Royal College of General Practitioners

RCGP position statement on mental health in primary care

Primary Care Mental Health Steering Group
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Dr Liz England

Contents

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Executive Summary

This paper has been written to set out the position of the RCGP on the provision of mental health care in primary care and update the previous position statement.[1]

Mental health has, and always will be an important part of general practice. As General Practitioners (GPs) we often provide mental health care as part of our holistic role.[2]

This position statement can help clarify the current roles and responsibilities of the PHCT in light of recent policy changes and developments. It recognises that many of the recommendations can only take place if appropriate resources are provided.[3] The statement considers the role of general practice in managing patients in the community, mental health problems and long-term conditions, parity of esteem of mental and physical health, inter-professional working as well as training and education.

Introduction

Primary mental health care is a relatively recent concept in health care. It is defined by the World Health Organisation (WHO) as follows:

- First line interventions that are provided as an integral part of general health care, and
- Mental health care that is provided by primary care workers who are skilled, able and supported to provide mental health services.

Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.[4]

- There are a number of reasons that mental health should be integrated into primary care:
- The burden of mental disorders is great.
- Mental and physical health problems are interwoven.
- The treatment gap for mental disorders is enormous.
- Primary care for mental health enhances access for all
- Primary care for mental health promotes respect of human rights.
- Primary care for mental health is affordable and cost effective.
- Primary care for mental health generates good health outcomes[4]

Mental health problems are common. One in six adults[5] and one in ten children[6] are likely to have a mental health problem in any year. Antidepressant prescribing has doubled in a decade. An average GP list of 2000 patients will have (at any one time):

- 352 people with a common mental health problem
- 8 with psychosis
- 120 with alcohol dependency
- 60 with drug dependency
- 352 with a sub-threshold[i] common mental health problem[7] [8]
- 120 with a sub-threshold psychosis
- 176 with a personality disorder
- 125 (out of the 500 on an average GP practice list) with a long-term condition with a co-morbid mental health problems
- 100 with medically unexplained symptoms not attributable to any other psychiatric problem (MUS).[9]

90% of people with mental health problems are cared for entirely within primary care, which includes people with serious and enduring mental illness (SMI)[ii] but primary care uses less than 10% of the total expenditure spent on mental health. Around 30% of people who see their GP have a mental health component to their illness.[10]

Providing care for people with mental health problems and promoting mental health is a priority for the NHS in each of the four countries of the UK.

General practice, which is part of wider primary care[iii], is charged with providing care for 'common mental health problems' and contributing to health promotion,[11] through the GP Contract, commissioned by NHS England but there is a lack of clarity around roles and responsibilities for the care of patients with chronic, complex and disabling non-psychotic mental health problems. Primary care also has a duty to provide physical health care including offering screening, to those people with SMI such as schizophrenia.[12] However, there is no clear direction as to who should manage people with stable SMI who no longer require the expertise of specialist secondary care services.[13] Many of these people are being discharged into primary care with no planning or support.[1, 2]

Primary care is in a unique position to deliver mental health care being most people's first port of call in times of health care need or the development of symptoms. It is the only part of our health service that offers 'cradle to grave' family orientated, person-centered care, often seeing and supporting patients through significant life events such as pregnancy and bereavement.

There are clear links between mental and physical health. Up to a third of people with many common chronic illnesses or long-term conditions such as diabetes suffer with co-morbid mental health problems such as anxiety or depression, which is also within the remit of primary care. There is also a large group of underserved people in primary care with persistent physically unexplained symptoms (also known as medically unexplained symptoms MUS).[14]

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i Background Subthreshold conditions (i.e. not meeting full diagnostic criteria for mental disorders in DSM - IVor ICD- 10)
ii Serious mental illnesses include schizophrenia, bipolar disorder and depression with psychosis- the disorder usually causes significant disability and has usually lasted more than 2 years.[36]
iii Primary care services provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS. Primary care includes general practice, community pharmacy, dental, and optometry (eye health) services.

Early intervention in primary care and other settings is important as 50% of mental health problems are established by age 14 and 75% by age 24. Early intervention and the prevention of mental illness could reduce illness,[15] save lives and money, but also reduce the general practice workload as well as promoting resilience and good mental health in the health care workforce.[16,17]

An increasing number of people who consult their GP are significantly psychologically distressed. It can be difficult to assess distress as it may not meet any of the criteria of a mental illness but both transient and persistent distress can lead to significant functional impairment. Distress may be a transient phenomenon related to specific stressors that subsides when the stressor disappears or as the individual adapts to the stressor or persistent if the experience of distress is far in excess of what is culturally appropriate or persists well after the termination of the stressor(s).[18] There is debate about the risk of over-medicalising a normal emotional response, the role of the GP here and the limitations imposed by our current primary care mental health systems in how far GPs can support people with persistent distress where frequently the only real option is to prescribe medication. This is an area where resources could be directed to support GPs and improve outcomes for patients.[19]

There is evidence that shows that people prefer to receive their mental health care in a primary care setting, which places and emphasis on providing care as close to the patient's home as possible, is able to take patients' views into account and is a less stigmatising environment. It also allows physical and mental health care to be more easily delivered together.[20] Primary care provides holistic care based on a bio-psycho-social model, rather than a medical model of care. GP training emphasises the importance of communication skills and relational continuity of care in the provision of the bio-psycho-social model.[2] Collaborative or integrated care models that use a personalised care planning approach are a Government policy priority. The mandate for the NHS explicitly promises that "everyone with long term conditions, including people with mental health problems, will be offered a personalised care plan that reflects their preferences and agreed decisions."[21] Integral to this model is the need for the individual to be an equal partner in the care planning process, which is outlined in the House of Care approach.[22] There is evidence to support personalised care planning in primary care for people with anxiety and depression in terms of improved mental health outcomes, however there is less evidence to support mental health improvement using a personalised care planning approach for people with SMI in primary care. The RCGP explicitly supports collaborative care and support planning (CCSP) and recommends that it should be core business for general practice and highlights it as an effective way to manage multimorbidity and recommends its inclusion in the RCGP curriculum.[23]

Other developing issues in primary care are the development of new models of care (Vanguards, Federated models and the move towards 24/7 care),[24] which aim to offer an at-scale model of practice, may impact on the relational aspects of personalised GP care and thus reduce continuity of care, which is so highly valued.[25] In addition, general practice services are currently under great strain due to increasing demands around access, which can impact on the quality of care provided.[26]

The increasing demand for General Practice Services and appointments in the United Kingdom can impact upon the quality of primary care mental health delivered.[27] Quality of care is measured currently by the framework of the NHS GP Contract and NHS Quality Outcome Framework (QOF) indicators in England.[28] There is a lack of specific Primary Care Mental Health targets or outcomes available. Dependence on GPs for mental health support is likely to grow as the NHS continues to manoeuvre support away from hospitals and into the community as outlined in the Mental Health Five Year Forward View.[29] Furthermore, many national mental health organisations are increasingly encouraging people to visit their GP if they are feeling unwell.[30]

The College has made mental health a 5-year clinical priority with a Mental Health and Whole Person Care Lead and Clinical Fellow for Mental Health. Policy and clinical evidence changes and develops over time, and it is important that a position statement is a dynamic document and able to remain relevant and useful.

The following set out the position of the RCGP on what constitutes primary care mental health and the role of the GP in managing mental health problems in primary care.

1. Mental health is a core part of the business of primary care.
2. The RCGP recommends that the role of the general practitioner managing mental health problems should be that of the expert generalist, rather than developing specialist or extended interest roles.[31]
3. The RCGP recommends that GPs should champion the development of mental health care for under-represented, potentially vulnerable groups of patients, including for example children and young people, people with dementia, asylum seekers and refugees, travellers, offenders, people with intellectual disabilities and/or autism, the homeless; and be aware that there are higher rates of problems in socially excluded and vulnerable groups.[32]
4. The RCGP officially endorses the delivery model for Collaborative Care and Support Planning (CCSP) as key to delivering person-centred care in the context of the growing prevalence of multimorbidity, long term conditions and mental health problems. CCSP should be part of General Practices core work.[23]

Prevention

5. The RCGP recognises that mental health is a positive state of being in its own right and is much more than the absence of a diagnosis of mental health problems. The RCGP recommends that GPs and Primary Care should work with a range of organisations including Clinical Commissioning Groups (CCGs), Health and Wellbeing Boards (HWBs) and local authorities (LAs) to map communities[33] (context, risk, resilience, resources, agencies, workforce and workforce development) so that this knowledge can be used to benefit patients and integrate mental health promotion and prevention into a practices daily work.[11]

Access

6. The RCGP recognises access to primary care mental health is critical and recommends that all people should be able to access Primary Mental Health Care and resources equally. The RCGP recommends applying reasonable adjustments where needed to facilitate this and training should be undertaken by health care staff when needed.

7. The RCGP is aware of increasing demand in the NHS and the need for new ways of offering appointments and services. Measures introduced including digital and phone communication, which may be a barrier to access for a range of people including those who are hearing impaired, have a degree of cognitive impairment, do not own the required technology, or are confused or mentally unwell. Care must be taken to ensure that these people are not excluded from services.

8. Access to healthcare can be difficult for some groups. The Asylum seeker dispersal programme may mean that large numbers of asylum seekers may be moved into a practice area without warning. The nature of the asylum seekers journey to the UK means they often have complex physical and mental health problems. The RCGP recommends additional investment for practices supporting asylum seekers to ensure they receive equitable care.[34]

Increased awareness and early intervention

9. The RCGP recognizes the importance of early recognition and diagnosis of mental health problems especially first episode psychosis, and recommends training and education in this area. This will ensure effective early treatment, referral to secondary services and early intervention for people with 'at risk mental states.'[35]

10. When considering suicide prevention, the RCGP recommends targeted case finding for high risk groups for depression as this can be effective when combined with an organisational zero suicide approach.[36] This requires strong links with specialist care, social care and third sector services, and should include facilities for data sharing.[37]

Diagnosis and stigma

11. Stigma around mental illness is still a contributory factor for people not seeking help, particularly in older adults and men. It is also a contributory factor to suicide.[38] The RCGP recommends that GPs and the PHCT (PHCT) undertake training to increase their awareness of stigma and mental health problems. In addition the RCGP recommends that those who work with men in different settings, especially primary care, need to be particularly alert to the signs of suicidal behaviour.[39, 40]

12. Primary care staff may also be the first point of contact for people who are bereaved or affected by the suicide of family members, friends and colleagues. The RCGP recommends that GPs and the wider PHCT undertake appropriate training in this area.[41]

Diagnosis and diagnostic criteria

13. The RCGP recommends that GPs are aware of current diagnostic criteria for mental health disorders, but also are aware that there may be individuals who do not quite meet the criteria for a particular mental health diagnosis but who can still be very distressed and require help from their GP.

14. The RCGP acknowledges that GPs have an important role in recognising psychological distress and in not over-medicalising people's situation. Studies have shown that people experiencing psychological distress (not meeting diagnostic criteria for a mental disorder) rarely want a specialist referral but actually want a listening ear, human contact, advice and support.[42] The GP is seen as a good source of advice, support and signposting to psychological therapies and counselling where appropriate. It is well known that many people present to GPs with physical symptoms that often have an underlying psychological component. The RCGP recommends careful and sensitive handling of such consultations which can result in positive outcomes, the resolution of symptoms and the person feeling understood.[43]

15. The RCGP recommends targeted screening of individuals with long term physical health conditions.[44] Physical illness is stressful and often places great demands on patients and their families.[45]

16. The RCGP recommends GPs use a holistic understanding of people's mental health based on the bio-psycho-social model.[iv] GPs should be skilled at using this model to identify the diverse factors that will affect a patient's mental health and aware of the full range of interventions and re-sources available to address mental health problems.[2]

Management of mental illness

17. The RCGP recommends that common mental health problems are managed using the stepped care approach recommended by NICE.[46] [v]GPs should manage patients using a combination of medication, psychological therapies, Support groups, befriending, rehabilitation programmes, educational and employment support services and referral for further assessment and interventions in secondary care if needed.

18. 'Case management' and 'collaborative care' models which use a multicomponent approach to management have been shown to be effective for people with post-natal depression and long-term conditions, depression and anxiety in primary care settings.[47, 48]

19. The RCGP recommends that everyone who presents with depression or anxiety should be assessed, treated and have rapid access to support and treatment, either home (online digital therapies such as computerised CBT), primary care based (such as through Improving Access to Psychological Therapies, which should be increasingly integrated

iv The Biopsychosocial model states that "Health is a positive concept emphasising social and personal resources, as well as physical capabilities." WHO,1986. It was proposed by Engel in 1977 who ws dissatisfied with the biomedical management of illness

v Common mental health problems include depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and social anxiety disorder

into primary care including co-located services based in general practices as per the Five year Forward View for Mental Health and the General Practice Forward View),[22], [24] or secondary care. GPs should be aware of their local pathways for referral for people needing urgent psychiatric assessment- crisis care pathway. GPs should follow the NICE guidance on depression,[49] which has been linked with falling patient suicide rates.

20. People with severe mental illness experience some of the starkest health inequalities- dying, on average, between 10 and 25 years earlier than the rest of the population. The RCGP recommends that the physical health care of people with SMI should be approached and managed in the same way as any other long-term condition.[50]

21. The RCGP recommends that all health professionals involved in delivering mental health care should have high quality communication skills in order to provide an empathic, safe, positive approach to the consultation. Within this the RCGP recommends that it is important that there is clear understanding of roles, responsibilities, provision and standards of care within each treatment setting.[51,52,53] The RCGP recommends communication is strengthened with other organisations to improve data sharing.

22. The College supports the inclusion of the process of care planning in the curriculum and training programmes reflecting the centrality of CCSP into the work of a general practitioner The College endorses care planning by the whole primary care workforce as part of the solution to address the growing issue of multimorbidity.

23. For some patient groups, the RCGP is aware that GPs often have an important role but feel it is necessary for the role of primary care to be further defined. These patients are those who often do not have active psychosis but may have multiple problems of chronic SMI but discharged from secondary care, personality issues, drug use and mental health problems with additional complex needs. The RCGP recommends further work with organisations responsible for workforce development and the commissioning of primary care services-Health Education England and NHS England for example, to clarify roles and responsibilities, develop integrated models of care and work with patients and their care and crisis plans.[2, 54, 55, 56] Integrated models of care could include Psychiatrists or mental health workers attached to practices particularly if practices are working together in federated models. This model is recommended by the World Health Organisation.[57] If primary care has an increased role in the management of mental health problems and supports more people in primary care rather than them languishing in secondary care, then the resources and funding should follow the patient and investment in primary care should increase.

24. The RCGP is aware of the significant barriers that children and young people currently face in accessing specialist mental health services. There is considerable variation in acceptance of referrals by CAMHS teams and waiting times.[58] There is also a paucity of non-specialist services that can support a child and their family. It is recommended that children and young people's mental health is 'everybody's business' which includes upskilling teachers, youth workers, school nurses and health visitors as well as GPs. In order to deliver effective primary care level services there needs to be greater

investment and resources to be focused on developing services in CYP friendly settings that promote early intervention and resilience, and more support, both from specialist services and other sectors, for professionals dealing with CYP who do not meet referral threshold to a Child and Adolescent Mental Health Service (CAMHS).[59] The RCGP also calls for in-patient beds for CYP to be located closer to home.

25. The RCGP recommends that GPs and the PHCT who have contact with people of all ages who self-harm or express suicidal ideation should be trained to understand the different roles and uses of the Mental Capacity Act (2005),[60] the Mental Health Act (1983; amended 1995 and 2007)[61] and the Children Act (1989; amended 2004). GPs should understand how issues of capacity and consent apply to different age groups and be able to assess mental capacity in people of different ages. They should also have access at all times to specialist advice about capacity and consent.

26. GPs should be aware of the issues around confidentiality and suicidal ideation. In line with good practice, practitioners should routinely confirm with people whether and how they wish their family and friends to be involved in their care generally, and when looking at information sharing and risk in particular. In cases where these discussions have not happened in advance, a practitioner may need to assess whether the person, at least at that time, lacks the capacity to consent to information about their suicide risk being shared. However, if a person is at imminent risk of suicide there may well be sufficient doubts about their mental capacity at that time. The RCGP recommends that relevant confidential information is disclosed, which may involve family, if it is considered to be in the person's best interest to do so.[62]

27. Mental health treatment for victims of torture or those who have fled from war may require a different approach. Research has shown that they experience significant obstacles to accessing primary care and mental health services. This results from a lack of specialist or culturally appropriate services, the language barrier, the influence of shame and stigma, and the practical problems of starting a new life in a strange country. In addition, migrants face racism and discrimination as a result of the prejudice and confusion felt by some people within primary care and mainstream mental health services. The current ten minutes available for the consultation in primary care may be unrealistic and primary care may not be able to manage the multiple complex issues asylum seek patients present with and there may not be appropriate services to refer people to. However, the core skills of general practice which include compassion and listening may well be helpful here.[63]

28. In common with other black and minority ethnic (BME) groups, cultural beliefs are cited as reasons for Gypsies and Travellers failing to access services. Beliefs include considering that health problems (particularly those perceived as shameful, such as poor mental health or substance misuse) should be dealt with by household members or kept within the extended family unit. Research has shown that the mental health needs of Gypsy and Traveller communities need to have a more joined-up approach and co-location of care. Travellers did not want referrals to specialist services and so services need to work across boundaries and be able to address health, social and economic factors that contribute to the distress of these communities. This may require a different model of working in primary care.[64]

Partnership working

29. The RCGP recommends managing people using a bio-psychosocial model, a holistic model of care often involves bringing into view multiple and 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).[65] The RCGP recommends working in partnership with a range of statutory and non-statutory organisations including but not limited to: housing organisations, Local Authorities, social workers, Criminal Justice Services, education, work and vocational training services, third sector organisations,[66] drug and alcohol teams and other community staff such as district nurses, midwives and health visitors.[20]

30. The RCGP recommends prioritising communication within these partnerships, particularly electronic, across different organisations and services to enable effective primary care mental health to be delivered. A particularly important area is crisis care in mental health where effective information sharing is critical. It is also necessary to ensure wider initiatives such as NHS 111 development, alcohol and drug management, public health and local authority services are developed to fit well with primary care models.

31. The RCGP recommends that future developments in primary mental health care are co-produced with patients and their family or carers and adequately resourced to enable long term strategic planning.[67]

32. The RCGP particularly supports the need for a shared vision for children and young people's (CYP) mental health across a number of organisations including health, education and justice departments, to deliver effective mental health care.[68] This is especially important when delivering crisis care and early intervention services for first episode psychosis[69] to minimise the need for admission, or, to admit a child as local to their home and family.[70]

33. Carers (paid, unpaid, family) play a vital role in the care of people with mental illness and are often unrecognised. They are also at greater risk of poor health than the general population and are more likely and anxiety. Commissioners could work proactively with practices to identify carers who could be at risk of mental health problems and ensure that social services departments systematically offer the assessments to which carers are legally entitled and follow up any findings with appropriate referral or intervention. There is a statutory requirement to act on the outcomes of the carer assessment if a critical risk is identified; systems should be put in place to ensure this happens.[3]

Recovery

34. There is debate about what constitutes 'recovery' in primary care for people with chronic serious mental illness.[71] The National Service User Network (NSUN), a service user organisation identifies a number of actions GPs can take, that contribute to a recovery orientated approach, which it recommends GPs use including listening, joint decision making and working with the patient, drawing on their experiences and ideas of what

constitutes recovery, adopting a whole life approach and recognising that medical treatment is useful only insofar as it assists patients with leading lives that they find meaningful and offering interventions accordingly.

35. The RCGP recommends that the principles of Parity of Esteem[vi] are applied in practice and that patients with mental health diagnoses are prioritised as much as patients with physical health problems, providing the former with high quality physical health treatment too? This also involves avoiding any assumption that physical health problems 'just' relate to a patient's mental health diagnosis.[72]

36. The RCGP recommends that GPs recognise that support from other patients, family, or friends may have a valuable role to play in a person's recovery. GPs should also recognise the importance of work and vocational activity as part of recovery and be responsible and discuss with the patient the completion of Fit notes and other medical certificates and so forth.[73]

Training and education

37. The RCGP will influence training courses for undergraduate medical students to include mental health especially when the role and functions of primary care are being taught to ensure Parity of Esteem.

38. The RCGP calls for an additional year training for GP Trainees. GP training is by its nature very broad and many GPs do not have the opportunity to undertake specific mental health training. The additional year of training could be focused on developing primary care focused mental health skills and children and young people's care. The additional year of training must be flexible and meaningful and relevant to primary care practice, with posts in community mental health services, psychological therapy services, children's mental health services, psychiatric liaison teams, and mental health services for people with learning disabilities, rather than in hospital settings. Posts can be tailored to local needs but should follow programmes recommended and approved by the General Medical Council.[74]

39. The RCGP recommends that GPs who wish to undertake further training in extended roles, all knowledge, skills, and competencies developed in specialist placements should be firmly grounded in primary care, which may require dual supervision by GPs and mental health specialists, and part time roles that allow for time in general practice each week to ensure other generalist competencies are kept up to date. The RCGP and Mind will continue to push for reform in mental health training and to recommend that it is coproduced by people with lived experience.[75]

40. The RCGP recommends training should enable GPs to become 'culturally competent' which can change both doctor and patient behaviour by improving their communication, increasing trust, improving ethnically specific knowledge of epidemiology and treatment

vi Parity of esteem is the principle by which mental health must be given equal priority to physical health. It was enshrined in law by the Health and Social Care Act 2012.

efficacy, and expanding the patients' options within their environment. These behavioural changes can lead to more appropriate utilisation of services and improved outcomes (better health status, functioning, satisfaction and cost-effectiveness) for the ethnic minority group. [76]

41. The RCGP recommends that inter-professional training is important, particularly to develop the whole practice team in mental health skills and includes GPs, practice nurses, psychiatric and psychological clinical colleagues and people with lived experience of mental health problems (which will also reduce stigma).[77]

42. The RCGP recommends that the training and educational needs of the whole PHCT should be met and appropriate to their role, including becoming skilled at identifying symptoms of crisis presentations, depression, anxiety, dementia, early psychosis, relationship difficulties, lifestyle problems, altered perceptions and people who present with physical manifestations of their psychological distress (medically unexplained symptoms).[78]

43. There is currently evidence that appears to support work based learning as having greater impact than guidelines and eLearning or didactic models of teaching.[79, 80, 81]

44. The RCGP acknowledges that training to specifically improve depression recognition and suicide risk evaluation by GPs is an important component of suicide prevention as it significantly reduces suicide rates.[82, 83] Therefore, the RCGP recommends that GPs should be able to evidence post-graduate learning in mental health as part of their CPD, assessed annually at their appraisal and undertake regular suicide prevention training in the same way that they are expected to undertake CPR training, safeguarding and Mental Capacity Act Training.[84] The RCGP recommends that Appraisers specifically ensure that the personal development plan for the coming year has comparable actions for mental and physical healthcare. Whilst the RCGP does not recommend currently any particular single model of suicide prevention training; current Appraisal and Revalidation recommendations suggest that a GP should be competent in a range of areas and recommends that it is for discussion between a GP and their Appraiser to discuss whether competency has been achieved.[85]

45. The RCGP will ensure that the MRCGP curriculum is kept up to date, is relevant and appropriate for GP trainees. The Curriculum will also be of relevance to GPs at all stages of their practice and will address all presentations of mental health in general practice in all ages. The RCGP recommends that trainee GPs should be assessed by the curriculum and the Member of the Royal College of General Practitioners (MRCGP) exam which has a range of mental health skills and competencies.

46. The RCGP will ensure that resources are made available to members (open access wherever possible) supporting them to manage mental health issues in their patients through the RCGP Mental health toolkit. These will be reviewed and updated regularly. They will encourage reflective practice so GPs consider their own, and the practice's attitudes and approaches to people with mental health problems.[86]

47. The RCGP recognises that improving mental health care requires the support of the wider PHCT and working in partnership with other Royal Colleges. The role of nurses in primary care mental health is critical. It is not within the scope of this document to recommend specific actions for nursing colleagues but nurses play have a valuable role in primary care often having more contact with patients with long term conditions than the GP. They are often a respected and valued resource by patients. Nursing colleagues may also have similar issues in terms of training in mental health and so many of the suggestions within this paper may be extrapolated to their training and development needs. There are a number of studies and reports that show how nurses add value to the treatment of long term conditions and mental health problems. It will be important going forward to work together with the Royal College of Nursing.[87] The RCGP recommends that psychiatry trainees should be encouraged to use special interest sessions to gain experience of primary care to improve their understanding of the management of mental health problems in primary care. This will require joint working across both the RCGP and the Royal College of Psychiatrists.[88]

48. The RCGP supports the development of a Joint RCGP and Royal College of Psychiatrists mental health working group with a focus on best practice working at the interface between primary and secondary care services to inform policy, service development, curriculum and research in this area.

Research

49. The RCGP recommends that there is increased investment in research and development and funds to support primary care mental health services to increase education and training of practitioners, case-finding and improve management of a wide range of mental illness in primary care with a focus on developing evidence in primary care settings.[24] The RCGP and the Royal College of Psychiatry have published a strategy for training primary care staff in psychological awareness.[89] It argues that all primary care staff require psychological awareness training in order to provide whole-person care.

50. The RCGP recommends another formal national survey on training needs for primary healthcare practitioners to guide education and learning.

51. The RCGP recommends specific work is undertaken to develop a suite of robust, evidence based outcome measures for primary care mental health, which can also be used to measure new models of care being developed. Commissioners will want to commission primary care mental health services that can demonstrate that they meet the recognised standards for their service, such as those found in NICE guidance. Payment and incentivizing systems should be based on delivery of outcomes and that integrated care is demonstrably achieved.[3]

Commissioning, policy and leadership

52. The RCGP will ensure there is consideration of mental health at policy and project meetings that examine and influence mental health care provision. The RCGP will ensure all relevant outputs from the College consider and represent physical and mental health equally. The Governance for this will lie with the Honorary Secretary of the College and will be included in the terms of reference.[90]

53. The RCGP will work in partnership with appropriate patient organisations who will sit on the mental health steering group. Currently the RCGP is in partnership with Mind. The RCGP is committed to ensuring the principles of parity of esteem are implemented at every level of GP practice from a national College perspective down to individual decision-making by GPs. This should be reflected by the inclusion of mental health routinely when policy-making, implementing decisions, designing new pathways and offering patients care. It is particularly important at the practice level when managing people with schizophrenia or psychosis and ensuring they receive appropriate physical healthcare. It is also important that policy makers consider the patient groups who might be forgotten such as victims of torture, immigration and detained persons).[91]

54. The RCGP supports clinically led commissioning and leadership that promotes a preventative, pro-active, anticipatory primary care mental health service, which is responsive, integrated and promotes recovery. Clinical leadership is critical for the successful implementation of a joint GP and psychiatrist-led integrated multidisciplinary team model. Clinically-led commissioning should use the values-based commissioning model for primary care mental health, which focuses on inclusivity and involves individuals and their family or carers in commissioning, planning and implementing service developments.[92]

55. The RCGP recommends that all CCGs and new models of care, have a specific clinical mental health lead with a primary care background.

56. The RCGP supports and will continue to advocate for future investment in primary care to enable the delivery of high quality mental health care. The RCGP recommends that the proposals found in the General practice Forward View in particular relating to the “3,000 new fully funded practice-based mental health therapists, an extra 1,500 co-funded practice clinical pharmacists” are fully implemented as intended as a practice resource. This commitment needs to be reviewed regularly and challenged if not implemented as intended in

GP and PHCT personal health

57. The RCGP has a duty as a member organisation to ensure that it supports its members with their own mental health and wellbeing in order that they can deliver effective, compassionate, high quality care. In order to allow GPs and their teams to manage the emotional demands of delivering compassionate mental health care, it is vital that both are well supported through supervision and training, including the provision of protected time

for thinking about the emotional impact of their work.[58] The RCGP will champion this. In addition, there should be training available for those GPs and healthcare practitioners who are supporting GPs who have mental health problems.

58. The RCGP recognises that the very qualities that make for a caring effective GP such as empathy and concern, are often the qualities that can lead to emotional distress and later mental health problems through excessive emotional toll. The RCGP will work with NHS England to ensure that there are specific services for GPs due to their unique situation. GPs should not be disadvantaged when compared to other doctors through not having access to an occupational health department.[93]

59. The RCGP recommends that resources are invested to enable GPs and practice staff to have time to consult and reflect upon more complex mental health cases with peers and other medical colleagues and to attend mental health educational learning events. The value of this is enhanced job satisfaction, better patient outcomes and reduced stress. Barriers to attending such events can include the costs of 'whole practice participation' (such as with suicide prevention training) and the time out of practice if locums cannot be found (or paid for).[94] Traditionally individual professional groups such as GPs and Psychiatrists have benefited from common training that was supported and maintained by continuing learning and professional development.[95] By meeting at educational sessions and other shared events, clinicians have described a more common sense of purpose, collectively serving their local community, underpinned by human relationships.[96]

Summary

- Accessible, high-quality, comprehensive primary care mental health services should be available for all communities
- A good in and out of hours care experience should be available for patients, carers and families as partners
- The RCGP recommends working with HEE and NHS England to develop an expanded, skilled, resilient and adaptable general practice workforce
- Investment in suitable community based premises for delivering care, primary care focused teaching, training and research in mental health
- Coordination and collaboration across boundaries, with less fragmentation of care
- Reduced health inequalities and increased community self-sufficiency
- Better access and treatment for children and young people with mental health problems and in-patient beds for CYP to be located closer to home.
- Greater use of information and technology to improve health and care
- Improved understanding and management of inappropriate variability in quality
- More primary care mental health focused development and quality improvement

- Better management and support for people with long term conditions and multiple morbidities and mental health problems and medically unexplained symptoms.
- Better access and management of people who have been tortured, war victims, asylum seekers and refugees.
- Development of more effective and integrated relationships and models of care between generalist and specialist services with appropriate support.
- A rapid, radical shift is needed from the current model of general practice to the use of federations and networks of practices able to work on the scale required for effective integration of services with psychiatry working with and co-located in primary care..
- Without changes to commissioning and funding arrangements, the argument for new models of care will remain theoretical. At the heart of this approach is the use of a population-based capitated contract under which providers would be expected to deliver defined outcomes for the populations they serve.
- Practices will need new skills in various areas: risk stratification of the population, quality improvement, collaborative working with other providers, greater capability in managing financial and clinical risk
- General practice is facing some of its toughest challenges, with workload and patient demand at unprecedented levels. The RCGP believes prioritising the mental health and wellbeing of the General Practice workforce is critical.

The devolved nations

THE RCGP AND MENTAL HEALTH IN WALES, SCOTLAND AND NORTHERN IRELAND

In Northern Ireland, prescribing for mood and anxiety disorders has increased by 20% between 2009 and 2013. Significant inequalities have also been shown in prescribing rates with deprived areas having nearly twice the prescribing rate of antidepressants compared to the least deprived areas. The percentage of public spending in Northern Ireland has been consistently lower than England and Scotland. When deprivation and social ends are taken into account the health and social care system spends 7-16% less than England. Austerity has deeply affected Northern Ireland as the region depends on public spending for a greater amount of its output compared to the rest of the UK.

Costs of mental health service are difficult to estimate as the structure of mental health services is different to the rest of the UK with health and social care being totally devolved. There is minimal uptake of mental health services by people from Black and Minority Ethnic Groups (BAME) and the Lesbian, Gay, Bisexual and Transexual (LGBT) community due to a range of barriers.

Community is an important part of the culture of Northern Ireland, however there are still polarised groups and segregation, due to political and religious affiliations. This results in higher rates of mental health problems and male suicides are 6.6 times greater than the rest

of the population. Evidence has found that exposure to trauma and conflict in Northern Island has led to trans-generational problems with children living in communities that are still deeply divided. In addition, LGBT people face significant discrimination and bigotry from both the public and public service providers. It is estimated that around 45,000 children and young people in NI have a mental health problem at any one time and that more than twenty per cent of young people are suffering 'significant mental health problems' by the time they reach eighteen.[97]

In early 2016, the then Health Minister, Simon Hamilton MLA, appointed an expert panel to lead debate on the configuration of health care services. His successor, Michelle O'Neill, published the Panel's report in October 2016, alongside the Department's report Health and Wellbeing 2026, Delivering Together.[98] She highlighted a commitment to achieving a parity of esteem between mental and physical health, including better specialist services (such as perinatal mental health), expansion of community services and those to deal with trauma of the past. 'Improving Mental Health' was 'indicator 6' in the Draft Programme for Government 2016-2021.

Making Life Better 2012–2023 is the public health strategic framework. 'Improved Mental Health and Wellbeing, Reduction in Self Harm and Suicide' is a key objective.[99] However, a significant gap identified includes improving access further to psychological therapies. Current challenges also include financial constraints; implementation of the Mental Capacity Act 2016[100]; and improved services for early intervention, dual diagnosis and suicide prevention. The Department of Health is considering service needs in relation to perinatal mental health, psychological therapies, mental trauma and eating disorders. Primary care provides step two of the stepped model of care, similar to stepped care in other parts of the UK. Primary care has access to talking therapies similar to IAPT in England.

Wales

The Welsh Government document: Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales is a 10-year strategy for improving the lives of people using mental health services, their carers and their families. It is the first mental health Strategy for Wales that covers people of all ages.[101] It is based on six high level outcomes:

1. The mental health and wellbeing of the whole population is improved.
2. The impact of mental health problems and/or mental illness on individuals of all ages, their families and carers, communities and the economy more widely, is better recognised and reduced.
3. Inequalities, stigma and discrimination suffered by people experiencing mental health problems and mental illness are reduced.
4. Individuals have a better experience of the support and treatment they receive and have an increased feeling of input and control over related decisions.
5. Access to, and the quality of preventative measures, early intervention and treatment services are improved and more people recover as a result.
6. The values, attitudes and skills of those treating or supporting individuals of all ages with mental health problems or mental illness are improved.

There are a range of outcomes expected including improvements in population wide physical and mental wellbeing, people live longer, in better health and as independently as possible, for as long as possible. People and communities are more resilient and better able to deal with the stresses in everyday life and at times of crisis. Child welfare and development, educational attainment, and workplace productivity are improved by addressing poverty. Receiving services through the medium of Welsh is a matter of need for many Welsh speakers and there are action plans to strengthen Welsh language services in health and social care.

Primary care mental health services have been strongly influenced by Mental Health Wales (2016) Measure,[102] which has introduced the need to deliver much more personalised care. Primary care mental health services are delivered through Local Primary Mental Health Support Services (LPMHSS) which were introduced by the Mental Health (Wales) Measure 2010 which provide:

- Comprehensive mental health assessments
- Short-term interventions
- Referral and coordination of next steps with secondary mental health services
- Provision of support and advice to GPs and other primary care staff
- Information and advice to individuals and their carers

However, LPMHSS will not cover all aspects of mental health support needed within primary care. Areas that can fall outside LPMHSS include:

- mental health support for people waiting for a mental health assessment and short- term interventions and if needed after receiving these services
- physical health support for people with mental health problems
- low level mental health support for those with physical long-term conditions
- ongoing mental health support for those with stable mental health problems who have been discharged from secondary care
- mental health support for those who fall outside the remit for LPMHSS or secondary care
- management of medications

Scotland

A significant difference in Scotland is the integration of health and social care. Legislation to implement health and social care integration, passed by the Scottish Parliament in February 2014, came into force on April 1, 2016.[103] This brings together NHS and local council care services under one partnership arrangement for each area.

For health and social concerns, the person that many people turn to first is often their GP. Mental health issues are a common feature of primary care consultations and around a third of GP consultations have a mental health element. Strategic planning and commissioning for primary care services is the responsibility of Integration Authorities.

Scottish Government sees the transformation of primary care as key to delivering the National Clinical Strategy. The Scottish Government is working with primary care providers to test new

models of service provision. They are also developing a Workforce Strategy, which will be crucial in ensuring that the broader NHS workforce is confident in dealing with mental health problems, and in ensuring the availability and capacity of specialist mental health staff.

Integration Authorities will want to consider how they can maximise the role of both clinical and non-clinical workers in primary care, such as Link Workers. Link Workers provide problem-solving, listening and signposting for physical, mental and social problems. They also work with people to optimise their own health, and monitor some chronic condition care plans. This approach will support the delivery of ask once, get help fast.

In primary care, this will mean that new multi- disciplinary models of supporting mental health in primary care to deliver “ask once, get help fast” will be delivered. Models of care are required that allow access to information about what help is available; information about what people can do to look after themselves; signposting and support to access facilities in the community (e.g. leisure services and activities); and information about who is available to provide support so they can make informed decisions about what is best for them.[104]

The Mental health strategy is the first national strategy in health and social care since their integration.[105] This provides new opportunities for local areas to develop their own approaches, to innovate and to work across service boundaries to meet the needs of the local population which might also include the health of prisoners. Again, deprivation and social inequalities have created worse mental health in some groups. Nearly 3 in 4 people living in the lowest household income bracket report having experienced a mental health problem, compared to 6 in 10 of the highest household income bracket.[106]

Endnotes

1 Royal College of General Practitioners Position Statement: Mental Health and Primary Care, London Journal of Primary Care, 2:1, 8-14, 2019 DOI: 10.1080/17571472.2009.11493235.

2 RCGP Curriculum 2010, revised 7 May 2014: Statement 1 Being a GP

3 Joint Commissioning Panel for Mental Health. Guidance for commissioners of primary mental health care services, Feb 2012.

4 World Health Organization and World Organization of Family Doctors (Wonca). Integrating mental health into primary care: a global perspective, 2008

5 Mental health and wellbeing in England: Adult psychiatric morbidity survey 2014. McManus S, Bebbington P, Jenkins R, Brugha T. (eds.) (2016). Leeds: NHS digital.

6 Mental health of children and young people in Great Britain, 2004. Office for National Statistics, Crown Copyright 2005.

7 Definitions and factors associated with subthreshold depressive conditions: a systematic review. Rodríguez, M. et al. BMC Psychiatry 201212:181 https://doi.org/10.1186/1471-244X-12-181

8 Subthreshold' mental disorders. A review and synthesis of studies on minor depression and other 'brand names'. Pincus et al. 1999. The British Journal of Psychiatry 174 (4) 288-296; DOI: 10.1192/bjp.174.4.288

9 McAteer, A. et al. Ascertaining the size of the symptom iceberg in a UK-wide community-based survey Br J Gen Pract 2011; 61 (582): e1-e11. DOI: https://doi.org/10.3399/bjgp11X548910

10 Jenkins R. Et al. Developing a National Mental Health Policy, Maudesley Monograph 43 Hove: The Psychology Press, 2002

11 https://www.england.nhs.uk/wp-content/uploads/2017/02/GMS-16-17.pdf

12 Reilly S, Planner C, Hann M, Reeves D, Nazareth I, Lester H (2012) The Role of Primary Care in Service Provision for People with Severe Mental Illness in the United Kingdom. PLoS ONE 7(5): e36468. https://doi.org/10.1371/journal.pone.0036468

13 Addicott, R. and Ham, C. Commissioning and funding general practice. Making the case for family care networks. The Kings Fund, 2014

14 Naylor, C. et al. Long-term conditions and mental health. The King's Fund and Centre for Mental Health, 2012

15 Silverman WK, Hinshaw SP. The Second Special Issue on Evidence-Based Psychosocial Treatments for Children and Adolescents: A Ten-Year Update. J Clin Child Adolesc Psychol. 2008 Jan-Mar;37(1).

16 Kessler R.C. et al. Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry 2005, 62 (6) pp. 593-602. doi:10.1001/archpsyc.62.6.593

17 Cultivating Mental Health Promotion and Prevention in General Practice. London J Prim Care (Abingdon). 2016; 8(1): 3–9. Published online 2016 Feb 24. doi: 10.1080/17571472.2015.1135659

18 Phillips, M. Is distress a symptom of mental disorders, a marker of impairment, both or

neither? World Psychiatry. 2009 Jun; 8(2): 91–92. PMCID: PMC2691169

19 Byng, R. Recognition of distress and depression in primary care: how far should we go? Family Practice 2012; 29:1–2

20 Lester, H. and Tritter, J. “Listen to my madness”: understanding the experiences of people with serious mental illness. Sociology of Health & Illness Vol. 27 No. 5 2005 ISSN 0141–9889, pp. 649–669

21 The Government’s mandate to NHS England for 2017-18. Department of Health, 2017 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/601188/NHS_Mandate_2017-18_A.pdf

22 Delivering better services for people with long-term conditions Building the house of care. Coulter, A. The Kings Fund, 2013.

23 Collaborative Care and Support Planning: Ready to be a Reality. RCGP, 2016.

24 NHS England. New Care Models: Vanguards - developing a blueprint for the future of NHS and care services, NHS England 2016

25 Royal College of General Practitioners. Continuity of Care in modern day general practice. March 2016.

26 Kings Fund. Understanding pressures in general practice. May 2016

27 General practice forward view. Health Education England and Royal College of General Practitioners, April 2016. Gateway publication reference: 05116. https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

28 https://www.nice.org.uk/standards-and-indicators?tab=qof

29 The Five Year Forward View for Mental Health. A report from the independent Mental Health Taskforce to the NHS in England. February 2016. https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

30 https://www.mind.org.uk/information-support/guides-to-support-and-services/seeking-help-for-a-mental-health-problem/understanding-your-gp/#.WZ8yE8bMzfY

31 The 2022 GP. A vision for general practice in the future NHS. Royal College of General Practitioners, 2013.

32 RCGP Consensus Statement on Health Inequalities. 2002 http://www.rcgp.org.uk/-/media/Files/Policy/A-Z-policy/RCGP-Health-inequalities-Standing-group-consensus-statement.ashx?la=en

33 THRIVE WEST MIDLANDS - A PLAN FOR CHANGE. West Midlands Mental Health Commission, Nov 2016 www.birmingham.ac.uk/ hsmc/mh-wm-combined-authority

34 Access to health care for asylum seekers and refused asylum seekers. BMA’s Medical Ethics Department, Sept 2008.

35 Position statement on children and young peoples’ mental health, 2017. Royal College of General Practitioners, Royal College of Psychiatrists and Royal College of Paediatrics and Child Health. http://www.rcpch.ac.uk/system/files/protected/news/Joint%20intercollegiate%20statement%20Joint%20intercollegiate%20statement%20on%20children%20and%20young%20peoples%20mental%20(1).pdf

36 http://zerosuicide.sprc.org

37 Screening for Depression in Adults: An Updated Systematic Evidence Review for the U.S. Preventive Services Task Force. 2016 Agency for Healthcare Research and Quality (US); 2016 Jan. Report No.: 14-05208-EF-1

38 Vannoy SD, Robins LS. Suicide-related discussions with depressed primary care patients in the USA: gender and quality gaps. A mixed methods analysis. BMJ Open 2011;1: e000198. doi:10.1136/bmjopen- 2011-000198

39 Rutz W., von Knorring L., Walinder J. Long-term effects of an educational program for general practitioners given by the Swedish Committee for the Prevention and Treatment of Depression. Acta Psychiatrica Scandinavica, 1992, 85(1):83-88.

40 Pfaff J.J., Acres J.G., McKelvey R.S. Training general practitioners to recognise and respond to psychological distress and suicidal ideation in young people. Medical Journal of Australia, 2001, 174(5):222-226.

41 http://www.wpro.who.int/mnh/TowardsEvidencebasedSPP.pdf

42 Walters, K et al. Help-seeking preferences for psychological distress in primary care: effect of current mental state, 2008. Br J Gen Pract. 2008 Oct 1; 58(555): 694–698. doi: 10.3399/bjgp08X342174

43 Guidance for health professionals on medically unexplained symptoms (MUS). The forum for Mental Health Jan 2011 http://www.rcpsych.ac.uk/pdf/CHECKED%20MUS%20Guidance_A4_4pp_6.pdf

44 Does a Depression Management Program Decrease Mortality in Older Adults with Specific Medical Conditions in Primary Care? An Exploratory Analysis. Bogner HR. Journal of the American Geriatrics Society 2016 Jan 64 (1) 126-31

45 Royal College of Psychiatrists and Royal College of General Practitioners (2009), The management of patients with physical and psychological problems in primary care: a practical guide

46 NICE. Common mental health problems: identification and pathways to care Clinical guideline [CG123] Published date: May 2011

47 A primary care approach to mental health and wellbeing. The NHS Confederation 2012. http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/Case-study-report-on-Sandwell.pdf

48 Goodwin N, Lawton-Smith S. 'Integrating care for people with mental illness: the Care Programme Approach in England and its implications for long-term conditions management'. International Journal of Integrated Care, 2010 vol 10

49 Depression in adults: recognition and management Clinical guideline [CG90] Published date: October 2009 Last updated: April 2016

50 NICE. Psychosis and schizophrenia in adults: prevention and management. Clinical guideline. Published: 12 February 2014 nice.org.uk/guidance/cg178

51 Improving the physical health of people with serious mental illness: a practical toolkit 2016. NHS England. https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/05/serious-mental-hlth-toolkit-may16.pdf

52 Improving the physical health of adults with severe mental illness: essential actions A report of the Academy of Medical Royal Colleges and the Royal Colleges of General Practitioners, Nursing, Pathologists, Psychiatrists, Physicians, the Royal Pharmaceutical Society and Public Health England. OP100, 2016.

53 What is primary care mental health? WHO and Wonca Working Party on Mental Health. Ment Health Fam Med. 2008 Mar; 5(1): 9–13. PMCID: PMC2777553

54 National Institute for Mental Health in England. (2003a). Personality disorder: No

longer a diagnosis of exclusion.
55 Borderline personality disorder - treatment and management. National Institute of Clinical Excellence, 2009.
56 Reilly S, et al. Collaborative care approaches for people with severe mental illness (Protocol). Cochrane Database of Systematic Reviews. Issue 1. 24: S. Reilly, C. Planner, S. Knowles L. Gask, M. Hann2012. Collaborative care approaches for people with severe mental illness (Protocol). Cochrane Database of Systematic Reviews. Issue 1.24 http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009531/pdf.
57 Integrating mental health services into primary health care. Geneva, World Health Organization, 2007 (http://www.who.int/mental_health/policy/services/en/index.html, accessed 4 September 2007; Mental Health Policy, Planning and Service Development Information Sheet, Sheet3).
58 Frith, E. Access and waiting times in children and young people's mental health services. Education policy institute. https://epi.org.uk/wp-content/uploads/2017/09/EPI_Access-and-waiting-times_.pdf
59 Frith, E. Children and Young People's Mental Health: The State of the Nation, Education Policy Institute, 2016: https://epi.org.uk/report/children-young-peoples-mental-health-state-nation/
60 HM Government (2005) Mental Capacity Act 2005, London: The Stationery Office. legislation.gov.uk/ukpga/2005/9/contents
61 Department of Health. (2008). Mental Health Act 1983. Amended 2008. London: HMSO
62 Information sharing and suicide prevention Consensus statement. Prepared by Mental Health, Equality and Disability Division. Crown copyright, 2014.
63 Refugees and asylum seekers in Primary Care: from looking after to working together. Medical Foundation for the Care of Victims of Torture, Vernon et al. 2009 file:///Users/lizengland/Downloads/Refugees_and_asylum_seekers_in.pdf
64 Better health working 12. The health of Gypsies and Travellers in the UK. Zoe Matthews. A Race Equality Foundation Briefing Paper November 2008
65 https://www.mentalhealth.org.uk/sites/default/files/impact-spirituality.pdf
66 Greig, I and Egan, E. Improving partnership working between primary care and money advice services. Glasgow Centre for Population Health, August 2016 http://www.gcph.co.uk/assets/0000/5673/Deep_End_GPs_Report.pdf
67 The Future of GP Collaborative Working. RCGP, April 2016.
68 House of Commons Library, Parkin, E and Powell, T. Children and young people's mental health- policy, funding, services and education. Briefing paper Number 07196, June 2017
69 Early intervention in psychosis: still the 'best buy'? Castle, D. and Swaran, S. The British Journal of Psychiatry Oct 2015, 207 (4) 288 292; DOI: 10.1192/bjp.bp.114.160630
70 Joint Commissioning Panel for Mental Health, Guidance for commissioners of CAMHS commissioning guidance (October 2013)
71 Pelletier J.F. Contribution of Service Users to the Revision of the WHO International Classification of Diseases: Should Recovery also Apply to General Practice? J Gen

Pract (2017) 5:289. doi:10.4172/2329-9126.1000289

72 Health and Social Care Act 2012, c.7. Available at: http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted (Accessed: 8 July 2017).

73 Getting the most out of the Fit note. GP guidance. DWP, Jan 2014. http://www.beh-mht.nhs.uk/Downloads/GP%20and%20referrers/Primary%20Care%20Academy/The%20Fit%20Note_%20GP%20Guidance.pdf

74 Preparing the future GP: the case for enhanced training. RCGP, 2013.

75 Parliamentary briefing from Mind. Improving mental health training for GPs and practice nurses November 2016

76 Watt, K. et al. Developing cultural competence in general practitioners: an integrative review of the literature. BMC Family Practice. BMC series – open, inclusive and trusted, 2016; 17:158

77 Pauzé E , Reeves S. Examining the effects of interprofessional education on mental health providers: Findings from an updated systematic review. J Ment Health 2010;19:258–71.doi:10.3109/09638230903469244

78 Tooling up and gearing up mental health in primary care. Transforming and strengthening the role of mental health in primary care. A primary care workforce training and education framework, checklist, and summary of education and training provided in London. London Clinical Networks. NHS England London region, 2016

79 Gilbody et al. Educational and Organizational Interventions to Improve the Management of Depression in A Systematic Review. Primary Care June 18, 2003JAMA. 2003;289(23):3145-3151. doi:10.1001/jama.289.23.3145

80 L Gask, B Sibbald, F Creed. Evaluating models of working at the interface between mental health services and primary care. The British Journal of Psychiatry Jan 1997, 170 (1) 6-11; DOI: 10.1192/bjp.170.1.6

81 Improving the Psychiatric Knowledge, Skills, and Attitudes of Primary Care Physicians, 1950–2000: A Review. Hodges et al. Published online: October 01, 2001 | https://doi.org/10.1176/appi.ajp.158.10.1579

82 Mann, J. et al. Suicide Prevention Strategies: A Systematic Review JAMA. 2005;294(16):2064-2074 (doi:10.1001/jama.294.16.2064)

83 Simpson et al. Suicide prevention training outside the mental health service system: evaluation of a state-wide program in Australia for rehabilitation and disability staff in the field of traumatic brain injury. Crisis. 2007;28(1):35-43.

84 Depression and suicide on Gotland. An intensive study of all suicides before and after a depression-training programme for general practitioners. J Affect Disord. 1995 Dec 18;35(4):147-52. Rihmer Z et al.

85 General Medical Council. Good Medical Practice. GMC, 2013.

86 http://www.rcgp.org.uk/clinical-and-research/toolkits/mental-health-toolkit.aspx

87 RCGP General practice foundation. General practice nurse competencies. Dec, 2012.

88 Primary Care Mental Health. Edited by Linda Gask, Helen Lester, Tony Kendrick and Robert Peveler. ISBN: 978 1 904671 77 0 Year: 2009 published by rcpsych publications (via turpin Distribution for the trade) www.rcpsych.ac.uk/publications

89 Psychological therapies in psychiatry and primary care. Royal College of General Practitioners and Royal College of Psychiatrists, June 2008

90 Primary Concerns: A consensus paper on primary care mental health care by the Mental Health Foundation and the Pharmaceutical Schizophrenia Initiative, 2007.
91 Fassel, Y and Burnett, A. Commissioning mental health services for vulnerable adult migrants. Guidance for commissioners. https://www.mind.org.uk/media/3168649/vulnerable-migrants_2015_mindweb.pdf
92 http://www.rcgp.org.uk/policy/centre-for-commissioning.aspx
93 Survey of GPs in England. BMA; 05 July 2016 https://www.bma.org.uk/collective-voice/influence/key-negotiations/training-and-workforce/urgent-prescription-for-general-practice/key-issues-survey#Workload
94 Continuing professional development in small group. Taylor, C. and Sparrow, N. First 5 initiative 2010. http://www.rcgp.org.uk/~/media/Files/Membership/First5/CPD%20in%20small%20groups%20-%20a%20guide%20for%20First5.ashx.
95 Collaboration between general practitioners (GPs) and mental healthcare professionals within the context of reforms in Quebec. Fleury, M. et al. Ment Health Fam Med. 2012 Jun; 9(2): 77–90.
96 Making time in general practice. October 2015 Prepared by Henry Clay & Rick Stern Editorial support from Daloni Carlisle. http://www.nhsalliance.org/wp-content/uploads/2015/10/Making-Time-in-General-Practice-FULL-REPORT-01-10-15.pdf
97 Wilson et al. An evaluation of mental health service provision in Northern Ireland Report prepared for Action Mental Health by Queen's University Belfast, 2015
98 Department of Health. An Roinn Slainte. Health and Wellbeing 2016: Delivering Together, Oct 2016
99 Making Life Better. A strategic framework for public health 2013-2023. Department of Health, Social Services and Public Safety, Oct 2014
100 Mental Capacity Act N.I 2016 http://www.legislation.gov.uk/nia/2016/18/contents/enacted
101 Together for Mental Health Delivery Plan 2016 – 2019. http://gov.wales/docs/dhss/publications/161010deliveryen.pdf
102 Mental Health (Wales) Measure, 2016. http://www.legislation.gov.uk/mwa/2010/7/contents
103 http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration
104 Fundamental Facts about mental health 2016. The Mental Health Foundation, 2016.
105 Mental Health Strategy for Scotland: 2012-2015 August 2012 ISBN: 9781780459950
106 Surviving or thriving? The state of the UK's mental health, The Mental Health Foundation. 2017