What would an ideal mental health service for primary care look like?

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Abstract

Key messages

- In order to commission an ideal mental health service for primary care, GP commissioners should challenge accepted distinctions and divisions.
- These include the division between mental health clinics and the GP surgery, and between short GP consultations and extended mental health ones.
- They also include the division between mental and physical illness, between severe and enduring mental illness and other difficulties, and between the individual and the family.
- GPs should also call into question the divisions between the mental, social and economic domains, between all the different mental health disciplines and ideologies, and between neighbouring localities or boroughs.
- Finally, they should challenge the distinctions between offering a diagnosis and treatment, and having a therapeutic conversation; and between the patient's voice and the doctor's decision-making.

Why this matters to me

As a GP who is also a part-time consultant in a mental health trust, I have spent the last 15 years trying to promote innovative thinking and ways of working at the interface between primary and secondary care. In spite of all the obvious risks and constraints that will accompany GP commissioning consortia, I believe they may offer an opportunity to challenge some or all of the false divisions and distinctions that currently bedevil mental health services and often lead to fragmented, inflexible, inappropriate or poor care for patients. Mounting such challenges could lead to mental health services that were more attuned to the realities of primary care and served patients far better.

Keywords: mental health services, primary health care

Abstract

The creation of GP commissioning consortia offers potential opportunities for GPs to challenge a number of divisions and distinctions that are currently taken for granted in mental health services, but may be neither necessary nor logical. I examine a range of these and suggest what GPs and patients might reasonably expect if we challenged them in order to imagine and commission an ideal mental health service for primary care. Among its features, an ideal service would cross the boundaries of mental and physical care, individual and family care, and the mental, social and economic domains. It would also transcend mental health ideologies, geographical borders and the artificial distinction between making a diagnosis, offering treatment and holding a therapeutic conversation.

What would an ideal mental health service for primary care look like?

More than a generation ago, the historian Frank Honigsbaum published a critical study of the way that primary and secondary care had gone their separate ways in the UK.[1] He argued that the division between the two had occurred for largely political reasons, was more rigid than in many other countries, and had mainly negative effects. Radical at the time, Honigsbaum's view has now moved into the mainstream and underpins government policy for health service commissioning.[2] However, the division that Honigsbaum described is only one among many that are still an accepted feature of the NHS landscape. In this article, I want to look at mental health services, examining a variety of divisions or distinctions that we currently accept as normal, but are neither logical nor necessary. I want to suggest what we could reasonably expect as GPs if we challenged them before making decisions as commissioners. In other words, what would an ideal mental health service for primary care look like?

The division between mental health clinics and the GP surgery

From a GP's point of view, one of the successes in mental health provision in recent years has been the relocation of many professionals into primary care. The growth of counselling in primary care[3] and the Improved Access to Psychological Therapies (IAPT) initiative[4] are examples of this. Yet although the vast majority of mental health consultations in the UK take place with GPs, these initiatives only represent a small proportion of mental health services and they generally work on a traditional outpatient model, with little communication between the practitioners and the GPs themselves. An ideal mental health service would relocate far more mental health professionals to primary care. It would recognise GPs and their teams as key mental health professionals, with others there to offer support to this role. It would encourage GPs and psychologists to see patients together,[5] offer each other supervision,[6] or regularly learn from each others' experiences and erspectives.[7]

The division between short GP consultations and extended mental health ones

The shift of primary care from a whole-person perspective to a more biomedical one has led to the relative demise of the consultations that GPs sometimes used to offer their own patients for complex problems involving psychosocial issues.[8] Equally, it has placed constraints on regular consultations that GPs can offer to unpack the causes of someone's distress, normalise their emotional suffering, negotiate a set of plans to address this, or prepare them for a referral where the goals and expectations are already established.[9] An ideal mental health service would free up GPs to make these interventions a matter of routine if they wish to do so. It would also carry out much-needed research to confirm that such interventions are more effective than conventional outpatient care, can prevent unnecessary investigation and referral to both medical and mental health services, and reduce attendance rates.

The division between mental and physical illness

Recent years have seen the welcome development of services for patients with so-called 'medically unexplained symptoms'[10] or for those with conditions like chronic fatigue syndrome and chronic musculoskeletal pain. Yet the emphasis on these categories of illness has had its down side too. It has reified certain kinds of experience that might be better seen as personal narratives rather than in doctor-centred terms.[11] More significantly, there are few services targeted at people who are suffering psychologically on account of chronic disease and disability, life-threatening illness or the trauma of sudden physical decline, including strokes. A true breakdown of boundaries between primary and secondary care would help mental health professionals encounter the whole range of life challenges that GPs see. An ideal mental health service would attend to people with physical illness and reject the Cartesian view that is currently implicit in the notion of a mental health service.

The division between severe and enduring mental illness and other difficulties

Political imperatives, often in response to high-profile murders, have led to a flow of resources towards mental health services for people who have a diagnosis of severe and enduring mental illness. Most GPs will welcome some of the results of this, including assertive community outreach and early intervention services. But this way of categorising patients has had its costs too. Inevitably, 'descriptions change what is being described'.[12] People who are described as having severe and enduring illnesses may regard themselves as being helplessly and permanently so, in spite of all that can be done for depressive and psychotic states through non-pharmacological means.[13] Conversely, GPs see many patients who elude formal diagnosis and may in fact have major psychological needs. There may not be DSM-IV[14] labels for people struggling with complex social and family problems, existential crises, longterm loss of confidence, permanent lack of direction or intractable self-absorption, however, they place great demands on primary care, and their levels of subjective distress may be no less than those who harm themselves or have hallucinations. An ideal mental health service would recognise the scale of difficulties experienced by people without a severe and enduring diagnosis and would make adequate provision for them.

The division between the individual and the family

General practice has progressively lost some of its identity as family medicine, and some would argue that this trend may be no bad thing.[15] Yet some GPs in London will still look after three or four generations of the same family. Even where patterns of residence and GP employment are shifting, the family dimension is ever-present. A significant proportion of GP consultations have more than one family member in the room. Nearly every patient's narrative in the surgery includes a mention of family members who are concerned about the patient's problems or affected by them. GPs see daily evidence of how physical and mental health is related to early childhood experience, and the quality of family relationships. In spite of this, most mental health services in London are oriented towards individuals only, with exclusions not only about seeing family members together, but also according to age. This is true even where there is good evidence that relationship-based treatment including family or couple therapy can be beneficial.[16] Conversely, GPs with the skill and enthusiasm to apply family- and couple-based approaches in the surgery, or to work with children and

parents, may lack the time, resources and training to do so.[17] An ideal mental health service would acknowledge the relational aspect of people's lives and redress the imbalance between individual work and family work.

The division between the mental, social and economic domains

The current president of the Royal College of General Practitioners has been a valiant advocate for treating the social and economic determinants of illness as well as the biomedical ones.[18] Whether or not all GPs are aware of the worsening health inequalities in the UK,[19] or the evidence showing how a nation's health is correlated with income inequality,[20] they will certainly know from the patients in front of them that it is illusory to attempt to treat illness without a parallel strategy to address their social and economic predicaments. An ideal mental health service would have assured communication and shared case management with local authority and welfare agencies.

The division between all the different mental health disciplines and ideologies

Many GPs are bewildered by the variety of different professions in the mental health world, their varying and sometimes contradictory ideologies and techniques, and the rules and restrictions they establish concerning so-called ‘appropriate referrals’. I have described these elsewhere as creating a virtual asylum that reproduces some of the illogicalities and cruelties of the physical asylums.[21] The creation of multidisciplinary community mental health teams, welcome in principle, has often put up an impersonal barrier against GPs who want to build trusting professional relationships with local mental health colleagues or to play a part in treatment decisions on behalf of patients.[22] An ideal mental health service would equip its practitioners to be generalists, able to move flexibly between different roles and settings, and to work through collegial conversations rather than by merely filling in forms. It would encourage them to respect alternative approaches and work alongside diverse discourses, even when these were foreign to their own original training.

The division between neighbouring localities or boroughs

In the last 30 years, government policy in relation to most specialties has swung between allowing them to set catchment areas in order to manage their resources, and then offering patients and referrers a choice of services in the name of competition. Never-theless psychiatry (along with care of the elderly) has been allowed to operate restrictive geographical practices with no right of appeal, and not even a temporary relaxation of the rules. It is hard to know how to interpret this, except to see it as an additional sign of how mental health is still seen as a Cinderella service, available on the same principle as the Poor Law, a privilege rather than a right. If GP commissioners want to promote a choice of services for every patient, there can be no excuse for excluding mental health from this approach. An ideal mental health service would be open to any patient who wishes to be referred there.

The division between offering a diagnosis and treatment, and having a therapeutic conversation

More than any other medical specialty, GPs are familiar with concepts such as the doctor as treatment,[23] listening as work,[24] relationship-centred care[25] and conversations inviting change.[26] With more training in consultation skills than any of their colleagues, they are aware that every utterance or gesture in a consultation is an intervention that can have positive or negative sychological effects. This includes the balance between medical and biographical inquiry, the balance between problem-oriented talk and an exploration of resilience, the decision whether or not to offer a diagnosis, and of which treatments to offer and how. We should share more of our experience of helping patients and their families use their own resources to solve their own difficulties for most of the time without any further professional help. We should point out that insensitive mental healthcare can make people worse, while quick, focused and reflective care can change lives. We should listen when mental health professionals tell us about poor care by GPs. An ideal mental health service would allow such conversations to happen freely and honestly between professionals as well as with our patients.

The division between the patient's voice and the doctor's decision-making

GPs now inhabit a world where it is routine for patients to know more about their conditions and treatment than anyone else. We are learning how to follow-up leads that patients have offered us in order to advance our own knowledge and assist them with their decisions. There is no reason why most patients suffering from mental health problems should be regarded as less competent than any other patients to make an informed choice of treatment, or nontreatment. An ideal mental health service would work from this premise, and would take heed of patients who tell us clearly, for example, that they prefer talking treatments for depression to pharmacological ones.[27]

Conclusion

The psychiatrist Michael Balint once proposed that psychological services should not be based in specialist clinics alone. He described how GPs could carry out psychological work that was inadmissible for others, and argued in favour of a coherent service that would unite GP training, primary care consultations, supervision and case consultancy, as well as referral to secondary centres. This view was vigorously supported by John Sutherland, who was medical director of the Tavistock Clinic where Balint worked.[28] It would be gratifying if their vision for a unified field of mental healthcare could finally be brought about through GP commissioning.

In spite of the industrial drive towards meeting targets and measuring outcomes,[29] general practice has also held on to a tradition of thinking – and insisting – that medical care should remain an interpretive, sense-making activity, not a merely technical one.[30,31] If we have anything to bring to the table in mental healthcare, it is an understanding of our relationships with patients in primary care as ‘ultra-brief, ultra-long therapy’.[32] GP commissioners should have the courage of their convictions, and trust their own experience of providing more

mental healthcare than any other profession in the UK. They should invite service proposals that are consistent with the realities of primary care, reject some of the arbitrary distinctions that have often been taken for granted, and aspire to provide responsive, flexible and imaginative mental health services instead. That truly would be ‘Liberating the NHS’.

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ETHICAL APPROVAL

Not sought as this is an opinion piece, with no research carried out on human or animal subjects.

CONFLICTS OF INTEREST

John Launer has been employed since 1995 by the Tavistock and Portman NHS Foundation Trust to promote service and training initiatives at the interface between primary and secondary mental health care.