half of older people are lonely some of the time, and 8% are severely and chronically lonely.³

Where loneliness is a factor, we suggest that GPs consider referral to community-based interventions such as one-to-one visiting, or social/supportive group activities. The Ministry of Health has evaluated these types of intervention as being effective for socially isolated older people.⁴

As an example, the Age Concern Accredited Visiting Service (AVS) client satisfaction surveys show that 86.6% of respondents feel happier for having a visitor. A case example sent in by a service coordinator demonstrates the potential benefits of the relationships formed:

An 84-year-old client was widowed three years ago. She was increasingly anxious about security and paying bills, and would continually go down to the local Health Service and talk to the nurses, who were very busy. Age Concern matched her up with a visitor. This client no longer ‘bothers’ the local health services, but pops in occasionally, and tells them about the new ‘daughter’ Age Concern found for her.”

Local Age Concerns around the country provide a range of social support options for older people including the AVS. They also hold information about services available through other organisations.

The following groups of older people have been identified as being disproportionately at risk for loneliness:⁵

- lower socioeconomic groups
- the widowed
- the physically isolated
- people who have recently stopped driving
- those with sensory impairment
- the very old.

We ask that GPs explore whether loneliness is a factor when patients from the above groups present with depression, anxiety, or non-specific symptoms, and that they remain abreast of community-based referral options for people whose primary need is for more company.

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References
and Law in a 2003 BMJ paper. The information for the public on cardiovascular disease and medicines is well written, although it would have to be for a well-informed person with a reasonably high level of education. The background to the development of the polypill, and the reactions—both positive and negative—to the original paper was very interesting, and the arguments for and against the concept were well put. Most pertinent points were covered. The book was not referenced per se, but there were references to many studies that were summarised in an appendix, plus a bibliography.

As with most medical stories, evidence moves on or there may be debate about a particular statement or study outcome. Without references to each statement, such as “unit-of-use sachets have been proven to hugely increase adherence”, there is a small level of frustration at times. The book also focuses on the polypill concept as was originally intended—as a primary prevention strategy for all men over 55 years old. This possibly detracts from what is likely to be the eventual use of the polypill by many—in secondary prevention or those at high cardiovascular risk (e.g. greater than 15% over five years, according to New Zealand guidelines).

This is a small and easily read book. With a polypill getting closer to routine use, it is worth a read by health practitioners, and then perhaps having a copy or two available for people who may be candidates for the polypill. It is unlikely to convert many health practitioners who oppose the polypill, but may generate more informed debate.

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COMPETING INTERESTS
Linda Bryant is on the steering group of the IMPACT Study—a study investigating the polypill for people with ischaemic heart disease or at high cardiovascular risk

Primary Care Mental Health

Edited by Gask L, Lester H, Kendrick T, Peveler R

Reviewed by Fiona Moir MBChB, MRCGP; Senior Lecturer, University of Auckland

This book is aimed at primary care practitioners and managers, especially those with a clinical role. It provides practical advice on all aspects of mental health, by summarising the latest evidence and demonstrating how to apply it in a day-to-day context. It also contains ideas about ways to educate the primary health care team, and addresses relevant issues such as the primary-secondary interface and mental health promotion. Throughout, it maintains a holistic focus and is inclusive of a service-user perspective.

The book is divided into four sections: “Overarching Themes and Concepts”, “Clinical Issues”, “Policy and Practice” and “Reflective Practice”. This review focuses mainly on the content in “Clinical Issues”. Throughout the text, there are numerous short summaries and lists of practical points. As well as the more traditional chapter headings of “Depression”, “Suicide” and “Substance Misuse”, others include: “Medically Unexplained Symptoms”, “Physical Health of People With Mental Illness”, and “Sexual Problems”. It is clear that the book’s editors and authors are familiar with the common presentations, dilemmas and roles that occur in primary care, and have structured the content accordingly. How refreshing.

In particular, I was pleased to see the inclusion of an excellent chapter on “Anxiety” with clear information about assessment and management, given the current lack of New Zealand guidelines. Over 40 authors contributed to the book and this chapter was co-authored by Auckland Professor, Bruce Arroll along with Tony Kendrick, one of the book’s editors. It includes a summary of how to diagnose and treat specific anxiety disorders, as well as highlighting presentations that are commonly unrecognised in primary care.

There were many things I liked about this book, one of them being that it is written for all primary care practitioners, not just those with a medical qualification, thus reflecting the multidisciplinary nature of primary mental health care, and emphasising the importance of up-skilling the whole team. It is packed with coherent practical advice, drawing on guidelines and protocols and presenting them in a useful fashion. For instance an established Eating Disorder protocol is ‘simplified and amended’ into succinct management points. The authors are also not afraid to voice an opinion about what