Research papers

Professional views on managing common mental health problems in primary care

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ABSTRACT

Aim To obtain a better understanding of the management of common mental health problems in primary care by considering the views of general practitioners, practice nurses, psychiatrists, clinical psychologists and community mental health nurses.
Rationale To establish how services can be improved for the increasing number of people who present with common mental health problems in general practice.
Method Vignettes designed for the study were used to structure focus groups and interviews with professionals drawn from one mental healthcare trust. The vignettes were also used as the basis for a questionnaire.

Conclusions There was considerable uncertainty among primary care practitioners and specialist groups about whether certain categories of patients should be treated in primary or secondary care. Neither primary nor secondary services appear to have strategies for the diagnosis, management and treatment of common mental health problems which cause considerable distress and have economic consequences for patients and the health services.

Keywords: focus group, mental health problem, primary care, specialist services, vignette

Introduction

Jenkins observed that estimates of mental health morbidity are now so high that no country, however affluent, can afford sufficient specialist personnel to meet the demand.[1] The Office of Population Censuses and Surveys (OPCS) was commissioned in 1993 by the Department of Health, The Scottish Home and Health Department and the Welsh Office to carry out a survey of 10 000 adults, aged 16–64, living in private households in Great Britain. In a one-week survey, the prevalence of 'neurotic health problems' was found to be 17% for women and 12% for men; the overall prevalence of alcohol dependence was found to be 5% and of drug dependence 2%.[2] In the previous decade, in the Camberwell area of South London, Bebbington *et al.* estimated a one-month prevalence

for depression and anxiety of 15% for women and 6% for men.[3] These figures coincided with those produced by most similar studies carried out in industrialised countries. Confirmation that this level of morbidity still prevails was provided by Goldberg and Gournay and it has recently been suggested that some forms of mental health problems appear to be increasing.[4,5] Commenting on the challenge that this poses for mental health services, and particularly a primary care-led National Health Service (NHS), Gask and Croft argue that much greater attention needs to be paid to service commissioning and development than hitherto.[6]

The most common mental health problems are anxiety and depression, frequently presenting together, and alcohol dependence, itself often compounded by anxiety and/or depression. Jenkins, amongst others, has pointed out how national mental health policies have tended to focus on the care of people with 'severe mental illness', and have neglected the more common forms of mental health problems.[1] Bowers criticised the term 'minor psychiatric disorder' as 'unfortunate'; since the conditions thus referred to may be 'severe, chronic and disabling' for those who suffer from them.[7] It is generally accepted that 25–30% of patients in Britain attending their general practitioner (GP) have a psychological component to their presentation but only 5–10% are referred to secondary mental health services.[8–11] It is unlikely that specialist care could cater for more than a small proportion of the large number of people with mental health problems but the costs of ignoring them are heavy in terms of repeated GP consultations, sickness absence, high labour turnover, reduced productivity, negative impact on families and children, and on the overall emotional well-being of the country and nation.[1,12]

Standard Two of the *National Service Framework for Mental Health* states that service users who contact their primary healthcare team with a common mental health problem should receive an assessment and be offered effective treatments, including referral to specialist services for further assessment, treatment and care if required.[13] In the OPCS National Study of Psychiatric Disorder only 9% of patients with mixed anxiety and depressive disorder were receiving any mental health treatment at all, and only 4%, counselling or psychotherapy.[2,5] For anxiety disorders, the figures were 19% and 9% respectively, and for depressive disorders, 28% and 14%. The study concluded that treatment needs are not being met. The solution could lie partly in acknowledging the difficulties of trying to manage complex emotional problems in a 10-minute GP consultation, and encouraging mental health workers to become more involved in these consultations.[6]

Following a new GP contract in 1990, greater flexibility in the categories of staff who could be attached to practices resulted in an increase in the number and variety of mental health practitioners working in primary care. At the same time, the rapid reduction in the number of inpatient psychiatric beds meant that the expanded primary care teams were now assuming responsibilities far beyond what had been envisaged even a decade earlier.[4] Usherwood *et al.* surveyed a random sample of over 500 practices in England and Wales and found a mean of 0.47 community mental health nurses (CMHNs) per practice (mainly attached rather than employed by the practice); 0.18 counsellors, 0.11 psychologists and 0.1 social workers.[14] Cape and Parham estimated that nationally, the number of practices with dedicated counsellors was about 30%.[15] Most practices had a half-day or day of counselling time per week, and a smaller number had more time available.

Burns and Bale urged that all initiatives to improve collaboration between specialist mental health services and primary care should be kept under review in order to identify effective ways of working.[16] Despite the historical and cultural differences between the two services, evidence is emerging that collaboration can improve mental health services for clients and their carers, and enable the aims of the national service framework (NSF) to be realised. However, in order for this to happen, rigorous and ongoing training will be required, alongside strong leadership and the availability of appropriate technology.[17,18] The present study aimed to achieve a better understanding of the management of common mental health problems in general practice in one Mental Health NHS Trust, and to consider the views of GPs, psychiatrists, psychologists, practice nurses and CMHNs.

Methodology

The study was carried out in three parts in an NHS community mental health trust (CMHT) in the Midlands. Part I involved focus group discussions with GPs, and the results, as well as being illuminating in their own right, informed the design of the interview and questionnaire for Parts II and III of the study. Part II consisted of face-to-face interviews with individual GPs and practice nurses. The final stage comprised a postal questionnaire sent to psychiatrists, psychologists, and CMHNs in the trust. (The trust serves an urban population of over half a million people and has a wide range of services which are typical of other urban areas). Three methods of data collection ('triangulation') were employed to enhance

the validity of the data obtained, in keeping with Denzin's advocacy of this approach.[19] In each arm of the study, vignettes were used as a vehicle for obtaining the views of participants. It was initially intended to use a standardised set of vignettes, such as those employed in the World Health Organization collaborative study on recording health problems triaxially.[20] However, these were not found to be suitable in the local context and four vignettes were designed especially for the project (see Appendix 1) to reflect some of the common problems with mental health components presenting in general practice. A small number of local GPs, representing rural and urban, single-handed and team practices, who were not participating in the study were asked to comment on the appropriateness of the vignettes and to make suggestions for improvement.

The vignettes described:

- a woman with chronic physical disease (diabetes) showing signs of stress
- a man with back pain and psychological problems, following an assault
- a 17-year-old male causing disruption at home and at college
- a young Asian woman with anxiety related to having a white boyfriend (see Appendix 1).

Membership of the focus groups comprised GPs practising within the locality of the mental health trust and who were known to have a specific interest in mental healthcare.

Two focus groups, each comprising eight GPs, held meetings on separate evenings that were audiotaped with the permission of the participants. Three or four of the authors were present on each occasion, and the discussion was led by a research psychologist. The following questions were explored with reference to the vignettes:

- how are mental health problems currently assessed in general practice?
- why are patients referred to mental health services?
- what do GPs expect from such referrals?
- how do GPs evaluate the effectiveness of services?
- how do GPs rate their relationship with mental health service providers?

For the second part of the study, the 102 practices aligned with the mental health trust were stratified by locality deprivation index and a mean Townsend score was calculated (5.09). Ten randomly selected practices above the mean and ten below were selected and it was from these that a sample of GPs and practice nurses working with different populations were identified. Where several GPs and practice nurses were working in the same practice, one GP and one practice nurse were invited to participate. The final sample consisted of 20 GPs and 15 practice nurses, with at least a GP or a practice nurse from each practice previously identified. All of the practice nurses were working in practices that also contributed a GP interview. The interviews were carried out and audiotaped with the permission of the participants by one of the researchers (JS) and held on the practice premises. Interviews lasted on average 45 minutes, but varied from 15 to 60 minutes. The case vignettes were used to structure the interviews and assist in the exploration of such questions as:

- can all mental health problems be treated in primary care?
- who are the professionals available in your practice to treat mental health problems and who normally does so?
- what are, or could be, the roles of different primary care professionals in treating mental health problems?
- what are the needs in your practice for training, information and communication in the mental health area?

For the third part of the study, questionnaires were sent to the 30 adult psychiatrists, 20 clinical psychologists and 51 CMHNs working in the mental health trust area. Seventeen psychiatrists (57%) responded; 10 clinical psychologists (50% response rate) and 17 CMHNs (33% response rate). Topics covered were the same as those put to the GPs and practice nurses interviewed in the second stage of the study.›

Analysis of results

Recordings made during the focus groups (Part I of the study) were transcribed manually and read by the four researchers. Themes were identified by each, and then compared and discussed until agreement was reached on the 'recurring motifs'.[21] The researchers remained constantly aware of their status as carriers of a 'complex and contradictory history' (p. 24) in order to try, as far as possible, to minimise bias in the identification of themes.[21]

For the second and third parts of the study, participants' responses to closed questions regarding the vignettes were listed by one of the researchers (PN) and counted to enable frequency tables to be drawn up. The data was enhanced by analysis of themes emerging from the interviews with the GPs and practice nurses (Part II of study). This analysis was carried out in the same way as for the focus groups and involved all four researchers.

Results

GP focus groups

Thirty-five GPs with a known interest in mental health issues were approached by the researchers to participate in the focus groups and eight males and eight females accepted (46%). Half of the female respondents were working part-time, while all of the males were working full-time except one. The GPs had been qualified from four to 32 years, with a median of 16 years. Five GPs came from ethnic minority groups. Five mentioned mental health or psychiatry as a special interest, and three, alcohol, drug or substance abuse. Other specialist interests included women's health, transcultural issues, community care, forensic medicine, evidence-based guidelines, palliative and hospice care.

Analysis of the tape recordings made during the focus group discussions showed that the same themes recurred in each group. There was a consensus among the GPs that the number of people presenting with mild to moderate mental health difficulties appeared to be increasing, that the complexity of these cases is also increasing and that the two factors combined are putting considerable pressure on surgery time and other services. The GPs found it difficult to distinguish transitory life crises that may resolve spontaneously, e.g. bereavement or being made redundant, from psychiatric conditions which might deteriorate. They were also reluctant to label people as having 'psychiatric' problems for fear of stigmatising them. There was a general feeling of ignorance about cultural issues in relation to mental health.

There was considerable variation in how patients with mental problems were handled. From what the majority of GPs said ($n = 12$), it appeared that some administrative staff working in primary care have more knowledge of referral systems than the GPs themselves. Referral decisions were sometimes dictated by availability of services rather than their appropriateness or quality. Ten GPs felt that a comprehensive mental health assessment was beyond the remit of primary care practitioners, and that they would like to see Mental Health Teams more involved in primary care. Fourteen GPs stated that they were grateful when specialist mental health services were easily accessible and responded quickly. They were dissatisfied with waiting lists and delays, and the comment of one GP that the mental health services appeared to have been encircled by 'a Berlin wall' since the 1970s was typical of the feeling of many. They appreciated community care but felt that some patients were turned around far too quickly by the CMHT and were back in the primary care arena before they had received appropriate help. Other issues that concerned the GPs included patient reluctance to take antidepressants, being under siege from drug companies, complex routes of referral, and uneven distribution of resources across geographical areas. Their work could be facilitated by a directory of mental health services in their locality, face-to-face contact with specialists, access to regular and appropriate training and clarification of the role of the CMHN.

Interviews with GPs and practice nurses

The majority of the respondents felt that three of the patients could be treated at least initially in the general practice setting (95% of GPs and 93% of practice nurses for vignette 1; 75% of GPs and 67% of practice nurses for vignette 2; 90% of GPs and 67% of practice nurses for vignette 4). However, they were less confident about managing a disruptive adolescent (35% of GPs and 47% of practice nurses for vignette 3). For some (eight GPs and ten practice nurses) this vignette raised the suspicion of psychosis, a condition they all felt was outside their sphere of expertise.

Table 1 shows the opinions of respondents on who would treat the patients in the four vignettes within their own practices. Respondents could nominate more than one professional group (for details of the vignettes see Appendix 1).

Practice nurses felt they were seeing more patients with psychiatric problems than was recognised by the GPs, although the majority of GPs ($n = 15$; 75%) acknowledged that practice nurses had a role to play in managing mental health issues. In the cases of hypothetical patients 1, 2 and 4, the majority of GPs and practice nurses thought that GPs would normally be involved in their treatment. The exception was case 3 where GPs appeared very lacking in confidence. In relation to each vignette, the number of practice nurses who believed they would be involved in the patient's treatment was greater than the number of GPs who thought that nurses would be involved. What is interesting, however, is the recognition amongst many primary care professionals that practice nurses already have a role in the treatment of psychological problems in general practice.

The key role that GPs are already playing in the treatment of mental health problems was recognised by all the GPs and practice nurses. However, only six GPs (30%) acknowledged that practice nurses were playing a key role in the management of people with mental health problems and only eight (40%) felt that they *could* have a key role. Twelve of the practice nurses (86%) stated that they saw a role for themselves in the care and treatment of mental health clients. Both GPs and practice nurses felt that health visitors, CMHNs, clinical psychologists, counsellors and social workers could play a much greater role in managing mental health problems than they do currently. It was

Table 1 Who normally treats psychological problems in primary care? The views of GPs ($n = 20$) and practice nurses ($n = 15$)

	GP	Practice nurse	CMHN	Counsellor
Vignette 1				
GPs' views	19	9	4	4
Practice nurses' views	8	11	3	3
Vignette 2				
GPs' views	16	3	5	3
Practice nurses' views	10	4	2	3
Vignette 3				
GPs' views	3	0	3	4
Practice nurses' views	9	4	0	2
Vignette 4				
GPs' views	18	4	1	7
Practice nurses' views	8	7	0	2

NB: In addition, clinical psychologists were mentioned five times (four times in relation to vignette 2, and once in relation to vignette 1); social workers were mentioned three times in relation to vignette 4, and health visitors once in relation to vignette 1

felt that the role of counsellors in particular could be expanded with 40% of GPs ($n = 8$) stating that counsellors now have a key role and 65% ($n = 13$) stating that they *could* have a key role; and 29% ($n = 7$) of practice nurses stating that counsellors now have a key role and 50% ($n = 7$) stating that they *could* have a greater role.

Questionnaires completed by psychiatrists, CMHNs and clinical psychologists

Table 2 summarises the views of psychiatrists, CMHNs and clinical psychologists on whether the clients described in the four vignettes *should* ideally be treated in primary care, and whether it was thought that currently they actually *would* be treated in primary care. For example, of the 17 CMHNs, 12 stated that vignette 1 should *ideally* be treated in primary care, of whom seven (the figure in brackets) stated that it should be treated *exclusively* in primary care. The remaining five, who do not appear in the figures, thought that the problem should *not* be treated in primary care. Only four, however, were of the opinion that this case would actually be treated in primary care, of whom only two (the figure in brackets) thought treatment would be exclusively in primary care.

Psychiatrists and CMHNs felt that less treatment was occurring at the primary care level than should be. Clinical psychologists rarely recommended treatment in primary care exclusively, but more often

thought joint primary and specialist treatment was ideal or offered this as an alternative to exclusive primary care.

There was a lack of consensus as to who should provide treatment and how mental health problems such as those described in the vignettes should be managed. The role of the GP was recognised by specialists in some cases, but generally by a minority only. The role of the practice nurse was totally unrecognised by the specialists except for a small minority of CMHNs who acknowledged a role for practice nurses in the treatment of case 1. A role for counsellors attached to practices was recognised, but with the exception of case 4, only by a minority of the specialists.

The majority of psychiatrists saw a role for themselves in the treatment of hypothetical cases 2 and 3, but only a small minority saw a role for themselves in cases 1 and 4. CMHNs and psychologists largely ignored psychiatrists while CMHNs felt they had a large role to play in the treatment of all the cases and especially in case 2. However, only a minority of psychiatrists and psychologists mentioned the role of CMHNs. Clinical psychologists were the most likely to recognise the role of psychologists. Specialist doctors or nurses (e.g. in diabetes), occupational therapists, family therapists, Asian therapists and mental health workers (vignettes 1, 2, 3 and 4 respectively) were amongst the range of other professional groups mentioned by respondents.

Table 3 describes the kind of treatments respondents would choose for the vignette clients, and the treatment they considered the clients would be likely

Table 2 Whether psychological problems are treated in primary care, ideally and actually: views of psychiatrists, CMHNs and clinical psychologists

	Psychiatrists $n = 17$	CMHNs $n = 17$	Clinical psychologists $n = 10$
Vignette 1			
Ideally	11 (6)	12 (7)	5 (2)
Actually	5 (4)	4 (2)	5 (2)
Vignette 2			
Ideally	6 (4)	6 (3)	5 (1)
Actually	7 (5)	3 (1)	5 (1)
Vignette 3			
Ideally	5 (2)	3 (1)	2 (1)
Actually	6 (2)	3 (1)	2 (0)
Vignette 4			
Ideally	9 (7)	6 (5)	5 (2)
Actually	7 (4)	4 (1)	4 (3)

Figures outside parentheses are the numbers of respondents mentioning primary care (PC, general practice, 'surgery', etc.) with or without specialist care; figures within parentheses are the numbers referring to treating exclusively in primary care. The numbers only refer to those who stated that the conditions should be treated in primary care

to receive. The views of the three groups have been combined as they were so similar.

Medication was only mentioned by some of the specialists, most often in relation to vignette 2. The general conclusion was that medication should play a subsidiary role in the treatment of the kinds of mental health problems described in the vignettes, with support and psychological treatment such as counselling or psychotherapy playing the major part. The gap between the ideal type of therapy and the actual number of patients receiving it was considered likely to be large. Of those who thought a psychological intervention was the most appropriate, only half thought that such a treatment would actually be offered. The consensus between the three groups of specialists about the nature of treatment required was remarkable considering that they held different views about which profession should provide the treatment. The figures for assessments maybe an underestimation because the wording of the question may have directed respondents to focus on treatments rather than assessments.

Discussion

This small-scale study was carried out in one mental health trust and we acknowledge that it has several

limitations. Selecting participants for Part I of the research on the basis of their being known or thought to have an interest in mental healthcare introduces an inevitable bias and this must be borne in mind when interpreting the results. Furthermore, the views of the health professionals who participated are clearly related to the particular problems that they encounter in their geographical area and these may not reflect the service as a whole. The samples for Parts II and III of the study were self-selecting, and the response rates were less than ideal. The small number of GPs and practice nurses who participated either in the focus groups or interviews cannot be considered necessarily representative of their professions nationally, although conscientious efforts were made to invite participants from areas serving different populations. Only certain professional groups were sampled and the voice of groups such as health visitors, occupational therapists and social workers was not heard. The four vignettes specially designed for the research facilitated discussion in the focus groups and helped participants crystallise their views for the interviews and questionnaires, but what was said and written might well also have been limited by the vignettes. The study, therefore, cannot claim to be comprehensive in presenting an account of mental health services in primary care. Notwithstanding these limitations, we believe that the triangulation of research methods employed means that the study has validity and coherence. Concordance with the findings of other

Table 3 Which treatments would be used for psychological problems, ideally and actually: collective views of psychiatrists, CMHNs and clinical psychologists ($n = 44$)

	Ideal	Actual
Vignette 1		
Psychological*	35	18
Medication**	6 (0)	8 (4)
Assessment***	7 (4)	3 (3)
None specified****	2	18
Vignette 2		
Psychological	33	16
Medication	14 (2)	14 (8)
Assessment	7 (3)	4 (2)
None specified	7	18
Vignette 3		
Psychological	32	16
Medication	7 (0)	4 (2)
Assessment	13 (7)	6 (4)
None specified	5	21
Vignette 4		
Psychological	33	16
Medication	2 (0)	8 (6)
Assessment	8 (4)	5 (4)
None specified	6	19

* A diverse category including: 'cognitive', cognitive behavioural therapy, anger management, anxiety management, counselling, supportive counselling, but excluding 'self-help' or simply 'support'
** Including antidepressants, psychotropic medication, or simply 'medication'
*** Sometimes referred to by psychiatrists as 'diagnosis'
**** Sometimes a profession(s) or service was referred to rather than a treatment (e.g. 'CMHN', 'refer to CMHT'); sometimes a 'none' or 'no idea'; sometimes a '?'; sometimes left blank
In the case of medication, figures outside parentheses are the numbers of respondents mentioning medication with or without other interventions; figures within parentheses are the numbers referring exclusively to medication. The same convention applies to assessment

researchers in the UK suggests that the study has some relevance for mental health primary care services nationally.[5,8,10,22]

GPs participating in this study were found to be insecure regarding the management of minor mental illnesses. They were unsure about which patients should be treated in primary care and by whom, and when to refer to 'specialists'. The 'specialists' (psychiatrists, CMHNs, clinical psychologists) were equally insecure about the treatment and management of the vignette clients, and how or whether collaboration with GPs could be achieved. There is clearly consider-able scope for improved communication between primary and secondary level care professionals.

The majority of GPs and practice nurses felt that the mental health problems depicted in the case vignettes could be treated in primary care. This is encouraging given the high prevalence of mental health problems amongst general practice patients, and the impossibility of specialist services catering for more than a small proportion of them.[1,2] However, the three groups of mental health specialists had mixed views on whether the problems described in the vignettes should be treated in primary care. They were much more likely to think that they were more suited to treating such clients than GPs. These findings suggest that there may be 'significant ambiguity concerning the tasks that the respective mental health professionals perform'.[23]

While there appeared to be willingness on the part of the specialist professionals to engage in the treatment of the vignette clients either exclusively or jointly with general practice, GPs and practice nurses often expressed unease about referring these clients to specialists. They were reluctant to diagnose 'life problems' as being a psychiatric condition, fearing the stigma associated with mental illness, the unacceptability of antidepressant medication, and the possibility that the primary care professional's relationship with the patient might be damaged by suggesting a mental health referral.

The role of the GP in treating clients such as those portrayed in the vignettes was recognised by the majority of GPs and practice nurses, but by only a minority of the mental health specialists. The role of practice nurses was not recognised by the specialists at all except for a small number of CMHNs, whereas it was very much acknowledged by the nurses themselves. Most GPs saw a subsidiary role for practice nurses in the treatment of mental health problems, but the nurses saw their role as potentially a key one. Disagreement about the actual and potential role of practice nurses existed alongside a lack of recognition that they are already considerably engaged in working with mental health clients.[24,25] Nolan et al. concluded that 'for a small expenditure in terms of training practice nurses, the care of mental health clients could be greatly improved' (p. 103).[26]

The infrequent mention by GPs and practice nurses of the role of health visitors and community nurses in caring for clients with mental health problems, suggests that the skills of health visitors are not being employed in this area.[25] The potential for greater involvement of health visitors was, however, recognised by many GPs, and some practice nurses mentioned a minor role for district/community nurses.

GPs and practice nurses were generally of the view that part-time or attached mental health specialists,

and especially clinical psychologists, could play a far greater role in primary care than they do at present. The study confirmed the presence of part-time mental health specialists in general practice. Both GPs and practice nurses commented favourably on the work of CMHNs in general practice.[23] Some GPs' experiences of CMHNs had not been so positive when there was a lack of close contact between the practice and the CMHN, and when CMHNs proved unable to work autonomously.

In contrast to their differing views on *who* should treat the vignette clients, there was consensus among the three specialist groups on what treatment would be appropriate. Medication was recommended by only a few participants, and the majority considered that some form of psychological intervention was indicated. A preference for cognitive and/or behavioural techniques was often expressed. Interpersonal psychotherapy or problem-solving therapy were rarely mentioned, although Goldberg considered the latter particularly helpful in treating common mental health problems in general practice.[27] The specialists were dubious about what they thought would actually be provided for the clients. Quite a few thought that only medication would be offered and that psychological treatments would not be available. These findings concur with those of Bebbington *et al.* who suggested a large measure of unmet need for counselling and psychotherapy.[5]

GPs and practice nurses working in the vicinity of the trust wanted better information about the specialist mental health services available, quick and easy access to services and regular communication with the specialists to whom they refer patients. They disliked long waiting times, geographical variation in the availability of services, not knowing the people to whom they refer clients, not being kept informed about patients' treatment, and patients being referred on without consultation.

Standard Two of the mental health NSF requires a smooth interface between primary and secondary care.[13] In this study, both primary care and specialist mental health respondents agreed that communication between them could be improved – through joint working, regular meetings, informal gatherings to get to know each other, providing clear information about their roles, and projects such as that of Badger and Nolan to improve communication between practice nurses and CMHNs.[28]

With regard to training and information needs, GPs wanted protocols to help them obtain relevant information from patients and make diagnoses; up-to-date information about people and places to whom patients might be referred, including specialist voluntary organisations; help in dealing with information overload regarding medication; advice on the use of antidepressants; education about cultural/ethnic issues,

and general training in a biopsychosocial approach. Practice nurses also wanted more training, confirming the work of Crosland and Kai and Secker *et al.* in relation to unmet training requirements of primary care professionals.[24,25] The focus groups suggested that training should be clinically based and involve feedback from other professionals.

Finally, although this was a local study, focusing on one trust, we believe that the findings could be used to inform discussions elsewhere about how primary mental health services could be improved, how personnel could be supported and managed and the importance of equipping staff with the appropriate skills and knowledge so that people with common mental health problems are recognised, assessed and treated effectively.

Conclusions

These findings suggest some key issues for those with responsibility for meeting Standard Two of the mental health NSF and improving services for people presenting with common mental health problems in general practice.

- Provision of appropriate education and training is urgently required for primary care personnel so that they feel able to engage in the provision of primary mental healthcare and deal with common mental health problems effectively.
- There is an urgent need to address the considerable shortfall between the demand for psychological treatments and their current provision in general practice.
- Primary care requires a comprehensive directory of sources of specialist treatment (voluntary and statutory) for patients with common mental health difficulties. The directory should indicate what systems are used by specialists to keep primary care professionals informed about their patients.
- Much more consideration is needed to ensure that all personnel agree, both in primary and secondary care settings, on which problems should be treated in primary care and which should be referred to secondary services.

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Appendix 1

Vignette 1

A 35-year-old single woman who is a solicitor attends her GP. She has had diabetes for 15 years which has not been well controlled. However, she attends her diabetic clinic regularly. She is a heavy smoker and has had two admissions to hospital for ketoacidosis over the last six months. She comments that she has become very stressed and has been coping by drinking and smoking more than usual. She is aware that this is not conducive to good diabetic control. When her GP advises her about the importance of good control, she becomes inconsolable and says it is impossible. She states that the condition makes her depressed and she cannot cope.

Vignette 2

A 55-year-old man who is a minicab driver attends his GP complaining of back pain and is having problems sleeping as he has been waking during the night with hot sweats and palpitations. He feels this injury is the result of an assault near his home; he was seen in casualty and has had a follow-up appointment with an orthopaedic surgeon. Since this assault he has had difficulty leaving the house; he is constantly tired and is currently off work. He is anxious that he will lose his job.

Vignette 3

A 17-year-old boy has been referred from his college following several incidents of unruly and disruptive behaviour in the classroom. These have included violent outbursts, which were unprovoked and for which he showed no remorse. He is an only child and lives with his mother. He has had no contact with his father since the separation from his mother three years ago. He was previously doing well in his course. His mother is very worried and mentions that his behaviour has become more threatening and unmanageable at home and she is at a loss what to do.

Vignette 4

A 21-year-old second generation Pakistani girl who works for the family business visits her GP. She says that she is feeling tired, lacking in motivation and concentration. She is anxious as she is not performing well at work and her periods have stopped. She is the oldest sister of three. She has a white boyfriend whom she has been seeing for over 2 years and whom she wishes to marry. She states clearly that they are not involved in a sexual relationship. Her parents are unhappy about this match and are banning her from seeing him. They are also taking steps to arrange marriages for her and her younger sisters. Whilst explaining her situation she becomes very tearful and states that she does not know where to turn, and is desperate.