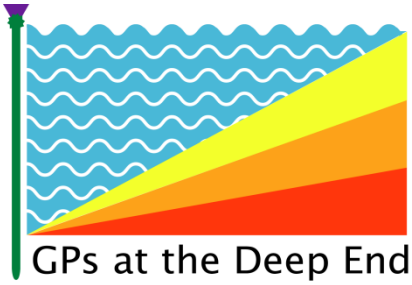

General Practitioners at the Deep End

Comments on

MENTAL HEALTH IN SCOTLAND – A 10 YEAR VISION

Scottish Government Consultation Document July 2016

General Practitioners at the Deep End welcome the opportunity to comment on this draft strategy paper. Our comments complement the Deep End response to the previous draft strategy and consultation earlier in 2016 (Annex A).

We welcome the ten year timespan of the new strategy, providing the necessary time for new arrangements to bed in and take root. With a long term approach, however, it is essential that the strategy and services are heading in the right direction and do not consolidate current weaknesses.

The Mental Health Strategy is largely concerned with the activities of mental health professionals and service, which are important, especially when specialist expertise is required, but cover only part of the range of mental health problems in Scotland. The Strategy needs to be broader in scope, both in ownership and delivery.

The Strategy is strongest in addressing the needs of patients suffering psychological trauma, whether acutely at any age or chronically as early life traumas exert long term effects. Such patients often require the specialist inputs which mental health services are best able to provide.

The Strategy is weakest in addressing the needs of patients with multimorbidity. While it is important to address the physical problems of patients with mental health problems (within mental health services) it is also important to address the larger problem of the mental health problems of patients with physical problems (mainly outside mental health services).

We have concerns in the following areas.

1. **Duplication and overlap**
2. **Balance between generalist and specialist care**
3. **Funding imbalance**
4. **Mental health as a co-morbidity**
5. **Treatment burden**
6. **Attached mental health workers**
7. **Link workers**

1. Duplication and overlap

Many of the Strategy's broader aspirations overlap substantially with those of professional colleagues in public health, health improvement and primary care, suggesting unnecessary duplication and inefficiency. The obvious way of integrating such aspirations is via the needs of defined local populations. General practice, with intrinsic features of population contact, coverage, continuity, flexibility and trust, is the natural hub around which local services should develop.

2. The balance between generalist and specialist care

Whether addressing the needs of patients with psychological trauma or mental health co-morbidity, the relationship between generalist and specialist care needs to be re-imagined.

Specialist care, whether based in hospitals or the community, is by definition exclusive. General practice excludes no one. The two approaches complement each other, to the huge benefit of patients and the NHS, but need to be kept in balance.

Specialist care is often evidence-based, delivering protocols for "what works". Both the research underlying such evidence, and the clinical guidelines which flow from them, exclude many patients, especially patients with multimorbidity. Unconditional, personalised, continuity of care may not be evidence-based but is the first and last line of support for many patients and keeps the NHS afloat.

Specialist services are characterised by strict referral criteria, waiting lists to control access, evidence-based protocols and discharge back to primary care when they are done. Such care is often delivered at a high level, but leaves a lot for general practice to do, for patients who don't meet the referral criteria, cannot wait several months to be seen, are not good at accessing services or who are not made better by the protocols on offer.

The draft Mental Health Strategy is strong in identifying areas where additional specialist care is needed. It is less strong in recognising and supporting the needs of the generalist care on which specialist services depend.

3. Funding imbalance

While the funding of general practice has fallen by a sixth in the last decade as a proportion of total NHS spending, funding of community health services, including mental health, has increased by 17%.(1) General practice manpower has stayed virtually constant; community health services staffing has increased by 46%. A key ten year objective should be to correct this imbalance.

If generalist primary care is weakened, pressure is put on other services. As specialist services find it difficult to cope, raise referral criteria and lengthen waiting lists, it is not necessarily the case that specialist care is where the investment is needed.

The current situation needs to be reversed, especially in deprived areas, where the prevalence of mental health problems is highest and GP funding per patient per annum is lowest. In a study of 3000 GP consultations, the lowest patient enablement scores were reported by patients in deprived areas with a mental health problem.(2)

When general practice is provided with additional resource, the Scottish Government-funded Govan SHIP Project has shown that a very wide range of patients with complex physical and mental health problems can be reviewed and have their care planned afresh.(3)

4. Mental health as a co-morbidity

Recent epidemiological studies of the 40 commonest chronic conditions in Scotland, including mental health conditions, show that patients with only these conditions and no other are a minority in each condition.(4) Most patients have two or more conditions. Multimorbidity begins 10-15 years earlier in deprived areas, where the commonest co-morbidity is a mental health problem. The prevalence of a mental health problem increases in direct proportion to the number of physical diagnoses. A fifth of patients are on prescription analgesics for chronic pain while a sixth are on long term antidepressants. The level of antidepressant prescribing has increased without evidence of a parallel trend in the prevalence of depression, suggesting that antidepressants are being used by practitioners and patients to deal with a broader problem.

A study of frequent attenders in general practice at Govan Heath Centre in Glasgow (10% of patients accounting for a third of all GP consultations) showed that 50% of these patients were taking antidepressants. 21% of these patients had had a referral to mental health services.(5) The data show that a substantial part of the workload of general practice in deprived areas is generated by mental health problems, much of which is not referred to mental health services.

About 10% of all patients in NHS Scotland have 4 or more physical conditions, yet these patients account for one third of unplanned and almost one half of potentially unplanned admissions to hospital.(6) The risk of hospital admission of admission to hospital is exacerbated by the coexistence of mental health conditions and socioeconomic deprivation. Compared with people living in the least deprived areas, people in the most deprived areas who had a mental health condition and 4 or more physical health conditions had about 18 times the odds of an unplanned admission to hospital and about 51 times the odds of a potentially preventable admission to hospital. The draft Mental Health Strategy does not address this issue and makes no mention of the Inverse Care Law as a factor undermining the care of these patients.(7)

5. Treatment burden

A major cause of stress in patients, especially patients with multimorbidity, is the treatment burden imposed on them by the need to seek help from a dysfunctional and fragmented health system.(8) Patients with complex physical, mental and social problems in deprived areas are often the least able to engage successfully with such arrangements.

The most obvious example of how services can cause or exacerbate mental health problems is the effect on patients and practices of the recent welfare benefit reforms, as described in Deep End Reports 16, 21, 25 and 27 (see Deep End website : www.gla.ac.uk/deepend).

More generally, as the population gets older and multimorbidity accrues, including the mental health problems associated with increasing physical illness, reducing the treatment burden will mean providing care close to home, with patients having access to a small local team of doctors, nurses and other

colleagues, working as generalists, knowing their patients well (especially what they want from their care), and linking to specialist care as required.

6. Attached mental health workers

General Practitioners at the Deep End have consistently argued for referral services that are quick, local and familiar. The geographical "attachment" of co-workers is no guarantee of successful joint working. The "collaboration ladder" attributes a score of zero to colleagues who work in the same locality but do not know of each other; a score of 1 for colleagues who know each other but have never met; a score of 2 for colleagues who have met but do not work together; a score of 3 for infrequent, haphazard joint working; and a score of 4 when they meet to review and plan joint work. Although some local arrangements work well, we know of too many which do not.

If the "best anywhere" is to become the "standard everywhere", key questions are how local joint working is assessed, by whom and using what criteria?

Deep End experience of a range of "attached workers", including social work, alcohol nurses, financial advisors and community link practitioners, is that such arrangements work best when the attached workers are known personally to the practice, can work flexibly and quickly to the practice agenda ("Your problem is our problem") and are not restricted by external criteria and accountability.

7. Link workers

We welcome the proposal to increase the number of link workers and peer support workers in primary care (Section 4). While link workers have benefitted many individual patients, especially those with complex issues, their widespread introduction is symptomatic of a more general problem namely the need to help patients engage with dysfunctional and fragmented health systems. The answer to this issue is not an army of link workers, and especially not a range of link workers for different services.

Link workers should be practice-based, and cover a wide range of practice links, following the successful example of the Scottish Government-funded Link Workers programme (See Annex B).

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ANNEX A

GPs at the Deep End Response to the Scottish Government Mental Health Strategy Consultation, March 2016

We are GPs working with communities in Scotland who experience high and often extreme socioeconomic deprivation. We would like to see a future where the provision of mental health services indeed all health services in these communities are world-leading examples of excellent practice - "to ensure that good medical care is provided where it is most needed"[1].

Here we set out the key factors and ingredients needed to achieve this:

1. Context

1.1. Communities experiencing high socio-economic deprivation have to cope with disproportionately negative social determinants of health and resultant mental health difficulties despite resilience factors being present [2, 3].

1.2. Measurable mental ill health is twice as prevalent in socio-economically deprived areas as in affluent areas. It is the commonest co-morbidity in deprived communities. The prevalence of mental ill health increases in direct proportion to the number of other problems a person has [4].

1.3. Such patients need integrated care, not the separation of the mental health component by stand-alone services.

1.4. The patients with the lowest enablement scores after seeing their GP are those with mental health problems in socio-economically deprived areas[5][6] - a symptom of how general practice is struggling to work effectively in this context. The high prevalence of long term antidepressant prescribing is another indicator of how general practice struggles to respond and cope [7] in the context of constrained resources [8].

1.5. Given the high prevalence of mental health conditions in deprived areas, it is a matter of continuing concern that general practices serving the most deprived 40% of the Scottish population receive less funding per capita that practices serving the most affluent 60% [8].

2. Concepts

2.1. ***Psychological distress*** is a more effective basis for the framing of patient care needs than diagnostic categories - which, from a general practice perspective, tend to screen people out rather than include people in. This is especially true of crisis, out of hours and community mental health services, which are experienced by many patients and their GPs as trying to find ways not to provide support.

2.2. This takes account of many patients' experience. People experience ***symptoms*** rather than a diagnostic label.

2.3. Greater recognition should be given to the effect that complex trauma and adverse childhood experiences have on mental ill health across the whole Scottish population[9][10] but especially in communities with higher levels of adversity.

2.4 This should be recognised and responded to by:

2.4.1. A continued focus on prevention in the early years and with families

2.4.2. By embedding trauma informed practice[11] and mentalizing skills [12] in all mental health services- rather than in pockets of good practice (e.g. Tomorrow's Women Glasgow, Homeless Trauma and PD team in Glasgow).

2.4.3. Problem substance use (including alcohol) should be reframed as "escape coping" (using substances to block memories, emotions or manage symptoms) rather than a problem separate for patients who experience mental health difficulties.

2.5. Service design and evaluation should be culturally sensitive[13] especially for people with ***low engagement patterns with care***, including specific consideration for people who are marginalised such as being homeless or a recent migrant.

2.6. There should be a focus on better understanding of resilience and vulnerability, in the short and longer terms, over a person's life course. This is in order to ***target episodic versus ongoing support needs*** so that patients experience continuity of care from the professionals around them.

3. Service structure

3.1. Solutions need to pay attention to the current large gaps experienced by patients and primary care professionals seeking to support patients with problem substance use and mental health symptoms. Both systems provide good quality care - but in silos - and this leads to patients with complex needs falling between the cracks and often experiencing very poor outcomes [14].

3.2. Recognition is needed that mental health functioning has an impact on patients ability to engage with all health care including physical health concerns. ***Multi-morbidity is the norm for most patients with mental health difficulties.*** The health service should be structured around patients' needs rather than the need of the health service to work in professional and disciplinary silos.

3.3. A reframing of services around ***complexity of needs*** (including physical needs) would be an effective way of re-organising mental health services away from diagnostic categories (see for example work on supporting patients who experience severe and multiple disadvantage [15]).

3.4. A key way to support this would be to co-locate mental health services within general practice clusters and provide attached mental health workers to work flexibly within practices. This works better not only for patients but also for professionals – better relationships, communication, continuity, and better use of community resources [16].

3.5. Shared records between mental health services, general practice and social work should support this development.

4. Attached complex needs mental health workers

4.1 Attached complex needs MH workers should engage and collaborate with community and specialist mental health services in adult and children's services to improve communication and joint working (this is a specific request for an attached MH worker, not necessarily a CPN) [17]. The MH worker would attend primary care/GP MDT meetings to discuss caseloads and patients' unmet needs with the extended primary care team, matching mental health care at the right level based on their needs. This may involve statutory mental health services or 3rd sector agencies [18].

5. Patient and community focus

5.1 Without detracting from the important contribution that mental health professionals make towards the support of patients experiencing mental distress, the role that other public sector organisations and community based organisations have in supporting patients when in crisis, when recovering, and when thriving should be recognised and supported.

5.2 We would like to see shared learning opportunities across mental health services, general practice and third sector based organisations to promote shared decision making and inter professional collaboration[19]. This would enhance everyone's professional practice [20]

5.3 A useful way to broker more effective community involvement would be the rolling out of the ***link worker model*** [21, 22] to include mental health services within primary care clusters.

5.4 Mental health services would then be better placed to support patients to access public sector and voluntary sector support for other needs such as housing and benefits.

5.5 Finally, ***at the centre*** of the new mental health strategy should be the ***people who use*** the services.

5.6 Much progress has been made – however, mental health services could learn from recent efforts to have peer support leads embedded in community addiction teams.

5.7 We support moves towards a human rights based approach to care for all service users across the health service - mental health services are in a strong position to lead the way in this.

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ANNEX B : BEST ARRANGEMENTS FOR LINK WORKERS

The following commentary is based on Records of Learning from the Scottish Government-funded Link Worker Programme and captures the essential features of the Link Worker role.

COMMUNITY LINKS PRACTITIONERS:

- Are employed and managed by a Third Sector Organisation, with a clear governance structure. There is an equal partnership between management and clinical leadership
- Undergo a robust selection process that involves clinicians and GP practices themselves: all current CLPs have a community development background
- Are employed in a senior position (Band 5 KSF Framework) so as to be able to operate as a 'pragmatic socially engaged generalist practitioner'
- Are integrated into the primary care team by a careful process of induction, training, trust building and relationship development
- Operate within a clear contractual framework (service level agreement, honorary contract).
- Have NO exclusion criteria- "if it's their problem it's our problem"
- Belong to two teams: GP practice team, Links worker team
- Go beyond social prescribing or signposting through working with individuals directly to find solutions and overcome barriers as well as providing whatever support may necessary.
- Work with individuals to address several issues, either concurrently or over a period of time. In order to do this effectively they must possess a range of skills and experience and be able to exercise a high degree of autonomy and professional judgment
- Work alongside people in an open, collaborative non-judgemental manner. This requires personal qualities of warmth, empathy and strong positive communication skills to be likely to establish the necessary conditions to be able to address often complex issues.
- Contribute to medical records via GP information systems.
- Have long appointment durations and scope for being flexible in their approach. This is also crucial in optimising the likelihood of meaningful engagement with individuals and getting to the root of often highly complex and emotional issues.
- Meet together every week for peer-to-peer learning and information and knowledge exchange as well as support. This is important for links workers in problem solving on many fronts.
- Meet regularly with their practice team and attend multidisciplinary meetings, practice meetings, practice events
- Play an active role in the development of the whole practice capacity to support patients and undertake social prescribing and signposting
- Build relationships with community resources, gathering and managing intelligence on these
- Are able to provide feedback on local services with a view to service improvement and to develop new responses to unmet need.

KEY CONSIDERATIONS

- GP practices require support to adapt to the new role as this is quite destabilising in the early stages
- Recording and data management requirements, while necessary and useful, can place a significant burden on links worker's capacity.
- Each links journey and interaction can vary widely, not least in intensity. Many links interactions are characterised by deeply emotional subject matter, for example bereavement or trauma.
- The 'peeling the onion' phenomena is typical of links journeys in that many underlying issues often come to the fore at various stages in the journey. The senior autonomous role of the links

practitioner is essential in ensuring that problems do not bounce back to the generalist practitioner because they are too complex (for example patients expressing suicidal feelings)
- The resilience of the people whom links practitioners work with is an important motivational factor in what is a busy, emotional and sometimes isolated role

COMMUNITY LINKED PRACTICES:

- Become oriented towards health and wellbeing, beginning with the team itself
- Develop the capacity to share learning and for continuous practice development
- Develop their awareness of the barriers and exclusions that patients face daily (especially in our practice systems)
- Develop the ability to process, store and access local intelligence about systems, resources & services for our patients
- Develop the capability of accessibly signposting patients with the full range of information and education they need
- Develop the mechanisms for problem solving with those who face the most barriers and exclusion
- Build relationships and network with local resources, third sector organisations and other services
- Develop these capacities via a practice development plan supported by collective working with other practices and access to a clinical meet and management support

A Links Practitioner who is not working in a GP practice that is working towards becoming more community linked is likely to have significantly less impact on patient wellbeing and mitigating the impact of health inequalities.