

## **Response to Draft Primary Care Mental Health Strategy**

**Craig Newnes, MSc. Dip. Clin. Psych.**

Psychological Therapies Director

(This is one of many responses to a recent Draft Strategy being considered by the Trust and which is currently being revised)

This is a response to the consultation exercise as part of Shropshire County Primary Care Trust's move towards an agreed strategy for primary care mental health. This response is in part in my role as Director and in part an agreed response from the Department of Psychological Therapies. In addition to my role as Psychological Therapies Director for the Trust I am the current chair elect of the Psychotherapy Section of the British Psychological Society, the longest serving member of the executive committee of the Division of Clinical Psychology of the BPS and editor of two psychological therapy journals. My response thus includes expertise in the areas of national policy, the evidence base for psychological therapies, national initiatives, local practice and an appreciation of good report writing.

I should first say that I welcome the attempt to develop a strategic vision for the Trust in Primary Care Mental Health. The previous Health Authority Strategy on Psychological Therapies written, after wide consultation, by myself has not been adopted outside the Department of Psychological Therapies and has been ignored by commissioners, despite its endorsement by the Health Authority in 1999. The current strategy includes many recommendations that I am happy to endorse: an increase in locally available evidence based psychological therapies, an increase in the clinical psychology resource available in primary care and an emphasis on equality of access and good clinical governance.

I should like to address two areas specific to the draft strategy; the consultation process and the strategy document itself.

**1. The Process of Consultation** The process of consultation subsequent to the report's production has been excellent. Paul Haycox, John Short and others should be commended on their

willingness to face questions and concerns from a variety of interested groups throughout the county. The consultation exercise leading to the report gives considerable cause for concern. The report lists people as attendees at a stakeholders meeting on 9 May 2002. My apologies are noted but I was not invited to that meeting. Therefore the only contribution from an attendee with any knowledge of psychological therapy was from Liza Morgan, a Relate trained sex abuse counsellor. No other psychological therapy services are represented. Clearly expertise was present in relation to general secondary mental health services, however, as much of the subsequent report discusses talking therapies, its reliability is immediately questionable. No service users were present at the meeting despite the government and Trust's declared interest in putting them at the heart of planning. Myself, other psychological therapy leads and service users could have been available for this first meeting had we been informed. Our absence distorts the subsequent conclusions and report and means that needless inaccuracies have been included.

**2 The Draft strategy.** The strategy includes a number of generally accepted and evidence based recommendations. In particular, it is clear that Shropshire has been under resourced in a variety of mental health services for many years. There is no doubt that additional resources are needed to enable effective training of PCHTs, better liaison with secondary mental health services and improved access to talking therapies in primary care. The document itself however is poorly structured, repetitive and over reliant on quoting from Government documents rather than using local data. This problem, in part relates to the early phases of preparation of the strategy. The strategy team had access to at least two major local reports on psychological therapies. The first of these, Shropshire Health Authority's existing Strategy for Psychological Therapies, covered in detail the make up of all the statutory, voluntary and independent sector agencies in operation in 1999. These agencies have changed little but there is no evidence that the strategy team used the readily available information on costs, activities and clinical governance details from this first Strategy. A second document, the annual report of the Trust's own Department of Psychological Therapies was also made available but the team appears not to have read it. The strategy is thus full of needless mistakes and inaccuracies and should be corrected with reference to this annual report. A third source of

information, the Department of Psychological Therapies' website ([www.shropsych.org](http://www.shropsych.org)), was also not used. This should be both mentioned and accessed in redrafting the strategy.

**Major inaccuracies.** The chosen method (of consulting with a small group of local managers rather than users and psychological therapists) resulted in useful discussion and some pointers to the future. The minutes of this meeting include no reference to the effectiveness of psychological therapies in Shropshire. Despite this, therapies are described as "ineffective" (p1 of executive summary). Data collected by the Trust, however, indicate that the Trust counsellors in general practice are extremely effective. This first consultation also concluded that referrals from outside of Shrewsbury to the Shrewsbury Centre for Psychological Therapies (Chaddeslode) are not made due to problems of access. In fact referrals to Chaddeslode from the North and South localities are in exact proportion to the populations in those localities. Patients require more locally accessible services. The strategy is misleading however in suggesting that patients from outlying areas receive no services from Chaddeslode House. The "highest cost parts of the psychological services" are not "inaccessible" (p. 10). The majority of the Trust's Psychological Therapies budget is currently spent in locality based CMHTs (for clinical psychologists) and in GP surgeries (for practice counsellors) Clinical Psychologists working in our CMHTs already have considerable skills and experience in Primary Care (p.9). As noted in our annual report we offer supervision to various members of the primary care team, participate in GP training and run three support groups for Shropshire GPs. The issue here is one of resource; no scoping exercise is needed. It is not clear that GPs are on board in terms of a mental health strategy. The PEC increases contact with certain GPs but there is considerable room for improvement in a number of areas involving GPs and counselling. For example, not all GPs are happy to provide administrative support for surgery counsellors and many still wish to charge the Trust for providing accommodation. Some GPs have turned down the offer of surgery counsellors. Outreach to Ludlow has similarly been refused.

**Recommendations for changes to the strategy.** Given the flaws outlined above there is doubt that the strategy can be salvaged. If it is to be rewritten it needs to be restructured to avoid repetition, written

in an easily accessible style and based on proper data gathering.

**Specific recommendations for change follow:**

1. The strategy needs to define the difference between primary and secondary care. Services tend to make these distinctions in terms of the people served but there is no reason why very disturbed people should not be seen by CMHT staff in GP surgeries.
2. The strategy needs to make clear that it is a strategy for mental health services rather than mental health as such. This is linked to the need to highlight prevention of mental distress. Much prevention includes work outside the current work of GPs and statutory mental health services and requires closer collaboration with education and child services
3. The foreword states that no criticism is intended but the document inaccurately describes one aspect of the current service as ineffective without any supportive evidence. There is confusion about inefficiency and inequity (page 10) in relation to the statement that, "Psychological and counselling services....(are) inequitable and ineffective." The statement should read, "Counselling services provided by the Department of Psychological Therapies are of proven effectiveness. They are, however, inequitably distributed in Shropshire".
4. As noted, the highest cost aspects of the service are not centrally located as claimed. Further it is more efficient for patients to travel than pay the travel expenses of clinicians. The strategy needs to note that this problem can only be addressed through increased resources enabling more surgery based practice.
5. The strategy should emphasise the need to de-medicalise problems. At present the diagnostic criteria for depression, anxiety and other difficulties are over-inclusive resulting in the labelling, drugging and referral of people without serious psychological distress. Related to this is the problem of drug company sponsorship. The strategy should recognise that the ubiquity of drug company representatives does not make partnership a necessity. Pharmaceutical links increase the medicalisation of problems. The strategy should explicitly aim to decrease the current spend on psychotropic medication. In a similar vein the recommendation for a "disease register" is offensive and should be reworded or dropped.
6. There should be a greater emphasis on the work of the real voluntary sector. It should be noted that some agencies, e.g., Relate, by charging for services are in effect private practices. Other

agencies that do not have this policy should be promoted more heavily.

7. The strategy needs to highlight the role of community psychology. This alternative to primary care psychology or secondary care CMHT work links well with primary care and has the considerable advantage of reducing the medicalisation of individuals while empowering communities.

8. Protocols should be far more collaborative as there is evidence that inadequately prepared protocols simply increase frustration and waiting lists as patients are referred to non-existent services. If protocols are to be developed, then the strategy should include increased provision of protocol linked services. The strategy should note that the self-referral schemes piloted at Chaddeslode House would indicate that protocols for common mental health problems could be rendered unnecessary.

9. The strategy should be more explicit on the relationship of the new Primary Care workers to the Department of Psychological Therapies. It is worth noting that in the Northumbrian pilot all current PC workers are graduate psychologists working in much the same way as PC assistant psychologists and supervised by local clinical psychologists, a major resource issue.

10. The suggestion of a radical review of psychological therapies does not follow from the data. The present Department of Psychological Therapies is following the strategy agreed with the then Health Authority in 1999. This earlier strategy made very similar suggestions in terms of deployment of resources, suggestions the Department is pursuing. A radical review is therefore unjustified although better integration of statutory and non-statutory counselling should still be emphasized.

11. The strategy needs to consider in more detail the issue of counsellor pay. There is an assumption that voluntary sector and independent counselling agencies represent better value for money than the current statutory provision. This is arguable in terms of clinical governance and the reliability of some voluntary counsellors (who can decrease their commitment at will). Equally important however is the current efforts by counselling agencies to secure a national pay scale. This would make voluntary and statutory sector employees equivalent in terms of cost.

12. Chaddeslode House is a Primary Care resource offering therapy to those who cannot or don't want to be seen in their surgeries. The strategy should note the usefulness of this option for patients.
13. The strategy should be more cautious in recommending the guidelines from the Treatment Choice in Psychological Therapies and Counselling document (Appendix B). This is now somewhat dated and has been criticised for its methodology.
14. Proper representation for psychological therapies should be available to the Local Implementation Team. No psychological therapists currently sit on this committee; despite user and government backing for talking therapies. This committee is very influential in planning future services.
15. Various user groups have outlined the kinds of information they require on psychological therapies. An information strategy should use these data as a basis for devising information leaflets for use in GP surgeries, libraries, etc.
16. The statement about financial resources beginning section 3 of the executive summary is false. £36,000 was withdrawn from psychological therapies in primary care this year. Withdrawal of medico-psychological support and OT resources from Chaddeslode House and The Dawley Centre, Telford (which dedicates two fifths of its resource to Shropshire referrals) and reduction in Health Authority spend on GP counsellors amounts to some £65,000 in the last three years. Although £25,000 has been received for "development", there has been a net loss of £76,000 since 1999.
17. The document is wrong in its allusion to recruitment and retention of psychological therapy staff. The Trust as a whole may be "off the pace" (p.2) and this is of course an issue nationally in clinical psychology but has not been a problem in Shropshire for many years. The strategy should note that the Department is a national leader in this regard with the Director regular asked to consult to other departments on their recruitment difficulties.
18. Clinical psychologists already support No Panic in relation to outcome measures and questionnaire design. The strategy should specify that it would be more appropriate if the local CBT service were to offer training and supervision (p 11).

Finally, it cannot be overstated what a difficult document this is to read. It is poorly structured, not based on good evidence and has had a demoralising effect on Trust staff, particularly some in psychological

therapies who have been both unrepresented and misrepresented. If the strategy is to be re-done I would strongly suggest the authors make an active effort to include local expertise in devising it and writing the next draft.