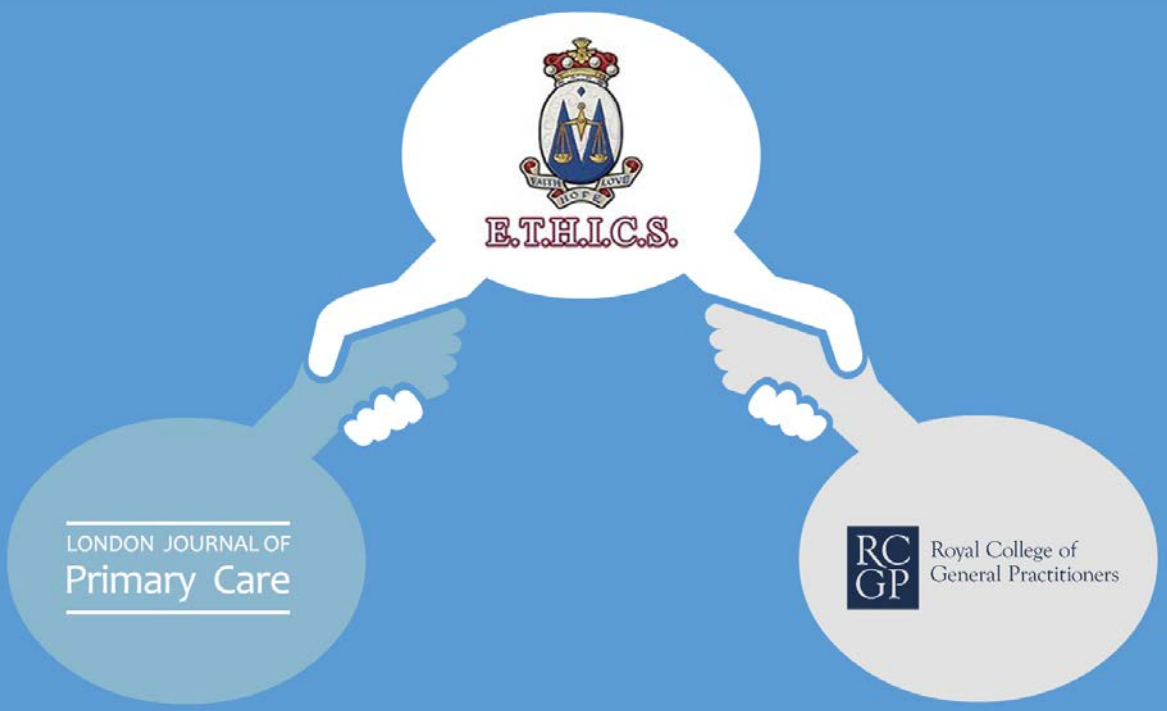
Cultivating Mental Health Promotion and Prevention in General Practice

A collaborative report from

Educational Trust for Health Improvement through Cognitive Strategies

London Journal of Primary Care

Royal College of General Practitioners



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I. The ETHICS/LJPC/RCGP Think Tank

These proposals arise from an expert Think Tank, convened by ETHICS in collaboration with the London Journal of Primary Care and Royal College of General Practitioners. The Think Tank included professionals from primary care, public health, psychiatry, community development, clinical practice and commissioning. There was expertise in qualitative and quantitative research, epidemiology, guideline development, education and training, inter-sectoral collaboration, situation appraisal and policy development.

The detailed recommendations made by the Think Tank for each level of the service (community, GP, practice, cluster of practices, CCG and HWB) and each stage of the life course (preconception to end of life) and the background briefing supporting them can be found on the ETHICS website (www.ethicsfoundation.org).

The members of the think tank include:

Rachel Jenkins	MA, MB, BChir, MD (Cantab), FRCPsych., FFOHM (Hon), MPH (with Distinction). Distinguished Fellow, APA. Chair of ETHICS Board of Trustees, Professor Emeritus of Epidemiology and Mental Health Policy, Kings College, London, Convener and Chair of ETHICS /LJPC/RCGP Collaborative Think Tank.
Paul Thomas	MB ChB, DCH, FRCGP, MD, DSC (Hon). RCGP Commendation for Outstanding Contribution to Primary Care and General Practice, 2012. Editor of *London Journal of Primary Care*, and Co-convener of Think Tank.
Nigel Mathers	MB, Ch.B, BSc, MD, PhD, F. RCGP. Secretary of the Royal College of General Practitioners.
Brian Fisher	MB, BChir, MSc, MBE, GP. Co-director of PAERS Ltd and Lead for Health Empowerment Leverage Project.
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Robert White	BSc, MSc. Occupational Therapist, Ealing Primary Care Mental Health Service Lead Practitioner, West London Mental Health Trust.
Steve Thomas	MB, ChB, MRCGP, MMedSci, Cert.Med.Ed. GP and Clinical Director, Mental Health/ Learning Disabilities/Dementia Portfolio, NHS Sheffield Clinical Commissioning Group.
Catherine Millington-Sanders	MB, BS, MRCGP. Kingston CCG Macmillan GP and RCGP/Marie Curie National Clinical End of Life Care Champion.
Tony Burch	MB, BS, FRCGP, GP and Trainer.
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Laura Calamos Nasir	PhD. Nurse Practitioner**.**
Kurt Stange	MD, PhD. Professor of Family Medicine and Community Health, Epidemiology and Biostatistics, Oncology and Sociology, Case Western Reserve University, Cleveland, Ohio, USA.
Lady Marina Marks	PhD. Founder President of ETHICS.

II. Interacting Mental Health Promotion and Prevention into General Practice

Welcome to our report!
Our report aims to encourage the integration of mental health promotion and prevention into general practice to reduce the burden of mental and physical disorders and the ensuing pressure on general practice. The rationale for this is that mental health promotion and prevention are too important to wait.

There is strong evidence for the value of mental health promotion and prevention to improve human, social and economic capital. The case for systematic attention to the implementation of mental health promotion and prevention is made by the magnitude of the global burden of mental disorder and the importance of its prevention; the current evolution of the role of clinical commissioning groups; the timely focus in the NHS's Five Year Forward View (2015-2020) policy on improving health and wellbeing, health promotion and prevention, and on developing a closer relationship between primary care and the community. We therefore propose 12 overarching messages to enable and support this process.
The core principles underpinning both this brief report and the wider think tank report on which it is based include the WHO definitions of health and mental health, the public health framework for health promotion and prevention, the need for parity (equality of time, energy, resources and commissioning expertise) between mental and physical health, and the value of a biopsychosocial approach to health.

The twelve messages to achieve improved mental health for all and to save lives:

1. Mental health promotion and prevention are too important to wait
2. Work with your community to map risk factors, resources and assets
3. Good health care, medicine and best practice are biopsychosocial rather than purely physical
4. Integrate mental health promotion and prevention into your daily work
5. Boost resilience in your community through approaches such as community development
6. Identify people at increased risk of mental disorder for support and screening.
7. Support early intervention for people of all ages with signs of illness
8. Maintain your biopsychosocial skills
9. Ensure good communication, interdisciplinary team working and intersectoral working with other staff, teams and agencies
10. Lead by example, taking action to promote the resilience of the general practice workforce
11. Ensure mental health is appropriately included in the strategic agenda for your cluster, at the Clinical Commissioning Groups, and the Health and Wellbeing Board
12. Be aware of national mental health strategies and localise them, including action to destigmatise mental illness within the context of community development

1. Mental health promotion and prevention are too important to wait

Despite the fact that UK General Practice and wider Primary Care is currently overwhelmed, overburdened and suffering from low morale, there are compelling reasons to implement mental health promotion and prevention in the GP setting. It will not only reduce illness, save lives and save money, but it will also ultimately reduce the general practice workload as well as promoting our own resilience and mental health.

Good mental health is important for the educational achievement of children and their future prospects, for the physical health of the population, for the social capital (amount of trust and reciprocity) of communities and for the economy. Nonetheless, despite increased efforts to improve mental health treatment services, it remains the case that 9.5% of children and 17.6% of adults have a mental disorder at any one time. Mental disorders in the UK cost around £100 billion a year. Mental disorders are the leading cause of sickness absence in UK, leading to 70 million sick days lost per year. Indeed, 44% of employment and support allowance benefit claimants report a mental disorder as the primary diagnosis. The cost of crime by those who had conduct problems in childhood is £60 billion in England and Wales.

The prevention, assessment and treatment challenge – typical prevalence rates of mental disorders

	Practice 10,000	Cluster 40,000	CCG 400,000	Sector 1,000,000
Children and adolescents				
Conduct	550	2,200	22,000	55,000
Emotional	390	1,560	15,600	39,000
Attention Deficit Hyperactivity Disorder	150	600	6,000	15,000
Autism	100	400	1,600	10,000
Learning Disabilities	300	1,200	4,800	30,000
Dyslexia	1,000	4,000	40,000	100,000
Total	1,000	4,000	40,000	100,000
Adults				
Clinical Mental Depression	1,800	7,200	72,000	180,000
Alcohol dependence	600	2,400	24,000	600,000
Hazardous drinking	2,500	10,000	100,000	250,000
Drug dependence	340	1,360	13,600	34,000
Psychosis	50	2000	20,000	50,000
ASPD	30	120	1,200	3,000
PTSD	300	1200	12,000	30,000
ADHD broad	820	3280	32,800	82,000
ADHD narrow	230	920	9,200	23,000
ASD	110	440	4,400	11,000
Eating disorders	640	2560	25,600	64,000
Pathological gambling	30	120	1,200	3,000

Work with your community to map risk factors, resources and assets

Work within your own Practice, your local colleagues (GP federations, associations or 'clusters' of local Practices as they develop), your Clinical Commissioning Group (CCG) and your Health & Wellbeing Board (HWB) to map your communities (context, risk, resilience, resources, agencies, workforce and workforce funding) so that this knowledge can be used to benefit your patient populations, your community and your practice.

Community appraisals can include information about the socio-demography of the population, urban/rural, age structure, ethnicity/language/migration, and the services available –health, social care, education, youth and criminal justice services, non-governmental /voluntary sector community organisations. What are the current interagency boundaries and what can be done to enable closer working? Local data is available on mortality, morbidity, risk factors, and resilience factors. If no local data is available or current, extrapolate with wisdom from national datasets. Consider the local resources already available to boost resilience and encourage their wider use and availability as local community assets e.g. parenting classes, community development, exercise classes, language classes for immigrants, and the "whole school approach" to mental health promotion. Consider the local risk factors e.g. income disparity, debt, marital breakdown, substance abuse and how they can be systematically addressed in your patients e.g. access to debt counselling, housing advice, benefit advice, marriage guidance, people with problems with alcohol. It is very difficult to address income disparity but much can be done to help people in debt by signposting to relevant agencies e.g. Stepchange (www.stepchange.org).

Consider the vulnerable groups covered by your practice e.g. looked after children, ex-prisoners, older isolated people, and teenage gang members and ensure a systematic proactive approach to meeting their biopsychosocial needs.

2. Good health care, indeed good medicine, and best practice are biopsychosocial rather than purely physical

A holistic approach is needed if good outcomes are to be achieved. We need to encourage a proactive biopsychosocial approach in all consultations for the assessment and management of both mental and physical disorders. Practice staff need to be aware of the common ways in which people with depression and anxiety may present, for instance: sick note requests, fatigue, back pain, headache, mood change, life transition, any long term condition, attendance by someone who rarely visits the practice especially an older male.

GPs and Practice staff also need to be aware of individual *social determinants* to inform prevention and management of mental and physical illness. The social risk factors, e.g. debt, unemployment, housing problems, marital problems, alcohol, tobacco and drug misuse once identified, can either be addressed by direct action where feasible, or

frequently by signposting to other relevant agencies, as well as by inter-sectoral collaboration. Linking with community development workers where available will facilitate tackling social determinants of health.

3. Integrate mental health promotion and prevention into your daily work

This can be as part of a systematic biopsychosocial approach to leadership, teaching, information systems, clinical consultations and management plans.

In addition, all clinicians need to be able to recognise teachable and learning moment*s* to work with our patients to promote mental health and prevent illness, so that all patients have access to evidence based mental health promotion and prevention. Such opportunities arise at new patient checks, call and recall systems, immunisation consultations, as well as in routine consultations. Much can be accomplished by the cumulative effect of health care workers paying attention to mental health needs as part of their daily work. Supporting people with opportunities for this are present when clinicians are caring for people and families at life transitions, with chronic health conditions and during prenatal and post-natal care etc.

We all need to consider how the practice environment can promote mental health, by using posters, videos and fliers to signpost local support organisations and other community assets. Encourage nurses and other practice staff to learn about available resources and work with local community development workers where available.

There are now many helpful apps for patients e.g. baby buddy for the care of new born babies (www.bestbeginnings.org.uk/babybuddy; Emma's diary, www.emmasdiary.co.uk; grandparents plus, www.grandparentsplus.org).

Undertake a practice audit to find out which clients have risk factors for mental disorder, and identify those with multiple risk factors and use clinical reminders systems (i.e. using Information Management and Technology solutions) to GPs and other clinical staff about the severity and range of individual social risk factors in each patient. Find out your practice rates of severe mental illness, autism, learning disabilities, drinking above safe limits, also people with needs for forensic psychiatry services, suicides, suicide attempts, and premature deaths in people with severe mental illness. It is also useful to check whether the practice has ready access to debt advice, housing advice, benefits advice, marital counselling, bereavement counselling and has appropriate practice policies for safeguarding and child abuse as well as clear referral pathways e.g. for people with severe depression or early symptoms of psychosis. It is important to check, share and discuss these matters amongst the whole practice team, and keep practice policies up to date.

4. Boost resilience in your community

Universal mental health promotion and prevention measures relevant for everyone include physical exercise, good nutrition including enough B vitamins, use of green space, volunteering and giving, parenting skills for all, and social networks. Social networks and social participation appear to act as a protective factor against cognitive decline and dementia, and social networks are consistently and positively associated with reduced morbidity and mortality. The *Five Ways to Wellbeing* are a set of evidence-based actions which promote people's wellbeing which were developed by the New Economics Foundation from evidence gathered in the UK government's Foresight Project on Mental Capital and Wellbeing. They are: *Connect*, *Be Active*, *Take Notice*, *Keep Learning and Give*.

Boosting social networks may best be supported by commissioning community development jointly by the CCG, the Local Authority and, where relevant, the local Trusts. This generic work is likely to enhance population resilience and to enable organisations to be more responsive to the requirements of the local populations. Collaborate with community development and voluntary organisation colleagues. NHS and Local Authority Commissioners should ensure that community development routinely underpins the provision of community care and primary care. Evidence shows that this approach will enable communities and statutory services not only to map local resources and assets but also to harness them co-productively for health gain. Building such social networks and the strength of local communities contributes significantly to resilience, confidence and mental health protection.

5. Identify people at increased risk of mental disorder for support and screening

Take a proactive approach across the life course to screening, assessment, prompt treatment and support of people who are at increased risk for mental health problems. It is important to know the risk and resilience factors at each stage of the life course in general as well as in your local area, implement age appropriate mental health promotion and prevention at each stage of the life course, and use the opportunities provided by new registrations, nurse new patient checks as well as routine consultations.

Familiarise yourself with the factors associated with higher rates of mental disorder among children which include: child abuse; bullying, violence and witnessed violence, institutional care in childhood; physical health problems; poor nutrition; Having special educational needs; lone parenthood; Reconstituted families; poor educational levels; unemployment; low income; psychological distress among mothers and family discord; poor parental mental health; separation of parents; parents in trouble with the police; illegal drug use; deprivation and lack of social cohesion; social and economic upheaval (www.childrenscommissioner.gov.uk/publications/ nobody-made-connection-prevalence-neurodisability-young-people-who-offend).

The factors associated with higher rates of mental disorder among adults include: being female, aged between 35 and 54, Social class V, tenants of Local Authorities and Housing Associations, separation or divorce, living as a one person family unit, or as a lone parent; debt; a predicted verbal IQ of 70–85, impaired personal functioning, no formal educational qualification, people with long term physical illness, disability, painful and life threatening conditions. (People with two or more long term physical health problems have a 7x increased risk of depression).

Consider different settings where groups at high risk may be found: high risk occupational groups, including the GP workforce; high risk housing groups including people who are homeless, those in local authority housing, prisoners, people in old people's homes, and looked after children, especially those in institutional care; and those at certain life stages , including postnatal women.

Most people who kill themselves have recently seen their GP. This is an important opportunity for prevention. Suicide prevention includes the assessment and management of suicidal risk, prompt treatment of underlying depression or other psychological illness, all the usual interventions to promote mental health and resilience, improving coping skills, social networks and social support, advising patients and families about restricted access to lethal medicines including paracetamol, intensive support after previous suicide attempt as there is a 100x increased risk in following year, and support for high risk occupational groups especially at times of increased risk.

The information about risk factors and risk settings helps us to target our prevention activities. Ensure that all practice staff receive regular skills based updates in assessment and management of suicidal risk, in much the same way as we would do for Child Protection or Cardio-Pulmonary Resuscitation.

6. <u>Support early intervention for people of all ages with signs or symptoms of illness. Early recognition and intervention is crucial</u>

Early intervention for Attention Deficit Hyperactivity Disorder results in improved educational and social outcomes and reduced difficulties in later life.

Individual parenting intervention programmes for conduct disorder result in improved child behaviour, improved family relationships, improved educational outcomes and reduced conduct disorder, antisocial behaviour and crime.

School based intervention programmes for children at highest risk and those with sub-threshold disorders result in improved mental health, improved behaviour at school and home and improved social skills and academic skills.

Early intervention for depression and anxiety *results in less impact on relationships, family and workplace*
Early intervention for psychosis results in fewer psychotic symptoms, a better course of illness, higher employment rates, reduced GP consultations and Accident and Emergency consultations.

Early intervention for antisocial personality disorder results in improved functioning for adults, reduced psychopathy and suicidal behaviour.

Early intervention for harmful drinking results in improved physical and mental health and social functioning.

7. Maintain your biopsychosocial skills

We are responsible for the whole person, not just their physical health, and so all of us need to be able to readily conduct systematic routine assessment of current mental state and suicidal risk in each consultation where indicated by a psychosocial presenting symptom or complaint. We also need to understand how to address risk and resilience factors in the life course as a long-term process.

We all need to be skilled, confident and comfortable in dealing with mental illness. We also need to be skilled at assessing the severity of depression and severity of suicidal risk. If there is a hint of depression in the consultation, its overall severity (range of symptoms, severity, frequency, chronicity, interference with daily life) should be assessed at the time. If depression is present, then suicidal risk should be assessed and appropriately managed. The most recent data indicates that about half of Common Mental Disorders (CMD) (mostly depression and anxiety) remains undiagnosed, and only a quarter receive treatment for CMD. We also need to be skilled at appraising social determinants of mental illness e.g. when people join the practice, and in ensuing consultations, and address them in long term management plans. Mental health must always be assessed in the context of assessment and management of long term physical conditions.

8. Ensure good communication, interdisciplinary team working and inter-sectoral working with other staff, teams and agencies

Joint commissioning, multiagency collaboration and inter-sectoral interventions with local authorities (e.g. public health, social care and education colleagues) and other key sectors is crucial to implement mental health promotion and prevention interventions across the life course continuum. Examples include the whole school approach to mental health promotion which works on the classroom environment, the curriculum, the school environment and the links between the school and the community in order to enhance trust, communication and a sense of security across the school; the provision of parenting classes both in schools and for adults; mental health first aid training for all; action on

personal debt; action on social networks for lonely and isolated older people; and suicide risk reduction.

Nursing care across the whole of the life course should support mental health promotion. All prevention, treatment, rehabilitation and prevention of mortality activities need to be organised for the whole person in the context of their family and community, whether in or out of hospital**.**

***Community Development should become a routine part of health care provision*.** This will aid inter-sectoral work and promote community-led work on mental health promotion.

Support and utilise communication solutions, including cross-sectoral referrals and appropriate electronic note sharing mechanisms (such as software, referral pathways etc.) for fast movement of patient information between services. Meet your local partners to clarify how best to share patient information, and give patients the right care they need at the right time as efficiently and effectively as possible, whilst maintaining appropriate levels of patient confidentiality.

To support inter-sectoral work across the whole clinical spectrum from consulting, coordinating care to health services development and training. For example, in the clinical consultation, this can be assisted by paying attention to effective use of consultation time, to planning patient care, to staffing, brief therapeutic approaches, multidisciplinary team working, and IT systems.

9. Lead by example, taking action to promote the resilience of the general practice workforce

Consider your own physical and mental health promotion and self-care as health professionals, conduct reflective practice and support a quality culture within your workplace practice and daily life. For example we need to:

- Learn ways to encourage, experience and ***model a positive climate in the workplace*** and a balanced lifestyle; including a staff environment which supports healthy diet, time for exercise, family time, and allows time to give positive feedback and congratulate successes.
- Ask for and expect protected time to engage in ***local community development***, serve on representative committees, attend Clinical Commissioning Groups and other board meetings, leadership development, and promote positive mental health and wellbeing in role as member of community.
- Interact with media and professional groups to ***raise awareness*** of general practice staff such as the practice nurse role in primary care; ask for and expect protected time for ***professional reflection and lifelong learning.***
- Encourage an environment where professionals in the practice can flourish, where there are opportunities for ***personal and professional growth***, under supportive and

inspirational leadership, and an enabling environment that supports shared learning for all.

- Encourage an environment where health professionals in the practice who experience bereavement, other loss or major trauma, have to face a life changing diagnosis , or are otherwise overwhelmed by multiple stresses can ***develop resilience and return to work*** when recovered.
- Encourage an environment where professionals ***plan appropriately for retirement.***

10. Ensure mental health is appropriately included in the strategic agenda for your cluster, at the Clinical Commissioning Groups, and the Health and Wellbeing Board

So that there is parity between mental and physical health, including equality of time, energy, resources and commissioning expertise.

Mental health promotion and prevention needs to be included in all commissioning contracts and in all service provision with explicit commitments to health promotion, prevention, a biopsychosocial perspective and addressing comorbidities. For example, by the inclusion of evidence-based interventions such as parenting classes, a whole school approach to mental health promotion, MH First Aid training, addressing major social risk factors such as personal debt, bullying and child abuse.

Promote IT systems that support Interactions between primary and secondary care; Patient online record access-www.england.nhs.uk/ourwork/pe/patient-online/; patient access to useful websites e.g. www.bigwhitewall.com, www.buddyapp.co.uk; inter-sectoral working between health, education, social care, criminal justice; good practice guidelines , clearly summarised for use within the consultation; clinical audit and service improvements, monitoring risk factors at individual and community levels, data sharing within practices, between practices, across Clinical Commissioning Groups, between primary and secondary care, and local authority public health planning programmes.

Integrate mental health promotion into all care pathways for people with physical and/or mental illness.

Inter-sectoral committee at commissioning level.

Inter-sectoral work at practice level, cluster level, Clinical Commissioning Groups and Health and Wellbeing Board.

11. Be aware of national mental health strategies and localise them, especially action to destigmatise mental illness within the context of community development

We need to talk about mental health and mental illness and make it ordinary.

III. Key References and Further Reading

The detailed recommendations made by the Think Tank for consideration at each level of the health system and each stage of the life course from pre-conception to end of life, together with a background briefing on mental health, can be found at www.ethicsfoundation.org

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2. Work with your community to map risk factors, resources and assets

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7. Maintain your biopsychosocial skills

- RCPSYCH (2013). *OP88 Whole Person Care: From Rhetoric to Reality (Achieving parity between mental and physical health)*. www.rcpsych.ac.uk/usefulresources/publications/collegereports/op/op88.aspx

8. Ensure good communication, interdisciplinary team working and inter-sectoral working with other staff, teams and agencies

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9. Lead by example, taking action to promote the resilience of the general practice workforce

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10. Ensure mental health is appropriately included in the strategic agenda for your cluster, at the Clinical Commissioning Groups, and the Health and Wellbeing Board

- Joint Commissioning Panel for Mental Health (2013). *Ten Key Messages for Commissioners*. www. jcpmh.info/wp-content/uploads/10keymsgs-publicmentalhealth.pdf

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11. Be aware of national mental health strategies and localise them, including action to destigmatise mental illness within the context of community development

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The twelve messages to achieve improved mental health for all and to save lives:

1. **Mental health promotion and prevention are too important to wait**
2. **Work with your community to map risk factors, resources and assets**
3. **Good health care, medicine and best practice are biopsychosocial rather than purely physical**
4. **Integrate mental health promotion and prevention into your daily work**
5. **Boost resilience in your community through approaches such as community development**
6. **Identify people at increased risk of mental disorder for support and screening.**
7. **Support early intervention for people of all ages with signs of illness**
8. **Maintain your biopsychosocial skills**
9. **Ensure good communication, interdisciplinary team working and intersectoral working with other staff, teams and agencies**
10. **Lead by example, taking action to promote the resilience of the general practice workforce**
11. **Ensure mental health is appropriately included in the strategic agenda for your cluster, at the Clinical Commissioning Groups, and the Health and Wellbeing Board**
12. **Be aware of national mental health strategies and localise them, including action to destigmatise mental illness within the context of community development**