Minutes of the Meeting of the Cross Party Group on Mental Health held on 20th of June 2018, 6.00pm, in CR4 of the Scottish Parliament

1. Introduction from Convenor and Deputy Convenor

2. PRESENT AND APOLOGIES

Clare Haughey MSP welcomed attendees to the meeting.

MSPs: Oliver Mundell MSP; Clare Haughey MSP; Maurice Corry MSP.

Non-MSP Members:

Organisation	Name
AdvoCard	Simon Porter; Patricia Rodger
Bipolar Scotland	Gordon Johnston
British Psychological Society	Lauraine MacDonald
Autism Rights	Tom Wightman
CAPS Independent Advocacy	Jane Crawford
Caritas Clinical	Leigh Fell
Mental Welfare Commission for Scotland	Kate Fearnley
Pasda	Cath Purdie
Police Scotland	Pamela Colvin
RCGP	Dr Jenny Bennison
RCPsych in Scotland	Dr John Crichton; Dr Linda Findlay; Elena Slodecki (Secretariat)
Royal College of Speech & Language Therapists	Robert MacBean
Royal Pharmaceutical Society	Suzanne Cameron-Nielsen
Scottish Council on Deafness	Sally Shaw
The Salvation Army Scotland	Olive Lomax
The Salvesen Mindroom Centre	Mig Coupe
UKCP	Emma Nelson
VoX	Andrew Muir
Your Voice	Alison Mahon; Alice Paul

Non-members in attendance: Wendy Bates; Andy Bowman; Luke Humberstone; Rose McDonald; David McLaren; Simon Potter; Alison Rankin; Abigail Rogers; Campbell Strang; Peter Glissov.

APOLOGIES

Apologies for absences were received from Tom Arthur MSP, Annie Wells MSP, Monica Lennon MSP, Alex Cole-Hamilton MSP and 14 non-MSPs.

3. MINUTES

Minutes of the meeting of the CPG on Mental Health held on 5 December 2017 were accepted as a true and accurate record. The minutes were proposed by Dr John Crichton and seconded by Clare Haughey MSP.

4. MENTAL HEALTH IN PRIMARY CARE

Life at the Interface

Dr Linda Findlay introduced herself as Vice Chair of the Royal College of Psychiatrists in Scotland and noted she had changed her presentation title to 'Life at the Interface.' Dr Findlay noted the interface between primary care and secondary care can be difficult to negotiate both for practitioners and those using services.

Dr Findlay stated more people are living longer and with multiple complex physical and mental health conditions, with 90% of healthcare contacts occurring in primary care. Dr Findlay suggested the balance of care is shifting towards less care being provided in hospital and more in the community. Dr Findlay spoke briefly about the new National Clinical Strategy and the Mental Health Strategy and referred to recent consultation on the next Suicide Prevention Strategy. Dr Findlay explained the new GP Contract aims to increase diversion of resources to primary and community care, with care increasingly being delivered by multidisciplinary teams. Dr Findlay reported between 2007 to 2017, there was only a 1% increase in GPs whereas the increase in hospital consultants over the period was 45%. Dr Findlay suggested the new GP Contract will free up GP's time by having multidisciplinary team members who can undertake some of the tasks currently being undertaken by a GP. The new GP Contract is also hoped to redress the previous 'condition specific' contract by moving toward seeing the whole person.

Dr Findlay challenged the statement that mental health doesn't discriminate, suggesting that it does due to unfairly affecting those who are impoverished. This is a significant public mental health challenge and, Dr Findlay suggested, needs to be addressed by promoting good wellbeing, health literacy, alternative treatments and by reducing stigma. Dr Findlay suggested mental health should be integrated into all policies and pointed out See Me are already making offers to Health and Social Care Partnerships to assess their strategic commissioning plans to ensure they are mental health inclusive. Dr Findlay spoke further about mental health inequalities and suggested some of the structures within the healthcare system, such as having to opt-in for counselling, make accessing services more difficult.

Dr Findlay finished her presentation by talking about the Distress Brief Intervention (DBI) pilot. This is a four-year pilot project which provides different levels of intervention for assisting people who are in distress but do not meet the threshold of a diagnosable mental health problem. This type of intervention demedicalises distress and helps people build their resilience, with around 360 people being assisted through the pilot so far. Dr Findlay told the story of a gentleman who turned up in distress at A&E on several occasions only to be turned away. On the third time presenting to A&E he was offered assistance

through the DBI pilot. Dr Findlay reported upon reflection the gentleman stated if the DBI pilot had been there in the first place, his life may have taken a different trajectory and he would not have taken an overdose.

Mental Health in Primary Care – a tale of inequalities
Dr Jenny Bennison, Executive Officer for Quality, Royal College of General Practitioners

Dr Bennison introduced herself as a GP working in Craigmillar and Niddrie, which is the third most deprived area of Scotland. Dr Bennison reported she would be speaking about what it is like caring for patients with mental health problems in a time of rising demand for services and a stretched workforce. Dr Bennison reported there are 24.2 million consultations with Scottish GPs every year, with one-third of these including a mental health component. Dr Bennison described an unforeseen consequence of expanding multidisciplinary teams in GP practices is that GPs are only dealing with very complex, difficult issues. Dr Bennison referred to several charts and graphs in her presentation and noted deprivation makes a big difference, with those in the most deprived areas having higher rates of consultations with GPs. People also die younger in deprived areas.

Only a small percentage of those seeing a GP for a mental health problem are referred to specialist services. Of those who are referred, not many are seen and there are long waits for psychological therapies for children and adults, as well as for chronic pain, drug misuse and other mental health problems. A high number of people who get appointments don't manage to attend appointments, which creates a vicious cycle of re-referral. Dr Bennison explained she conducted a small project within her own practice which showed that of all the people in the 3500-patient practice within a 6-month period, only 21 people were referred to adult mental health services. Of those 21, 4 were seen and 3 were referred on to psychology with 12-15 month waiting time. Some of the rest were declined and advised to increase medication, arrange counselling or refer to self-help. Another proportion of those people did not manage to opt-in successfully for their outpatient appointment. Dr Bennison explained that opting-in for an outpatient appointment is difficult and especially difficult if the person is suffering from depression/anxiety. Dr Bennison suggested there is not a good match between those who get seen and those GPs feel need to be seen (inverse care law).

Dr Bennison spoke briefly about the link worker in her practice. Patients can self-refer to Mark or the GP can refer to him. Mark is someone who can accompany people to their appointments and will support them. Dr Bennison noted there is heavy reliance on the third sector in primary care. Dr Bennison told the group about a patient 'Michelle' who has eight children, a history of adverse childhood experiences, depression, repeat overdoses, hearing voices, dissociative seizures and fibromyalgia. Michelle was eventually diagnosed with emotionally unstable personality disorder. Michelle doesn't engage very well with services and

recently had an interaction during a PIP assessment which resulted in her being taken by police to the Royal Edinburgh Hospital. Michelle waited at the hospital for hours before being given more medication and being told to go back and see her GP. Dr Bennison said Michelle now receives most of her support and care within 200 yards of the General Practice and it is important Michelle is seen as her own person. Dr Bennison stated compassion and kinship are central to supporting people like Michelle. If people know they can get support from their practitioners, then a therapeutic alliance can be built. When Michelle is confident she has the support she needs in crisis, she seeks that support locally. Dr Bennison finished by reminding the group the burden of mental health in primary care is enormous and a challenge for everyone, not just GPs.

Q&A

Clare Haughey MSP thanked both speakers and opened up for questions.

Andrew Muir, VoX, expressed his concerns that there are few patient representatives and suggested there was a need for MSP support, as if a local MSP is unwilling to support an individual there is nowhere else to go.

Robert MacBean, Royal College of Speech and Language Therapists, asked Dr Bennison to further explain the first graph in her presentation. Robert explained he was very interested in how funding and demand for services were tracking over time. Dr Bennison explained the figures are from a time when the old GP contract was in place and reflect a system where payments were disease-led. Dr Bennison commented it is striking that during the 2004 contract, money is distributed in a way that exacerbates the inverse care law.

Oliver Mundell MSP stated he was interested in Michelle's story and commented a commonality he comes across at a constituency level is that people are unable to build a relationship with their GP because they don't have an allocated GP, and locums are often used. Mr Mundell asked whether there is a solution to this. Dr Bennison replied that as most GPs do not work full-time, they cannot always be there for a patient. Dr Bennison noted there is some work being done to encourage patients to choose their own GP and present to them whenever they can. Dr Bennison suggested the full-time link worker provides some continuity and there is work to be done improving notetaking.

Clare Haughey MSP asked Dr Findlay whether she would like to comment about the work she's doing to improve continuity. Dr Findlay suggested bigger multidisciplinary teams might mean a non-GP is the most consistent person in a patient's care, but they have to trust this person as well. Dr Findlay also reported there are moves to address patients seeing several different psychiatrists during their care.

Patricia Roger, AdvoCard, suggested individuals should have access to their formulation, so if they go into a consultation with someone new they have a document to explain their story. This would help reduce the trauma of individuals having to retell their history each time they see a new person and helps people feel more in control of the process. Dr Bennison noted her practice is piloting a process called Care Planning. This involves an annual double appointment with a nurse, then a double appointment with the GP. At the end of the appointments the individual has a care planning assessment to take away with them. Dr Findlay suggested the days of doctors holding all the information is over and suggested the question now is about how information can be given to people in a way they find useful and accessible.

Sally Shaw, DeafScotland, asked how the link between long-term physical conditions and mental health relates to sensory conditions, such as eyesight or hearing loss. Sally asked what happens in the situation where an individual cannot hear well enough to have a conversation or where a sign language interpreter isn't available? Dr Findlay acknowledged this is a group which perhaps is not thought about enough. Dr Findlay suggested she would be interested to know whether there is anything else clinicians can do.

Kate Fearnley, Mental Welfare Commission (MWC) noted she was struck by the case of Michelle and reported the MWC would soon be publishing a report on Personality Disorder. Kate asked how accessible therapies such as Dialetical Behaviour Therapy (DBT) or mentalization were for people such as Michelle. Dr Bennison responded there are long waiting lists for DBT. Dr Bennison reported the culture around Personality Disorder has changed, and it is now viewed as something which can be treated. Dr Findlay explained DBT is a form of talking therapy and has been evidenced as useful for people with personality disorder.

Gordon Johnston, Bipolar Scotland, suggested health and social care integration means mental health has become less integrated, as services could be provided through the council, Health Board or Health and Social Care Partnership. Gordon noted where things go wrong there are issues at the interface of services, and communication between agencies is problematic. On a positive note, Gordon said there is a lot to gain from the new GP contract and additional link workers. However, he suggested what is missing is a public education campaign around these changes, as individuals may feel that if they are not being seen by a doctor it is a lesser service. Dr Bennison stated she agrees communication is difficult and a public campaign could be useful but would need to recognise all practices being different. Dr Findlay stated she shared Gordon's concerns and agreed that educating the public about changes would be a good thing.

Luke Humberstone, NUS Scotland, told the group he encountered a man on the train recently whose behaviour concerned him. If he collapsed or had a physical health issues most people would know first aid. However, mental health first aid

isn't available to everyone. Luke asked whether a level one DI response should be rolled out nationally. Dr Findlay responded more mental health first aid is needed and that DBI is in a pilot phase but she would take the suggestion of a national level one response to the DBI board.

Alice Paul, Your Voice, suggested the P in Health and Social Care Partnerships (HSCPs) should stand for People, and that the value of service users as an asset should not be underestimated. Alice also suggested peer support has an important role in enhancing HSCP services and is of value to all concerned.

Maurice Corry MSP noted he had spent the morning talking about armed forces and mental health, with reports of mental health issues appearing 20 years after service. Referring to Andrew Muir's earlier remark, Mr Corry suggested talking about mental health is still a new thing, so it may take time to resolve some of these issues. Mr Corry thanked Dr Bennison and Dr Findlay for their input.

Dr John Crichton, Royal College of Psychiatrists in Scotland, responded to Maurice Corry MSP's comments stating he was involved in setting up the Veterans First Point service in Edinburgh. A great success of the V1P service was seeing the positive influence of peer workers. Dr Crichton has now piloted peer workers in a medium secure unit and suggested if it can work there, it can work everywhere in mental health.

Rose MacDonald, trainee at Redhall Gardens in Edinburgh (SAMH project) noted services having time-limits imposed on them is problematic and causing distress. Rose advocated for systems to be more trauma-informed and for services to be open ended. Dr Bennison commented GP services are not time limited, and GPs are there for people in the long term. Dr Findlay noted you do not get limited meetings with a psychiatrist, but some psychological therapies do have time limits. Rose MacDonald also stated that she was seeking support for a grass-roots movement to ensure greater representation of service user and patients views and experience. She cited the work of Patricia Rodger preventing the closure of the Outlook Project (Adult Education for mental health service users) as her inspiration for this.

5. DATE AND TIME OF NEXT MEETING

The next meeting will take place on 4 September 2018 at 1pm in room TG22. This meeting will include the AGM. Clare Haughey MSP reported because there are so many CPG meetings the group is struggling to get accommodation. The next big meeting will be on 15 December. The September meeting will be an AGM with no further agenda items. Ms Haughey asked the secretariat to contact the group and wider membership for topic suggestions for the coming year.

Addendum:
The December meeting will be on the 12th of December, not the 15th as stated during the meeting.