An exploration of primary care policy and practice for reducing inequalities in mental health

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Summary of a PhD thesis

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Background

Mental health problems in individuals and in the Scottish population are less well defined by routine data and diagnostic criteria than are physical health problems, but they have similar relationships to social gradients. Primary care in Scotland in recent years has been given an emphasis on health inequalities and on prevention and is also increasingly expected to provide frontline services and ongoing support to patients with mental health problems. Addressing health inequalities and inequalities in mental health are thought to require action on social circumstances as well as on biological conditions. Policies express a general expectation that all public sector services have addressing health inequalities built in to their functions, but there is evidence to suggest that primary care has not yet found its place in meeting this expectation. To date there have been few concrete proposals for action and no guidelines for primary care to address inequalities in health or in mental health. The study set out to identify the contribution that primary care can make to reducing and preventing inequalities in mental health.

Process

Interpretive policy analysis was used as the framework for the study. Interpretive policy analysis regards stakeholders' interpretations of policy as drivers for change on the ground rather than the policies themselves. Four stakeholder groups were identified as relevant to this study: policymakers; primary care strategic staff; primary care and mental health frontline professionals; and service provision. The policymakers' perspectives on health inequalities and inequalities in mental health were drawn from an appraisal of nine health and social policies and the other three groups were identified within a Community Health Partnership in the West of Scotland. Data were collected using document analyses, observation of a primary care mental health needs assessment and interviews with 21 frontline primary care and mental health professional staff from 14 different disciplines. Identification of the services a patient might expect in respect of inequalities in mental health was elicited through frontline professionals' responses to a vignette concerning a patient.

Results

All nine policy documents in the appraisal included aims to tackle some aspects of health inequalities, but inequalities in mental health were barely mentioned. The documents presented a disjointed picture of definitions for inequalities that lacked a clear overall interpretation of inequalities in health and proposed actions which often did not flow from the given definitions. The disjunctions obscured the identification of expectations on primary care for addressing inequalities in mental health. The confused policy picture was mirrored by similar disjunctions between definitions and actions among strategic and frontline professional staff in the Community Health Partnership. In addition, there were clear differences between definitions identified in policy documents and those given by professionals, suggesting that frontline professional staff appeared to draw information about mental health and inequalities from public media and practice experience rather than from research and policy.

Observation of a mental health needs assessment included appraisal of the local strategic context and additional interviews with key senior staff. The observation found that inequalities were not considered for action in the mental health needs assessment nor in most of the other local strategic processes. This was despite some key strategic staff's individual perspectives that social inequalities can impact on mental health, and despite information about local social and mental health inequalities being made available to the needs assessment process. The observation concluded that the culture of the organisation was not conducive to tackling inequalities in mental health.

Frontline and strategic staff were generally unlikely to explore or respond to the social circumstances that might put a patient at risk of having or developing mental health problems. Although some frontline professionals linked mental health and social inequalities in their understanding of health inequalities, most were unlikely to intervene on addressing a patient's social circumstances. While frontline professionals and strategic staff almost universally defined health inequalities as differential access to services, few indicated that they would take action to ensure access, for example, by following up a patient's non-attendance.

Conclusion

The contribution of the Community Health Partnership to reducing inequalities in mental health was at an early stage. The organisation's culture did not appear to be conducive to driving change on inequalities in mental health despite some key individuals within it believing that social circumstances were related to inequalities in health and in mental health. Interpretive policy analysis identified disjunction and gaps in understanding and leadership to address inequalities in mental health within policy, planning and practice, but it also helped to identify potential areas for development. The study concluded that some of the building blocks are already in place for the primary care organisation to respond to policy leadership on inequalities in mental health should that time come.