Irish College of General Practitioners

Submission of the Irish College of General Practitioners to the Oireachtas Joint Committee on the Future of Mental Health Care in relation to GP led primary care expansion

Improving care for people with mental health care needs

Essential for health system transformation and sustainable health care

December 2017

Index

Note: Accompanying documents submitted separately

Opening statement

The Irish College General Practitioners (ICGP) is the professional body for general practice in Ireland. The College's primary aim is to serve the patient and the general practitioner by encouraging and maintaining the highest standards of general medical practice. It is the representative organisation on education, training and standards in general practice.

The College is the recognised body for the accreditation of specialist training in general practice in Ireland and is recognised by the Medical Council as the representative academic body for the specialty of general practice.

There are 4,156 members and associates in the College, comprising over 85% of practising GPs in the Republic of Ireland. There are 205 members in Northern Ireland, the United Kingdom, Canada and other overseas locations, and 690 GP trainees.

Introduction

The ICGP would like to thank the chair and members of the Joint Committee on the Future of Mental Health Care for the invitation to reflect on the development of GP led primary care as it relates to mental health.

The ICGP representatives include:

- Dr John O'Brien — ICGP Vice President and Incoming ICGP President.
- Dr Brian Osborne — Assistant Director, Postgraduate Resource Centre (PRC), ICGP; Director, Mental Health Programme, ICGP.
- Dr Brendan O'Shea — Director, Postgraduate Resource Centre (PRC), ICGP.

General practitioners are at the heart of the Irish healthcare system.

Every day, thousands of people all over the country get to see their family doctor without any waiting time, getting quality attention and care. Between one quarter and one third of such consultations include a mental health component. Over 90% of mental health care takes place in a general practice setting. To ensure we can continue to provide that cradle to grave service, for a growing population, with more challenging conditions, and address our retention and manpower crisis, we urgently need to commit to greater resources and a new contract to further develop GP led primary care.

A large proportion of these daily interactions are driven by the mental health needs of people attending. Maintaining quick and easy access for people to generalist healthcare professionals in the community must be an overarching objective in the future expansion of primary care, enabling people, who are well known to each other in a personal sense, to engage collaboratively, to address the needs of people attending, in their own communities, and to assist in building their resilience. Because general practice services are not associated with any particular health condition, stigma is reduced when seeking mental health care from a general practice team, making this level of care far more acceptable and accessible for people and their families.

The work of general practice is prevention and earlier intervention. Our values relate to lifelong personal medical care, where people choose and are enabled to attend a doctor or nurse who they know well, and who knows them and their circumstances well, and where mutual confidence is to the fore, down the years and across the generations.

In this submission, we demonstrate what the expansion of GP led primary care means with respect to mental health, what the challenges are, and what our legislators need to do, to ensure general practitioners can continue to be at the heart of a reformed health service.

It is the view of the ICGP that unless adequate capacity is built in GP led primary care, the remainder of primary care, the secondary care sector, and the broader health system will never function safely, efficiently or effectively. Collectively, we need to undertake a realignment from a hospital focused system to a more balanced system, where much more care is delivered in communities.

In addition to grave difficulties in secondary care as a result of chronic underfunding of GP led primary care, there are separate intractable difficulties regarding how secondary care is delivered in the Irish health system, and it is not the task of primary care to fix these. These difficulties in secondary care relate to an over reliance on NCHDs working exclusively with public patients, and a continued failure of secondary care to embrace electronic medical records and administration. Poor communication and a lack of integration between general practice teams, primary care health professionals and secondary care, lead to reduced efficiency and effectiveness of the whole system.

Protracted and grave difficulties are evident relating to critical bottlenecks in emergency departments, in waiting times for most public hospital services, in sub optimal healthcare outcomes, in perceived and actual gross inequalities in access, and in well identified system risks arising from poor continuity of care, which will all continue as the inevitable consequences of a hospital centric health system, where decades of systematic under resourcing of GP led primary care are also clearly evident.

Specialist services ('consultant led') in a hospital centric model will continue to remain unable to safely or effectively address present volumes of clinical workload. Much of this workload is best addressed in the community setting, delivered by teams of GPs and practice nurses, working in a generalist service, based in practices adequately supported by administrative staff, allied health professionals, with access to focused educational supports, so that more mental health care needs of most people can be addressed in the community, closest to where people live, and at the most appropriate levels of cost and complexity. Timely and equitable access to essential and valued specialist care, where necessary, is an integral part of developing an effective overall system.

Strong international consensus exists in relation to developing a health system based on strong GP led primary care. Development of universal access to strong primary care delivers substantial benefits to all citizens, and must now be considered relatively inexpensive, in terms of whole system healthcare costs. With respect to mental health, increasing the numbers of GPs and practice nurses, and training and retaining them, is important so that there is adequate capacity to meet the rapidly evolving demand from a growing population. The importance of easy access for people to GPs as point of first contact and early intervention is broadly agreed internationally (Joint Commissioning Panel for Mental Health[1], Naylor, Taggart & Charles[2]).

Within the ICGP during these last years, we recognise that over medicalisation has become more apparent in the health system, characterised by a continued and almost exclusive focus on technical, hospital based medical care. We also ask to what extent does the Irish health system support Talking Therapy? We accept that we spend over 1 billion euros on drugs (a large proportion of which relates to psychotropic drugs), when we spend less than 10 million euros per annum on services such as CIPC Service (Counselling in Primary Care). We rely on a GP led primary care sector which is seriously understaffed.

Initial steps towards achieving a health system based on GP led primary care must be the immediate reversal of resource cuts introduced under the Financial Emergency Measures in the Public Interest (FEMPI) legislation, and the replacement of the present GMS contract with one which addresses the needs of people who attend GPs and their practice teams for ongoing medical care.

These two issues (FEMPI & GMS Contract) are constantly to the fore in communications between our College and GPs who are College members, with GP trainees, and with practice nurse colleagues. These two issues have made it exceptionally difficult to recruit and retain adequate numbers of GPs and practice nurses in GP led primary care.

GP led primary care is presently delivered by approximately 3,700 GPs and 1,700 practice nurses. In health systems which are considered more effective than ours (we refer you to Scotland, Canada, The Netherlands, Australia and Denmark); there are more GPs and practice nurses, who work uniquely with a truly generalist and holistic approach.

In Ireland, we presently have approximately 64 GPs per 100,000 population. They are unevenly distributed, with less than 40 per 100,000 in three counties. In Scotland and Canada, the number is in the order or 90-100 GPs, with effective ratios of 0.8 to 1 between GPs and practice nurses. The view of the ICGP is that we need to plan for a population of 5 million, with corresponding increases in GP and practice nurse numbers.

The acute and outstanding needs of rural practice, and practice in deprived areas, require to be supported appropriately and urgently, with serious thought given to geographical and deprivation weightings in funding.

GP led primary care is a key support throughout the lives of Irish citizens, supporting them from before birth to end of life care and grieving. Every day, people who are troubled by mental health problems attend GP led teams, with large volumes of care provided by GPs, through mild and moderately severe spectrum mental health conditions, including unipolar and bipolar affective disorders, suicidality, obsessive compulsive disorders, acute anxiety, phobias, post traumatic stress disorder, personality disorders, the full spectrum of addiction disorders, for methadone maintenance, the psychoses, for ongoing support over years in body image disorders, dementias and post-partum depression. In caring for people suffering from these conditions, general practice has done so without the levels of inequality regrettably associated with most secondary care services.

However, during the last decade of 2007-17, GP led primary care has been allowed to weaken to an alarming extent.

Stronger Primary Care

Why is generalist care important?

Generalist care is important because people are complex and they rarely present with single issues in real life.

Generalists deals with the totality of problems that people present with, addressing them with regard to their physical, psychological, social and existential context.

If people are funnelled into specialised services for common problems they will quickly become frustrated with 'dead ends' at every step, and such a system grinds to a halt around these dead ends. It is the view of the ICGP that this phenomenon is substantially at the heart of over 650,000 people on public waiting lists at present.

Failure to grasp this reality results in serious problems in terms of being able to comprehensively respond to the range of problems people experience in relation to their health.

We strongly recommend that legislators recognise the difference between generalist and specialised care, and take effective steps to increase capacity in generalist primary care, in communities.

Generalist care and mental health

The ICGP is presently committed to collaborating with the HSE, and all other relevant stakeholders, in assisting in the development of better care for people with long term illnesses. In the long term, the ICGP supports free at point of access primary care, fully resourced in communities, as critical for success in this objective. We recognise this as an essential, socially redistributive undertaking in our unequal health system.

The ICGP recognises the importance of mental health as a key prognosticator across the range of all common long term illnesses, and this, together with more effective end of life planning, are areas which we have identified as key points in re-orientating our historic focus on specialist orientated hospital care. The people we care for with diabetes and heart failure have better outcomes if underlying depression and anxiety are detected and treated earlier and more systematically. This takes more time on the part of GPs and practice nurses to deliver. However, GP teams are critically short of time.

> *"In all the care I've ever gotten for my diabetes, nobody ever asks me how I am! How am I feeling? It's all about my HbA1C, the weight, the blood pressure, and the tablets…"*
>
> Patient representative at an ICGP faculty consultation on regional diabetic care.

Having sufficient numbers of GPs and practice nurses to switch on fully the practice of brief interventions in relation to mood, alcohol, better eating habits and stress handling is essential. General practitioners are highly and consistently accessible to families, parents, carers, children and adolescents. Turnover within general practice teams is exceedingly low, good continuity is evident in the provision of service over years and decades, and there is a high level of contextual

knowledge in general practice teams, which is simply absent in most instances in mental health teams, and elsewhere within the health system.

What more can GP led teams do?

The ICGP is presently committed to actively delivering key national strategies including Healthy Ireland, and Making Every Contact Count. The College is broadly supportive of Slaintecare, and also Forwards Together.

Further, we are collaborating actively with the National Office of Suicide Prevention (NOSP). In our elaboration of chronic disease management, we will be advising that mental health and end of life planning be reflected across all the main disease centres, and in 2018, we will be rolling out a national programme of education for GPs on suicide prevention and deliberate self-harm, in collaboration with NOSP.

However, we urgently need more GPs and practice nurses so that there is time for more, and earlier, talk therapy.

It is a most pressing concern that increasing numbers of rural practices and practices in deprived communities are closing. Elsewhere, the composition of practice teams is changing; they are very slowly enlarging, accommodating the personal needs of younger GPs, who are more likely to work part time, and who will not work 60 or 70 hours per week as the current generation of older colleagues have done.

In the context of these larger practice teams, the ICGP supports the idea of basing sessional allied health professionals, particularly in psychology, counselling and life skills coaching into practices. Further, we advise that determination of the most appropriate skills mix be determined at the level of the practice, and with reference to the specific needs of the community. The ICGP is supportive of the role of more involvement by allied health professionals, but is impatient at delays in this roll out, and remains acutely concerned at the overall shortage of GPs and practice nurses.

GP led teams and primary care teams

The ICGP is concerned regarding the experience of GPs with Primary Care Teams (PCTs) during the last decade. Research conducted by the ICGP (Collins, O'Riordan[3]) indicates that while over 70% of GPs are well disposed towards PCTs, fewer than 13% of GPs surveyed reported positively on their experiences with PCTs. While all individuals working in GP led teams engage in full electronic communication, at the time of writing, most members of HSE PCTs do not have functioning email addresses, and utilise paper based records. Further, it is known that mental health is poorly reflected and integrated in PCTs at present (McHugh, Byrne[4]).

GP led teams have, as far as funding constraints have allowed, developed services relevant to people who attend them, but this occurs on a non-systematic basis, and unevenly.

The reality regarding mental health care is that most psychiatric illness is cared for in the general practice setting. Further investment here will enable better and earlier prevention, and less expensive intervention. However, it needs to be recognised in Ireland that GP led primary care is relatively very under resourced.

Concluding comments

Increasing numbers of GPs and practice nurses, with additional sessional inputs from relevant health care professionals will enable better prevention, earlier detection, more immediate care in communities, and a shift in mental health care from psychiatric OPDs, if it is adequately resourced.

Focused transitional funding is essential for this to happen, to increase training and improve retention for GPs and practice nurses.

Legislators, administrators and patients can all be confident that given the highly computerised nature of GP led primary care, that any additional resourcing can be supported by agreed full system de-identified data analysis, so that all stake holders can be assured that funding is tied to agreed activities.

This process is already well established in general practice in terms of PCRS and Heartwatch data returns, and in iPCRN activities.

It is the view of the ICGP that FEMPI legislation has destabilised general practice, particularly in rural and deprived communities. Within the NHS, and many Commonwealth, Scandinavian and Dutch health systems, the proportion of health spending in primary care is in the order of 8 to 11% of total health spending, whereas in Ireland, the proportion is in the order of 3.7 to 4%, or less than half.

This striking historic under resourcing of GP led primary care in Ireland is an important rate limiting factor in improving mental healthcare for individuals and families at this point in time.

The ICGP is confident that given adequate resourcing for GP led primary care, substantial improvements can be achieved in the experiences and outcomes for many people with mental health needs who use our health service. The College is closely aligned with best international evidence, and with our own national policy framework.

The key sequencing must be the stabilisation of GP led primary care, through relevant and essential investment in building capacity in GP led primary care, following which we can confidently implement key policies, and continue to make real and positive differences to people who rely on the Irish health system to deliver their essential healthcare, particularly mental healthcare.

Action points identified by the ICGP in relation to improving mental health care

1. Address the instability in general practice arising from cuts in funding under FEMPI legislation.
2. Replace the present GP contract with an evolving contract to support the primary care needs of all Irish citizens.
3. Use of deprivation / geographical weightings to address greater healthcare needs in deprived / rural areas.
4. Extend use of electronic medical records / administration beyond general practice to the whole health system.
5. Provision of adequate sessional allied health professionals in GP led primary care.
6. Review and appraise the functioning of primary care teams, increasing input from mental health practitioners.
7. Ensure mental health is effectively reflected across all evolving chronic disease programmes.
8. Increase numbers of GPs and practice nurses towards 5,000 WTEs of each.
9. Stabilise staff turnover in all psychiatry services, reducing dependence on NCHDs for service delivery.
10. Critically appraise care pathways in all psychiatry services, which at times appear profoundly disjointed.

References

1. Joint Commissioning Panel for Mental Health. Joint Commissioning Panel for Mental Health: Guidance for commissioners of primary mental health care services, Volume Two: Practical mental health commissioning. 2012; Available at: http://www.rcpsych.ac.uk/pdf/JCPH%20primary%20care%20%28March%202012%29.pdf. Accessed 12/11, 2017.

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3. Collins C., O'Riordan M. The future of Irish general practice: ICGP Member survey 2015. 2015; Available at: https://www.icgp.ie/go/library/catalogue/item/E21F0871-DDC4-1AD4-20024CFC3C37FE68?highlight=future%20collins. Accessed 12/11, 2017.

4. McHugh P. BM. Profile of the shared care activities of mental health teams in Ireland. 2013; Available at: http://www.lenus.ie/hse/bitstream/10147/305845/1/CareActivitiesofMentalHealthTeamsinIreland.pdf. Accessed 12/11, 2017.

Appended documents

1. 2016 ICGP Submission to the Oireachtas Committee on Health
2. 2017 ICGP Submission to the Oireachtas Committee on Future Health
3. ICGP 'Beyond 2020 – A statement of Strategy'