Editorials

Reimagining mental health in primary care:

a blueprint for STPs

Recently a man called David told me his story. Desperately low, and at his wit's end having lived in a homeless hostel for 8 years, without family contact or a job, his GP put him in touch with the MIND Esteem Team — designed to help people with complex lives. A year later he has his own place and a new life as a peer support worker. He said it only took one person to help him find his way, but that one person needs the support of a system working well together.

Our understanding of primary care mental health is continually evolving. Shaped by changing societal and medical perceptions, we strive to bring equity, effectiveness, access, and efficiency to our care pathways amid the chaos of human distress. The tug between the biological and psychosocial, symbolised by the apparently polarising questions 'What is wrong?' and 'What has happened?' illustrates the dichotomy that lies at the heart of caring for humans in distress, and troubles a medical profession still wrestling with mind–body dualism.

The GP Five Year Forward View and the introduction of sustainable transformation plans, now partnerships (STPs), provide a clear opportunity for primary care to embark on a journey of reimagining mental health; making mental wellbeing everyone's business, in response to people's distress and illness, which are often undifferentiated and complex, not neatly fitting diagnostic categories, but representing responses to the challenges of everyday living and the impact of adverse childhood experiences, profoundly influencing future health and success in life. It also requires an integrated system-wide response in which primary care is at the forefront of access and engagement, and, thus, prevention, early intervention, and recovery.

However, at a time when the NHS and its primary care workforce are experiencing unprecedented pressures, with expectation and demand rising in tandem with an emerging crisis in the profession, mental health is a key and growing challenge for GPs and other primary care clinicians. If there truly is *'no health without mental health'*[1] then a progressive, evolving NHS will want to think hard about what that actually means for patients and staff across its many sectors. In reality, however, mental health and wellbeing often attract less genuine understanding and funding than other areas of health care. A Freedom of Information request has identified that 57% of clinical commissioning groups (CCGs) plan to reduce their spending on mental health in 2016/2017 compared with 2015/2016.[1] It is also notable that the STPs published in early 2017 largely focus on acute care, and where there is reference to mental health transformation it rarely considers the role of GPs and other primary care practitioners.[2]

> *"... [there is a need for us] to balance 'what has happened?' with 'what is wrong?'."*

Policymakers and system leaders grapple for solutions to such difficult realities, leading us to oversimplify or assign problems to the 'too hard' tray. Papers by Machin *et al*[3] and Kendrick *et al*[4] in this *BJGP* issue describe how important it is for patients and clinicians to be aware of often subtle, underlying psychological issues (for example, post-traumatic stress following injury), and how this care affects the outcome of interventions for long-term conditions or getting people back to work.

Improving Access to Psychological Therapies (IAPT) programmes have pivotally contributed to changing attitudes in the UK to the treatability and stigma surrounding mental health problems, spawning self-help, self-referral, psychoeducation, and access to evidence-based psychological therapies. These are changes that need to be celebrated. However, in addressing common mental health problems we need honesty, both about the contribution and the limitations of IAPT services, so that we are rightly wary of them becoming the *de facto* panacea for all distress.

In primary care most people present with undifferentiated distress, sometimes psychological and sometimes somatic; some will have depression or anxiety and therefore benefit from NICE-mandated therapies. Many, though, manifest the effects of early childhood experiences: the grinding realities of living in poor housing or unemployment; repeated losses; the pain of abuse, war, or torture; or absence of love and disordered interpersonal relationships. These can all present in ways that clinicians find hard to distil and care for, but they would benefit from help targeted to the cause. A recent survey illustrated the stress arising from GPs not being able to demonstrate compassion and care, which are the cornerstones of family medicine.[5] In this *BJGP* issue Murray describes how many of us GPs develop considerable resilience to keep working.[6]

Two-thirds of people who present with mental distress in the UK do not receive the care or treatment they need.[7] Half of people who are referred to IAPT never reach an assessment or are ineligible,[8] and half of people attending their first outpatient appointment in acute medical and surgical clinics will have a nonorganic cause for their symptoms.[9] Such people do not disappear just because we have not counted their cost.

Let us not underestimate the challenge. Bridge-building between every stratum of health and care from policy to practice is an indivisible prerequisite;[10] as are NHS targets and outcomes, which stimulate and sustain solutions. STPs must bring together various sectors of care provision with different priorities, competing for fragile funding and problematic data-sharing, inspiring co-production between people with lived experience, commissioners, and providers; so readily undermined by the unintended consequences of market forces and power. An NHS-wide focus on compassion in the workplace is needed, a vital ingredient of intelligent kindness, what Ballatt and Campling call 'kinship', to sustain resilience and care in an increasingly specialised healthcare system.[11] And, finally, while striving for evidence-based services, we must not allow interventions to become synonymous with care.

The reimagination of primary care mental health is pressing and we are working as a collaboration in the West Midlands to do just this, drawing on experience and evidence from innovative approaches. Our thinking is informed by real-life primary care — uniquely positioned to respond to a wide diversity of mental health presentations, long-term conditions, and entrenched social issues. Our premise is to begin and end with what people need: patients in distress and the people who provide help for them, recognising that effective mental health support and treatment requires well-coordinated collaboration between

primary care and a wide range of other services. These critical resources, assets, interdisciplinary skills, and often untapped potential include specialist mental health services, patients, their families and communities, the increasingly well-evidenced contribution of peer support, and a range of initiatives within the voluntary and charity sector. Within this context, we suggest there are four areas that primary care should work on to transform the front end of mental health care:

- focus on prevention, building resilience and addressing adverse childhood experiences;[12]
- get triaging right by linking biopsychosocial solutions for common mental health presentations;
- collaborate with public health to develop the data, skills, and research based around primary care to describe and manage the spectrum of distress to mental illness, including crisis and complex presentations (these challenges are described with reference to perinatal disorders by Ford *et al* in this issue of the *BJGP*); and[13]
- address the gaps between physical health and mental health (life expectancy, long-term conditions, and medically unexplained symptoms).[14,15]

Examples of good practice abound. Although often short lived, they sometimes exist across regions and systems of care. Piecing them together into equitable cohesive and sustainable plans linked to actual need is the challenge. In Lancashire there is exemplary work on adverse childhood experiences, aiming to minimise the impact of adversity. In Northamptonshire Action for Happiness personalised health plans are being extended across the county. Social prescribing is gaining momentum nationally with over 100 schemes. Sandwell and Edgbaston Wellbeing Hubs combine triage, psychosocial resources, listening, and guidance,[16] with Esteem Teams for complex problems.[17] PRISM in Cambridge uses peer support to enable step-down for stable patients. Bradford and Cambridgeshire have co-created highly effective interdisciplinary crisis services. Various liaison teams are developing multidisciplinary work linking psychological and physical care for long-term conditions. In City and Hackney, a primary care psychotherapy service has been set up to manage complexity and psychological trauma.[18] Mental health problems account for so much of the burden of life in the world and represent major challenges for GPs. As STPs develop nationally, we need to use this window of opportunity for genuine reflection, ensuring that we collectively provide more nuanced ways of factoring primary care in, rather than ignoring it or assuming that the task of supporting people with mental health problems can be shifted to primary care without support. GPs sit in a vital place between the medical and the nonmedical, the physical and the emotional, psychological, spiritual, and social, trying to balance 'what has happened?' with 'what is wrong?'. We need the support of a collaborating system to make good decisions with and for our patients.

David said this: '*We are the forgotten people, whom society acknowledges and chooses to ignore.*' People like him have a lot to tell us if only we can listen.

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Provenance

Commissioned; not externally peer reviewed.

DOI: https://doi.org/10.3399/bjgp17X691769

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