The aim of this article is to explore how community mental health nurses (CMHNs) can assist the primary care team, in particular practice nurses, to address and begin to meet standard two of the National Service Framework for Mental Health. The focus of the paper will be on depression, one of the commonest mental disorders presented in primary care.

At the end of this article, you should be able to:

1. Identify the main points of standard two of the National Service Framework for Mental Health;
2. Discuss the prevalence of depression in primary care;
3. Identify why many patients with depressive disorders remain undetected;
4. Discuss the possible role of community mental health nurses in primary care in relation to practice nurses.

The National Service Framework (NSF) for Mental Health was published in September 1999 and focuses on the mental health needs of adults up to the age of 65. It stresses that mental illness has traditionally not received the attention it rightfully deserves, despite its prevalence. In calling for this imbalance to be redressed, the government is giving mental illness a much higher priority. The NSF is intended to lay down models of treatment and care which people will be entitled to expect in every part of the country.

The NSF addresses seven standards. These are founded on a solid evidence base and are to be used as a guide to investment in mental health services over the next two years. Standard two states: ‘All service users who contact their primary health care team with a common mental health problem should:

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

You may have found there were varying answers to your questions. It will be useful to consider the implications of these on the overall implementation of the NSF.

Prevalence and identification of depression

Psychiatric morbidity among patients attending primary care has been estimated as 230 per 1,000 population per year (Goldberg and Huxley 1992), with neurosis forming a substantial part of the burden in primary care (Shah 1992). Depression is one of the commonest mental illnesses encountered in primary care. It has been estimated that five per cent of attenders have a major depressive disorder; five per cent...
have dysthymia and ten per cent have significant depressive symptoms which impair functioning (Lloyd and Jenkins 1995). The lifetime prevalence of depression has been estimated as high as 26 per cent for women and 12 per cent for men (Sobieraj et al 1998). Goldberg et al (1998) have further shown that 50 per cent of patients with a milder type of depression still met the criteria for ‘caseness’ at a one-year follow-up. Many patients with depressive symptoms have significant physical or psychiatric comorbidity and chronic physical disorders such as asthma, hypertension and diabetes have been shown to be associated with symptoms of psychiatric morbidity (Rubin 1993; Wilkinson et al 1987).

The burden of this common illness is enormous, not only in terms of costs to the NHS and lost working days but also in terms of its impact upon members of a family in which someone is suffering from this disorder. In fact, Sobieraj et al (1998) found a significant association with increased physical morbidity in families where a member was depressed.

A general practitioner (GP) with a list size of 2,500 patients identifies approximately 300 patients with a non-psychotic mental illness a year (Lloyd and Jenkins 1995), however, a substantial number of patients with depressive disorders remains unrecognised by the GP. Studies of GPs’ detection rates have consistently shown that approximately 50 per cent of patients suffering from a mental disorder, who consult their GP are not detected (Goldberg and Huxley 1992). The various reasons for this can be identified by examining patient and doctor variables (Casey 1990).

**TIME OUT 3**

Why do you think so many patients with mental disorders remain unrecognised in primary care? Make a list of reasons under the headings of patient (e.g. the way patients present in a consultation) and doctor (e.g. the characteristics and behaviour of the GP).

**Patient variables:**
- Many patients describe only the physical symptoms of depression such as fatigue, sleep disturbance and headaches, even though their primary pathology may be psychological;
- Some patients may feel their doctor only wants to hear about their physical symptoms so they avoid mentioning those symptoms concerned with emotions;
- Patients may have a sense of guilt or stigma about these feelings;
- Patients may consult with a genuine physical symptom but not disclose the psychological effects of these, even if these are severe.

**Doctor variables:**
Marks et al (1979) described two aspects of GP diagnosis – bias and accuracy. Bias refers to the doctor’s tendency to make or avoid making a psychiatric diagnosis and accuracy refers to the correctness of the diagnosis, either in terms of severity or labelling.

**Bias:**
Is determined by the interest the GP has in this area. The GP’s interest is reflected in his/her interview style. This style would include questions that have a psychiatric focus, contain empathic comments and have an awareness of the psychological factors in illness. The GP will identify the verbal and non-verbal cues.

**Accuracy:**
Is governed by the personality attributes of the doctor and by the style of the interview:
- Self-assured doctors, who are extrovert and aware of their own feelings, are more accurate;
- An interview style where the GP deals with over-talkativeness, clarifies symptoms, makes eye contact and avoids reading notes during the interview will contribute to the accuracy.

**TIME OUT 4**

These variables form part of the results of a study carried out by Marks et al (1979). This is a classic study and is quoted, and has been replicated, in numerous studies since then. Obtain a copy of this paper from your library. This will be very helpful to you in your role in primary care. The full reference is given at the end of this article.

**Point of contact for patients in primary care**

The GP has traditionally been the first port of call for the majority of patients experiencing mental health problems (Shepherd 1966) but as the role of other primary care team members has expanded, this is no longer always the case. Practice nurses make up the largest health professional workforce in primary care with an estimated 30,000 current practice nurse posts (Goldberg and Gournay 1998).

The most frequent tasks performed by practice nurses remain those of a physical nature such as venepuncture and travel and child immunisations (Atkin and Lunt 1995; Bryan 1995; Greenfield et al 1987; Jeffries et al 1995; Makereth 1995; Ross et al 1994). Practice nurses have a well-established role in the management of the chronic physical illnesses of asthma and diabetes and the focus of their post-registration training is typically upon these illnesses and health promotion activities. However, there is good evidence that practice nurses are already working with patients experiencing mental health problems, especially depressive disorders.

Gray et al (1999) conducted a national survey of 1,500 practice nurses to investigate their involvement in mental health interventions. Forty-three per cent of nurses reported that depressed patients ask for information about symptoms of depression, with 51
per cent of practice nurses reporting that patients asked for information about antidepressant medication. Forty-four per cent of nurses gave information and advice about depression. Forty-two per cent of practice nurses did not agree that antidepressant medication was the best method of treating severely depressed patients and only 52 per cent believed that antidepressants were not addictive.

Practice nurses were asked about their involvement in the administration of depot antipsychotic medication. Sixty-one per cent reported administering depot antipsychotics at least once a month and, of these, just over half monitored the patients for side-effects. Thirty per cent of nurses said they had some contact with a CMHN but only seven per cent reported having frequent contact. Ninety-six per cent had no contact with psychiatrists and 40 per cent did not have contact with any mental health professionals. Seventy per cent of practice nurses had received no mental health training in the last five years.

Ten per cent of practice nurses’ caseload were reported-ed as having psychological or mental health problems. Gray et al (1999) suggest this low figure may either be due to lack of recognition or because people with mental health problems are not seen by practice nurses but are treated by other members of the primary care team. However, in the first phase of a large randomised controlled trial being undertaken at the Institute of Psychiatry, Plummer et al (2000) found that 37 per cent (n = 1,710) of patients attending practice nurses clinics scored at probable ‘case’ level on the 12-item General Health Questionnaire. (‘Case’ level refers to the probability of a person having a recognised psychiatric disorder requiring further treatment.) Plummer et al (2000) further found that only 16 per cent of these patients were recognised by the practice nurses as experiencing a significant level of psychological distress. This detection rate is similar to that found in a pilot study of practice nurses’ recognition of psychological distress (Plummer et al 1997). These findings are perhaps not surprising when viewed against the results of Gray et al (1999).

It can be seen therefore that a substantial number of patients consulting with practice nurses are experiencing a significant level of psychological distress and may be suffering from some form of common mental disorder. Recognition of mental disorders in primary care remains not only an issue for GPs but also for practice nurses.

Role of community mental health nurses

What then, is the role of the CMHN in primary care? The answer to this is not uniform because roles vary throughout the country and the different models of practice are a continued subject for debate. Community mental health nurses, themselves, vary in their opinions of their roles (Corney 1999) and indeed their future role is unclear with the forthcoming advent of primary care trusts. It is clear, though, that the focus of CMHNs’ work should be with patients suffering from severe and enduring mental illnesses (Department of Health 1994; Gournay and Brooking 1994). Indeed, a randomised controlled trial conducted by Gournay and Brooking (1994) found no difference in clinical outcomes between patients receiving usual GP care for neurotic disorders and patients seen by the CMHN. However, a consistent result from a variety of surveys is that the CMHN is the most frequent point of referral, by GPs, for patients with common mental disorders in primary care (Badger and Nolan 1999). There are approximately 8,000 to 10,000 CMHNS in post and, in terms of resources, this is a low workforce number who cannot be expected to take on all types of referrals.
the primary care team members can start to recognise, assess and identify their patients’ mental health needs. The question is how this can be facilitated and the answer may be different in each community health team and primary care team setting. However the teaching is facilitated, there are common areas that would need to be addressed. It should be remembered that practice nurses have an enormous wealth of skills and that these need to be identified, built upon and new skills developed.

A useful starting point is to consider the common mental disorders presented in primary care. These are typically depressive disorders, anxiety disorders, somatisation and eating disorders. For the purpose of this paper, depression will be used as an example of a teaching subject and it is assumed that community health nurses already have adequate knowledge of this.

Baseline knowledge

It is evident from Gray et al (1999) that practice nurses’ overall knowledge of depression is generally poor and that nurses themselves recognise this and want further training (Armstrong 1997). Before practice nurses can begin to recognise patients who are depressed, they need some baseline knowledge of the signs and symptoms of depression and the criteria used to make a diagnosis. There are numerous guidelines in existence addressing the care of depression in primary care and the majority of which reflect the joint consensus statement produced by the Royal College of General Practitioners and the Royal College of Psychiatrists in 1992 (Littlejohns et al 1999). These guidelines were produced as part of the Defeat Depression Programme. However, current literature suggests that guidelines have varying degrees of success (Kendrick 2000). Practice nurses also need to be aware that psychiatric symptoms and disorders commonly accompany physical disorders.

Assessment

The results from Marks et al’s (1979) large randomised controlled trial are important when considering this skill. We have seen that accuracy depends upon interviewing style and technique, with particular attention paid to maintaining eye contact and observing the verbal and non-verbal cues. Appointment length needs to be considered as, although practice nurses generally have longer appointment lengths than GPs, they need to be able to ask focused questions in the time they have available to gain the maximum amount of information.

Techniques borrowed from behavioural type assessments can be useful, asking specific questions such as when, where, how often, duration, circumstances and severity. The use of reliable, validated assessment measures can be introduced.

One such measure is the Beck Depression Inventory which is a well-tested measure of severity of depression and change over time in response to treatment. Its weighting towards cognitive, rather than somatic, aspects of depression makes it particularly suitable in general practice (WIlkin et al 1992). However, if practice nurses are to use this, they need instruction on scoring methods and the sections that suggest suicidal intentions. Practice nurses may be very wary about asking depressed patients about suicidal thoughts and ideas and need sensitive support to be able to approach this with patients. It is quite possible that nurses avoid asking these questions because they believe that in doing so, it will prompt the patient to harm themselves or commit suicide.

Not only is accuracy an important skill, but bias, the nurses’ interest in this subject, needs to be considered. Gray et al (1999) found that the majority of practice nurses were registered general nurses, only a minority (3 per cent) had undertaken psychiatric nurse training and 70 per cent had not received any mental health training in the past five years. This may well reflect the nurses’ interest and beliefs about psychiatry and patients with psychiatric problems. It is vital that nurses are given the opportunity to discuss their feelings about working with patients with psychiatric symptoms.

Following the practice nurses’ assessment, there has to be a decision made about whether to deal with the problem at the time, if this is impractical, ask the patient to come back for another appointment of a longer length, or refer the patient onto the GP.

There ideally needs to be a protocol in the general practice of when to refer onto the GP and local policy initiatives and policy guidelines often govern these. Protocol for referrals onto specialist services by members of the primary care team vary in general practices. However, the nurse needs to make a concise note of the problem and, if necessary make a credible, professional referral onto the appropriate person.

Treatment

The majority of practice nurses will be able to deal with a distressed patient and then make a decision about their immediate care. Nurses and primary care teams need to consider the extent to which they are prepared/trained to offer psychological interventions which could range from problem-solving techniques to cognitive behavioural therapy. Both of these interventions have shown to have good outcomes. There is much discussion currently about the role of practice nurses in the care of depression in primary care with a number of small studies showing positive results of training interventions (Orris et al 1999; Mynors-Wallis et al 2000; Peveler et al 1999). However, the shortcomings of recognition and detection need to be addressed first in any education programme.

One area where practice nurses may have a specific role is that of medication management. Adherence to antidepressant medication is low (Peveler 1999) and this is for many reasons. Practice nurses have a potential role as a case manager for patients receiving pharmacological treatment but need to have training on medication and its management. Indeed, preliminary results of a randomised controlled trial to train CMHNs in medication management.
agement, being carried out at the Institute of Psychiatry look promising.

**TIME OUT 7**

From your reading, make an action plan of how you might facilitate some of the above teaching for one or a group of practice nurses. What methods of teaching would you use? How could this be organised? What might the barriers to this be in terms of the practice nurse, the surgery infrastructure or your current role?

It is difficult to outline, in this article, a definitive plan of action for every CMHN as their roles will be different, depending upon the models of community mental health team/primary care team working is adopted. Such a plan needs to be discussed fully within each team and there will be a variety of issues that need exploration.

**Advice/Resource**

There may be times when the practice nurse needs to give advice to patients and/or their carers on resources that are available to them in the community. One role of the CMHN is to provide directories of local services if they are available to practices. These can be kept in consulting rooms and also in waiting rooms.

**TIME OUT 8**

Find out if directories of local and national mental health services are available in the general practices you work in. If they are, where are they kept? Who has access to them? How often are they referred to? How up to date are they? A list of useful national resources can be downloaded from: www.iop.kcl.ac.uk/IoP/Departments/HSR/PsychNurs/Addresses.stm or by contacting the authors of this article. A further list of useful resources can be found in the World Health Organization Guide to Mental Health in Primary Care. This book addresses the common mental disorders in primary care and we highly recommend this is used as a resource. The full reference can be found in the reference list.

There may be local agreement between primary care teams that a community mental health nurse attends practice meetings or case meetings on a regular basis and this is an opportunity for the CMHN to act in the role of advisor. There may also be agreement that he/she is contactable by phone to give clinical advice if it is needed. Again, the extent of this role requires team discussion and planning.

**Conclusion**

In this article, we have outlined standard two of the NSF for Mental Health. In order to discuss how community mental health nurses can help the primary care team, particularly practice nurses meet these standards, we have used depression as a focus for this article. Barriers to recognition and assessment have been explored and the various potential roles for CMHNs have been discussed.