# Introduction

Mental and neurological disorders are common and affect all of us at some time; if not ourselves directly, then friends, family or work colleagues. Most people who suffer from mental and neurological disorders and who receive care from the health service do so in primary care. Mental health problems alone are now implicated in one in four primary care consultations, making mental health consultations second only to those for respiratory infections (ref 1, 2). Depression is the third most common reason for consultation in UK general practice (ref 3). While most people suffer from mild conditions and recover quickly, a significant proportion suffer from chronic conditions (ref 4) that cause moderate or high disability (ref 5).

Standard two of the National Service Framework for Mental Health (ref 6) emphasizes the importance of primary care in addressing mental health problems:

Any service user who contacts their primary healthcare team with a common mental health problem should:

- have their mental health needs identified and assessed
- be offered effective treatments, including referral to specialist services for further assessment, treatment and care, if they require it.

To achieve this standard, each primary care group will need to work with the support of specialized mental health services to:

- develop the resources within each practice to assess mental health needs
- develop the resources to work with diverse groups in the population
- develop the skills and competencies to manage common mental health problems
- agree the arrangements for referral for assessment, advice or treatment and care
- have the skills and necessary organizational systems to provide the physical healthcare and other primary care support needed, as agreed in their care plan, for people with severe mental illness.

This Guide has been written to support primary care professionals, primary care organizations and local user groups in their delivery of primary care mental and neurological health services. It deals with conditions frequently seen in primary care, or those that have a high profile, and which can be managed effectively by general practitioners (GPs) and their teams, supported as appropriate by secondary care.

In response to feedback from the first edition and the sister publication Mental Health in Primary Care in Prison, (ref 7) this second edition now includes guidelines on the following:

- Child and adolescent mental health disorders and related problems, such as bullying and abuse. For a few conditions, for example, Obsessive-compulsive disorder, Psychosis and Sleep problems, the special considerations particular to children and adolescents have been described at the end of the relevant adult guideline;
- Common neurological disorders. We received a number of requests to include common neurological conditions, and so have included several relatively common ones, which can all be severe and disabling;
- Domestic violence, Personality disorder, Postnatal disorders, Obsessive-compulsive disorder, Self-harm and Smoking cessation.

Most of the conditions in the Guide are classified in ICD-10; however, a few are behavioural problems that do not have an ICD-10 code. These, for example domestic violence, are included here at the request of the Department of Health (DoH). The current ICD-10 classification does not distinguish between adults and children and adolescents for disorders such as depression.

Personality disorder is encoded under ICD-10 but was omitted from the first edition because it was not included in the original World Health Organization (WHO) version. It is included in this second edition at the request of the DoH.

A brief summary of how to diagnose and manage each condition is given. The management summaries include information for the patient, advice and support, descriptions of treatment methods and indications for liaison and specialist referrals. They are supported by a linked set of resources to help the GP or other members of the primary care team to carry out the management strategies recommended, as well as contact details of relevant voluntary sector organizations.

**References**

**1** McCormick A, Fleming D, Charlton J. Morbidity Statistics from General Practice: Fourth National Study 1991-1992. London: HMSO, series MB5 no 3, 1995.

**2** Ustun TB, Sartorius N. Mental Illness in General Healthcare: An International Study. Chichester: John Wiley & Sons, 1995.

**3** NHS Centre for Reviews and Dissemination. Improving the recognition and management of depression in primary care. Effect Healthcare Bull 2002, 7(5): 1-12.

**4** Mann A, Jenkins R, Besley E. The twelve-month outcome of patients with neurotic illness in general practice. Psychol Med 1981, 11: 535–550.

**5** Meltzer H, Gill B, Petticrew M, Hinds K. OPCS Survey of Psychiatric Morbidity in Great Britain Report 3: Economic Activity and Social Functioning of Adults With Psychiatric Disorders. London: HMSO, 1995.

**6** Department of Health. National Service Framework Mental Health. London: HMSO, 1999.

**7** Mental Health in Primary Care in Prison. London: Royal Society of London Press, 2002.

# Resources provided

- **A mental disorder assessment guide**. This is to help the assessment of depression, anxiety, alcohol, sleep, chronic tiredness and unexplained somatic complaint disorders. To use it, start with the screening questions (in top boxes) to explore the presence of disorders and, if the disorder exists, you can continue below.

- **Interactive summary cards**. For the six disorders most common in primary care (depression, anxiety, alcohol problems, chronic fatigue, unexplained somatic complaints and sleep problems) two-page summaries have been produced. One page contains information for the practitioner, the other for the patient. With less information than the main summaries, but easier to see at a glance, they are meant to be used interactively. (see Interactive summary cards). They may be printed out and mounted on either side of

a piece of A4 card and used to facilitate discussion between practitioner and patient within a consultation.

- **A linked set of patient information and self-help leaflets** (see Patient resources) giving more information about the treatment and self-help strategies recommended. These can be printed out and given to patients to help reinforce the information that has been provided and also to encourage active participation in treatment. These vary in length and complexity. Some (eg the one-page problem-solving sheet) are suitable for use by GPs in a consultation. Others are more likely to be used by another member of the team, such as a counsellor, nurse or physiotherapist. Leaflets from the first edition have been retained because they have been found to be useful, but leaflets have not been provided for those guidelines new to the second edition, owing to the plethora of information now available on the Internet.

## Why were these disorders chosen?

This Guide contains categories of mental disorders from the ICD-10 classification, together with common neurological disorders from the ICD-10 classification and several common behavioural issues, such as domestic violence and bullying, which are not all classified in ICD-10.

The choice of disorder is the result of a selection process that reflects the following:

- The public health importance of disorders (i.e. prevalence, morbidity or mortality, disability resulting from the condition, burdens imposed on the family or community, healthcare resources need). A few rarer disorders (e.g., Attention-deficit/hyperactivity disorder and Autism spectrum disorders) are included because of their high profile.
- Availability of effective and acceptable management (i.e. interventions with a high probability of benefit to the patient or their family are readily available within primary care and are acceptable to the patient and the community).
- A reasonable consensus exists among primary care practitioners and mental health and neurological professionals regarding the diagnosis and management of the condition.
- Cross-cultural applicability (i.e. suggestions for identification and management are applicable in different cultural settings and healthcare systems).
- Consistency with the main ICD-10 classification scheme (i.e. each diagnosis and diagnostic category corresponds to those in ICD-10) (with the exception of those problems included at the request of the DoH - domestic violence and bullying, which do not have ICD-10 codes).

We have also set out the clinical terms equivalents for the ICD-10 codes, because these are more widely used in UK primary care practice than are the ICD-10 codes.

All disorders included in this Guide are fairly common in primary care settings and a management plan can be written for each of them.

The section for people with a learning disability has been identified separately because recognition and treatment of mental disorders present particular difficulties in this group and because mainstream adult mental health services might not be appropriate for them. Learning disability is, of course, not itself a mental disorder.

# How the diagnostic and management summaries were developed

WHO developed a state-of-the-art classification of mental disorders for use in clinical practice and research. The Tenth Revision of the International Classification of Diseases (ICD-10) has many features that improve the diagnosis of mental disorders. To extend this development to primary care settings, where most patients with mental disorders are seen, diagnostic and management guidelines were combined into the WHO book Diagnostic and Management Guidelines for Mental Disorders in Primary Care (ICD-10 Chapter V, Primary Care Version). The guidelines were developed by an international group of GPs, family physicians, mental health workers, public health experts, social workers, psychiatrists and psychologists with a special interest in mental health problems in primary care, using a consensus approach. The WHO guidelines were field-tested extensively in over 40 countries by 500 primary care physicians to assess their relevance, ease of use and reliability. This work has been published (ref 8,9). Field trials using the WHO guidelines continue in various centres in the UK.

The diagnostic and management summaries in this Guide consist of the WHO's International Diagnostic and Management Guidelines for Mental Disorders in Primary Care, specially adapted (and updated) for use in the UK. They have been adapted in two stages. The first stage of adaptation to the UK setting was carried out in south Bristol by a panel of GPs and multidisciplinary representatives from community mental health teams, using a consensus methodology. A randomized controlled trial of the Guide in 30 general practices in Bristol, measuring a range of mental health outcomes, was then carried out.

The second stage of adaptation was carried out by a national, editorial team, coordinated by the WHO Collaborating Centre of the Institute of Psychiatry, London. The evidence base was reviewed (see next page - 'The evidence on which the summaries are based'), information on psychological therapies was added, and information (on the Mental Health Act of England and Wales 1983, community resources and referral) was made appropriate to the whole of the UK. Representatives of primary care nurses, counsellors and patient groups have made valuable suggestions to ensure that the information is accessible to these important groups. Several rounds of consensus, including a conference, were held to debate the amendments and agree the final text. Names of those involved in this stage can be found in the Acknowledgements section.

For this second edition, guidelines from the first edition and new guidelines have been reviewed by specialists, GPs and the voluntary sector, intensively discussed at a consensus meeting, and piloted by a number of general practices.

The interactive handy cards, the diagnostic checklists and most of the patient information leaflets (see Patient resources) were produced by the WHO's Division of Mental Health and Prevention of Substance Abuse, and endorsed by The Collegium Internationale Neuro-Psychopharmacologicum, the World Organization of National Colleges, Academies and Associations of General Practitioners and Family Physicians and the World Psychiatric Association. Some of the leaflets were developed by the WHO Collaborating Centre for Mental Health and Substance Abuse, as part of the Treatment Protocol Project.

**References**

**8** Goldberg D, Sharp D, Nanayakkara K. The field trial of the mental disorders section of ICD-10 designed for primary care (ICD10-PHC) in England. Family Practice 1995, 12(4): 466–473.

**9** Ustun B, Goldberg D, Cooper J et al: A new classification of mental disorders based on management for use in primary care (ICD10-PHC). B J Gen Pract 1995, 45: 211–215.

# The evidence on which the summaries are based

Where applicable, the diagnosis sections are based on the ICD-10 classification of disorders. ICD-10 is itself a consensus document and has been tested for reliability. The ICD-10 PHC diagnostic criteria presented here have been tested among primary care professionals to check for validity and usefulness.

References supporting evidence have been given in line with the principles set out below.

**Treatments (medication and psychotherapies)**

The recommendations about medication are all in line with the British National Formulary (BNF). Where recommendations about medication are unexceptional and in line with both the BNF and established practice for many years, references have not been given.

References have been reserved for key statements about medication and about particular psychotherapies or for statements about which evidence and opinion are divided. It should be noted that most studies have been carried out in a secondary care setting. The mixed presentations of disorders found in primary care means that, generally speaking, both drugs and psychotherapies prove less efficacious, compared with placebo, in that setting than they do in more selected groups in secondary care. We have therefore included some discussion about what the evidence says, along with the references to the studies themselves. A grading of the quality of the evidence is also provided in the reference sections (see References [adult disorders] and References [child and adolescent disorders]). Where possible, evidence has been given from Cochrane reviews, high-quality published reviews and meta-analyses or randomized controlled trials (RCTs). Discussions have been held with experts and authors of key areas of research.

The evidence has been graded as follows:

**Strength of the evidence supporting the recommendation**

A = Good evidence to support
B = Fair evidence to support
C = Preliminary evidence to support.

**Quality of the evidence supporting the statement**

I = Evidence obtained from a meta-analysis of trials, including one or more well-designed RCTs
II = Evidence obtained from one well-designed RCT
III = Evidence obtained from one or more controlled trials, without randomization
IV = Evidence obtained from one or more uncontrolled studies
V = Opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committees. Occasionally, the 'respected authorities' comprise collective patient experience. Where this is the case, it is clearly stated.

Where a qualitative review of previously published literature without a quantitative synthesis of the data is referenced, it has been graded in accordance with the type of studies the review includes.

**Information and advice**

The sections on ‘Essential information for patient and family’ and ‘General management and advice to patient and family’ are primarily the result of consensus. There are no trials comparing the outcome of patients given different sorts of advice by their GP. The advice itself is based on a mixture of evidence and consensus of professionals and/or patients. A small number of references to supporting evidence have been given.

**Referrals**

The referral recommendations are based on consensus and will vary from place to place, depending on services available in all care sectors.

## Connections to ICD-10 and NHS clinical terms

The first edition of this Guide was based on the disorders included in the ‘The ICD-10 PC Chapter V Mental Disorders Classification, Primary Care Version’, is a ‘user-friendly’ version of the ‘Tenth revision of the International Classification of Diseases (ICD-10) Chapter V’. For practical reasons, the ICD-10 PC is a condensed version of ‘ICD-10 Chapter V’ for easy application in busy primary care settings. It has 23 categories instead of 457. It intends to cover the universe of mental disorders seen in primary care settings in adults. As a classification, it is ‘jointly exhaustive and mutually exclusive’. It may seem simplistic; however, it corresponds to the ICD-10 main volume. A chart that shows the grouping of the detailed specialty-adaptation categories into ICD-10 PC categories can be found below (Connections between ICD-10 PC and ICD-10 Chapter V).


Connections between ICD-10 PC and ICD-10 Chapter V

Connections between ICD-10 PC and ICD-10 Chapter V

This second edition now includes a number of additional neurological, behavioural and childhood disorders. Where possible, relevant ICD-10 codes and NHS clinical terms have been given. A table of these codes can be seen below.

| Disorder | ICD-codes | Clinical Term Codes |
|---|---|---|
| Acute psychotic disorders | F23.9 | Eu23 |
| Adjustment disorder (including acute stress reaction) | F43.2 | Eu43.2 |
| Alcohol misuse | F10 | Eu10 |
| Bereavement and loss | Z63.4 | E2900 |
| Bipolar disorder | F31 | Eu31 |
| Chronic fatigue syndrome/ME | G93.3 | |
| Chronic mixed anxiety and depression | F41.2 | Eu41.2 |
| Chronic psychotic disorders | F29 | Eu20 |
| Delirium | F05 | Eu05 |
| Dementia | F03 | Eu00 |
| Depressive disorders | F32 | Eu32 |
| Dissociative (conversion) disorder | F44 | Eu44 |
| Domestic violence (new) | | |
| Drug use disorders | F10-19<br><br>Mental and behavioral disorders due to use of:<br><br>F11 opioids<br>F12 cannabinoids<br>F13 sedatives or hypnotics<br>F14 cocaine<br>F15 other stimulants, including caffeine<br>F16 hallucinogens<br>F17 tobacco<br>F18 volatile solvents<br>F19 multiple drug use and the use of psychoactive substances | Eu11 |
| Eating disorders | F50 | Eu50 |
| Epilepsy | G40.9 | F25 |
| Fatigue states, including chronic fatigue | F48.0 | Eu46.0 |

| | | |
|---|---|---|
| Generalized anxiety | F41.1 | Eu41.1 |
| Headache (including migraine) | R51 headache<br>G43.9 migraine<br>G44.2 tension<br>G44.0 cluster | R040 |
| Motor neurone disease | G12.2 | F152 |
| Multiple Sclerosis | G35 | F20 |
| Panic disorder | F41.0 | Eu41.0 |
| Parkinson's disease | G20 | F12 |
| Perinatal disorders | | Eu204 |
| Personality disorder (new) | F60 | Eu6 |
| Phobic disorders | F40 | Eu40 |
| PTSD | F43.1 | Eu43.1 |
| OCD (new) | F42 | Eu42 |
| Sexual disorders (female) | F52 | Eu52 |
| Sexual disorders (male) | F52 | Eu52 |
| Sleep problems (Insomnia) | F51 | Eu51 |
| Smoking (new) | F17.1 | (no letter 137 i.e. it's a symptom not a disorder |
| Stroke | I64 | G66 |
| Suicide/deliberate self-harm (new) | X60-X84 | U2... |
| Unexplained somatic complaints | F45 | Eu45 |
| Learning disability | F81.9 | Eu70 |

**Children and adolescents Mental and Neuorlogical disorders**

Disorders of childhood and adolescence F90-F98. Where there is no appropriate code within F90-F98, we have used the relevant adult codes.

| **Disorder** | **ICD-codes** | **Clinical Term Codes** |
|---|---|---|
| Abuse | Z61.4 | ZV612 |
| Autism | F84.0 | Eu840 |

| | | |
|---|---|---|
| Asperger | F84.5 | Eu845 |
| Anxiety (including phobia, OCD) | F93 | Eu93 |
| Conduct disorder | F91 | Eu91 |
| Bullying at school | | 13ZF. |
| Bereavement and loss | Z63.4 | Eu2900 |
| Adolescent psychosis | No ICD code of adolescence | No clinical term for adolescence |
| Substance abuse | No ICD code of adolescence | No clinical term for adolescence |
| Depression in adolescence | No ICD code of adolescence | |
| ADHD | F90.0 | Eu97 |
| CFS and somatoform | G93.3 | Eu460 |
| Deliberate self-harm/suicide | X60-X84 | Eu2 |
| Eating disorders | F98.2 this code is for infants and early childhood only | Eu50 |
| Mental health needs of refugee and asylum seeking children | No ICD code | No clinical term |

## How an individual practitioner might use this Guide

In the field trials, some practitioners used the summaries as a resource between consultations, to look something up. Others used the summaries interactively with the patient, to help explain the disorder and determine a treatment plan. The appropriate information and/or self-help leaflet (see Patient resources) can be printed out and given to the patient to reinforce what is said in the consultation. The interactive summary cards can be used to facilitate discussion between clinician and patient.

**Patients as partners**

It is important that patients and practitioners can negotiate a shared understanding of the problems before a management plan can be agreed. A successful dialogue during which patient and professional communicate well with each other can have a positive effect on clinical outcome (ref 10,11) and will help to reduce the well-documented high level of 'non-adherence', where people do not take the medication prescribed for them. However, medication is not the only answer, particularly for mild to moderate conditions. A partnership approach will help patients to understand ways in which they might be able to help themselves, and to make informed decisions about what is likely to work for them. Many patients want to take part in making decisions about their treatment and care, and they can get better faster or cope better with chronic illness if they

are actively involved in understanding what is happening to them and making changes to their lifestyle. This approach applies to all patients, but shared understanding is particularly important where the cultural background of the professional is different from that of the patient.

**Beyond diagnosis: a multi-axial approach**

Patients presenting in primary care with mental and neurological health problems often have a mixture of social, psychological, physical, medical and emotional difficulties, and primary care mental health and neurological services are being encouraged to develop a multi-axial approach, rather than a purely medical perspective.

A short diagnostic summary cannot capture the full clinical and social picture. The summaries focus on the diagnosis, severity and duration of the disorder, as an essential prerequisite of a specific management plan. The practitioner needs to add to this, as appropriate, assessing other factors such as social stresses linked to the symptoms, physical health, past and family history and the level of social support available from family and friends. Some of the management strategies outlined in the summaries and patient leaflets are easier for a patient who has good support from family or friends. Increased professional support could perhaps then be focused on those people who are more isolated.

**Care programme approach**

Where a patient is receiving care from mental health services, they should have a care programme (comprising a written care plan reviewed regularly, and a named key worker who coordinates their care). There needs to be clear agreement about which elements of care are provided by the GP and which by the community team. Both team and patient need to know what the plan is in case of relapse, and have names and telephone numbers of the key people (eg the care manager, identified on the front page of the notes) to contact easily to hand. The summaries assume that these discussions will take place.

**Medication**

Wherever possible, medication recommendations refer to a class of drug or a generic form. Where it is considered particularly useful or important, however, examples of particular named drugs are given. These are examples only and should not be taken as a WHO recommendation to prescribe that particular brand. The summaries should be read in conjunction with the BNF, which contains information on every individual drug.

**Self-help**

Self-help materials are mostly available as books or computer programs and are designed to teach patients how to self-manage and overcome their symptoms and related difficulties. It is becoming increasingly relevant in the management of chronic mental illness, not least because of the shortage in some areas of staff trained in providing psychotherapy both in primary and secondary care. Self-help has a number of advantages: (ref 12)

- Patients like the idea of working on their own to deal with their problems and reducing their reliance on professional help
- Taking responsibility for self-management may be empowering, which could be particularly important in dealing with feelings of hopelessness and despair. It also gives the patient a sense of control over their illness
- Self-help can be returned to as often as the patient wants and whenever they want
- Self-help is more accessible and may be able to provide some psychological support without delay.

Self-help material is included in the resource section of the guidelines although there is still limited evidence for the effectiveness of individual publications. For some people and some conditions, self-help could be an effective option (ref 12).

Contact details of voluntary organizations, many of which run local groups, are also given at the end of each guideline.

**References**

**10** Kai J, Crosland A. Perspective of people with enduring mental ill health from a community-based qualitative study. Br J Gen Pract 1995 2001, 51: 730–737.

**11** Peck E, Gulliver P, Towel D. Information, consultation or control: user involvement in mental health services in England at the turn of the century. J Mental Health 2002, 11(4): 441–451.

**12** Lewis G, Anderson L, Araya R et al. Self-help interventions for mental health problems. http://www.nimhe.org.uk.

## How a practice team, primary care organization or local health group might use this Guide.

### Team working and training within primary care

The diagnostic and management summaries assume that the resources available to primary care teams will vary widely. The 'advice to patient and family' can be offered by any member of the primary care team who has suitable training and skills. GP, nurse, health visitor, school nurse, practice counsellor and psychologist may all contribute, and discussion to clarify the roles of each is essential. It will be helpful to carry out an assessment of the mental health skills available within the team (see Mental health in your practice), in order to make best use of the skills of all members and inform practice training plans, as well as referral to external resources. This assessment could be done by an individual practice, group of practices or whole primary care organization. A list of sources of training in primary mental healthcare and a checklist of ways a practice can respond to the mental health needs of its patients is provided can be found under Sources of primary mental healthcare training.

### Team working between primary, secondary and social care

Primary care organizations could use the diagnostic and management summaries as a basis to discuss and agree locally appropriate referral criteria with specialist mental health services. It would be possible to work on a small number of disorders or to work through all of them. This process might reveal gaps in local services, for example in the availability of structured psychological therapies for affective disorders. Primary care organizations might wish to consider ways of addressing these gaps in their service development plans or in the commissioning plans of training consortia.

Some primary care organizations or health groups might wish to go further and address systems for communication between primary and secondary care. Effective communication is a crucial element of effective care, and misunderstandings between primary care and mental health services are very common. Primary care teams and community mental health teams may wish to

meet to agree the roles, responsibilities and expectations of each member of both teams. Various different models have been tried, to improve communication as a whole and to improve the care of patients who are 'shared' between primary and secondary care in particular. Joint case registers of people with chronic mental illness is one of these. (see Suggested issues for practice and PCT audit).

### Information about resources in the community

The primary care organization or local health group might also produce a locally appropriate directory of services and community resources and distribute this to its constituent practices. The information could be made available on computer or in a wall-chart format. Consideration will need to be given to regular updating of this information. Within each practice, the practice manager or other team member will need to consider how best to make the patient information leaflets available, how to obtain and insert the information about local services into the template wall charts and how best to make that information readily accessible to patients and all members of the practice team.

### Localization

The diagnostic and management summaries are meant as a resource to local agencies. They will only be useful if they are actively disseminated at practice, primary care organization and Health Authority levels. Local adaptation of the summaries to suit particular situations is welcomed and encouraged. To make it possible, we have included the text of the summaries in an electronic format. These can be found on the WHO Guide to Mental and Neurological Health in Primary Care website. Locally adapted pages can be inserted easily, where required. A template, to be filled in with information about local services, is provided. Although the diagnostic information is standard and used internationally, the management plan, particularly the referral criteria, will vary according to the availability of services locally and the training of healthcare workers.

The copyright for the diagnostic and management summaries rests with the WHO. Where a primary care organization or local health group is producing locally adapted guidelines using the WHO summaries as a basis, we ask that you contact Professor Rachel Jenkins at the WHO Collaborating Centre Office, Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5 8AF, UK. Tel: +44 20 7848 0383; E-mail: r.jenkins@iop.kcl.ac.uk.

## Special considerations

### Needs of carers

The term 'carer' is taken to mean informal caregivers, rather than those providing care in the statutory sector on an organized and paid basis. Three in five people in the UK will become carers at some point in their lives (ref 13). The strain on these informal carers, particularly those living with the ill person or young carers who may feel burdened by the responsibility, can be severe, resulting in an increased risk of both physical and mental ill health. Many carers have to give up work in order to look after their relative or friend, and become economically disadvantaged and socially isolated. Carers often have no respite from their role, and may find themselves experiencing feelings such as frustration, resentment, guilt, anger, fear, depression and loneliness.

Those caring for people with a mental or even neurological illness often have the additional burden of stigma to cope with. About half of those with severe mental illness live with family or

friends, and many others receive considerable support from them. It is important to review how the carer is managing and to encourage them to find ways of reducing the stress on them. Self-help groups, day care and respite care can all help. The assessment and care planning process should take the mental and physical health of carers, and their ability to continue coping, into account. Standard Six of the Mental Health National Service Framework lays down guidance to ensure that health and social services assess the needs of carers who provide regular and substantial care for those with severe mental illness, and provide care to meet their needs.

Checklist for GPs and primary care teams: (ref 6)

- Have you identified those patients who are carers, and patients who have a carer?
- Do you check carer's physical and emotional health whenever a suitable opportunity arises?
- Do you routinely tell carers that they can ask social services for an assessment of their own needs?
- Do you always ask patients who have carers whether they are happy for health information about them to be told to a carer?
- Do you know whether there is a carers' support group or carers' centre in your area, and do you tell carers about them?

Carers are entitled to an assessment of the needs of the carer (under the Carer's Recognition and Services Act 1995) and this can be requested from the local Social Services department. This advice is relevant to all chronic disorders; it is not repeated on each individual summary.

**Gender** (ref 14)

Service delivery should be sensitive to gender issues. Mental and neurological ill health is common in both men and women, but important differences in the family and social context of their lives, and the presentation and type of their mental illness, will influence their care and treatment needs:

- Anxiety, depression (particularly during pregnancy and in the post-partum period) and eating disorders are more common in women; substance misuse and antisocial personality disorder are more common in men (ref 15).
- Women often present with a combination of physical complaints and mental ill health, and the former can obscure the recognition of the latter.
- Women must often juggle many roles; the competing demands of work and major responsibility for the home and care of children and other dependent family members can place them under considerable stress and have an adverse effect on their mental health.
- Women are more vulnerable to poverty and social isolation, which are strongly associated with mental ill health. They generally outlive their partners, are less likely to work, and if they do, earn less; they are less likely to own a car. Lone mothers are three times more likely to be depressed than any other group of women.
- Women are more likely to experience abuse and violence, both in childhood and adulthood.
- Women who have children under 5, particularly if lone parents, are vulnerable to mental ill health
- A woman's mental ill health may have wide repercussions for children and other dependent relatives.
- Although psychological therapies should be considered routinely for mental health problems, women are more likely to be prescribed psychotropic drugs, particularly antidepressants, anxiolytics and hypnotics, than men. This practice will also have consequences for fetal development or breast-feeding, or the effectiveness of contraception.

Specific issues identified for general practice in Women's Mental Health: Into the Mainstream are as follows:

- Recognition and appropriate treatment of depression (including postnatal depression), anxiety and eating disorders, such as increased availability of psychological treatments and appropriate use of antidepressants/anxiolytics.
- Review of long-term prescribing, particularly of benzodiazepines.
- Detection and management of issues/conditions that often remain hidden - self-harm, substance misuse, and experience of violence and abuse.
- Access to support services, such as benefits or housing advice.

Among the key components of assessment and care planning should be experience of violence and abuse, caring responsibilities, social and economic support, physical health, ethnicity and culture (see below), dual diagnosis with substance misuse, and risk assessment and management.

**Ethnicity and culture** (ref 16,17)

Service delivery must also be sensitive to different cultural needs.

- Minority ethnic communities are over-represented among the lower social classes, with higher unemployment rates and poorer housing and employment status, all of which are associated with poor mental health. In addition, in some cases racism might contribute to increased levels of stress and distress.
- If the practitioner and patient are from different ethnic groups, there is a higher likelihood that misunderstanding may occur, particularly if they hold different explanatory models of illness. It is important to ensure that adequate time is set aside for these consultations.
- There may be a language barrier between doctor and patient:
  - The use of skilled professional interpreters wherever possible is essential. Family and friends fulfilling this role is not adequate - accurate interpretation cannot be relied upon, confidentiality cannot be maintained, a patient may not reveal details of their problem, and issues such as domestic violence might remain hidden.
  - Access to fully trained medical translators is often limited, and the practitioner must be extra vigilant, using clear terminology and giving precise instructions and guidance both to the translator and the patient.
  - Simple language and open questions should be used as much as possible to enhance understanding; for example, 'What do you think caused your problem?' 'Why do you think it started when it did?' 'What does your illness do to you?'
  - Two-way checking (ie that the practitioner has understood the patient's concerns and the patient has understood and agreed to the management plan) is important to avoid misunderstanding.
  - Written information prepared with the translator can be invaluable for patients to take home with them.

- **Cultural differences:**

  - Different beliefs about causes, interventions and outcomes of illness will affect when and how people present, and how they understand messages about treatment. Exploring these issues will maximize the ability to address a patient's concerns and ensure as collaborative a relationship as possible.
  - How symptoms are displayed may be different; for example, depression might manifest as severe headaches. It is helpful to consider this possibility, while never assuming the case.
  - Patients might not share a Western view of the difficulties they experience.

Psychological problems are often described by terms - for example, nervous breakdown, broken hearted - that might not be understood by non-Western cultures or vice versa.
- Familiarity with Western methods of treatment should never be assumed; for example, the concept of 'talking as a cure' might not be accepted. Clear explanations and rationales for these should be given.
- Families might make use of other health resources within their communities (eg a herbal Chinese practitioner) before consulting their GP.

- **Children:**

  - Most children from ethnic minority communities will have been born in the UK, but many might need to negotiate two different cultures. It can be very complex for a child to manage two possibly conflicting belief systems (ie the family and the peer group). Worries and stresses arising from this are unlikely to be volunteered and thought needs to be given to asking about these, if appropriate.
  - These children may be at higher risk of experiencing bullying and racism.

**Refugees and asylum seekers**

In addition to the points listed above under Ethnicity and culture, those working in primary healthcare need to be aware of the following:

- the range of experiences that asylum seekers and refugees may have suffered in their home country
- the likelihood that they will experience ongoing difficulties of poverty and isolation in the host country
- asylum cases may take years to be resolved, a process that can have psychological implications.

It is estimated that over 50% of refugees suffer from a mental health disorder (ref 18). Common symptoms in refugees and asylum seekers include depression, anxiety, panic attacks, agoraphobia, sleep difficulties, loss of memory and poor concentration, and there are high levels of Post-traumatic stress disorder (ref 19). Patients may also be suffering bereavement following the loss of, or the loss of contact with, friends and relatives.

They have often been exposed to traumatic events (eg torture, imprisonment, rape and war), and separation from family and friends. They then face further stress and anxiety from relocation to a country where they may have no contacts, common language or knowledge of social and legal systems. They might have a lingering distrust of authority. They could suffer racial discrimination and abuse, as well as poverty and social isolation. Experiences en route to and within the host country should not be overlooked as factors that could undermine mental health. Problems can stem predominantly from the dislocating experience of seeking refuge, rather than from experiences in the home country. Often facilitation of support groups and even just the opportunity for social meeting can be of benefit by reducing feelings of social isolation.

Asylum cases can take a long time to be resolved fully, and until refugee status is granted the asylum process can have an impact on the progress and maintenance of mental health problems.

**Further support to primary-care teams**

1. The NHS Plan 2000 contained two targets specifically focused on supporting primary care - first, new graduate primary-care workers and second, gateway workers. Information about both of these is on the Department of Health website (http://www.doh.gov.uk/mentalhealth).

2. The National Institute of Mental Health for England established a primary care mental health programme in Spring 2003, see NIMHE for further details. The aim is capacity-building in primary care around service modernization to improve access, choice and responsiveness of services.
3. There is a Doctors' Support Network (http://www.dsn.org.uk) and Doctors' Support Line (http://www.doctorssupport.org) for doctors who need anonymous and confidential support and/or information.

The Doctors' Support Line (0870 7650001) is staffed Monday-Friday from 6pm to 10pm; in addition it is staffed on Tuesdays from 9am to 2pm and 6pm to 11pm, and Sundays from 10am to 10pm. The Doctors' Support Network can be contacted on 07071 223372.

**References**


**6** Department of Health. National Service Framework Mental Health. London: HMSO, 1999.

**13** Carers UK. It Could Be You. London: Carers UK, 2001.

**14** Department of Health. Women's Mental Health: Into the Mainstream. London: Department of Health, 2002.

**15** Gold J. Gender differences in psychiatric illness and treatments: a critical review. J Nervous Mental Dis 1998, 186(12): 769–775.

**16** Bhugra D (ed). Mental Health Practice in Multicultural Britain. London: Royal College of Psychiatry, 1999.

**17** Malek M, Joughin C. Mental Health Services for Minority Ethnic Children and Adolescents. London: Jessica Kingsley, 2003.

**18** Bruntland GH. Mental health of refugees, internally displaced persons and other populations affected by conflict. Acta Psychiatrica Scand 2000, 102(3): 159–161.

**19** Burnett A, Peel M. Health needs of asylum seekers and refugees. BMJ 2001, 322: 544–547.


## Key to signs used in the main text

**F23** This is the code in ICD-10 PC Chapter V (ie the International Classification of Diseases, primary care version, mental health chapter. A full list of how the primary care codes relate to the codes from the main ICD-10 volume can be found here.

**G30** This is the code in ICD-10 VI, neurology chapter.

**Eu23** This is the clinical term (or closest equivalent).

Reference numbers: A grading of the evidence can be found in the reference sections (see References [adult disorders] and References [child and adolescent disorders]).

The evidence has been graded as described here.

Eu - mental health clinical terms
F - neurological clinical terms
G - cardiovascular clinical terms