

Royal College of General Practitioners Position Statement

Mental Health and Primary Care

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STATEMENT ON MENTAL HEALTH AND PRIMARY CARE

Foreword

No less than those with physical illnesses, people suffering mental distress need and deserve the skilled support and advocacy of their doctors. Some forms of mental illness – schizophrenia, bipolar disorder, severe depression – rightly have a high profile because of their potential for catastrophe. For these conditions, the principles of good care are relatively clear and, for the most part, relatively well implemented.

But, like the proverbial iceberg, the greater mass of human mental pain is hidden below the diagnostic waterline. Countless lives are chronically blighted by experiences, ungraced by formal psychiatric labels, such as sadness; worry; unfairness; hostility; loneliness; frustration; guilt; disappointment; low self-esteem; problem drinking; and anti-social behaviour.

Does such a catalogue of anguish fall within the remit of primary care? Yes of course it does. If caring for individuals means anything at all, it means doing our best to help them through whatever circumstances put their well-being in jeopardy. As you will see, there is much more that we can do, at every level of intervention, than we perhaps give ourselves credit for. This wide-ranging statement reminds us how much it matters, and how much informed and focused action we can take if we apply ourselves.

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President

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November 2005

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INTRODUCTION

There is an undoubted link between mental health and inequalities; the relationship is complex however. This RCGP position statement first outlines our understanding of what constitutes mental health and the role of primary care – primary care clinicians need to bear in mind both medical and social models of mental health problems when considering recognition and treatment. It then examines the impact of inequalities on both mental health problems and the care provided in general practice.

Clear and practical guidance is provided as to how general practitioners, practices, primary care organisations and national bodies can address inequalities with respect to promoting mental health and providing care. Specific emphasis is placed on patient participation, understanding mind–body links, supporting professionals and collaborative working.

UNDERSTANDING MENTAL HEALTH AND ILL-HEALTH, AND THE ROLE OF PRIMARY CARE

- Mental health is a positive state of being in its own right and is much more than the absence of a diagnosis of mental illness; low-level symptoms and unhappiness, not reaching diagnostic criteria, are associated with poorer quality of life.¹
- When mentally well we have awareness of, and control over, different strands of our life. We have the will to live life to its full potential; things make sense to us. In the eyes of others, a mentally healthy person talks and behaves in a culturally appropriately way; there is an apparent ability to maintain their health and develop a role in society. If mental health implies a sense of coherence we must remember that what is coherent to one person is not necessarily so to another.
- Mental illness touches on the lives of everyone. Many of us will have some kind of mental health problem at some time in our lives and we will all know someone affected by such illness. Mental illness accounts for 28% of the years lived with a disability in most world regions, and for 10.5% of the total

global burden of disease.² At a national level, antidepressants account for 7% of the UK's primary care drug budget; the total cost to the economy of treating people with mental health problems is greater than that for ischaemic heart disease, breast cancer and diabetes combined.³

- The families, groupings and cultures that help form the identity of an individual can profoundly affect their mental health. For example, an overly bullying, unappreciative, abusive or dismissive pattern of behaviour can push someone from mental balance towards confusion and a distorted self-image; this may result in anxiety, depression or defensive behavioural patterns.
- All citizens, families and social groups have a role to play in building a mentally healthy society. Mental health may be promoted by reinforcing aspects of community that help to create a protective and nurturing environment.⁴ This may be at the level of the individual (e.g. improving self-esteem), the community (e.g. improving housing), and also at the societal level (reducing health inequalities).
- Personal choice and autonomy are critical in maintaining mental health. Often people want to help themselves, approaching the family and peer group before coming into contact with primary care. When asked, people repeatedly say that they want to learn how to manage their own problems for themselves as well as draw upon resources in the community.
- Generalists, specialists and communities can all help those in distress to reintegrate and maintain their sense of self; they can do this by building on the positive and exploring ways of minimising harm from the negative. This process often involves bringing into view multiple and often-related issues such as life events (e.g. redundancy), social factors (e.g. unhappy relationships), physical factors (e.g. disease), environmental factors (e.g. poor housing), and spiritual imbalance (e.g. limited ability to reflect).
- General practitioners and other primary care professionals frequently identify, treat and refer people who have severe mental health problems. However, we more commonly encounter patients who are both mentally healthy and unhealthy at the same time. Physical, emotional and psychological symptoms are intertwined. The continuing splitting of mental from physical functions

itself perpetuates the stigma, discrimination and exclusion associated with having a mental illness.

- The core of the generalist role is to help patients make sense of often paradoxical symptoms in the context of their whole life story. Listening and helping patients to reflect can often be more relevant than having correct answers. How someone is able to function within a family and a community is more important than their diagnostic label. At its best, when the system is welcoming and the clinicians have both the skills and time available, general practice is ideally placed to work with patients with mental health problems; however, poor primary mental health care also has the potential to do harm.
- Primary care practitioners are also familiar with the concepts of early intervention and self-management for people in many predicaments and with various illnesses, such as diabetes. Interventions for mental health problems can be operated according to the same high-level principles and practices. Delay in diagnosis, failure to involve patients in treatment and poor follow up can lead to further deterioration of illnesses such as schizophrenia and depression.⁵
- The experience of mental health specialists who treat mental health problems is different. In the main they encounter people whose mental ill-health has been a dominant aspect of their lives. This situation inevitably makes the condition for which they have been referred the focus of initial conversations. The patient will often have been given – and may have accepted – a diagnosis that may not adequately account for physical, social and environmental factors affecting them. Another issue marking the singularity of specialist care is that the setting of their care may be further from the patient’s home. Some patients do value a specialist input and this too can, at times, be provided in primary care settings and in conjunction with their general practitioner.
- Primary care teams can play a key role in helping to prevent and limit mental health problems in children and adolescents. Health visitors, general practitioners and other members of the team are in a prime position to observe the dynamics in vulnerable households and offer interventions when coping thresholds are reached. Generalists potentially see people along their whole life cycle and so can provide continuity with the transition to adulthood.

THE IMPACT OF DISADVANTAGE ON MENTAL HEALTH AND CARE FOR MENTAL HEALTH PROBLEMS

- Significant deterioration in emotional and psychological well-being occurs disproportionately within populations that are socio-economically or culturally disadvantaged, or disadvantaged by a variety of unpleasant life events. Those with severe mental health problems are likely to end up in socially disadvantaged situations and, whilst the relationship between the two is highly complex,⁶ there is evidence that social adversity causes mental illness.
- Overcoming the challenges to personal vulnerability can also result in great mental strength. Health care professionals need to work with both the vulnerability and creativity that can be found in such disadvantaged groups.
- In the UK only 13% of people with long-term mental health problems are in employment, compared with 35% of disabled people generally;² they are over-represented in poorly paid and less secure jobs, as well as in the homeless population.⁷ Mental illness also affects greatly families and children, who often act as unpaid carers. Children experience more emotional problems in deprived areas and the elderly are less likely to receive adequate mental health care.
- Stigma is common with mental illness. This can be even greater in some disadvantaged groups within society, including the elderly, those with less education, the poor and certain ethnic groups. Suicide rates are higher amongst young men in deprived localities.⁸ Stigma is a contributory factor to suicide.⁹
- Individuals with mental health problems are also sometimes less able to contribute to the social capital of society (through caring acts and the development of trusting cohesive communities). Fear, stigma and communication difficulties can also make them less able to benefit from this social capital, as well as from statutory services.
- Mental health care services in the UK have in the past over-emphasised institutional and coercive models of care. Indeed it is acknowledged that institutional racism exists within the services that should be caring for such individuals.¹⁰ There have been situations where non-European people have

been diagnosed as psychotic even though they were behaving in a way that was considered to be normal within their own culture.¹¹ The RCGP recognises the efforts being made to provide more community-based treatment and interventions to prevent admission to hospital; this is particularly valuable to communities that value community, family and faith contributions to improving mental health.^{12,13}

- The language of health professionals, whether informed by a medical, social or psychological model, is less accessible to those with little education, reduced literacy, those for whom English is a second language and to those whose cultural models of mental illness are different. Such individuals are also often further adversely affected by the impaired mental function associated with their mental illness or learning disability. This makes creating meaning of their distress, sharing understanding and decisions, enabling self-help and talking therapies more difficult to achieve. The RCGP supports the use of plain English or a patient's first language in the communication of information.
- Many people with mental health problems have inadequate housing, including threatened or actually enforced homelessness. Special attention to this is needed if the best possible environment is to be provided within which a person can improve.
- Deprived urban localities often have disproportionately large numbers of patients with multiple problems of personality, drug use and mental health problems. Most of these patients will not have a psychosis but will have complex needs. Often specialist mental health services do not engage this group and primary care professionals may not have the skills to provide high-quality care. The RCGP supports the development of more effective relationships and new models of care between generalist and specialist services, as well as the development of integrated care for patients with mental health problems co-existing with substance misuse.
- The National Service Framework for Mental Health, for England and Wales, and other policy initiatives across the UK, outline roles for primary care in managing both common and severe mental illness.¹⁴ The new GMS contract provides mechanisms to reward such work, including payments for enhanced services in depression.¹⁵ However, it is likely that these aims will be harder

to achieve in disadvantaged areas and will require particular support from a diversity of agencies. Indeed, there are dangers that expecting a higher level of service and qualification has the unintended effect of reducing the number of practitioners prepared to contribute; having practitioners with a special interest in mental health could reduce the interest and core skills of the remainder.

THE RCGP RECOMMENDS THAT PRIMARY CARE PRACTITIONERS AND EDUCATIONALISTS:

- Promote a holistic understanding of mental health. This will be helped by the provision of training for primary care practitioners to practise a ‘narrative’ approach,¹⁶ which involves an equal and full exchange of information and shared decision making to the extent desired by patients, particularly the most socially excluded groups.^{17,18}
- Become skilled at bringing into view the diverse factors that will affect a patient’s mental health and aware of the full range of interventions and resources available to address mental health problems.
- Involve patients, to the extent they prefer, in understanding the cause of their distress, in deciding whether a diagnostic label will be given, and in decision making about management of their mental health problem.
- Develop skills of multi-disciplinary team working to provide adequate support for patients, mindful that patients also often value the continuity afforded by one-to-one relationships. Both supports are needed. There is good evidence to support the value of proactive follow up of patients with depression.¹⁹
- Ensure that the training and educational needs of all primary care clinicians regarding mental health are met, including becoming skilled at identifying symptoms of depression, anxiety, dementia, early psychosis, relationship difficulties, lifestyle problems and altered perceptions. Provide appropriate training for reception staff.

- Become skilled at using language that facilitates a discussion about mental health issues with disadvantaged patients. Ensure that patient concerns and experiences are integrated into such discussions. Explain and promote talking therapies to socially excluded patients when appropriate. Use translators, advocates and language lines when required.
- Raise awareness and encourage the use in primary care of methods that will assist all patients to increase their potential to help themselves and creatively contribute to society, and its understanding of mental health. These may include self-help techniques such as diary writing, development of a life plan, cognitive behaviour therapy, meditation, art, assertiveness, negotiation and basic life skills such as reading and writing.
- Facilitate return to work (from unemployment or absence due to sickness) for those who are stressed, low and anxious, or who have a mental illness, by timely advice, the use of cognitive behavioural techniques, being an advocate for the patient and the skilled use of new certification procedures (e.g. suggesting phased early return).^{20,21}
- Become skilled at working with, and advising on, the range of voluntary, community and specialist mental health organisations and individuals who can help patients with complex needs.
- Improve the physical care of patients with mental health problems. First, through understanding the latest evidence dealing with co-morbidity and medically unexplained symptoms. Secondly, by evaluating and acting on the physical health needs of patients with severe mental health problems. This may require developing recall systems and joint working with specialists.²²
- Improve practice- and primary care-based services, in conjunction with patients, by examining local needs, appraising the evidence base, looking for locally applicable examples of good practice, monitoring standards and developing new services.

THE RCGP RECOMMENDS THAT PRIMARY CARE ORGANISATIONS:

- Make mental health a priority for primary care within the NHS. This should be supported by a positive, evidence-based holistic understanding of mental health and of the causes of mental health problems, and that its effective management may involve a number of agencies and individuals with complementary roles.
- Facilitate promotion of mental health, for example as advanced by *mentality*,⁴ through joint work in communities and by encouraging clinicians to work with individuals to identify health-promoting solutions to life's problems.
- Consider piloting reforms of the whole system of care for mental health based on improving the patient's journey. There is now considerable experience of how to do this in a sensitive, managed way;^{23,24} learning from change may involve a closer integration of research and service development. Developing longer-term working relationships between generalists, specialists and lay experts is essential. This will require considerable skills of whole-system facilitation. Such schemes must include a long-term plan for these stakeholders to review and reform plans as a *learning community*, in response to changing needs and opportunities.
- Ensure that developments in primary mental health care include
 - involvement with early intervention and assertive outreach functions of specialist services
 - timely availability of specialist mental health advice or support for the management of patients with complex non-psychotic conditions
 - joint working with drug and alcohol agencies
 - systems for review of physical health needs of patients with long-term mental health problems
 - systems for review of the mental health needs of those patients with long-term mental health problems who are not receiving specialist care.
- Use policy levers to promote sustainable system-wide change. Integrate gateway workers and graduate mental health workers fully into local systems of primary mental health care so they can work productively to promote mental health and support improvements in care.

- Use opportunities, such as the intended refocusing of child and adult mental health services towards primary care, as pilots of models of system reform. Institutional boundaries between mental health services for children, adults and elders must be flexible.
- Develop a strategy and plan to support those practitioners least able to provide high-quality mental health services. This will need to take account of the mental well-being as well as the skills and educational needs of clinicians, and the stage of organisational development of practices. Localities that are difficult to doctor need to be prioritised to develop enhanced services for mental health that include partnership between medical and non-medical stakeholders, including carers and users. Multi-faceted facilitated interventions are likely to be required.²⁵
- Support individual and community development approaches to mental health promotion that enhance a person's social networks and sense of value within society.²⁶ These should involve all citizens and encourage particular roles for the social services, housing, credit unions, mutual societies, the voluntary sector, faith communities, education, sport and leisure industries, and business. The development of a range of social prescribing options, which may require brokers to facilitate uptake²⁷ (e.g. Time Banks²⁸), for clinicians to offer in addition to medication and talking therapies is particularly important for patients presenting with symptoms relating to life problems.
- Facilitate local collaboration between health services and other organisations with an impact on mental health. Examples include
 - the integration of mental health care and promotion into initiatives to combat unemployment
 - joint working between citizens advice bureaux (and other advisory agencies) and primary care
 - working with local education authorities, juvenile courts and schools to encourage the identification of vulnerable children in need of mental health promotion or services
 - joint working between primary care teams and nursing and residential homes to promote health and identify needs.

- Highlight local and national examples of good practice in mental health services, where all members of families/households/support networks are offered support, regardless of their age.
- Provide to practitioners and patients an up-to-date handbook and website of local statutory and non-governmental services for mental health.²⁷
- Develop IT data transfer and coding systems, which encompass holistic health promoting care as well as disease-focused management. Develop practice-based registers of those with long-term mental illness as a basis for voluntary, optimal proactive care. Develop primary care data collection and disease management IT systems that prompt encouragement of self-management, shared decision making and options for health promotion.²⁵
- Ensure that anonymised data about mental health services, crucial for commissioning, audit and service improvement, are collected accurately and consistently across primary care. Personalised identifiable data should only be used to further individual clinical care.

AT A NATIONAL LEVEL THE RCGP RECOMMENDS:

- Collaboration between opinion-forming organisations to frame discussions about mental health within the broad understanding outlined here, and the better integration of training of those concerned with the mental health of children and the elderly. These organisations include the Royal Colleges (General Practitioners, Nursing, Physicians and Psychiatrists), associations that support relevant professional groups including the Faculty of Public Health Medicine, voluntary, user and carer groups, Social Services and the Department of Health.
- Support to activities that are receptive to users, ensuring that their recommendations are listened to and responded to. Patient and public involvement (PPI) is required at all levels. Links need to be built from national primary care organisations with the Commission for Patient and Public Involvement in Health, the Patient Experience Team at the Modernisation Agency, the expert patient movement and with the Department of Health.

- The Department of Health and Educational Authorities pay special attention to children and adolescents not attending school, many of whom have mental health problems, often associated with illicit drug use. A significant proportion of children in secure accommodation have not attended school for a substantial period of time before their detention; a considerable proportion of these experience mental health problems.
- Specific advances can be made nationally by providing housing security for people with mental health problems, by promoting recovery through improved sickness certification, and by integrating mental health care (e.g. cognitive behavioural techniques) with job-finding initiatives.²¹
- Support for a broader understanding, by undergraduate and postgraduate education providers and by research funders, of the issues outlined here about primary mental health care.
- Collaboration with the media to promote the everyday nature of mental health problems, the capacity for recovery, the reduction of stigma and the availability of support.

REFERENCES

1. Thomas P, Evans S, Gately C, Stordey J, Huxley P, Rogers A et al. State–event relations among indicators of susceptibility to mental distress in Wythenshawe. *Social Science & Medicine* 2002; **55**: 921-35.
2. Sayce L and Morris D. *Outsiders Coming in? Achieving social inclusion for people with mental health problems*. London: Mind, 1999.
3. Dawson, A and Tylee A (Eds). *Depression: Social and economic time bomb – strategies for quality care*. London: BMJ Books, 2001.
4. Department of Health and mental health. *Making it Happen. A guide to delivering mental health promotion*. London: DoH & mental health, 2001.
5. Von Korff M and Goldberg D. Improving outcomes in depression. *British Medical Journal* 2001; **323**: 948-9.
6. Rogers A and Pilgrim D. *Mental Health and Inequality*. Basingstoke: Palgrave Macmillan, 2003.
7. Roulstone A. *Enabling Technology: Disabled people, work and new technology*. Buckingham: Oxford University Press, 1998.
8. Dorling D and Gunnell D. Suicide: the spatial and social components of despair in Britain 1980-2000. *Transactions of the Institute of British Geographers* 2003; **28(4)**: 442-60.
9. Eagles JM, Carson DP, Begg A and Naji SA. Suicide prevention: a study of patients' views. *British Journal of Psychiatry* 2003; **182**: 261-5.
10. Bhui K, McKenzie K and Gill P. Delivering mental health services for a diverse society: marrying policy and practice. *British Medical Journal* 2004; **329**: 363-4.
11. Littlewood R and Lipsedge M. *Aliens and Alienists: Ethnic minorities and psychiatry*. London: Unwin Hyman, 1989.
12. National Institute for Mental Health in England. Inside Outside: improving mental health services for black and minority ethnic communities in England. 2003. www.nimhe.org.uk/downloads/inside_outside.pdf (accessed October 2005).

13. Department of Health. *Delivering Race Equality: A framework for action*. London: DoH, 2003. www.dh.gov.uk/assetRoot/04/06/72/29/04067229.pdf (accessed October 2005).
14. Department of Health. *National Service Framework for Mental Health. Modern standards and service models*. London: DoH, 1999.
15. British Medical Association and the NHS Confederation. *The New GMS Contract 2003: Investing in General Practice*. London: BMA, 2003.
16. Launer J. *Narrative-based Primary Care. A practical guide*. Oxford: Radcliffe Medical Press, 2002.
17. Richards T. Partnership with patients. *British Medical Journal* 1998; **316**: 85-6.
18. Patients as Teachers research team. Shared decision-making? Patients' views about their treatment for depression in Primary Care. A qualitative research study. London: Lewisham PCT, 2003.
19. Simon GE, Von Korff M, Rutter C and Wagner E. Randomised trial of monitoring, feedback, and management of care by telephone to improve treatment of depression in primary care. *British Medical Journal* 2000; **320**: 550-4.
20. Royal College of Psychiatrists. *Employment Opportunities and Psychiatric Disability*. Council report CR11. London: Royal College of Psychiatrists, 2002.
21. Sainsbury Centre for Mental Health (SCMH). Mental health and inequality: a response to the social exclusion unit consultation. 2003. www.psychminded.co.uk/news/news2003/oct03/ScmhResponse2003.pdf (accessed October 2005).
22. Phelan M, Stradins L and Morrison S. Physical health of people with severe mental illness. *British Medical Journal* 2001; **322**: 443-4.
23. Pratt J, Gordon P and Pampling D. *Working Whole Systems: Putting theory into practice in organisations*. London: King's Fund, 1999.
24. Iles V and Sutherland K. *Managing Change in the NHS. Organisational change: a review for health care managers, professionals and researchers*. London: National Coordinating Centre for NHS Service Delivery and Organisation R&D, 2001.

25. Lewisham Depression Programme: supporting practices to deliver improved care. London: Lewisham PCT, 2003.
26. Fisher B. *Supporting PCTs in Engaging with Their Communities*. London: DoH Strategy Unit, 2004.
27. Lewisham Social Prescribing Project. Lewisham PCT, 2002. www.natpact.nhs.uk/uploads/LSPPSum.doc (accessed October 2005).
28. Garcia I. *Keeping the GP Away – Community Time Banks and health*. London: New Economics Foundation, 2002.