The extraordinary potential of primary care to improve mental health

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We are currently experiencing many changes in primary care mental health services. Some would describe it as a revolution, although the synonyms for this are not very appealing—mutiny, insurrection, riot, revolt. The RCGP is perhaps more creative describing ‘a vision of primary care in the future.’ Whichever words we use, The White Paper ‘Equity and excellence: Liberating the NHS’ introduced a raft of changes with the aim of ‘putting patients first…trusting professionals [to] drive up standards and deliver better value for money and create a healthier nation.’

Equity and excellence: Liberating the NHS’ outlines the rationale for reform and the changes that will take place stating that “First, patients will be at the heart of everything we do. Second, there will be a relentless focus on clinical outcomes. Third, we will empower health professionals and through the development of clinical leadership, drive improved outcomes and efficiency and finally recognise the economic context and financial constraints. To achieve this, change is needed in many areas including commissioning, provider roles, public health, education and work force development, the collection and use of patient information, patient involvement and the role of local authorities.

This is perhaps the best opportunity for years to tackle chronic under-investment, stigma and inequalities in mental health.

Why is a renewal of primary mental health care needed now more than ever?

Moving towards a vision of high quality, modern health for all requires that health systems respond to the challenges of a changing world and growing expectations for better performance. There are a number of issues that require substantial reorientation and reform of primary care.

- There is an increase in the volume and complexity of health and social care needs more people live for longer with long-term and often multiple conditions.
- There is a move to deliver more complex care in the community, as a means of both bringing care closer to patients and their families and reducing costs which requires ways of transforming services to reduce costs, whilst maintaining and increasing quality.
- Recent fundamental changes to the structure of health and social care have the potential for greater service fragmentation as a result of the use of multiple competing providers and continuing barriers to better integration between health and social care.

These long-term trends mean that expert generalist care is needed now more than ever. Only a healthcare professional with highly developed holistic, generalist skills is able to apply his or her medical expertise to the growing range of long-term conditions; to incorporate this knowledge into ‘whole-person’ understanding of the patient and their family; to manage risk safely; and to share complex decisions with patients and carers, while adopting an integrated approach to their care.

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Mental health care in primary care

Currently, around 300 in every 1,000 people experience mental health problems every year. Of those 300 people, 230 will visit a GP, 102 will be diagnosed as having a mental health problem, 24 will be referred to a specialist psychiatric service and 6 will become inpatients in a psychiatric hospital.

Over 1.25 million people used the NHS mental health services in 2010, representing access rates of around 2,700 per 100,000 of the population, the highest number of individuals since data collection began. In addition, the number of individuals accessing mental health services was 4% higher than in the previous year, with numbers rising for both men and women in all age bands and ethnic groups.

According to figures from the 2003 National Survey of NHS patients, approximately 91 per cent of people with a mental health problem will be treated within the primary care system, meaning that very few are referred to specialist mental health services. Figures suggest that at least 25% of individuals with symptoms of mental health conditions such as depression and anxiety do not report this to their GP and, of those who do, up to 50% only provide details of their physical symptoms and do not disclose any mental and emotional aspects.

It has been suggested that the reason many cases of mental health conditions go undiagnosed and unrecognised may be related to a lack of effective training for GPs and other professionals. One study revealed that only one third of doctors had received mental health training in the past five years, with 10% admitting they felt concerned about their training and experience with regards to mental health. There are clearly a number of areas where mental health care in primary care could benefit from increased attention and focus.

Good primary care is the bedrock of a cost-effective health care system and research suggests that the NHS has a stronger primary care orientation than the health care systems of most other countries. Surveys show that public satisfaction with the NHS is higher than it has ever been and that GPs and the primary care team as a whole enjoy high levels of trust and confidence from patients. Although the majority of patient contacts in the NHS take place in general practice, many of the initiatives to measure and improve quality have been focused on the acute sector.

Primary care? Flexible? Adaptable?

To achieve this vision and future goals and aspirations for primary care, services must be flexible and adaptable. Flexibility is also important when considering the environment in which primary care now finds itself. Services have to adapt to meet the needs of an ageing population in which there is an increased prevalence of chronic disease. Small practices are often highly valued by patients but may not be able to deliver these care reforms alone and a case can be made for practices collaborating in federations to reduce the risk of isolation and to have the capacity to offer a wider range of services.

Nowhere are these changes more important than in the provision of mental health care in primary care, which has traditionally been viewed as the ‘Cinderella of the health system’.

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However, there is some evidence that Cinderella may go to the ball after all. Current UK Government policy is concerned with the nation’s mental health: “Poor mental health is the largest cause of disability in the UK. It’s also closely connected with other problems, including poor physical health and problems in other areas like relationships, education and work prospects. If we want to improve these aspects of people’s lives, we’ll need to make improvements to mental health and wellbeing.” The UK Government’s current mental health strategy recognises that “mental health is central to our quality of life, central to our economic success and interdependent with our success in improving education, training and employment outcomes and tackling some of the persistent problems that scar our society, from homelessness, violence and abuse, to drug use and crime…”[we] aim to mainstream mental health in England. We are clear that we expect parity of esteem between mental and physical health services…Our approach aims to improve outcomes for all… So this strategy takes a life course approach

In the last few years, mental health services in primary care have attracted increasing interest and the importance of mental illness in primary care is becoming ever more apparent. Nine out of ten depressed patients are treated only in primary care.x Over three quarters of patients consulting their general practitioner admit to at least one psychosocial problem, over one third report that psychosocial problems impact on their present health,x and up to two thirds of suicide victims contact a general practitioner in the four weeks before their death.xii

In addition, the general public, surveyed more than a decade ago, preferred to see GPS rather than psychiatrists for depression and to receive psychological treatments rather than drug treatment. This perhaps indicates that seeing a psychiatrist is still associated with considerable stigma, but also provides primary care with an opportunity to engage patients effectively.xvi Despite the critical importance of the role of primary care in mental health care, there have often been reports of the variation in quality of care provided to people with mental health problems.xiii, xiv

A continuing commitment from the RCGP

The RCGP clearly recognises this and the importance of developing and supporting primary health care teams to provide high quality care for people with mental health disorders. The RCGP Position Statement on Mental Health and Primary Carexiv clearly highlights mental health as a national priority for primary care in the UK. Key messages of the statement include reducing stigma, addressing health inequalities, improving quality and enhancing communication with secondary care through collaborative working. The RCGP continues to focus on mental health and affirmed its commitment recently through a number of initiatives.

- In 2011, the RCGP collaborated with the Royal College of Psychiatrists and a number of other organisations to develop the Joint Commissioning Panel for Mental Health (JCPMH).xvi Co-chaired by the RCPsych and the RCGP, the JCPMH aims to inspire commissioners to improve mental health and wellbeing, using a values-based commissioning model. The JCPMH has developed practical guidance on what good services for mental illness, dementia and learning disabilities should look like, plus
guidance on public mental health and values-based commissioning.

- Under the auspices of the RCGP clinical priorities programme, which is managed by the Clinical Innovation and Research Centre (CIRC), the College has been able to demonstrate its continuing commitment to mental health and other related clinical areas. Indeed, mental health was one of the first four clinical priority areas to be championed over a three-year period to December 2010. Since then, clinical priority programmes have been, or continue to be, led on learning disabilities (January 2010 – December 2012), dementia (April 2012 – March 2015), youth mental health (April 2013 – March 2016) and perinatal mental health (April 2014 – March 2017).

- In April 2014, mental health and whole-person care became a five-year UK-wide priority for the RCGP. Building on the strong foundations of previous work, the creation of this programme is intended to encourage learning and development in mental health, as well as an environment in which quality improvement in mental health can flourish. The College needs to take a strategic perspective, but will be responsive to current and future clinical guidance and policy. Strong leadership is essential to foster a clear vision and set of common values around the principles of mental health care in primary care to support and guide colleagues through the range of policies and initiatives that affect mental health care delivery in primary care.

These developments, although extremely timely and welcome, are unlikely to change the role of mental health services in primary care immediately and universally. There are several areas within mental health that require prioritisation including the provision of mental health services for children, older adults and BME groups. There are also a number of key policy areas that need to be considered, including parity of esteem, introduction of choice in mental health, development and implementation of the crisis care concordat and reducing mortality in people with severe and enduring mental illness.

**The primary health care team and new ways of working**

Delivering high-quality mental health care in primary care requires new models of shared care to be developed with other care providers, including those working in the community, hospitals and care and well-being services. Multi-specialty local clinical partnerships need to develop that integrate services across boundaries. Such models of care will need to articulate the roles and responsibilities of general practice clearly to ensure that patient care is well coordinated. For people who experience depression or long-term mental health problems, high-quality care involves being supported by a planned system of ‘collaborative care’, which involves case management, systematic follow-up and improved primary–secondary care integration. High-quality care also requires sensitivity towards the perceptions of each patient around the cause and nature of the problem. Evidence suggests the need for a holistic bio-psycho-social approach that both provides treatment but also seeks to aid recovery.

For people with complex needs, including more serious mental health problems, general
practice needs to see itself, and be seen more widely, as the hub of a broader system of care. General practice must take responsibility for coordinating and signposting to services beyond health care, in particular social care, housing and benefits. The development of these collaborative ways of working heralds a move from the traditional primary care gatekeeper role for the GP to that of a navigator.

**Commissioning**

Developing an environment for quality improvement also requires action to be taken at many different levels. Policy-makers, regulators, commissioners and the professional bodies all have roles to play in creating a better environment that supports general practice in its quest for quality.

There is an opportunity to provide CCGs with the levers to drive improvements and challenge poor practice. Member practices need a system of rewards and penalties that is genuinely influential and that focuses on local priorities. The outcomes that should result from effective commissioning of primary care mental health services include better quality of life across populations with long-term conditions, reduced discrepancy in under-75 mortality within populations, improved wellbeing in those at risk of poor wellbeing within populations, reduced suicide across populations, recovery in people with mental health problems, social inclusion, reduction of duration of untreated disorder, improved wellbeing and improved patient and carer experience.\textsuperscript{xvii}

**Generalism and holistic care**

Traditionally, discussion around change in general practice has often ended with calls for more education, more training, more evidence-based guidelines and/or more research.\textsuperscript{xviii, xix} An alternative way forward might be to focus on the skills and competencies we already have as GPs and within primary health care teams. This is where the core principles and values of general practice are important. ‘Being a General Practitioner’ is an RCGP curriculum statement which defines the learning outcomes for the discipline of general practice and describes the skills required to practise medicine as a GP. The six domains of core competences include primary care management; person-centred care; specific problem-solving skills; a comprehensive approach, community orientation and a holistic approach.\textsuperscript{xx} Kemper described holism within the context of medicine as ‘caring for the whole person in the context of the person’s values, their family beliefs, their family system, and their culture in the larger community, and considering a range of therapies based on the evidence of their benefits and cost’.\textsuperscript{xxi} Holism and patient-centredness are core values of general practice. It is these values that have led to the recognition that illnesses have both mental and physical components, and that there is a dynamic relationship between them. Using the bio-psycho-social model emphasises the individual approach to care. One size does not fit all. This clearly helps when considering whether we should be prescribing antidepressants, referring for psychological therapies or enhancing an individual’s autonomy by promoting self care.

The diagnosis and understanding of depression, or the often ambiguous and vague
symptoms people may present with in distress, can be helped by using the bio-psycho-social model which gives equal importance to biological, psychological and social determinants for pathogenesis, diagnosis and therapy - in other words, the holistic approach. The holistic view acknowledges objective scientific explanations of physiology, but also accepts that people have inner experiences that are subjective, spiritual and personal which may affect their health and health beliefs.

There is good evidence that holism is promoted by longer consultations and by greater continuity of care. Currently, however, it may be difficult to provide this approach fully within the regular ten-minute GP consultation. This supports the current RCGP campaign ‘Put Patients First: Back General Practice’ which argues that accessible, high quality holistic primary care is vital to keep our patients healthy for longer, enabling more people to successfully manage their conditions in the community, and avoiding unnecessary hospital admissions. However, this requires adequate resources. One role of the RCGP clinical lead for mental health and whole-person care will be advocacy for more resources for primary care to enable better management of mental health.

**Conclusion**

The role of the RCGP clinical lead for mental health and whole-person care is to promote Generalism both as the key to the future of the NHS and in improving mental health care, and to emphasise that the system needs to value this. Instead of GPs developing more specialist knowledge in mental health, general practice needs to make specialist support available during the consultation process with all primary health care professionals, during care planning, and in ongoing care to support patients to manage their own illness. General practice needs to see itself at the hub of a wider system of care, taking responsibility for coordination and signposting to services beyond health care.

Concerning mental health care management, research suggests that GPs possess many GPs have the right skills, but some lack the confidence, support or time to use them. An holistic approach based on the bio-psycho-social model, which is grounded in the way that general practice works, is a potential solution. This approach requires enhancing the skills and knowledge that are already present in most members of the primary care team but perhaps need reviving, refreshing and reinvigorating. This will form the basis of the work of the RCGP mental health and whole person care programme over the next five years.

Primary care addresses all of the areas key to delivering high quality mental health care. It facilitates ongoing relationships between patients and clinicians, within which patients participate in decision-making about their health and health care; it builds bridges between personal health care and patients’ families and communities. Primary care opens opportunities for disease prevention and health promotion as well as early detection of disease. Primary care requires teams of health professionals: physicians, nurse practitioners, and assistants with specific and sophisticated biomedical and social skills and primary care requires adequate resources and investment, and can then provide much better value for money than its alternatives.

Clinical News, June 2014
http://www.telegraph.co.uk/health/healthnews/7880592/Biggest-revolution-in-the-NHS-for-60-years.html

ii A vision for general practice in the future NHS. Royal College of General Practitioners, 2013

iii Equity and excellence: Liberating the NHS. Crown copyright 2010

iv A vision for 2022 General Practice. Royal College of General Practitioners, 2013


vii Starfield, B. Remember Barbara Starfield: primary care is the health system’s bedrock BMJ 2013; 347.

viii Department of Health, 2013. Making mental health services more effective and accessible.


xv Royal College of General Practitioners Position Statement, Mental Health and Primary Care November 2005

xvi http://www.jcpmh.info/


xxii Goodwin et al. Managing people with long-term conditions. An Inquiry into the Quality of General Practice in England. The Kings Fund 2010