Harnessing primary care to enhance recovery from severe mental illness

Governments across the English-speaking world have stated that mental health services for people with severe mental illness (SMI) must focus on the redefined notion of recovery.[1] In what has become the seminal definition, Anthony states that:

'Recovery … is a way of living a satisfying, hopeful, and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability.'[2]

This emphasis on recovery derives from evidence that SMI is not necessarily a lifelong, chronic, and disabling condition. On the contrary, people with SMI can make an excellent recovery.[1,3]

Numerous national mental health strategies, including those of England, Canada, and Australia, recommend that GPs and primary health care could and should play a greater role in enhancing recovery. The mental health strategy for England has 'an ambitious aim to mainstream mental health in England', stating that local GP consortia should provide and/or commission high-quality mental health care, as well as taking action to reduce the multiple physical comorbidities frequently afflicting those with SMI.[4] Likewise, the Canadian national strategy states that a priority must be to 'expand the role of primary care in meeting mental health needs'. More specifically it states that action should be taken to 'integrate recovery approaches into primary care'.[5]

Drake and Whitley recently argued that a shift in continuing care from tertiary and secondary care to primary care for people with SMI would be entirely consistent with the philosophical and ethical underpinnings of the recovery paradigm.[6] They contend that recovery by definition involves living an everyday normative life in the community. Hence, separation into specific mental hospitals and ghettoised services is inconsistent with recovery, as it perpetuates segregation and perceived 'difference'. A shift in service delivery towards primary care could thus reduce the social exclusion and stigma frequently felt by people with SMI. Indeed, this is noted in the mental health strategy for England, which acknowledges the 'institutionalised discrimination inherent in many organisations, including support services'.[4]

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PATIENT PREFERENCES

Research does indeed suggest that people with SMI frequently report a preference for primary care as a favoured form of service delivery.[7] Reasons given for such a preference include the capacity of primary care to deal simultaneously with mental and physical health issues. This is particularly important given that people with SMI suffer multiple physical health problems and a decreased life expectancy.[1,4] Other positive factors associated with primary care include the continuity of care and person-centred approaches inherent in primary care settings. Patients favourably report the familiarity present in treatment discussions, as well as the lack of necessity to retell painful stories.[7] This is especially important given the high rates of staff turnover in secondary and tertiary psychiatric care.[8] Finally, primary care has less documented association with stigma. In contrast, secondary and tertiary institutions are a source of fear and avoidance for patients and community members alike, contributing to high drop-out rates.[9]

While it is clear that general practice is a desirable arena for the delivery of recovery-oriented mental health care, there is a lack of empirical knowledge regarding the penetration of the recovery paradigm into general practice. This is an egregious knowledge gap given the potential for primary care to enhance recovery. That said, some knowledge can be extrapolated from other literature, particularly on patient-centred and holistic care, both of which are fundamental to the modern delivery of general practice.

PERSON-CENTRED CARE

In fact, there is considerable overlap between the philosophical and ethical underpinnings of progressive primary care and the recovery paradigm. Much of what is currently perceived as desirable standard procedure in general practice overlaps significantly with recommended recovery practice.

According to a seminal study on the topic, recommended primary care practice is premised on person-centred care which has three main elements:

1. effective communication between patient and physician, including understanding the patient's story and context of illness and healing;
2. partnerships and shared decision making regarding treatments; and
3. a peripheral vision that looks beyond specific conditions towards health promotion and healthy lifestyles.[10]

These elements align with much of the literature describing the underlying principles of recovery. They overlap considerably with the principles of recovery-oriented care put forward in the Australian National Mental Health Plan, namely:

- recognition of the uniqueness of individuals;

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> "Primary care staff must be trained to ensure that they adopt a positive, strengths-based, hopeful stance when dealing with patients with SMI."

- offering real choices;
- fostering appropriate attitudes and rights;
- treatment of people with dignity and respect;
- partnership to ensure effective communication for engagement; and
- evaluation of services and outcomes.[11]

Such natural affinity between patient-centred primary care and the recovery paradigm could be better harnessed to advance the care of people with SMI. This can be advanced through further changes in domains such as training, funding, and competencies. Specifically, we outline below three proposals essential to building a lasting recovery orientation in primary care. These proposals are based on knowledge derived from studies in the psychiatric and general practice literature, and their degree of consistency with the recovery paradigm.

REDISTRIBUTION OF RESOURCES

Firstly, we call for a redistribution of funding and the restructuring of wider health systems. It has been noted that approximately 50% of mental healthcare funding goes towards tertiary hospital care.[12] Such a financial emphasis is inconsistent with the recovery paradigm, which emphasises community integration and the beneficial nature of normative life activities, for example, employment. If the recovery paradigm is to become a reality, we argue that some resources currently devoted to tertiary care should be reallocated to primary and secondary care. This implies expansion and wider investment in holistically-oriented community health care with a wide range of intervention options available, including psychosocial rehabilitation programmes such as supported employment.

EDUCATION AND TRAINING

Second, such a course of action would require further education and training of existing primary care staff, and a new generation of family physicians and nurse practitioners well-versed in the recovery paradigm. This could be done through incorporating the recovery paradigm into the medical curriculum, continuing medical education and targeted workshops to translate and implement the current conceptualisations of recovery. Primary care staff must be trained to ensure that they adopt a positive, strengths-based and hopeful stance when dealing with patients with SMI. Statements such as 'schizophrenia is a chronic disease', or, 'you will need to be on medications all your life' are not consistent with the evidence or a recovery orientation.

SHARED DECISION MAKING

Finally, there is a need for the continuance and consolidation of shared decision making in primary care for people with SMI. Shared decision making refers to a process whereby clinicians and patients openly discuss the variety of intervention options and associated risks and benefits to arrive at mutually-satisfying decisions. This can empower patients to play an active role in their own care, resulting in a strong therapeutic alliance that can enhance adherence and diminish drop-out. This would be building on solid ground, as much evidence suggests that many primary care clinicians currently encourage such choice and autonomy.[10] The concept of autonomy is considered essential to notions of recovery, and has historically been denied to people with SMI due to paternalism and stereotypes over patient competency.

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REFERENCES

1. Slade M . *Personal recovery and mental illness.* Cambridge: Cambridge University Press, 2009.
2. Anthony WA. Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosoc Rehabil J* 1993; **16(4):** 11.
3. Harding CM, Zubin J, Strauss JS. Chronicity in schizophrenia: revisited. *Br J Psychiatry Suppl* 1992; **18:** 27–37.
4. Department of Health. *No health without mental health: a cross-government mental health outcome strategy for England.* London: HM Government, 2011.
5. Mental Health Commission of Canada. *Changing directions changing lives: the mental health strategy for Canada.* Calgary: Mental Health Commission of Canada, 2012.
6. Drake RE, Whitley R. Recovery and severe mental illness: description and analysis. *Can J Psychiatry* 2014; **59(5):** 236–242.
7. Lester H, Tritter JQ, Sorohan H. Patients and health professionals views on primary care for people with serious mental illness: focus group study. *BMJ* 2005; **330(7500):** 1122–1122.
8. Woltmann EM, Whitley R, McHugo GJ, *et al.* The role of staff turnover in the implementation of evidence-based practices in mental health care. *Psychiatr Serv* 2008; **59(7):** 732–737.
9. Thornicroft G. *Shunned: discrimination against people with mental illness.* New York, NY: Oxford University Press, 2006.
10. Bauman AE, Fardy HJ, Harris PG. Getting it right: why bother with patient-centred care? *Med J Aust* 2003; **179:** 253–256.
11. Department of Health. *Fourth national mental health plan: an agenda for collaborative government action in mental health 2009–2014.* Canberra: Australia, 2009.
12. Alonso J, Chatterji S, Yanling H. *The burdens of mental disorders: Global perspectives from the WHO World Mental Health Surveys.* New York, NY: Cambridge University Press, 2013.