



scottishdevelopmentcentre
for mental health

**Making Connections:
Mental Health and Primary Care**

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Conference Summary

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Making Connections - Mental Health and Primary Care

1. Introduction

This conference, which was held in Dundee at the Park Centre in January 2002, set out to explore and develop the range of opportunities to promote mental health and address mental health problems in primary care by:

- Raising awareness among members of the primary healthcare team and among other services about the work each is currently doing to address the mental health needs of local populations and how this might be enhanced
- Sharing knowledge and ideas to stimulate new ways of working within primary care and Local Health Care Co-operatives, to address the range of local mental health needs
- Providing an opportunity to learn from examples of good practice and from research evidence in relation to the structures, relationships and interventions that are effective in promoting mental health and well being
- Exploring the nature of partnerships required to deliver better outcomes for individuals, families and communities - partnerships involving primary and secondary healthcare, social care and community health initiatives.

The conference aimed to enable participants to make connections and to enhance their awareness and understanding of examples and approaches which may have application in their own local context. It provided examples from across Scotland of innovative mental health work in primary care and helped to create a forum in which to discuss and debate the key issues for local service and practice development, in the context of current policy objectives.

The conference attracted a wide range of participants, including those who have experience of mental health problems and of using services, as well as those working in primary health care, secondary mental health services, social care, the voluntary sector, community health and public health.

2. Developing Mental Health in Primary Care

Dr Iain Wallace, Medical Director, Greater Glasgow Primary Care NHS Trust

Scale of the problem

The common ‘mild to moderate’ mental illnesses (such as depression and anxiety) are 40 times more common than psychotic disorders. In general practice, 25% of patients will have some form of psychological distress and it is estimated that a third of GP time is spent on psychological problems. National statistics show that depression and anxiety combined are the most common reason for presentations in general practice. Return consultations constitute over two fifths of all mental health consultations – the ‘revolving door’ syndrome reported by GPs. By any estimation, this is a massive problem for primary care services^{1,2,3}.

Hidden needs

However the scale is compounded by other factors. Perhaps as much as a half of psychological problems are not detected by GPs. Within the population, particular groups present special needs. Presentations may be twice as high in the most deprived areas. Presentations amongst women are much higher and the suicide rate amongst young men is increasing. Up to 15% of mothers with post natal depression and up to 15% of over 75s suffer from depression. There is less clarity about the needs of (for example) ethnic minorities or asylum seekers – apparently low levels of morbidity may reflect access problems^{1,2,4,5}.

Thus mental health issues are a massive ‘burden’ for primary care – and it perhaps surprising that there are no major policy initiatives in this area – but the scale is important in terms of the motivation for primary care to manage this area effectively. This has been recognised for some time. Writing in 1995, the RCGP noted:

*“The public health burden of the common mental disorders is immense and is growing. Much of this burden falls to primary care... [and] because people with depression and anxiety are generally extremely heavy consulters in primary care, the benefits to be gained by adequate assessment and management are immense...”*⁶

Thus the opportunity for events to explore this area and share experiences - such as today’s - are overdue and should be welcomed.

The nature of the needs of people with ‘mild to moderate’ mental health problems

Part of the problem is the capacity of primary care. GPs only have five or ten minutes to deal with presentations and they are aware that the origin and solution to patients’ problems are wide ranging. HEBS recently put this well:

*“People with less severe mental health problems almost always have wider difficulties in their lives which have contributed to these problems and interact with them. Tackling their mental health problems is not just a matter of trying to change something in the individual, by medication, therapy or counselling. It usually requires changing the person’s circumstances, or the person’s ability to cope with these circumstances. Many different things may help with this: practical help, friendship, advice and the understanding and esteem of other people.”*⁷

A significant number of people do not conform to a ‘diagnosis’ but this does not diminish their distress - nor their ability to benefit from help. They are likely to have many needs - emotional and practical, medical and social. Again these needs have long been recognised. Writing in the late 70’s, a major research programme by Brown and Harris concluded:

*“attention to a person’s environment may turn out to be at least as effective as physical treatment.”*⁸

It is important to stop here and reflect on the diversity of needs that people with the common mental illnesses will have. The diversity of need demands a diversity of response – it is a multi-disciplinary and a multi-agency exercise.

What works?

Pharmacological treatments are common– they are known to be effective (about 70% of patients respond)⁴ but they are expensive, there are concordance problems and issues relating to stigma and patient preferences demand other responses. Psychological therapies – ‘talking treatments’ – have an increasing evidence base⁹ and are popular but are not always available. In a policy context where patient involvement has to be balanced with evidence based practice, specific interventions present challenges. Counselling is supported by equivocal evidence but has a popularity with patients, and voluntary sector provision, for example stress centres and social support, is equally popular but the evidence base is less clear.

However, overall there is an abundance of evidence for known treatments and supports that work,^{4,10} but there simply isn’t enough of it. Additionally, the supports people need or prefer may not be available or accessible when they are most needed. Individual professionals might not have the time or feel confident to deal with specific illnesses. Understandably, limited options force those professionals encountering distress to offer (or refer to) what is available. This may not always be appropriate and may be based on rigid, inaccurate or outdated assumptions of ‘who does or can do what’. As a result, inter-professional and inter-agency tensions can arise. Crucially, it neither benefits patients nor professionals. To modernise services, this must change.

Nature of the problem

There is a danger of thinking in terms of primary care mental health in terms of specific diagnoses, or ‘SMI’ (severe mental illness) versus ‘mild to moderate’. It is helpful to consider the types of illness that will commonly present to focus service responses – from psychological disturbances (stress, bereavement) to common illnesses (depression, anxiety) to more complex illnesses (phobias, eating disorder). A better distinction than diagnosis is thinking in terms of the duration and degree of disability the illness causes (and the risk to self or others): depression in this sense may demand specialist help whilst someone with schizophrenia may have that illness well maintained but have significant contact with primary care for physical health needs. It is helpful to indicate (for example to highlight training needs) which illnesses can be appropriately managed by the primary care team but it’s important to avoid mechanically linking specific diagnoses to specific treatment by a specific profession. There are three reasons for this:

Firstly, individual patients’ experience of the same illness will vary and for each individual their needs may also vary over time. Patients may move across services in these circumstances. Secondly, there are a range of treatments (and supports) that are effective for any illness – including combination therapies. Patients’ preferences should inform the treatment they receive and who delivers it. This may include a desire to be treated in a familiar and non-stigmatising setting. General practices and health centres offer this. It is important to recognise the social origins of illness and the need for social support in regaining mental health and in maintaining mental well-being. The social origins of illness and the stressors that exacerbate them are often socially-based. People need coping and life skills and the primary care team should be equipped to provide this if it is to provide an effective response.

Thirdly, secondary care resources must be protected as certain human resources are scarce in the community. Through a team approach at an LHCC level, specialisms can be shared and equipping a range of professionals with appropriate skills makes best use of (ultimately limited) resources. The approach in Glasgow has been informed by thinking about needs (at both individual and population levels), the response required, the skills and competencies to deliver that response and who is or could be trained to deliver them.

Role and scope of a primary care service

All the above issues suggest the role and scope of a primary care service. There are four components to it to meet the needs of communities:

- The promotion of the mental health and well-being of all sections of the community and the promotion of positive attitudes to mental health and illness
- Intervening: the screening, diagnosis, treatment, care and support of individuals (and their carers) living in the community who are experiencing mental distress. This will include the need to address physical health and social supports

- Appropriate liaison with colleagues in secondary settings (and other agencies) to co-ordinate the care needs of individuals in receipt of or in need of secondary services. And further, networking with other provider agencies
- Ensuring that patients and their carers are routinely involved in determining treatment options and in the planning and evaluation of services

Policy and the policy gap

'Modernising' is a key phrase in health and social care policy documents that reflects a desire to set aside accepted practice and embrace a philosophy that reconciles evidence with the views of service users. What does that actually mean for primary mental health care?

The policy emphasis in the national mental health framework concerns severe and enduring mental illness. In practice it says very little about the primary care area. The basis of this policy prioritisation was the move from hospital to community care alongside concerns such as those raised by inquiries like that of Christopher Clunis. This policy focus is reflected in Greater Glasgow where an extensive programme for the needs of those with severe and enduring illness has been developed – indeed Glasgow has invested heavily here but there has been no framework for primary care until recently.

The policy gap has meant there has been no joining up of the (good) evidence base to offer a framework for primary mental health care service delivery. Obviously local structures and resources will shape this – but many of the discussions in the literature concern support models for secondary services to assist primary care with the severe and enduring caseload. Nevertheless the kind of values and principles contained in the national framework apply equally to those with milder forms of illness and these values have been incorporated into the approach we have taken in Glasgow.

The values are important and worth restating: meaningful user/carer involvement at all levels, equity of access, flexible and comprehensive services, quality and continuity of care, addressing special needs and measuring outcomes.

The Glasgow Experience

It sounds simple: know the scale, know the solutions, know the values... but we did not have a framework. It was a priority to produce this and our thinking was brought together in 'Primary Care Mental Health in Greater Glasgow – a Direction Statement'. And we are currently refining operational details relating to this: management models, implementation, standards and so on.

The context in Greater Glasgow

Demographic context – population of 950,000 with high levels of deprivation, drug and alcohol misuse. Ethnic minority population of 2.94% of overall population but much higher levels in some communities. Nearly 8,000 asylum seekers living in the city from diverse backgrounds and with significant mental health needs.

Organisational considerations – primary care services delivered through 16 LHCCs with a geographical area covering parts of 6 Local Authorities. Services delivered across 800 sites. Mental health services for secondary care delivered for adults across 9 localities. Older people’s mental health services delivered across different areas. Social work in the Trust’s main Local Authority partner (Glasgow City) is delivered through nine area teams. None of these coterminous!

The approach in Glasgow should be seen in the context of the Primary Care Strategy process. The Trust sponsored a series of stakeholder events – 300 to 400 people each time - to ask LHCCs to identify areas of priority in primary care. Mental health was identified as a priority for three LHCCs. The aim is to establish ‘priority projects’ in each LHCC and roll these out across the city over time. We will have invested £3.3m in recurrent funding for primary mental health care by 2005.

It is important to locate this in the overall development of a primary care strategy for Greater Glasgow but the challenge is also to ensure that the primary care approach is integrated within this wider 'Modernising Mental Health' agenda.

GPs are well aware of the problems – and LHCCs have proposed a range of service models. There have been differing, and arguably uninformed views, about what the capacity presently is and what is needed – linked to the general capacity of LHCCs to manage and deliver services. We have used the Direction Statement as a framework to shape thinking – based around the concept of a multi-disciplinary team with an appropriate skill mix to deliver the range of therapies required.

We recognise the need to link the new response with existing services and other agencies. However, additional funding gives an opportunity to build a new service with good practice – key elements of this are the measurement of outcomes and the involvement of users and carers in service design and delivery.

Unresolved issues, tensions and challenges

So what are the major challenges we face in Greater Glasgow? There are probably three major areas:

Practicalities – there is a massive training need and we have to find the resources to meet this. We have to recruit people with scarce skills, we don’t yet have the premises to house the new services, our needs assessment is not sophisticated enough to ensure targeted delivery in terms of location and access issues. To some extent we have the money but not the time to deliver. What models and what therapies represent the ‘best value’ investment?

Policies – the management of services has highlighted challenges also – particularly in ensuring that staff work within the appropriate clinical governance framework. We wish to work in partnership with other agencies but be able to evidence their role in the primary mental health care service. What is the role of the voluntary sector in core provision, what is the role of social care? Who should manage the service – the LHCCs

have a great desire to run their ‘own’ services, but do they have the skills and expertise to do so? How do we reconcile the suspicions and anxieties that have grown around the primary and secondary care interface?

Philosophies – we want to include users, carers and communities. Indeed we are committed to it. But how do we respond to the desire of patients for services like counselling and stress centres when the clinical evidence that policy exhorts us to use is inconclusive? How do we improve access when we have the opportunity to design services ‘from scratch’ but know so little about local needs? How do we reconcile our wish and LHCCs’ desire to lead with their capacity to do so?

And perhaps the greatest challenge of all for primary mental health care services – how do we evolve from a reactive, medicalised model service into one that is proactive, addresses social origins, builds partnerships with communities and is fully accessible to all sections of the community?

References:

- 1 Gruer, L. and Morrison, G. (1999) *Mental Health and Illness in Greater Glasgow*. Glasgow: GGHB
- 2 Stirling, A.M., Wilson, P. and McConnachie, A. (2001) Deprivation, psychological distress, and consultation length in general practice. *British Journal of General Practice*, 51, 456 - 460
- 3 ISD (2001) *Scottish Health Statistics 2000*. Edinburgh: TSO
- 4 Neurolink (2000) *Depression Guidelines – Recognition and Management in General Practice (2nd edition)*. London: Neurolink/Wyeth
- 5 Glasgow Association for Mental Health (1999) *Promoting Awareness – perception of the mental health needs of black and ethnic minority communities in Glasgow*. Glasgow: GAMH
- 6 Armstrong, E. (1997) *The Primary Mental Health Care Toolkit*. London: RCGP/DoH
- 7 Health Education Board for Scotland (2001) *Mental Health and Primary Care: a needs assessment*. Edinburgh: HEBS
- 8 Brown, G. and Harris, T. (1978) *The Social Origins of Depression*. London: Tavistock
- 9 Department of Health (2001) *Treatment Choice in Psychological Therapies: Evidence-based clinical treatment guideline*. London: DoH
- 10 *Clinical Evidence 5*: electronically available through NHS Scotland website/BMJ Publishing Group.
- 11 Greater Glasgow Primary Care NHS Trust (2001) *Shaping the Future of Primary Care*. Glasgow: GGHB
- 12 Greater Glasgow Primary Care NHS Trust (2000) *Modernising Mental Health Services*. Glasgow: GGHB

3. Understanding Needs:

3.1 Population Mental Health Needs Assessment in Argyll and Clyde

Dr Imogen Stephens, Consultant in Public Health Medicine, Argyll & Clyde Health Board

Argyll & Clyde NHS Board is a complex area for which to plan and develop services. The area is divided by the River Clyde and its estuary, around which most of the population is concentrated. It encompasses five council areas: all of Argyll & Bute and around half of West Dunbartonshire north of the Clyde, and all of Inverclyde and Renfrewshire plus about a quarter of East Renfrewshire (the deprived part!) south of the Clyde. Urban deprivation is particularly marked in Inverclyde and the Argyll & Clyde part of East Renfrewshire, with pockets of severe deprivation within Renfrewshire and West Dunbartonshire. The rest of the area is sparsely populated and rural (87% of the population lives in around 15% of the entire area), with 27 inhabited islands whose populations range from 1 to over 7000 further complicating the picture.

The ultimate aim of health needs assessment for mental health is to improve the mental health of the population. It is part of a strategic approach to health improvement, which also includes: defining available resources, examining the evidence-base for interventions and identifying priorities. It also allows targeting of resources, and aids equity. In the mental health field it is less easy to define needs, since there are significant other influences (social, educational, housing, employment etc). A multi-agency, collaborative approach is required.

Mental health needs assessment (MHNA) is not just about collecting and analysing routine data. This is fortunate, since routine data in mental health (health or social data) are not always of best quality- indeed, may be neither available nor of sufficient quality to be useful. MHNA should also include:

- impact of disease on individual / family / population
- effectiveness of interventions
- availability of services
- people's perceptions and experiences
- views of professionals
- social values
- political philosophy

In practice, a combination of methods is used (triangulation).

There are many definitions of mental health: this one, which is less illness-focused, seemed to encapsulate our consideration of mental health as a multidimensional phenomenon:

'mental health is the emotional and spiritual resilience which enables us to enjoy life and survive pain, suffering and disappointment. It is a positive sense of well-being and an underlying belief in our own and others' dignity and self-worth.'

In mental health the shift towards providing care in the community has tended to develop in a rather unjoined up way – Primary Care Trusts (PCTs) use differing systems to collect information, if at all; councils all use differing information systems. None of these systems speaks to others....Unmet need - by definition - is hard to count; we need to look upstream for indicators, which are notoriously difficult to identify.

The perceptions of users and carers in MHNA is essential but must be meaningful; it is best at the local level, where users and carers have best knowledge, relevant experience and stand to gain most from involvement in monitoring and developing services. Voluntary organisations are likewise important but difficult to involve in this kind of exercise; they are often under-resourced, provision is patchy and again we need to consider how best to use their scarce time - best at the local level.

Prevalence studies are remarkably consistent, but much of the work is now quite outdated. Goldberg, Kay and Thomson's much-cited study from 1974 forms the basis of the oft-quoted figure that '1 in 4 (sometimes 5) of the population will experience a mental health problem at some point in their life'. From a GP survey in a not particularly deprived area, using the General Health Questionnaire, they found psychiatric illness rates overall of around 1 in 6 (1 in 9 for males; 1 in 4 for females).

A much larger (American) study found a 32% lifetime risk of 'any mental disorder'. A GP-based register found a one year prevalence of 19%, with a 10% point prevalence; lifestyle surveys carried out in the UK have found mental health disorders in 16-20% of the population. The CMR project in Scotland, which reflects only GP-point contacts, consistently finds 10-12% of all consultations to have a mental health component. These consultations form a large part of a GP/practice workload but don't easily fit into the 7 minute or even 15 minute consultation; GPs don't always feel comfortable dealing with this. Three quarters of the entire mental health 'morbidity' presents to general practice, yet this has never attracted the concomitant investment compared with psychiatric specialties.

The visionary publication by Goldberg and Huxley ('Mental Illness in the Community: the pathway to psychiatric care, 1980) recognised that patients followed a pathway through the system (not just health) and analysed the factors or filters that helped or hindered this journey:

First Filter: the decision to consult a GP

- passed more easily if: more severe illness; unmarried/divorced/separated; unemployed; lonely
- passed less easily if: less severe illness; married (women and men); old and poor

Second Filter: recognition of mental health problem by the doctor

- passed more easily if: severe illness; women; middle aged; seen often before
- passed less easily if: physical symptoms; men; younger or older; better educated

Third Filter: referral to psychiatrists

- passed more easily if: very severe or chronic illness; young; men; better educated
- passed less easily if: mild illness; new /acute /transient illness; women.

It is important to consider the wider spectrum of mental health problems, from those yet to develop them (but with plentiful risk factors) through to those with severe and enduring mental illness; we also need to include unmet need. How could we take a wider view, yet at the same time look in detail at service provision locally? How could we incorporate the views of users and carers, which are only really meaningful at the local level? Service profiling, too, is best done at the local level, where people have most expertise.

We needed a general overview, but at the same time we needed to look in detail at needs and service provision at the level of local communities. Since the Framework for Mental Health was published in 1997 some Health Board areas had tackled MHNA, but none had taken an inclusive multi-agency approach. In Argyll and Clyde, our joint commissioning project had demonstrated that the overall mental health spend in Argyll and Clyde was at least equivalent to elsewhere - but was being spent largely on institution-based models. Argyll & Clyde now has two community mental health teams - but further investment in community based services is needed, especially north of the Clyde. These need to be multi-agency, jointly commissioned teams- hence the high level of interest in this project.

We decided to tackle this project in two phases: Phase I would take a 'helicopter' view, making use of routine health and social data across our population, and identifying 'hot spots' of need for mental health services. Phase II would look in much closer detail at the level of local communities, in an approach similar to that described next by Dr Woodburn.

Our holy grail was to produce a formula, to be applied at the population level, to allow for most efficient and equitable distribution of resources both **towards** mental health (from the total allocation) and **within** mental health (once this had been established at Health Board and Local Authority level). Arbuthnott attempted this for Health Board general allocations; one of the eight care programmes was mental health - but this was entirely hospital-based, and only considered health indicators. The York Index, developed by a group of Health Economists at the University of York, has attempted to do this for mental health only, and has been used by the Department of Health since 1995. However the formula is weighed against bed utilisation, which is highly skewed by long stay cases, and no longer relevant to modern patterns of mental health service development.

From a literature review we identified 12 risk factors for the development of mental health problems, and a raft of 7 'countable' indicators of service utilisation: These have been used, at the level of council areas, to describe the population's level of mental health.

Risk factors:

1. Lone parent households
2. Looked after and accommodated young people
3. Ethnic minorities
4. Adults living alone
5. Standardised Morbidity ratio
6. Unemployment / economic inactivity
7. Permanent sickness
8. Homelessness/rented housing tenure
9. Urban environment
10. Social class
11. Overcrowding
12. Household income.

Service utilisation indicators:

1. CPN contacts
2. SW referrals (all reasons)
3. Psychiatric outpatient referrals
4. Acute psychiatric admission rates
5. Forensic caseload
6. CPA patients
7. Suicide rates and deliberate self-harm.

This 'tool' enables us to assess a wide spectrum of mental health 'need' at the population level, and can be analysed relatively easily using routine health and social data. With minor adjustments this tool could also be adapted for population needs assessments for other age groups and sub-populations. Much of the data analysed comes from the 1991 census; once more recent information is available this can be very easily updated.

3.2 Mental Health Workload Study

Dr Alastair Woodburn, GP, Chairman of Lomond LHCC

Introduction

It is well recognised that workload in a general sense is continuously increasing in General Practice for a variety of reasons, e.g. patient expectations and wants are escalating, medicine can now treat many more conditions than previously, people are living longer with a consequent increase in ailments and more preventative measures are available to hopefully halt disease processes. More specifically there has been an impression that mental health problems are occupying more time in primary care, again for reasons that are fairly obvious – social disintegration with lack of extended families, an increase in single parent families, a rise in drug addiction problems, more pressure on individuals in the work place, all of which filter through the whole fabric of society. Both the Health Board and the PCT mental health strategies prioritise severe and enduring conditions for resourcing, with little mention of reactive mental health conditions that occupy so much NHS time. There is a possibility that if these conditions are treated and managed properly at an earlier stage they may not become severe and enduring.

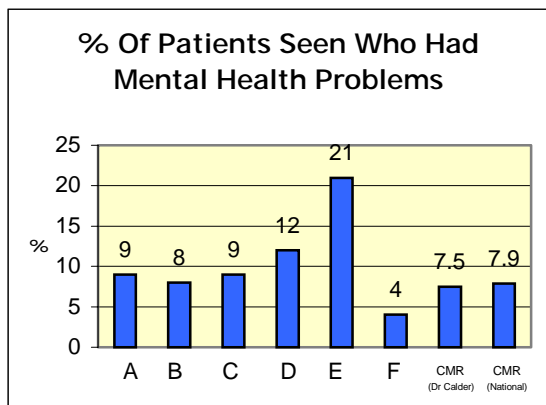
Project

Lomond LHCC decided to initiate a study to find out what proportion of the GPs' workload was occupied with mental health problems. Six practices in the area were asked to participate by collecting workload data over an eight week period of all mental health problems that occurred in the consulting room using the attached capture sheet (appendix 1). The practices were chosen to represent different types and styles of practice, two from Dumbarton Health Centre, two from Alexandria, one from Helensburgh and one from Kilcreggan. This offered a reasonable spread of levels of deprivation, size of practice (two doctor to seven doctor practices), rural and urban. The practices were asked to categorise these patients using psychiatric diagnostic categories with the appropriate Read codes. Each practice sent the capture sheets to the practice in Helensburgh for entry into a database for analysis and comparison. The practices also collected the total number of patients seen during the project period.

Results

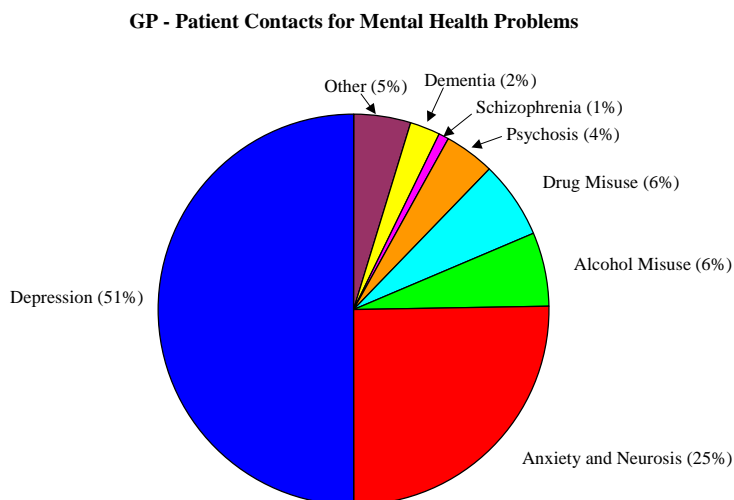
As can be seen from Table 1, four practices recorded that between 8-12% of patients seen had mental health problems. One practice registered 21% and another practice 4%. It came to light that the latter practice was undergoing severe internal problems resulting in a practice split and hence was eliminated from the study. As the other practice at 21% is now a Continuous Morbidity Recording (CMR) practice we will re-look at the incidence of mental health problems to verify what we have collected during the study period.

Table 1



The practice in Helensburgh has been recoding CMR data for the past 10 years and in the yearly report ending December 1999 of the top 20 diagnostic categories, depression and anxiety were shown to account for 7.6% of consultations. This correlates well with the national average in the year of 7.9%. It is salutary to note in this data comprising the 17 most frequent diagnostic categories occurring in general practice, mental health lies second only to respiratory infections.

Figure 1



Source: CMR database, Nov 97 - Oct 98 (4 GP practices in Argyll & Clyde)

Looking in more detail at the types of mental health problems occurring in primary care, it is noted that 40-55% was due to depression, 20-30% is due to stress anxiety and 5-30% is due to drug and alcohol problems. This is similar in each practice we looked at, with the drug and alcohol variability due to the fact that certain doctors have a special interest and work in the Lomond Drug Service. Although the more severe forms of mental illness are very disabling for individual patients, cumulatively they only account for a very small percentage of the mental health workload.

Table 2

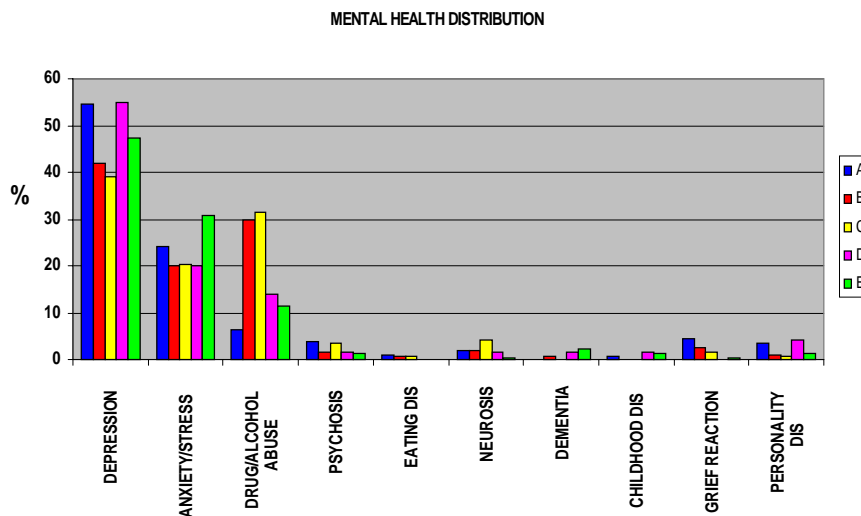


Table 3 shows that 7% of patients were referred to secondary care during the eight week period. 20% were already attending secondary care during the study period and if a CPN-type person was available in primary care it was estimated that 80% of patients could be treated and monitored by that person.

Table 3

Primary / Secondary Care Interface

- Patients Referred to 2° Care 7%
- Patients Already Attending 2° Care 20%
- Patients Who Could Be Monitored By CPN 80%

Conclusion

1. Mental health workload accounts for about 10% of total workload in primary care.
2. Mental health is the second commonest reason for consulting a general practitioner both locally and nationally.
3. The most frequent problems encountered in General Practice by all practices studied are depression, anxiety/stress and drug and alcohol problems.
4. Despite the volume of this problem, this type of less severe mental illness is not a significant priority recognised by the PCT Mental Health Strategy.
5. A mental health generic worker, whether CPN or not, could absorb a huge amount of this workload hence releasing GP time for other tasks.

The evidence has become overwhelming that GP morale is at rock bottom and there is a huge demand for longer, more complete consultations where each and every patient is given an adequate amount of time with a health-care professional. Either we employ more doctors, who seem to be a scarce commodity, or we devolve more work to other health-care colleagues. This study shows that such imaginative investment could make a fundamental difference to patient care.

Recommendation

It is proposed the LHCC develop plans with colleagues locally to develop a mental health resource within practice based integrated nursing teams. It is envisaged that in the short term this may be an appropriate use of investment funds available for developing community mental health teams, but that as a longer term aim a full service proposal should be evolved for inclusion in the Health Improvement Plan.

4. Community Developed Responses to Mental Health Needs

Helen Mein, Independent & formerly Coordinator of CHANGES Community Health Project

I'd like to start by reading extracts from someone's personal story which I hope will give you a flavour of what community development can be about and what its results can be. Let me reassure you that I contacted Margaret, who wrote this piece, to ask her permission to read it to you and she was pleased if it could serve a useful purpose, which I hope it will.

'This time last year ...my life, and that of my children had spiraled out of control. I was suffering from depression, anxiety and struggling against the desire to commit suicide. I was alone and lonely and had been cutting myself off from other adult contact.

You can just imagine how hot it was during last summer in my house when I had the heating on to dry the clothes because I was too frightened to hang the washing out. 'Normal' human beings might have seen me. I felt no joy or hope. Guilt ate away at me but I knew I had to do something to change things, even though it was 'only' for the kids' sake. But what?'

This is a very graphic account of how mental health difficulties destroy quality of life. Many of you will have faced that kind of hopelessness whether in your patients or in yourself or someone close to you. Margaret went on to say:

'Well, I went to the Positive Parenting Forum to see if there were any support groups. I was desperate to be with people who understood my worries. That was when I found out about CHANGES Annual Event, 'Taking control of your Life'. I was very stressed, as I had to put my small son into the crèche, something I was not used to doing. My son was also my shield, my reason for being. I was a non-entity when he was not with me. When I saw the amount of people at the Event I wanted to run back home, I was frightened to make eye contact with anyone. But I stayed. And wasn't I glad I did.

When I went to the workshops and found that I was not the only one who felt the way I did, I experienced an overwhelming sense of relief. I was not as alone as I thought I was. At the end of the Event I thought I was walking on air. I had experienced pleasure for the first time in a long time. I had actually enjoyed myself. I felt that I wanted and needed to do more, and not 'just for the kids' but for me! I consciously held on to that feeling determined not to let it go, and started to make changes in my life. I became a volunteer with the Parenting Forum and attended a counsellor. I then set about making some small goals in my life, attended a short course at University, joined a parents' support group, went on an assertiveness course, as well as joining the planning group for the next year's Event. I have to say that hanging out the washing for the first time without feeling scared was a wonderful achievement.

How did I manage? Through change that came from within. Taking small steps at a time. The CHANGES Event enabled me to see that I could only do so much at once. I also learned that I was important, my needs mattered and that it was OK to try to fulfill some of those needs. I have also had a tremendous amount of support from the Positive Parenting Forum and its parent CHANGES. They have boosted my confidence and helped me to feel valued as a person in my own right’.

Encouraging? But the punch line of this story is that Margaret was saying all this at the following year’s Event! She was standing up in front of 90 people introducing the theme for the Day: “Discover your Oasis”. When she was asked if she would do this, she agreed because she felt that it would allow her to give something back. Her openness about her own vulnerability and her struggle was inspirational to the people listening, all of whom, like Margaret, had some degree of mental health problem. There was hardly a dry eye in the place.

Margaret’s story reinforces findings by Lynn Jones in Mental Health and Primary Care Needs Assessment research (1). He found that what people with mental health problems most often want is:

- someone to listen and give them time
- information and/or practical help
- mutual support from others in similar situations or with similar feelings
- reassurance that they are normal in their feelings

He also found that people need a combination of different kinds of help, some short term, some long term, and that they need different things at different times.

Margaret’s story also illustrates most of the characteristics of a community development approach to mental health needs.

Community development

The community development approach is not a rival to the traditional approach, but it is an important way of widening and enhancing how we look at ways of helping people whose lack of mental health and well-being significantly affects the quality of their lives. In other words we are on the same side, its ‘both and’ not ‘either or’.

So what are these characteristics of a community development approach?

- Listening to people identify their problems and the kind of solutions they would like
- Participation by people with mental health problems in arriving at solutions; in other words a ‘bottom up’ approach
- Working with groups rather than individuals
- Promoting equality of access to services and information – providing crèches, transport, accessible information

- Recognition of the value of the process as potentially health-promoting and empowering in itself
- Adopting a holistic definition of health, which takes account of the social, environmental and economic context of people's lives.

Community development is already providing responses to mental health needs and promoting emotional well-being in the voluntary sector and through community health projects. The statutory sector is now also promoting mental health and well-being through a community development approach via:

- new community schools
- social inclusion partnerships
- local learning plans
- healthy living centres

It is important to stress that the community development approach is a valid approach across the board for different groups and ages.

So what do we need to think about and do differently if we are going to incorporate a community development approach into the way we 'do the business' in primary care? We need to keep on and on reminding ourselves that the best results come from working in partnership.

Partnership with patients

- listening to them in an affirming way
- acknowledging their contribution of self-understanding (however much or little that is) to making sense of their problems
- encouraging them to cope with their situation and/or to make changes rather than colluding deliberately or inadvertently with the traditional dependency model of relationship.

Partnership with colleagues

- in primary and secondary care
- in local authority settings
- in the local and national voluntary sector - however different their culture and even however 'unconventional' their training might seem to be.

Working in this way involves putting much more emphasis on relationships, on equality and on ensuring that bureaucracy is the servant of the process, not its dictator.

Relationships

So what is it that helps to make these relationships, that are the foundation of good partnerships, work better?

- Humility - we don't have a monopoly on the right answers!
- Personal commitment to making some of the significant mental shifts that are necessary when introducing a community development approach
- Mutual respect
 - Opportunities to deal with and get over professional, departmental and agency rivalries
 - Recognition and sensitivity to the different work cultures and values that potential partners in the voluntary sector will hold
 - Awareness that how every interaction with a patient is handled, from the receptionist to the CPN to the GP, contributes to or detracts from that patient's self-esteem.
- Time is a big factor in helping partnerships to work, because community development does not happen overnight. Time to:
 - Listen to patients
 - Find out what other people and organisations are doing
 - Network and build alliances across a wide spectrum.
- Joint working – adopting a community development approach should almost always involve joint working of some kind
- Acknowledging the contribution of the local agencies which have been promoting mental health and well-being for a long time. Partnership in community development involves real consultation and development of shared goals before joint planning and working can be effective
- Value of working with groups - adopting a community development approach also means giving a much higher value to groups as means of addressing mental health needs than is the norm in the NHS. Using a community development approach can also mean asking communities as well as individuals to define their own health needs and inviting them to be involved in planning and carrying out solutions
- Being a learning organisation – being open, reviewing progress, offering training and consultation for staff - is a pre-requisite for being able to adopt a community development approach. This also includes recognition of the complementary resources, skills and approaches of staff in the NHS, the local authority and the voluntary sector
- Providing information in accessible language about different conditions and what people can do to help themselves. People also need information about help available through groups and organisations in the community, which is complementary to help provided through the GP or community psychiatric nurse or health visitor
- Tapping into existing exchange mechanisms for locally done research/initiatives and developing more mechanisms across the NHS/voluntary sector
- Finally, persistence and belief in the process! In contrast to our target driven culture, it is in the nature of community development that not every idea or initiative works, at least not in the terms of the present climate. As long as we reflect and learn together from what didn't work then that is all part of the bigger process and we move on with

what we have learnt to try to achieve our aim another way, or to review whether our aim was appropriate in the first place! Community development is a process that works and whose outcomes in promoting mental health and well-being through empowerment can be extraordinarily satisfying. Remember Margaret!

Reference:

- 1 Health Education Board for Scotland (2001) *Mental Health and Primary Care: a needs assessment*. Edinburgh: HEBS

5. Area-based Workshops - Meeting Local Needs

Conference participants met in six geographical groups to look at how best to meet the need for accessible services and support within local primary care services.

Access to support

Living in a rural area has positive aspects such as more ‘family’ practices and close social and community networks, but rural residents can find the lack of anonymity difficult to deal with. Participants asked ‘What do people do to cope when they cannot get the help they need?’

The motivation to seek help for mild to moderate mental ill-health can be low. This is partly because there is a lack of information about what help is available. It was felt to be important to get the right information both to staff within services and to the people in the community who are the first stop for those seeking support. The type of interventions which participants wished to see developed further included:

- Interventions using person centred planning
- Interventions focusing on early identification and prevention
- Psychological interventions making use of self help packs.

It was acknowledged that there is unequal access to services across Scotland. For example cities and urban areas often have Community Mental Health Teams while other areas, particularly rural and remote areas, may not.

Planning and development

The recording of issues or illnesses by GPs was seen a key issue in service planning. It is difficult to get consistency among GPs about the way patient issues are defined. GP records act as a basis for decisions about planning and developing services in primary care, and recording is therefore a key concern (perhaps more for non GPs than for GPs). Participants asserted that needs assessment should be a responsibility shared among primary care staff and saw it as a central element of service planning. A needs assessment carried out in Highland, for example, had shown that community psychiatric nurses attached to GP practices decreased referrals to secondary services whereas in practices without an attached CPN, referrals had increased. Participants were concerned about the levels of unmet need for primary care mental health services and expressed anxiety as to how this need would be met. If a service is set up to meet this need, will it simply uncover new levels of demand? If better ways of identifying potential users are developed, will services be able to respond effectively?

Integrated service structures

Participants saw mental health as a continuum from mild and moderate problems to severe mental ill-health. In terms of services, however, mental health is split into levels of need and when services are separated along those lines, people can fall through the gaps. Key issues included:

- The importance of avoiding professional preciousness
- The value of the range of professional expertise available within a primary care team
- The potential for focusing on people with severe problems **and** with mild or moderate problems
- Integration has to be across the whole community, not just within the primary care service structure

Partnership

There were good examples of partnership working across all the groups, but participants also thought that there were issues about the capacity and readiness for partnership working at primary care level. Voluntary organisations can offer community services which are complementary to health care services, but they can find it hard to link in effectively with primary care. Community health initiatives can assist health professionals in building community links, but sustainable resourcing is necessary for health projects to develop a viable role in relation to primary care partnerships.

Where to start?

We need to start work on understanding what we have now in order to identify how resources can best be used in the future. This will involve:

- **Planning:** There has been a lack of joint planning in primary care. This should involve commissioners, planners, statutory providers and voluntary organisations
- **Service Profiling:** There are so many changes to service structures that sometimes it feels that services never stay the same long enough to draw up a meaningful profile
- **Needs Assessment:** This requires resources, so it may be necessary to access funding to undertake such an exercise
- **Using Resources Creatively:** Need to start to identify creative ways to maximise budgets between different agencies and service sectors. This will involve better partnerships and less clinging on to individual budgets
- **Joint Training:** Both between statutory services and the voluntary sector, and between primary and secondary care

6. Parallel Sessions: Models of Practice – ideas for development

6.1 Local Mental Health Service Developments in Primary Care – multi agency approaches

Julie Haslett, Development Manager – Disability, East Dunbartonshire Council.

Julie described the development of a Local Healthcare Co-operative (LHCC) primary care mental health team in Anniesland, Bearsden and Milngavie. The seven person multi-disciplinary team includes:

- Administration coordinator
- Senior social worker/mental health officer
- Community psychiatric nurse
- Psychologist
- Counsellor
- Two homemakers.

The team has an office base and works in GP surgeries and people's homes. People eligible for the service include those who:

- Are aged over 16
- Have been diagnosed with a mild or moderate mental health problem
- Will benefit from a time limited intervention (up to 12 weeks)
- Consent to being treated by the primary care mental health team

The team has a steering group with members from social work, the LHCC and the Primary Care Trust. Daily management is provided by the social work team leader. The benefits of this approach to providing services for people with mild and moderate mental health problems include:

- Early intervention possible, and at time of crisis
- Prevention of deterioration in mental/physical condition
- Prevention of family breakdown
- Prevention of loss of employment and/or accommodation

Health or social care?

Participants commented that there was a risk of creating health services when the issues are mainly social and that we should be wary of creating a Community Mental Health Team model within primary care. Some people thought that a more relevant role for primary care might be a liaison or 'brokering' role, offering access to supports such as debt counselling. Participants saw that it was essential to work with a social model of health, but to be clear about the need for medical (GP) input, to address physical health needs. A further difficulty was identified of getting social work to 'buy in' to the place of

mental health within primary care. It was felt that there was a failure to see the connection and its relevance to social work caseloads – ‘not a priority’.

Community resources

The model outlined in the presentation of early intervention and short term support presupposes good links with a range of community resources. Participants emphasised the importance of non-stigmatising, accessible, local supports based within primary care. It was felt that help is more often needed with ‘life’ issues, rather than medical problems. This has important implications for the current skill mix within primary care. Developing and supporting self help initiatives was seen as an important role for the primary care mental health team, with locality planning seen as a way of getting broad engagement from the voluntary and community sectors.

Outcomes

Successful outcomes were seen as including:

- Improved access to health and social care
- Access to wider range of professionals
- Health gain – short and long term
- Absorbing a proportion of inappropriate CMHT referrals
- Changing the pattern of return visits to GPs
- Enabling effective liaison with other services e.g. child care.

6.2 Developing Psychological Interventions in Primary Care

Mari Brannigan, Cognitive Behavioural Psychotherapist, Forth Valley PC NHS Trust

This session aimed to explore the challenges that face local agencies in developing comprehensive psychological services. The increasing public interest and the increasing evidence base for psychological interventions in a range of mental health problems means that demand for such treatments far outweighs supply. Whilst there is a continuing need for resources to be targeted at those individuals experiencing severe and enduring mental health problems there is an increasing awareness of the need for services in the community for people suffering from less severe commonly occurring problems such as anxiety and depression. Often tensions can arise as a result of the conflicting demands on services as to where to best target resources.

Forth Valley Primary Care Trust is one of four Trusts that have participated in a one year Scottish Executive funded Waiting List Initiative Pilot for Psychological Therapies. The work undertaken as part of the pilot contributed to the development of the recently launched Annex A of The Framework for Mental Health Services in Scotland. Annex A outlines a tiered approach to the delivery of psychological services. The tiered approach provides a framework for services to be tailored to need.

Training

Participants saw training as a key issue and commented that it should be offered at all levels of skill, as not everyone needs to be an expert in psychological interventions. They thought that currently, it is often the staff with the most specialised skills, such as psychologists, who see the clients with the mildest needs. Participants questioned whether primary care staff know what training they need.

Access

- GPs are the current gatekeepers to psychological therapy and they are responsible for safeguarding against people ‘falling through the net’. They need support to make the right decisions as to which therapy is appropriate and whether the individual will benefit from it. One stop triage is an option that is being considered in some areas
- Social work cannot refer direct to psychological therapy; this can cause a barrier to quick access
- There has been work in Dundee University looking at shared assessment at each entry point to the system to ensure access to the appropriate therapy, but this is not something that is in place on a local level
- It is important to have more flexible service delivery systems, where therapy session times can vary according to needs and where rigid programmes of a set number of sessions are not mandatory because this can sometimes lead to patients being ‘dropped’ with no follow-on support in place.

Working together

- The Framework Annex A should be for all mental health services, not just those providing psychological therapies. It is important to bring together all disciplines to take a whole systems approach to provide comprehensive care
- Cross-discipline supervision is essential
- Many GPs and primary care teams are desperate to be involved but don’t feel that they have the resource to commit time to developing their capacity to support psychological therapies
- There are difficulties in engaging GPs because of the level of priority of mental health within their practice. This raises issues around whether and how equitable access can be achieved across GP practices
- The voluntary sector has responded well to client need and have adapted their services accordingly. There is a need for better engagement and recognition of the voluntary sector as part of the psychological therapies delivery system.

Stages of Development

Each area of the country is at a different stage of development. Dumfries and Galloway are applying the Northumberland Tiered approach. There is a triage system with supervision in place so that therapists have to justify their decisions about therapy according to the individual's needs. In some areas waiting times are so long that some GPs think it is not worth referring.

6.3 Who Calls the Tunes? Links, Relationships and Communications – from identification to inclusion

Sandra Shafii, Clinical Development Manager, Lanarkshire Primary Care NHS Trust
with Anne Docherty and Janice Longford.

This session aimed to share some examples of development from Mental Health Services in the Monklands Cumbernauld Locality of Lanarkshire. These examples demonstrate the development of links, relationships and communication between primary care and secondary care and illustrate the issues that emerge from the implementation of policy and strategy. It illustrated how the clinician is leading service design, development and decision-making and explored the issues that arise for practice and professions when taking forward this partnership approach.

There will never come another time like this for the clinician. It will soon become clear whether services and practitioners are truly driven by patient care and the needs of people. We must be able to demonstrate that we can leave aside professional barriers, boundaries and rivalries. Mental health is everyone's business. Mental health service providers must be active, positive and confident within the health continuum from working together with the problem to active participation in the "health as a social issue" agenda.

Issues for discussion included:

- The implications and opportunities for practitioners and providers of primary and secondary mental health services
- The shift in emphasis from the "service-minded" practitioner to the "curious" practitioner
- The implications and responsibilities of moving from joined-up thinking to joined-up working.

The three examples of practice used as a starting point for discussion were:

- Using the vehicle of Health Promotion – Airdrie LHCC
- Picking up the Public Health Agenda for Mental Health – Coatbridge LHCC
- Developing an inclusive approach to the delivery of Mental Health Services – A network of resources – Cumbernauld LHCC.

Participants commented that everyone should contribute to decisions about calling the tune around client needs but there is need for a culture change in the way that staff are managed in terms of partnership working. This is a vital change in view of the importance attached to the development of accessible, non-stigmatising responses at primary care level that offer a range of supports/resources and have capacity to help people with the 'real life' issues that impact on their mental health and well-being.

New or existing services?

Did the presentation relate to new or existing services? The work described involved identifying current capacity and the potential to support primary care staff. It was not always the case that more was needed, rather there was a need to know what was there and how to make the different elements work together effectively. Staff need support to build their own capacity.

Joined up thinking

The practice examples showed evidence of 'joined up' thinking and working at individual practitioner level. It remains difficult, however, to find formal partnership agreements, but there is definitely a fundamental shift in the way many people are now prepared to work together.

Inclusive practitioners

The notion of inclusive practitioners was found to be useful. For example, a district nurse may visit someone with a physical health problem and recognise that they may be developing a mental health problem. The practitioner can then initiate early identification and liaison with other agencies to work out the best means of providing support. In this way, the practitioner will be able to create a package of mental health care around someone originally visited for another reason. How do practitioners work together? What support do they need from mental health staff? There is a need to develop the services to refer people on to – to get all of the pieces of the jigsaw in place. This is changing the way people work. If someone is lonely, then a district nurse, for example, could get a neighbour to go in for a chat. It is about more than just seeing the medical problem.

6.4 Promoting Mental Health and Well Being – where does community planning come in?

Morag Hamil, Public Health Development Officer, COSLA

Morag Hamil lead the workshop with a presentation on the role, remit and structure of the community planning process. Morag identified some of the key opportunities for mental health practitioners and community volunteers to engage with the process, in particular influencing the Joint Health Improvement Plan.

Participants in the morning workshop were open to the new possibilities being created through community planning. They explored potential processes and resources that could help them engage and use community planning to further mental health priorities. A number of opportunities were identified to further commitment to prioritise mental health within the process.

Opportunities

- Assessing the nature and extent of need
- Determining criteria for effective models of working e.g. input, output and outcomes
- Ensuring Public Health Practitioners are equipped to promote and support community development responses to mental health
- Being proactive in influencing the work of LHCCs.

Barriers

Many of these reflected issues relating to partnership working itself:

- Bureaucracy – unnecessary red tape, and decision-making stages to get through
- Organisational structures that are inappropriate to the delivery of services
- Boundaries with partners are not co-terminus
- Cultural barriers between partners – lack of understanding about different partners ways of working
- Short-termism – approaches and initiatives not designed or resourced for long term sustainability, often driven by the Scottish Executive itself
- Lack of ownership in engaging with the overall process, particularly experienced by community representatives and users of mental health services
- Under funding and resources in capacity building for representatives of mental health services and community representatives to meaningfully participate in the process.

Challenges

Participants in the afternoon workshop were very questioning of the mental health gains to be derived from community planning:

- Is this just another strategy that will be flavour of month and then dismissed in favour of something else?
- What difference will community planning make in comparison to other local health strategies?
- Whose responsibility is it to ensure that community planning is effectively implemented?
- How can mental health services and community volunteers influence priorities to ensure they are more responsive to mental health?

Participants challenged the process to:

- Ensure that community planning is more effective and has a greater impact than other strategies. This will depend on good lines of accountability and communication between all partners and adequate funding for capacity building
- Ensure meaningful engagement with the community and voluntary sectors
- Ensure awareness of 'Who's Doing What'. For example, there are many national health networks like Voluntary Health Scotland that have a wealth of information on contacts, models and methods of working. Communities need to know about these networks and use them accordingly
- Identify the added value that community planning can bring to mental health improvement. Time needs to be taken to identify where and what community planning can make a significant difference in addressing mental health
- Use of evidence based practice. Initiate a range of opportunities to share and disseminate the outcomes from evidence based practice.

6.5 Partnerships within Communities **- LHCCs, the community and voluntary sectors, the public**

Louise Parker, CMHT Team Leader, North Cunningham CMHT and Morag McGrath

The three examples of practice used as a starting point for discussion were:

Volunteers in a Health Centre Programme - Mind to Volunteer project

- Funding from Ayrshire and Arran NHS Board and Volunteer Development Scotland
- Had to be based in a Social Inclusion Partnership area – the Three Towns
- Active partnership with NHS Trust primary care team, some initial difficulties with GPs
- Matching of volunteers and clients in individual partnerships
- Can signpost to other services, clubs, leisure etc
- Comprehensive training for volunteers
- Valued resource for primary care
- Empowerment of clients.

Mental Health Implementation Group

The Mental Health Implementation Group is a good example of cooperation in North Ayrshire. It was set up by the LHCC and led to:

- Shared records for severe and enduring mental ill health
- An audit of training needs – training for carers and users as needs assessment compilers
- Training provided for health visitors and GPs by Community Mental Health Team with LHCC money.

Healthy Living initiative

This is a new initiative being developed in the Three Towns.

Discussion Points

Practitioners commented that it can be difficult to gain the confidence of GPs. It was suggested that individual GPs may be very supportive of partnership working. Even in successful partnerships, different member agencies have different priorities and ways of meeting need. It was felt that the role to be played by the new Public Health Practitioners would be useful in helping to achieve more effective partnership working. Strict demarcation lines between specialist teams in mental health (16-65, 65+ etc) are sometimes not helpful in joint working, but it was thought that single shared assessment arrangement should help, starting with over 65s and extending to all community care groups.

Ingredients of successful partnerships?

- Local mental health co-ordinator
- Local forum for community support networks
- Management support
- Commitment at shop floor level
- Building up relationships
- If a group or project works, get others on board.

6.6 Empowerment and Enablement

– the role of health and social care in promoting self help and self management

Iain Ramsay, Health Development Freelance Advisor
Ann Kerr, HEBS

This session focused on Depression Alliance Scotland, which is a branch of a UK charity which provides information and support for people suffering from depression and for people caring for them. It runs a phone-line and facilitates support groups for people with depression. Iain has recently completed a review of all aspects of Depression Alliance's operation in Scotland.

Key issues for people calling the phone-line

- Issues around confusion with 'low mood'
- Shock of diagnosis
- The sheer awfulness of depression
- Not being believed
- Isolation and low self-esteem

- Stigma and lack of understanding by others
- Worry about employment and unemployment
- Concern about taking pills
- Concern about waiting lists for referral services.

People who call the information line in Scotland value the anonymous and confidential approach offered by ordinary people with experience of depression. They also value the positive framework within which calls are handled, and being listened to.

How professionals are viewed

For those with good experiences of professional interventions, professional staff are seen as invaluable. For those reporting negative experiences, issues revolve around the following:

- personal feelings of low self esteem
- perceived lack of empathy
- lack of consultation time
- compliance (or not) with medication
- ‘medicalisation’ of depression (men particularly wary of this)
- issues around levels of education and social distance between ‘patient’ and health professionals.

Support groups

People calling the phone-line perceive the groups supported by Depression Alliance as ‘a lifeline’. Groups offer the time which professionals don’t have and provide support from people who understand. They are attended by ordinary people with experience of depression, can help counter feelings of isolation, provide insights and coping mechanisms and help people make friends.

Some of the difficulties experienced by people attending the groups include:

- The life of groups – many groups need a great deal of support to keep going
- The different needs of individuals within groups
- Where do people move on to?
- Alcohol, drugs and difficult behaviour
- Dominant individuals
- Feedback in terms of what happens to people who have attended groups.

Starting from this discussion around the work of a group actively working to support self help and self management the two workshops explored the ways in which the voluntary and statutory sectors could work together to support this type of work. The discussions in the groups were very different with one taking a more strategic view.

There were a range of themes that emerged:

Needs

- For some users, not to have to involve professionals
- To meet expressed needs
- For a range of options to be available to users
- For continuity and long term provision
- Simple resource support – eg meeting rooms.

Risks

- Short life of some groups
- Job loss for staff
- Statutory staff fear of groups collapsing.

Partnership

- Local partnership between groups and statutory sector would be valuable
- Possibly base partnership development around local Mental Health Fora
- Mutual respect needed to develop good relationships (GPs in particular seen as reluctant to engage with voluntary sector)
- Local structures are needed to embed work and make links.

Planning

- At time of applications for funding- a local overview/collaboration would be helpful
- Statutory sector financial support is limited- co-ordinated planning could help
- Potential of community plans.

Equity

- Provision of voluntary sector support varies geographically.

Learning

Potential training needs:

- To develop mutual understanding
- To change attitudes and reduce stigma
- To encourage statutory sector to make better use of voluntary sector
- To assist voluntary sector in understanding how the statutory sector works
- To develop local partnerships
- To support local planning.

7. Final plenary and panel discussion

Key themes from the day were outlined by Dr John Loudon. These included hearing echoes throughout the day of the Framework for Mental Health Services, the importance of being able to meet needs close to home and of having services which are fit for purpose and developed in partnership. John saw that the challenge of organisational change would be a challenge for everyone, requiring openness, trust and flexibility of outlook. He stressed the need to follow the established sequence of events in relation to planning, priority setting and resource allocation.

The plenary discussion raised a number of issues:

- The challenge for local and national bodies of stimulating the development of primary care – how can national regulation and performance management give impetus to this?
- The role of needs assessments in developing services. Many people will talk about need from their own personal experiences, which misses unmet need and does not quantify risk factors. Needs assessment is an interactive process and a learning process, telling us where resources are short and how they can be distributed to meet needs
- The importance of whole population approaches to mental health needs, not to exclude people over 65.

Appendix A – Conference Participants

Mr Douglas Adams	Joint Head of Mental Health Commissioning, Greater Glasgow NHS Board
Ms Brenda Agneu	Senior Community Care Worker, Barony Housing Association Ltd
Ms Linda Allen	Community Care Director, Edinvar Community Care
Mr Harry Allison	Clinical Services Development Manager, Lothian Primary Care NHS Trust
Dr Ceri Barclay	General Practitioner, The Care Practice
Mr Brian Beacom, MBE	Project Co-ordinator, North Glasgow Community Health Project
Ms Yvonne Bestwick	Training Officer, Aberdeenshire Council
Mrs Ruth Bilton	User & Carer Involvement
Mr Clark Bremner	Assist. Divisional Manager, Church of Scotland, Board of Social Responsibility
Ms Jackie Britton	Project Manager, Scottish Executive
Dr Cindy Brook	Clinical Director/Primary Care Directorate, West Lothian HC NHS Trust
Mrs Catherine Bryce	NSF (Scotland)
Ms Sue Cameron	Development Worker, Gorgie/Dalry Community Health Project
Mr Andrew Carter	Head of Personnel, Greater Glasgow Primary Care NHS Trust
Ms Elaine Clark	CPN, Lanarkshire Primary Care NHS Trust
Mr Tom Claxon	Anniesland, Bearsden & Milngavie LHCC
Mrs Avril Cleary	Senior Charge Nurse, Lanarkshire Primary Care NHS Trust
Ms Caroline Colville	Deputy Manager, Perth Cyrenians
Mr Terry Coulton	Clinical Psychologist, Dumfries &Galloway Primary Care NHS Trust
Mr Bill Cowling	Project Manager, Grampian NHS Trust
Ms Sarah Cox	Outreach Worker, Princess Royal Trust Centre
Mrs Val Davidson	Carer, The Princess Royal Trust Dundee Carers Centre
Ms Katherine Dickie	Project Manager, GAMH
Dr Gillian Dickson	General Practitioner, Lothian Primary Care NHS Trust
Mrs Isobel Doyle	Senior 1 OT, Ayrshire & Arran Primary Care NHS Trust
Mr Sandy Dustan	General Manager, Grampian NHS Trust
Ms Linda Entwistle	Project Co-ordinator, Glasgow City Council
Miss Allison Fannin	Project Manager, Tayside Primary Care NHS Trust
Miss Christine Flannery	LHCC Development Manager, East Lothian LHCC
Mr Alex Fleming	Clinical Nurse Specialist, Greater Glasgow Primary Care NHS Trust
Mr Neil Fraser	Project Co-ordinator, Tayside Primary Care NHS Trust
Mr Chris Goode	Information & Development Officer, Voluntary Organisations North East Fife
Ms Linda Hamill	Govan Community Mental Health Project
Mr Phil Harley	Senior Executive Officer, Scottish Executive

Mr Phil Harrison	Service Manager MH/Elderly Continuing Care, West Lothian PC NHS Trust
Mr Johnny Heenan	Public Health Facilitator, Forth Valley Primary Care NHS Trust
Mrs Jan Hiddleston	Project Co-ordinator, User & Carer Involvement
Mr Brian Hughes	Linkliving
Mr John Humphries	Unit Manager, Church of Scotland Board of Social Responsibility
Mr Kevin Hurst	Service Development Officer, West Lothian Council
Mrs Vicky Irons	General Manager, Lomond & Argyll Primary Care NHS Trust
Mrs Jan Jamieson	Service Manager, Mental Health Services, Forth Valley PC NHS Trust
Ms Fiona Jenkins	Manager, Perth Cyrenians
Mrs Marion Johnston	Unit Manager, Church of Scotland Board of Social Responsibility
Mrs Bernadette Jordan	Development Officer, The Richmond Fellowship Scotland
Dr Monica Keenan	Staff Grade Psychiatrist, Greater Glasgow Primary Care NHS Trust
Mrs Lorraine Keith	Edinburgh Carers Officer, NSF (Scotland)
Miss Lynne Kennedy	Locality Manager MH, Lomond & Argyll Primary Care NHS Trust
Dr John Kerr	North East Fife LHCC
Ms Jan Killeen	Public Policy Director, Alzheimer Scotland
Ms Oksana Last	Carer
Dr William Lauder	Associate Head of Department, University of Stirling
Mr Ken Laurie	Director of Mental Health Strategic Change, Fife Primary Care NHS Trust
Dr Ken Lawton	General Practitioner, Great Western Road Medical Group
Dr Bruce Low	Consultant Psychiatrist, Borders Primary Care NHS Trust
Mr Stuart Lygate	Primary Care Mental Health Nurse, Priority Project, Westone LHCC
Ms. Mary Lyle	CPN Team Leader, Renfrewshire & Inverclyde Primary Care NHS Trust
Mrs Margaret Lynn	CPN, Greater Glasgow Primary Care NHS Trust
Mr Eddie MacDonald	General Manager, Forth Valley Primary Care NHS Trust
Mrs Lesley MacLeod	Assistant Director of Finance, Renfrewshire & Inverclyde PC NHS Trust
Mr. Gerry Maley	Community Support Worker, West Dunbartonshire Council
Ms Johanna Maloney	CPN, Forth Valley Primary Care NHS Trust
Mr Dan Markus	Consultant Clinical Psychologist, Greater Glasgow PC NHS Trust
Miss Lori Marshall	CPN, Greater Glasgow Primary Care NHS Trust
Mrs Jill Martin	Head OT Adult Mental Health, Tayside PC NHS Trust (P&K LHCC)
Mrs Georgina Mathewson	CPN, Greater Glasgow Primary Care NHS Trust
Ms Sue Maxwell	Principal for Sexual & Relationship Therapy, Couple Counselling Scotland
Mr Michael McCaffery	CPN, Forth Valley Primary Care NHS Trust
Mr Frank McCaffrey	Liaison Medical Health Nurse Practitioner, Forth Valley PC NHS Trust

Mr Colin McCormack	PC Strategy Development Officer, Greater Glasgow PC NHS Trust
Mrs Gillian McCready	Commissioning Co-ordinator, Inverclyde Council
Mrs Lorna McCurrach	Planning Officer, Perth & Kinross Council
Ms Ilona McDowell	Consultant Clinical Psychologist, Greater Glasgow PC NHS Trust
Ms Annie McGeeney	Team Leader Mental Health, South Lanarkshire Council
Ms Morag McGrath	Volunteer Co-ordinator, Mind to Volunteer
Miss Anne McGregor	Primary Care Liaison CPN, Renfrew & Inverclyde Primary Care NHS Trust
Ms. Ann Marie McKay	Senior Health Promotion Officer (MH), Forth Valley NHS Board
Mrs Linda McKechnie	Service Development Manager, Dumfries & Galloway PC NHS Trust
Dr Ian McKee	General Practitioner, Wester Hailes Health Centre
Mrs Phia McKinnon	Volunteer Psychosexual Counsellor, Couple Counselling Tayside
Mr Dennis McLafferty	Development Co-ordinator Community Care, North Lanarkshire Council
Mr Graham McLaren	Project Manager - Adult Mental Health, Forth Valley PC NHS Trust
Ms Alison McLeod	Primary Care CPN, Priority Project, Westone LHCC
Ms Fiona McMahan	Nurse Team Leader, Greater Glasgow Primary Care NHS Trust
Miss Lisa McNay	Nurse Consultant, Lothian Primary Care NHS Trust
Mr John McNeish	MH Services Dev. Co-ordinator, Ayrshire & Arran Primary Care NHS Trust
Mrs Karen Meehan	CPN, Greater Glasgow Primary Care NHS Trust
Mr Jack Merriman	District Mental Health Officer, The City of Edinburgh Council
Ms Annie Millar	Project Manager, Cumbernauld Action for Care of the Elderly
Ms Alison Miller	Counselling & Groupwork Manager, Sandyford Initiative
Dr Alan Mordue	Consultant in Public Health Medicine, Borders NHS Board
Mr Bradley Morris	Lothian Primary Care NHS Trust
Dr Lynda Morton	Principal in General Practice, Carnoustie Medical Group
Mr Victor Morton	Clinical Nurse Specialist in CBT, Tayside Primary Care NHS Trust
Dr Alastair Muir	GP, Maryhill-Woodside LHCC
Dr William Mutch	Medical Director, Tayside Primary Care NHS Trust
Ms Amanda Nichol	Nurse Member, Borders Primary Care NHS Trust
Ms Penny Nowell	Regional Manager, NSF (Scotland)
Mr Kevin O'Neill	Project Manager (Mental Health), Lanarkshire NHS Board
Miss Lynne Palmer	
Mr Iain Paterson	User & Carer Involvement
Mr Joe Pearson	Project Leader, Moray Assoc. for Mental Health
Mr Alistair Pender	Operational Service Manager, Angus Council
Mr Alastair Philp	MH Project Information Manager, ISD, Common Services Agency

Mrs Isobel Plunkett	Social Worker/Development, West Dumbarton Council
Mrs Anne Poustie	Community Mental Health Nurse, Tayside Primary Care NHS Trust
Dr George Ralston	Clinical Psychologist, Greater Glasgow Primary Care NHS Trust
Ms Gwyneth Rees	Research Fellow, University of Stirling
Mrs Linda Reid	Joint Commissioning Manager, Aberdeenshire Council
Ms Wilma Reid	Education & Training Manager, HEBS
Mrs Agnes Rooney	Nurse Team Leader, Greater Glasgow Primary Care NHS Trust
Dr Robert Rosbottom	General Practitioner LHCC, Coldsides Medical Practice
Mr Neil Rothwell	Consultant Clinical Psychologist, Forth Valley Primary Care NHS Trust
Mr Robert Samuel	Nursing Officer, Scottish Executive
Ms Angela Sharpe	Senior Social Care Worker, Barony Housing Association Ltd
Mr Warwick Shaw	LHCC Manager, Borders LHCC
Mrs Elinor Smith	General Manager, Grampian NHS Trust
Mrs Jane Smith	Manager, Princess Royal Trust (E Ayrshire Carers Centre)
Mr Tony Smith	Social Care Worker, Barony Housing Association Ltd
Dr Alasdair Sneddon	General Practitioner/Mental Health Lead, Kirkcaldy & Levenmouth LHCC
Dr Kathryn Sowerbutts	Consultant Psychiatrist, Ayrshire & Arran Primary Care NHS Trust
Mr Steve Spence	Clinical Development Co-ordinator, Highland Primary Care NHS Trust
Ms Cathy Stephenson	Govan Community MH Project
Mr Craig Stewart	Community Mental Health Team Leader, Ayrshire & Arran PC NHS Trust
Miss Fiona Stewart	Service Manager Mental Health, Perth & Kinross Council
Dr Mark Storey	GP, Mental Health Lead in LHCC, West Renfrewshire LHCC
Mrs Isabel Swan	Lead Nurse, Borders Primary Care NHS Trust
Ms Susan Tait	Involvement Officer, Linkliving
Mrs Kate Thomson	Project Manager Mental Health, Fife Primary Care NHS Trust
Miss Carolyn Warden	Staff Nurse, Tayside Primary Care NHS Trust
Ms Ruth Warner	Acting Director of Nursing, Forth Valley Primary Care NHS Trust
Ms Carol Watson	Professional Officer (MH Nursing), National Board for Nursing
Mrs Dorothy Weaks	Senior Charge Nurse Specialist, Tayside Primary Care NHS Trust
Mrs Nan Whetton	Policy Officer, Scottish Executive
Mr David White	General Manager, Lothian Primary Care NHS Trust
Mrs Lesley Wilkes	Mental Health Advisor, Scottish Health Advisory Service
Mrs Gillian Wilson	Health Worker, Youth Housing & Support Team
Ms Liz Wisniewski	Area Manager, Glasgow City Council
Mr Bill Wood	Principal Officer, SENSE Scotland

Appendix B - Presenters

Dr Liz Jordan, Medical Director, Renfrewshire & Inverclyde PC NHS Trust

After completing GP training Liz worked in Public Health for 2 years before returning to Primary Care. She has also worked in the Scottish Executive's Primary Care Unit with a remit including LHCC's, mental health and clinical governance. In 2001 she took over as Medical Director in Renfrewshire and Inverclyde Primary Care Trust, which includes General Practice, Mental Health, Learning Disability and Continuing Care of Older People.

Dr Iain Wallace, Medical Director, Greater Glasgow PC Trust

After completing his GP training Iain worked as principal in general practice for 10 years. He has also been GP Commissioner and GP Adviser to Greater Glasgow Health Board. Iain was appointed Medical Director in June 1999 and chairs the Trust's Clinical Governance Executive Group and Medicine Resource Management committee.

Dr Imogen Stephens, Consultant in Public Health Medicine, Argyll & Clyde NHS Board

Imogen's work within Argyll & Clyde currently focuses on mental health, learning disabilities and sexual health. Since coming into her present post in 1999 she has been particularly involved in an ambitious project to describe the mental health and well-being of the population of Argyll & Clyde. This is the first such attempt in Scotland which looks at all tiers of service provision both within and outside the NHS.

Dr Woodburn, GP and Chairman of Lomond LHCC

Dr Woodburn has been a full time principal in General Practice in Helensburgh since 1976 to the present day. He is also a member of the Area Medical Committee and LMC, Chairman of Lomond LHCC, Vice Chairman of LHCC Professional Committee, an Independent Medical Assessor for GP complaints and an undergraduate tutor for the Glasgow University Department of General Practice.

Helen Mein, Independent & formerly Coordinator for CHANGES Community Health Project

Helen Mein trained as a social worker and counsellor, but 'converted' to community development after 5 years in Africa. For 25 years since then she has worked in the voluntary sector in Scotland establishing innovative community projects from playgroups to good neighbour networks, dementia day centres, HIV/AIDS practical help, and a community health project.

Julie Haslett, Development Manager - Disability, East Dunbartonshire Council

Julie Haslett is currently in the post of Development Manager – Disability. Julie is responsible for overseeing developments in the field of Mental Health, Learning Disability, Children with Special Needs and Autistic Spectrum Disorder. Prior to this post, Julie acted as Planning and Development Officer – Mental Health, and was involved in the planning of the Primary Care Mental Health Team along with health colleagues in Anniesland, Bearsden and Milngavie LHCC.

Mari Brannigan, Cognitive Behavioural Psychotherapist, Forth Valley PC NHS Trust

Mari has wide experience in training and supervising others in brief psychological therapies and is an associate lecturer at the University of Stirling. During the past year she has been seconded to the post of Lead Clinician (Forth Valley) for the Psychological Therapies Pilot Implementation Project. This is a Scottish Executive funded initiative on waiting times in Psychological Interventions.

Sandra Shafii, Clinical Development Manager, Lanarkshire PC NHS Trust

Sandra is currently responsible for managing, supporting and facilitating the clinical development for adult mental health services in the Monklands & Cumbernauld locality. This involves the development of people, services, partnerships and teams, using strategy, standards, clinical governance, policy direction and good practice and creativity as tools.

Anne Docherty, Public Health Practitioner, Airdrie LHCC

Recently appointed Public Health Practitioner (PHP) Anne has been involved with the Airdrie Mental Health Project for some months in her previous role as Health Promotion Projects Officer. Anne's specific remit was to link with two local LHCCs, including Airdrie. The importance of building on established links and developing new partnerships is also central to her role as PHP.

Janice Longford

Janice is a qualified Health Visitor and is currently the Clinical Service Manager for Coatbridge LHCC.

Morag Hamil, Public Health Development Officer, COSLA

Morag is currently leading a small team whose prime tasks are to:

- Develop local authorities as public health organisations
- Take forward health improvement within community planning.

Louise Parker, CMHT Team Leader, North Cunninghame CMHT

Louise has been the Team Leader of the multi-disciplinary Community Mental Health Team in North Cunninghame for 10 years. She is committed to developing the service offered to adults survivors of childhood sexual abuse who are referred through mental health services and is involved in training on this subject.

Iain Ramsay, Health Development Freelance Adviser, Depression Alliance

Iain Ramsay has worked in health education and health promotion for over twenty years. He has worked in both voluntary and statutory sectors and in higher education. He now works as a freelance adviser.

Ann Kerr HEBS

Ann is Programme Manager for the health service at the Health Education Board for Scotland

Appendix C - Making Connections: Programme

0900 hours	Registration and Coffee/Tea
0950 hours	Welcome and Introduction <i>Chair: Dr Liz Jordan, Medical Director, Renfrewshire & Inverclyde Primary Care NHS Trust</i>
1000 hours	Developing Mental Health in Primary Care <i>Dr Iain Wallace, Medical Director, Greater Glasgow Primary Care NHS Trust</i>
1025 hours	Understanding Needs <i>Dr Imogen Stephens, Consultant in Public Health Medicine, Argyll & Clyde Health Board</i> <i>Dr Alastair Woodburn, GP, Chairman of Lomond LHCC</i>
1050 hours	Community Developed Responses to Mental Health Needs <i>Helen Mein, Independent & formerly Coordinator of CHANGES Community Health Project</i>
1115 hours	Questions
1125 hours	Coffee/Tea Break
1145 hours	Workshop: Meeting Local Needs
1245 hours	Lunch
1345 hours	Parallel Session I Models of Practice: ideas for development <ol style="list-style-type: none">1. Local Mental Health Service Developments in Primary Care – multi agency approaches2. Developing Psychological Interventions in Primary Care3. Who Calls the Tunes? Links, Relationships and Communications – from identification to inclusion4. Promoting Mental Health and Well Being – where does community planning come in5. Partnerships within Communities – LHCC’s, the community and voluntary sectors, the public6. Empowerment and Enablement – the role of health and social care in promoting self help and self management
1445 hours	Coffee/Tea Break
1505 hours	Parallel Session II, repeated as above
1605 hours	Final Plenary and Panel Discussion
1645 hours	Close and Depart