

## Section 1

## Conceptual Basis and Overarching Themes

## Chapter

## 1

# What Is Primary Care Mental Health?

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## Primary Care Mental Health

This book is about *primary care mental health*, a concept that has emerged relatively recently in the history of health care. The World Health Organization (WHO) has defined ‘primary care mental health’ to incorporate two aspects (WHO & WONCA, 2008):

- first-line interventions provided as an integral part of general health care;
- mental health care provided by primary care practitioners who have expertise and skills, and who are supported to provide mental health care services.

Doctors have provided emotional care in the form of support, advice and comfort for their patients for centuries, alongside other professional, spiritual and lay workers, friends and families. However, in the past 60 years or more in the United Kingdom, since the pioneering research carried out first by the husband-and-wife team of Watts and Watts (1952) and later by John Fry (1960), within their own practices, and by Michael Shepherd and his colleagues at the General Practice Research Unit in London (Wilkinson, 1989), there has been a particular interest in mental health care provided within primary and general health care settings by a range of professionals who are not specialists in mental health. In that time, the focus of both research and development has shifted and changed in a number of different ways: from an emphasis on detection of disorders, towards better ‘chronic disease’ management; from the general practitioner (GP) working alone to the partnership between the doctor, the extended primary care team and the local community; from the narrow focus of research on the behaviour of the doctor towards an exploration of the view of the patient; and, in policy terms, a shift from viewing the GP as an ‘independent’ agent towards increasing attempts to influence the decisions that he or she makes in the assessment and management of mental health problems and the promotion of good mental health.

Many of these changes are encapsulated in the change of terminology from ‘psychiatry and general practice’, the title of the forerunner to this publication, which was jointly published by the Royal Colleges of Psychiatry and General Practice more than two decades ago (Pullen *et al.*, 1994), to a broader view of ‘primary care mental health’ (from the title of this publication first published by the Royal College of Psychiatrists in 2009, and now in its second edition) reflecting the wider involvement of a range of health professionals in primary and specialist settings.

## Definitions

### Primary Care

We recognize that there is enormous international variation in what is meant by the term ‘primary care’.

The Alma-Ata Declaration (World Health Organization, 1978) defined primary care thus:

the role of primary health care as the local, universally available, essential, first point of contact with the health system, based on practical, scientifically sound and socially acceptable methods and technology at a cost the community and country can afford.

Numerous studies from multiple countries show that when systems are organized around primary care, outcomes are better with improved equity and lower costs. For example, when people have a primary care doctor as opposed to a specialist as their personal physician, their mortality risk drops by nearly 20 per cent and their costs are about one third less (Ford, 2008).

The World Health Organization views the development of primary health care as one of the key challenges for health system reform. Now, 40 years after the Alma-Ata Declaration, the vision of primary care for all has yet to be achieved, but according to Gunn and her colleagues (Gunn *et al.*, 2008), the generalist holds the key to providing truly personalized care:

A fundamental role of the generalist is to balance the biotechnical with the biographical. The generalist must know and understand how each life story and social context are constantly influencing and being influenced by physical and emotional health. To achieve the balance between the biotechnical and biographical aspects of each interaction, the generalist must have the skills to reach a mutual understanding of the priorities and challenges that individual patients face when managing their health. (p. 111)

This very personal model of care is nevertheless greatly challenged by forces which seek to fragment the process and provision of care in the belief that this will lead to improved quality of care. Innovations such as the Quality and Outcomes Framework in the United Kingdom (Mangin & Toup, 2007) have focused on single diseases rather than on multi-morbidity, and solely on disease-centred outcomes rather than also taking into consideration what are the patient’s goals. This is particularly problematic when managing people with complex co-morbid and multi-morbid conditions.

Primary care systems can be categorized according to whether they act as gatekeepers to specialist services (as in the United Kingdom), provide free-market services in parallel to specialist services or function in a complex system containing both free-market and gate-keeper functionality (as in the United States); whether they are free to patients at the point of care delivery; whether they are led by doctors or non-medical personnel; and the degree to which they provide continuity of care. For the person with multi-morbidity, the primary care professional, doctor or nurse, is a key person in helping them to navigate an increasingly complex landscape.

## Mental Health

According to the WHO (2014), it is:

a state of well-being in which the individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

That is, it is not merely the absence of illness. Cultural differences, subjective assessments and competing professional theories all affect how ‘mental health’ is defined.

The concept of mental illness is more highly contested. Unlike in physical health care, the underlying pathology of most mental ‘illness’ is far from clear, so, except in rare cases like Alzheimer’s ‘disease’, we cannot apply this term. Instead, psychiatry recognizes symptoms which commonly occur together, and such a constellation is given the name of a ‘syndrome’. ‘Illness’ is the term applied when the presence of symptoms leads to loss of functioning or impairment. ‘Disability’ can occur in the context of mental and physical illness as a result of society’s actions and reactions to the impairment (Lester & Tritter, 2005). But inability to function is largely a subjective experience, particularly with the common mental health problems that are treated in primary care. A further complication is that the classification systems used throughout the world for the diagnosis and treatment of mental disorders have evolved from research in specialist settings (see Chapter 6), where fewer than 10 per cent of those with mental health problems in the community are actually seen and treated. We favour a patient-centred rather than a disease-based approach, so that, even though we do have chapters based on disorders, and we do discuss epidemiology, we recognize the need to treat symptoms which do not meet the criteria for particular disorders, adopt an integrated, individually tailored approach and take the lead from the patient (Tinetti & Fried, 2004; Johnston *et al.*, 2007).

## Mental Health Problems in the Primary Care Setting

The setting of primary care has, in the past two decades, assumed a considerable international importance for both the recognition and the treatment of mental health problems (WHO & WONCA, 2008). There is increasing international recognition of the economic and social burden of mental illness (Murray & Lopez, 1997; Layard, 2006). In high-income countries, the majority of mental health problems seen in the primary care setting fall into the category of ‘common mental disorders’, such as anxiety and depression, while more severe and enduring mental health problems, such as schizophrenia and other psychoses, are treated, at least initially, by specialist mental health services. Although ‘common mental disorders’ are, on average, less severe than those disorders seen in secondary care, the total public health burden that they pose in terms of disability and economic consequences is considerably greater (Andrews & Henderson, 2000). Mental health issues are the second most common reason for consultations in primary care in the United Kingdom (McCormick *et al.*, 1995). In 2012, a total of 202 GPs in the United Kingdom reported that 84 per cent of their consultations were attributed to factors associated with stress and anxiety, and 55 per cent reported mental health issues (Aviva, 2013). In England, between 2013 and 2014, nearly 3 million adults were on GP registers, coded for depression, and approximately 500,000 for a severe and enduring mental health problem (Care Quality Commission, 2015).

Even in countries where specialist mental health services are well developed, such as the United Kingdom and the United States, many people with more severe and enduring mental illness receive their ongoing mental health care primarily within primary care, for reasons of choice or lack of access to specialist care. In low- and middle-income countries, specialist mental health care may be poorly developed or even non-existent, such that, by default, primary care will be the primary provider of mental health care (Patel, 2003).

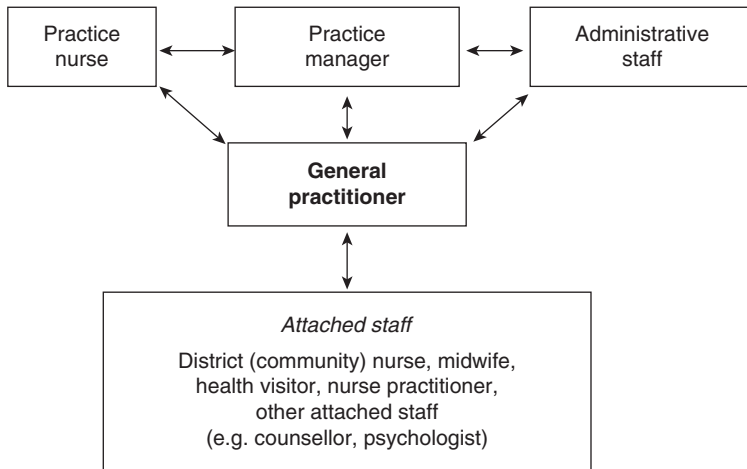
There is considerable international variation in the way in which primary care practitioners engage in providing mental health care (for an excellent and detailed comparison of practices in European countries, see WHO Europe, 2008). For example, in some European countries, GPs cannot prescribe psychotropic medication without agreement from a psychiatrist, and in others no role is seen for primary care in the management of people with severe and enduring mental health problems.

There are important differences in the way that people with mental health problems present in primary care compared with secondary care. There is often co-morbidity with physical illness, and a common mode of presentation of emotional problems in the primary care setting is that of physical symptoms, which may or may not be recognized by the physician as indicative of underlying emotional distress, even in the presence of expressed verbal and non-verbal cues of distress (Ring *et al.*, 2005). The critical point here, however, is that primary care clinicians will often encounter undifferentiated, unfiltered and unrecognized symptoms, concerns, worries and problems (Balint, 1964), which may or may not be identifiable as mental health syndromes. Specialist mental health clinicians, in contrast, are far more likely to encounter filtered symptoms that are recognized and understood as representative of a mental health problem.

## Providing Mental Health Care

From the perspective of both the patient and the health care system, there are numerous advantages to providing mental health care in the primary care setting. Care can be provided closer to the patient's home, in a setting that is free from the stigma that is still inevitably associated with mental health care facilities, by a health care worker who will ideally have pre-existing knowledge of the patient and his or her family, who is able to provide holistic treatment and continuity of care for the full range of the patient's problems, including physical problems, and good links to local resources for assistance with associated social problems. Research into the views of people with serious mental illness has revealed the importance that they place on the care provided in the primary care setting from their own GP (Lester *et al.*, 2005). Specialist mental health care resources can then be directed towards those most in need and likely to benefit from more intensive care.

Disadvantages of treatment in the primary care setting, however, are that primary care workers may lack the time, the specific interest, a positive attitude and the skills or knowledge to recognize and manage people with mental health problems optimally. There is considerable variation, both between and within countries, in how mental health problems are managed in primary care (Üstün & Sartorius, 1995) and in rates of referral to specialist services. GPs in the United Kingdom, for example, have been criticized for a perceived failure to diagnose mental illness (particularly depression) and their inability to provide good physical health care for people with severe and enduring mental illness. However, as described earlier, primary care is a complex environment – a 'messy swamp' of experiences and interpretations that rarely conform to textbook definitions (Schon, 1983). Many GPs



**Figure 1.1** Typical primary health care team structure in the United Kingdom

have little formal training in mental health. Data obtained by the mental health charity MIND have shown that in England, on average, less than half (46 per cent) of trainee GPs undertake a training placement in a mental health setting (MIND, 2016), and this is almost always in a specialist mental health unit where the skills needed to manage people with common mental health problems such as depression and anxiety are much less likely to be acquired.

## The Primary Care Team

Across the world, many GPs still work as single-handed practitioners. Figure 1.1 shows a typical primary care team structure in the United Kingdom. However, in many countries primary care has increasingly been provided by a team of professionals working together: doctors, practice nurses and the extended team of health care assistants, receptionists and other workers who visit the practice. They may include not only a range of specialized nurses (health visitors, community nurses, midwives) but also mental health professionals, such as community mental health (psychiatric) nurses, psychologists, graduate mental health workers (see later) and psychiatrists. The role of the extended practice team in providing mental health care has been acknowledged, and in recent years there have been specific initiatives aimed at members of the team, such as training health visitors in the recognition and management of postnatal depression (Morrell *et al.*, 2009) or practice nurses in the management of people on depot neuroleptic treatment (Gray *et al.*, 1999).

In some places, mental health professionals are closely linked with the team. In the United Kingdom, counsellors became increasingly common in primary care in the late 20th century, but, in England, have largely been replaced by the Improving Access to Psychological Therapies services (see Chapter 29). GPs have been encouraged to develop special interests ('GPs with a special interest', or GPwSI) in mental health (as have nurses). Some of these doctors have developed their interest within their own practice, while others have been working at an intermediate level between primary and specialist care.

## Organizing Care

The primary care organization needs not only to provide primary mental health care to its patients or service users, but also to have clearly defined pathways of care and protocols for the delivery of treatment and for referral to other services (primary care mental health services, specialist mental health services, social care and voluntary agencies). It also needs effective means of data collection and management and record-keeping to ensure that people with mental health problems, especially those with more severe disorders, who are vulnerable or at risk or who are in receipt of repeat medication, receive effective and timely mental and physical health care. It also has to ensure that the team of staff is properly trained and up to date and that the mental health needs of the workforce are adequately catered for in what can be a very stressful job.

## Mental Health Policy and Primary Care

As far back as the 1960s, when GPs in the United Kingdom were beginning to work in group practices, Michael Shepherd and his colleagues (1966) suggested:

[T]he cardinal requirement for improvement of mental health services ... is not a large expansion of and proliferation of psychiatric agencies, but rather a strengthening of the family doctor in his/her therapeutic role.

The WHO echoed this belief in 1978, in its Alma-Ata Declaration, which stated that ‘the primary medical care team is the cornerstone of community psychiatry’ (WHO, 1978). However, the key role of primary care in the provision of mental health care was *not* formally acknowledged in the Alma-Ata Declaration.

Throughout the next two decades, the emphasis in both international research and policy was on documenting the extent of morbidity of mental health problems in primary care and the quality of care provided by primary care workers, with a strong theme of increasing recognition and treatment of depression in the community. This work included the development of guidelines for depression and numerous ‘initiatives’ on depression such as the Defeat Depression Campaign in the United Kingdom (Wright, 1995), the Depression Awareness, Recognition and Treatment Program (DART) (Regier *et al.*, 1988) in the United States, the Beyond Blue project in Australia ([www.beyondblue.org.au](http://www.beyondblue.org.au)) and the Nuremburg (now European) Alliance Against Depression in Germany ([www.eaad.net/enu/general-population.php](http://www.eaad.net/enu/general-population.php)).

In addition to public education, the focus of many of these campaigns was on educating primary care workers. Recent years have seen financial incentives in the United Kingdom (under the Quality and Outcomes Framework) with application across the care of people with depression, dementia and the physical health care of people with severe and enduring mental illness (Doran *et al.*, 2008).

However, training on its own has been demonstrated to be insufficient to improve clinical outcomes, and organizational change is required (Gilbody *et al.*, 2003). Collaborative care models, which appear to be more effective for improving outcomes in depression and anxiety (Archer *et al.*, 2012), are discussed in Chapter 28.

Mental health policy on the role of primary care has developed considerably over the past 25 years, with increasing interest in the configuration and delivery of evidence-based mental health care. Guidelines for improving the quality of mental health have also

emphasized the role played by primary care (e.g. those produced by the National Institute for Health and Care Excellence in the United Kingdom). Specific references are provided in the appropriate chapters.

In the United States there is now increasing recognition of the crucial role that primary care has to play in providing mental health care in the ‘patient centred medical home’ (Croghan & Brown, 2010).

## The Interface between Primary Care and Specialist Care

A significant area of international policy interest has been developing the interface between primary and specialist care (WHO & WONCA, 2008) (see also Chapter 27). The ‘pathways to psychiatric care’ were first described by Goldberg and Huxley (1980) (see Table 2.1), and their model delineates the filters through which people with mental health problems must pass from community to specialist care. This work is discussed further in Chapter 2, in relation to epidemiology. In many countries, newly developed primary care services are taking over the care of people with mental illness who were previously either institutionalized or under the care of mental health services. This process began in the United States and the United Kingdom 50 years ago and ever since there has been ongoing debate about who should be referred to specialist mental services (or behavioural health services in the United States), who should receive care in a primary setting and how the interface should be most efficiently configured to promote joint working between professionals and optimal outcomes for patients (Gask, 2005; Souza *et al.*, 2015).

Health policy in the United Kingdom has been particularly concerned, not just in mental health but across the field of health care, in shifting the care of many people who would previously have received specialist care in the hospital setting back into primary care (Department of Health, 2006). Despite the universal health care funding provided by the National Health Service (NHS), problems exist at the interface because of the different funding mechanisms for primary care services and hospital services in England and Wales. Similar problems exist in integrating care across the ‘divide’ in other countries, where, for example, funding for primary care and hospital care may be provided by different parts of government, or state or nationally (as in Australia), or different types of organizations or professionals may be funded to provide only particular types of health care by insurers, as may be the case with behavioural health in the United States.

## Integrating Mental Health into Primary Care

From an international policy perspective (WHO & WONCA, 2008), integrating mental health services into primary care is the most viable way of closing the treatment gap and ensuring that people get the mental health care they need (Box 1.1).

Primary care for mental health is affordable, and investments can bring important benefits; however, certain skills and competencies are required to effectively assess, diagnose, treat, support and refer people with mental disorders. It is essential that primary care workers are adequately trained and supported in their mental health work. It is also clear that, with the considerable international variation in the way that both primary and specialist services are provided, there is no single best practice model that can be followed by all countries. Rather, successes have been achieved through sensible local application of broad principles. Integration is most successful when mental health is incorporated into health policy and legislative frameworks, and supported by senior leadership, adequate

**BOX 1.1 Seven Good Reasons for Integrating Mental Health into Primary Care**

1. The burden of mental disorders is great.
2. Mental and physical health problems are interwoven.
3. The treatment gap for mental disorders is enormous.
4. Primary care for mental health enhances access.
5. Primary care for mental health promotes respect of human rights.
6. Primary care for mental health is affordable and cost-effective.
7. Primary care for mental health generates good health outcomes.

From WHO and WONCA (2008)

resources and ongoing governance. To be fully effective and efficient, primary care for mental health must be coordinated with a network of services at different levels of care and complemented by broader health system development.

Numerous models attempt to address the problems at the interface between primary and specialist care in order to provide truly 'shared care' (Craven & Bland, 2002; Bower & Gilbody, 2005; Gask & Khanna, 2011; Souza *et al.*, 2015). Much of the research has focused on attempting to improve outcomes for people with common mental health problems by integrating new staff such as counsellors or psychologists into the primary care team (Bower & Sibbald, 2000). However, work on the model of 'collaborative' care, which was developed in the United States (Katon & Unutzer, 2006) and which builds on earlier work on the redesign of delivery systems for people with chronic health problems such as diabetes (e.g. [www.improvingchroniccare.org](http://www.improvingchroniccare.org)), is now generating a great deal of interest. Guidelines for the care of common mental health problems in the United Kingdom ([www.nice.org.uk/guidance/CG123](http://www.nice.org.uk/guidance/CG123)) have also highlighted the concept of 'stepped care' in service delivery, with differing levels of intensity of care from primary to specialist care provided seamlessly, with decision-making about 'stepping up' or 'stepping down' according to severity, progress and patient choice. These models are described in more detail in later chapters.

## People, Patients and Service Users

There has also, more latterly, been increasing interest from both the research and policy perspective in understanding not only the views and wishes of the primary care professionals but also those of the patient. A new strand of qualitative work in primary care mental health has focused both on patients' experiences of mental health and illness and help-seeking behaviour and on their experiences of mental health care from their primary care providers. This has included studies on depression (Gask *et al.*, 2003; Lawrence *et al.*, 2006), severe and enduring mental illness (Lester *et al.*, 2005) and the experiences of such diverse groups as African-Caribbean women in Manchester (Edge, Baker & Rogers, 2004) and older people (Burroughs *et al.*, 2006).

At this point we should consider terminology. Mental health policy in the United Kingdom uses the term 'service users' for people with mental health problems. While this is a commonly used term in specialist settings, it is not widely used for people with mental health problems who receive their care only in the primary care setting (where most people are happy to be called 'patients'), and it is not universally used across the world. In this book,



we use the terms ‘patient’, ‘service user’ and ‘people with mental health problems’ as appropriate to the setting being described.

## Depression and ‘Depressive Illness’

We have given chapter authors freedom to decide how they refer to ‘depression’, a term which can be used to mean anything from sadness to severe clinical depression. This is because this book is aimed at primary care professionals who see and manage the full range of ‘depression’. In our view what is important is severity of symptoms rather than specification of when this becomes ‘illness’. In the appropriate chapters this distinction is examined in more detail.

## The Focus of This Book

We have written this book with the needs in mind of people working in primary care who provide first-line treatment for people with a range of mental health problems. We adopt an international perspective in our discussion of primary care mental health, recognizing the different ways in which health and social care, particularly primary care, is delivered in different countries (and indeed within some countries) and how this influences the way in which mental health care is delivered. However, it is inevitable, given our own backgrounds, that our starting point will be the care provided by GPs and the wider primary care team in the United Kingdom. Nevertheless, our guiding principle throughout is that ‘holistic care will never be achieved until mental health is integrated into primary care’ (WHO & WONCA, 2008).

### Key Points

- Primary care mental health is a relatively recent concept in the history of health care.
- There are important differences in the way that people present with mental health problems in primary and specialist settings.
- There is increasing interest in the role of primary care in the delivery of mental health care across the world.
- However, integrating primary and specialist care effectively remains a challenge.

## Further Reading and E-resources

WHO & WONCA (2008) Integrating Mental Health into Primary Care: A Global Perspective. [http://www.who.int/mental\\_health/policy/services/integratingmhintopriarycare/en/](http://www.who.int/mental_health/policy/services/integratingmhintopriarycare/en/)

The European Mental Health Action Plan 2013-2020. Downloadable from [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0020/280604/WHO-Europe-Mental-Health-Acion-Plan-2013-2020.pdf](http://www.euro.who.int/__data/assets/pdf_file/0020/280604/WHO-Europe-Mental-Health-Acion-Plan-2013-2020.pdf)

[www.improvingchroniccare.org](http://www.improvingchroniccare.org) – introduces the ‘chronic care model’ for depression and a range of other common disorders in primary care.

[www.mind.org.uk](http://www.mind.org.uk) – an information-packed website from a leading mental health charity in England and Wales.

Mental Health in Primary Care: A Briefing Guide for Clinical Commissioning Groups [https://www.mind.org.uk/media/4556511/13296\\_primary-care-policy\\_web\\_op.pdf](https://www.mind.org.uk/media/4556511/13296_primary-care-policy_web_op.pdf)

www.rethink.org – website of a leading UK mental health charity which focuses on severe mental illness.

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