Time for change, now more than ever!
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The European Forum for Primary Care working group for Mental Health believes there is a need for a paradigm shift in mental health delivery, echoing the United Nations call for a ‘Revolution in Mental Health’ (Pūras, 2017).

Primary Care has a central role to achieve this, being key to the development of comprehensive services and rooted in communities. These services offer local solutions in an integrated and coordinated way, that enables access to prevention, early intervention, treatment, rehabilitation and recovery (World Health Organization, 2018). This will be achieved by placing people and their communities at the centre of design, implementation, delivery, and evaluation of mental health services, systems, and policies. Mental health must be managed in the community in a holistic, compassionate manner and requires support at a government level to achieve this.
INTRODUCTION

The European Forum for Primary Care Mental Health (EFPCMH) working group collated the experiences and views from a series of workshops over six years. The insights shared are from primary care practitioners and service users, across Europe, Singapore, South, and North America. The workshops produced recurring themes that have been collated and are reflected in this position paper. There was consensus that the current system, where everyone with a mental illness is expected to be treated by a specialist, is not economically feasible or desirable. The workshop’s outcomes showed that Primary Care should be a central part in the development of comprehensive community-based services that reflect local needs and local solutions. By placing people at the centre of design, implementation, delivery, and evaluation of mental health services, systems and policies, this can be achieved. This document challenges the position of primary care’s readiness for such a role based on the views of clinicians, patients, and their caregivers.

The workshop participants shared many beliefs and values, embracing the move to destigmatise mental health, through co-production, to include the patients’ and caregivers’ voices and skills in the research and development of services. There was a recognition that anyone of us, or our families, could be affected by mental ill-health at any level, at any time. Partnership and dialogue with EUCOMS showed that community-based service models are gaining in strength identifying solutions including integration with primary care (Keet, 2019, Pieters, 2017). The workshops discovered that there is no universal framework for integration, the feedback showed a patchwork of primary care response, poor data collection, limited investment and little research on outcomes for the service users and their families. This environment means that some countries have not changed their practice, still using asylums with no access to primary care. Other countries with more sophisticated systems have pockets of excellent practice but are still reliant on medication and legislation to manage mental ill-health. There was a consensus that those in society who are most vulnerable and have the most needs are not getting them met. Themes from across the whole life course were identified as priorities for transformation to enable primary care to be pivotal in a new system of mental health.

These themes are not exhaustive, they offer a holistic framework where primary care would enable a psychosocial, spiritual and cultural perspective to work alongside the physical health model to ensure holistic care.
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STATEMENT THEMES

-1- ACCESS

**Issue**

Early intervention and support are evidenced to alleviate distress and improve outcomes. (Bird et al., 2010, McGorry & Mei, 2018, Read, Roush & Downing, 2018). However, the workshops showed that early intervention is not available in all countries. It was reported that people met barriers and received little or no help until they reach the threshold to meet the criteria to enter services. However, not all receive access to specialised treatment due to their diagnosis or having a co-morbidity such as addictions or physical health problems. Access barriers leave people suffering on waiting lists, often unrecognised, misdiagnosed, misunderstood or ending up in different parts of the system, notably the criminal justice system. Countries with a health insurance funding system reported that treatment was only available for those with symptoms that fitted specific “diseases”. Countries without health insurance reported a ‘lottery’ of health care with no consistency of services nor allocation of resources. All countries reported that funding for mental health services is not equal to physical health.

**Solution**

There should be no artificial limits if you require care. Access needs to be at the right time, in the right place, by the right person with the right skills. Primary care can enable swift access at a low level and recognition stage (Dowrick et al., 2016). Collaboration ensures that the patient can get the support they need when they need it, including housing, benefits, work, family, social support, therapy, and specialized mental and physical health services. Primary care offers a continuation of support that matches need, freeing up demand for specialist services. Specialist services need to be working collaboratively with communities that involve patient and caregiver voices, primary care, social care and the voluntary sector in an integrated system to support the patient on their path to recovery (Woltmann et al. 2012).
-2- CO-CREATION

**Issue**
Throughout the workshops, it was voiced that there could be no improvements and decisions made without the patient at the heart of all that was done. Concern was expressed that co-creation is frequently discussed and is represented in international policy documents and is rightly best practice, but, is seldom delivered upon. A systematic review of the literature (Manikam, Shah, Reed, Santini & Lakhanpaul, 2018) evidences this view demonstrating the growth of published material from 6 to 150 papers from 2006. However, these are across all of health showing co-creation remains an under-resourced and under-invested area of Primary Care Mental Health. Evidence shows that language and access to some cultural communities are barriers in meeting their mental health needs and co-production could increase participation rates to improve the quality of services (Lloyd, Johnson, Sturt, Collins & Barnett, 2008, Minogue & Girdlestone, 2010).

**Solution**
To do justice to co-creation patients and caregivers need to be at the heart of all we do, and their voices must be heard within any system change. Integrated pathways of care will work when patient and caregiver experiences are shared, and their world view is understood. The World Health Organisation (Murray, Lopez & World Health Organization, 1996) emphasise the need for people-centered health services which sees people as participants as well as beneficiaries of health care services. Primary Care Mental Health services of the future to be integrated, responsive and compassionate in their response. Patients need the education and support they need to make decisions and participate in their care. (World Health Organisation, 2015). This will ensure that services are tailored to meet the breadth and depth of need from local community sources. Investment and mainstreaming of patient-led research and evaluation will benefit services, communities, and individuals alike.

-3- COMPLEXITY IN PRIMARY CARE

**Issue**
Mental health is individual with complex biological, social, spiritual, cultural, medical, psychological, existential and economic factors interconnecting. Clinical guidelines and evidence-based medicine focus on single issues and the best treatment for a sample population that tends to exclude people by age, culture, and gender (Smit & Derksen, 2017). We need to acknowledge the individual, consider co-morbidity and the interconnectedness of all factors. It is time to change systems of care (Sturmberg, Martin & Katerndahl, 2014).
Solution
Building teams around primary care to link patients into the community and local mental health services is a good way of ensuring that every individual can be supported to meet their complex needs (Thota et al., 2012). The EFPC underlines that primary care practitioners are experts in complexity, acknowledging the individual, their surroundings and the interactions between physical and mental health and the need to look after both (Kringos, Boerma, Hutchinson, Van Der Zee & Groenewegen, 2010). They are rooted in their communities and in a good position to know about both the problems and the assets within the areas they work in.

-4- DIAGNOSIS OF MENTAL HEALTH DISORDERS

Issue
The use of psychiatric diagnosis in primary care is problematic (Vanheule, 2019). A psychiatric diagnosis misses the individual context of the patient, which is needed to weigh up the symptoms and to answer the request for help (Van Os, 2019). The complaints of the patient are often compounded. Moreover, there is a huge amount of overlap in symptoms resulting in difficulties with classification. A diagnosis does not tell us much about what kind of treatment the patient needs (Allsopp, 2019). The professional guidelines, linked to the DSM 5 diagnoses, tend to medicalise mental problems, whereas in primary care contextualized mental health problems are presented and managed.

Solution
Instead of focusing on the diagnosis regarding mental health problems, the focus should be much more pragmatic. This pragmatic approach allows recognition of individual experience and gives a better understanding of the distress of the patient (Allsopp, 2019). This could be as easy as asking four questions (Van Os, 2017, Delespaul, 2017).
1) What happened to you?
2) What is your vulnerability and what is your strength?
3) Where do you want to go?
4) What do you need?

From an integrated care perspective, we advocate for a centralised role for the patient based on their individual needs supported by a whole system approach including local caregivers. Primary care mental health problems should be seen in a context where treatment will stimulate normalisation and self-care in harmony with the patient.
**Issue**
The views were that there is a lack of awareness and skills in communicating and managing wellbeing and mental health across the whole population, resulting in fear and stigma. The literature supports this view of stigma not just being at a population level but also across professions (Schulze, 2007), education (Martin, 2010), disciplines including physicians (Wallace et al., 2009), communities and whole countries (Saraceno et al., 2007).

![Diagram of a whole population approach to education adapted from the Austrian model of 'Health Hygiene' (Hill, L. 2018)](image)

*Figure 1 shows a whole population approach to education adapted from the Austrian model of ‘Health Hygiene’ (Hill, L. 2018)*

**Solution**
A workforce, fit for the future, requires education that is fit for purpose at all levels. There is a need for education that enables awareness of mental health and wellbeing from an early age to enable
prevention, early detection and to address stigma, the entire population requires a level of knowledge. Research shows that contact combined with education seems to be the most promising avenue (Rüsch, Angermeyer & Corrigan, 2005, Thompson, Dogra & McKinley, 2010). Professionally, mental health needs to be embedded across the curriculum of all discipline starting at an undergraduate level and continuing through post-graduate training and continuing professional development. Co-production and a wider knowledge base that builds on the needs and experience of service users for their recovery journeys (Leamy, 2011, Stuart, Tansey & Quayle, 2017) is key, as is reflecting peoples cultural and spiritual needs.

-6- INEQUALITY

**Issue**

Mental health is not discriminatory. We know that certain areas are at higher risk of mental health problems because of greater exposure and vulnerability to unfavourable social, economic, and environmental circumstances (Wilkinson & Pickett, 2017, Ribeiro et al., 2017, Barnett, 2012). Nurture, love, support, and freedom to grow are necessary to develop into a healthy adult, but those born in poorer families and poorer areas have an increased risk of mental health problems in later life (Vannieuwenborg, Buntinx & De Lepeleire, 2015, Tong et al., 2018). There are fewer mental health problems in societies where the population feels they have control over their lives and are involved in decision making. The poor have less choice and societies are happiest where inequalities are lowest. Poverty divides society and is a major factor for mental illness, the dispossessed lose hope and feel left behind whilst the rich fear losing the security of their wealth.

**Solution**

Inequalities caused by adverse life events, racism and other forms of discrimination, abuse, violence, neglect, immigration, refugees, asylum seekers, illness, bereavement, relationship breakdown, contact with the criminal justice system and institutional care are all related to an increased risk of mental health problems. There is enough evidence that we should strive for fewer income differences to improve the health and wellbeing of populations (Pickett & Wilkinson 2015, Barnett et al., 2012). We will not reduce the stigma associated with mental illness unless we recognise this and focus on the causes and reduction of their impact, instead of blaming it on inherent weakness in the individual (Clement et al., 2015).
-7- INFORMATION TECHNOLOGY

**Issue**
Concern was shared regarding the growing shortage of General Practitioners all over Europe. It was voiced that health care systems alone will not be enough to meet the growing need for treatment of mental health problems (Bodenheimer & Smith, 2013). Social media can isolate and be the cause of deterioration of mental health through cyber-bullying and social isolation, but it can also be used to benefit mental health by providing education and therapy programs. There is a gap in our knowledge as to the impact of these programs.

**Solution**
Information Technology has the potential to help those with mental health problems, alongside those who support them. We must make this information technology accessible for everyone, not only for people who can afford it (Allen & Christie, 2016). E-health, web-based health interventions have been shown to increase access to care (Hilty et al., 2013). There is evidence of websites, apps and other technologies, which used wisely can be of benefit, particularly to those unable or unwilling to access health and social care services. Guided Internet interventions seem to be cost-effective (Donker et al., 2015)

Information Technology cannot replace the human touch; however, it can be used to the benefit of many, either with or without therapist and clinician support. Further research and investment are needed in this area.

-8- LEADERSHIP

**Issue**
To create change, there needs to be governmental, clinical, community and patient ownership. Within these areas champions for mental health are needed. Like all other conditions presenting in primary care, the approach should be bio-psychosocial and existential. ‘There needs to be an integrated approach which is case managed with a recognition that it corresponds with complexity sciences which have cohesion and dynamics in their focus’ (Smit & Derksen, 2015).
**Solution**
The process of change is one that needs guidance and understanding, which requires leadership at all levels. We know ‘one size does not fit all’, so it is important to recognise the uniqueness of each environment and tailor services to meet population needs with leaders to inspire that change. These leaders need to be visible throughout society in schools, faith centres, education, and medicine. Their role is simple to inspire others to create change and develop ownership. Therefore, to enable the rhetoric of national and international statements advocating a change in mental health to become a reality we need transformational leadership to inspire the change (Hallinger, 2003, Day & Harrison 2007, Plsek & Greenhalgh, 2001, Plesk & Wilson 2001, Sturmberg & Martin 2012, Sturmberg, O’halloran & Martin, 2012).

**MODEL OF CARE**

**Issue**
Family doctors, from all countries, support people across society and at all stages of their life course. Good primary care provides compassion and cares for the individual, from conception to a good death. There needs to be the recognition that every child, man or woman has their own unique needs when experiencing mental ill-health. There also needs to be a clear recognition of the families and caregivers, who also have distinct needs that are often not understood in the school, community and workplace environments.

**Solution**
Integrated working is a priority across community, health and social care, with best practice examples needing to be understood and shared. It was agreed that integration needs to be at a local level, with skill mix and holistic representation linked to primary care. For more complex needs a dedicated team around the person, offering available support twenty-four hours a day, was identified as key. Mental health needs a clear equitable model of care, which includes investment in prevention, early intervention, access, treatment, and recovery. There is evidence from the USA, Belgium, and the UK that approximately 50% of healthcare costs come from 5% of the population. These high costs, high need patients are often complex and involve multiple agencies (Blumenthal et al., 2016, Rosen, 2018). Adopting a risk stratification model (Figure 2) as a framework to develop a fresh approach for mental health, will ensure that investment and integration are key pillars of development. It will also address those more complex patients presenting with co-morbidities (Thornicroft et al., 2016). Whilst increasing expenditure on mental health is important it is not the sole driver of change. Improved care and outcomes are equally as important. Reducing inequities in geographic coverage
and meeting unmet need means using Primary Care as the first point of support and entry prevents the spiraling of distress and enables the reduction in avoidable hospitalisations. Kaiser Permanente, an American Health Organisation, has developed a risk stratification model (Jadad, 2010). ‘Case management’ ensures coordination for individuals with complex needs requiring integrated high health and social care support. ‘Care management’, at the next level, provides for high-risk individuals using peer support and education. ‘Supported self-management’ is the level of care for individuals with good control of their mental health in recovery needing only routine medical review. The ‘risk stratification’ allows a framework for both health promotion in the community and for identifying clients at risk.

Figure 2: Proposed model of care for mental health based on Kaiser Permanente risk stratification pyramid.

-10- PREVENTION

Issue
The European Forum for Primary Care Mental Health (EFPCMH) recognises that the mental health issues presented in primary care are often preventable and can be caused by external and
environmental factors (Patel et al., 2010, Hughes et al., 2017). These factors are diverse and include global issues such as war (Lindert, Carta, Schäfer & Mollica, 2016, Miller & Rasmussen, 2017), disease (Scott et al., 2009), inequalities (Wilkinson & Pickett 2018), maltreatment in childhood (Angelakis, Gillespie & Panagiotti, 2019, Norman, Byambaa, Butchart, Scottt & Vos, 2012), poverty (Patel et al., 2010) and debt (Sweet, Nandi, Adam & McDade, 2013). Within affluent societies, despite policies and investment, mental health needs are not a priority are not reducing and in some countries are increasing (Jorm, 2014). Current predictions indicate that by 2030 depression will be the leading cause of disease burden globally. (World Health Organisation, 2011) The impact is far-reaching, going beyond a global economic issue, to one which, on a personal, family and community level, impact on people’s spiritual, social, economic, physical and psychological wellbeing.

**Solution**

To enable mental and physical health to be of equal status and ensure parity of esteem requires research, evidence, and investment (Sabbe, 2013). The use of education, including mental health promotion, would enable a population approach to manage this ever-increasing problem. Supporting this is the move toward social prescribing in primary care and the use of the community and third sector (Maughan et al., 2016). Therefore, a fundamental paradigm shift towards prevention (Jorm, 2014, Keet et al., 2019) and community-based services including primary care is required (Knapp, McDaid & Parsonage, 2011). This needs to be holistic and compassionate requiring both government strategic support and investment.

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**Research**

Due to a paucity of accurate data and data analysis regarding primary care mental health, there is a lack of knowledge and extensive rhetoric at national and international levels that is not well informed. In line with the paradigmatic shift towards an understanding of a praxis of health care that takes account of its complexities, we also need new methods for research (Sturmberg et al., 2019).

**Solution**

Accurate data will allow the rebalance between self-care and professional care, addressing this data gap. It will inform the redrafting of strategy and policy in primary care mental health and guide a whole system review for a system that works. It is imperative that research is independent and informed by the patient’s voice, carers and professionals working in communities. Technological solutions also need to be researched as to what works and why only then can complexity be properly addressed.
**-12- SELF CARE**

**Issue**
Psychological, social and medical care is available for only short periods, compared to the amount of time that people need to self-care. We are social creatures, for whom altruism, doing things for others, well-evidenced for creating wellbeing and happiness (Post, 2005, Aknin, Broesch, Hamlin & Van Der Vondervoort, 2015). Increasingly, particularly in affluent societies loneliness and isolation, known to be detrimental to health (Jessen, Pallesen, Kriegbaum & Kristiansen, 2017, Victor & Yang, 2012, Beutel et al., 2017, Stickley & Koyanagi, 2018) and chasing money, rather than happiness, is becoming the norm. Data shows that obesity (Davillas, Benzeval & Kumari, 2016), smoking (Steinberg, Williams & Li, 2015) and taking drugs (Morley, Lyskey, Moran, Borschmann, & Winstock, 2015) and drinking alcohol (Mäkelä, Raitasalo & Wahlbeck, 2015) are more common in those with mental health issues as is lower life expectancy.

**Solution**
Self-care should not be an excuse for no care. Primary care is in an excellent position to work with patients to create individual lifestyle choices that benefit themselves and the wider community. This will also address issues, such as the negative symptoms normally associated with mental illness, stigma, and isolation as well as promoting wellbeing across the life course. Physical health and mental health are interlinked (Ohrnberger, Fichera & Sutton, 2017) and health promotion is required at an entire population level. The cornerstone of recovery is hope (Hobbs & Baker, 2012) and underpinning all self-care is that you can recover to be the best you can be.

**-13- SPIRITUALITY**

**Issue**
We recognise that there are often cultural and spiritual interpretations of mental ill-health, such as black magic, Jinn or juju, the workforce, and society struggle to understand these non-western concepts. They can result not only in isolation and fear for the patient but also for the wider community.

**Solution**
Working with communities to understand their worldview is a vital part of primary care, who are placed in the heart of the community. Recruiting people from different backgrounds with different

knowledge bases and adopting a policy of community engagement will enable understanding. Harnessing the knowledge of existing staff and the wider community will also help. Within primary care, there is a growing evidence for the use of Chaplains for Wellbeing supporting issues such as bereavement and loss (Kevern & Hill, 2015, Mc Sherry, Boughey & Kevern, 2015, Mowat, Bunniss & Kelly, 2012, Puchalski, Vitillo, Hull & Reller, 2014; Balboni, Pucchalski & Peteet, 2014).

-14- WORKFORCE DEVELOPMENT

Issue
Within the EFPCMH workshops, patients stated that they feel they are not being listened to. General practitioners and nurses expressed that there is little time to listen and they had not been adequately trained. Primary care staff felt overwhelmed with the volume of mental health and felt that they were left to manage it unsupported, self-reporting burn out and stress and placing pressure on General Practice (Baird, Charles, Honeyman, Maguire & Das, 2016).

Solution
Mental Health in Primary Care needs to be delivered by a workforce with the skills to assess, manage and treat mental health. This involves developing the interpersonal skills to enable recovery, offering hope and trust. The person needs to be available at the right time, in the right place, offering the right care in the right manner.

Suggestions for new roles in primary care that have been trialed successfully include the role of a social navigator, to navigate the patient through the complexities of the health and social care system (Dohan & Schrag 2005, Natale-Pereira, Enard, Nevarez & Jones, 2011). Case managers, potentially a generalist role, that pro-actively supports and co-ordinates people with mental health problems at a primary care level (Bodenheimer, Wagner & Grumbach, 2002, Wallace et al.2015) and Chaplains for Wellbeing (Kevern & Hill 2015, Mc Sherry et al. 2016).
REFERENCES


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