

## Section???

# Political correctness, therapeutic naivety: the furtive future of primary mental healthcare

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### ABSTRACT

This discussion paper aims to explore the impact on the quality of care provided to individuals suffering mental health problems or mental illnesses resulting from the professional and organisational changes to the UK health and social care workforce. Since 1997, the UK National Health Service (NHS) has been involved in a modernisation process aimed at reforming the way health and social care is provided and delivered. The approach is driven through primary care trusts (PCTs), new organisations that are leading an empowered primary healthcare sector in the commissioning and delivery of services. A number of workforce issues have been recognised as being possible impediments to achieving this modernisation agenda. The response, however,

is a large range of new workers being developed which we argue, raises ethical and professional concerns over the quality of care being made available to those diagnosed with common mental health problems but who often have underlying complex psychopathologies. The paper argues that it is unlikely that these new workers will be able to recognise and/or respond to service users with common but complex mental health problems in the same way as a qualified mental health nurse might.

**Keywords:** common mental health problems, graduate primary care mental health worker, policy, therapeutic working

## Introduction

Since 1997 in the UK NHS, a modernisation process aimed at reforming the way health and social care is provided and delivered has resulted in a shift in emphasis from secondary care to primary care. Primary care trusts (PCTs) are leading a nearly empowered primary healthcare sector in the commissioning and delivery of services. It has been noted that in the context of mental healthcare, these organisations have a specific responsibility for delivering Standards two and three of the National Service Framework (NSF) for mental health services in providing services to those considered to have 'common' mental illnesses, formerly and euphemistically

referred to as the 'worried well', and have an integral role to play in commissioning services for people with a severe mental illness (SMI).<sup>1–5</sup>

A number of workforce issues have been recognised as being possible impediments to achieving this modernisation agenda. In an attempt to address this, a range of 'new workers' are in the process of development. These new workers include the support, time and recovery (STR) workers, mental health assistant practitioners and the graduate primary care mental health worker (PCMHW). *The NHS Plan* in support of the NSF implementation ensured some £300 million of investment was made available,

specifically to create 1000 new graduate mental health staff to help support the work of existing primary healthcare workers.<sup>6,7</sup>

We argue that despite these welcome increases in resources, the development of these new workers raises ethical and professional concerns over the quality of care being made available to those deemed to have a common mental health problem, but who have underlying complex psychopathologies. We have discussed the challenges raised by some of these new workers elsewhere.<sup>8</sup> This paper focuses on exploring the viability of the graduate PCMHW being equipped to recognise and/or meet the needs of service users whose problem presentation belies complex mental health aetiology. This paper addresses three main areas: (1) the underlying complexity of mental health problems; (2) the expertise required to provide a service for these people; and (3) the emergent graduate PCMHW role. Our starting point is to consider the policy context for these workforce developments in primary care.

## Policy (mis)directions

The proposals for modernising mental health services set out in *The NHS Plan* were said to be the most radical in the history of the NHS.<sup>7,9</sup> *The NHS Plan*, places mental health alongside coronary heart disease and cancer as a clinical priority for health.<sup>7</sup> It acknowledges that most mental health problems are managed in primary care, with one in four general practitioner (GP) consultations being with people who are experiencing mental health problems, and a GP is still likely to be the first primary care professional to see a patient with a mental health problem.<sup>10</sup> The Workforce Action Team report notes the way people with mental health problems present can typically involve a mixture of social, psychological, medical, emotional and financial difficulties.<sup>11</sup> However there are implications of these different forms of problem presentation for those working in primary care. The most important perhaps is the need to develop integrative policies which facilitate the development of future primary mental healthcare services and which involve the full range of primary care professionals.<sup>12</sup> The National Institute for Mental Health England (NIME) has established a specific primary mental healthcare programme, recognising the central role primary healthcare has to play in delivering comprehensive services to those who experience a range of mental health problems. The underlying approach to this programme is predicated on the promotion of more patient-centred approaches to service delivery and organisation.

Although this evidence relating to mental health problems has been known for nearly 40 years, the structure and organisation of primary healthcare *per se* has changed considerably over this time.<sup>13</sup> Currently many primary healthcare clinics are run by other healthcare professionals, particularly nurses who increasingly see patients for a wide range of presenting problems.<sup>10</sup> Sadly this has not often been the case for developing mental health services. In the UK during the 1980s and 1990s, there was a policy/practice shift which resulted in many community psychiatric nurses (CPNs) opting to work with those deemed to have common mental health problems at the expense of those with a SMI. Regardless of this, integration of CPNs and other community mental health nurses into primary care services remained sporadic.<sup>14</sup> This was problematic for service users and service providers as the availability of expert intervention was not readily accessible, leaving those working in primary healthcare floundering when confronted with mental health problems. Following high-profile cases reported in the media and the publication of the NSF, government policy has in some respects widened the chasm between primary and secondary mental health services by refocusing the work of CPNs towards people with a SMI.<sup>15</sup> Unfortunately, this polarisation of need and prioritisation of resources is yet one more example of the splitting process, which has inhibited the development of a comprehensive and inclusive mental health service. We are concerned that this splitting will also be mirrored in the delivery of mental health services in that those who are most qualified to recognise and offer appropriate intervention will be restricted to working with those diagnosed as having a SMI, while those least qualified will work with those with common, but in reality complex, mental health problems.

It could be argued, that these splitting processes also reflect the persistent polarisations of health/social, psychiatry/psychology, primary/secondary, mind/body.<sup>1</sup> These anomalies and tensions often lead to service user bewilderment at a time when what they seek is coherence and continuity from those who provide their health and social care. It has been argued that primary care has a particularly important responsibility in counteracting the pathologising of everyday human experience by providing a route back from patient to person.<sup>16</sup> In contrast, the importance of risk assessment in terms of the potential for committing suicide and those presenting to primary care services has also been highlighted.<sup>17</sup> However the development of current mental health policy, aimed at prioritising action for those with the highest level of morbidity and risk has perpetuated the distinction made between people with a SMI and those with a common mental health

problem. Such a distinction only serves as derision and is unhelpful in meeting the needs of those with common yet complex problems.

## The complexity conundrum

We argue there is a damaging divisiveness (of effort and resources) in creating these two political groups of mental illness. One implicit message of such division is that one group of people is more deserving of specialist services than those identified as being members of the other group. This reinforces social constructions of health and illness; for example, only 'real illness' (pneumonia) is worthy of professional attention and care, whereas 'minor ailments' (colds, flu) can be addressed by drawing on personal resources. The reductionist use of simplistic labels in this way belies the layered complexity of the individual's distress. It has been the group deemed to have common mental health problems, possibly construed as being akin to 'minor ailments' that was most likely to receive interventions from those least qualified to work with people experiencing mental distress, for example, health visitors, general practice nurses. Although these practitioners often have a wealth of experience within their own area of expertise, their lack of knowledge relating to mental health issues, and perhaps on a more practical level a lack of time, impacts upon their ability to effectively address the problems presented to them. It was in recognising these difficulties, coupled with a paucity of clinical psychological services, that the graduate PMHCW role emerged. It appears that in the development of current mental health policy an assumption was being made that these workers would be the solution to the difficulties of providing services to people with common mental health problems in primary care. We argue that this is a somewhat naïve assumption in terms of the demand and hidden complexity of the mental health problems encountered in primary healthcare services, and the expectations placed on what must be considered novice (often limited experience of mental health care) practitioners. In marrying the two facets of care, the needs of the individual and service provision, consideration needs to be given that for the majority of people this will be their first experience of mental healthcare and, as such, most will feel vulnerable and exposed to stigmatisation, thus creating a further layer of complication for the novice practitioner and the organisation.

## The paradox

It has been observed that often 'the so-called worried well are worried sick', and that they can consume a great deal of the GP's time.<sup>1</sup> Tomson and Shiers note that GPs find a significant psychological component in 70% of all consultations, and in 20–25% of patients a mental health problem would be the sole reason for consultation.<sup>1</sup> The sheer numbers of people presenting with these type of psychological distress can cause problems for all concerned, and therefore it is not surprising that others have noted that GPs may be reluctant to explore psychosocial issues with patients in light of the emotional burden that can result from this.<sup>18,19</sup> As was noted above, GPs are not the only primary healthcare professional seeing patients with mental health problems. Most patients present their problems as undifferentiated mixtures of physical, emotional family and social symptoms. Diagnosis of these problems is predominately categorical, and one consequence of this (in the context of primary mental healthcare) is that once a diagnostic label is given, these problems can then be surreptitiously treated from a 'tool kit' of interventions, namely that of pharmacology, brief therapy and/or cognitive behaviour therapy (CBT).<sup>1</sup> We argue this not only risks compromising the understanding of the individuals' story, it also fails to acknowledge the complexity of the individual experience and the intra-psychic framework in which they consequently function.

Thus, paradoxically, what the literature demonstrates is that the nature of mental health problems seen in primary care far from being 'common' (i.e. ordinary, without special qualities) is often complex (consisting of many different and connected parts, difficult to understand). For example, there is a high correlation between adult mental health problems and complex traumatic life events, predominantly that of childhood sexual abuse.<sup>20–22</sup> Childhood sexual abuse has been identified as a predictor of suicide behaviour in young adults, and as such needs addressing with sensitive expertise.<sup>23</sup> While referring to secondary services for the complexities that belie their primary mental health problem might be an appropriate option, evidence suggests that there is reluctance on the part of mental health professionals working in secondary services to address the issue of abuse.<sup>24,25</sup> This could be viewed as a parallel process in that some patients may not wish to address previous traumatic life experiences, preferring to work at a pragmatic level with the symptoms they are experiencing in the here and now. It is for these people, that the brief therapies provided by the graduate PCMHW can ensure that their needs are appropriately met. However, Yalom (2001) cautions

against relying on the false assumptions that long term problems yield to brief therapy, and that patients only present one definable symptom.<sup>26</sup>

As primary mental health care services are often the first point of contact for people experiencing psychological distress, it is imperative that the response they receive is appropriate and sensitive to their emotional needs. Central to achieving this is a rigorous assessment process. However, in primary healthcare, the five-minute consultation is unlikely to provide the opportunity for such an assessment. Likewise, changes in secondary care assessment approaches have seen a move away from using an unfolding of life history to the 45-minute cross-sectional assessment interview on the part of professionals, which in turn often leads to narrowly constructed care intervention.<sup>27</sup> As a result of these changes in practice, many people who are referred to mental health services will not have their underlying problems addressed. In both primary and secondary healthcare environments, possible impediments to addressing such traumatic life events include: a lack of training, lack of time and the emotional burden these issues bring to the clinician.<sup>28</sup> In not having the underlying problem addressed, the symptomatology relating to the primary diagnosis is likely to persist or at best re-occur. The consequence of this is that people who are experiencing these problems will have no alternative but to again seek out help from primary care services.

Whilst in the longer term, PCTs face the challenge of responding to such complexity through developing integrated approaches that address the socio-political factors that can contribute to mental ill-health (dysfunctional families, housing, unemployment and so on), the current demand for services is seen to represent a significant burden for those working in primary health care.<sup>22</sup> It is paradoxical then, that it was in recognising the burden of how to more effectively meet the needs of these sometimes 'hidden populations', that along with other new mental health workers, the creation of graduate PCMHW was proposed, although it is still not clear how these new workers could be used to be most effective.<sup>7,29</sup>

## The primary care mental health worker(s): panacea for all ills?

It is argued that new health care roles and/or modifications to existing ones do not result from health-care professions themselves, but are largely driven by external pressures.<sup>30</sup> As governmental notions of

what constitutes best practice, i.e. what should be done by which healthcare professional, and where it should be done, prevail, professional insecurities give rise to defensive behaviour. Tribalism is often an inherent feature of a profession representing an evocation of protectionism as a response to other similar professions changing their boundaries of practice and/or to new threats from the external environment.<sup>31</sup> The emergence of the graduate PCMHW perhaps presents as such a threat. Although, the initial cohorts of graduate PCMHWs are at an early stage of development and little evaluation is available of their impact,<sup>32</sup> there is some evidence that their role has been greeted with antagonism and resistance by members of the existing primary mental health team. While not necessarily being seen as a panacea for all the workforce concerns, high expectations were raised as to what the graduate PCMHW would be able to do. *Fast-forwarding Primary Mental Health* described how the graduate PCMHW will offer interventions and self-help for people of all ages with common mental health problems, strengthen the information available for patients, support the development of practice-based information systems, audit and outcome measures, improve user satisfaction with care, and improve knowledge within the practice about the network of community resources for people with mental health problems.<sup>9</sup>

In preparation to address this remit, PCMHWs receive one year of postgraduate training. The curriculum for this includes assessment of need and risk (although they will not carry sole responsibility for assessment in its entirety); a number of evidence-based techniques and the required skill development to deliver therapeutic interventions; cultural competency; gender awareness; an understanding of the context of working in primary healthcare and knowledge of the legislative frameworks relating to adults and children.<sup>9</sup> Those embarking on the one-year course will hold a first degree in a health-related subject, for example psychology, and/or have personal experience of mental health problems. As educationalists and mental health professionals, we need to consider the reality of delivering this vast amount of content in a curriculum spanning one academic year. Such a course can only be considered feasible if it can ensure that the workers it produces are adequately prepared to meet the demands of the primary mental healthcare patient-centred agenda. It would appear that part of the training involves 'learning on the job' and that both during the training programme and following its completion the graduate PCMHW will need clinical supervision, help with troubleshooting, monitoring workload and personal support.<sup>32</sup> During training this will be provided by those involved in the

educational process, however on completing the programme, who will be expected to provide this support might prove problematical.<sup>32</sup>

It is vital that this question is addressed, as the inherent difficulties in the trajectory from novice to expert might engage the practitioner working in primary mental healthcare in the unconscious process of developing maladaptive ego defence mechanisms such as denial, projection and rationalisation.<sup>33</sup> While this may protect them from their own anxieties arising from their perceived lack of knowledge and experience in dealing with the complexities of the mental health problems they are faced with, it may create a block to the therapeutic intervention needed to facilitate their patients' traumatic experiences and the consequential emotional distress. Just as those who are distressed and seek help need to be held in a safe environment, so too do those who provide that therapeutic help. Within the infancy of new ways of working, those involved need to be nurtured while conflicts and insecurities are bounded and held. This will allow the emergence of inner self-confidence, which will enable them to successfully execute the challenges put before them. While we acknowledge that it is unlikely many PCTs are viewing the graduate PCMHW as the solution to more effectively providing services to those with a common mental health problem, we need to be cautious over how the role is perceived and interpreted in the realities of practice, not least because there is an issue for the graduate PCMHW (and their organisations) as to what career pathways are open to them as this role develops. Careful consideration needs to be given to a future career structure if the graduate PCMHW is to gain a sense of belonging in relation to the rest of the primary mental healthcare team. This sense of 'belonging' will help ensure that future focus of the role is on the '*being*' rather than the '*doing*' aspects of the graduate PCMHW in order to gain an inner self-confidence to hold the realities of their patients' emotional distress.

## Conclusion

In this paper we have identified what could be described as the furtive future of primary mental healthcare, namely that of the complex nature of people's mental health problems facing a primary care workforce that is sometimes floundering, in the dark, but always on changing and ever-shifting sands. Perhaps in looking forward to functional service models for primary health care, PCTs might wish to consider looking back to the work of anti-psychiatrist movement and the more recent harrowing inquiries

confronting the NHS. In the 1960s, Szasz<sup>34</sup> warned of the dangers of diagnosing disease where pathology was non-existent, believing that such anomalies only led to limitations inherent in adopting a biomedical view of the individual and their problems, while in 2001 Kennedy's influential report relating to the Bristol Royal Infirmary Inquiry made a plea for a truly patient-centred health service where 'patients must be seen first as people who live complex lives, rather than a set of clinical problems with a collection of symptoms'.<sup>34,35</sup> The complex aetiology of mental health problems cannot be ignored. As we have suggested in this paper, others have also argued that in defining who might require access to primary mental healthcare services, it is imperative that we consider situational and historical factors and their co-existence to the presenting problem rather than intra-psychic factors alone.<sup>36</sup> In such an approach, the ensuing description of the service users' expressed experience may at least supplement or even at best replace psychiatric labelling. For the practitioner with restricted experience, education and training in working with those experiencing mental health problems, it can be difficult to hear and accept the services users' experience as being a legitimate description of their distress. It could be argued that the new breed of graduate PCMHWs will not carry the same baggage resulting from the socialisation process encountered by those professionals educated and trained to work in predominately secondary and tertiary mental health services. However, the cost for those presenting with mental health problems, professionals already working in primary healthcare services and the graduate PCMHWs themselves could be phenomenal in terms of finance, resources and, not least, emotional burden. We should not set ourselves or others up to fail. The complexity of delivering an appropriate and responsive primary mental health service mirrors the complexity of the mental health problems presented within that arena. Thus the development of the graduate PCMHW role needs to reflect the limitations of their brief training and, in some cases, their experiences of mental health issues. There is clearly a place for such workers as primary mental healthcare services are developed by PCTs. While the skills and knowledge of such workers can be used in collaborative and complementary ways with other existing members of the primary mental health care team, caution needs to be exercised to ensure complex mental health problems are both recognised and addressed by those most able to do so. While this might involve professionals who have undergone specific preparation for working with all people who experience mental health problems, it must also include the patients themselves, their experiences and aspirations. It is only in harnessing and nurturing this expertise that

the provision of a quality primary mental health service will be achieved.

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CONFLICTS OF INTEREST

None.

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