

The importance of sustainability

The universe tends towards entropy (increasing disorder) and a constant input of energy is required to prevent this. The weeds come back when we stop gardening and we become hungry and thirsty if we do not eat and drink. We do these things every day and take them for granted. Promoting those activities and interventions that minister to our minds is no different. Importantly, we also do not change the way we eat or garden because there is a different political party in power. Promoting mental health places value on the principle that "the fundamental things apply as time goes by"

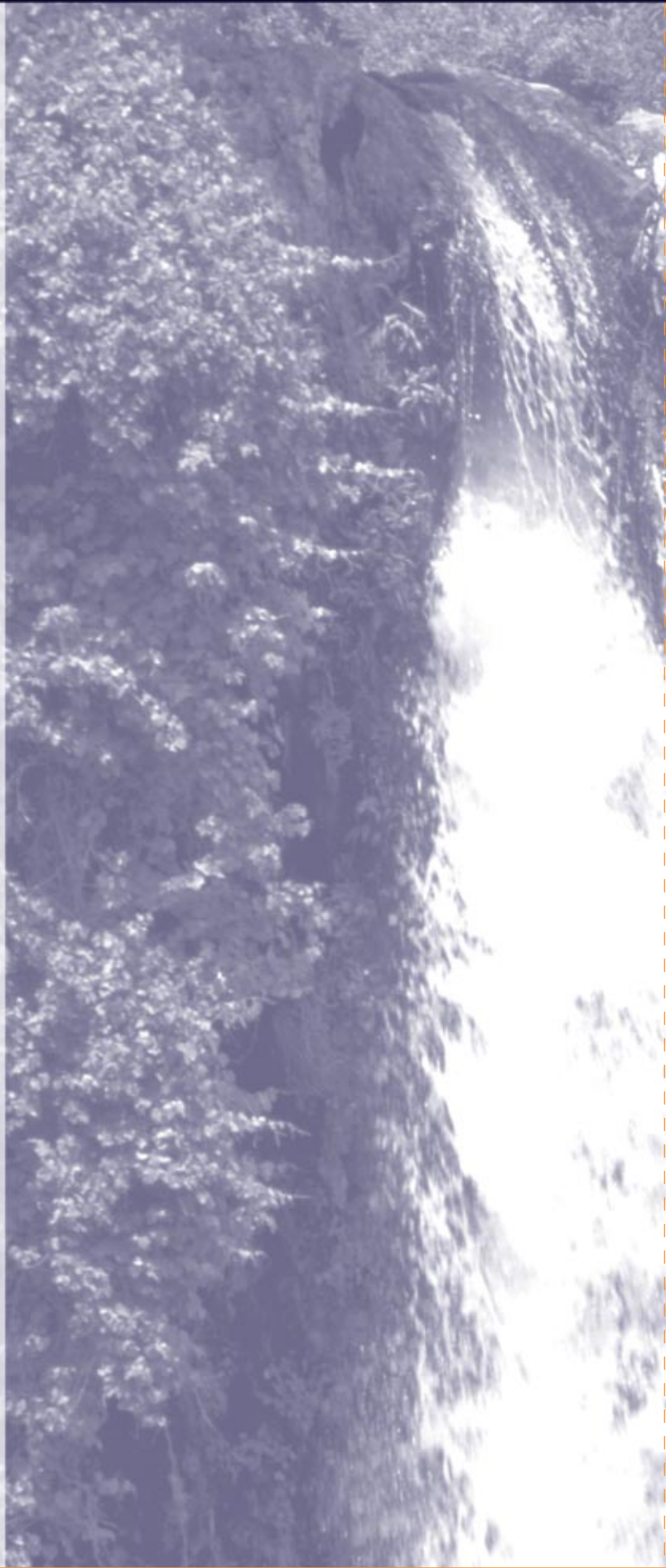
<http://www.vincasa.com/indexastime.html> . This idea is clearly in tension with constant change in complex systems also being a universal principle, <http://bmj.com/cgi/content/full/323/7313/625> however, there clearly are 'severe and enduring' dependencies that we all possess.

We do now have the opportunities and permissions to do things differently and to do different things. Let us not moan about problems any longer, but work towards shared solutions...what could be better for our mental health and those we are privileged to care for.

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Resource Pack

**Promoting mental health, cultivating social inclusion
and managing mental health problems in primary care**

**A guide to developing integrated services
in line with the national service frameworks for mental health**

*Rivers are
magnets for the imagination,
for conscious pondering
and subconscious dreams, thrills, fears*

Tim Palmer

Position Statement



Primhe's position on primary care mental health

"If you go on doing what you've always done, you'll go on getting what you've always got".

Welcome to this resource pack. Primhe intends and hopes that it will be a stimulating and useful guide to supporting good work and developing best practice.

We are living in a time where saying the right things can subsume the action or create a feeling that the rhetoric itself delivers the reality. Delivering that reality, having "scoped the vision", can often itself be further obfuscated by traditional ways of working, turf wars, time-expired models, unmet personal agendas and needs and a lack of quality time and space in which to develop our thoughts, approaches, feelings and skills. There is a tension all the time between centrism and localism and a feeling that empowerment is fine, but as soon as it is exercised, someone, or an organisation with more of it, comes along to say - "I think we'd like that back."

The reality is also that 'joined-up thinking and working' represents the UK's health, social and cultural revolution and it is up to us all, as aspirant citizens, to contribute positively towards it. Many have burned out trying to do so, others are fired up and raring to go...which are you?

There is so much going on and we do all need to be able to see that, build on existing work, strengths and friendships and, most importantly, give them sustainability beyond the next funding round, political fashion and NHS mega-shift. It is changing people's attitudes and behaviours towards working together that will deliver best care, not just endless deckchair choreography.

Primhe chimes with NIMHE

Primhe believes that the National Institute for Mental Health in England (NIMHE) www.nimhe.org.uk has a crucial role here, serving as the bedrock on which to hold fast as the waters constantly break over our heads. So much of what needs to happen goes way beyond the short-term and Primhe believes that it is now high tide and time to consolidate successes to build a future for mental health. The NIMHE itself, whilst of necessity currently focussed on the delivery of key elements of care such as early intervention, assertive outreach and home treatment, represents far more than that. It is early days and all of us with an interest in mental health have a duty to support its work and help in its development. As a charity, we are not exclusively beholden to the NIMHE, any more than the NIMHE is beholden exclusively to primary care, but we espouse its values and focus where they overlap.

What are Primhe's values?

Most folk do not enter health and social care to deliver mediocrity and Primhe believes that it is extremely counter-productive solely to beleague and deluge people with top-down dictats, edicts and targets. Some, or all, of these may be entirely consistent with the highest possible aspirations for the delivery of quality services but, in themselves, they often do little to inspire, enthuse or support front-line work and those who have to do it. Further, they are deleterious to the mental health of the workforce and the cause of lack of capacity and problems with recruitment, retention and best outcomes for patients.

People benefit from good leadership and close teamwork, rather than arms-length, but intrusive, administration. Top-down policy, target and performance management must exist within a culture of shared and mutual respect for successes achieved - a tick in a box is a parody of the care and attention to detail that professionals give to their patients; it is a lowest common denominator derived from highest common standards. Surely, if people deliver to the key performance indicators and standards required, there should be real value attached to such achievement, every day, day in and day out. Good management is underwired, uplifting, seamless and comfortable, rather than inadequate, 'floppy' and bursting out all over the place.

Top-down should meet with what Primhe calls a 'bubble-up' approach. This is more dynamic than mere 'bottom-up' (with its rather challenging associations for some practitioners?). It denotes an energy, sense of coalescence and the placing of value on the building of robust and sustaining networks. All policy depends for delivery on a valued, motivated and healthy workforce. This itself ties in with Standard One of the English NSF, Improving Working Lives, mindOUT and best evidence-based practice.

What Primhe believes:

- Health ≠ (does not equal) Absence of Illness ("Peace is more than the absence of war");
 - Illness ≠ Absence of health ("Noise is more than the absence of silence");
 - Mental health ≠ Mental illness, with the above two provisos equally applying <http://www.mensana.org/index.php>
 - Mental health is health and personal wellbeing and underpins and overarches all policy and National Service Frameworks;
 - Mental health issues flow through every consultation - involving both you and the person(s) you are seeking to help;
 - 'Mental health problem' is a variously interpreted term. If people have a problem with their mind, then they can no longer be in a state of health. It also implies that such problems are in some ill-defined way, 'softer' or less serious than 'real' mental illness, when they are often not. Their impact on the day-to-day workload in primary care alone demonstrates the reality of their importance. It is vital to agree what it is we are talking about at the outset. When designing any strategy to deal with them, all materials and initiatives should be explicit about the definition and scope of this term when it is deployed.
 - 'Mental health problems' both cause, and result from, all conditions and the ups and downs of life. People with mental health problems are the same people we deal with every day. At least 25% of consultations in primary care are prompted exclusively by a mental health problem <http://www.nimhe.org.uk/archivepolicy/nsf.asp#1> and psychological and mind-connection issues pervade all human interactions, whether the service provider 'believes' in mental health and illness or not;
 - Severe and enduring mental illness is not just psychosis and schizophrenia. It is a descriptive term, again variously interpreted around the UK, and open to much misinterpretation. If any mental illness is severe and enduring in the experience of the person with it, then it is. Further, people do suffer from mental illness and not just experience it. Ignoring these issues is not an option; mental health problems and illness cost £32bn/year (at least): <http://www.nimhe.org.uk/archivepolicy/nsf.asp#1> and the importance and place of both in primary care is extremely well established, documented and described: http://www.mentalhealthstrategies.co.uk/pdf_files/primarycaremhguide.pdf
- Primhe has started its own "Dump Descartes" Campaign, in line with current thinking that we are indeed 'Wired for Health': <http://www.bbc.co.uk/radio4/reith2003/lectures.shtml> <http://www.wiredforhealth.gov.uk/>

The need to link mind and body ("Dumping Descartes")

- "The only way to separate the mind from the body is with an axe" (Walton, I., 2002 - personal communication). 'Mental' means 'of the mind'; it is time to reclaim the word and have healthy and invigorating debates about what it means in terms of the way we are wired and the way we work. <http://bmj.com/cgi/content/full/325/7378/1433>

- The continuing juxtaposition use of the terms 'mental' and 'physical' itself perpetuates the stigmatisation and marginalisation of those with brain (and other organ) conditions that cause mental illnesses and mental health problems. They imply that genuine conditions or states of mind have their basis and causation in some reality or place other than a physical organ or the systems that integrate with it physically (such as the immune, endocrine, peripheral CNS and ANS). This does not mean that the mind is 'just' a function of the brain either, or indeed needs to be limited to that organ, or indeed that body?

<http://bmj.com/cgi/content/full/325/7378/1434>. "We do not know what we do not know" (Tylee, A., personal communication 1997)

It is also unacceptable that people with mental illness have their other health needs neglected; neglecting these is as inappropriate as not looking after the foot or eye care of someone with diabetes, on the basis that the primary illness is solely a disease of the pancreas;

- Co-morbidity is a neat 'Trojan horse' for levering mental health into many a conversation - it is an opportunistic term for thinking about, and moving people towards, discussion of our wholistic selves, contexts and interactions and the consequences of ignoring them:

<http://bmj.com/cgi/reprint/318/7187/826.pdf> and references below.

- We are all more than the sum of our parts, needs and diagnoses. Diabetes, childhood, schizophrenia, adolescence, depression, coronary heart disease, being old, long term medical conditions, are not mutually exclusive states and can all exist in the same person during an average lifetime, at times simultaneously;

<http://bmj.com/cgi/content/full/310/6992/1422>
<http://bmj.com/cgi/reprint/325/7356/149.pdf>
<http://bmj.com/cgi/reprint/326/7388/512.pdf>

- 'Them R Us'. We are all "people first and foremost" - before any diagnostic, taxonomic system, service supplier or well-meaning enthusiasts gets their hooks in. Doctors, patients and nurses are "what we do" in specific environments, they are not "who we are". In the same way, people are not diabetics, schizophrenics and depressives, but people with a "diagnosis of ...". Recovery means that a diagnosis is not a life-long sentence, but a label of shared recognition for the duration required to obtain relevant help and no longer.
- "Perception is reality". If you think or feel that you are ill, then you are. There are no such beings as the "worried well", only the "worried sick". This is a severe and enduring fiscal and workload problem for primary care (Curtis Jenkins, 1996) with all its associated co-morbidity and somatisation issues. (Kroenke and Mangelsdorff, 1989; Berkman and Breslow, 1983; Bridges and Goldberg, 1985; von Korff, Ormel, Katon, and Lin, 1992; Katon, 1995; Lin et al., 1991; Bloch 1993;
- Good health and social care should be about skills to meet needs; it is about flexible principles, not entrenched positions. "My hairdresser has been on a CPR course and keeps up to date...that's where I want to be when I have my coronary". GP TARGET Doncaster March 2001, <http://www.targetmedicaleducation.org/>. The traditional carousel of "Doctors, nurses and patients" may work in hospitals, but we in primary care can be brave and bold and do it differently;

The need for a whole systems approach:

"I would like to be able to 'treat' whole communities, not just individuals."

GP at educational and learning event: "**Mind the Gap**" June 1999.

"I certainly feel both mentally and physically better because I have gained confidence. I do not visit the doctor as regularly and I have been able to cut down on medication. I don't know whether it is a coincidence but it happened when I started learning." Prescriptions for Learning (**1999 Adult Learners' Week award winner**)

<http://www.niace.org.uk/research/health/Prescription.htm>

Services must exist for people, not the other way round: this principle applies from top-to-bottom and bottom-to-top;

It is obvious that we cannot go on as we have done; the cost of high-technology care, delivered with traditional models, continues to escalate. In the face of an apparently increasingly healthy nation, the cost and burden of health and social care continue to mount, however justified the spend.

Traditionally, politicians, professionals and the public have assumed that health equates to more doctors and more hospitals. All the evidence from the Broad Street Pump to BSE, <http://www.ohn.gov.uk/>

<http://www.doh.gov.uk/ohn/inequalities.htm>

clearly demonstrates the limited impact of a medical model practised and applied in isolation from any overall biopsychosocial context. In this sense, there is only one principle underlying all National Service Frameworks, which is that the person using the services must be placed at the heart of them. Many evidence-based interventions, such as physical activity within a context of healthy work-life balance and meaningful relationships deliver the NSFs across the top.

Someone with heart disease or diabetes has a 40% chance of co-existing depression, either as a cause or an effect, or both, of their so-called 'physical' problem. Someone with a 'brittle' medical condition is probably frustrated, angry, in denial, anxious, depressed, or being beaten up at home. To expect that a 7 minute consultation terminating in a prescription will sort this out is naïve at best and inept at worst. The pain will go on until we do it differently, deploying effective interventions and involving people and organisations with the relevant skills to meet the particular needs. How much 'treatment resistant' depression, or any other condition for that matter, is occasioned by a medical model being applied in isolation?

In order to achieve maximum benefit, all interventions need to deliver a whole-systems approach. We now know enough about what works well for the people who use services and those who provide them. It is vital that evidence-based practice and practice-based evidence lead the work.

<http://bmj.com/cgi/content/full/326/7388/512>. Contracts must never be permitted to be the tail that wags the dog; they are artificial constructs for engagement, no more and no less. Primary care will also become a dreary place indeed just as if people only practice according to target-driven agendas and can bring nothing of their own individuality and creativity to the party. It would be ironic indeed if patients are being rightly encouraged to become far more creatively involved in their care, professionals are now to become more paralysed by risk avoidance and bureaucracy.

There is very good evidence that many of the mental health problems secondary to 'stress' which present in primary care, are themselves the direct consequence of the body having evolved for 'fight-flight-freeze' responses in active, sudden and acute situations. However, the bodily control mechanisms of many people are now often constantly triggered by unremitting pressures and this results in the chronic over stimulation of the hypothalamo-pituitary-adrenal (HPA) axis, as our bodies react to a perceived and continuing threat. As a result, the adrenal hormone cortisol and other nervous, hormonal and immune system transmitters are released. The body systems that respond to these molecular messengers react accordingly and apart from the production of anxiety, panic, phobias and depression, which have all the consequences so familiar to all, there are also many other equally physical, non-nervous system, consequences <http://bmj.com/cgi/content/full/318/7187/826>. This all results in blighted lives, staggeringly high levels of sickness absence and much of the daily grind and drain on precious NHS resources.

Clearly, there is no point in simply having hundreds of practitioners just dishing out tablets to deal with all these affected individuals. It feels futile to these professionals, and unsatisfactory to those who have to engage with the services they provide. This is why promoting mental health and social inclusion and dealing with mental health problems is the issue of the day; every other activity flows out from this key principle and ignoring it results in much of the illness that impacts on health and social care services.