

KENDLER KS AND EAVES LJ. Models for the joint effect of genotype and environment on liability to psychiatric illness *Am J Psychiatry* 1986; 143(3): 279–89

KENDRICK T, BURNS T, FREELING P. Randomised controlled trial of teaching general practitioners to carry out structured assessments of their long term mentally ill patients *BMJ* 1995; 311: 93–8

MONTGOMERY P AND DENNIS P. Cognitive behavioural interventions improve some sleep outcomes in older adults *Cochrane Database Systematic Review* CD003161, 2002

MORGAN K, DIXON S, TOMENY M, MATHERS N, THOMPSON J. *Psychological Treatment in the Regulation of Long Term Hypnotic Drug Use* London: NHS R&D National Co-ordinating Centre for Health Technology Assessment (NCCHTA), 2002

MUKHERJEE S, DECINA P, BOOLA V, *et al.* Diabetes mellitus in schizophrenic patients *Compr Psychiatry* 1996; 37: 68–73

NOLAN P AND BADGER F (eds). *Promoting Collaboration in Primary Mental Health Care* Cheltenham: Nelson Thornes, 2002

PHELAN M, STRADINS L, MORRISON S. Physical health of people with severe mental illness *BMJ* 2001; 22: 443–4

ROSENBERG SD, GOODMAN LA, OSHER FC, *et al.* Prevalence of HIV, hepatitis B, and hepatitis C in people with severe mental illness *Am J Public Health* 2001; 91: 31–7

ROTH A AND FONAGY P. *What Works for Whom? A critical review of psychotherapy research* London: Guilford Press, 1996

SAINSBURY CENTRE FOR MENTAL HEALTH. *Primary Solutions* London: Sainsbury Centre for Mental Health, 2002

SAINSBURY CENTRE FOR MENTAL HEALTH. *Economic and Social Costs of Mental Illness* London: Sainsbury Centre for Mental Health, 2003

SAINSBURY CENTRE FOR MENTAL HEALTH. *Investing in General Practice – the new General Medical Services contract for GPs. Policy briefing 21* London: Sainsbury Centre for Mental Health, 2003

SINGLETON N, BUMPSTEAD R, O'BRIEN M, *et al. Psychiatric Morbidity among Adults Living in Private Households, 2000: summary report* London: Office of National Statistics, 2001

VON KORFF M AND GOLDBERG D. Improving outcomes in depression *BMJ* 2001; 323: 948–9

Web resources

www.doh.gov.uk	Site for Department of Health (separate locations for NSF, NHS Plan, etc.)
www.nice.org.uk	National Institute for Health and Clinical Excellence. Site for NICE guidelines
www.nimhe.org.uk	Site for National Institute for Mental Health in England
www.scmh.org.uk	Site for Sainsbury Centre for Mental Health
www.nas.org.uk	National Autistic Society
www.cpc-online.co.uk	Counsellors and Psychotherapists in Primary Care
www.npcrdc.man.ac.uk	National Primary Care Research and Development Centre
www.sdcmh.org.uk/	Scottish Development Centre for Mental Health
www.niamh.co.uk/	Northern Ireland Association for Mental Health
www.wales.nhs.uk/sites/home.cfm?orgid=438	NHS Wales NSF Mental Health

Appendix 1

National Service Framework for Mental Health (England only)

This National Service Framework[21] sets standards in five areas. Each standard is based on the evidence and knowledge base available, and is supported by service models and examples of good practice.

- Standard one addresses mental health promotion and the discrimination and social exclusion associated with mental health problems.
- Standards two and three cover primary care and access to services for anyone who may have a mental health problem.
- Standards four and five cover effective services for people with severe mental illness.
- Standard six relates to individuals who care for people with mental health problems.
- Standard seven draws together the action necessary to achieve the target to reduce suicides as set out in *Saving Lives: our healthier nation*.[22]

Appendix 2

Ten essential shared capabilities for mental health practice

Working in partnership

Developing and maintaining constructive working relationships with service users, carers, families, colleagues, lay people and wider community networks. Working positively with any tensions created by conflicts of interest or aspiration that may arise between the partners in care.

Respecting diversity

Working in partnership with service users, carers, families and colleagues to provide care and interventions that not only make a positive difference but also do so in ways that respect and value diversity including age, race, culture, disability, gender, spirituality and sexuality.

Practising ethically

Recognising the rights and aspirations of service users and their families, acknowledging power differentials and minimising them whenever possible. Providing treatment and care that is accountable to service users and carers within the boundaries prescribed by national (professional), legal and local codes of ethical practice.

Challenging inequality

Addressing the causes and consequences of stigma, discrimination, social inequality and exclusion on service users, carers and mental health services. Creating, developing or maintaining valued social roles for people in the communities they come from.

Promoting recovery

Working in partnership to provide care and treatment that enables service users and carers to tackle mental health problems with hope and optimism, and to work towards a valued lifestyle within and beyond the limits of any mental health problem.

Identifying people's needs and strengths

Working in partnership to gather information to agree health and social care needs in the context of the preferred lifestyle and aspirations of service users, their families, carers and friends.

Providing service user-centred care

Negotiating achievable and meaningful goals; primarily from the perspective of service users and their families. Influencing and seeking the means to achieve these goals and clarifying the responsibilities of the people who will provide any help that is needed, including systematically evaluating outcomes and achievements.

Making a difference

Facilitating access to and delivering the best-quality, evidence-based, values-based health and social care interventions to meet the needs and aspirations of service users and their families and carers.

Promoting safety and positive risk-taking

Empowering the person to decide the level of risk he or she is prepared to take with his or her health and safety. This includes working with the tension between promoting safety and positive risk-taking, including assessing and dealing with possible risks for service users, carers, family members and the wider public.

Personal development and learning

Keeping up to date with changes in practice and participating in life-long learning, personal and professional development for one's self and colleagues through supervision, appraisal and reflective practice.

Appendix 3

Mental health disorders in primary care, with Read codes

NB the Eu Read code maps exactly to the ICD 10/DSM IV code

Disorder	Read code
Bereavement	13M …
Dementia	Eu0
Delirium	Eu05
Alcohol misuse	Eu10
Drug use disorders	Eu11
Chronic psychotic disorders (including schizophrenia)	Eu20
Acute psychotic disorders	Eu23
Bipolar disorder	Eu31
Depression	Eu32
Phobic disorders	Eu40
Panic disorder	Eu41.0
General anxiety	Eu41.1
Chronic mixed anxiety and depression	Eu41.2
Adjustment disorder	Eu43.2
Post-traumatic stress disorder	Eu43.1
Dissociative disorder	Eu44
Unexplained somatic complaints (somatoform disorder)	Eu45
Eating disorder	Eu50
Sleep problems	Eu51
Sexual disorders female	Eu52
Sexual disorders male	Eu52
Learning disability	Eu70
Chronic fatigue syndrome	F286

Appendix 4

Assessing the severity of depression in primary care

Key symptoms:

- Persistent sadness or low mood, and/or
- Loss of interests or pleasure
- Fatigue or low energy.

At least one of these, most days, most of the time for at least two weeks. If any of above present, ask about associated symptoms:

- Disturbed sleep
- Poor concentration or indecisiveness
- Low self-confidence
- Poor or increased appetite
- Suicidal thoughts or acts
- Agitation or slowing of movements
- Guilt or self-blame.

Then ask about past, family history, associated disability and availability of social support.

1 Factors that favour general advice and watchful waiting:

- Four or fewer of the above symptoms
- No past or family history
- Social support available
- Symptoms intermittent, or less than two weeks duration
- Not actively suicidal
- Little associated disability.

2 Factors that favour more active treatment in primary care:

- Five or more symptoms
- Past history or family history of depression
- Low social support
- Suicidal thoughts
- Associated social disability.

3 Factors that favour referral to mental health professionals:

- Poor or incomplete response to two interventions
- Recurrent episode within one year of last one
- Patient or relatives request referral
- Self-neglect.

4 Factors that favour urgent referral to a psychiatrist:

- Actively suicidal ideas or plans
- Psychotic symptoms
- Severe agitation accompanying severe (more than 10) symptoms
- Severe self-neglect.

ICD-10 definitions: mild depression, four symptoms; moderate depression, five or six symptoms; severe depression, seven or more symptoms, with or without psychotic features.

Appendix 5

Mental health improvement[23]

Mental health improvement works at three levels and at each level is relevant to the whole population, individuals at risk, vulnerable groups and people with mental health problems.

Strengthening individuals – by increasing emotional resilience through interventions designed to promote self-esteem, life and coping skills, e.g. communicating, negotiating, relationship and parenting skills.

Strengthening communities – by increasing social support, social inclusion and participation, improving community safety, neighbourhood environments, promoting child care and self-help networks, developing health and social services that support mental health, improving mental health within schools and workplaces, e.g. through anti-bullying strategies and mental health strategies.

Reducing structural barriers to mental health – through initiatives to reduce discrimination and inequalities, and to promote access to education, meaningful employment, housing, services and support for those who are vulnerable.

'Reducing structural barriers to mental health and introducing policies which protect mental well-being will benefit those who do and those who do not, currently have mental health problems, and the many people who move between periods of mental health and mental illness.' [24]

Aims

1 Raising awareness and promoting positive mental health.
2 Eliminating stigma.
3 Preventing suicide.
4 Promoting recovery.

Choosing Health

'We know that children and young people who have good mental health learn more effectively. Emotional problems such as depression and anxiety and conduct problems have increased in children since the 1980s. Deprived and abused children are more likely to suffer from mental health problems than average. ... Although there is strong association between emotional problems in children, teenage pregnancy and poor outcomes in adulthood, effective and timely interventions can reduce the incidence of serious health and social problems later in life.' [25]

Appendix 6

Referral guidelines[26]

A main objective of the *WHO Guide to Mental and Neurological Health in Primary Care* is to extend the expertise of the primary care clinician and improve the cooperation and communication between primary care and secondary mental health services. With this understanding, the following guidelines have been prepared.

Referral to adult specialist primary care or secondary mental health services

Referral to secondary mental health services should be considered in the following circumstances:

- Where the patient is displaying signs of suicidal intent or if there seems to be a risk of harm to others
- Where the patient is so disabled by their mental disorder that they are unable to leave their home, look after their children or fulfil other activities of daily living
- Where the GP requires the expertise of secondary care to confirm a diagnosis or implement specialist treatment
- Where the GP feels that the therapeutic relationship with the patient has broken down
- Where primary care interventions and voluntary/non-statutory options have been exhausted
- Where there is severe physical deterioration of the patient
- Where particular psychotropic medication is required (e.g. clozapine, lithium or donezepil)
- If the patient requests a referral.

When making a referral to secondary mental health services, social services or voluntary/non-statutory organisations, the GP should:

- Have access to a local resource directory
- Consider coordination issues around the referral (e.g. care programme approach, care manager)
- Consider implications for the continuing care of the physical health of the patient.

All referral criteria constitute part of the guideline for that particular disorder and assume that, as far as possible, the guideline for diagnosis and management has been followed.

Referral to child and adolescent mental health services

Referral to Child and Adolescent Mental Health Services (CAMHS) should be considered in the following circumstances:

- Where the young person is displaying signs of suicidal intent
- Where assessment of the young person is not suitable for primary care (e.g. psychotic symptoms, attention-deficit/hyperactivity disorder [ADHD])
- Where the young person is likely to require medication and treatment is not suitable for primary care (e.g. depressive disorder in a child, severe obsessive-compulsive disorder)

- Where the young person is so disabled that they cannot go to school or see friends
- If the young person or parent requests a referral
- Where primary care or other options have failed.

Referral to other agencies may be necessary. Criteria include the following:
- Any form of suspected abuse (social services)
- Young person who is no longer in the care of their parents and is at risk of harming themselves or others (social services)
- Young person who is at risk of harming other children or adults (police)
- Young person with school attendance problems (Educational Welfare Service)
- Young person with suspected specific learning disability (school special needs department)
- Young person with a substance misuse problem (local young person's drug and alcohol services).

Voluntary organisations can often help children and adolescents with emotional or behavioural problems – for example, the NSPCC, local parental support groups (e.g. ADHD groups) and parenting groups run through programmes such as Sure Start.

When making a referral to other service providers, the GP should have access to a local resource directory.

Appendix 7

Identifying people at risk

- Frequent attendances with minor illnesses.
- Frequent attendance with the same symptoms or with multiple complaints.
- Attendances with a symptom that has been present for a long time.
- Attendance with a chronic disease that does not appear to have changed.
- Incongruity between the patient's distress and the comparatively minor nature of the symptoms.
- Failure to recover in the expected time from an illness, injury or operation.
- Failure of reassurance to satisfy the patient for more than a short period.
- Frequent visits by a parent with a child with minor problems (the child as a presenting symptom of illness in the parent).
- An adult patient with an accompanying relative.
- Inability to make sense of the presenting problem.

Source: McWhinney A. *Textbook of Family Medicine* Oxford: Oxford University Press, 1997, Chapter 7.

Depression

Primary care practitioners should be alert to the possibility of depression in the following groups of patients:

- Those who have suffered recent unemployment, bereavement (or any form of loss), divorce, financial difficulties or housing problems
- Women with a recent childbirth, demanding child care or menopausal symptoms
- Those who have been bereaved in the last 12 months, those who are caring for a disabled relative and those who are living in residential care
- Those who are suffering from a recent myocardial infarction or cerebrovascular accident, or malignancy
- Those with early dementia, Parkinson's disease, Huntington's disease, diabetes mellitus, chronic obstructive pulmonary disease, chronic pain – and other long-term conditions
- Patients with multiple unexplained symptoms.

Source: Jones R, Britten N, Culpepper L, *et al*. (eds). Oxford Textbook of Primary Medical Care Oxford: Oxford University Press, 2004 (with additions).

Appendix 8

Guiding principles for the development of the recovery process[27]

Principle I

The user of services decides if and when to begin the recovery process and directs it; therefore, service user direction is essential throughout the process.

Principle II

The mental health system must be aware of its tendency to promote service user dependency.

Principle III

Users of service are able to recover more quickly when their:

- Hope is encouraged, enhanced and/or maintained
- Life roles with respect to work and meaningful activities are defined
- Spirituality is considered
- Culture is understood
- Educational needs as well as those of families/significant others are identified
- Socialisation needs are identified
- They are supported to achieve their goals.

Principle IV

Individual differences are considered and valued across the life span.

Principle V

Recovery from mental illness is most effective when a holistic approach is considered; this includes psychological, emotional, spiritual, physical and social needs.

Principle VI

In order to reflect current 'best practices' there is a need for an integrated approach to treatment and care that includes medical/biological, psychological, social and values-based approaches. A recovery approach embraces all of these.

Principle VII

Clinicians' and practitioners' initial emphasis on 'hope' and the ability to develop trusting relationships influences the recovery of users of services.

Principle VIII

Clinicians and practitioners should operate from a strengths/assets model.

Principle IX

Users of service with the support of clinicians, practitioners and other supporters should develop a recovery management or wellness recovery action plan. This plan focuses on wellness, the treatments and supports that will facilitate recovery, and the resources that will support the recovery process.

Principle X

Involvement of a person's family, partner and friends may enhance the recovery process. The user of service should define whom they wish to involve.

Principle XI

Mental health services are most effective when delivery is within the context of the service user's locality and cultural context.

Principle XII

Community involvement as defined by the user of service is central to the recovery process.

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