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Invited papers

Primary care mental health: a new dawn

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Primary Care Mental Health arrives at a time of unprecedented investment in mental health in the UK.[1,2] Current policies, relying heavily on standards, targets and performance management, can only get us so far. Implementation requires a balance between policy and support for development.[3,4] In recognising the potential contribution of primary care to improving mental health services it is thus really welcome that the National Institute of Mental Health for England (NIMHE) has created a specific primary care programme.

Primary Care Mental Health has an opportunity to synergise with that initiative in developing better understanding of the needs of patients using primary care for their mental health problems and how these can be supported by front-line practitioners. This can be articulated by *Primary Care Mental Health* adopting two principles which underpin the emerging NIMHE primary care programme:

- 'see it through the eyes of patients and their families'
- 'help practitioners (the whole range of staff) do a difficult job better'.

'See it through the eyes of patients and their families'

How many publications, plans and policy documents start by placing the user of services at the centre only to proceed then to discuss service and professionally centred concerns for the rest of their length? It is the needs of users that should guide this new journal in its quest for best practice, and supporting evidence. Many of the professional, service and cultural distinctions – health/social, psychiatry/psychology, primary/secondary, mind/body – and the sometimes ferocious disputes that break out around these boundaries, make little sense to users searching for the right relationships with the right people, information and services at the right time and in the right place. *Primary Care Mental Health* can challenge this tendency for a single ideology, institution or discipline to seek centre stage. Put simply the watchword must be – does it make sense to the user?[5]

'Help primary care practitioners do a difficult job better'

There is another type of user, also long-neglected – the jobbing primary care professional (general practitioners, a range of primary care and community nurses, counsellor, pharmacist and others) whose need for a number of key resources (epidemiology and nosology of mental health in generalist settings, effective generalist interventions, effective partnerships with specialists, accessible and relevant knowledge) remain largely unmet. The training of these front-line staff was found seriously wanting when reviewed by the primary care subgroup of the Mental Health Workforce Action Team.[6] This journal can become a much needed trend-setter which challenges the 'publish or die' approach of traditional educational systems that have privileged research and publication at the expense of learning and service development.

'Do it together'

Perhaps a third principle can be added to the above – namely that of the need for greater mutual respect and resulting partnership in a number of related areas:

between professionals irrespective of their background in primary, specialised or community services; between professionals and patients and their family and carers; between professionals and community, voluntary sector and social networks. This journal can set an example by celebrating the breadth of the potential workforce and the value patient and families gain from a workforce that works on a principle of mutual respect and partnership.

Some of the challenges

In helping these patients and primary and specialised practitioners *Primary Care Mental Health* can develop new and much needed insights. We have described some of the themes we hope may feature:

Primary care as the central provider of statutory mental health services

One of the myths that has impeded primary care mental health development is that mental illness is the exclusive business of specialised mental health services, and that primary care deals with the 'worried well'.[7] The evidence belies this: in a typical workday a GP expects a significant psychological component in 70% of consultations and in 20–25% of patients a mental health problem would be their sole reason for consultation. Common mental health problems in primary care are characterised by anxiety, depression and somatisation. They are frequently provoked by stress from family, work, social isolation, chronic physical illness and lifestyles such as substance abuse. These so-called 'worried well' are 'worried sick' and just as disabled as most sufferers of chronic physical diseases, generating major social and financial burdens to families, friends and employers, and consuming scarce health resources.[8] Nor are GPs the only professionals working in primary care. Counsellors have provided valuable care for several years. Nurses, receptionists, social workers, and pharmacists all deal with mental disorders, and usually with rudimentary training and little confidence about primary care mental disorders.

Alliance with families and carers

Patients themselves, their families and their carers, are the main providers of care for people with mental distress.[9] Within the statutory sector, primary care is the key provider and its characteristics make it a valuable partner in mental healthcare, although not always acknowledged, owned or acted upon by primary care practitioners or organisations. Nor is the quality of provision uniformly good. If primary care is to fulfil its key role then it must embrace the responsibility it has to co-deliver mental health with its aforementioned partners. The challenge is in helping primary care recognise, own and be energised in this role.

The partial utility of specialist models: the issue of volume

Specialist models of care are characterised by attempts to gain clarity about specific categories of condition and their detailed treatment. Increasing specialisation is a response to the challenge of the suffering individual patient. Whilst important to our understanding of those with psychosis: the first episode of psychosis, the hard to reach, the patient in crisis; specialised services have become preoccupied by depth and, sometimes albeit often reluctantly, by risk. It can never deal with the issues of volume, the 90% of patients who form the main pre-occupation in primary care settings.

For this reason specialised models of mental disorder do not transfer well to primary care. Thus we need new thinking, new knowledge, new service developments, new mental health technologies. We need to recognise and work with the strengths and skills that patients, families and carers already bring to the table. We need to extract from specialist models those things that can be usefully adapted to primary care. The challenge is in reversing the learning, service development and research emphasis – putting 80% of the effort on foundational skills and implementation rather than the current emphasis on developing specialist GPs with high-level skills unable to meet the demands of volume.

The distinct culture of primary care

Primary care has a quintessentially distinct style of working, in a context well characterised as a 'swamp where problems are messy, confusing and incapable of technical solution'.[10]

Consider that primary care:

- provides for the majority of NHS consumers most of their medical and psychosocial interventions
- is a free, universal, voluntary, demand-led system working to whole populations and not just to small percentages, requiring intensive resources
- sees its consumers for short times but over long periods as and when they want, presenting with undifferentiated mixtures of physical, emotional, family and social problems
- feels the impact of socio-economic problems through increased consultation rates and workloads[11]
- is delivered by specialists in generalism – defined by James Willis as taking an interest in whatever is

of interest to its clients;[12] it occupies an important space at the interface of clients, families, communities and professional worlds, negotiating meaning around health, illness and disease
- offers a healthcare setting which is generally preferred by consumers and carers, partly because it holds multiple explanatory models often closer to the views of consumers[13]
- offers a model based on continuity of care and the importance of the professional/patient relationship, which in turn lends itself to the increasingly important ideas of recovery, focusing on strengths rather than deficits.[14]

Prevention and promotion: moving towards a public health perspective

Primary care has a critical role in strengthening individuals and communities and removing the barriers to better mental health.[15] Tackling a public health agenda, so important in mental health, can allow us to identify ways to work upstream while still developing new ways of fishing people out of the river downstream. Primary care has a particularly important responsibility in counteracting the pathologising of everyday human experience by providing a route back from patient to person.

Need for new epistemology and nosology

Most patients present their problems as undifferentiated mixtures of physical, emotional, family and social symptoms, further complicated by shifting combinations of symptoms over time. Current diagnosis is predominantly categorical, attempting to separate the biomedical from the psychological and social.

Consider:

- only 20% of patients presenting persisting symptoms in primary care had discoverable physical causes and 10% had clear psychological causes[16]
- the ten most common persisting symptoms are fatigue, back pain, dizziness, dyspepsia, cough, insomnia, weight loss, abdominal pain, numbness, constipation. These account for 40% of all GP consultations and yet one year later only 15% will have a clearly attributed physical cause[17]
- the highest 10% of healthcare utilisers use more consultations, as many prescriptions and more consultant referrals than the lowest 50% of utilisers.[18] Of these high utilisers, over half are significantly psychologically distressed. Even more interestingly, the primary care physicians find more than a third of the high utilisers frustrating to work with, as these patients tend to express their distress in somatisation and anxiety
- 20% of patients attend solely for psychological problems.[19] However adding to that the role of psychological factors in physical illness the figure climbs to 75–80%[20]
- 15–25% of primary care medical decisions made by GPs are based on health morbidity; the remaining decisions are based on psychosocial needs, patient preferences and the doctor–patient relationship.

There are two issues which flow from this.

Inadequacy of current 'disease' models

Primary care clinicians may seemingly struggle to identify depression as the 'disease' their patient 'has', often requiring a more complex negotiation over time as to the usefulness of one particular label or other.[21] Thus, although diagnosis and the proven usefulness of intensive treatment and chronic disease management models can help certain types of depression, these approaches are only a partial answer to the challenge of mental distress in primary care.

Current notions of causality and time provide an inadequate epistemology for generalist settings. For instance the first episode of self-induced vomiting does not by itself constitute an eating disorder but it is clearly unhelpful to delay action or attention until it can be entitled a definitive illness or disease. It is a condition where there is a direct correlation between length of symptoms and difficulty of alleviation. Better understanding of so-called 'sub-syndromal' conditions, circular and complex causality,[22] the pathway of symptom constellations over time and the role of earlier intervention may provide a better 'fit', improve outcome and reduce overall costs.

'Body or mind'

The limitation of a simplistic 'body or mind' approach is challenged by several studies of mental disorders in primary care[23–26] which consistently report the co-occurrence of physical, emotional and social problems in patients, and furthermore show such patients to be the highest utilisers of these services.[18] The very idea that it is useful to separate mind and body in this way is particularly problematic. Particularly unhelpful in primary care settings is an either/or philosophy which sees diseases as simply either biomedical or psychosocial. Mind–body splits bedevil all our efforts to work with patients in effective ways. A both/and philosophy is the essence of 'family practice' within a modern primary healthcare team.[27]

Conclusion

The biggest resource we have for developing good mental healthcare in this country lies in the ideas,

strengths and energy of our own primary care workforce and the people who use our services. Unfortunately this has been poorly recognised and developed over many years. Thus the appearance of this new journal is timely and welcomed. We sincerely wish *Primary Care Mental Health* a most successful future.

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