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# Private minds in public bodies: the public mental health role of primary care

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I can see why expanding the role of the GP [general practitioner] from medical practice to cover tasks of moral guidance and social surveillance appeals to government. But why should it appeal to GPs?<sup>1</sup>

## Introduction

The public health role and potential of primary care is high on the policy agenda. It is considered crucial to the delivery of the public health white paper *Choosing Health*, and features strongly in a policy discussion paper on changing behaviour from the Prime Minister's Strategy Unit.<sup>2,3</sup> It is also recognised in the new General Medical Services (GMS) contract, notably in its focus on health promotion and the scope for a range of agencies that influence the determinants of health to be involved in meeting patients' needs.

Of course there is ongoing debate about the public health versus the biographical model, and fidelity to the individual patient versus meeting national health objectives,<sup>4,5</sup> but for physical health, the argument has largely been won. Smoking, exercise and diet are routinely addressed within primary care. Prevention is not an optional extra, for example primary care teams must assess patients' risk of cardiovascular disease and the same is true of diabetes.<sup>6,7</sup> Primary care trusts take an increasingly proactive stance in addressing policy and structural barriers to the health of their communities, and have an explicit obligation to tackle health inequalities through local delivery plans.<sup>8</sup>

We are still lagging behind, however, in identifying what, if any role primary care has in delivering *public mental health*, and what might be described as the five fruit and vegetables of mental health. The public are beginning to accept the message that if

they feel depressed, they can go to their GP, but there is very limited information on how to look after your mental health in the first place. Notwithstanding an apparent epidemic of common mental disorders, the mental health promotion equivalents of smoking cessation and immunisation are barely visible and barely resourced in most localities. Spending of £2.75 million was reported in 2003–04, unchanged from the previous year, but around half the sum reported in 2001–02. Although these figures may underestimate true spending, because they do not include national initiatives and because of ambiguities in how mental health promotion spending is defined, expenditure on mental health promotion in England is lower than in Scotland, as well as in countries like New Zealand and Australia.<sup>9</sup> This is a very small investment relative to the substantial amounts of money spent on mental health services.<sup>10</sup>

## Mental health and inequalities

One reason for this may be that public pronouncements and mental health policy alike reinforce the notion that mental illness is a random misfortune, rather than the product of social, economic, environmental and lifestyle factors that are well understood.<sup>11</sup> Mental health status is strongly associated with material deprivation: education, employment and the environment are key factors in understanding which one in four is most at risk of mental health problems across the spectrum of disorders. The most up-to-date source of evidence on risk and protective factors and effective interventions to promote mental health is the National Electronic Library for Health (Mental Health Promotion).<sup>12</sup> As with physical health, it is the poorest and most deprived families who bear the main burden of mental distress. Lone parents, those with physical illnesses and

the unemployed make up 20% of the population, but these three groups contribute 36% of all those with neurotic disorders, 39% of those with limiting disorder and 51% of those with disabling mental disorders.<sup>13</sup> Other adverse life events which increase risk include being a carer, workplace stress, bereavement and bullying. There is also increasingly robust evidence for an association between lifestyle behaviours and mental health status and outcomes. These include physical activity, diet, alcohol consumption and the use of cannabis and other psychotropic substances. Certain emotional and cognitive skills and attributes are also associated with positive mental wellbeing, including feeling satisfied, optimistic, hopeful, confident, understood, relaxed, enthusiastic, interested in other people and in control.<sup>14–16</sup>

## A case for treatment?

On the face of it, the policy environment for mental health is favourable. Improving mental health and wellbeing is one of six key priorities in *Choosing Health* and should form an integral part of local delivery plans.<sup>8,17</sup> *Choosing Health* includes a specific commitment to new services to improve the mental and emotional wellbeing of the whole population and states:

we will ensure that standard one of the NSF for Mental Health, which deals with mental health promotion, is fully implemented.

The importance of mental health promotion is also recognised in the NSF progress report by the National Director for Mental Health, *The National Service Framework for Mental Health: five years on*, which notes:

we need to broaden our focus from specialist mental health services to the mental health needs of the community as a whole.<sup>18</sup>

But we still lack a strategy for public mental health, what has been called ‘the art, science and politics of creating a mentally health society’, and an analysis of how to address the mental health needs of the whole population: in schools, in the workplace and in communities. Although it is rarely acknowledged, everyone has mental health needs, whether or not they have a mental illness diagnosis, just as everyone has physical health needs, whether or not they are sick. It is widely recognised that physical wellbeing is a resource to be promoted through a combination of legislation, policy, education and fiscal measures. Public mental health, (of which mental health promotion is one element), provides a strategic

and analytical framework for addressing the wider determinants of mental health, reducing the enduring inequalities in the distribution of mental distress and improving the mental health of the whole population.<sup>19,20</sup>

Neuroscience has contributed centrally to the evidence that how we think and feel is fundamental to physical health, but public health has yet to catch up.<sup>21</sup> Research in this field, for example, substantiates the view that there is not a categorical difference between ‘mad’ and ‘sane’. Almost all of us probably carry some ‘schizophrenia’ or ‘depression’ genes, most of us would develop psychotic symptoms if sufficiently stressed, and many people (probably 15–20%) have had psychotic experiences at some point in their lives.<sup>22,23</sup> These findings apply to every aspect of normal and abnormal psychology, and point to the crucial importance of understanding and addressing the ‘mental health impact’ of policy, economics, environment and life circumstances.

In the absence of a public mental health strategy, it is little wonder that primary care finds itself impotent and overwhelmed in the face of an epidemic of ‘common mental disorders’ and ‘frequent attenders’. Data on the prevalence of mental health problems in primary care are limited, partly due to the often complex process of diagnosing such conditions and partly due to problems with coding and collecting data. Two national surveys of psychiatric morbidity in adults can be used to estimate the caseload for selected conditions among patients of a ‘typical GP’.<sup>24,25</sup> These figures suggest a 13% increase in the overall prevalence of neurotic disorders among patients between 1993 and 2000.<sup>26</sup> Major employers face a relentless rise in stress-related sickness absence and the prevalence data on adolescent mental health problems suggests an increase of 70% in the past 25 years.<sup>27</sup> At the other end of the life cycle, one in eight older people living at home, and two in five of those living in care homes suffer from depression; if symptoms below those necessary for a clinical diagnosis, often referred to as malaise, are included, prevalence doubles.<sup>28</sup>

The (often reluctant) response of primary care is the prescription of antidepressants. The number of prescriptions in England has nearly trebled in a decade: 26.3 million in 2002 (compared with 9 million in 1991), at a cost of £381 million in 2002 (Department of Health Statistics 1991–2003),<sup>29</sup> with little robust evidence of effectiveness in the case of mild to moderate depression.<sup>30</sup> There has been a rise in prescriptions for antidepressants to children under 18 of 70% between 1992 and 2001.<sup>31</sup> In the UK overall, 700 000 prescriptions for psychotropic medication are given to children annually, a rise of 68% in just two years and the biggest increase in the world.<sup>32</sup>

There has also been a rapid increase in the number of counsellors in primary care; by 2001 over 51% of practices had access to a counsellor, although again, evidence of effectiveness is relatively limited.<sup>33,34</sup> Counselling and other talking treatments provided by trained professionals, while generally preferred by patients, are no more cost-effective than medication.<sup>35</sup>

## Making the case

The case for public mental health is threefold: cost, impact of mental health on physical health, and the opportunity it offers to reduce the prevalence and impact of mental health problems.

### Cost

Most economic analyses of mental health focus on the cost of mental illness.<sup>36</sup> The Sainsbury Centre for Mental Health has estimated that mental health problems cost over £77 billion a year through care costs, economic losses and premature death.<sup>10</sup> About 900 000 people are claiming incapacity benefit for a mental health problem – more than the number of unemployed people claiming Jobseekers' Allowance. These are important studies, but diagnosis is not a reliable indicator of the mental health of the nation – you can't pee in a bottle and have the matter settled one way or the other. Wanless has calculated that the cost benefit of better mental healthcare would be a net saving across government as a whole of some £3.1 billion a year.<sup>37</sup> This does not take into account the savings from promoting mental health and preventing problems in the first place, so the total potential for savings is obviously much greater than Wanless's estimate.<sup>38</sup>

Mental health is about how people think and feel, individually and collectively, and the impact that this has on all aspects of their lives. What is apparent is that there are clear links between emotional health (notably in childhood) and educational achievement, criminality, employment status and health behaviours. How people feel is not an elusive and abstract concept but a significant public health indicator and key determinant of their behaviour, attainment, health and prosperity.

### Impact on physical health

Stress epidemiology helps us to understand the physiological basis, via the nervous system, the

cardiovascular system and the immune system, for the impact of mental health on physical health.<sup>39,40</sup> How people feel – depressed, angry, frustrated, out of control, hopeless, isolated, excluded – is written on the body and evident in higher blood pressure, higher cholesterol levels, reduced immunity and restricted growth in childhood. Such effects influence recovery, for example from myocardial infarction and health outcomes for chronic diseases like diabetes, and are independent of other risk factors e.g. smoking, exercise, obesity. Poor mental health is associated with poor self-management of chronic illness and a range of health-damaging behaviours, including smoking, drug and alcohol abuse and poor diet.

### Opportunity

Current threats to public health are largely so-called lifestyle diseases, which have proved resistant to public health measures for a significant minority of the population. A piece of fruit per schoolchild per day will do little to offset other health-damaging behaviours, many of which may be survival strategies in the face of multiple problems and despair related to occupational insecurity, poverty and exclusion. These problems impact on intimate relationships, the care of children and care of the self. Broadly speaking, between a fifth and a quarter of the population are, as the white paper acknowledges, finding it hard to choose health. The 20–25% who are obese and continue to smoke are concentrated among the 26% of the population living in poverty, measured in terms of low income and multiple deprivation of necessities.<sup>41</sup> This is also the population with the highest prevalence of anxiety and depression.<sup>13</sup> Public health needs to engage much more centrally with mental health if it is to understand the mechanisms through which inequality erodes emotional, spiritual and intellectual resources essential to psychological wellbeing: agency, trust, autonomy, self-acceptance, respect for others, hopefulness and resilience. A notable silence in public health discourse is any analysis of the mental health impact of socio-economic changes in the UK over the past two decades.

## But what about primary care?

The question is, what can primary care do, if anything, about public mental health? Concerns about potentially high levels of 'caseness' and about the rapid increase in prescription of antidepressants,

have generated major debates about alternative responses to mental distress in primary care. Concern has been expressed about attaching a diagnosis to what may be, in effect, socio-economic problems.<sup>42</sup> Meanwhile, the highly critical inquiry by the House of Commons select committee on health into the influence of the pharmaceutical industry raises further questions about adverse effects and disease awareness campaigns (e.g. the Royal College of Psychiatrists' Defeat Depression Campaign, and the Depression Alliance's national depression week), which, says the select committee, can result in an increased pressure on doctors from patients demanding drugs when they are not necessarily appropriate.<sup>43</sup>

## Social prescribing

One option is to strengthen the use of primary care as a gateway to alternative sources of support for those experiencing or vulnerable to mental distress across the spectrum.<sup>44</sup> Social prescribing is a mechanism for linking patients in primary care with non-medical sources of support within the community. These might include opportunities for arts and creativity, physical activity, learning, volunteering, mutual aid, befriending and self-help. Social prescribing provides a framework for:

- developing alternative responses to mental distress
- a wider recognition of the influence of social and cultural factors on mental health outcomes across the whole spectrum of disorders.

The most common examples of social prescribing are primary care-based projects which refer at-risk or vulnerable patients to a specific programme, for example *Exercise on Prescription*, *Prescription for Learning* and *Arts on Prescription*.<sup>45–47</sup> However it also includes a very wide range of initiatives in which primary care staff provide a signposting or gateway service, linking patients with sources of information and support within the community and voluntary sector.

Social prescribing has been quite widely used for people with mild to moderate mental health problems, with a range of positive outcomes including enhanced self-esteem, reduced low mood, opportunities for social contact, increased self-efficacy, transferable skills and greater confidence.<sup>48–54</sup> For non-clinical populations, some of the most promising research focuses on addressing risk and protective factors for mental health, for example social networks, problem-solving skills and self-esteem. Both naturalistic studies and controlled trials suggest that psychosocial situations generating new hope are associated with improved outcomes for depression and for those at risk of depression.<sup>55</sup>

There is also a growing interest in social prescribing as a route to reducing social exclusion, both for disadvantaged, isolated and vulnerable populations in general, and for people with severe and enduring mental health problems.<sup>56,57</sup>

Broadly, social prescribing is one route to providing psychosocial support for:

- vulnerable and at-risk groups, for example low income single mothers, recently bereaved elderly people, people with chronic physical illness
- people with mild to moderate depression and anxiety
- people with severe and enduring mental health problems
- frequent attenders.

The long-term aim of social prescribing is to improve mental health and quality of life and/or to ameliorate symptoms, measured through, for example, improved General Health Questionnaire (GHQ) or social functioning scale scores. Short- and medium-term outcomes might include:

- increased uptake of arts, leisure, education, volunteering, sporting and other activities by vulnerable and at-risk groups, including people using psychiatric services
- increased levels of social contact and social support among marginalised and isolated groups
- reduced levels of inappropriate prescribing of antidepressants for mild to moderate depression
- reduced waiting lists for counsellors.

## Addressing the barriers

All primary care trusts (PCTs) should now be collating information on local self-help groups for practitioners, in addition to providing a wider range of data on community-based support and services within education, leisure and welfare, for example. This might take the form of a local directory, patient information leaflets, notice boards etc, in addition to more proactive provision of space and facilities for community groups within primary care practices.

Social prescribing can also be integrated within the 'stepped approach' to care, which involves the delivery of low-intensity, low-cost treatments (for example supported self-help), as a first option prior to referral to higher-intensity, high-cost care.

Social prescribing sits within, and may also include, a range of emerging areas of service provision for which there is promising but limited high-quality evidence of effectiveness, for example telephone support, self-help and computer assisted therapy.<sup>30,58</sup>

All PCTs should have protocols for managing anxiety, depression, postnatal depression and other common mental health problems within primary care. In practice, such protocols usually focus on the prescription of medication, and referral to talking therapies – notably cognitive behavioural therapy. Recent research by the Mental Health Foundation reveals a significant difference between GPs' beliefs about how mild or moderate depression ought to be treated, and how they actually respond to it in practice.<sup>59</sup> Of the 78% of GPs who prescribed an antidepressant despite believing that an alternative approach might have been more appropriate, 66% did so because a suitable alternative was not available. The research found that despite having a substantial evidence base and clear clinical guidelines, exercise therapy is very unlikely to be offered to patients who present to their GP with depression. Although GPs are lukewarm in their attitude to antidepressants, and feel they need more access to alternatives, the promotion of exercise therapy to patients with mild or moderate depression barely features in their thinking. Five per cent of the 200 GPs surveyed for the Mental Health Foundation reported use exercise referral as one of their three most common treatment responses to mild or moderate depression, compared with 92% who use antidepressants as one of their three most common treatment responses.<sup>59</sup>

Notwithstanding these findings, interest in social prescribing is fuelled by a growing recognition that primary care (and indeed the NHS) is unable to meet demand. This suggests that primary care needs both to work more closely with agencies which influence the broader determinants of mental health and to develop links with alternative responses to and sources of support for, mental distress.

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#### CONFLICTS OF INTEREST

None.

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