

Assessment under the Mental Health Act England and Wales 1983 — a basic guide for General Practitioners

General Practitioners can be involved in Mental Health Act assessments in a variety of settings:

- *Hospital*: The patient may have already been admitted informally and is now wanting to leave or is refusing treatment.
- *Home*: The patient may be causing serious concern to family or neighbours. If access is denied, section 135 (warrant to search for and remove patients) may need to be used. This warrant is obtained by an approved social worker (ASW) from a Magistrates' Court.
- *Police station*: As a place of safety (section 136), or after arrest for an offence.

The 1983 Mental Health Act provides the legal framework in England and Wales for compulsory admission and treatment of patients suffering from mental illness.

Use of the Mental Health Act

Compulsory admission for assessment and/or treatment can only occur when:

- there is a mental disorder; *and*
- it is in the interest of the health and/or safety of the patient; *or*
- it is in the interest of the protection of others.

The act allows the compulsory admission of a patient who is very distressed or ill (for example, actively psychotic or manic) solely in order to improve their health, even if they are not thought to be at immediate risk of harming themselves or others. It cannot be used for the compulsory treatment of addictions unless the above criteria are also met.

Mental disorder comprises mental illness, mental impairment, severe mental impairment and psychopathic disorder. In the Act, mental illness is not defined but is a matter for clinical judgement.

How to arrange a Mental Health Act assessment

A Mental Health Act assessment is activated by telephoning the duty-approved social worker (ASW) or the duty psychiatrist, depending upon local policy.

He/she will need the following information:

Name, date of birth, address, reason for assessment, previous history, including name of keyworker, next of kin (if known) and past history of violence of self harm (if known).

He/she will need enough information to decide if there is the possibility of an admission under the Mental Health Act, and that the full assessment process is warranted.

If you want to discuss the management of the patient, either telephone the duty ASW or the duty consultant.

The ASW will then take responsibility for coordinating the assessment, bringing relevant papers, ensuring the process complies with the law and arranging for the transport of the patient.

Before the assessment

Information is an important component of the assessment.

- If you can access your records, check for previous history and response to treatment, risk of neglect, violence or self harm, any known contact names.
- If there is a relative or informant, ask about the recent situation, its duration, whether there is any support, whether there have been threats or violence and if the patient is known to carry or have access to weapons.
- Liaise with the ASW about directions, access to premises, where to meet and the need for police attendance.
- It is good practice (because it is safer, communication is better and disruption of the patient is minimized) if the medical assessments take place jointly with the ASW at the same agreed time (although, if this is not possible, they are legally allowed to be five days apart. In any case, the two doctors must discuss their decision).

If the patient is suffering from the short-term effect of drugs, alcohol or sedative medication, discussion should take place about deferring the assessment until a more productive interview can take place.

During the assessment

The team necessary to implement a Section 2 (28 days for assessment) or Section 3 (six months for treatment) is:

- an approved psychiatrist (often the duty consultant or specialist registrar)
- a doctor with prior knowledge of the patient (ideally the GP)
- the ASW.

The GP and others in the primary-care team often have prior knowledge of the patient, including access to records and an existing relationship with the patient and or family, which facilitates the assessment. The psychiatrist may not know the patient, but often contributes clinical experience and expertise. The ASW makes a more comprehensive assessment of the social aspects of the case and advises on the legal issues that may arise during the process. He/she sees that the patient is interviewed 'in a suitable manner'.

The patient is interviewed as comfortably as possible, with the following questions in mind:

- Is there any possible evidence of mental illness?
- Is there a risk to the health or safety of the patient or a danger to others?

If the answer to both of these questions is yes:

- Will the patient consent to informal admission, and if so, is that realistic, based on past experience or aspects of the current interview?
- Are there any community alternatives to admission? For example, giving medication at home, community psychiatric nurse visits, crisis services, day hospitals.

All professionals strive to reach a consensus and *if* the doctors agree to make the medical recommendations for compulsory admission, the social worker makes the application to the admitting hospital managers.

Section 2 is appropriate if there is no previous history, the diagnosis is unclear or no treatment plan is in place.

Section 3 specifies the category of mental disorder and is mainly used for patients already known to the service. If the nearest relative objects to the detention, the application cannot proceed.

Arranging admission

If the decision of the team is to admit the patient, the level of security required should be considered. Arrangements are usually

made by the psychiatrist for a bed and the ASW for appropriate transport. The ASW usually accompanies the patient and delivers the section papers in person. He/she is responsible for securing the premises of the patient's home. The ASW informs the patient and next of kin of the decision.

If the patient is not admitted

When the patient is not admitted to hospital, a package of follow-up care needs to be agreed with the patient and next of kin, if appropriate. Arrangements may need to be made to contact mental-health or social work teams during working hours to inform them of the assessment, to make a referral, or both. *You are entitled to submit a claim form* (usually held by the ASW).

This is not intended to be a comprehensive guide to the Mental Health Act. Consultation of the most recent Code of Practice is recommended.

Assessment under the Mental Health (Northern Ireland) Order 1986 — a basic guide for General Practitioners

The 1986 Mental Health (Northern Ireland) Order provides the legal framework in Northern Ireland for compulsory admission and treatment of patients suffering from mental illness. GPs can be involved in Mental Health Order assessments in different settings:

- *Community*: The patient may be causing serious concern to family or neighbours. An application may be made for compulsory hospital admission for seven days, renewable to 14 days for assessment (Article 4). In extreme circumstances, if access is denied, a warrant authorizing a police constable to secure access may need to be used (Article 129). This warrant is obtained by an approved social worker (ASW), other officer of the Health and Social Services Trust or a police constable from a Justice of the Peace. If the constable has to enter the premises, by force or otherwise, he must be accompanied by a medical practitioner (usually a GP), who will administer medical treatment if required.
- *Hospital*: The patient may have been admitted informally and is now wanting to leave or is refusing treatment. An application for assessment involves the patient's own GP (or another practitioner who has previous knowledge of the patient) attending hospital to give the medical recommendation. A doctor on the staff of the hospital in which it is intended that the assessment should be carried out cannot give the recommendation except in a case of urgent necessity.

Use of the Mental Health Order

Compulsory admission for assessment of a patient can only occur when:

- he/she is suffering from a mental disorder of a nature or degree which warrants detention in hospital for assessment (or for assessment followed by medical treatment); *and*
- failure to detain the patient would create a substantial likelihood of serious physical harm to him or herself or to other persons.

Criteria for likelihood of serious physical harm are evidence of one of the following:

- the patient has inflicted, or threatened or attempted to inflict, serious physical harm on him/herself;
- the patient's judgement is so affected that he/she is, *or would soon be*, unable to protect him/herself against serious physical harm and that reasonable provision for his/her protection is not available in the community; *or*
- the patient has behaved violently towards other persons or so behaved such that other persons are placed in reasonable fear of serious physical harm to themselves.

Mental disorder comprises mental illness, mental handicap, severe mental handicap and severe mental impairment. In the Order, mental illness is defined as a 'state of mind which affects a person's thinking, perceiving, emotion or judgment to the extent that he requires care or medical treatment in his own interests or the interests of other persons.'

The Order *cannot be used* for the compulsory treatment of *addictions, personality disorders or sexual deviancy*, unless the above criteria are also met.

How to arrange a Mental Health Order assessment

An application for compulsory admission needs to be made by either the nearest relative (on Form 1) or an ASW (Form 2), supported by a medical recommendation (Form 3), usually the patient's own GP or, if not, a doctor who knows the patient personally and is not (except of urgent necessity) on the staff of the receiving hospital. Guidance on who is considered to be the 'nearest relative' under the Order is on the back of Form 1.

A Mental Health Assessment is activated by telephoning the duty-approved social worker. An ASW may be essential (in order to make the application), or highly desirable in order to support and advise the relative who is making the application. The ASW also makes an assessment of the social aspects of the case and provides a social report. Telephone them with the following information: name, date of birth, address, reason for assessment, previous history, including name of keyworker, next of kin (if known) and past history of violence of self harm (if known).

He/she will need enough information to decide if there is the possibility of an admission under the Mental Health Act and that the full assessment process is warranted.

If you want to discuss the management of the patient, either telephone the duty ASW or the duty consultant.

Before the assessment

Information is an important component of the assessment.

- If you can access your records, check for previous history and response to treatment, risk of neglect, violence or self harm, and any known contact names.
- If there is a relative or informant, ask about the recent situation, its duration, whether there is any support, whether there have been threats or violence and if the patient is known to carry or have access to weapons.
- Contact the ASW. An ASW may be essential (in order to make the application) or desirable in order to support and advise the relative who is making the application. Liaise with the ASW about directions, access to premises, where to meet and the need for police attendance.
- Where no ASW is involved, liaise with the nearest relative or other informant about directions, access to premises and need for police attendance, *bring Forms 1 and 3 with you* (available from the Health and Social Security Trust). Arrange police attendance if necessary.
- It is good practice (because it is safer, communication is better and disruption of the patient is minimized) for the professionals involved in the application for admission to be present at the same time (although it may be helpful for each to interview the patient separately). Everyone involved should be aware of the need to provide mutual support. In any case the applicant — whether relative or ASW — must have seen the patient within two days of signing the application and the doctor must examine the patient not less than two days before signing the application.

If the patient is suffering from the short-term effect of drugs, alcohol or sedative medication, discussion should take place about deferring the assessment until a more productive interview can take place.

During the assessment

The team necessary to make an application for compulsory admission is either:

- the nearest relative and a doctor (patient's own GP or a doctor who knows the patient personally); *or*
- an ASW and the patient's own GP or a doctor who knows the patient personally.

Where the nearest relative makes the application, advise them

that they can ask for an ASW to consider making the application in their stead (as sometimes making such an application may be detrimental to family relationships). Guidance on who is considered to be the 'nearest relative' under the Order is found on the back of Form 1.

Where an ASW makes the application, he/she must consult the nearest relative, unless this causes unreasonable delay. If the nearest relative objects to the application, the ASW must consult another ASW. Where no ASW is involved, a social worker (not necessarily an approved one) must interview the patient as soon as is practicable and provide a social report to the RMO in the receiving hospital.

The patient is interviewed as comfortably as possible with the following questions in mind:

- Is there any possible evidence of mental illness?
- Is there a substantial risk of serious physical harm to the patient or others?

If the answer to both of these questions is *yes*:

- Will the patient consent to informal admission, and if so, is that realistic, based on past experience or aspects of the current interview?
- Are there any community alternatives to admission? For example giving medication at home, community psychiatric nurse visits, crisis services, day hospitals.

The relatives and, if practicable, other significant informants, are interviewed to find out their views of the patient's needs, and whether, and in what ways, the patient's behaviour is different from his/her normal behaviour.

All parties strive to reach a *consensus*, and if the doctor agrees to make the medical recommendation for compulsory admission, the social worker or the nearest relative makes the application to the admitting hospital managers.

The doctor's recommendation must be made on *Form 3* and must include the following information: the grounds, including a clinical description of the mental condition of the patient, for the opinion that the detention is warranted; and the evidence for the opinion that failure to detain the patient would create a substantial likelihood of serious physical harm. Examples of what may be considered in assessing the likelihood of serious physical harm include: uncontrolled over-activity likely to lead to exhaustion, gross and protracted neglect of diet which would lead to malnutrition, gross neglect of hygiene and personal safety

which would create a hazard to the patient or others, disinhibited behaviour likely to lead to serious physical harm to the patient, his/her family or other persons. A diagnosis of the specific form of mental disorder is not required

Arranging admission

If the decision of the team is to admit the patient, the level of security required should be considered.

If an ASW is involved, arrangements are usually made by the doctor for a bed and the ASW for appropriate transport, unless an ambulance is required, in which case the doctor arranges this. The ASW usually accompanies the patient and delivers the application papers in person. He/she is responsible for securing the premises of the patient's home. The ASW informs the patient and nearest relative of the decision.

If no ASW is involved, liaise with the receiving hospital about arrangements for the patient's admission, transport to hospital and patient's need for care during removal, including medical and nursing escorts if required. Ensure the premises are secured and inform the patient of the decision. The nearest relative may accompany the patient and deliver the application papers.

The patient must be admitted to hospital within two days from the date on which the medical recommendation was signed, otherwise the authority to detain him or her expires.

If the patient is not admitted

When the patient is not admitted to hospital, a package of follow-up care needs to be agreed with the patient and nearest relative, if appropriate. Arrangements may need to be made to contact mental health or social work teams during working hours to inform them of the assessment and/or to make a referral.

This is not intended to be a comprehensive guide to the Mental Health Order. Consultation of the Code of Practice, the Guide and the Mental Health Order is recommended.

Use of the Mental Health (Scotland) Act 1984 — a basic guide for General Practitioners

The 1984 Mental Health (Scotland) Act provides the legal framework in Scotland for compulsory admission and treatment of patients suffering from mental disorder. GPs can be involved in using the Mental Health Act in a variety of circumstances:

- *Emergency recommendation for detention (Section 24)*: Used where admission is urgently required and use of Section 18 would introduce undesirable delay. Admission under Section 24 allows for a period of 72 hours of assessment. Any doctor can legally make the recommendation, but the consent of a Mental Health Officer (a social worker with special training) or a near relative, must be obtained, wherever practicable.
- *Non-emergency admission for up to six months (Section 18)*: Used where admission is required less urgently (eg where the patient's mental state deteriorates over time). In practice, this is mainly used for patients known to the service. An application is required from a Mental Health Officer (or occasionally the nearest relative) and recommendations from a Section 20-approved doctor (usually a psychiatrist and, where the patient is known to the service, the patient's own consultant psychiatrist) and the GP or another doctor with previous knowledge of the patient.
- *Power of entry (Section 117)*: This may need to be used where a patient with possible mental disorder in the community refuses assessment and help. For example, the patient may be behaving eccentrically, live in very poor conditions, may be ill-treated or neglected by others or alone and unable to care for him/herself. This warrant is obtained by a Mental Health Officer from a Justice of the Peace. It allows a police officer, accompanied by a doctor, to force entry. The person may then be removed to a place of safety with a view to assessment for admission under Section 24.
- *Treatment of a patient who is on leave of absence*: A detained patient may be allowed out of hospital on a 'leave of absence' of up to year. GPs must only prescribe psychiatric medications that are consistent with the agreed treatment plan, set out on Form 9

(where the patient is consenting to treatment) or Form 10 (where the patient is not consenting to treatment). GPs should expect to be told of the conditions of the leave of absence, the circumstances in which the patient is likely to be recalled to hospital and the arrangements in relation to treatment.

Use of the Mental Health Act

Compulsory admission can only occur when:

- there is a mental disorder; *and*
- the patient requires hospital admission in the interest of the health or safety of the patient *or* the protection of others; *and*
- such admission cannot be achieved without compulsory measures.

The Act allows the compulsory admission of a patient who is very distressed or ill (for example, actively psychotic or manic) solely in order to improve their health, even if they are not thought to be at immediate risk of harming themselves or others.

Mental disorder comprises mental illness, mental impairment, severe mental impairment and disorder manifested only by persistent abnormally aggressive or seriously irresponsible conduct. In the Act, mental illness is not defined but is a matter for clinical judgement. Dependence on alcohol or drugs is excluded *per se*, but psychiatric symptoms secondary to drug and alcohol abuse (eg drug-induced paranoid psychosis, Korsakoff psychosis) are included. Mental disorder manifested only by mental impairment or only by abnormally aggressive or seriously irresponsible conduct may be grounds for detention under Section 18 only where treatment in hospital is likely to alleviate or prevent a deterioration in the patient's condition.

Before the assessment

Information is an important component of the assessment.

- If you can access your records, check for previous history and response to treatment, risk of neglect, violence or self harm, and any known contact names.
- If there is a relative or informant, ask about the recent situation, its duration, whether there is any support, whether there have been threats or violence and if the patient is known to carry or have access to weapons.
- Contact the duty Mental Health Officer (MHO). For Section 24, involvement of an MHO is desirable; for Section 18, it is

essential. He/she will need the following information: the name, date of birth, address, reason for assessment, previous history, including name of keyworker, next of kin (if known) and past history of violence of self harm (if known). He/she will need enough information to decide if there is the possibility of an admission under the Mental Health Act

- Liaise with the MHO about directions, access to premises, where to meet and the need for police attendance. It is good practice (because it is safer, communication is better and disruption of the patient is minimized) if the medical assessment(s) take place jointly with the MHO at the same agreed time. For Section 24, only one medical recommendation is needed. For Section 18, two are required; they may be provided up to five days apart.
- If the patient is suffering from the short-term effect of drugs, alcohol or sedative medication, discussion should take place about deferring the assessment until a more productive interview can take place.
- Take copies of Form A (the emergency detention form) with you. If no copies of Form A are available, take practice-headed notepaper.
- If you want to discuss the management of the patient, either telephone the duty MHO or the duty consultant.

During the assessment

The patient is interviewed as comfortably as possible with the following questions in mind:

- Is there any possible evidence of mental disorder?
- Is there a risk to the health or safety of the patient or a danger to others?

If the answer to both of these questions is *yes*:

- Will the patient consent to informal admission, and if so, is that realistic, based on past experience or aspects of the current interview?
- Are there any community alternatives to admission? For example, giving medication at home, community psychiatric nurse visits, crisis services, day hospitals.

For Section 24:

- Seek the consent of the MHO or a near relative. A list of who is considered a 'relative' under the Act can be found on Form A. Being involved in the compulsory admission of a relative to

hospital can sometimes damage family relationships; therefore, if it is practicable, advise the relative that there is an alternative (that is, an MHO can perform the consent role). If it is not practicable to seek consent from either an MHO or a near relative, a single doctor's recommendation is sufficient, but the reason for failure to seek consent *must* be explained on the recommendation form. If the relative and MHO refuse consent, compulsory admission cannot go ahead.

- Complete the recommendation on Form A (or on practice-headed notepaper), include full details of your qualifications, a declaration that you have examined the patient at the time of the application, that the patient is subject to a mental disorder, that treatment is necessary in the interests of the health or safety of the patient or the protection of others, reasons why detention is urgently necessary and the use of Section 18 is precluded, and whose consent has been obtained (or reasons why it has not been possible to obtain the consent of an MHO or a near relative). The documentation must be completed on the same day as the patient examination.

For Section 18:

The MHO will normally take responsibility for coordinating the assessment, bringing relevant papers and ensuring the process complies with the law.

The team needed for a Section 18 (six months for treatment) is:

- A Section 20-approved doctor. Where the patient is known to the service, this doctor should be the patient's own consultant psychiatrist.
- The nearest relative or an MHO. The MHO makes a more comprehensive assessment of the social aspects of the case and advises on the legal issues that may arise during the process.)
- A doctor with prior knowledge of the patient (ideally the GP).

All professionals strive to reach a *consensus*, and if the two doctors agree to make the medical recommendations for compulsory admission, the MHO makes the application to the Sheriff within seven days. The MHO must make the application even if he/she disagrees with the medical recommendations. The Sheriff may call a hearing, which may involve the attendance of the GP to court.

Arranging admission

If the decision of the team is to admit the patient, the level of security required should be considered.

Discuss with the MHO how the patient is to be managed, including who is to accompany the patient and deliver the section papers, who will secure the premises and who inform the patient and relative of the decision. Liaise with the receiving hospital to ensure a bed is available, to discuss arrangements for the patient's admission, transport to hospital and patient's need for care during removal, including medical and nursing escorts, if required.

Emergency detention is not a 'treatment order' and the patient cannot therefore be forced to accept any form of treatment. However, in emergency circumstances, medication can be given under the common law principle of necessity to control acute symptomatology or behavioural disturbance where risk to life and safety are involved.

If the patient is not admitted

When the patient is not admitted to hospital, a package of follow-up care needs to be agreed with the patient and next of kin, if appropriate. Arrangements may need to be made to contact mental-health or social-work teams during working hours to inform them of the assessment and/or to make a referral.

This is not intended to be a comprehensive guide to the Mental Health Act. Consultation of the most recent Code of Practice is recommended.

Template chart for local resources — statutory services

It is important for clinicians in primary care to have ready access to information about local agencies that can help their patients. The following page contains a suggested template for a simple wall chart. Alternatively, the information can be available on computer in consultations. You may find it helpful to fill in the names and telephone numbers of local agencies, plus the arrangements for referral (for example, what is considered to be an emergency and the standard time to appointment for an urgent referral), enlarge and copy the chart and put it on the walls of all consulting rooms. Set a date for re-checking the telephone numbers and up-dating the charts and delegate this task to a specific person. This could be done on a primary care organization or practice basis.

Template for local resources

Local statutory services for mental health and learning disability				
	Adults	Elderly	Child and adolescent	Learning disability
Inpatient services				
Community services		Old age psychiatrist Neurologist Community resource team Day care Chiropody Incontinence nurse	Child psychiatric clinic Day unit Child psychotherapy Clinical psychology	Learning disability psychiatric team Occupational therapist Learning disability nurse Child development centre Toy library Physiotherapy Speech therapy Day care
Social services	Adult mental health teams ASW services.	Elderly teams Occupational therapist Elderly mental health services		Adult learning disability social care team Residential care
Department of Social Security				
Agreed priority groups				
Referral arrangements:				
Emergency referrals (9 am-5 pm Mon-Fri)				
Emergency referrals (outside working hours)				
Urgent referrals				
Routine referrals				

Template chart for local resources — voluntary agencies

Non-statutory, voluntary services for mental health and learning disability		
Alcohol/drug support	Carer support	Ethnic support
Anxiety/stress	Depression	Parents and children
Learning disability	Counselling	Suicidal thoughts and self harm
Bereavement	Elderly support	Relationships
Welfare Citizens Advice Bureau Benefits Agency Debt Counselling	Mental illness MIND Manic Depression Fellowship National Schizophrenia Fellowship User support service	Young people

This is a suggested template for a simple wall chart. Alternatively, the information can be available on computer in consultations. You may find it helpful to fill in the names and telephone numbers of three local agencies under each heading, enlarge and copy the chart and put it on the walls of all consulting rooms. Set a date for re-checking the telephone numbers and up-dating the charts and delegate this task to a specific person. This could be done on a primary care organization or practice basis.

Resource directory

The following self-help, non-statutory and voluntary organizations are all national organizations, and the numbers are head-office numbers. Many of the agencies have networks of support groups across the country and they will be able to tell you where your nearest group is. All encourage self-referral. You may wish to adapt this directory to include details of your local groups.

Alcohol misuse

AI — Anon Family Groups UK and Eire (local groups)
61 Great Dover Street, London SE1 4YF

24-hr helpline: 020 7403 0888

Understanding and support for families and friends of alcoholics whether still drinking or not.

Alateen for young people 12–20 years affected by others' drinking.

Alcoholics Anonymous (local groups)

PO Box 1, Stonebow House, General Service Office, Stonebow,
York YO1 7NJ

01904 644026 Administration

Helplines:

020 7352 3001/020 7833 0022 (London)

0141 226 2214 (Scotland)

01907 625574 (Mid-Wales); 01685 875070 (South Wales); 01639
644871 (Swansea)

Helpline and support groups for men and women trying to achieve and maintain sobriety and help other alcoholics to get sober.

Drinkline

UK helpline: 0800 9178282 (Monday to Friday 11 am–11 pm)

Asian Line: 0990 133 480 (Monday 1–8 pm) Hindi, Urdu, Gujarati
and Pujabi

120 Confidential alcohol counselling and information service.

Northern Ireland Community Addiction Service
40 Elmwood Avenue, Belfast BT9 6AZ
02890 664 434.

Scottish Council on Alcohol
2nd Floor, 166 Buchanan Street, Glasgow G1 2NH
0141 333 9677.

Anxiety, panic and phobias

No Panic (local groups)
93 Brands Farm Way, Telford TF3 2JQ
Helpline: 01952 590545 10 am–10 pm
Head Office: 01952 590005
Information line only: 0800 783 1531
Helpline, information booklets and local self-help groups for
people with anxiety, phobias, obsessions and panic.

Stresswatch Scotland
The Barn, 42 Barnweil Road, Kilmarnock KA1 4JF
01563 574144 (office)
Helpline: 01563 528910 10 am–1 pm Mon–Fri, excluding Wed
Advice, information and materials on panic, anxiety and stress
phobias. 35 local groups.

Triumph Over Phobia (TOP UK) (local groups)
PO Box 1831, Bath BA2 4YW
01225 330353 (office)
Structured self-help groups for those suffering from phobias or
obsessive compulsive disorder. Each group has a volunteer leader
and four or five supporters. Average recovery rate is five months.

Bereavement

Cruse Bereavement Care (local groups)
126 Sheen Road, Richmond, Surrey TW9 1UR
020 8940 4818
National helpline: 0345 585565
Help for bereaved people and those caring for bereaved people.

Foundation for the Study of Infant Deaths (FSID) (local groups)

14 Halkin Street, London SW1X 7DP

020 7235 1721 24-hr helpline

020 7235 0965 (enquiries)

National helpline, local parent groups and befrienders.

Still Birth and Neonatal Death Society (SANDS)

28 Portland Place, London W1N 4DE

020 7436 5881

020 7436 7940 (Admin)

Support for parents whose baby is stillborn or dies within 28 days of birth.

Compassionate Friends

53 North Street, Bristol BS3 1EN

Helpline: 0117 953 9639 9.30 am–5 pm

National organization of bereaved parents offering friendship and understanding to other bereaved parents.

Bipolar disorder (Manic depression)

Manic Depression Fellowship (local groups)

8–10 High Street, Kingston-upon-Thames, Surrey KT1 1EY

020 8974 6550

Advice, support, local self-help groups and publications list for people with manic depressive illness.

Manic Depression Fellowship (Scotland)

7 Woodside Crescent, Glasgow G37UL

0141 331 0344

Carers

Carers National Association (local groups)

20–25 Glasshouse Yard, London EC1A 4JS

020 7490 8818

Helpline: 0808 808 7777 10 am–12 noon and 2 pm–4 pm

122 Activities include information and advice service for carers.

Association of Crossroads Care Attendants Scheme (local groups)

10 Regent Place, Rugby CV21 2PN

01788 573653

One hundred and ninety regional centres throughout UK, providing practical support and help for carers, including respite care, day centres, befriending and night care. Scheme for young carers also.

Children and adolescents (see also 'Parents and children' below)

Childline

0800 1111 24 hours, free

Confidential helpline for children and young people.

ERIC (Enuresis Resource and Information Centre)

Helpline: 0117 960 3060 (9.30 am–5.30 pm, weekdays)

Information, pen-pal system for children, and details of all enuresis clinics in the country.

Young Minds Trust

102–108 Clerkenwell Road, London EC1 5SA, UK

020 7336 8445

Parent information service: 0800 018 2138

Produces a range of leaflets for parents and young people.

Counselling and psychotherapy

UK Register of Counsellors

01788 568739

Supplies names and addresses of British Association of Counsellors (BAC)-accredited counsellors. They are all appropriately trained and qualified, work to codes of ethics and are subject to complaints procedures.

United Kingdom Council for Psychotherapy (UKCP)
020 7487 7554

Provides information on registered therapists and training organizations.

Counsellors in Primary Care (CPC)
95 Hewarts Lane, Bognor Regis, West Sussex PO21 3DJ
01243 268322

Members are counsellors who work in primary care and who meet defined standards of training and practice.

The British Confederation of Psychotherapists
020 8830 5173

Register of psychotherapists, including psychoanalysts, analytical psychologists, psychoanalytical psychotherapists and child psychotherapists.

British Psychological Society
St Andrew's House, 48 Princess Road East, Leicester LE1 7DR
0116 2549 568

Produces a directory of chartered clinical psychologists. The directory is also available in most reference libraries.

British Association for Behavioural and Cognitive Psychotherapy
c/o Harrow Psychological Health Services, Northwick Park Hospital, Watford Road, Harrow, Middlesex HA1 3UJ

Produces a directory of accredited cognitive behavioural practitioners. List is free but please encloses an SAE.

Institute for Counselling and Personal Development Trust
Interpoint, 20–24 York Street, Belfast BT15 1AQ
02890 330996

124 Offers counselling and psychotherapy (normally free), course for helpers and community training and development courses.

Debt (see also 'Welfare' below)

National Debtline
0645 500511

Dementia

Alzheimer's Disease Society (local groups)
Gordon House, 10 Greencoat Place, London SW1P 1PH
020 7306 0606

National Helpline: 0845 300336 8 am–6 pm
Support to families and friends of people with dementia.

Domestic violence

Women's Aid
National Helpline 0345 023468

Domestic Violence Unit or Community Safety Unit
Contact local Police Force for details

Depression

Depression Alliance (local groups)
35 Westminster Bridge Rd, London SE1 7JB
020 7633 9929 (Answerphone)

National network of self-help groups, information for people suffering from depression and carers.

Aware Defeat Depression Ltd (local groups)
Depression Information Centre, 22 Great James Street,
Derry BT48 7DA
02871 260602

Provides information leaflets, lectures and runs support groups for sufferers and relatives.

Association for Post-Natal Illness

25 Jerdan Place, London SW6 1BE

020 7386 0868 (Monday to Friday 10 am–5 pm)

Runs a network of volunteers to support sufferers throughout the UK. Leaflets available.

Seasonal Affective Disorders Association

PO Box 989, Steyning BN44 3HS

Information about Seasonal Affective Disorder (SAD). Offers advice and support to members.

Drug misuse

The Council for Involuntary Tranquilliser Addiction (CITA)

Cavendish House, Brighton Road, Waterloo, Liverpool L22 5NG

0151 474 9626

Helpline: 0151 949 0102 10 am–1 pm Monday to Friday

Support and information to help people withdraw from tranquillizers.

Narcotics Anonymous

For advice, information and counselling on drug addiction

020 7730 0009

For leaflets, telephone the UK Service Officer on 020 7251 4007.

Adfam National

Waterbridge House, 32–36 Loman Street, London SE1 0EE

Helpline: 020 7928 8900 10 am–5 pm Monday, Wednesday,

Thursday and Friday, 10 am–6.45 pm Tuesday

Confidential support and information for families and friends of drug users.

Families Anonymous (local groups)

UK Office, Unit 37, The Doddington and Rollo Community Association, Charlotte Despard Avenue, Battersea, London SW11 5JE

020 7498 4680 Monday to Friday 1 pm–5 pm

Runs self-help groups in the UK for families and friends of those with a drug problem.

Release

Advice line: 020 7729 9904 10 am–6 pm

24-hr helpline: 020 7603 8654

Drugs in Schools helpline: 0345 366 666 10 am–5 pm
Monday–Friday

Advice, support and information to drug users, their families and friends, on all aspects of drug use and drug-related legal problems

Eating disorders

Centre for Eating Disorders (Scotland)

3 Sciennes Rd, Edinburgh EH9 1LE

0131 668 3051

Information, private psychotherapy, self-help manuals.

Eating Disorders Association

1st Floor, Wensum House, 103 Prince of Wales Road, Norwich
NR1 1DW

01603 619090

Helpline: 01603 621414 Monday to Friday 9 am–6.30 pm

Youth helpline (for under 19s): 01603 765050 4–6 pm weekdays

Information packs for patients and professionals, including pack for purchasers.

Overeaters Anonymous (local groups)

01454 857158 (recorded message)

Self-help groups for those suffering from eating disorders or overeating.

Anorexia Bulimia Careline

84 University Street, Belfast BT7 1HE

02890 614440.

Ethnic minorities

Commission for Racial Equality (local groups)
10 Allington Street, London SW1E 5EH

020 7828 7022

This is a statutory body set up under the Race Relations Act. It can help individuals with cases of racial discrimination and investigate instances of discrimination. It is a network of 80 or more Race Equality Councils in most of the UK's large towns and cities.

Jewish Association for the Mentally Ill (JAMI)
707 High Road, Finchley, London N12 0BT

020 8343 1111

Offers guidance, counselling and support to sufferers and carers. Runs a help and referral line.

NAFSIYAT
278 Seven Sisters Road, London N4 2HY

020 7263 4130

An intercultural therapy centre. Its own services are local; however, it may be able to assist in providing information about counsellors from black and ethnic minority groups in other areas of the UK.

Refugee Council
3 Bondway, London SW8 1SJ

020 7820 3000

Gives practical support and advice to refugees. Provides information on mental health services to refugees and their advisers.

Learning disability

Mencap
123 Golden Lane, London EC1Y 0RT

020 7454 0454

Information line: 020 7696 5593

Information and support for people with a learning disability and their families in the UK. Provides residential, employment, further education and leisure and holiday services.

Mencap Northern Ireland

Segal House, 4 Annadale Avenue, Belfast BT7 3JH

02890 691351

Family Advisory Service Line: 0345 636227

Down's Syndrome Association

155 Mitcham Road, London SW17 9PG

020 8682 4001 (Tuesday, Wednesday and Thursday, 10 am–4 pm)

Information and support for people with Downs Syndrome and their families.

Scope (formerly the Spastic Society) — local groups

12 Park Crescent, London W1N 4EQ. Tel: 020 7636 5020

Website: <http://www.scope.org.uk/>

Freephone Cerebral Palsy Helpline: 0800 626216

Information, emotional support, and support groups for people with cerebral palsy and their families. Only some people with cerebral palsy have learning disabilities in addition to their physical disabilities.

National Autistic Society (local groups)

393 City Road, London EC1V 1NG

Helpline: 020 7903 3555

Office: 020 7833 2299

Information service, literature, national diagnostic and assessment service, supported employment scheme, befrienders and other services.

Mental health and illness — general

MIND (local groups)

Granta House, 15–19 Broadway, Stratford, London E15 4BQ

0208 519 2122

Variety of information sheets and booklets for users, local groups and other publications.

MINDinfoLINE

08457 660 163 (outside London)
020 8522 1728 (Greater London)

National telephone information service on Mental Health Issues.
Open 9.15 am–4.45 pm, Monday to Friday

SANELine

Helpline: 0345 678000 seven nights 2 pm–midnight
National helpline for mental health information.

Mental Health Drugs Helpline

Run by the UK Psychiatric Pharmacy Group and staffed by experienced mental-health pharmacists, this provides independent advice and information about drugs to patients and carers.

020 7919 2999 (11 am–5 pm Monday–Friday, excluding Bank Holidays).

Drug information website for service users

Run by the Chair of the Psychiatric Pharmacy Group, this site contains detailed, user friendly information on psychiatric drugs.

URL: <http://www.nmhc.co.uk>.

Mental Health Foundation

20/21 Cornwall Terrace, London NW1 4QL

020 7535 7400

Has a series of free leaflets about mental illness and learning disabilities for the general public.

Hearing Voices Network (local groups)

Dale House, 35 Dale Street, Manchester M1 2HF

0161 228 3896 Monday, Tuesday, Wednesday, Friday 10 am–3 pm; answerphone at all other times

Self-help groups to allow people to explore their voice-hearing experiences in a secure and confidential way. Information pack available.

Cause for Mental Health

2 Castle Village, Carrickfer, County Antrim BT38 7BH

01960 367728

Helpline: 0845 6030291

Northern Ireland Association for Mental Health

Central Office, 80 University Street, Belfast BT7 1HE

02890 328474

Provides services in the community for people with mental-health needs and campaigns to increase public awareness of mental health issues.

Scottish Association for Mental Health

Cumrae House, 15 Carlton Court, Glasgow G59JP

0141 568 7000

Information about any aspect of mental health.

Parents and children

Home-Start UK (local branches)

2 Salisbury Road, Leicester LE1 7QR

0116 233 9955. 8.30 am–5.15 pm

Volunteers offer support, friendship and practical support to young families with at least one child under five, who are experiencing difficulties and stress.

Parentline (and the National Stepfamily Association)

Helpline: 0808 8002222 (9 am–9 pm Monday to Friday, 9.30 am–5 pm Saturday, 10 am–3 pm Sunday)

Office: 01702 554782

Information sheets and books about belonging to a stepfamily:
020 7209 2460

Offers help and advice to parents on all aspects of bringing up children and teenagers. Provides support for parents under stress.

Parents Anonymous (local groups)

020 7263 8918

Offers friendship and help to parents who are at risk of abusing their children and those who may have done so. Offers telephone counselling and network of local groups.

Parent Network (local groups)

020 7735 1214

Self-help groups for parents.

Newpin (Northern Ireland) (local groups)

Development Office, 8 Windsor Avenue, Lurgan, County Armagh
BT67 9BG

01762 324843

Befriending and support groups for parents of young children who are under stress. Work focuses on alleviating maternal depression and distress. Provides training in parenting skills, family play programmes.

Relationship problems

Relate (local groups)

Herbert Gray College, Little Church Street, Rugby CV21 3AP

01788 573241

Web site: www.relate.org.uk

For access to a network of local counselling and advice centres. Relationship counselling for couples or individuals over 16. Sex therapy for couples. Clients pay on a sliding scale.

Rapport — couple counselling

(Care for the Family) covers whole of UK

029 2081 1733.

Self-care for professionals

British Medical Association Stress Counselling Service
0645 200169

24-hr, free, confidential counselling service available to doctors, their families and medical students, to discuss personal, emotional and work related problems.

National Counselling Service for Sick Doctors
0170 935 5982

Confidential advisory service. Deals with concerns about own health or that of a colleague.

Medical Council on Alcoholism
020 7487 4445

Royal College of Nursing

0345 726 100

24-hr service for information and advice. Calls charged at local rates. Service is free.

Schizophrenia

National Schizophrenia Fellowship (local groups)
28 Castle Street, Kingston-upon-Thames, Surrey KT1 1SS

020 8547 3937

NSF (Scotland), Claremont House, 130 East Claremont St,
Edinburgh EH1 4LB

0131 557 8969

NSF (Northern Ireland), 'Wyndhurst', Knockbracken Health Care
Park, Saintfield Rd, Belfast BT8 8BH

01232 402 323

Monthly social groups for clients with schizophrenia living in the
community and relatives support.

Self-harm

Bristol Crisis Service for Women
PO Box 654, Bristol BS99 1SH

0117 925 1119 (office and helpline)

Helpline: Friday and Saturday night 9 pm–12.30 am

Telephone counselling and information service relating to self-injury. Bi-monthly newsletter *Shout* on self-harm.

Basement Project

PO Box 5, Abergavenny, Gwent NP7 5XW

01873 856 524

Publications on self-harm, run groups and workshops and work with people (mainly women) who have been abused. They have a national forum of people who work with self-harm.

National Self-Harm Network

PO Box 16150, London NW1 3WW

They provide information sheets and training, and campaign for the understanding of people who self-harm.

Suicidal feelings

Samaritans (local groups)

National Office — administration only: 10 The Grove, Slough, Berks SL1 1QP

01753 532713

Support by listening for those feeling lonely, despairing or suicidal.

UK-wide telephone helpline: 0345 909090

Website: www.samaritans.org.uk

CALM (for young men)

Helpline: 0800 58 58 58

Trauma

Trauma Aftercare Trust (TACT)

Buttfields, The Farthings, Withington, Glos GL54 4DF

01242 890498 (Administration)

24-hr helpline: 01242 890306

Provides information about counselling and treatment for post-traumatic stress disorder

Victim Support

National Office, Cranmer House, 39 Brixton Road, London SW9 6DZ

020 7735 9166; Fax: 020 7582 5712

Victim Supportline

PO Box 11431, London SW9 6ZH

0845 30 30 900 (9 am–9 pm, Monday–Friday; 9 am–7 pm, Saturday and Sunday; 9 am–5 pm, Bank Holidays)

Provides emotional support and practical information for anyone has suffered the effects of crime, regardless of whether the crime has been reported.

Welfare and advice for practical problems

Citizens Advice Bureau (See local telephone directory for nearest one)

National Association of Citizens Advice Bureau: 020 7833 2181

Provide a wide range of free and confidential advice and help. Subjects include social security benefits, housing, family and personal matters, money advice and consumer complaints.

Benefits Enquiry Line

0800 882200

For information about Disability Living Allowance and Invalid Care Allowance and other benefits.

Shelter Helpline

0800 446441

Free 24-hr helpline, giving general advice and help on housing problems.

Mental health in your practice: what does your practice offer?

You may like to consider the following:

Practice organization:

1. A practice policy for what receptionists should do when faced with a patient who is very agitated or anxious.
2. Some longer slots booked in surgeries to allow for people with emotional problems.
3. Routine follow-up appointments for people prescribed antidepressants, with a doctor or another member of the team.
4. Encouraging patients with chronic mental disorders to see the same team member at each visit.
5. A register of patients with severe or chronic mental illness to ensure regular follow-up and monitoring.
6. Reviewing the 'mental health workload' of each partner. If it falls disproportionately on one or a small number of partners, consider ways of relieving the pressure; alternatively, consider acknowledging and supporting the partners' specialization as part of the way the team operates.

Information and support for patients:

7. Information leaflets or audio-tapes for people suffering mental ill health.
8. Information readily available to patients and all members of the practice team about community or voluntary groups who can help patients suffering mental ill health.

Skills within the primary-care team:

9. Reviewing the skills of all members of the team — doctors, health visitor, practice nurse, counsellor, district nurse, school nurse. What kinds of problems/patients is each competent to deal with? Are all members of the team aware of the skills already available within the team?
10. Checking the training and support needs of practice nurses or others who are involved in activities, such as giving depot injections or monitoring of lithium.
11. Developing further primary mental-health skills within the team. Consider:

- structured problem-solving
 - activity planning — depression
 - teaching controlled breathing — anxiety
 - teaching relaxation — anxiety
 - motivational interviewing — alcohol and drug misuse
 - supporting graded exposure to feared situations — anxiety, particularly phobias
 - encouraging more appropriate thinking (cognitive skills) — depression and anxiety
 - re-attribution of symptoms from physical to emotional causes
 - asking about suicidal intentions
 - managing self-harming behaviours.
12. Seriously considering clinical supervision, peer or external, for team members who take on a significant counselling or mental health work load.

Liaison with community mental-health and substance-abuse services:

13. Regular, face-to-face meetings with the relevant person from the community mental health team(s) which serve your practice.
14. Arrangements to 'share' people with a severe mental illness and those with substance abuse.
15. Displaying the contact details of the key worker for each person with a severe mental illness prominently on the patient notes.

Psychological therapies:

16. Reviewing the access, via secondary care or non-statutory agencies, to cognitive, behavioural, family or other psychological therapies.

Stress management for the primary-care team:

17. Meeting with members of the practice team to consider how you might provide support for each other to minimize your own stress.
18. Liaison with the primary care group to consider some form of regular psychological support system for health professionals.

Further reading and websites

Clinical

Andrews G, Jenkins R (eds). *Management of Mental Disorders* (UK edition). Sydney: World Health Organization Collaborating Centre for Mental Health and Substance Abuse, 1999.

Excellent, accessible textbook for use by GPs and generalist mental-health clinicians working in community settings. Lots of practical advice, resource materials and assessment instruments. Covers core management skills, medication, affective disorders, anxiety and somatoform disorders, schizophrenic disorders, dieting disorders, substance-use disorders, child and adolescent disorders, personality problems, sexual dysfunction and sleep disorders.

Armstrong E. *Mental Health Issues in Primary Care: a Practical Guide*. Basingstoke: Macmillan Press, 1995.

Written for generalist nurses in primary care by a health visitor and mental-health educator. Discusses treatments available and strategies for prevention for depression, anxiety and schizophrenia.

Taylor D, McConnel D, Abel K, Kerwin R. *The Bethlem and Maudsley NHS Trust Prescribing Guidelines*. London: Martin Dunitz Ltd, 1999.

Provides detailed, annually updated information on prescribing psychotropic drugs. Helpful charts and flow charts.

Bazire S. *GP's Psychotropic Handbook (2nd edition)*. Salisbury: Quay Books, 1998
Compact, up-to-date information on psychiatric drugs. Contains community oriented information.

Padesky C, Greenberger D. *Clinicians Guide to Mind over Mood*. New York: Guilford Press, 1995.

Guide to cognitive therapy. Supports clinicians in acting as guides to patients using the companion volume *Mind over Mood: a Cognitive Treatment Manual for Clients*. Suitable for use by primary-care counsellors, or others with appropriate training.

Daines B, Gask L, Usherwood T. *Medical and Psychiatric Issues for Counsellors*. London: Sage, 1997.

Proudfoot J. *Beating the Blues*. London: Ultramind Group plc, 1999.

Eight-session, interactive, multimedia therapy programme for the treatment of anxiety and depression. Department of Psychology, Institute of Psychiatry Maudsley Hospital, De Crespigny Park, Denmark Hill, London SE5 8AF. Phone: 020 7600 6777.

Service development in primary care

Mental Health Foundation. *Knowing Our Own Minds: a Survey of How People in Emotional Distress Take Control of Their Lives*, 1997.

138

Valuable summary of what people with mental-health problems find useful; many simple, cost effective options.

Byng R, Single H. *Developing Primary Care for Patients with Long-term Mental Illness: Your Guide to Improving Services*. London: Kings Fund, 1999.

Practical guide for primary-care teams and community mental-health teams to developing shared care.

Clinical Standards Advisory Group. *Depression*. London: Department of Health (forthcoming).

Evidence-based standards for services for depression, review of state of current services and recommendations for improving services. Focuses largely on primary care.

Gask L, Sibbald B, Creed F. Evaluating models of working at the interface between mental health services and primary care. *Br J Psychiatry* 1997, 170: 6–11.

Guide to setting up and running a managed primary care counselling service. Counselling in Primary Care. 95 Hewarts Lane, Bognor Regis, West Sussex PO21 3DJ. Tel: 01243 268322.

Cohen A, Paton J. *Developing an Integrated Mental Health Service: a Workbook for Primary Care Groups*. London: Sainsbury Centre for Mental Health, 1999.

Internet resources for mental health

Centre for Evidence-Based Mental Health.

This centre has established a website with extracts from the journal *Evidence-Based Mental Health*, which includes a useful evidence-based mental health toolkit. It is a gateway to many other related sites through its links.

URL: <http://www.cebmh.com/>

The Cochrane Collaboration

URL: <http://www.update-software.com/ccweb/default.htm>

NHS Centre for Reviews and Dissemination

URL: <http://www.york.ac.uk/inst/crd/welcome.htm>

Health Evidence Bulletins Wales

URL: <http://www.uwcm.ac.uk/uwcm/lb/pep>

Institute of Psychiatry, Kings College, London

URL: <http://www.iop.kcl.ac.uk/main>

See the Institute's library page for links to other resources.

Mental Health Foundation

URL: <http://www.mentalhealth.org.uk>

PriMHE (Primary Care Mental Health Education)

Information and links specific to primary care mental health.

URL: <http://www.primhe.org>

UK Psychiatric Pharmacy Group

Useful resources section, including 'Bespoke', an individualized patient information system.

URL: <http://www.ukppg.co.uk>

What do the different mental-health professionals do?

Community mental-health teams

Community mental-health teams provide assessment, treatment and care for individuals and groups, outside hospitals. They comprise a mix of the professionals described below but not all are represented in every team. Community psychiatric nurses (CPNs) are the most numerous.

Psychiatrists

These are doctors who have specialized in mental health and who work both in hospitals and, increasingly, in the community. They are responsible for diagnosis, the general mental health and physical care of patients, including medication, and have specific responsibilities in the implementation of the Mental Health Act. Some have further specialist training in areas such as the psychiatry of old age or psychotherapy.

Psychiatric nurses

These are the most numerous professionals in mental health. Most of their basic training takes place in hospital.

Community psychiatric nurses

CPNs are usually registered mental nurses, some of whom have completed the ENB training for community work. They are based in the community and care for people with mental illness in their own homes and communities. Their role can include psychological therapies, long-term support, counselling and administering medication by 'depot' injection.

Clinical psychologists

Clinical psychologists have a degree in psychology and a postgraduate qualification in clinical work. They play a key role in assessment and may carry out a wide range of treatments, such as behavioural therapy and cognitive therapy. They may provide training and supervision in this kind of work to other professionals.

Psychotherapists, psychoanalysts and counsellors

These professionals all offer 'talking treatments'. The methods, intensity of treatment and the length of time involved varies. Individual or group therapy may be offered. Many psychotherapists are also psychiatrists, psychologists or nurses. Primary-care counsellors offer a brief, focused intervention across a wide spectrum of mild to moderate disorders.

Occupational therapists

OTs work in hospital and in the community. Their role is to help people to develop confidence and skills in daily living, using a variety of techniques, such as creative therapies and training in practical tasks.

Mental-health social workers

Mental-health social workers have a general qualification in social work and may have specialized later in mental health. They act as care managers:

- assessing people with severe and complex needs
- working closely with health colleagues
- coordinating and monitoring care plans
- ensuring service users get the services they need — respite care, residential accommodation, supported housing, or support from a community care worker.

Less frequently, they may also provide formal counselling or psychotherapy.

**Approved social workers (ASW) — in Scotland:
Mental health officers**

These have undertaken specialist training in mental health and are approved under the Mental Health Act 1983 (in Scotland, the Mental Health Act 1984, and in Northern Ireland, the Mental Health Order 1986), to carry out the following duties:

- Assessments for urgent admission to hospital — approved social work assessments under the Mental Health Act
- Acting as supervisors under the supervised discharge procedures
- Acting as social supervisors for mentally disordered offenders subject to Home Office supervision.

Community care workers/support workers

Community care workers are non-professional members of the community mental-health team, who support and encourage

people to regain or maintain their confidence and independence by offering help in the following ways:

Practical:

- Budgeting/debt management
- Employment-paid and unpaid
- Social contact/using community resources
- Daily living skills
- Advocacy/negotiation with other agencies
- Life and social skills.

Emotional:

- Listening
- Confidence-building
- Esteem-building
- Stress/anxiety management
- Continuous regular contact.

Day care services

Day care services aim to provide a number of groups that offer a supportive environment, and a safe space to relax in. This helps people build self-esteem and confidence, while giving an opportunity to meet others. Drop-in sessions, sports and activity groups, and outings are all included as part of the day service.

Child guidance and child psychiatric clinics

These are usually staffed by a multidisciplinary team, including psychologists, social workers, specialist nurses and play therapists. Child psychiatric assessments usually involve the child and his/her parents. Sometimes, the whole family is involved. With the family's permission, contact with the school is often made.

Educational psychologists and education welfare officers

Provide a service for schools and help with problems associated with school.

Learning disability teams

Learning disability teams (similar to community mental-health teams) provide specialist health and social care services. Multidisciplinary teams usually include community learning disability nurses, psychiatrists, psychologists, speech and language therapists, physiotherapists, occupational therapists and may also include a dietitian.

Psychological therapies: what are they?

Behavioural therapy

Behaviour therapy is based on the belief that many of our actions are the result of things that we have learned. The focus of behavioural interventions is on definable behaviours which can be readily monitored and addressed in therapeutic interventions. It is a very directive therapy which sets objectives (in collaboration with the patient) for the patient to attain. Patients are given homework assignments. It is particularly good for treating phobias, obsessional and compulsive behaviour and can also be helpful in dealing with some sexual problems. Anxiety management and exposure therapy are particular types of behavioural therapies.

Anxiety management

This approach involves a varying mixture of behavioural strategies often taught in a group setting to people with anxiety problems. The strategies commonly include education about the nature of anxiety (eg fight-or-flight-response), recognising hyperventilation, the slow breathing technique, relaxation training and graded exposure. Stress management, assertiveness training and structured problem-solving may also be included, depending upon the training and background of the therapist and the needs of the clients.

Graded exposure

Patients who avoid particular places or people because of anxiety (ie those suffering from phobias, obsessive compulsive disorder or panic) are encouraged to gradually face the things that they fear, starting with easy situations and building up slowly to harder things. Breathing and relaxation techniques are used to help the patient remain in the feared situation until the anxiety diminishes and the patient learns that they can cope with the situation. The clinician supports the clients but does not need to accompany them in their assignments.

Cognitive therapy

Cognitive therapy is based on the idea that how you think largely determines the way you feel. Cognitive therapy teaches the

individual to recognise and challenge upsetting thoughts. Learning to challenge negative or fear-inducing thoughts helps people think more realistically and feel better. Patients are given homework assignments. Cognitive therapy is more complex than positive thinking. It is usually given in fifty minute sessions over 10–15 weeks.

Cognitive behavioural therapy (CBT)

This is a structured treatment combining elements of cognitive and behavioural therapy approaches, used to change a patient's thought processes and behaviour in order to bring about relief of symptoms or other practical objectives agreed by the patient. The range of techniques used includes challenging irrational beliefs, replacing the irrational beliefs with alternative ones, thought stopping, exposure, assertiveness and social skills training. Patients are given homework assignments.

Compliance therapy

This is a form of counselling, usually used for people with severe mental illness who are reluctant to take medication. It encourages patients to take an active role in monitoring their illness and negotiating treatment decisions. The patient's views about medication are elicited, ambivalence explored and options considered in an atmosphere of support and empathy, avoiding blaming. This interactive approach has proved more successful than a simple didactic approach.

Counselling

The term 'counselling' covers a wide range of skills and techniques. Counsellors may, for example, use cognitive or behavioural techniques. In the main, however, it provides a supportive and non-judgemental atmosphere for people to talk over their problems and explore more satisfactory ways of living. Counselling generally deals with specific life situations and is more short term than analytical psychotherapies — in primary care, usually 6–12 sessions. It is generally used for less severe problems. Counselling is often focused, with counsellors or agencies specializing in particular problems, eg relationship problems, rape or bereavement.

Family interventions for people with schizophrenia

A form of 'psycho-social intervention', this comprises giving information to the patient's family about the illness, and helping them to improve their ability and confidence in tackling problems

effectively. The approach is broadly behavioural and the family is encouraged to set realistic goals. This means that the family is able to avoid making unrealistic demands of the patient, making the environment of the person who is ill less stressful. Relapse rates are reduced.

Interpersonal therapy

Interpersonal psychotherapy uses the connection between the onset of symptoms and current interpersonal problems as a treatment focus. It deals with current, rather than past, relationships, and maintains a clear focus on the patient's social context and dysfunction rather than their personality. Treatment is carried out by experienced therapists over 10–15 sessions.

Problem-solving

Structured problem-solving can help patients sort out and deal with stresses that contribute to worry and depression. It involves encouraging the patient to identify specific problems, to order them in terms of importance and then to focus on one problem at a time, writing down potential solutions and identifying specific steps that he/she might take to implement the solutions. A main aim is to assist people to incorporate the principles of efficient problem-solving and goal achievement into their everyday lives. The aim is not for the clinician to solve everyone's problems for them but to give people skills so that they can effectively overcome problems and achieve goals for themselves. Self-management is a key goal, with the clinician adopting the role of teacher or guide.

Psychodynamic therapy (analytical psychotherapies)

These are usually offered by psychotherapy departments after assessment by a psychotherapist. They are based on psychoanalytical ways of understanding human development (Freud and his successors). The therapy concentrates on unconscious conflicts and explores the person's inner world, as well as his or her external situations. Analytical therapies may be offered on an individual, couple, family or group basis. Individual sessions are usually for 50 min over several months. Group sessions usually last an hour a week for a year or more. Couple and family sessions are usually more wide spread, with homework tasks set between sessions.

Training for primary-care teams in mental-health skills

This is a template for a chart for information on local and regional sources of training and support. You might like to compare this with the review of the training needs of your practice team or primary care organization/local health group. On the next page, we have listed some national resources which may be drawn upon to help fill identified local gaps. The list of national resources is not exhaustive.

Topic	Multi-disciplinary training	GPs	Nurses	Receptionists/ non-professionals	Counsellors
Mental-health awareness					
Communication skills					
Counselling skills					
Problem-solving					
Cognitive strategies					
Motivational interviewing					
Depression					
Post-natal depression					
Anxiety					
Schizophrenia					
Dementia					
Re-attribution — somatization					
Suicide and self-harm					
Child and adolescent mental health					
Alcohol misuse					
Drug misuse					

The following providers of courses or training packs are all national organizations. You may wish to adapt this list to include details of your local or regional providers of training.

Training courses

Training courses may be organized locally via Educational Consortia, university departments of General Practice or Nursing, Health Authorities or primary care groups, often utilizing locally available skills. The following provide courses or training packs on a national or regional basis.

Royal College of General Practitioners Unit for Mental Health Education in Primary Care

regularly runs courses for people wishing to teach mental-health skills to primary-care teams in their local areas. The emphasis is on provision of flexible, inpractice, multidisciplinary training to teams. Those attending usually operate as pairs (eg GP–nurse, or GP–counsellor) in their work with practices. This ‘National Teachers Course on Mental Health Management in Primary Care’ can be provided in different parts of the country, depending upon demand. The course is modular, with practical experience between modules. There is also an ongoing network of people who have attended the course and are working as educators in primary care. Contact Dr Andre Tylee, Director of RCGP Unit for Mental Health Education in Primary Care, Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5 8AF. Tel: 020 7919 3150

The Depression Care Training Centre provides a range of courses including:

- accredited two-day course for all general nurses in primary care settings (‘Caring for people with depression’);
 - multi-professional, module-based programme for primary care teams (‘Recognition and management of depression’ — a series of half day sessions);
 - Trainers’ course: Three-day course to train and license up to 10 people to lead depression care training courses in their own area. Carries a compulsory assessment;
 - One-day course for general nurses on Schizophrenia.
- Training can be provided nationwide. Contact Elizabeth Armstrong or Martin Davies, National Depression Care Training Centre, Nene University, Thornby 1, Park Campus, Boughton Green Road, Northampton NN2 7AL. Tel: 01604 735500 ext 2640/2712. Email: liz.armstrong@nene.ac.uk.

PRiMHE (Primary Care Mental Health Education) is an initiative to bring together health professionals active in primary mental-health care to provide a nationally coordinated programme of mental health education. Discussion forums for teachers, researchers and primary care group/LHG mental health leads. Co-chairs are Dr Andre Tylee and Dr Chris Manning. For information about their journal, network, educational meetings, training materials and training programme, contact: PRiMHE Secretariat, 29 Park Road, Hampton Wick, Surrey KT1 4AS. Tel: 020 8977 7173. Email: PriMHE@compuserve.com. Website: URL <http://www.Primhe.org>.

The National Primary Care Research and Development Centre runs a modular course for GP Registrars in 'Managing mental disorders in primary care' and other courses on a needs basis. Contact Dr Linda Gask, Reader in Psychiatry, University of Manchester Dept of Community Psychiatry, Royal Preston Hospital, Sharoe Green Lane, Preston PR2 9HT. Tel: 01772 710071/2.

The National Primary Care Facilitation Programme runs a course on 'Facilitation in Primary Care'. It also runs an educational and support network for primary care facilitators who include mental health in their work. Contact the Mental Health Development Officer, The National Primary Care Facilitation Programme, Block 10, The Churchill, The Oxford Radcliffe Hospital, Oxford OX3 7LJ. Tel: 01865 226076/35.

The Counselling in Primary Care Trust keeps information about additional training for counsellors in issues particular to work in general practice, including a postgraduate diploma course. Contact Dr Graham Curtis-Jenkins, Counselling in Primary Care Trust, Majestic House, High Street, Staines TW18 4DG. Tel: 01784 441782.

Resources for use by trainers

Training packages, including videos, for use in skills-based training (watching the skills demonstrated on the video followed by practising them in role play) are available on the following topics:

- Managing somatic presentation of emotional distress (re-attribution, 2nd edition)
- Helping people at risk of suicide or self-harm
- Problem-based interviewing in general practice.

Contact Nick Jordan, Video Producer, University of Manchester, Dept of Psychiatry, Withington Hospital, West Didsbury, Manchester M20 2LR. Tel: 0161 291 4359. Email: Nick.Jordan@man.ac.uk. Online catalogue: www.man.ac.uk/psych.

Other topics available include:

- Anxiety (non-pharmacological approaches)
- Dementia
- Chronic fatigue
- Psychosis in general practice

from Dr Andre Tylee, RCGP Unit for Mental Health Education in Primary Care, Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5 8AF. Tel: 020 7919 3150

- Counselling depression

from the Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG. Tel: 020 7235 2351

- Problem-solving

available from Dr L Mynors Wallace, Warneford Hospital, Oxford

- Alcohol misuse (including motivational interviewing)

from Dr Barry Lewiss, Department of Post-Graduate Medicine, Gateway House, Piccadilly South, Manchester M60 7LP. Tel: 0161 237 2109

- Child and adolescent mental health

available from Professor Elena Garralda, Academic Unit of Child and Adolescent Psychiatry, Saint Mary's Hospital, Praed Street, Paddington, London W2 1NY. Tel: 020 7886 1145.

Audio tapes on depression and anxiety for patients and for primary care professionals are available from Wendy Lloyd Audio Productions Ltd, 30 Guffitts Rake Meols, Wirral L47 7AD. Tel: 0151 632 0662.

An interactive compact disc teaching/revising basic clinical skills for primary care clinicians is produced by the Clinical Research Unit for Anxiety Disorders (CRUFAD) in Australia, which is a WHO Collaborating Centre for Mental Health and Substance Abuse. The CD-Rom covers interviewing skills, prescribing skills, patient education, structured problem-solving and control of hyperventilation. It costs A\$70. Details of this and many other

resources, usually based on cognitive behavioural methods, including treatment manuals (suitable for use by counsellors or others with appropriate training) on obsessional compulsive disorder, panic, generalized anxiety and phobias can be found on CRUFAD's website: <http://www.crufad.unsw.edu.au>, or by contacting Professor Gavin Andrews, University of New South Wales Clinical Research Unit for Anxiety Disorders, 299 Forbes Street, Darlinghurst, NSW 2010, Australia. Fax: (612) 9332 4316. E-mail: gavina@gecko.crufad.unsw.edu.au.

A video, training manual and nurse interview schedule to help nurses and others in primary care learn how to detect depression in elderly people is available from Professor Anthony Mann, Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5 8AF.

'The Primary Care of Mental Health — Team Training Programme' training pack for guided use by primary-care teams in their own surgery is available from Royal Institute of Health and Public Hygiene, 28 Portland Place, London W1N 4DE.

'RCN Nursing Update' produces the following Learning Units: Unit 27 — *Lifting the Cloud*; Unit 28 — *Suicide: a Target for Health*; Unit 049 — *Best Practice in Counselling Skills*; Unit 068 — *Depression — Moving On*. Details from Royal College of Nursing Institute, Nursing Update Office, 20 Cavendish Square, London W1M 0AB. Tel: 020 7409 3333.

A learning resource pack for use by health professionals and others on 'Understanding Depression in People with Learning Disabilities' is available from Pavilion Publishing Ltd, 8 St. George's Place, Brighton BN1 4ZZ. Tel: 01273 623222. Price: £125 plus VAT and p&p.

A variety of other resources for trainers are available from MIND, the Mental Health Foundation and the Samaritans. For example, the Mental Health Foundation sells a training pack: 'Working With People Who Self Injure', and MIND provides inhouse training on mental health awareness and other mental health issues. These training resources are generally aimed at a broad audience, including clinicians, but are not specifically produced for primary care. For catalogues, contact MIND Conference and Training Unit, Granta House, 15-19 Broadway, London E15 4BQ and The Mental Health Foundation, 20/21 Cornwall Terrace, London NW1 4QL.

Support network for primary-care groups and local health groups

The Royal College of Psychiatrists is working with partners from primary care to plan support to primary care organizations and LHCs regarding clinical governance for mental health. Contact Tim Kendall, Royal College of Psychiatrists Research Unit, 11 Grosvenor Crescent, London SW1X 7EE. Tel: 020 7235 2351. E-mail: timkendallCRULondon@compuserve.com.

References

References are graded A–C, I–V, as discussed in the introduction and in the key on p. 5.

1 Birchwood M. Early intervention in schizophrenia: theoretical background and clinical strategies. *Br J Clin Psychol* 1992, 31: 257–278. (BIV)

For more information about early detection of psychosis, see the Early Psychosis Prevention and Intervention Centre (EPPIC). *The Early Psychosis Training Pack*. Cheshire, UK: Gardiner-Caldwell Communications Ltd, 1997. Tel: (03) 9342 2800.

2 World Health Organization. Schizophrenia: an international follow-up study. Chichester: John Wiley & Sons, 1979. (AIV)

Large outcome study with two-year follow-up, showed that only 10–15% of patients did not recover from their illness in that two year period. Another, shorter term follow-up study show 83% of first episode psychotic patients treated with anti-psychotic medication remitting by one year post -inpatient admission. (Lieberman J, Jody D, Geisler S *et al*. Time course and biologic correlates of treatment response in first episode schizophrenia. *Arch Gen Psychiatry* 1993, 50: 369–376.)

3 Kavanagh DJ. Recent developments in expressed emotion and schizophrenia. *Br J Psychiatry* 1992, 160: 601–620. (AIII)

Family support and education, which promotes a more supportive family environment, can reduce relapse rates substantially.

4 Driver and Vehicle Licensing Agency. *At a Glance Guide to Medical Aspects of Fitness to Drive*. Swansea: DVLA, 1998.

Further information is available from The Senior Medical Adviser, DVLA, Driver Medical Unit, Longview Road, Morriston, Swansea SA99 ITU, Wales.

5a Mental Health Commission. *Early Intervention in Psychosis: Guidance Note*. Wellington, New Zealand, 1999.

b Falloon I, Coverdale J, Laidlaw T *et al*. Family management in the prevention of morbidity of schizophrenia: social outcome of a two-year longitudinal study. *Psychol Med* 1998, 17: 59–66.

Involvement of the family is vital. Education is important for engaging individuals and families in treatment and promoting recovery. Psychological therapies may be helpful.

6 Atypical antipsychotics appear to be better tolerated, with fewer extrapyramidal side-effects, than typical drugs at therapeutic doses. Even at low doses, extrapyramidal side-effects are commonly experienced with typical drugs. Whether or not atypicals improve the long-term outcome has yet to be established. Risperidone, amisulpride and possibly olanzapine have a dose-related effect. Selected references (BII):

a American Psychiatric Association. Practice guidelines: schizophrenia. *Am J Psychiatry* 1997, 154(Suppl 4): 1–49.

This reports 60% of patients, receiving acute treatment with typical antipsychotic medication, develop significant extrapyramidal side-effects.

b Zimbroff D, Kane J, Tamminga CA *et al.* Controlled, dose-response study of sertindole and haloperidol in the treatment of schizophrenia. *Am J Psychiatry* 1997, 154: 782-791.

Haloperidol produced extrapyramidal symptoms at 4 mg/day.

c Mir S, Taylor D. Issues in schizophrenia. *Pharmaceut J* 1998, 261: 55-58.

This paper reviews evidence on efficacy, safety and patient tolerability of atypical antipsychotics.

d Duggan L, Fenton M, Dardennes RM, El-Dosoky A, Indran S. Olanzapine for schizophrenia. Cochrane Library, Oxford: Update Software, 1999.

e Kennedy E, Song F, Hunter R, Gilbody S. Risperidone versus conventional antipsychotic medication for schizophrenia. Cochrane Library, Issue 2, 1998.

7 People suffering first episode of psychosis develop side-effects at lower doses of antipsychotic drugs than patients who are used to these drugs. For patients treated with high potency typical antipsychotics who are used to the drugs, the mean dose at which extrapyramidal side-effects appear is below the average clinically effective dose. The average clinically effective dose for those suffering a first episode has not yet been established, but clinical practice indicates that it is significantly lower than for patients used to the drugs. Selected references (BIID):

a McEvoy JP, Hogarty GE, Steingard S. Optimal dose of neuroleptic in acute schizophrenia: a controlled study of the neuroleptic threshold and higher haloperidol dose. *Arch Gen Psychiatry* 1991, 48: 739-745.

First episode patients developed extrapyramidal side-effects at mean doses of haloperidol of 2.1 mg/day \pm 1.1 mg/day, whereas 'experienced' patients did so at mean dose of 4.3 \pm 2.4 mg/day.

b See reference 6a.

Optimal therapeutic dose for most patients appears to be in the range of 6-12 mg/day haloperidol or equivalent. Evidence on optimal dose for first-onset patients is not yet clear.

8 Bollini P, Pampallona S, Orza MJ *et al.* Antipsychotic drugs: is more worse? A meta-analysis of the published randomized control trials. *Psychol Med* 1994, 24: 307-316. (AI)

For most patients, higher than moderate doses bring increased side-effects but no additional therapeutic gains.

9 A1 Dixon LB, Lehman AF, Levine J. Conventional antipsychotic medications for schizophrenia. *Schizophrenia Bull* 1995, 21(4): 567-577.

This paper presents overwhelming evidence that continuing maintenance therapy reduces risk of relapse. Concludes that it is appropriate to taper or discontinue medication within six months to a year for first-episode patients who experience a full remission of symptoms.

10 Taylor D, McConnell D, Abel K, Kerwin R. *The Bethlem and Maudsley NHS Trust Prescribing Guidelines*. London: Martin Dunitz Ltd, 1999.

Available from Martin Dunitz, 7-9 Pratt St, London NW1 OAE, UK. Tel: 0207 482 2202. Price: £14.99 plus £2 postage and packaging.

11 Consensus (BV). As people reacting to stresses such as unemployment or divorce are at high risk of developing a mental disorder, however, studies on prevention in high-risk groups may be relevant. These support the offering of social support and problem solving. (NHS Centre for Reviews and Dissemination. Mental health promotion in high-risk groups. *Effect Health Care Bull* 1997, 3(3): 1-10.)

12 Catalan J, Gath D, Edmonds G, Ennis J. The effects of not prescribing anxiolytics in general practice. *Br J Psychiatry* 1984, 144: 593-602.

This work demonstrates that GP advice and reassurance is as effective as administration of benzodiazepines. Mean time spent by the GP for giving advice and reassurance was 12 minutes, compared with 10.5 minutes for giving prescription.

13a Roth AD, Fonagy P. *What Works For Whom? A Critical Review of Psychotherapy Research*. New York: Guilford Press, 1996. (CII)

This book concludes that the efficacy of counselling in primary care settings is difficult to assess because of the methodological problems of available research. It seems more appropriate for milder presentations of disorders, however, than for more severe presentations, and that evidence is better for counselling focused on a particular client group (eg relationship or bereavement counselling).

b A Cochrane review will soon be available: Rowland N, Mellor Clark J, Bower P *et al*. *The Effectiveness and Cost-Effectiveness of Counselling in Primary Care*. Cochrane Database of Systematic Reviews.

14 Rosenberg H. Prediction of controlled drinking by alcoholics and problem drinkers. *Psychol Bull* 1993, 113: 129-139. (BII)

This is a qualitative review of the literature. Successful achievement of controlled drinking is associated with less severe dependence and a belief that controlled drinking is possible.

15 NHS Centre for Reviews and Dissemination. Brief interventions and alcohol use. *Effect Health Care Bull* 1993, 1: 1-12. (AI)

Brief interventions, including assessing drinking and related problems, motivational feedback and advice, are effective. They are most successful for less severely affected patients.

16 McCrady B, Irvine S. Self-help groups. In: Hester R, Miller W, Wilmsford N (eds). *Handbook of Alcoholism Treatment Approaches*. New York: Pergamon Press, 1989. (AIV)

This chapter discusses the characteristics of patients who are good candidates for Alcoholics Anonymous. Several studies show AA to be an important support in remaining alcohol-free to patients who are willing to attend.

17 American Psychiatric Association. *Practice Guidelines: Substance Use Disorders*, 1996. (BIV)

Where patients have mild to moderate withdrawal symptoms, general support, reassurance and frequent monitoring is sufficient treatment for two thirds of them, without pharmacological treatment.

18 Collins MN, Burns T, Van den Berk PA, Tubman GF. A structured programme for out-patient alcohol detoxification. *Br J Psychiatry* 1990, 156: 871-874. (BIV)

154 19 Duncan D, Taylor D. Chlormethiazole or chlordiazepoxide in alcohol detoxification. *Psychiatr Bull* 1996, 20: 599-601. (AIV)

This paper describes randomized controlled trials that show chlordiazepoxide and chlormethiazole to be of equal efficacy, and uncontrolled studies showing that chlormethiazole has generally mild adverse effects, while those of chlordiazepoxide may be very serious.

20 Tallaksen C, Bohmer T, Bell H. Blood and serum thiamin and thiamin phosphate esters concentrations in patients with alcohol dependence syndrome before and after thiamin treatment. *Alcohol Clin Exp Res* 1992, 16: 320-325. (BIV)

21 Kranzler H, Bureson J, Del Boca F *et al.* Buspirone treatment of anxious alcoholics: a placebo-controlled trial. *Arch Gen Psychiatry* 1994, 51: 720-731. (BII)

22 Department of Health, Scottish Office, Welsh Office, DHSS Northern Ireland. *Drug Misuse and Dependence — Guidelines on Clinical Management*, 1999.

23 Alcohol Concern. *Brief Interventions Guidelines*. London, 1997.

Available from Alcohol Concern, Waterbridge House, 32-36 Loman Street, London SE1 OEE, UK. Tel: 020 7928 7377.

24 Holder H, Longabaugh R, Miller W, Rubonis A. The cost effectiveness of treatment for alcoholism: a first approximation. *J Stud Alcohol* 1991, 52: 517-540. (AI)

Treatments aim to improve self-control and social skills, eg relationship skills, assertiveness and drink refusal.

25 Hunt G, Azrin N. A community reinforcement approach to alcoholism. *Behav Res Ther* 1973, 11: 91-104. (AI)

This approach uses behavioural principles and includes training in job-finding, support in developing alcohol-free social and recreational activities, and an alcohol-free social club.

26 Raphael B. Preventive intervention with the recently bereaved. *Arch Gen Psychiatry* 1977, 34: 1450-1454. (BIII)

This paper demonstrates that 'high-risk' bereaved people who receive counselling have fewer symptoms of lasting anxiety and tension than those who do not.

27 Murray Parkes C, Laungani P, Young B (eds). *Death and Bereavement Across Cultures*. London: Routledge, 1997. (AV)

28 *Inside Out: A Guide to Self-Management of Manic Depression*. London: Manic Depression Fellowship, 1995. (BV)

Available from The Manic Depression Fellowship 8-10 High Street, Kingston-upon-Thames, London KT1 1EY, UK. There have been no trials to establish ways to stop a high. The advice in this book comes from the shared experience of people with manic depression who have tried these techniques.

29 Chou JC-Y. Recent advances in treatment of acute mania. *J Clin Psychopharm* 1991, 11: 3-21. (BII)

The authors conclude that antipsychotics are effective in mania, and they appear to have a more rapid effect than lithium.

30 Rifkin A, Doddi S, Karajgi B *et al.* Dosage of haloperidol for mania. *Br J Psych* 1994, 165: 113-116. (BII)

This paper concludes that doses of haloperidol over 10 mg a day in management of mania confer no benefit.

31 American Psychiatric Association. *Practice Guidelines: Bipolar Disorder*. Washington, DC, 1996. (AII)

This reviews four randomized control trials that show that benzodiazepines are effective, in place of, or in conjunction with, a neuroleptic, in sedating acutely agitated, manic patients.

32a Cookson J. Lithium: balancing risks and benefits. *Br J Psychiatry* 1997, 171: 113–119. (BIII)

b Dali I. Mania. *Lancet* 1997, 349: 1157–1160 .

c Bowden C, Brugger A, Swann A *et al*. Efficacy of divolproex versus lithium and placebo in the treatment of mania. The Depakote Mania Study Group. *JAMA* 1994, 271: 918–924.

33 Zornberg G, Pope H Jr. Treatment of depression in bipolar disorder: new directions for research. *J Clin Psychopharmacol* 1993, 13: 397–408. (BIII)

Review of nine controlled studies shows high response rate to lithium for acute bipolar depression. Response may take six to eight weeks to become evident, however.

34a Goodwin G. Lithium revisited: a re-examination of the placebo-controlled trials of lithium prophylaxis in manic-depressive disorder. *Br J Psychiatry* 1995, 167: 573–574. (BIII)

Trials show prophylactic use of lithium to be effective, although most trials have had methodological flaws.

b Berghofer A, Kossmann B, Muller-Oerlinghausen B. Course of illness and pattern of recurrence in patients with affective disorders during long-term lithium prophylaxis: a retrospective analysis over 15 years. *Acta Psychiatr Scand* 1996, 93: 349–354.

The prophylactic effect of lithium can be maintained over at least 10 years.

35 See reference 31.

The upper limits of the therapeutic range for lithium is 1.0 meq/l. However, although the efficacy of lithium at 0.6–0.8 meq/l has not been formally studied, this is the range commonly chosen by patients and their doctors, as giving the best balance between effectiveness and side-effects.

36 Schou M. Effects of long-term lithium treatment on kidney function: an overview. *J Psychiatry Res* 1988, 22: 287–296.

A qualitative literature review.

37 Suppes T, Baldessanni RJ, Faedda GL. Risk of recurrence following discontinuation of lithium treatment in bipolar disorder. *Arch Gen Psych* 1991, 48: 1082–1088. (AIII)

38 Sachs G, Lafer B, Stoll A *et al*. A double-blind trial of bupropion versus desipramine for bipolar depression. *J Clin Psychiatry* 1994, 55:391–393. (CII)

Preliminary evidence.

- 40 Joyce J, Hotopf M, Wessely S. The prognosis of chronic fatigue and chronic fatigue syndrome: a systematic review. *Quart J Med* 1997; 90: 223–233. (BIV)
- 41 Price JR, Couper J. Cognitive behaviour therapy for CFS. Cochrane Library Issue 4, 1998. (AI)
- 42 Fulcher KY, White PD. A randomised controlled trial of graded exercise therapy in patients with the chronic fatigue syndrome. *BMJ* 1997, 314: 1647–1652. (AII)
- 43 See reference 39. (BIII)
- 44 Carette S, Bell MJ, Reynolds WJ *et al.* Comparison of amitriptyline, cyclobenzaprine, and placebo in the treatment of fibromyalgia. *Arthritis Rheum* 1994, 37: 32–40. (CII)
- 45 Hannonen P, Malminiemi K, Yli-Kerttula U *et al.* A randomised double-blind placebo controlled study of moclobemide and amitriptyline in the treatment of fibromyalgia in females without psychiatric disorder. *Br J Rheumatol* 1998, 37: 1279–1286. (CII)
- 46 Greden JF. Anxiety or caffeinism: a diagnosis dilemma. *Am J Psychiatry* 1974, 131: 1089–1092. (AV)
- 47 Wallin M, Rissanen A. Food and mood: relationship between food, serotonin and affective disorders. *Acta Psychiatr Scand* 1994, 377(Suppl): 36–40. (CV)
Quoted in *Guidelines for the Treatment and Management of Depression by Primary Health Care Professionals*. National Health Committee of New Zealand, 1996.
- 48 Hawton K, Kirk J. Problem-solving. In: Hawton K, Salkovskis PM, Kirk J, Clark DM (eds). *Cognitive Therapy for Psychiatric Problems: A Practical Guide*. Oxford: Oxford University Press, 1989. (AII)
- 49 Glenister D. Exercise and mental health: a review. *J Roy Soc Health* 1996, February: 7–13. (BIII)
- 50 McCann L, Holmes D. Influence of aerobic exercise on depression. *J Personal Social Psychol* 1984, 46: 1142–1147. (BIII)
Quoted in *Mental Health Promotion: a Quality Framework*. London: Health Education Authority, 1997.
- 51 Consensus, plus some, usually small, trials. For example, Donnan P, Hutchinson A, Paxton R *et al.* Self-help materials for anxiety: a randomised controlled trial in general practice. *Br J Gen Pract* 1990, 40: 498–501. (BV)
Audiotape and booklet is given to patients with chronic anxiety. Intervention led to reduced scores for depression, as well as for anxiety.
- 52 The differences in outcome between active drug and placebo are less in primary-care depressions than among more severe cases. (Clinical Practice Guideline Number 5: *Depression in Primary Care*. US Department of Health Human Services, Agency for Health Care Policy and Research, 1993; Treatment of Major Depression. AHCPR publication 93-0551.)
Fluoxetine does not produce better outcomes than tricyclic drugs in general primary-care depression (Simon G, VonKorff M, Heiligenstein J *et al.* Initial antidepressant

choice in primary care: effectiveness and cost of fluoxetine versus tricyclic antidepressants. *JAMA* 1996, 275: 1897–1902.)

Paroxetine and citalopram are both licensed for panic as well as depression, so may be useful where panic symptoms are prominent. Both selective serotonin re-uptake inhibitors and tricyclic antidepressants may initially worsen anxiety and panic symptoms, so should be introduced at low doses and slowly increased.

53a Linde K, Mulrow CD. St John's Wort for depression. Cochrane Library, Issue 1, 1999. (AI)

b Philip M, Kohnen R, Hiller K-O. Hypericum extract versus imipramine or placebo in patients with moderate depression: randomized, multi-centre study of treatment for eight weeks. *BMJ* 1999, 319: 1534–1539.

54 Thiede HM, Walper A. Inhibition of MAO and CoMT by hypericum extracts and hypericin. *J Geriatr Psychiatr Neurol* 1994, 7(Suppl 1): S54–S56.

55 Interactions with tyramine-containing foods (eg beans, some cheeses, yeast, bovril, bananas, pickled herrings), are theoretically possible. However, there is, to date, an absence of spontaneous reports of these problems occurring.

56 Breckenbridge A. *Important Interactions Between St John's Wort (Hypericum perforata) Preparations and Prescribed Medicines*. Committee for Safety of Medicines, 29 February 2000.

Letter advises that hypericum reduces the therapeutic effect of indinavir, warfarin, cyclosporin, oral contraceptives, digoxin and theophylline, and may reduce the effect of other drugs — except topical medicines with limited systemic absorption and non-psychotropic medicines excreted renally. Adverse reactions may occur if combined with triptans (used to treat migraine) or SSRI antidepressants.

Information for professionals and the general public is available on the Medicines Control Agency website: URL: <http://www.open.gov.uk/mca/mcahome.htm> or by telephoning 020 7273 0000 (health professionals) or NHS Direct on 0845 46 47 (public).

57 McLean J, Pietroni P. Self care — who does best? *Soc Sci Med* 1990, 30(5): 591–596. (BIII)

This article describes a controlled trial of a general practice-based class teaching self-care skills, relaxation, stress management, medication, nutrition and exercise. Significant improvements were maintained after one year.

58 Catalan J, Gath DH, Anastasiades P *et al*. Evaluation of a brief psychological treatment for emotional disorders in primary care. *Psychol Med* 1991, 21: 1013–1018. (BII)

This paper describes a small randomized controlled trial. Patients receiving problem-solving therapy did significantly better than those receiving routine care. Patients were selected on the basis of higher symptom scores, however. Another group of patients with lower symptom scores, who were not treated, showed equal improvement to the treated group.

59 Gloaguen V, Cottraux J, Cucherat M *et al*. A meta-analysis of the effects on cognitive therapy in depressed patients. *J Affect Disord* 1998, 49: 59–72. (AI)

158 The studies supports cognitive therapy in patients with mild to moderate depression.

- 60 Sheldon T, Freemantle N, House A *et al.* Examining the effectiveness of treatments for depression in general practice. *J Mental Health* 1993, 2: 141–156. (BI)
This is a review of four randomized controlled trials that concluded that there is some evidence of effectiveness for cognitive therapy in depression in primary care, but that it is considerably weaker than cognitive therapy in major depressive disorder in secondary care.
- 61 Brown S. Excess mortality of schizophrenia: a meta-analysis. *Br J Psychiatry* 1997, 171: 502–508. (AI)
This article reports on life expectancy and excess mortality, including from physical illnesses, in patients with schizophrenia.
- 62 Adams CE, Eisenbruch M. Depot versus oral fluphenazine for those with schizophrenia. *Cochrane Library*, Issue 2, 1998. (AI)
- 63 Kendrick T, Millar E, Burns T, Ross F. Practice nurse involvement in giving depot neuroleptic injections: development of a patient assessment and monitoring checklist. *Prim Care Psychiatry* 1998, 4(3): 149–154. (AIV)
Of the 25% of people with schizophrenia who have no specialist contact, many have a practice nurse as their only regular professional contact. Levels of knowledge of schizophrenia and its treatment of those nurses was often no better than a lay persons.
- 64 Kemp R, Kirov G, Everitt B, David A. A randomised controlled trial of compliance therapy: 18 month follow up. *Br J Psychiatry* 1998, 172: 413–419. (AII)
Patients who received specific counselling regarding their attitudes towards their illness and drug treatment were five times more likely to take medication without prompting than controls.
- 65 Mari JJ, Streiner D. Family intervention for people with schizophrenia. *The Cochrane Library*, Issue 1, 1991. (AI)
Families receiving this intervention, which promotes a more supportive family environment, may expect the family member with schizophrenia to relapse less and to be in hospital less.
- 66 Jones C, Cormac I, Mota J, Campbell C. Cognitive behaviour therapy for schizophrenia. *Cochrane Library*, Issue 1, 1999. (AI)
Four small trials show that cognitive behaviour therapy is associated with substantially reduced risk of relapse.
- 67 Rabins PV. Psychosocial and management aspects of delirium. *Int Psychoger* 1991, 3(2): 319–324. (BV)
Reviews 21 papers. The evidence base is very thin.
- 68 Rummans TA, Evans JM, Krahn LE, Fleming KC. Delirium in elderly patients: evaluation and management. *Mayo Clinic Proc* 1995, 70(10): 989–998. (BV)
Reviews 55 papers. The evidence base is thin.
- 69 Eurodem Prevalence Research Group, Hofman PM, Rocca WA, Brayne C *et al.* The prevalence of dementia in Europe: a collaborative study of 1980–1999. *Int J Epidemiol* 1991, 20: 736–748.

70 Ballard C, Grace J, McKeith I *et al*. Neuroleptic sensitivity in dementia with Lewy bodies and Alzheimer's disease. *Lancet* 1998, 351: 1032-1033.

71a Stein K. *Donepezil in the Treatment of Mild to Moderate Dementia of the Alzheimer Type (SDAT)*. Report to the South and West Development and Evaluation Committee (DEC) no. 69. Bristol. NHS Executive, June 1997.

b Rogers SL, Farlow MR, Doody RS *et al*, and the Donepezil Study Group. *A Twenty Four Week, Double Blind, Placebo-Controlled Trial of Donepezil in Patients with Alzheimer's Disease*. *Neurology* 1998, 50: 136-145.

The limited number of studies available to date show that donepezil produces some improvement in a minority of patients with mild to moderate Alzheimer's disease (defined as those with a mini mental state examination score of between 10 and 26). There is no evidence to date that donepezil has any effect on the non-cognitive manifestations of Alzheimer's disease.

72 Martinsen E. Physical activity and major depressive disorder: clinical experience. *Acta Psychiatrica Scand* 1994, 377(Suppl): 23-27. (BIV)

This paper reviews 10 experimental studies which all indicate that aerobic exercise is more effective than no treatment for major depressive disorder.

73 Schuckit M. Alcohol and major depressive disorder: a clinical perspective *Acta Psychiatrica Scand* 1994, 377: 28-32. (AIV)

74 Schulberg H, Katon W, Simon G, Rush AJ. Best clinical practice: guidelines for managing major depression in primary care. *J Clin Psychiatry* 1999, 60(Suppl 7): 19-24. (BII)

This paper concludes that recovery rates for an acute episode of major depression in primary care are similar for guideline-driven pharmacotherapy and depression-specific psychotherapies, such as interpersonal therapy and problem-solving treatments. Medication takes four to six weeks to show effect and psychotherapies six to eight weeks.

75 Lave J, Frank R, Schulberg H, Kamlet M. Cost-effectiveness of treatments for major depression in primary care practice. *Arch Gen Psychiatry* 1998; 55(7): 645-651. (BII)

This paper describes a high-quality randomized controlled trial comparing standardized treatment by nortriptyline, interpersonal psychotherapy and primary physician's usual care ($n > 90$ for each group) for major depression in primary care. Both standardized therapies were better than usual care, and more expensive. Those taking drugs did slightly better with respect to both quality of life and economic outcomes.

76 Paykel E, Hollyman J, Freeling P, Sedgwick P. Prediction of therapeutic benefit from amitriptyline in mild depression: a general practice, placebo-controlled trial. *J Affective Disord* 1988, 14: 83-95. (BIII)

Antidepressants don't show efficacy in mild acute depression. However, there is some evidence of efficacy in dysthymia (chronic, mild depressive syndrome that has been present for at least two years (Lima M, Moncrieff J. A comparison of drugs versus placebo for the treatment of dysthymia: a systematic review. Cochrane Database of Systematic Reviews, Depression, anxiety and neurosis module. Cochrane library, Issue 2, 1998).

77 NHS Centre for Reviews and Dissemination, University of York. The treatment of depression in primary care. *Effect Health Care* 1993, March(5): 1-12. (AII)

78 See reference 74.

Another conclusion from this paper is that recent randomized controlled trials conducted in primary care show a 50-60% response rate to all classes of antidepressants in primary-care patients.

79 Prien R, Kupfer D. Continuation drug therapy for major depressive episodes: how long should it be maintained? *Am J Psychiatry* 1986, 143: 18-23. (BII)

Concludes that patients treated for a first episode of uncomplicated depression, who respond well to an antidepressant, should receive a full therapeutic dose for at least 16-20 weeks after achieving full remission.

80 Reimherr F, Amsterdam J, Quitkin F *et al.* Optimal length of continuation therapy in depression: a prospective assessment during long-term fluoxetine treatment. *Am J Psychiatry* 1998, 155: 1247-1253. (BIII)

81 Kupfer D, Frank E, Perel J *et al.* Five-year outcomes for maintenance therapy: possible mechanisms and treatments. *J Clin Psychiatry* 1998; 59: 279-288.

This study was carried out by psychiatric patients. There are no comparable clinical trials of maintenance treatments' efficacy in reducing recurrence of depression in primary care.

82 Donaghue J, Taylor D. A review of the sub-optimal use of antidepressants in the treatment of depression. *CNS Drugs* 1999, In press. (BIII)

83a DeRubeis RJ, Crits-Cristoph P. Empirically supported individual and group psychological treatments for adult mental disorders. *J Consulting Clin Psychol* 1998, 66(1): 37-52. (BI)

This work supports cognitive behaviour therapy, behaviour therapy and structured problem-solving. The studies reviewed are based in secondary care.

b Schulberg HC, Bock MR, Madonia MJ *et al.* Treating major depression in primary care practice: eight month clinical outcomes. *Arch Gen Psychiatry* 1996, 53: 913-919. (BII)

This work supports interpersonal therapy.

c Mynors-Wallis LM, Gath DH, Lloyd-Thomas AR, Tomlinson D. Randomised controlled trial comparing problem solving treatment with amitriptyline and placebo for major depression in primary care. *BMJ* 1995; 310: 441-445. (AII)

Where the therapies have been compared with each other, none appears clearly superior to the others. More variance in outcomes may be due to the strength of the therapeutic relationship rather than to the treatment method used. Problem-solving is the easiest therapy to learn and can be provided by GPs and primary-care nurses. Brief cognitive behaviour therapy is difficult to deliver, even using trained therapists (Scott C, Tacchi M, Jones R, Scott J. Abbreviated cognitive therapy for depression: a pilot study in primary care. *Behav Cogn Psychother* 1994, 22: 96-102), so the time taken is unlikely to be reduced below 8-10 hours (Scott J. Editorial: Psychological treatments for depression — an update. *Br J Psychiatry* 1995, 167: 289-292). Evidence for the effectiveness of therapies in depression in primary care tends to be weaker than in major depressive disorder in secondary care.

84 Thase M, Greenhouse J, Frank E *et al.* Treatment of major depression with psychotherapy or psychotherapy–pharmacotherapy combinations. *Arch Gen Psychiatry* 1997, 54: 1009–1015.

A Cochrane review on this topic is pending.

85 Evans M, Hollins S, De Rubeis R *et al.* Differential relapse following cognitive therapy and pharmacotherapy of depression. *Arch Gen Psychiatry* 1992, 49: 802–808.

86 Ostler KJ, Thompson C, Kinmonth ALK *et al.* The association between area socio-economic deprivation and depression among patients consulting in primary care. *Br J Psychiatry* 2000, In press.

Shows strong link between high indices of deprivation and poor prognosis for depression in primary care.

87 Kaltenbach K, Finnegan L. Children of maternal substance misusers. *Curr Opin Psychiatry* 1997, 10: 220–224.

Most harm caused is indirect, eg via ill health of mother, poor antenatal care or cigarette smoking. There is a smaller risk of direct harm caused by heroin — growth retardation — and cocaine and amphetamines.

88 Miller W, Rollnick S. *Motivational Interviewing: Preparing People to Change Addictive Behaviour*. New York: Guilford Press, 1991. (AV)

89 Gossop M, Stewart D, Marsden J. *NTORS at One Year: The National Treatment Outcome Research Study. Change in Substance Use, Health and Criminal Behaviour One Year After Intake*. London: Department of Health, 1998. (A1)

b Ward J, Mattick R, Hall W. *Maintenance Treatment and Other Opioid Replacement Therapies*. London: Harwood Academic Press, 1997.

c Jeffries V, Gabbay M, Carnwath T. Treatments for opiate users in primary care. Monograph for Enhancing Shared Care Project, Chapel Road, Sale, Manchester, M33 7FD. In press.

90 Lader M, Russel J. Guidelines for the prevention and treatment of benzodiazepine dependence: summary of a report from the Mental Health Foundation. *Addiction* 1993, 88(12): 1707–1708.

91 The Task Force to Review Services for Drug Misusers. *Report of an Independent Review of Drug Treatment Services in England*. London: DoH, 1995.

92 American Psychiatric Association. *Practice Guidelines: Substance Use Disorders*. Washington DC, 1996. (BII)

Reports a large randomized controlled trial replicated in a controlled trial comparing drug counselling, drug counselling plus supportive psychotherapy, and drug counselling plus cognitive behaviour therapy for methadone maintenance patients. Those with moderate to high depression or other psychiatric symptoms did better with either therapy in addition to drug counselling. For patients with low levels of psychiatric symptoms, all three treatments were equally effective.

93 Khantzian E. The primary care therapist and patient needs in substance abuse treatment. *Am J Drug Alcohol Abuse* 1988; 14: 159–167.

This paper reviews studies of relapse prevention through, for example, encouraging improved social and other relationships and activities.

94 Department of Health, The Scottish Office, The Welsh Office and DHSS Northern Ireland. *Drug Misuse and Dependence: Guidelines on Clinical Management*, 1999.

95 Although some patients may benefit from maintenance on low doses (eg 10–20 mg/day), in general, higher doses (>60 mg/day (range: 60–120 mg/day; average: 70–80 mg/day)) are associated with better outcome (Ball J, Ross A. *The Effectiveness of Methadone Maintenance Treatment*. New York: Springer-Verlag, 1991 (a prospective cohort study)). Doses for stabilization in withdrawal are also often above 60 mg/day and are determined by the patient's response, based on objective signs of withdrawal. (See reference 91).

96 Marsch LC. The efficacy of methadone maintenance interventions in reducing illicit opiate use, HIV risk behaviour and criminality: a meta-analysis. *Addiction* 1998, 93: 515–532. (A1)

97 Johnson R, Jaffe J, Fudala P. A controlled trial of buprenorphine treatment for opioid dependence. *JAMA* 1992, 267: 2750–2755. (CIII)

Additional research is needed, particularly in a UK setting.

98 Bearn J, Gossop M, Strang J. Randomised double-blind comparison of lofexidine and methadone in the in-patient treatment of opiate withdrawal. *Drug Alcohol Depend* 1996, 43: 87–91. (BII)

Concludes that lofexidine is as efficacious as methadone.

99 Brown AS, Fleming PM. A naturalistic study of home detoxification from opiates using lofexidine. *J Psychopharmacol* 1998, 12: 93–96.

100 McLellan AT, Arndt IO, Metzger DS *et al*. The effects of psychosocial services in substance abuse treatment. *JAMA* 1993, 269: 1953–1959. (BII)

Patients who received employment help, psychiatric care and family therapy had better outcomes than those who received counselling, who in turn had better outcomes than those who received methadone only.

101 Imipramine, desipramine, trazodone and fluoxetine have all shown some efficacy. In the imipramine studies, most patients reduced their symptoms by at least half, and a third became free of symptoms. Higher doses of fluoxetine are needed than normally used for treating depression. Several trials of medication may be needed to establish the one most suitable for an individual patient. Fluoxetine is currently the only antidepressant licensed in the UK for bulimia nervosa. Selected references:

a Mitchell J, Raymond N, Specker S. A review of the controlled trials of pharmacotherapy and psychotherapy in the treatment of bulimia nervosa. *Int J Eating Disord* 1993, 15: 229–247. (BIII)

b American Psychiatric Association. *Practice Guidelines: Eating Disorders*. Washington DC, 1996. B(II)

102 Uncontrolled trials and one small controlled trial have suggested that fluoxetine may help some patients in the weight maintenance phases, but many patients do not improve with this or any other currently available medication. However, for patients with persistent depression, the use of antidepressants should be considered. Consider medication with fewer cardiovascular side-effects. Selected references:

a See reference 101b. (AIII)

b Leach A. The psychopharmacotherapy of eating disorders. *Psychiatr Annals* 1995, 25: 628–633.

c Kaye W, Gendall K, Strober M. Serotonin neuronal function and selective serotonin re-uptake inhibitor treatment in anorexia and bulimia nervosa. *Biol Psychiatr* 1998, 44: 825–838. (CIII)

103 Russell GFM, Sz mukler GI, Dare C, Eisler I. An evaluation of family therapy in anorexia nervosa and bulimia nervosa. *Arch Gen Psychiatr* 1987, 44: 1047–1056. (CIII)

This paper shows that patients with anorexia nervosa with onset at or before age 18, and duration less than three years, did better with family therapy than individual therapy. Moreover, older patients did better with individual therapy. However, a major UK review, while supporting these recommendations, states that there are currently no high-quality reviews of psychological treatments for anorexia nervosa (see reference 59).

104 Whitbread J, McGown A. The treatment of bulimia nervosa: what is effective? A meta-analysis. *Int J Clin Psychol* 1994, 21: 32–44. (BI)

A Cochrane review is currently in progress.

105 Treasure J, Schmidt U, Troop N *et al.* First step in managing bulimia nervosa: controlled trial of a therapeutic manual. *BMJ* 1994, 308: 686–689. (BIII)

106 Shear K, Schulberg H. Anxiety disorders in primary care. *Bull Menninger Clinic* 1995, 59(2, Suppl A): 73–82. (BI)

This paper reviews studies of provision of psychoeducation and minimal interventions in primary care. Observations suggests that they show considerable promise as first-line interventions for anxiety disorders in primary care; however, more severely ill patients will require more sophisticated intervention.

107 See reference 12. (BII)

108a Gould RA, Otto MW, Pollack MH, Yap L. Cognitive behavioural and pharmacological treatment of generalised anxiety disorder: a preliminary meta-analysis. *Behaviour Ther* 1997, 28(2): 285–305. (BI)

This paper revealed highest effect sizes for diazepam. Buspirone had a much lower effect size than either benzodiazepines or antidepressants, and its onset is slow (up to four weeks). However, problems with dependence and withdrawal are minimal compared with benzodiazepines.

b Lader MH, Bond AJ. Interaction of pharmacological and psychological treatments of anxiety. *Br J Psychiatry* 1998, 173(Suppl 34): 165–168.

Firm conclusions are not possible. Observations suggests using benzodiazepines for treating anxiety initially, as these produce rapid symptomatic improvement; then psychological treatments can take over.

109 Imipramine and paroxetine have both been shown to reduce anxiety symptoms in the short term. Onset is slower than benzodiazepines but addiction is not a problem. Relapse rates following longer-term use are not known. Selected references (BII):

a Kahn R, McNair D, Lipman R *et al.* Imipramine and chlordiazepoxide in depressive and anxiety disorders II. Efficacy in anxious out-patients. *Arch Gen Psychiatry* 1986, 43: 79–85.

b Rocca P, Fonzo V, Scotta M *et al.* Paroxetine efficacy in the treatment of generalised anxiety disorder. *Acta Psychiatr Scand* 1997, 95: 444–450.

110 Tyrer P. Use of beta blocking drugs in psychiatry and neurology. *Drugs* 1980, 20: 300–308.

111 Gould RA, Otto MW, Pollack MH, Yap L. Cognitive behavioural and pharmacological treatment of generalised anxiety disorder: a preliminary meta-analysis. *Behaviour Ther* 1997, 28(2): 285–305. (BI)

Cognitive behavioural therapy (CBT) and anxiety management were found to be the most efficacious of psychological treatments. Medication and psychological therapies were equally efficacious in the short term. Gains of CBT and anxiety management were maintained at six months.

112 Kupshik G, Fisher C. Assisted bibliotherapy: effective, efficient treatment for moderate anxiety problems. *Br J Gen Pract* 1999, 49: 47–48. (BIII)

Learning self-help skills through reading, supported by contact with a clinician, lead to significant improvement of symptoms. Greater numbers improved with a greater amount of clinician contact, especially patients with less educational achievements.

113 See reference 57. (BIII)

114 Swinson RP, Soulios C, Cox BJ, Kuch K. Brief treatment of emergency-room patients with panic attacks. *Am J Psychiatry* 1992, 149: 944–946. (BIII)

People presenting to accident and emergency with panic provided with psychoeducation and exposure instructions had a significantly better outcome than controls.

115 American Psychiatric Association. Practice guideline for the treatment of patients with panic disorder. *Am J Psychiatry* 1998, 155(Suppl): 1–26. (AII)

Concludes that tricyclic antidepressants (TCAs), selective serotonin re-uptake inhibitors, monoamine oxidase inhibitors and benzodiazepines have roughly comparable efficacy in the short term. Benzodiazepines are useful in the very short term in situations where very rapid control of symptoms is critical. TCA side-effects may be problematic. Short-term use of medication commonly results in relapse, so longer-term use is recommended — 2–18 months — after which period, the relapse rate is not known).

116 Benzodiazepines are effective in many cases in suppressing panic in the short term. They are not an effective treatment for chronic panics or phobias, as there is no evidence that gains made continue when drugs are withdrawn; there is some evidence that they don't. Where patients are undergoing exposure therapy — ie dealing with the fear by gradually facing it — there is some evidence that benzodiazepines may actually interfere with maintaining longer-term therapeutic gains.

Selected references (BII):

a American Psychiatric Association. Practice guideline for the treatment of patients with panic disorder. *Am J Psychiatry* 1998, 155(Suppl): 1–26.

b Marks I, Swinson P, Basoglu M *et al.* Alprazolam and exposure alone and combined in panic disorder with agoraphobia. A controlled study in London and Toronto. *Br J Psychiatry* 1993, 162: 776–787.

117 See reference 13a.

The authors conclude that 85% of chronic patients stay well between the one- and two-year follow-up, when treated using cognitive behaviour therapy.

118 Marks I, Swinson RP. Alprazolam and exposure for panic disorder with agoraphobia; summary of London/Toronto results. *J Psychiatric Res* 1990, 24: 100–101. (AII)

Where agoraphobic fear and avoidance is present, with panic, exposure — a behavioural treatment — proved to be twice as effective as alprazolam.

119 Wade WA, Treat TA, Stuart GL. Transporting an empirically supported treatment for panic disorder to a service clinic setting; a benchmarking strategy. *J Consult Clin Psychol* 1998, 66: 231–239. (CIII)

120 Murray B, Stein M, Michael R *et al.* Paroxetine treatment of generalized social phobia (social anxiety disorder): a randomised controlled trial. *JAMA* 1998, 280: 8. (CII)

Symptoms improved in short term — ie 11-week trial). However, relapse rates are very high after discontinuation, and relapse rates after longer-term treatment are not known. (See Stein MB, Chartier MJ, Hazen AI *et al.* Paroxetine in the treatment of generalised social phobia: open-label treatment and double-blind, placebo-controlled discontinuation. *J Clin Psychopharmacol* 1996, 16: 218–222.)

121 DeRubeis RJ, Crits-Cristoph P. Empirically supported individual and group psychological treatments for adult mental disorders. *J Consult Clin Psychol* 1998, 66(1): 37–52. (AII)

Exposure with cognitive therapy shows efficacy for social phobia; exposure with cognitive behaviour therapy shows efficacy for agoraphobia.) Efficacy of exposure behaviour therapy has proven twice that of alprazolam for agoraphobic fear and avoidance (see reference 118).

122 Fichtner C, Poddig B, deVito R. Post-traumatic stress disorder: pathophysiological aspects and pharmacological approaches to treatment. *CNS Drugs* 1997, 8(4): 293–322. (CII)

The research base is limited. There is evidence of only limited efficacy for a wide range of drugs. Fluoxetine is the most widely studied selective serotonin re-uptake inhibitor. Phenelzine appears more effective than tricyclic antidepressants (TCAs) for re-experiencing symptoms. The most studied TCAs were imipramine and amitriptyline.

123 See reference 13a.

Concludes that effective treatments appear to involve relatively complex combinations of cognitive techniques and exposure and may best be administered by staff specializing in this disorder.

124 Foa EB, Meadows EA. Psychosocial treatments for post-traumatic stress disorder: a critical review. *Ann Rev Psychology* 1997, 48: 449–480. (BII)

It shows that exposure — a behavioural treatment — and supportive counselling are equally effective at the end of treatment, but exposure is superior after three months.

125 Boolell M, Gepi-Atee S, Gingell C, Allen MK. Sildenafil: a novel effective oral therapy for male erectile dysfunction. *Br J Urol* 1996, 78: 257–261. (AII)

126 Padma-Natham H, Hellstrom WJG, Kaiser RE *et al.* Treatment of men with erectile dysfunction with transurethral alprostadil. *New Engl J Med* 1997, 336: 1–7. (AII)

127 Linet OI, Ogrine FG. Efficacy and safety of intracavernosal alprostadil in men with erectile dysfunction. *New Engl J Med* 1996, 334: 873–877. (AII)

128 McClusky HY, Milby JB, Switzer PK *et al.* Efficacy of behavioural versus triazolam treatment in persistent sleep-onset insomnia. *Am J Psychiatry* 1991, 148: 121–126. (BVplus)

This small trial found that triazolam had an immediate effect on persistent insomnia, and behavioural treatment took three weeks to have an equivalent effect. Behavioural treatment is more effective at one-month follow-up.

129 Eisen J, MacFarlane J, Shapiro C. Psychotropic drugs and sleep. *BMJ* 1993, 306: 1331–1334.

130 Rasmussen P. A role of phytotherapy in the treatment of benzodiazepines and opiate drug withdrawal. *Eur J Herbal Med* 1997, 3(1): 11–21. (CIV)

Quoted in: Wallcraft J. *Healing Minds: A Report on Current Research, Policy and Practice Concerning the Use of Complementary and Alternative Therapies for a Wide Range of Mental Health Problems*. Mental Health Foundation, 1998. (Refers to trials — some in animals — showing that valerian can improve the quality of sleep, and without a hangover effect the next day. No studies of the long-term safety of valerian have been reported. The effect on sleep is weak.

131 Bootzin R, Perlis M. Non-pharmacological treatments of insomnia. *J Clin Psychiatry* 1992, 53(6 Suppl): 37–40.

This review found sleep hygiene training during individual counselling and stimulus control instructions are more effective than relaxation training.

132 WHO. *Insomnia: Behavioural and Cognitive Interventions*. Geneva: Division of Mental Health, 1993.

133 Goldberg R, Dennis H, Novack M, Gask L. The recognition and management of somatization: what is needed in primary care training. *Psychosomatics* 1992, 33(1): 55–61. (BV)

134 Smith GR, Rost K, Kashner M. A trial of the effect of a standardised psychiatric consultation on health outcomes and costs in somatising patients. *Arch Gen Psych* 1995, 52(3): 238–243. (BII)

135 Fishbain DA, Cutler RB, Rosomoff HL, Rosomoff RS. Do antidepressants have an analgesic effect in psychogenic pain and somatoform pain disorder? A meta-analysis. *Psychosom Med* 1998, 60(4): 503–509. (B1)

136 Pilowsky I, Barrow C. A controlled study of psychotherapy and amitriptyline used individually and in combination in the treatment of chronic intractable psychogenic pain. *Pain* 1990, 40: 3–19. (CIII)

137a Speckens A, Van Hemert A, Spinhoven P *et al.* Cognitive behavioural therapy for medically unexplained physical symptoms: a randomized controlled trial. *BMJ* 1995, 311: 1328–1332. (BII)

Six to 16 sessions of cognitive behaviour therapy were conducted in medical outpatients. Intervention was found to be effective and acceptable to patients, and gains were maintained at 12-month follow-up.

References

b Kashner TM, Rost K, Cohen B *et al.* Enhancing the health of somatization disorder patients: effectiveness of short-term group therapy. *Psychosomatics* 1995, 36: 924-932. (BII)

Random controlled trial of 70 patients in primary care offered eight sessions of group therapy. Improvements, both physical and emotional, were maintained at one year.

c Guthrie E. Emotional disorder in chronic illness: psychotherapeutic interventions. *Br J Psychiatry* 1996, 168(3): 265-273.

This review includes eight studies of somatic presentation of psychological problems. Two studies show cognitive behaviour therapy to be effective in atypical chest pain and functional dyspepsia, and hypnosis to be effective in two studies for irritable bowel syndrome. Compliance is poor, however. Patients with a long history of symptoms and marked abnormal illness behaviour are unlikely to respond to a brief intervention

Acknowledgements

The primary care classification of mental disorders would not have been possible without the advice, support and collaboration of primary-care workers, researchers, WHO Collaborating Centres and other agencies. WHO wishes to express its particular thanks to the following for their valuable collaboration:

International version

J Banda (Zambia), D Berardi (Italy), A Bertelsen (Denmark), E Busnello (Brazil), A Carla (France), J E Cooper (UK), N Dedeoglu (Turkey), M P Deva (Malaysia), D Goldberg (UK), M Gomel (Australia), O Gureje (Nigeria), C Hunt (Australia), R Jenkins (UK), S Murthy (India), K Ogel (Turkey), C Pull (Luxembourg), D Roy (Canada), G E Simon (USA), P Verta (France), M Von Korff (USA) and N Wig (India).

D Goldberg and G E Simon were chief consultants for the project and compiled the information for each category of disorder.

Overall management and coordination of the project was carried out by Dr T B Ustun.

World Organization of National Colleges and Academies and Academic Associations of General Practitioners/Family Physicians (WONCA):

C Bridges-Webb and H Lamberts.

World Psychiatric Association:

N Sartorius and J J López-Ibor Jr.

National Institute of Mental Health, USA

K Magruder, D Regier, J Gonzales and G Norquist.

Bristol version

The editorial team were Catherine Crilly, Jonathan Evans, Glynn Harrison, Gemma McCann, Debbie Sharp, Cameron Smith, Ellen Wilkinson. Brendan Blair assisted with the guide to the Mental Health Act.

UK version

Expert input on particular topics was generously provided by the following people:

Dr Sube Banerjee, Dr Tom Carnwath, Professor Anna Cooper, Dr Michael Crow, Dr Katy Drummond, Dr Jim Dyer, Dr Mike Farrell, Dr Mark Gabbay, Dr Clare Garrada, Dr Linda Gask, Professor Sir David Goldberg, Professor Sheila Hollins, Dr Gundi Kiemle, Professor Tony Kendrick, Professor Malcolm Lader, Professor Alistair MacDonald, Professor Isaac Marks, Mr John Park, Mr Stephen Popplestone, Ms Sue Plummer, Professor Jan Scott, Dr Ulrike Schmidt, Dr James Strachan, Mr David Taylor, Dr Andre Tylee, Dr John Turvill, Professor Simon Wessely. Jo Paton researched the evidence base and compiled the references and notes section and adapted the patient information leaflets. Lynette Timms checked all the contact details for the Community Resources.

UK National Editorial Team

David Goldberg, Linda Gask, Rachel Jenkins, Barry Lewis, Jo Paton, Debbie Sharp, André Tylee. Overall management and coordination of the project was carried out by Jo Paton, under the direction of Professor Rachel Jenkins.

UK National Consensus Group

Mrs Elizabeth Armstrong, Director, National Depression Care Training Centre; Dr Sube Banerjee, Lecturer Institute of Psychiatry; Dr Mary Burd, Primary Care Psychology and Counselling Service; Dr Richard Byng, Lecturer, Dept of General Practice and Primary Care, UMDS; Professor Anna Cooper, Professor of Psychiatry of Learning Disability, Glasgow University; Dr Katie Drummond, Psychiatrist of Disability; Ms Joan Foster, Chair, Counsellors in Primary Care; Dr Mark Gabbay, Senior Lecturer, Department of General Practice, Liverpool University; Dr Clare Garrada, RCGP Mental Health Task Force and Senior Policy Advisor, Department of Health; Dr Linda Gask, Reader in Psychiatry, University of Manchester; Professor Sir David Goldberg, Professor of Psychiatry, Institute of Psychiatry; Professor Glynn Harrison, Professor of Psychiatry, Bristol University; Professor Sheila Hollins, Department of Psychiatry of Disability, St. George's Hospital; Professor Rachel Jenkins, Director, WHO Collaborating Centre for Research and Training for Mental Health; Professor Tony Kendrick, Professor of General Practice, University of Southampton; Dr David Kessler, GP, PRiMHE; Professor Michael King, Royal Free Hospital; Professor Malcolm Lader, Professor of Clinical Psychopharmacology, Institute of Psychiatry; Dr Chris Manning, GP, co-Chair PRiMHE; Dr Richard Maxwell, GP, PRiMHE; Ms Sue Plummer, Research Nurse, Department of Psychiatric Nursing, Institute of Psychiatry;

Professor Debbie Sharp, Professor of General Practice, University of Bristol; Professor Chris Thompson, Professor of Psychiatry, Southampton University; Professor Simon Wessley, Institute of Psychiatry; Dr Ellen Wilkinson, Lecturer, Department of Mental Health, Bristol University; Dr Alastair Wright, GP, formerly Editor, *British Journal of General Practice*; Ms Jo Paton, Researcher, Institute of Psychiatry.

Commenters

The following people also provided valuable comments: Marion Beeforth, Service User; Nigel Duerdoth, Mental Health Foundation; John Mellor Clark, Psychological Therapies Research Centre; Dr Peter Orton, GP Advisor, Royal Society of Medicine; Dr Salman Rawaf, Public Health Department, MSW Health Authority; Ms Jackie Carnell, General Secretary, Community Practitioners and Health Visitors Association; Ms Jo Hesketh, Director, The Queens Nursing Institute; Ms Karen Gupta, Chair, Practice Nurse Forum, Royal College of Nursing; Mr Ian Moore, Community Mental Health Team Association; Brian Rodgers, Community Psychiatric Nurse Association.

Permissions

We are grateful to the following organizations who kindly granted copyright permission for us to reproduce or adapt their work: The World Health Organization Division of Mental Health and Substance Abuse: material from *Mental Disorders in Primary Care; a WHO Educational Package* — patient leaflets numbers 3-2, 4, 6, 7, 11 and 12, all the interactive summary cards and the diagnostic checklist.

World Health Organization Collaborating Centres in Mental Health, Sydney and London: extracts from Andrews G, Jenkins R (eds). *Management of Mental Disorders*, UK Edition. Sydney: World Health Organization Collaborating Centre for Mental Health and Substance Abuse, 1999 — used in patient leaflets numbers 1, 2, 3, 5, 6, 8-2, 9, 10 and 11 and the Social and living skills checklist (13-4).

Mental Health Foundation: Extract from *Managing Anxiety and Depression: a Self-Help Guide*, used in patient leaflet 1-2.

Nottingham Alcohol and Drug Team: extract from *Problem Drug Use*, used in patient leaflet 8-1.

Chronic Fatigue Syndrome Research Unit, GKT School of Medicine, London: material from Patient Management Package used in patient leaflets 6-2 and 6-3.

Acknowledgements

This guide has been endorsed by:

- The Royal College of General Practitioners' Unit for Mental Health Education in Primary Care
- The Royal College of Psychiatrists
- The Royal College of Nursing
- The Patients' Association
- Primary Mental Health Education (PriMHE)
- The Association of Primary Care Counsellors
- The Community Practitioners' and Health Visitors' Association
- The Queens Nursing Institute
- The Community Psychiatric Nurse Association
- The Depression Care Training Centre.