RCGP Health Inequalities Standing Group Consensus Statements

1.   Statement on Homelessness and Primary Care 2002

Foreword

On March 7th 2002, the RCGP Standing Group on Health Inequalities hosted a conference entitled *Housing, Health and Homelessness: The Challenge to Primary Care* in Leeds supported by a generous grant from Leeds Health Authority. The conference brought health professionals together with people working in housing and social services and staff and clients from voluntary agencies working with homeless people.

The main objective of the day was to develop a consensus statement on homelessness and health. The intention was that this would lead to improved services for homeless people by providing an agenda for closer working between the different sectors involved and influencing the College's policy in this area. The model for the statement was a similar document produced within the College nearly a decade previously, which had been innovative at the time but which no longer reflected current thinking and aspirations.

The Standing Group on Health Inequalities had chosen to work during 2001-2002 on the theme of homelessness, on the grounds that homeless people are consistently at the losing end of health inequalities and are the group most likely to encounter all the barriers to equity in health care that may occur within current NHS arrangements. By bringing together a large multi-disciplinary group and providing a structure in which to elicit and record their ideas for action, as the end-point of a year of writing and campaigning, the group hoped to summarise their thinking about homelessness and also suggest areas for further activity, which could be taken up by other agencies, primarily Primary Care Organisations.

The attached text has been endorsed by Council of the RCGP and also by the Council of the Faculty of Public Health Medicine and both colleges commend its policy recommendations to the attention of the relevant bodies.

Iona Heath

2002 RCGP STATEMENT ON HOMELESSNESS AND PRIMARY CARE

Vision and values
The RCGP recognises that:

- A home is more than a physical structure. It is a sense of belonging and of personal affirmation. The best way to improve the health of homeless people is to provide appropriate and secure housing.

- Homelessness extends beyond the familiar images of people sleeping on the streets to encompass hostel-dwellers, travellers, families in B&B accommodation, people in squats and those in temporary or overcrowded accommodation such as asylum seekers and many refugees

- All people have a right to equity of access to primary care services and to receive services which will enhance their dignity and independence

- Individual professional advocacy is important in homelessness at all levels, from the consultation where the quality of the practitioner-patient relationship is paramount, to local, regional and national arenas

- New service models must be developed which utilise the complementary strengths of generalist and specialist expertise. Interdisciplinary working and multi-agency partnerships including social service are vital to the development of effective services in order to avoid costly duplication of effort and dangerous gaps in care. The focus should be on inclusive practice, needs not diagnostic labels and solutions not problems

- New ways of thinking and working are challenging and should be underpinned by explicit support and valuing of the workforce charged with implementing change

At an individual PRACTICE LEVEL the RCGP recommends that:

- Primary care practitioners should provide a welcoming and sensitive service to homeless people and enable them to access the full range of health and social services required to meet their needs

- Homeless people should be registered permanently wherever possible and integrated into all health prevention and promotion activity within the practice

- Housing agencies could be encouraged to hold advice sessions in a primary care practice setting

At an individual PRIMARY CARE ORGANISATION level the RCGP recommends that:

- In view of the impact of homelessness on health, homelessness issues should be recognised as part of the core PCO agenda

- PCOs should acquire a good understanding of the numbers of homeless people in their area and the problems they face, as well as the range of local agencies equipped to meet their needs. This information will be vital in both the planning and delivery of services for homeless people

- PCOs should provide resources for ongoing and substantive support for homelessness services and develop diverse, well-resourced and locally appropriate services

- PCOs should encourage multi-agency links that are both viable and adequately sign posted to encourage integrated services

- Agencies should work together to develop shared protocols and operating procedures that aid integrated working and co-ordinated care for homeless people

- PCOs should develop IT support and computer codes that will enable the recording of degrees of homelessness and the status and security of housing provision

- PCOs should work with local authorities to provide social, educational and employment opportunities for homeless people. Information about these opportunities should be made available to primary health care teams

- Specialist opinions from appropriately experienced psychiatrists should be readily available to practitioners working with homeless people

- Funding should be provided in recognition of the work involved in preparing medical reports for housing agencies

At NATIONAL level, the RCGP recommends that:

- Political support be offered to those working in the field of homelessness

- Resource allocation methods should reflect the real costs of providing primary care for homeless people

- The new GP contract negotiations should address structural barriers that may affect the permanent registration of homeless people including the removal of perverse incentives such as deprivation and target payment anomalies

- Planning for electronic transfer of patient records should address the needs of mobile populations within the appropriate constraints of consent and confidentiality

- A collaboration should be developed with the National Treatment Agency to explore ways of improving services for homeless people with drug dependency

- A national web-site for homelessness should be set up to act as a living interactive resource for individuals and agencies involved in the area

- The RCN and the RCGP collaborate to acknowledge the aspiration of nurses in the field of homelessness to be recognised as a specialism with a core curriculum, training opportunities and qualification

When considering the education and learning priorities in working with homeless people, the RCGP recommends that:

- Service users are actively involved in planning service configurations, delivery, and education and learning initiatives

- Workforce confederations and PCOs work together in partnership as learning organisations to develop appropriate education and learning opportunities at all entry levels

- The extent and pervasive nature of negative stereotyping is recognised as an important barrier to good quality primary care and that appropriately focused education and learning initiatives are developed in this area

- Education and learning initiatives around homelessness issues should be multidisciplinary in nature

- Education and learning opportunities should include diversity training, methods of risk assessment and dealing with complex needs such as alcohol and substance misuse and mental illness

- Continuing learning and professional development should be focused on the interfaces between different agencies

When considering the care of homeless children, the RCGP recommends that:

- The UN Convention on the rights of the Child 1989, endorsed by the UK Government, which gives all children the right to the highest level of health possible is recognised and acted upon at all organisational levels

- The causes of child homelessness which include family difficulties, domestic violence, immigration and asylum seeking, abuse and substance misuse are recognised, acted upon and that appropriate education and learning opportunities are available for practitioners in the field

- The consequences of child homelessness, including adverse physical health, poor uptake of immunisation and preventative services, increased accidents, developmental delay, malnutrition, psychosocial effects such over activity, aggression, poor sleep patterns and increased risk of child abuse are recognised, acted upon and that appropriate education and learning opportunities are available for practitioners in the field

When considering refugee homelessness, the RCGP recommends that:

- Training in homelessness issues should include aspects specific to refugee homelessness

- Extra resources are made available in areas of high refugee homelessness including particularly adequate interpreting and translation services

- Agencies work together to promote positive images of refugees and asylum seekers

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On behalf of the RCGP Health Inequalities Standing Group

STATEMENT ON HOMELESSNESS AND GENERAL PRACTICE

1   Context and Quality

1.1   The Royal College of General Practitioners believes that all people must have equity of access to primary care services and to receive services which will enhance their dignity and independence. We have a duty as General Medical Practitioners to provide a welcoming and sensitive service to homeless people which will enable them to access the full range of health and social services required to meet their needs. The most important issue in the provision of care to any individual or group is the quality of the doctor-patient relationship.

1.2   Homelessness and poor or inappropriate housing are major indicators and causes of ill-health and mental stress; work with homeless people therefore forms an important part of all general practitioners work.

1.3   We believe that the best way to improve the health of homeless people is to provide appropriate and secure housing for them. We also stress that

homelessness extends beyond the familiar images of people sleeping on the streets to encompass hostel-dwellers, travellers, families in B&B accommodation, people in squats and those in temporary or overcrowded accommodation such as recently arrived migrants and many refugees.

2 The Policy Issues

2.1 General Practice and Homeless People

The College recognises that many of its members provide excellent and sensitive primary care services to homeless people, whether as individual or group practitioners, or as part of other specialist services. These services are often in conjunction with other health and social care colleagues and take place in a variety of settings. We will support such work wherever possible, and continue to argue for proper recognition of and remuneration for such generally unacknowledged GP services.

2.2 The Tomlinson Enquiry into London's Health Service

We consider the opportunities for innovation in primary health care in London highlighted by the Tomlinson Enquiry Recommendations can offer particular benefits to homeless people. Good practice developed in London can be used as a model by the whole country.

2.3 Purchasing, Contracting and Fundholding

The College looks to new health service structures to provide us with new opportunities to give a high priority to our work with homeless people. Many GPs are now becoming involved – through purchasing groups or GP forums – in the contracting process for secondary services and this can be used as a way to point up the particular needs of homeless people. Fundholders have this opportunity – and responsibility – at a practice level when deciding their contracts with local providers.

2.4 The GP Contract

Several of the targets in the 1990 GP contract are a disincentive to work with homeless people or other disadvantaged or mobile groups because of the difficulties in integrating them into health promotion targets. The College will continue to argue – through the GMSC – for local relaxation of such target figures and urges its practitioners working with homeless people to press the same case with their local FHSA.

3   Practice Issues

3.1   Registration

We accept that registration does not guarantee access. Nonetheless, and whilst acknowledging the great pressure – deprivation, mobile populations etc – within which many urban practices operate, the College urges its members to practice equity in its registration policy. Homeless people should be registered permanently wherever possible and integrated into all health profile and promotion activity within the practice. A permanent address is not necessary for registration; please consult your own FHSA for their guidance on this.

3.2   Staff Training and Health Promotion

All front-line staff in general practice – and particularly receptionists – must be trained in non-discriminatory practice with regards to homeless people. Similarly we encourage you to consider integrating the particular needs of homeless people in your health promotion work and targeting homeless groups.

3.3   Practice Staff Reimbursement

We urge you to highlight your work with homeless people when approaching your FHSA for practice staff reimbursement; many authorities are sympathetic to GP work with homeless groups.

3.3   The Local Context

Practices which provide the best services to their patients are those most aware of the local context within which they work. A good understanding of the numbers of homeless people in your area and the problems they face, as well as the range of other local agencies equipped to meet their needs, will be helpful in both the planning and delivery of services to homeless people. Both your FHSA and the local LMC should be able to help you build these understandings.

3.4   Work with Refugees and Ethnic Minority Groups

Inner London, and other British cities, has a large and growing population of refugees – mostly from Africa and Asia but with the probability of growing numbers from Eastern Europe over the next few years. The College believes that the immigration status of patients is irrelevant to primary health care providers and would advise that passports are not asked for from people presenting for registration or emergency treatment. For work with people with poor spoken or written English, members should make use of available professional advocacy and translating services – both from the health and social services and the community sector. This ensures confidential and effective use of services and is to be preferred to the informal use of friends

and children. In many inner-city areas – notably City and East London – bilingual advocates can be arranged for most language/cultural groups.

Produced on behalf of Council by the Steering Group on Improving Primary Care of Homeless People in London.

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Dr Alan Cohen (RCGP)
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Dr Jim Lawrie (RCGP)
Mr Jim Smellie (City and East London FHSA)
Mr Rick Stern (Access to Health)
Ms Tracy Stein (Access to Health)
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March 1993

2.   Hard Lives: Improving the Health of people with Multiple Problems 2003

Foreword

Wherever you travel in the UK, every single house that you see – however grand or beautiful, however poor or squalid – is on a GP's patch. Those Cotswold villages and those blocks of flats with lifts that don't work and stair wells that smell of urine are all part of our NHS.

As you take the train into our big cities you see back to back houses, tower blocks, and terraces. Each and every one of them has a GP who considers the patients in those houses are his or her patients.

Each of these GPs works in a Primary Care team whose skills are available to serve those populations. Each team is now linked to a Primary Care organisation, and each PCO has a different challenge.

Health Inequalities, whether rural or urban, are perhaps the biggest challenge facing everyone in the NHS. The most deprived patients are also more likely to have more than one medical problem. Co-morbidity, for which guidelines and national service frameworks are rarely as helpful as we would wish, is a truly major challenge for everyone involved in healthcare.

The Royal College of GPs exists to encourage, foster and maintain the highest possible standards in general medical practice. As such, tackling health inequalities – and inequality in health care quality – has long been one of our main reasons for existence.

This booklet is of real importance to our understanding of health inequalities. I commend it to you highly.

David Haslam

Members of the Standing Group on Health Inequalities, 2002-2003

Iona Heath: Chair	Alistair Howie
Paul Thomas: Vice-Chair	Helen Lester
Gilles de Wildt	Una MacLeod
Paramjit Gill	Liam Smeeth
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Vision and Values

The RCGP recognises that:

- The term co-morbidity describes the occurrence of more than one illness[i] affecting an individual, each of which may impact on the course and management of the others.

- Co-morbidity occurs disproportionately within populations that are socio-economically disadvantaged or elderly, and particularly within populations which are both.[ii] [iii] It also disproportionately affects populations that are disadvantaged by ethnic group, or who suffer racism.

- The purpose of clinical governance is to promote the highest possible standards of clinical practice.[iv] Its scope includes life-long learning, organisational and systemic learning, reflective practice, communication skills, applied research and the wise application of scientific evidence within locally sensitive development.[v]

- There is a socio-economic gradient in the incidence and prevalence of almost all major disease categories, meaning that individuals and families who are socio-economically disadvantaged are at risk of a compounding burden of health and social problems.[vi] [vii]

- Co-morbidity poses challenges to the delivery of effective health care which, to date, have received almost no official attention.[viii]

- Those who suffer multiple illnesses, both physical and mental, suffer them simultaneously and inseparably. The patient with diabetes and depression and congestive cardiac failure does not have these conditions in separate compartments of her life. She has all three inseparably and she may also be lonely and frightened and all of this is a single condition. No one aspect can be treated in isolation from the others.[ix] [x]

- Primary care clinicians have considerable experience and skills in managing multiple health problems to achieve optimal outcomes for each particular individual. [xi] This is done by the careful negotiation of an individual care plan that makes sense to the patient in the context of his life story and the full diversity of his health and social problems, and which accommodates his values and aspirations. The necessary skills have been mostly unrecognised and undervalued and are systematically concealed by routine audits of the management of single disease states.
- High quality care of multiple and compounding health problems depends on the ability of the clinician to deliver personal and continuing care over time. Such care also needs longer consultations.[xii] [xiii] Where patients from disadvantaged ethnic groups also require interpretation and advocacy, consultation times need to be at least doubled.

- The evidence base of clinical practice is derived almost entirely from research into single disease states. Older people, those with significant co-morbidity and those who are disadvantaged, either socio-economically or by ethnic group, are usually under-represented and often excluded from clinical research trials.

- Health care that is both driven and evaluated increasingly by protocols derived from studies of single disease conditions seems likely to disadvantage systematically those with complex and overlapping health problems.

- There is an urgent need to know much more about the optimal management of co-morbidity.

For PRIMARY CARE the RCGP recommends:

A. In relation to the development of primary care teams:

1. Practices as multidisciplinary teams should be provided with explicit incentives to provide co-ordinated, personal and continuing care to all patients. They should pay particularly attention to those with multiple problems, who will be over-represented among those who are elderly, of minority ethnic group and/or socio-economically disadvantaged. Models of managing multiple problems should be widely available and locally supported.

2. In a situation where there is a scarcity of clinicians, particularly in primary care and particularly in deprived areas where health care needs are greatest, there is an urgent need to maximise the specific expertise that clinicians are able to bring to both face to face work with patients and management organisations. Clinicians who have NHS management responsibilities should be encouraged to take strategic roles in the management of multiple morbidity. Bureaucratic or administrative tasks that could be done by others should not be required of clinicians.[xiv]

3. PCOs should encourage and support multi-agency participation in planning and service delivery, including schools and local authorities. Health professionals need to be enabled to work effectively with patient groups and informal carers. PCOs should encourage the attachment of social workers and health visitors to primary health care teams and a variety of social and lifestyle support practitioners.

4. PCOs should prioritise the development of collaborative practice between those who serve whole populations and those who serve a personal list.

5. Innovative projects are more likely to succeed if people from all parts of the system concerned (e.g. the care pathway) are involved at every stage of the planning. Clinical governance programmes could explore the implications of this with interface audits, whole system research, and participatory and action approaches to research.

6. The trend towards ever-increasing specialisation within secondary care tends to disadvantage patients with co-morbidity. The disappearance

of the role of the general physician within secondary care, particularly with an interest in the care of older people, means that patients are obliged to attend many different hospital departments with huge duplication of effort and frequent conflicting recommendations. Polypharmacy[xv] becomes almost inevitable. The effective management of such patients now depends heavily on primary care. Innovative ways need to be found in which general practitioners can be supported by a range of specialist experts to provide appropriate care for patients with complex and overlapping health problems.

7. The current political enthusiasm for specialisation within primary care with the creation of GPs with a special interest (GPSIs)[xvi] has the potential to either undermine or improve the care of those with multiple problems within primary care. Additional clinical expertise gained by GPs needs to be harnessed predominantly within primary care so as to optimise the primary care treatment of those with multiple morbidity

8. All primary care professionals should work together to co-ordinate and facilitate the care of patients and families affected by co-morbidity. However, the professional to whom the patient first presents should involve other members of the practice team only if the patient actively consents and where the involvement brings the possibility of significant benefit. Patients and families with multiple health and social problems may find it difficult to establish trusting relationships with professionals. There may be circumstances where the active exclusion of other parties from the clinician-patient relationship is desirable in the interests of building trust and encouraging concordance.

B. In relation to primary care research

1. Public health and academic professionals should work with general practices to document the extent and effects of co-morbidity in individuals and families.

2. "R&D practices" should be developed as organisations skilled at whole system development and research and therefore developing a deep understanding of how to think about multiple problems. They should work with their PCO and a significant number of other practices to integrate clinical governance, research, organisational development and service development. PCOs should find ways of weaving together resources from undergraduate and postgraduate education, research and PCO development funds to establish a network of practices to lead on quality.

3. In England, Teaching PCTs, Research PCTs and Primary Care Research Networks could work with Strategic Health Authorities, Universities and Colleges to develop a shared vision and an infrastructure of support for R&D. Locally available courses could contribute modules to established courses to harness educational

experience and local knowledge; for example local leadership courses could be connected to Open University courses, the former assisting the development of local networks and the latter established teaching experience.

4. PCOs should promote an approach to research that makes it as relevant as possible to local development. This would include using a wide variety of research methodologies to better understand the issues of co-morbidity relevant to primary care. Traditional quantitative methodologies will need to be complemented by participatory action approaches and qualitative research to better understand the relationship between co-morbidity and health inequalities.

C. In relation to the learning of primary care practitioners

1. Time out for learning and reflection within and across practices should be explicitly valued as ways of understanding others who contribute to health care. These should be adequately funded within appropriate structures of accountability and reporting.

2. Clinical governance should help practitioners to improve continuity of care and develop trusted relationships with patients. It must enable practitioners to treat people rather than diseases and to understand the connections between different aspects of health. There should be explicit recognition of the dignity and autonomy of individual patients and of the right of patents to exercise choice.[xvii] No patient should be pressured into accepting treatments or disadvantaged for not accepting treatments, which do not accord with their own values and aspirations, even if the treatments are in line with nationally recommended protocols.

3. Clinical governance should be a learning tool and not a performance management tool. Practitioners need help to think and solve problems; micromanagement works against this. Too many clinical governance demands on struggling practices may overwhelm them and therefore disadvantage those most in need of development.

For NATIONAL POLICY the RCGP recommends:

A. In relation to the role of primary care:

1. The core role of the general practitioner to help people to make sense of multiple problems must be highlighted as different and equally valuable to the specialist role concerned with curing established disease, and the public health role concerned with preventing ill-health. These roles are complementary. We all need better ways of understanding these different strengths and weaknesses and facilitating partnership working between these essential roles.

2. Both primary and secondary care practitioners need to better understand the interaction of multiple problems and the way they are perceived differently by different people. Better use of story-telling, patient experience and case studies would assist this.

3. Resource allocation formulae must take account of the demands that co-morbidity places on the health care system and that this affects deprived areas disproportionately.

4. Targets for the management of single disease states need to be weighted to reflect the compounding effects of co-morbidity. Without this, practices that serve people with multiple problems will be systematically disadvantaged.

B. In relation to a research approach appropriate for primary care

1. Quantitative and qualitative research should be funded and facilitated:
   * into the extent, causes, implications and context of co-morbidity in patients;
   * to increase understanding of the impact of co-morbidity on patients and families;
   * into the extent to which co-morbidity contributes to health inequalities.

2. Those responsible for researching health inequalities should pay much more explicit attention to the extent of co-morbidity and the challenges that arise from it.

3. IT systems[xviii] should be developed to facilitate the documentation of the extent of co-morbidity and to support the management of affected patients and families co-morbidity. However, it is important to recognise that IT is by its nature reductive and systems of computer based quality assurance may fail to recognise high standards achieved in the care of patients with multiple and compounding health and social problems.

C. In relation to educational support for primary care

1. Interactive electronic information databases, designed to encourage reflective practice, are developed, piloted and evaluated. They should prompt practitioners to explore the diversity of experiences of patients and to discourage the idea that problems are simple and can be divorced from other aspects of people's lives. If found to be of proven usefulness, they should be made available to all practitioners.

2. Undergraduate and postgraduate education should pay particular attention to the challenges posed by the clinical care of co-morbidity. At present, medical students and doctors in training have very little

opportunity to appreciate the evolving and complex nature of continuing disease, nor the difficulty of managing it, particularly where disease is compounded by significant co-morbidity. Undergraduates rarely see the same patient twice, and almost never on a longitudinal basis over time. Doctors in training do not often take responsibility for management decisions, and even when they do, current patterns of shift working mean that they have very limited opportunities to learn from the outcomes of their own decisions. This leaves a huge curriculum for the 12 months spent as a registrar in general practice. There is an urgent need for educational reforms at both undergraduate and postgraduate levels to ensure that doctors are properly equipped to provide appropriate care for patients with significant co-morbidity.

3. The MRCGP examination should require candidates to demonstrate an understanding of the problems posed by multiple interacting problems. Successful candidates must be able to recognise the strengths and weaknesses of different research approaches in illuminating situations with the multiple interacting factors. They need to be skilled at a narrative approach to consulting that will locate discrete diagnoses inside the patient's personal narrative.

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3.   Statement on Mental Health and Primary Care 2004

There is an undoubted link between mental health and inequalities: however the relationship is complex. This statement first outlines our understanding of mental health and the role of primary care; primary care clinicians need to

maintain both medical and social models of mental health problems when considering both recognition and treatment. It then examines the impact of inequalities on both mental health problems and the care we provide in general practice.

Clear and practical guidance is provided as to how general practitioners, practices, primary care organisations and national bodies can address inequalities with respect to promoting mental health and providing care. Specific emphasis is placed on patient participation, understanding mind-body links, supporting professionals and collaborative working.

Our understanding of mental health and ill-health, and the role of primary care

- Mental health is a positive state of being in its own right and is much more than the absence of a diagnosis of mental illness; low level symptoms and unhappiness, not reaching 'diagnostic criteria' are associated with poorer quality of life.[1]

- When mentally well we have awareness of and control over different strands of our life; we have the will to live life to its full potential; things make sense to us. In other people's eyes, a mentally healthy person talks and behaves in a culturally appropriately way; there is an apparent ability to maintain their health and develop a role in society. If mental health implies a sense of coherence we must remember that what is coherent to one person is not necessarily so to another.

- Mental illness touches everyone's lives. Many of us will have some kind of mental health problem at some time in our lives and we will all know someone affected by such illness. Mental illness accounts for 28% of the years lived with a disability in most world regions, and for 10.5% of the "total global burden of disease".[2] At a national level, antidepressants account for 7% of the United Kingdom (UK) primary care drug budget; the total cost to the economy of people with mental health problems is greater than ischaemic heart disease, breast cancer and diabetes combined.[3]

- The families, groupings and cultures that help form the identity of an individual can profoundly affect their mental health. For example an overly bullying, unappreciative, abusive or dismissive behaviour can push someone from mental balance towards confusion and distorted self-image; this may result in anxiety, depression or defensive behaviour patterns.

- All citizens, families and social groups have a role to play in building a mentally healthy society. Mental health may be promoted by building protective factors and reducing vulnerability factors.[4] This may be at the level of the individual (i.e. improving self esteem), the community

(i.e. improving housing), and also at the societal level (reducing health inequalities).

- Personal choice and autonomy are critical in maintaining mental health. Often people want to help themselves, with the family and peer group coming before contact with primary care. When asked, people repeatedly say that they want to learn how to manage their own problems for themselves as well as draw upon resources in the community.

- Generalists, specialists and communities can all help those in distress to reintegrate and maintain their sense of self; they can do this by building on the positive and exploring ways of minimising harm from the negative. This process often involves bringing into view multiple often-related issues such as life events (e.g. redundancy), social factors (e.g. unhappy relationships), physical factors (e.g. disease), environmental factors (e.g. poor housing), and spiritual imbalance (e.g. limited ability to reflect).

- General practitioners and other primary care professionals frequently identify, treat and refer people who have severe mental health problems. However we more commonly encounter patients who are both mentally healthy and unhealthy at the same time. Physical, emotional and psychological symptoms are intertwined. The continuing splitting of 'mental' from 'physical' functions itself, perpetuates the stigma, discrimination and exclusion associated with having a 'mental' illness.

- The core of the generalist role is to help patients make sense of often-paradoxical symptoms in the context of their whole life story. Listening and helping patients to reflect can often be more relevant than having 'correct' answers. How someone is able to function within a family and a community is more important than their diagnostic label. At its best, when the system is welcoming and the clinicians have the skills and make time, general practice is ideally placed to work with patients with mental health problems; however, poor primary mental health care also has the potential to do harm.

- Primary care practitioners are also familiar with the concepts of early intervention and self-management for people in many predicaments and with various illnesses, such as diabetes. Interventions for mental can be operated according the same high level principles and practices. Delay in diagnosis, failure to involve patients in treatment and poor follow up can lead to further deterioration of illnesses such as schizophrenia and depression.[5]

- The experience of mental health specialists who treat mental health problems is different in that in the main they encounter people whose mental ill-health has been a dominant aspect of their lives. This

situation inevitably makes the condition for which they have been referred the focus of initial conversations. The patient will often have been given and may have accepted a diagnosis that may not adequately account for physical, social and environmental factors; the setting of their care may be further from home. Some patients do value a specialist input and this too can, at times, be provided in primary care settings and in conjunction with their general practitioner.

- Primary care teams can play a key role in helping to prevent and limit mental health problems in children and adolescents. Health visitors, general practitioners and other members of the team are in a prime position to observe the dynamics in vulnerable households and offer interventions when coping thresholds are reached. Generalists potentially see people along their whole life cycle and so can provide continuity with the transition to adulthood.

The impact of disadvantage on mental health and care for mental health problems

- Significant deterioration in emotional and psychological well-being occurs disproportionately within populations that are socio-economically or culturally disadvantaged, or disadvantaged by a variety of unpleasant life events. There is evidence that social adversity causes mental ill-health. Also that those with severe mental health problems are likely to end up in socially disadvantaged situations and whilst the relationship between the two is highly complex[6], there is evidence that social adversity causes mental illness.

- Overcoming the challenges to personal vulnerability can also result in great mental strength. Health care professionals need to work with both the vulnerability and creativity that can be found in such disadvantaged groups.

- In the UK only 13% of people with long-term mental health problems are employed, compared with 35% of disabled people generally;[2] and they are over represented in poorly paid and less secure jobs, as well as in the homeless population.[7] Mental illness also has a great effect on families and children who often act as unpaid carers. In deprived areas children have more emotional problems and the elderly are less likely to receive adequate mental health care.

- Stigma is common with mental illness. This can be even greater in some disadvantaged groups within society, including the elderly, those with less education, the poor and certain ethnic groups. Suicide rates are higher amongst young men in deprived localities.[8] Stigma is a contributory factor to suicide.[9]

- Individuals with mental health problems are also sometimes less able to contribute to the social capital of society (through caring acts and the

development of trusting cohesive communities). Fear, stigma and communication difficulties can also make them less able to benefit from this social capital, as well as from statutory services.

- Mental Health care services in the UK have in the past over emphasised institutional and coercive models of care. Indeed it is acknowledged that institutional racism exists within the services that should be caring for such individuals.[10] There have been situations where non-european people have been diagnosed as psychotic because they were behaving in a way that was considered to be normal within their own culture.[11] The RCGP recognises the efforts being made to provide more community-based treatment and interventions to prevent admission to hospital; this is particularly valuable to communities which value community, family and faith contributions to improving mental health.[12;13]

- The language of health professionals, whether informed by a medical, social or psychological model, is less accessible to those with little education, reduced literacy, with English as a second language and to those whose cultural models of mental illness are different. Such individuals are also often further adversely affected by the impaired mental function associated with their mental illness or learning disability. This makes finding meaning within distress, sharing understanding and decisions, enabling self-help and therapies based on talk more difficult to achieve. The RCGP supports the use of plain English or a patient's first language in the communications of information.

- Many people with mental health problems have inadequate housing, including threatened or actually enforced homelessness. Special attention to this is needed if the best possible environment is to be provided within which a person can improve.

- Deprived urban localities often have disproportionately large numbers of patients with multiple problems of personality, drug use and mental health problems. Most of these patients will not have psychosis but will have complex needs. Often specialist mental health services do not engage this group and primary care professionals may not have the skills to provide high quality care. The RCGP supports the development of more effective relationships and new models of care between generalist and specialist services; and also the development of integrated care for patients with mental health problems and substance misuse.

- The National Service Framework for Mental Health, for England and Wales, and other policy initiatives across the UK, outline roles for primary care in managing both common and severe mental illness.[14] The new GMS contract provides mechanisms to reward such work, including payments for enhanced services in depression.[15] However it

is likely that these aims will be harder to achieve in disadvantaged areas and will require particular support from a diversity of agencies. Indeed there are dangers that expecting a higher level of service and qualification has the unintended effect of reducing the number of practitioners prepared to contribute; and that having practitioners with a special interest in mental health could reduce the interest and core skills of the remainder.

The RCGP recommends that Primary Care Practitioners and educationalists:

- Promote an holistic understanding of mental health. This will be helped by training for primary care practitioners to practice a "narrative" approach[16] which involves an equal and full exchange of information and shared decision-making to the extent desired by patients, particularly the most socially excluded groups.[17;18]

- Become skilled at bringing into view the diverse factors that will affect someone's mental health, and of the full range of interventions and resources available to address mental health problems.

- Involve patients, to the extent they prefer, in understanding the cause of their distress, in deciding whether a diagnostic label will be given, and in decision-making about management of their mental health problem.

- Develop skills of multidisciplinary team working to develop adequate support for patients, mindful that patients also often value the continuity afforded by one-to-one relationships. Both are needed. There is good evidence to support the value of proactive follow up of patients with depression.[19]

- Ensure that their training and educational needs of all primary care clinicians and receptionists regarding mental health are met, including becoming skilled at identifying symptoms of depression, anxiety, dementia, early psychosis, relationship difficulties, lifestyle problems and altered perceptions.

- Become skilled at using language that facilitates a discussion about mental health issues with disadvantaged patients. Ensure that their concerns and experiences are integrated into such discussions. Explain and promote talking therapies to socially excluded patients

when appropriate. Use translators, advocates and language lines when required.

- Raise awareness and encourage the use in primary care of methods that help all patients to increase their potential to help themselves and creatively contribute to society, and its understanding of mental health. These may include self-help techniques such as diary writing, development of a life plan, cognitive behaviour therapy, meditation, art, assertiveness, negotiation and basic life skills such as reading and writing.

- Facilitate return to work (from unemployment or absence due to sickness) for those who are stressed, low or have a mental illness, by timely advice, the use of cognitive behavioural techniques, being an advocate for the patient and the skilled use of new certification procedures (eg suggesting phased early return).[20;21]

- Become skilled at working with, and referring to the range of voluntary, community and specialist mental health organisations and individuals who can help patients of all ages and backgrounds with complex needs.

- Improve the physical care of patients with mental health problems. Firstly, through understanding the latest evidence dealing with co-morbidity and medically unexplained symptoms. Secondly by evaluating and acting on the physical health needs of patients with severe mental health problems. This may require developing recall systems and joint working with specialists.[22]

- To improve practice and primary care based services, in conjunction with patients, by examining local needs, appraising the evidence base, looking for locally applicable examples of good practice, monitoring standards and developing new services.

The RCGP recommends that Primary Care Organisations:

- Make mental health a priority for primary care within the NHS. This should be supported by a positive, evidence-based holistic understanding of mental health and of the causes of mental health problems, and that its effective management of may involve a number of agencies and individuals with complementary roles.

- Facilitate promotion of mental health, for example as advanced by Mentality,[4] through joint work in communities and by encouraging clinicians to work with individuals to identify health promoting solutions to life's problems.

- Consider piloting reforms of the whole system of care for mental health based on improving the patients' journey. There is now considerable experience of how to do this in a sensitive managed way;[23;24] learning from change may involve a closer integration of research and service development. Developing longer-term working relationships between generalists, specialists and lay experts is essential. This will require considerable skills of whole system facilitation. Such schemes must include a long-term plan for these stakeholders to review and reform plans as a *learning community*, in response to changing needs and opportunities.

- Ensure that developments in primary mental health care include: involvement with early intervention and assertive outreach functions of specialist services; timely availability of specialist mental health advice or support for the management of patients with complex non psychotic conditions; joint working with drug and alcohol agencies; systems for review of physical health needs of patients with long-term mental health problems; and systems for review of the mental health needs of those patients with long-term mental health problems who are not receiving specialist care.

- Use policy levers to promote sustainable system-wide change. Integrate Gateway Workers and Graduate Mental Health Workers fully into local systems of primary mental health care so they can work productively to promote mental health and support improvements in care.

- Use opportunities such as the intended refocusing of Child and Adult Mental Health Services towards primary care as pilots of models of system reform. Institutional boundaries between mental health services for children, adults and elders must be flexible.

- Develop a strategy and plan to support those practitioners least able to provide high quality mental health services. This will need to take account of the mental well being of clinicians, the stage of organisational development of practices as well as the skills and educational needs of clinicians. Localities that are hard-to-doctor need to be prioritised to develop enhanced services for mental health that include partnership between medical and non-medical stakeholders, including carers and users. Multifaceted facilitated interventions are likely to be required.[25]

- Support individual and community development approaches to mental health promotions that enhance a person's social networks and sense of value within society.[26] These should involve all citizens and

encourage particular roles for the social services, housing, credit unions, mutual societies, the Voluntary sector, faith communities, education, sport and leisure industries and business. The development of a range of social prescribing options, which may require brokers to facilitate uptake,[27] (e.g. Time Banks[28]) for clinicians to offer in addition to medication and talking therapies is particularly important for patients presenting with symptoms relating to life problems.

- Facilitate local collaboration between health services and other organisations with an impact on mental health. Examples include the integration of mental health care and promotion into initiatives to combat unemployment; joint working between citizens advice bureaus (and other advisory agencies) and primary care; working with local education authorities, juvenile courts and schools to encourage the identification of vulnerable children in need of mental health promotion or services; and joint work between primary care teams and nursing and residential homes to promote health and identify needs.

- Highlight local and national examples of good practice in mental health services, where all members of families/households/support networks are offered support, regardless of their age.

- Provide to practitioners and patients an up-to-date handbook and website of local statutory and non-governmental services for mental health.[27]

- Development of IT data transfer and coding systems which encompass holistic health promoting care as well as disease focused management. Develop practice based registers of those with long-term mental illness as a basis for voluntary optimal proactive care. Development of primary care data collection and disease management IT systems which prompt encouragement of self management, shared decision making and options for health promotion.[25]

- Ensure that anonymised data about Mental Health Services, crucial for commissioning, audit and service improvement, is collected accurately and consistently across primary and secondary care sectors. Personalised identifiable data should only be used to further individual clinical care.

At a National level the RCGP recommends:

- Collaboration between opinion-forming organisations to frame discussions about mental health within the broad understanding outlined here, and better integrate the training of those concerned with

the mental health of children and elders. These organisations include the Royal Colleges (General Practitioners, Nursing, Physicians and Psychiatrists), associations that support relevant professional groups including the Faculty of Public Health Medicine, Voluntary, User and Carer Groups, the Social Services and the Department of Health.

- Supporting activities that listen to users ensure that these recommendations are listened to and responded to. Patient and Public Involvement (PPI) are required at all levels. Links need to be built from national primary care organisations with the Commission for Patient and Public Involvement in Health, the Patient Experience Team in the Modernisation Agency, the Expert Patient movement and with the DoH Patient Experience Team.

- The Department of Health and Educational Authorities need to pay special attention to children and adolescents who are not at school. Many of them have mental health problems, often associated with illicit drug use. A significant proportion of our children in prisons have not been to school for a significant period of time before their detention, and a significant proportion suffer from mental health problems.

- Specific advances can be made nationally by providing housing security for people with mental health problems, by promoting recovery through improved sickness certification, and by integrating mental health care (eg cognitive behavioural techniques) with job finding initiatives.[21]

- Support for a broader understanding, by undergraduate and postgraduate education providers and by research funders, of the issues outlined here about primary mental health care.
- Collaboration with the media to promote the everyday nature of mental health problems, the capacity for recovery, the reduction of stigma and the availability of support.

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