Part I: Conceptual basis and overarching themes

The seven chapters in Part I cover a range of fundamental concepts and provide the keys to understanding much of the rest of the book. They highlight a series of interesting themes, including the fundamental and growing importance of primary care mental health, but also the problems inherent in its delivery, as well as the importance of context and the tension in encouraging service users to have a choice and a voice within a wider system that tends to exclude people with mental health diagnoses.

We start by asking a fundamental question – what is primary care mental health? This first chapter provides an overview of the concept and describes the range of relevant policy initiatives in this area, the types of mental health problems seen and treated in primary care and strategies that are being used nationally and internationally to improve integration across the interface between primary and secondary care.

The international focus is continued with a chapter on primary care mental health in low- and middle-income countries and a thoughtful essay by Sartorius, informed by 40 years of work on the world stage, on the extent to which and manner in which treatment of mental disorders and their prevention differ between settings.

The chapters on the epidemiology and the classification of mental illness in primary care both highlight the complexities of primary care mental health. Describing the rates of disorder within primary care, for example, is difficult, since it is almost impossible to obtain a representative sample of primary care physicians to collaborate with a research team. Patients in primary care are also much less likely to present with clearly identifiable diagnostic syndromes, which affects both the classification process and the epidemiological evidence base. Understanding these issues sheds light on the apparent under-diagnosis of many mental health problems by primary care practitioners.

Perhaps above all, Rogers and Pilgrim in Chapter 4, looking through a critical sociological lens, capture the spirit of many chapters in Part I by suggesting that primary care has moved from the margins to the mainstream and now represents a new and central field of the management of mental health in society.
Primary care mental health

This book is about primary care mental health, a concept that has emerged relatively recently in the history of healthcare.

The World Health Organization (WHO) has defined 'primary care mental health' to incorporate two aspects (WHO & Wonca, 2008):

- first-line interventions that are provided as an integral part of general healthcare
- mental healthcare that is provided by primary care workers who are skilled, able and supported to provide mental healthcare 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 40 years or more in the UK, since the pioneering research carried out by first by the husband and wife team of Watts & Watts (1952) and later by John Fry (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 the mental healthcare that is provided within primary and general healthcare 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 over a decade ago (Pullen et al, 1994), to a broader view of ‘primary care mental health’ (from the title of this publication now commissioned by the Royal College of Psychiatrists) reflecting the wider involvement of a range of health professionals in primary and specialist settings.

Definitions

We recognise that there is enormous international variation in what is meant by the term ‘primary care’. According to the Institute of Medicine (1996) in the USA, primary care is the:

provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal health needs, developing a sustained partnership with patients, and practicing in the context of the family and community.

Primary care systems can be categorised according to whether they act as gatekeepers to specialist services (as in the UK), provide free-market services in parallel to specialist services, or function in a complex system containing both free-market and gatekeeper functionality (as in the USA); 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.

How can we define mental health? According to the WHO (2007), it is:

a state of well-being in which the individual realises his or her own abilities, 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 healthcare, 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 recognises 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 7), where fewer than 10% 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 recognise 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 UK (McCormick et al, 1995) and GPs spend on average approximately 30% of their time on mental health problems (Mental Health Aftercare Association, 1999). It is of course perfectly possible for one individual to have both a common mental health problem and a more severe and enduring mental illness.

However, even in countries where specialist mental health services are well developed, such as the UK and USA (Department of Health and Human Services, 1999), many people with more severe and enduring mental illness receive their ongoing mental healthcare primarily within primary care, for reasons of choice or lack of access to specialist care. In low- and middle-income countries, specialist mental healthcare may be poorly developed or
even non-existent, such that, by default, primary care will be the primary provider of mental healthcare (Patel, 2003).

There is considerable international variation in the way in which primary care practitioners are engaged in providing mental healthcare (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 comorbidity with physical illness and a common mode of presentation of emotional problems in the primary care setting is that of medically unexplained symptoms, which may or may not be recognised 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 unrecognised 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 recognised and understood as representative of a mental health problem.

Providing mental healthcare

From the perspective of both the patient and the healthcare system, there are numerous advantages to providing mental healthcare 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 healthcare facilities, by a healthcare 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. Primary care is also best placed to manage those problems, such as medically unexplained symptoms, that straddle the artificial interface between ‘mind’ and ‘body’. 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). From the perspective of the healthcare system, effective primary care is cost-effective (Starfield, 1991). Specialist mental healthcare 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 recognise and manage mental health
WHAT IS PRIMARY CARE 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 UK, for example, have been criticised for a perceived failure to diagnose mental illness (particularly depression) (Docherty, 1997) and their inability to provide good physical healthcare for people with severe and enduring mental illness. However, as described above, primary care is a complex environment – a ‘messy swamp’ of experiences and interpretations that rarely conform to textbook definitions (Schon, 1983). Many GPs have little formal training in mental health. One survey found that only a third of GPs had had mental health training in the previous 5 years, while 10% expressed concerns about their training or skills needs in mental health (Mental Health Aftercare Association, 1999).

The primary care team

Across the world, many GPs still work as single-handed practitioners. Fig. 1.1 shows a typical primary care team structure in the UK. 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 healthcare assistants, receptionists and other workers who visit the practice. They may include not only a range of specialised nurses (health visitors, community nurses, midwives) but also mental health professionals, such as community mental health (psychiatric) nurses, psychologists, graduate mental health workers (see below) and psychiatrists. The role of the extended practice team in providing mental healthcare 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 (Holden et al, 1989) or practice

![Fig. 1.1 Typical primary healthcare team structure in the UK.](attachment:image.png)
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 UK, counsellors have become increasingly common in primary care over the past two decades and more recently a new group of ‘graduate mental health workers’, usually graduate psychologists with a training in brief psychological interventions to diploma level, have come into post in some areas. 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 with new ‘primary care mental health teams’ at an intermediate level between primary and specialist care.

Organising care

The primary care organisation needs not only to provide primary mental healthcare 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 healthcare. 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 UK were beginning to work in group practices, Michael Shepherd (1966) suggested:

the 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, as indicated by Norman Sartorius in the next chapter, the key role of primary care in the provision of mental healthcare was not formally acknowledged in the Alma-Ata Declaration. Throughout 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 UK (Wright, 1995), the DART (Depression Awareness, Recognition and Treatment Programme) (Regier et al, 1988) in the USA, the Beyond Blue project in Australia (http://www.beyondblue.org.au) and the Nuremburg (now European) Alliance Against Depression in Germany (http://www.eaad.net/enu/general-population.php).

In addition to public education, the focus of many of these campaigns has been on educating primary care workers. In later chapters we critically discuss this and other approaches to quality improvement in primary care mental health, such as ‘quality improvement breakthrough collaboratives’ in the USA (Katzelnick et al, 2005) and the recent introduction of financial incentives in the UK (under the Quality and Outcomes Framework).

Mental health policy on the role of primary care has developed considerably over the past two decades, with increasing interest in the configuration and delivery of evidence-based mental healthcare in the post-institutional era (Department of Health, 1999). Primary care in the UK, for example, has specific responsibility for delivering standards 2 and 3 of the National Service Framework (NSF) for Mental Health and is also integrally involved in the delivery of the other five standards. The NHS Plan (Department of Health, 2000) further underpinned the NSF with over £300 million of investment to help implementation, included specific pledges to create 1000 new graduate mental health workers to work in primary care and encourage a shared care approach. Guidelines for improving the quality of mental health have also emphasised the role played by primary care (e.g. those produced by the National Institute for Health and Clinical Excellence in the UK). Specific references are provided in the appropriate chapters.

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). The ‘paths to psychiatric care’ were first described by Goldberg & Huxley (1980) (Table 1.1) 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 3, 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 institutionalised or under the care of mental health services. This process began in the USA and the UK 40 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 USA), 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).

Health policy in the UK has been particularly concerned, not just in mental health but across the field of healthcare, in shifting the care of many people
who would previously have received specialist care in the hospital setting into both primary care and, more recently, new 'intermediate care' services, at the interface between primary and specialist care (Department of Health, 2006). Despite the universal healthcare funding provided by the National Health Service (NHS), problems still 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 organisation or professional may be funded to provide only particular types of healthcare by insurers, as may be the case with behavioural health in the USA.

Table 1.1 Pathways to psychiatric care

<table>
<thead>
<tr>
<th>Levels and filters</th>
<th>Factors operating</th>
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<tr>
<td>Level 1: Psychiatric morbidity in the community</td>
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| First filter: decision to consult | Severity/type of problems  
Learned behaviour  
Stress  
Availability of services  
Money |
| Level 2: Total primary care morbidity | |
| Second filter: GP recognition | GP interviewing skills  
Personality  
Training  
Attitudes  
Presenting symptoms of the patient  
Demographics |
| Level 3: Conspicuous primary care morbidity | |
| Third filter: Referral | Confidence  
Attitudes  
Symptoms/attitudes of patient and family  
Services available |
| Level 4: Patients in formal mental health services | |
| Fourth filter: Decision to admit | Availability of beds  
Community services  
Symptoms/risk to self or others  
Attitudes of patient/family |
| Level 5: In-patient care | |

From Goldberg & Huxley (1980).
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 healthcare 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 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 exist that 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). 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 USA (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. http://www.improvingchroniccare.org),

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**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 & Wonca (2008).
is now generating a great deal of interest. Recent guidelines for the care of depression in the UK (see http://www.nice.org.uk/CG023) 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 over the past decade has focused both on patients’ experiences of mental health and illness and help-seeking behaviour and on their experiences of mental healthcare 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 et al, 2004) and Caucasian Scottish women in Edinburgh (Maxwell, 2005) with postnatal depression.

At this point we should consider terminology. Mental health policy in the UK 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 that is being described.

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 a range of mental health problems. We adopt an international perspective in our discussion of primary care mental health, recognising 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 healthcare 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 UK. Nevertheless, our guiding principle throughout is that ‘holistic care will never be achieved until mental health is integrated into primary care’ (WHO & Wonca, 2008).
WHAT IS PRIMARY CARE MENTAL HEALTH?

Key points

- Primary care mental health is a relatively recent concept in the history of healthcare.
- 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 healthcare across the world.
- However, integrating primary and specialist care effectively remains a challenge.

Further reading and e-resources


http://www.improvingchroniccare.org – introduces the ‘chronic care model’ for depression and a range of other common disorders in primary care.
http://www.mentalneurologicalprimarycare.org – UK version of the WHO guide to mental and neurological health in primary care, partly done as an online textbook resource for primary care mental health.
http://www.rethink.org – website of a leading UK mental health charity which focuses on severe mental illness.

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