

however, this has important implications for our practice. In our opinion the following are of particular importance:

- (a) Basic information such as the baseline frequency of bullying on psychiatric units and the proportion of incidents of which staff are aware are not known. It may be levels are higher than in schools due to the characteristics of the children who are admitted, or lower due to the unit's philosophy or skill of the staff.
- (b) Studies in schools have shown single level interventions and behavioural policies are not in themselves sufficient to address bullying. Research is needed to establish whether on psychiatric units an anti-bullying policy is necessary or whether a standards of behaviour policy and individual nursing care plans are sufficient to significantly decrease the level of bullying.
- (c) If anti-bullying policies are needed it will be necessary to adapt current guidelines on how to develop, implement and evaluate an anti-bullying policy as these are all aimed at the school environment and do not take into account the specific problems associated with psychiatric units.

Acknowledgements

We thank John Pearce, Professor of Child and Adolescent Psychiatry, Academic Department, Queens Medical Centre, and Paul Cawthron, Consultant Child and Adolescent Psychiatrist, Thorneywood Adolescent Unit, Nottingham.

References

- OLWEUS, D. (1993) *Bullying at School*. Oxford: Blackwell.
- PARKER, J. G. & ASHER, S. R. (1987) Peer relations and later personal adjustment: are low-accepted children at risk? *Psychology Bulletin*, **102**, 357-389.
- PEPLER, D., CRAIG, W., ZEIGLER, S., *et al* (1993) A school-based anti-bullying intervention: preliminary evaluation. In *Understanding and Managing Bullying* (ed. D. Tattum). Oxford: Heinemann Educational.
- REID, K. (1983) Retrospection and persistent school absenteeism. *Educational Research*, **25**, 110-115.
- SMITH, P. K. & SHARP, S. (1994) *School Bullying: Insights and Perspectives*, London: Routledge.
- WHITNEY, I. & SMITH, P. K. (1993) A survey of the nature and extent of bullying in junior/middle and secondary schools. *Educational Research*, **35**, 3-25.

Stephanie Sommers, Registrar in Psychiatry, Nottingham Healthcare NHS Trust, and *Lucia Whitney, Consultant Child and Adolescent Psychiatrist, Rivermead, Belper, Derby DE56 1UU

*Correspondence

Attendees at a primary care-based mental health promotion drop-in clinic

Social and clinical characteristics and outcomes

Chris Gilleard and Ros Lobo

This paper describes the social and clinical characteristics of patients who attended a mental health promotion drop-in clinic that was set up in a primary care group practice. From consideration of the characteristics of the patients, the problems they presented with and the results of the consultations, we argue that there is a viable role for mental health

promotion as a form of primary prevention of mental health problems, distinct from an extended treatment or therapeutic role. It is open to question whether the particular way we delivered the service is necessary to achieve such an objective and we draw attention to some of the constructive criticisms the primary health care team made at the final evaluation of the project.

Mental health promotion is "a relatively neglected area of health promotion" (Tudor-Smith, 1997) and the outcome from most mental health promotion programmes often only gradually emerges over time. Nevertheless, the recent *Manifesto for Mental Health* announced by the Royal College of Psychiatrists (1997) (available upon request from the College External Affairs department) has recognised the priority to be given to promoting mental health and preventing mental health problems if we are to make serious inroads into the burden that mental health problems present. Examples of effective mental health promotion activities are few and far between, and recent reviews of this area point to the almost total reliance on North American research in evaluating the impact of such activities (Hodgson & Abbassi, 1995; Tilford *et al.*, 1997).

The present report is an account of one component of a mental health promotion project called Health in Mind which explored a number of strategies for promoting mental health within the primary care setting. A team of three part-time mental health professionals (psychiatric registrar, community psychiatric nurse and counselling psychologist) each provided up to three sessions per week to a large group practice in south-west London to establish and run the Health in Mind project (see Brown *et al.*, 1997 for a description of the whole scheme). One of the central elements of the project was a twice weekly 'drop-in' clinic where patients could contact a member of the Health in Mind team to discuss mental health-related issues affecting themselves or their family. The present report describes the characteristics of the people who used the resource, the range of problems they presented, and the outcomes of the consultations. While it is impossible to judge the unique impact of this element of the service, we thought it useful to provide information about what it did, for whom and with what consequences.

The study

The clinics were established in June 1996 and ran for one year. The drop-in clinics were held two afternoons per week in the practice and each clinic was run by two members from the Health in Mind mental health promotion project group. There was no system of appointments and patients were free to drop-in at any time during the clinic opening (14.00–16.30). Patients unable to get into the clinic were able to make telephone contact.

The staff in the primary health care team (PHCT) were briefed about the project and emphasis was placed upon the primary advice

and consultation role of the project and its eschewing of any direct therapeutic activity. This was an important point to stress, both to the PHCT and to the project staff, since all three Health in Mind staff involved were primarily clinicians used to treating patients and it was at times difficult for them to resist pressure to serve in a diagnostic or therapeutic capacity.

For each patient (or couple) that dropped in to the Health in Mind clinics, a brief contact sheet was completed. The contact sheet recorded the gender and age group of the patient, their presenting problem, how they were referred and what other problems were identified during the consultation. Finally, a record was made of the outcome of the consultation.

Findings

Fifty-five contacts were recorded for the period from beginning of July 1996 to the end of May 1997, which represents just over one contact per week. Patterns of consultation were sporadic throughout this period, though more occurred in the second five months ($n=37$, includes two contacts by the same person, from January to May 1997) than in the first five months ($n=19$, from July to December, 1996). This is perhaps not surprising since publicity about the clinics was slow to circulate and no doubt had cumulative effect. The characteristics of the contacts are outlined in Table 1.

In general, the people who dropped in to the Health in Mind clinics were young or middle aged, they presented with problems of stress or depression, they had had no previous contact with specialist mental health services and most often they were given self-help information and/or advised to contact local non-statutory organisations. Only a small minority were existing users of the local community mental health services and there was no evidence that the people using the clinics created a significant demand upon the specialist mental health services. In most cases staff felt they could be managed through advice, self-help information and contact with local non-statutory organisations.

In addition to the presenting problem, many of the people who attended the drop-in clinics also described other problems in their life. We examined all the problems reported by the patients, irrespective of their 'presenting' concern and found that on average people had a median of two problems, ranging from none through to seven. In terms of frequency, the most common problems mentioned were depression (49%); stress (38%); relationship problems (26%); social isolation/loneliness (18%); work problems (16%); grief (10%); money

Table 1. Characteristics of drop-in contacts and outcome of consultation

Characteristics of drop-in contacts	
Age group	
16–34	35%
35–54	51%
55+	15%
Gender	
Male	38%
Female	56%
Couple	6%
Source of referral	
Self	57%
General practitioner	36%
Nurse	8%
Presenting problem	
Depression	27%
Stress	25%
Relationship problems	9%
Work-related problems	7%
Financial worries	4%
Sexual abuse	4%
Sleep problems	4%
Health concerns	2%
Panic	2%
Housing worries	2%
Family member's mental health	2%
Family member's drug problem	2%
Other	10%
Previous contact with mental health services	
Yes current	6%
Yes in past	22%
None	73%
Outcome of consultation	
No action taken, listening only	4%
Given self-help information	24%
Advised to contact non-statutory agencies	30%
Advised to contact in-house evening group	28%
Advised to (re) contact specialist mental health services	4%
Referred to general practitioner	6%
Referred to other statutory services (social services, social security, housing)	4%

worries (9%); health, housing, sleep and sexual abuse (7% each); drug use in family members, mental health problems in family members, domestic abuse (6% each); suicidal concerns (4%); and panic disorder, sexual dysfunction, eating disorder, anger control and recent trauma (2% each).

In terms of primary prevention of mental health problems, it is worth noting that few people presented their problems as existing psychiatric disorders (with the unsurprising exception of depressed mood). In fact many of the patients were seeking help to deal with stressors – precipitants or triggers to mental

health problems like loss, relationship breakdown, work difficulties, social isolation and financial concerns. The drop-in clinic appeared to serve a preventive rather than treatment role and very few patients seen at the clinic were referred on to the psychiatric services.

Comment

This brief account of the mental health promotion drop-in clinics suggests that mental health promotion and the prevention of mental health problems can be undertaken in primary care. The problems presented are amenable to relatively inexpensive interventions focusing upon support, information, guidance and advice. People dropping in to the clinic were rarely existing users of specialist mental health services and in most cases were self-referrals. Such clinics seemed to appeal to young and middle-aged adults, although some older adults did attend. We feel that the drop-in clinics were appropriately and effectively targeted but how measurably effective the interventions were in promoting mental health and preventing mental ill health among the practice population cannot be answered definitively in the absence of other outcome measures.

The staff in the primary care team had mixed feelings about the clinic. For some there was an evident wish for the Health in Mind project to attend to issues concerning treatment or offering therapy to people who had existing mental health problems. For others, conscious that the clinics were slow to get off the ground, and that the Health in Mind staff were often under-occupied, there was a degree of concern over the efficiency of the service. Finally, there were concerns that the clinics were held on only two afternoons per week and some doctors particularly felt that it would have been preferable to hold the drop-in clinics in the mornings when there would have been more interchange with the PHCT.

Although it seems unnecessary to run such a drop-in clinic with expensive extra-mural staff, one direct benefit to the practice of bringing in staff with a background in community mental health work was their use and development of resources outwith the PHCT setting. These included useful, accessible mental health-related information in the form of leaflets, posters, booklets, and local resource directories, improved liaison and links with local non-statutory services and organisations and a broader perspective on what can constitute 'mental health resources'. These are some of the concrete benefits that the practice has gained which are being passed on now the project has ended. Developing those resources and networks

within primary care could have occurred in ways other than our extra-mural service, but however such developments come about they do seem necessary for primary care to become an effective site for mental health promotion.

Acknowledgements

The funding for this project came from the Merton, Sutton and Wandsworth Health Authority's Specialist Health Promotion Service, for whose support we are grateful. We thank Dr Richard Chegwiddden for his initial support for the project, and Dr Vino Frances, Dr Mary-Ellen White, Ms Julie Belfield, Ms Saira Razzaq and Ms Michelle Brown for their contribution to the project.

References

BROWN, M., GILLEARD, C. & LOBO, R. (1997) *Health In Mind. A Mental Health Promotion Service in Primary Care.*

Evaluation Report. London: Merton, Sutton and Wandsworth Health Authority, Department of Public Health.

HODGSON, R. & ABBASSI, T. (1995) *Effective Mental Health Premonition: A Review of the Effectiveness of Health Education and Health Promotion.* Technical report No. 13. Cardiff: Health Promotion Wales.

TILFORD, S., DELANEY, F. & VOGELS, M. (1997) *Effectiveness of Mental Health Promotion Interventions: A Review.* London: Health Education Authority.

TUDOR-SMITH, C. (1997) Commentary. In *Effectiveness of Mental Health Promotion Interventions: A Review* (eds S. Tilford, F. Delaney & M. Vogels). London: Health Education Authority.

*Chris Gilleard, *Director of Psychology, Pathfinder Mental Health Services, NHS Trust, Springfield University Hospital, Tooting, London SW17 7DJ; and Ros Lobo, Mental Health Primary Care Facilitator, Merton Sutton and Wandsworth Health Authority Specialist Health Promotion Service, Mitcham, Surrey*

*Correspondence

Nature and extent of dental pathology and complications arising in patients receiving ECT

Nita Bell and Peter Bentham

This study aimed to describe the prevalence of dental pathology in patients receiving electroconvulsive therapy and to prospectively determine the incidence of dental complications arising during treatment. Of 30 subjects, 93% complained of a dry mouth and 83% were taking drugs with anticholinergic properties. A third wore dentures and the dentate population had a mean of 15 decayed, missing or filled teeth. Oral hygiene and periodontal condition was poor with one-third requiring scaling and 30% complex periodontal treatment. Temporomandibular pain followed 44% of treatments, and minor buccal lesions occurred in 22%. Greater emphasis must be placed on dental care, and guidelines are suggested to improve practice.

Injuries to teeth and oral soft tissues are well known risks associated with electroconvulsive therapy (ECT). The muscles of mastication are directly depolarised by the electrical stimulus bypassing the effect of the muscle relaxant. High stresses are produced during the forceful closure of the jaws. The incisors are particularly at risk as they are normally inclined forwards. Strong occlusal forces will tend to rotate them on a transverse axis, the risk of damage being greater if malocclusions such as deep overbites, proclinations or retroclinations are present (Durrant, 1966). Uneven load distribution may result in the fracture or loosening of posterior