Analysis

Mental health in context:

structural vulnerability and support in primary care

INTRODUCTION

In 2018, the British Medical Association drew attention to the increasing concern of GPs about the scale of mental health problems in the UK in light of insufficient resources.[1] Due to the influence of social factors on mental health, the document highlights the importance of coordinating a public mental health response to address social determinants such as poverty, unemployment, housing, social environments, and relationships, and the symbiosis between physical and mental health.[1] Three years on, the above issues have been compounded by the COVID-19 pandemic and its socioeconomic consequences, including poverty, isolation, and the political alienation of entire communities. These are known risk factors for the development of mental health problems.[2]

At present, structural factors rarely feature in assessment and treatment of mental health problems in the NHS. Instead, psychotropic prescriptions — and the risks associated with their use — increase year on year. Data from England indicate a 6.8% yearly increase in psychotropic prescriptions, with antidepressants increasing by 10% annually,[3] and the number of antidepressant prescriptions has almost doubled over the past decade from 36 million in 2008 to 70.9 million in 2018.[4] So why is this? The reasons are multifactorial but, we argue, chief among these is the ongoing conceptualisation of mental health within a biomedical model.

FROM BIOMEDICAL TO BIOPSYCHOSOCIAL

New insights on the physiological basis of distress, and its impact on the brain and nervous system, are changing clinical practice. Brain structures such as the amygdala and the limbic system are key in our experience of emotion, memory, and autonomic function.[5] The clinical application of this understanding is most apparent in the treatment of anxiety and selective memory resulting from traumatic experiences. Autonomic responses (for example, increased heart rate, dizziness, difficulty breathing), cognitive appraisal (for example, negative automatic thoughts, flashbacks), and ensuing emotions (for example, anxiety, fear, worry) are highly distressing. The resulting apprehension of a situation in which distress is triggered influences the development of coping strategies and behaviours, and is amenable to psycho-education with patients.[5] Individually focused explanations of distress have favoured physiological and psychological understandings of mental health, but we contend that a truly biopsychosocial approach requires greater attention to the social and structural aspects of distress too.[6]

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CONCEPTUALISATION OF MENTAL HEALTH AND ILLNESS

Mental health diagnoses can be useful to some patients to make sense of their difficult experiences and, in the current system, can help patients access treatments and welfare support, and facilitate communication between different services. In recent years, however, there has been growing criticism of the biomedical (diagnosis-based) model of mental health.[2] This model, rooted in the Western psychiatric tradition, removes the context in which mental distress often emerges, and conceptualises mental health within a 'What's wrong with you?' approach. Based on the tenets of positivism, this approach separates mind from body, emotions from behaviours, individuals from their social context, and favours addressing chemical rather than social imbalances.

In more recent years, a pioneering group of researchers and clinicians launched the Power Threat Meaning Framework (PTMF) (Box 1).[7] This encapsulates ideas and principles that clearly depart from the biomedical, diagnosis-based model of mental health, in an attempt to reframe mental health towards a 'What has happened to you?' narrative. In brief, the PTMF highlights how emotional and behavioural difficulties are underpinned by various threats that the negative use of Power poses to individuals and communities, and how, in turn, these individuals and communities have learned to respond to Threat. In addition, the PTMF considers the Meaning(s) derived from these experiences and how wider sociocultural contexts increase feelings of shame, guilt, marginalisation, and fear.

THE ROLE OF STRUCTURAL VULNERABILITY

Structural vulnerability is the violence of injustice and inequity, embedded in ubiquitous social structures and normalised by stable institutions and regular experience.[8] Structures in this context refer

Box 1. The Power Threat Meaning Framework (PTMF)

Power	The operation of POWER within biological/embodied, coercive, legal, economic/material, ideological, social/cultural, and interpersonal environments. *What has happened to you? (How has POWER operated in your life?) What are your strengths? (What access to POWER resources do you have?)*
Threat	The THREAT that the negative use of power may pose to an individual, a group, and/or a community, with particular reference to emotional distress and how this is mediated by physiology (for example, autonomic response). *How did it affect you? (What kind of THREATS does this pose?) What did you have to do to cope/survive? (What kinds of THREAT RESPONSE are you using?)*
Meaning	The central role of MEANING in shaping our understanding, experience, and expression of power and threat, and how we respond to threat (within broader social and cultural discourses). *What sense did you make of it? (What is the MEANING of these situations and experiences to you?) What is your story?*

Source: adapted from Johnstone and Boyle.[7]

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to social relations, including economic and political factors, which contribute to shaping how individuals and groups interact with a social system. In turn, these structures create vulnerabilities by further marginalising people and communities, constraining their capability and agency, and sustaining inequalities. Therefore, experiencing structural vulnerability and the pain it produces can be called social suffering. Furthermore, social suffering captures the lived experience embedded in feelings of distress and injustice, while exposing the indiscernible interrelation of personal and societal problems.[6]

CURRENT CLINICAL PRACTICE EXPERIENCE

In the Global North, the structural vulnerability framework is particularly applicable to individuals who live in the most socioeconomically deprived suburban areas, where distress is most prevalent.[9] As practitioners in Deep End practices, the patients we work with often describe complex psychosocial issues. These include intergenerational trauma, poverty, substandard housing, substance use, and, at times, abusive relationships that have been present throughout the person's life. This can have a substantial and dangerous impact on patients' ability to take up offers of, and engage with, health service care.[10] The complexities and potential barriers related to accessing care for these populations include issues around continuity of care, the role of communities in mediating access, and, more broadly, the role of stigma.[11]

Under these circumstances, providing compassion and understanding, and attending to a person's distress, can be substantiated by employing a structural approach that takes into account social issues such as poverty, socioeconomic deprivation, and disempowerment. This explanation can, on the one hand, attend to the person's distress as it is being experienced at an intrapersonal level and, on the other, encourage the understanding that feeling distress is a natural human response to difficult social circumstances rather than wrongly diagnosing this as a 'disorder'.[2] In our experience, the importance of developing a strong therapeutic relationship based on common trust, non-judgement, congruence, and an exploration of power dynamics present in people's lives, the threat these pose, and the meanings that people ascribe to their experiences, are often far more important and therapeutic than the diagnostic tools used to categorise symptoms. This is evidenced by a need to contextualise complex behaviours as potentially functional responses to trauma and thus, through a trauma-informed approach, building trust and a sense of safety in the context of a therapeutic relationship.[12]

Moreover, psychological services sensitive to patients' often complex needs are required to meet the need for psychological and emotional support in primary care. Although evidence-based psychological treatments such as cognitive behavioural therapy (CBT) are effective in treating distress, a broader biopsychosocial approach, in line with the 'What has happened to you?' narrative embodied by the PTMF, can increase the potential of psychological therapy, within formulation.

THE ROLE OF FORMULATION

Formulations are individually tailored, co-produced hypotheses, resulting from a strong therapeutic alliance and attempting to explain why a person is experiencing distress.[13] Formulation aims to provide an understanding of a person's distress in the context of past experiences, present difficulties, and current coping strategies to derive a biopsychosocial intervention that addresses the person's needs within a broader context. In addition, formulation takes into account the presenting problem as it manifests in the here and now, in light of *precipitating* factors (for example, triggers); *predisposing* factors (for example, family history, socialisation); *perpetuating* factors (for example, social environment); and *protective* factors. Taken together, these represent the basis on which a tailored intervention can be collaboratively derived. In brief, formulation frames a problem and devises an intervention based on what the individual describes, rather than relying on a psychiatric diagnosis.[14] Based on biopsychosocial principles, formulations offer a unique opportunity to incorporate broader structural issues and how these influence individuals' wellbeing. Structural vulnerability provides a theoretical framework within which structural issues can be included in an individual's formulation.

BRINGING IT TOGETHER

While we recognise the benefits of increasing evidence-based collaborative approaches within primary mental health care,[15] potential issues embedded in scaling up services include: self-referral and long waiting times,[16] sociocultural issues related to talking about distressing emotions with a stranger; logistical issues, and, for those on precarious or zero-hours contracts, taking time from work to attend weekly therapy.[11] These barriers are most prevalent in socioeconomically deprived communities. In contextualising this, we argue that the longer-term goal of services to support positive mental health needs to take into account not only the individual's experience of distress but also the broader structural factors that *precipitate* and *perpetuate* these experiences. It is no longer sufficient to advocate for increased funding in mental health services. We join others in making a case for imagining and applying a paradigm shift in the ways mental health is understood and treated.

WHAT COULD THE FUTURE LOOK LIKE?

A PTM and structural vulnerability framing of a positive future for service provision is one in which experts by experience are included in all aspects of design and delivery of services. In advance of that, and drawing on what we know from research,[17] clinical intelligence, and pragmatic knowledge of other care settings, here is our view of what that should look like:

- *Access*: when patients express a request for support, they get it; there is 'no wrong door' into support for positive mental health.[12]
- *Patient focused*: services are designed and adapted to best meet patients' needs. So, if 'one to one' care or online learning modules are needed, or the focus is on purposeful activity, then that is what is on offer. Vitally, this is with a focus on collaborative solutions, without patients needing to repeatedly tell their story. This can be achieved by improving the interface between GPs and available mental health services. In so doing, increasing supervision and staff training lowers the risk of vicarious trauma and

burnout, which increases staff's ability to provide high-quality, patient-focused care.[18]

- *Exit*: Patients retain active mental wellbeing input until they feel it is time to stop and that departure is a positive sign of recovery, not rejection.
- *'Stickability'*: Services consider low engagement as a risk marker for more intensive or a co-produced reassessment of patients' care needs, though acknowledging that issues such as trauma and distress affect the neurological, biological, psychological, and social aspect of a person's life.[15]
- *Community embedded*: Services that do specific mental health recovery work do so much more collaboratively with primary care. Indeed, co-location of clinicians or services may be appropriate in community settings, in order to enable joint, collaborative, and community-focused approaches, which increase engagement with treatment.[19]
- *Therapeutic recovery focused*: Evidence indicates that adopting trauma-informed practice aids recovery from mental health by increasing hope, empowerment, and avoiding re-traumatisation.[19] Augmenting this with PTM and structural vulnerability frameworks means that solution-focused mental health care is about a range of concerns — depending on the patient's priorities and formulation. This means that patients will have input from different professionals depending on expertise, and this will change over time. This may be a mental health link worker for support with housing or benefits; a trauma-focused clinician if dealing with the practical and historical issues from childhood sexual abuse; or a CBT expert if, for example, struggling with feeling distressed and/or unable to sleep. Patients would have a coordinating care manager who supports them in reviewing their planned care and the intensity of support required.

Primary care teams would continue to support mental health services to ensure that physical health is attended to; and the expertise of mental health recovery professionals would be shared with primary care teams to ensure that they are psychologically informed and supported professionally to enact good self-care.

CONCLUSION

The COVID-19 pandemic has shone a light on the cracks in our society like never before in our lifetime. As the socioeconomic consequences begin to bite, inequalities are likely to widen, and mental distress will increase, particularly among those most marginalised in society. Now more than ever, we need mental health services that are accessible, timely, responsive to patients' needs, and well integrated with other health and social care services and community resources. We have seen in the past year how resources can be mobilised in unprecedented ways that were previously unimaginable. Now is the time to imagine a better, fairer response to mental distress — one that hopefully we can all get behind.

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