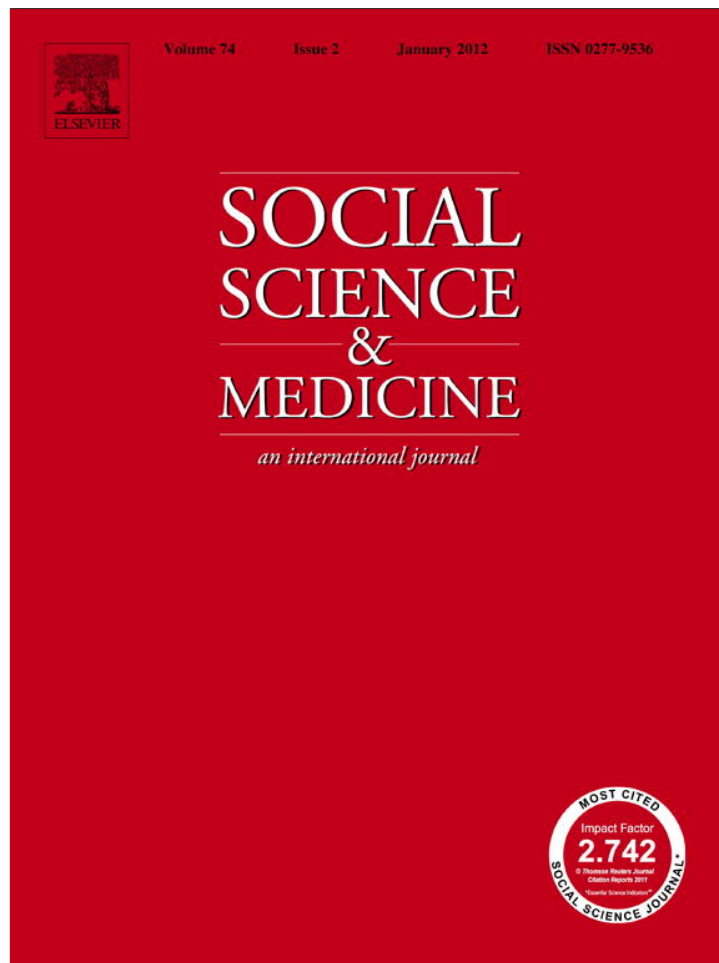


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Beyond symptoms: Defining primary care mental health clinical assessment priorities, content and process

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ABSTRACT

The assessment of undifferentiated psychological distress is a daily aspect of primary care practice. Primary care practitioners' underlying values influence the priorities, process and content of assessment. Currently there is a lack of definition of these values in primary care clinical mental health assessment. This paper presents the case for adopting the philosophical values and principles of holistic transdisciplinary generalism to influence practice worldwide. Furthermore, it raises awareness of current constraints on practice, including an overreliance on the psychiatric paradigm of care and resulting criteria-based diagnoses. Finally, the paper seeks to promote discussion among primary care practitioners and researchers globally about how to define primary care clinical mental health assessment priorities, process and content.

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*"the way a question is posed constrains the possible answers."
(Sadler, 2005, p.7)*

Introduction

Clinical mental health assessment of psychological distress in primary care is part of everyday practice (Buszewicz, Pistrang, Barker, Cape, & Martin, 2006; Cape, Barker, Buszewicz, & Pistrang, 2000; Dowrick, 1992). Encounters with this highly prevalent presentation, involving depression and other undifferentiated psychological and somatic disturbances (Arnou et al., 2006; Delany, 2007; Stone & Clarke, 2007) are integral to the role of primary care practitioners. The way in which psychological distress is assessed: the 'expertise of knowing when, where and how to look' (Gregory, 2009), determines not only what questions are posed but also the quality of the assessment and subsequent management and care.

Despite calls from the World Health Organisation to integrate mental health care into primary care (Ivbijaro et al., 2008; Palmer et al., 2010;), clear theoretical or practical frameworks do not exist to guide this process globally. In addition, threats to generalism, and the traditional values of general practice, in what some

call a reductionist age (Gillies, Mercer, Lyon, Scott, & Watt, 2009; Gregory, 2009), suggest that perhaps it is time for primary care to define what core values, skills and priorities it proposes to offer to the community in mental health assessment.

A reported rise in the diagnosis and treatment of clinical depression suggests a change in how we address normal human sorrow (Horwitz & Wakefield, 2007). The controversy over primary care practitioners' diagnostic skills (Armstrong & Earnshaw, 2004) with claims of both under-diagnosis and under-treatment (Shedler, Beck, & Bensen, 2000), and over-diagnosis (Mitchell, Vaze, & Rao, 2009) suggests that the quality of such assessment needs to be clearly defined. There is a concern that psychiatric criteria-based diagnoses of depression and the symptom reduction treatment goals they spawn, do little to affect clinical outcomes that matter to patients (Dowrick, 2004; Hutschemaekers, Tiemens, & de Winter, 2007; Tyrer, 2009). Patient dissatisfaction and the concept of treatment resistant depression may also point to inadequate assessment and subsequent treatment (Gask, Rogers, Oliver, May, & Roland, 2003; Souery, Papakostas, & Trivedi, 2006).

This paper draws on clinical and theoretical literature pertaining to clinical assessment in mental health worldwide to argue that the field of primary care should define its own clinical assessment priorities (why assess?), process (how do we assess?) and content (what are we assessing?). Defining and honing primary care values, process and content in mental health assessment may have far reaching effects on both individual treatment outcomes and on primary care delivery globally.

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A call to generalism

Generalism is a core value and competency in primary care. It situates the biopsychosocial model within the unique cultural and existential milieu of each patient (Freeman, 2005). As Gunn et al. (2008) state, the generalist must know and understand the interplay and influence between each life story and social context, and physical and emotional health, linking the biomedical and other aspects of being human.

Primary care clinical assessment of people with undifferentiated psychological distress requires an intentional examination of the many aspects of their lives. The cause and progression of most morbidity is multidimensional and is influenced by each individual's unique experiences (Small, 2003). Benson and Thistlethwaite (2009) remind us that patterns of interaction with family, community and wider society are part of the aetiology of despair and hopelessness. Multiple problem management is an assumed norm in primary care (Britt et al., 2008), as is the focus on the person within his or her context (person-centred care). Klerman, Vaillant, Spitzer, and Michels (1984) remind us that for research in psychiatry the unit is the disorder, while for general practice and primary care the unit is the individual.

For example, the much-used diagnosis of depression is an individual response to multiple biological, psychological, social and cultural factors (Wright, 1999) with limited usefulness in primary care (McPherson & Armstrong, 2009). It has been proposed that this complexity lends itself to a generalist holistic approach to assessment, set within a collaborative relationship between patient and practitioner (Plsek & Greenhalgh, 2001; Dew, Dowell, McLeod, Collings, & Bushnell, 2005; Kenny et al., 2009). Furthermore, Barry, Stevenson, Britten, Barber, and Bradley (2001) have suggested that primary care clinical mental health assessment should not limit its assessment paradigm to that of symptomatic pathology or disordered behavioural responses.

Holism in health care requires a transdisciplinary approach (Bernard & Anita, 2006). This enables the practitioner to understand each contributing discipline's underlying assumptions (Martin, 2003) and to 'integrate the natural, social and health sciences in a humanities context, and in so doing, transcend their traditional boundaries' (Choi, 2008; Soskolne, 2000). This clearly evokes the primary care context and core values. Freeman (2005, p.154) defines the scope of primary care in the general practice context:

"An approach to health and medicine that is not reductionist is an implicit part of the comprehensive care provided by general practitioners. We are not doctors for particular diseases, or particular organs, or particular stages in the life cycle – we are doctors for people."

Clinical assessment – what we choose to measure, the questions we ask or pose (Sadler, 2005), and the observations made within the consultation process, are informed by the culture of the practitioner. Tradition and training create paradigms of care with assumed, unexamined decision-making criteria (Sadler, 2005; Thompson, Ostler, Peveler, Baker, & Kinmonth, 2001). A transdisciplinary approach can inform the process of examining and integrating information from many research traditions, paradigms, cultures and disciplines of care, as well as assisting in the integration of information from each person's past and present. Consequently, we suggest that transdisciplinary generalism could become a guiding principle in determining priorities, content and processes in primary care clinical mental health assessment as well as determining treatment goals. This approach may facilitate thorough assessments that look beyond symptoms to whole person care.

Current constraints on primary care mental health assessment

Despite calls to value the culture and strengths of primary care (including holism) and policy changes to move from hospital to primary led care worldwide (Lester, Glasby, & Tylee, 2004), the questions that are posed in primary care mental health assessment (hereafter called primary care assessment) are currently constrained by secondary care assumptions about the meaning of good quality care (Lester et al., 2004). Primary care assessment is made in a very different and unique physical and clinical setting to that of tertiary or secondary care (Gillies et al., 2009). Nevertheless, it is commonplace to assess the diagnostic validity of primary care assessment based on its congruence with specialist psychiatric diagnostic criteria (Maurice-Tison et al., 1998; van Weel-Baumgarten, van den Bosch, van den Hoogen, & Zitman, 2000).

Many primary care practitioners have considerable experience and expertise in assessing and managing depression (Harman, Veazie, & Lyness, 2006; Mitchell et al., 2009). Nonetheless, general practice and other primary care providers' mental health assessment skills have been criticised (Lester et al., 2004) and been found to mismatch when compared against psychiatric criteria-based diagnosis (Armstrong & Earnshaw, 2004). There have been calls for education programs to train primary care practitioners in mental health skills (Armstrong & Earnshaw, 2004), calls to increase primary care screening for mental health disorders (Vazquez et al., 2006), and, in Australia, quality control measures and primary care funding linked to psychiatric criteria-based diagnoses (Medicare Australia, 2010). Much of this criticism of primary care expertise is based on an assumption that psychiatric criteria-based diagnostic frameworks should be the gold standard for primary care assessment. Proponents endorse the use of psychiatric criteria as a way to ensure that primary care practitioners are not distracted by many presenting complaints or blinded by foreknowledge (van Weel-Baumgarten et al., 2000); a greater focus on symptoms is perceived to be a way to simplify primary care assessment (van Marwijk & Terluin, 2008) and ensure communication in a shared language (Hutschemaekers et al., 2007).

The paradigm of care represented by one of these psychiatric diagnostic frameworks, the Diagnostic Statistical Manual (DSM), has been described as 'mapping the outside world from an ascendant position' (Verhaeghe, 2004). The authors of the DSM intentionally position themselves as atheoretical observers (Cole, McGuffin, & Farmer, 2008), choosing not to participate in discussions regarding aetiology, theories, or context (Ghaemi, 2009). Instead, the authors limited their assessment to what could be described and categorised by observation (Sadler, 2002). These values underpin psychiatry's care for the severely unwell patient, as well as research communication and comparisons of treatment (Shepherd, 1991). Currently, this paradigm of care defines the questions that are posed in primary care. Even though the DSM is multiaxial, in practice it focuses on observable symptoms and psychiatric categorising, ignoring the internal world of the patients or their context (Summerton, 2004).

General criticism of the psychiatric diagnostic approach has questioned its validity (Kirk & Kutichins, 1992) and its taxonomy (Haslam, 2003). The DSM has been described as an 'enumeration of symptoms that produces negative value judgements, promotes conformity and has no meaning for treatment' (Verhaeghe, 2004). Even the much discussed and measured diagnosis of depression is labelled 'an over-inclusive term with a lack of conceptual clarity between symptom, syndrome, episode and illness' (Casey, Dowrick, & Wilkinson, 2001). Some criticise the criteria-based process – arguing that it is a hospital-based diagnostic code (Shepherd, 1991), that it lacks relevance (Tyrer, Higgs, & Strathdee, 1993), and does not

acknowledge the unique setting of primary care (Wilhelm, Finch, Davenport, & Hickie, 2008). Others warn that the focus on symptoms risks dehumanising the patient (Sadler & Hulgus, 1992). Alternative models, such as those that see mental illness as dimensional, have been proposed as more precise and comprehensive ways to classify psychopathology, with greater epidemiologic validity and relevance to primary care assessment and treatment (Haslam, 2003; Thompson et al., 2001; Widiger & Sankis, 2000).

Despite all this debate, use of the psychiatric diagnosis as gold standard has persisted (Pilgrim, 2007), and the practice of those primary care practitioners who do not adhere to this standard is declared not conventionally evidence based (Small, 2003). Some primary care practitioners have developed their own taxonomy (Clarke, Cook, Smith, & Piterman, 2008) or diagnostic constructs for mental health assessment (Armstrong & Earnshaw, 2004). Congruence amongst general practitioner assessments has been found to be higher using their own idiosyncratic but recognisable multidisciplinary framework than by criteria-based categorisation (Shepherd, 1991). In addition, primary care practitioners frequently resist diagnostic frameworks that medicalise what they see as problems that are part of life (Macdonald et al., 2009). Armstrong and Earnshaw (2004) suggest that general practitioners may be identifying aspects of psychological distress that are uniquely grounded in the primary care context. This suggests the existence of an undefined and undervalued generalist approach to psychological distress that is not merely tertiary psychiatric care relocated into the community (Hickie, 1999).

In addition to the significant structural and logistical time constraints of primary care internationally, and the variability of competence, training and interest amongst individual generalists (Cape et al., 2000), guidelines indicate a narrowing of primary care tasks in the assessment of psychological distress to either prescribing medication or referring to specialists (Palmer et al., 2010). This constriction of role assumes that case-finding of mental disorders (Boardman & Walters, 2009) is the main role of primary care practitioners. However, using the psychiatric value system in mental health care conceptualisation and therapeutic decision making is not based on proven patient outcomes or alignment with primary care values or context (Moncreiff, 2008).

The current dominance of assumptions from secondary and tertiary care about best practice, despite queries about their application to the primary care setting and their usefulness to patient's recovery, as well as the concomitant narrowing of primary care roles in psychological care, brings into clear focus the need for the discipline of primary care to define itself in the area of clinical mental health assessment.

A call to self definition

Primary care practitioners need to define their own paradigm of mental health care, maintaining their generalism and valuing their position with their patients in community, rather than as ascendant observers (Verhaeghe, 2004). Primary care commentators urge for clarification of the role and scope of primary care (Dowrick, 1992; Marshall, 2009) and affirm that it is possible to ground this within the values and built on its recognised strengths (Lester et al., 2004). Without self definition, primary care risks losing its unique generalist role, as Balint (1993, p. 17) forewarned:

"It is the unfortunate fate of generalists that everyone else seems to have a clear idea of how they should be spending their time... "the GP is ideally placed" has become an almost ubiquitous phrase in medical literature. With its own main characteristics poorly defined, the face of general practice becomes common ground for all who pass to etch out a reflection of their own particular interests."

The overall values of primary care have been carefully defined, including access and equity, prevention and early intervention, advocacy, generalism and whole person care within the community (Greenhalgh, 2008). Assessment in primary care involves the skills of managing complexity and uncertainty (Gregory, 2009; Wilson, Holt, & Greenhalgh, 2001), using intuitive judgement (Greenhalgh, 2002), and the use of foreknowledge (van Weel-Baumgarten et al., 2000). It also values not foreclosing too early on diagnosis or premature categorisation (Todres, Galvin, & Dahlberg, 2007), and gives primacy to considering the patient's perspective (Summerton, 2004). Whole person patient centred care – seeing the person and his or her perspective – has been defined as central to primary care worldwide. This approach has even been operationalised in the language of Reason for Encounter that is part of the International Classification of Primary Care (ICPC). ICPC values the language and patient perspective, allowing social, psychological and physical symptoms, as well as diagnoses, to be part of primary care professional formulations (Lamberts & Wood, 2002). Primary care also relies on interpersonal continuity (enabling diagnoses to be developed over time) and community awareness, in order to construct a thorough and realistic assessment (Baker et al., 2007; Gilbody, Sheldon, & Wessely, 2006; Summerton, 2004).

Some of these skills and the primary care values of holism are currently being constrained or neglected in primary care mental health assessment. This does not mean that primary care practitioners are not already providing many of these aspects of care, rather these skills and values lack definition, which risks the imposition of other values and agendas. This imposition may come in the form of critique, changes in funding or public policy, pragmatic or logistical constraints, or even community opinion about what the primary practitioner role should be in the care of undifferentiated mental distress.

Perhaps it is time for primary care to define and value its own skill set and role in mental health assessment. Unclear values affect standards (Gillies et al., 2009) and the outcome of patient assessment influences treatment priorities and outcomes; the questions constrain the answers.

Ideal measures of quality include aspects of outcome sought, process, and structure (Mercer & Howie, 2006). So as part of promoting discussion within the discipline of primary care worldwide, we pose the following three key questions for discussion:

1. Why assess? What are the priorities of primary mental health care clinical assessment?
2. How should we assess? What are the appropriate processes for mental health care assessment that embody the core values and principles of primary health care?
3. What should we assess? What content is adequate to ensure that assessment leads to a comprehensive understanding of the individual, the individual's problem and his or her context?

Defining primary care values in mental health assessment

WHY assess? Defining priorities in primary care clinical mental health assessment

The ultimate aim of primary care assessment is to ensure that the whole person is seen, understood, and connected with, in order to facilitate thorough care and comprehensive treatment options. A key priority is to lay a relational foundation for ongoing therapeutic process. Primary care assessment priorities may be influenced by more relational and contextual treatment goals than those of tertiary care. Primary care practitioners aim not to identify psychiatric disorders and eliminate them, rather to help each

person cope, and if possible thrive, within his or her context, managing personal limitations while building on strengths. These integrative concepts are not foreign to the primary care literature and reflect the real complexity of working with people within their community.

Based on the literature, we suggest that the definition of practical clinical priorities for mental health assessment in primary care should include establishing a safe working relationship, understanding the individual, facilitating hope, ensuring physical and psychological safety, defining joint treatment goals, and doing no harm (Fig. 1).

Some researchers have described what they see as priorities or goals for assessment in primary care. These include Cape et al. (2000), who identified core goals of primary psychological care as establishing a positive therapeutic relationship; developing a shared understanding of the problem and promoting change in behaviour, thoughts or emotions. Buszewicz et al. (2006) notes goals of 'developing a working relationship', which he defines as showing interest, listening, showing understanding and acceptance and providing continuity, and 'facilitating change', defined as making sense of problems, advise and facilitate decision making and support action and progress. Korner, Bendit, Ptok, Tuckwell, and Butt (2010) mention enhancing therapeutic engagement, again restating the centrality of relationship to therapeutic outcome. A further objective of assessment is to enable the primary care roles of gatekeeper and advocate (Trinch, 2001). These descriptions may represent the start of discussion in the literature regarding priorities in primary care mental health assessment.

The key word 'understand' implies a shared process and comprehensive scope, both highly valued attributes in primary care. As Harris asserts: 'the desire to understand is an indispensable characteristic of every good general practitioner' (Harris, 1986). Being understood is linked with patient satisfaction (Gask et al., 2003). Safe communication is also highly valued in assessment, as it has direct effects on patient disclosure, affecting information gathering and therefore therapeutic outcomes (Sankar & Jones, 2005). Primary care can provide a safe place to be heard (Buszewicz et al., 2006). This literature values a patient centred approach, rather than priorities that are driven by practitioner-

defined symptom lists or disease orientation. We agree with Jacobson and Greenley (2001) that facilitating a sense of safe connection, hope for change, and empowering the person to take active responsibility for his or her growth within his or her personal context are essential elements of primary care assessment.

HOW should we assess? Defining process in primary care clinical mental health assessment

Many of the values underpinning the process of primary mental health assessment are undermined by economic realities, health care structures, decreasing loyalty to and trust in the local primary care practitioner, as well as changes in how individuals relate to each other in the general community. Nevertheless, relationship, collaboration and shared language are core values shared by many primary care practitioners. We hope that defining and validating these values will increase primary care practitioners' resolve to continue to offer them to the community.

A definition of the process of primary care assessment should include the development of a safe and empowering collaboration between patient and practitioner through the use of shared language and empathic attunement to the needs of the patient (Fig. 1).

In primary care, an assessment is not an isolated diagnostic event, but a therapeutic encounter where the patient has initiated seeking care. Thus, relationship building is an ongoing process as well as a key goal. These elements create a unique situation where trust and interpersonal connectedness can be built into a therapeutic relationship or working alliance (Oades et al., 2005) between therapist and patient. These concepts go beyond person-centred consumerism (Todres et al., 2007) to the development of a partnership (Marshall, 2009) with responsibilities as well as rights. Such a partnership recognises 'the patient's need for self-expression and [the practitioner's] need to achieve pattern recognition, action and closure', where both the patient's narrative and the practitioner's normative style contribute to the relationship (Clark, 2008). This approach clearly makes the person and the therapeutic relationship the focus of care, rather than the disease (Starfield & Horder, 2007).

Why?	How?	What?
What are the <i>priorities</i> of assessment in primary care?	What <i>process</i> of assessment is best in the primary care setting?	What <i>content</i> is adequate to ensure assessment forms a comprehensive understanding of this person, their problem and their context?
<ul style="list-style-type: none"> Establish a safe working <i>relationship</i> <i>Understand</i> the people we care for <i>Facilitate hope</i> for their recovery and growth Check on their physical and psychological <i>safety</i> Develop <i>joint treatment goals</i> <i>Do no harm</i> 	<ul style="list-style-type: none"> Ensure connection and <i>empathic attunement</i> in the therapeutic relationship Safe and empowering <i>collaboration</i> Communication in a <i>shared language</i> 	<ul style="list-style-type: none"> Transdisciplinary <i>integration</i> of many paradigms of mental wellness Holistic awareness of <i>context</i> and <i>history</i> Assess the <i>patient</i>, their <i>relationships</i> and their sense of <i>meaning</i>

Fig. 1. Suggested definition of primary care clinical mental health assessment priorities, process and content.

Attending to the lived experience of each person is not straightforward. This therapeutic relationship is influenced by the practitioner's assumptions and values (Halling & Goldfarb, 1996), and his or her attunement to the psychosocial concerns and the voice of the sufferer (Salmon, Dowrick, Ring, & Humphris, 2004). The attachment and neurobiological literature reiterate the importance of the connection between patient and practitioner, and the relationship that modulates change in both, contributing to 'interrelational repair' (Schore & Schore, 2008). Indeed, the impact of therapeutic relationship has been linked to outcomes (Haggerty, Hilsenroth, & Vala-Stewart, 2009; Hilsenroth & Cromer, 2007). General practice research has confirmed the importance to patients of the role of listening in the ongoing context of primary care relationship (Johnston et al., 2007).

The process of assessment requires shared communication. Treatment goals and assessment priorities that are acceptable and understandable to both patient and primary practitioner are a vital part of collaborative interaction and require a shared language (Clark, 2008). This necessitates intentional management of the potential problem of the power, knowledge and influence that the therapist wields (Cattan & Tiford, 2006). As Todres et al. (2007, p 54) warn:

"...medical and technical conceptions of health and illness have become a language which is used in very powerful ways to perpetuate the depersonalising and dehumanising practices of care."

Speaking in the language of the patient—consciously adapting to match the language of the sufferer, validating them and allowing them to feel heard and understood—is an acquired primary care skill (Clark, 2008). Language is a vital part of the commitment to being with the individual in their context (Korner et al., 2010). Perhaps this intentional 'being with' the individual in a shared collaborative relationship and language is the challenge and the privilege; the key therapeutic tool of primary care.

WHAT should we assess? Defining the content of primary care clinical mental health assessment

The generalist focus of whole person care within his or her context needs to be defined with regard to the content of assessment, since content has been dominated by a disorder-focussed tertiary specialist paradigm. The generalist is challenged to cultivate curiosity (Harris, 1986) and attend to information from paradigms of care that may have contradictory evidence or ways of seeing. These may not be from a traditional mental health discipline, and include the literature written by patients on what they consider quality care. This area requires further research, and theoretical analysis of many bodies of literature in order to provide useful generalist (rather than psychiatric) clinical assessment tools. The increased breadth of understanding in assessment will influence the quality of treatment available.

We suggest that in order for primary care clinical mental health assessments to be formed with a comprehensive understanding of the individual, the individual's problem, and context, there needs to be a deliberate integration of many paradigms of mental wellness, so that the patient is assessed in a holistic manner, aware of context and history, and attending to the patient, their relationships and sense of meaning (Fig. 1).

At present there are aspects of being human that are absent from primary mental health assessment content. Bowlby (1984) states that it has been 'extremely unfashionable to attribute psychopathology to real life experience'. Awareness of each person's life experience has not been a standard part of assessment. The trauma and abuse literature asserts that the impact of trauma

on individuals is marginalised by mainstream services (Humphreys & Thiara, 2003) and is not included in mental health training (Courtois & Ford, 2009). Despite loss being a universal experience (Murray, 2001), a significant issue in primary care (Clark, Marley, Hiller, Leahy, & Pratt, 2005), a contributor to depression (Hedelin & Strandmark, 2001) and later life function (Holmes, 1993), understanding the losses faced by each person and their impact is not part of current standard primary care assessment (Enns & Cox, 2005). In addition, an assessment of the mental health effects of early childhood experiences noted in the fields of attachment and neurobiology (Cozolino, 2006; Holmes, 1993; Maunder & Hunter, 2001, pp. 556–567, 2009) is not routinely evaluated in primary care.

As well as this information about each person's history, we can be more thorough in whole person assessment in the areas of social, somatic and behavioural experiences (including addiction and neurobiological symptoms of trauma), mood regulation, sense of self, hope, meaning making and spirituality. In all of these areas, generalist primary care would do well to look for strengths and resilience and growth as well as disorder (e.g., Blanch, 2007; Calhoun & Tedeschi, 2006; Haggerty et al., 2009; Mikulincer, 1995; Neimeyer, Herrero, & Botella, 2006; Schore, 2003).

The growing body of recovery literature written by patients/consumers outlining internal and external factors they have found helpful in recovery (Brown & Kandirikirira, 2007) has yet to be incorporated into clinical assessment content. These include hope, healing, empowerment and connection (Jacobson & Greenley, 2001); movement from despair to hope, passive to active sense of self, others in control to being in personal control, and disconnectedness to connectedness (King, Lloyd, & Meehan, 2007); finding meaning in life, redefining identity, and taking responsibility for recovery (Andresen, Oades, & Caputi, 2003).

Integrating these many disciplines into a scheme of assessment needs to be intentionally transdisciplinary, and yet practical and scientific and globally applicable. How these issues can be incorporated into primary care assessment is not currently outlined and remains a subject for future research.

Limitations

Many of the values discussed above already exist within the discipline of primary care, and yet are undervalued or constrained. This state of affairs will not be easy to address. Many of these ideas are not new; whole health systems have tried to address them (Hutschemaekers et al., 2007), yet powerful forces and discourses including economic and hierarchical ones maintain the status quo (Mitchell, 2009) worldwide. What is new, is conceptualising concerns in the primary care context as opposed to tertiary care, which might justify a new valuing of the transdisciplinary generalist primary care way of seeing undifferentiated psychological distress.

This approach to the diagnosis of mental distress may appear impractical. However, it fits well with the multi-faceted approach to the whole person that is the hallmark of primary care. It requires the practitioner to consider multiple perspectives of the problem. The longstanding relationships that are part of primary care enable gradual disclosure and thus an understanding of the individual's mental health problem. Treatment is also delivered as part of that relationship.

This paper proposes a conceptual framework for a definition of primary care mental health assessment, and only alludes to how primary care values could influence treatment priorities, outcome measures and clinical practice. We suggest that primary care as an international discipline needs to develop its own research agenda in mental health, grounded in its own values. It points to further discussion and research that could include observational studies of

primary care consultations, trials of primary care-based mental health interventions (Cape et al., 2000), and more in-depth consideration of the place of several theoretical paradigms of care in primary care mental health assessment. These could include loss and grief, attachment theory, trauma, abuse, recovery and health promotion.

Conclusion

This discussion paper seeks to promote thought and debate on how primary care clinical mental health assessment would benefit from a clear definition and validation as a unique skill set. This approach to the assessment of psychological distress includes the robust concepts of patient-centred care, collaboration between patient and practitioner, and generalism, and is safeguarded from bias and assumptions by an intentional transdisciplinary approach. This multi-faceted approach to the whole person is the hallmark of primary care, and rests on longstanding patient-provider relationships and delivery of care. Intentionally valuing and honing these priorities could make a significant difference in the clinical setting worldwide.

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