Final Report
September 2020

“Listen…”
Exploring Distress and Psychological Trauma

Prepared for:
Health Improvement on behalf of Primary Care
Glasgow City Health and Social Care Partnership

Contract No: 3609

FMR RESEARCH

Acknowledgements

FMR would like to take this opportunity to thank the many participants, organisations and stakeholders who took the time to give their views and helped to make this research happen. There are too many of you to name-check individually, but we recognise that your time is valuable and very much appreciate that you gave us your considered insights and assistance when asked. It was a tough topic – for patients and staff – which makes it all the more important that so many of you got involved.

Special thanks must be given to this project's Steering Group members, who have all given their time, thoughts, experience and enthusiasm so willingly – you have been a joy to work with and have added value to the process and its outputs. Ruth Donnelly, Health Improvement Lead – NE Locality, Glasgow City Health and Social Care Partnership, deserves a special mention for getting the project moving and managing us all so adeptly.

Thank you!

The many discussions which have taken place over the last few months have produced rich data which should be useful to decision-makers and practitioners in moving forward the response to distress and trauma informed care in Glasgow.   I think we are all hopeful that it will make a positive difference to those experiencing distress and those who have experienced trauma. We need to listen to what people have said and do this better – it matters.

Nikki Bell, Director, FMR Research Ltd

Executive Summary

Introduction

Glasgow City Health and Social Care Partnership (GCHSCP) commissioned this research in November 2019 to quantify the scale of distress presenting to general practice and better understand the experiences and needs of general practice in Glasgow City around trauma informed practice (TIP). This was driven by the Glasgow Primary Care Improvement Plan's mental wellbeing model, which commits to scope effective and efficient service responses to divert work from GPs, learn from existing initiatives, develop tests of change with a few clusters and consider learning needs of general practice in relation to mental health, particularly trauma informed practice.

The research is intended to inform future service provision and training, with a particular focus on whether the newly-commissioned out-of-hours Compassionate Distress Response Service should also provide in-hours support to general practice.

Distress and psychological trauma are two distinct but sometimes related issues. **Distress**, for the purposes of this project, related to emotional upset or stress – sadness, worry or anger – where patients needed assistance beyond the scope of their GP team, but not sufficient to necessitate crisis clinical mental health support. **Trauma** can be experienced as a one-off incident, such as rape, a significant road traffic accident, assault or terrorist attack or as a more complex and sustained experience of physical, mental or sexual abuse or neglect at home, particularly as a child, which may impact on a person's quality of life, relationships and capacity to cope with everyday life (at the time and/or later in their lives).

What did we do?

The project was overseen by a steering group of GPs, GCHSCP and NHS Greater Glasgow & Clyde (NHSGGC) staff and involved three key phases:

- a brief literature review and desk research;
- considerable qualitative engagement (by telephone interview, face to face discussion and group discussion) with different types of staff roles based within general practice across the city (discussions with 34 GPs, 32 Practice Nurses and 25 other team members were achieved prior to Covid-19 lockdown, when other scheduled discussions had to be cancelled); and
- validation discussions with people with lived experience of trauma (5 group Zoom discussions with 30 participants in total and 12 individual telephone interviews were undertaken post-lockdown once alternative routes in to people with lived experience were identified, rather than the intended face to face group discussions).

What did we find?

DISTRESS

The research confirmed anecdotal evidence that distress is perceived to be a significant and growing issue in general practice, presenting particularly strongly (daily for some) to GPs, Community Links Practitioners (CLPs) and reception staff. Where staff were able to estimate time spent on distressed patients (recognising there are limitations to these estimates), low/average/high costs of distress were calculated for general practice.

Using the **lowest** estimates provided by participants, the total cost is **£1.9million**.
Using the **mean** of estimates provided, the total cost is **£3.9million**.
Using the **highest** estimates provided, the total cost is **£8.0million**.

These figures are sufficiently significant to justify investment in support for general practice and their distressed patients. Some of the main reasons cited for distress include challenges around poverty, benefits, housing, relationships, work and trauma – which may well all have been heightened by lockdown - in addition to overt concerns around the impacts on mental health of social isolation, bereavement and other fears relating to the global pandemic.

Investment in better support for distressed patients would have a positive impact on both patients and GP teams. There was a sense of staff being at or close to breaking point, with such high need for patient support and the willingness to help them but limited resources within practices, without access to sufficient and/or appropriate meaningful referral services. The current 'sticking plaster' approach with short-term inputs is not considered to be working for patients or health care professionals, who find the interface with mental health services to be frustrating and time-consuming, with little positive return for them or their patients.

Recommendation 1:
This suggests that there is a need for the new out-of-hours compassionate distress response service operated by GAMH to be extended in-hours for primary care. It is understood that this is already being actioned. This (and other services) needs to have:

- *clarity around who it is for and what to expect;*
- *mixed contact modes (online, face to face when possible, telephone);*
- *a responsive and accessible approach;*
- *local access points where possible;*
- *a hand over of the 'baton of trust' from a trusted health professional or self-referral, as appropriate; and*
- *minimal form-filling and re-telling of people's stories.*

It is important to note that this is not the only outcome for GPs with regard to the PCIP and mental health, but it aims to be a helpful resource which reduces the burden of care on GPs. This sits within the wider context of the mental wellbeing model and agreed programme of work to be trialled by clusters to support and trial new ways of working.

The lack of local, relevant data, and sharing of what exists, on distress and trauma was challenging. It is difficult to address the issue properly if the scope and scale is not clear.

Recommendation 2:
We need better data on distress and trauma. It is understood that a new IT system (SNOMED is replacing Read codes) is being developed so it would be helpful if the design could take a more consistent and comprehensive approach to coding distress and trauma from the outset.

TRAUMA INFORMED PRACTICE

Awareness and understanding

Trauma informed practice (TIP) was not a well-known term, so there is work to be done on awareness and understanding in the first instance. Community Links Practitioners were all aware of it, as they had recently received training on TIP. Many GPs felt that, whilst they may not call it that, they have always been trauma-informed and some of their staff do it very well, intuitively. There was recognition that this is not the case across the board, however. This was echoed by people with lived experience, who highlighted that a positive relationship with their GP and practice receptionist can make all the difference – knowing their history so they do not have to repeat it, getting them in and out quickly if appropriate, giving them time, listening to them and supporting them through crises – but this is not consistently good.

Very few participants were aware of the NES National Trauma Framework, associated Training Plan or tools. There is support and interest to become better at trauma informed practice within general practice, but caution around this too. It needs to build on learning and good practice to date with a clear corporate context for TIP and a whole systems approach to embed this as good practice within the organisation.

TIP training
Changing the attitudes of some staff were perceived to be the biggest challenge in moving forward trauma informed practice. Helping staff to understand the importance of the language they use, the assumptions they make and ways in which they may be consciously or unconsciously biased are critical to changing attitudes, culture and the equity of service provided to patients. It may be easier to address environmental factors (if buildings allow) but this should not become a distraction or a tick box exercise. Participants with lived experience very clearly said that whilst environmental factors can make a difference, it is more important that they are heard and supported appropriately, so attitudes are key.

Recommendation 3:
It needs to be easy for busy staff in general practice to grasp the relevance, importance and practicalities of trauma informed practice so that it becomes embedded, with opportunities to share good practice. This means:

- *spelling out what it means;*
- *what difference it can make to patients, staff and colleagues; and*
- *providing practical tips, checklists and tools which can be quickly implemented. This does not mean dealing with a person's trauma but asking the right questions in the right way, acknowledging/validating and managing trauma disclosures safely and helping patients to access support where required and wanted, in a positive, meaningful and collaborative way.*

TIP could be included as core training for all staff, like equalities issues. There may also be merit in each practice having HSCP support to devise and implement a TIP plan. There is perhaps a need to tailor the NES resources to both the Glasgow and general practice contexts, however, to deliver an appropriate response to this agenda and meet the City's aspirations around TIP. This might include a scoping review of what would work to support practices, including other stakeholders like the Local Medical Committee, Royal College of General Practitioners and postgraduate training to become more 'TIP'd'.

Shifting culture and practice
The variation in provision and culture of general practice across the city was evident during the research, as was the difference this can make to both staff and patients.

Recommendation 4:
Share learning from good practice within Glasgow and elsewhere to make it easier for practices to shift what they do and how they do it in a more positive direction.

Patients reaching the right support quicker, reducing the burden on GPs
There is a need to manage access to GPs better – if people feel bad they go to the GP but they may not be the best person to help a patient in distress as they do not have much time to actively listen to them. The PCIP and the primary research recognise that GPs' workload needs to be reduced and distress is increasing so patients in distress need to be directed elsewhere if possible.

Recommendation 5:
As receptionists/recorded messages encourage patients to go to the optician for eye issues, etc., can patients with low level distress also be directed to appropriate services? Strong

messaging from the Scottish Government and HSCP may also help to change the current culture of attending the GP as a first point of contact.

Staff wellbeing
There is little in the way of support for staff dealing with patients who are distressed or have experienced trauma, but the mental wellbeing of staff, including GPs, is a component of TIP.

Recommendation 6:
Consider how best to provide mental wellbeing support for GPs and practice staff at HSCP and individual practice level. and encourage staff to access this.

Equalities and accessing services
As with everything else, the full range of equalities and access issues need to be considered. For example, where people require interpreters or where there are literacy issues it can be challenging to disclose trauma. Talking therapies are not for everyone so clarity is required on what the alternatives are for men, for example. Is counselling or other support available culturally appropriate?

Recommendation 7:
Active consideration needs to be given to equalities and access issues for all of Glasgow's citizens to make sure barriers are removed to disclosure of trauma or distress and that support solutions are appropriate for all.

This applies to those attending appointments and also giving consideration to reasons for non-attendance.

Recommendation 8:
General practice and other NHS services need to follow up non-response or non-attendance, consider whether trauma or other accessibility issues are a factor and provide appropriate support to access services if so.

THE BIGGER PICTURE

Practices can become trauma informed but it there is no meaningful therapeutic support for patients who have experienced trauma or are distressed, this does not go far enough. Patients need to be identified and heard, but they need to then access the right support to help them get to and stay in a more positive mental space.

The need to review mental health support services
Feedback from stakeholders was more wide-ranging than the original research aims. The impacts of Covid-19 and lockdown have also sharpened the focus on mental health support services more broadly within the city – how they are structured, accessed and whether they meet the needs of Glasgow's residents and GP teams in supporting distress and trauma. It appears to be a cluttered yet fragmented landscape.

Recommendation 9:
A full review of mental health services – the scope, scale, structure plus how they connect to each other and allied services like GPs and Addictions – is required.

This is not intended to be critical of mental health services in the city but to help move provision forward to better meet the needs of patients, referrers and assist mental health professionals do their job more effectively too.

A paradigm shift?

Presentations of mental illness and poor health are complex with GPs varying in their expertise and what they consider as part of their GP role, so this does suggest that a single point of entry for mental health support – major or minor – would be helpful, or a 'no wrong door' joined up, flexible person-centred approach. At the moment it appears to be very much about what can be delivered, not what people need, so short term support is provided for those worst affected and many patients rebound to their GP. There is much talk of a mental health 'ticking time bomb' given lockdown and the forthcoming recession, so the more that can be done to respond to this now the better. Some of this is about more generic practical and emotional support as people deal with challenges in their lives, such as bereavement, relationship breakdown, money advice, etc., but it is also about minimising risk of harm.

Recommendation 10:
Can this be turned around to consider positive mental health (not simply management of mental illness) and how this can best be supported and achieved? A preventative model focusing on improved coping skills, practical support to help people face the challenges which cause distress and longer term co-ordinated support from mental health, addictions and other services for people to properly improve their mental health would require a paradigm shift from where services currently stand, but that initial investment and proactive approach to managing mental health could make all the difference and be more cost effective than the current system which stakeholders referred to as a 'revolving door'.

Recommendation 11:
Future mental health support is likely to be delivered via a mix of statutory and Third Sector services, but these need to be co-ordinated so that people **are only assessed once** *before then receiving the support they need, rather than being stuck in a cycle of repeated assessment, short-term support, no support at all or accessing their GP for support in lieu of/while waiting for specialist support..*

Improving the interface between GPs and mental health services

Feedback suggests there is a tension between GPs referring to mental health services, particularly CMHTs, and the number of patients accepted (those with 'medical' mental health issues rather than environmental or social issues causing distress who are often referred to the Third Sector). The resources and capacity of the Third Sector also needs to be considered here, particularly given recent grant funding cuts.

Recommendation 12:
There is a need for better communications between mental health services and GPs and greater clarity around matching patients to services.

The need for more 'lower level' support

It would appear that the system is best at responding to those with florid mental ill health and the new service will help with those who are very distressed. However, feedback suggests there is a large cohort of patients at any one time who do not need that rapid response, but are experiencing significant ongoing distress who need better practical support and a listening ear. Going to a GP may result in medication they do not need or really want, particularly for those wishing to reduce medication.

Recommendation 13:
This research suggests there is a case for increasing access to CLPs, Money Advice Workers, talking and other therapies , i.e. a route to less cost-intensive staff who can support patients in a practical, longer-term way. There is a clear role for greater Third Sector input in addition to other options like peer support, but it needs to be provided in a joined up way.

This again suggests either a single point of entry or a 'no wrong door', person-centred approach is required. This would avoid patients having to re-tell their story and ensure that once they have been referred to/have entered mental health support services (in the widest sense, be that statutory or Third Sector provision) they will receive support until – with discussion and their consent – they no longer need mental health input. Responsibility then lies with mental health services to ensure the patient is recovering within the different tiers of support, rather than the patient and/or GP having to diagnose and navigate the services on offer on a one-by-one basis.

Feedback to participants
Some participants asked if they would see the findings and the plans for responding to the issues raised are even more important to share, to show that participants have been heard and GCHSCP wishes to improve services provided.

Recommendation 14:
The final recommendation is that the findings of the research and GCHSCP's response to these are communicated to research participants.

Contents

1 Introduction

1.1 Background

This report outlines the findings of research commissioned by Glasgow City Health and Social Care Partnership in late November 2019 to quantify the scale of distress presenting to general practice and better understand the experiences and needs of general practice in Glasgow City around trauma informed practice. The purpose of the research was to inform future service provision, with a particular focus on whether the newly-commissioned out-of-hours Compassionate Distress Response Service should be extended to provide in-hours support to general practice. This was driven by the Glasgow Primary Care Improvement Plan's mental wellbeing model, which commits to scope effective and efficient service responses to divert work from GPs, learn from existing initiatives, develop tests of change with a few clusters and consider learning needs of general practice in relation to mental health, particularly trauma informed practice.

The research was conducted by FMR Research Ltd, supported by a steering group of GPs, GCHSCP and NHSGGC staff.

1.2 Context

Our collective understanding of trauma, its impacts and awareness of the degree to which trauma is experienced has improved significantly over the last few decades. Increased globalisation, the rise of the internet and social media usage have had an impact on people's knowledge, conversations, views, expectations and emotional intelligence, in addition to bringing new dangers and ways to experience distress and trauma. The discovery of historic and current child sexual exploitation, the #MeToo movement and changing attitudes towards domestic abuse and bullying behaviours (particularly towards specific groups such as women, LGBTIQ+, minority ethnic communities or disabled people), for example, have all raised our collective awareness of the issues. There have also been a number of academic studies to quantify and explore the impacts of trauma.

As NHS Education for Scotland's (NES's) Psychological Trauma Training Plan highlights, recent studies and reports suggest the incidence of abuse and trauma is much more widespread than previously thought.[1] Trauma can be experienced as a one-off incident, such as rape, a significant road traffic accident, assault or terrorist attack or as a more complex and sustained experience of physical, mental or sexual abuse or neglect at home, particularly as a child. Not everyone experiencing these traumatic experiences will be affected by them, but some will be deeply affected (at the time and/or a later date) and this may impact on their quality of life, relationships and capacity to cope with everyday life. Experience of trauma is believed to be higher in areas of deprivation and distress is more acute when people do not have good social support.

The impacts of Adverse Childhood Experiences (ACEs, which include abuse, neglect, community violence, homelessness and adults/care givers with mental health issues or harmful drug or alcohol use) and their continuing impacts on health and wellbeing have been the subject of increasing focus in recent years.[2] For example, survivors of trauma and abuse are known to be more likely to experience physical and mental health issues, including being more likely to be heavy drinkers, smoke and/or to use drugs, and to be more likely to be both victims and perpetrators of violence. This can impact on their ability to work, enjoy positive

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[1] https://www.nes.scot.nhs.uk/media/4321706/Scottish%20Psychological%20Trauma%20Training%20Plan%202019.pdf last accessed 14/11/19

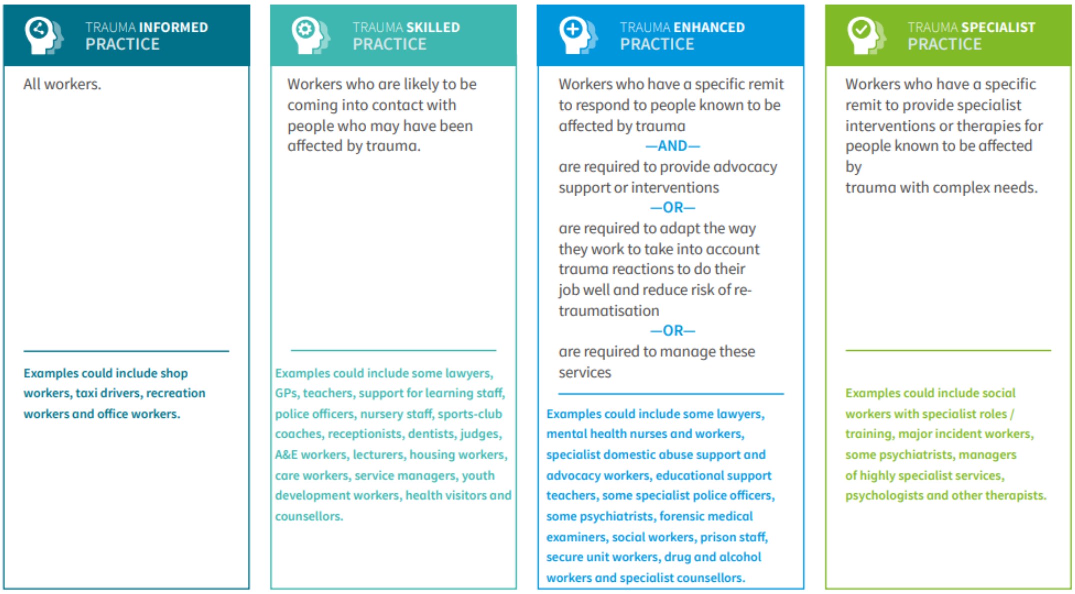
[2] https://www.gov.scot/publications/adverse-childhood-experiences-aces/#:~:text=ACEs%20research-,ACEs%20overview,lasting%20effect%20on%20people's%20lives last accessed 9/09/20

relationships and can lead to involvement in the criminal justice system and/or homelessness.

Increased societal awareness can lead to reduced stigma and an increase in the number of people actively seeking help, so services – particularly front line services – need to be equipped to respond. For example, trauma may stop people from accessing health services, e.g. women who have been raped may not routinely attend for smear tests. Those who do engage may find questions and procedures more challenging than might be expected because of the trauma they have experienced although it may not be immediately clear that is the reason at the point of service delivery, e.g. when physically examined, or when kindness is shown by a health professional. Others may present in an overtly distressed state.

Trauma informed practice is about practitioners *actively* knowing service users and colleagues may have experienced trauma and thinking about the potential impacts that may have on their physical and mental health, in addition to their behaviour or response to situations. Trauma informed practice therefore looks at adapting environments and practice to minimise trauma-related stressors and avoiding re-traumatising people by building trust, ensuring they feel safe and working collaboratively with patients so they feel empowered and have some control and choice over their care.

The Scottish Government wishes Scotland to become a Trauma Informed Nation. This means communicating and delivering services in a more appropriate way, recognising that patients (and colleagues) may have experienced trauma and working in a supportive way rather than re-traumatising people or generating barriers to them accessing services. Trauma-informed services aim to be accessible and appropriate for people who have experienced trauma but this does not mean that disclosure of trauma is required or overt. It means that those delivering a service understand what they do and how they do it can impact on people with experience of trauma and the service prioritises people's physical and emotional safety, choice and control. At national level, this is supported by NHS Education for Scotland's (NES's) Psychological Trauma Training Plan which was published in 2019. This reinforces that everyone needs to be at least aware of trauma, recognise when people they come into contact with may have experienced trauma and respond appropriately depending on their role. NES has identified 4 practice levels for trauma informed practice, as shown below:[3]



TRAUMA **INFORMED** PRACTICE	TRAUMA **SKILLED** PRACTICE	TRAUMA **ENHANCED** PRACTICE	TRAUMA **SPECIALIST** PRACTICE
All workers.	Workers who are likely to be coming into contact with people who may have been affected by trauma.	Workers who have a specific remit to respond to people known to be affected by trauma **—AND—** are required to provide advocacy support or interventions **—OR—** are required to adapt the way they work to take into account trauma reactions to do their job well and reduce risk of re-traumatisation **—OR—** are required to manage these services	Workers who have a specific remit to provide specialist interventions or therapies for people known to be affected by trauma with complex needs.
Examples could include shop workers, taxi drivers, recreation workers and office workers.	**Examples could include some lawyers, GPs, teachers, support for learning staff, police officers, nursery staff, sports-club coaches, receptionists, dentists, judges, A&E workers, lecturers, housing workers, care workers, service managers, youth development workers, health visitors and counsellors.**	**Examples could include some lawyers, mental health nurses and workers, specialist domestic abuse support and advocacy workers, educational support teachers, some specialist police officers, some psychiatrists, forensic medical examiners, social workers, prison staff, secure unit workers, drug and alcohol workers and specialist counsellors.**	**Examples could include social workers with specialist roles / training, major incident workers, some psychiatrists, managers of highly specialist services, psychologists and other therapists.**

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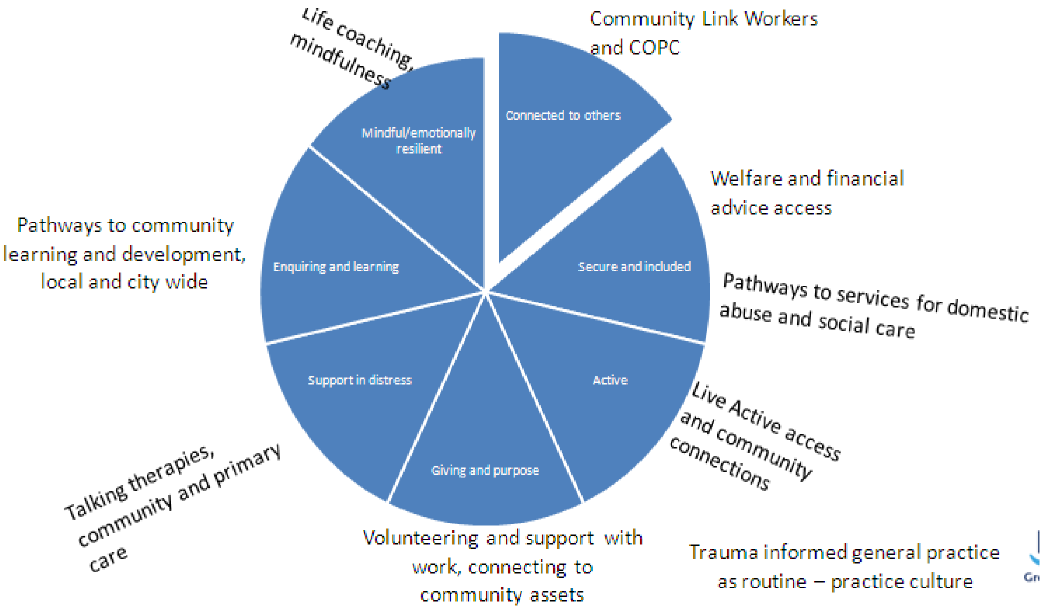
[3] https://www.nes.scot.nhs.uk/media/4321706/Scottish%20Psychological%20Trauma%20Training%20Plan%202019.pdf last accessed 9/9/20

NES has produced various training materials to support the plan and training was due to commence being piloted in Glasgow just as Covid-19 happened. The purpose of the NES training is to ensure values, language and skills are shared across the country in relation to trauma and that good practice is developed and delivered consistently for everyone's benefit.

In Glasgow, activity is taking place which may support ambitions to become trauma informed, for example an out-of-hours Alternative Distress Response Service - to help those experiencing distress but do not require a clinical response - was recently commissioned by mental health services. The GCHSCP Primary Care Improvement Plan considers capacity in general practice to support patients' mental health and broader wellbeing. This includes exploring the wider social factors which influence a person's health and who may be best placed to provide support, to reduce the clinical burden on GPs. The Primary Care Improvement Plan and associated programme of work – the Mental Wellbeing in Primary Care Model - also recognises there is a variety of evidence-based support for the mental health needs of residents which clusters can participate in. These include the anti-depressant and exercise pilot, learning on prescription, development of bereavement resource and normalising grief training programme and embedded Money Advice Workers in primary care. Additional Lifelink resource has also been commissioned. The Mental Wellbeing Model is as follows:[4]



Emotional or psychological distress is one such area where a non-clinical service response may be more appropriate and may reduce the burden of poor mental health in general practice. Distress for the purposes of this project related to emotional upset or stress – sadness, worry or anger – where patients needed assistance beyond that which could be provided by their GP team, but not necessitating crisis clinical mental health support.

However, anecdotal evidence suggests that an increasing number of patients present to general practice experiencing acute distress, often on an unscheduled basis. This will be challenging for the individual and staff members, impacts on the efficient and effective service delivery of the practice which also in turn impacts on other patients. Whilst it is important for staff to be trained to recognise and support patients who are distressed or have experienced trauma, it may be helpful to offer a specialist distress service to support people more fully and allow general practice to focus on its core activity. Glasgow City HSCP therefore wished this research to explore the need for an in-hours Alternative Distress Response service, investigating the experiences and needs of general practices in Glasgow in terms of trauma practice and to quantify those who might benefit from an in-hours distress

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[4] S. Glennie (May 2019) *Responding to Mental Health Presentations in a Primary Care Setting*

service, in order to inform the development of any such service. That research is the focus of this report.

1.3 Objectives

The overarching aim of the work was to better understand and quantify the experiences and needs of general practice in the city around distress and trauma practice, to inform future service provision. In particular, the research was designed to:

- investigate and make an informed estimate of the number and type of ‘unscheduled’ presentations in General Practice of very distressed patients who require an immediate response (but do not need clinical assistance); and

- investigate the level, nature and needs of general practice in Glasgow City in terms of trauma practice (levels 1-3 NES framework).

2 Method

2.1 Overview

The key elements of the project were:

- brief literature review and desk research;
- qualitative engagement with multi-disciplinary teams within general practice;
- validation discussions with communities of interest; and
- analysis and reporting of interim and full findings.

2.2 Challenges

Any project has challenges to address and this was no exception, as follows:

- Timescales were tight. The first steering group/inception meeting took place at the end of November 2019 and it was hoped that the majority of the project would be complete by the end of March 2020. This was expanded slightly as the project progressed as the steering group did not wish to compromise the quality of the outputs by rushing (Covid-19 then impacted on timescales further).
- Given the tight timescales, great efforts were made to check ethical considerations, discuss the most appropriate process to invite general practices across the city to participate and to act on that as quickly as possible. In retrospect, the two week festive season close down may have impacted on recruitment of participants in the North East and North West of the city as invitations to participate were issued prior to the festive break, but after the festive break in the South (where there was a better response, but this may have happened anyway).
- The route into practices was agreed to be via Practice Managers but they, and GPs, were extremely busy in January completing financial returns which were critical to their ongoing funding. This may have impacted on recruitment.
- Many Practice Manager’s direct email/telephone contact details were not available, and practice receptionists were very protective of these, so this presented an unforeseen hurdle to contact them, despite them expecting to be contacted about the research (as the letter from the Clinical Directors indicated). In addition, many practice managers wished to discuss the research at practice meetings and the frequency of these varied from once a week to once every six weeks so this also added another element of delay.
- The researchers were very conscious that GP and other practice staff are very time-poor and qualitative research requires time. The approach therefore had to be as flexible as possible to enable practice staff to engage however and whenever suited them.

Despite all of this, the research made excellent progress until the Covid-19 pandemic hit in March 2020. This stopped or delayed additional primary research being undertaken (some of which had already been scheduled or agreed to in principle) and meant that information which had been agreed was not then shared, for example data logs of distress promised by some practices, and sharing of information by other practitioners to inform the desk research.

However, a substantial amount of data had already been gathered, particularly from GPs, so the decision was taken to make the most of the work completed to date and move to the analysis and draft reporting stage. Validation discussions with communities of interest were then convened online or via telephone once this was possible.

Each stage of the methodology is explained more fully below.

2.3 Inception meeting

The project started with an inception meeting with the commissioning steering group to:

- discuss and agree the overall project methodology, objectives, scope and timescales;
- discuss sampling and access to staff in general practice;
- explore key research questions and discuss the parameters of the literature review;
- agree project reporting protocols and output expectations; and
- consider potential dates for future steering group meetings and validation events, etc.

The steering group met approximately monthly (in person then online) over the course of the project. Steering group participants were as follows:

Dr Andrea Williamson (Chair)	Mental Health Lead GPs at the Deep End Scotland Senior Clinical University Lecturer, General Practice and Primary Care, SoMDN, University of Glasgow GP Homeless Health Services, Medical Officer Alcohol and Drug Recovery Services, Glasgow
Dr Lynn Templeton	GP Annfield Medical Centre, Glasgow
Dr Ruth Spencer	GP Homeless Health Service, Glasgow City Health and Social Care Partnership (retired from group Feb 2020)
Dr Fiona Kinnon	GP, Clinical Director North West Glasgow City (joined spring 2020)
Dr Mhairi Selkirk	Consultant Clinical Psychologist The Anchor, Glasgow Psychological Trauma Service
Margaret McGranachan	Public Health Researcher NHSGGC
Margaret Black	Primary Care Development Officer – North West Locality Glasgow City Health and Social Care Partnership
Ruth Donnelly (FMR client)	Health Improvement Lead - North East Locality Glasgow City Health and Social Care Partnership
Carol McGurin	Health Improvement Senior – Financial Inclusion, North East Glasgow City Health and Social Care Partnership
Nikki Bell	Director FMR Research

2.4 Literature review and desk research

The research brief included the conduct of a limited literature review. The purpose of this was to help 'calibrate' the research, building on what is already known and identify learning from other areas rather than starting with a blank sheet of paper. The literature review was not intended to be a full, lengthy academic exercise. It was intended to be a judicious use of limited resources to help frame the primary research, ensure the researchers were well informed (so could use this knowledge when designing and conducting the fieldwork) and when 'joining the dots' to make appropriate conclusions and recommendations.

The strategy for the literature review was discussed at the inception meeting and two key points were made. Firstly, NHS Greater Glasgow & Clyde had recently commissioned a staff training needs analysis, including literature review, of trauma informed practice for addictions, homelessness, and criminal & community justice teams in various NHSGGC areas. Secondly, steering group members felt it unlikely that there would be much of direct relevance to the focus of the commissioned research. It was therefore agreed that a very brief literature search would be conducted, focussing specifically on:

- Trauma Informed Practice in primary care; and
- unscheduled distress presentations to general practice.

The brief particularly highlighted studies conducted in the UK, and Scotland specifically, over the last 5 years. Trauma informed approaches first gained traction in the US, but the UK is now moving on this. We conducted internet searches to identify articles of potential relevance and mined bibliographies and references cited by authors to help identify further potential sources. However, little emerged of direct relevance to this project. Reading 'around the subject' was very useful to bring the researchers up to speed on some of the issues, however.

The bulk of this element of the budget was therefore used to conducted interviews with steering group members and other key players, for example, those perceived to be doing relevant work elsewhere, to help identify key issues to explore in the primary research. Contact was also made with those who may be able to help provide background information such as referral or prescribing data. Unfortunately, whilst several meetings were convened with a variety of people, 'hard' data on those presenting to GPs in distress, prescribing of relevant drugs or referral to mental health services were not available, either because it did not exist or because Covid-19 work took priority at that time.

2.5 Sampling and fieldwork

This was a qualitative research project, so aimed to achieve in-depth discussion with a variety of stakeholders. Each of the three Clinical Directors tailored a draft letter signed off by the steering group, lending their support to the research and encouraging practices to engage with the research. This was issued just before or after Christmas 2019.

FMR then made contact with practices, inviting participation and efforts were made to achieve a sample as representative of the wider staff and GP practice profile as possible. The number of practices invited to participate grew – different tranches were invited in subsequent weeks if practices did not respond – until finally all practices had received an invitation to participate.

The sample is obviously biased towards those practices which were willing to engage in the study but there was significant additional targeting of practices to balance the sample as much as possible. The HSCP did not have profile data of general practice, in order to compile a representative sample so efforts were made to ensure a spread of geography, size of practice and range of staff roles. Some practices have Third Sector staff aligned to their practice, such as Money Advice workers, so efforts were made to include these staff where possible. Some GPs maintain an individual practice, whilst others have several GP partners and some are based in larger health centres with multiple practices and allied health professionals. The sample sought to achieve a spread of practice type accordingly.

According to the PCIP2, there are 146 practices across the city with a total of 1,775 staff, as follows:[5]

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[5] Glasgow City Primary Care Improvement Plan (PCIP2) 2019-21 https://glasgowcity.hscp.scot/sites/default/files/publications/Glasgow%20City%20PCIP%202%20May%2019_0_0.pdf last accessed 9/9/20

600 GPs
340 nurses
125 practice managers
450 administrators
150 Health Care Support Workers
40 Community Links Workers
70 pharmacists and pharmacy technicians

Whilst the commissioning brief highlighted the need to include all roles, the steering group asked GPs to be prioritised if possible as this was the key role to be affected by distressed patients and other staff such as pharmacists based in general practice to be included but not in significant numbers unless early interviews suggested they should be well represented. The researchers were aware that there may be some bias as several GPs were on the steering group, but the data has borne out the steering group perspective.

FMR consistently took a flexible and pragmatic approach throughout the fieldwork period, working to achieve engagement around the research with as many staff roles as possible, whilst recognising practices' operational requirements. The fieldwork therefore consisted of a mix of individual interviews and small/large group discussions face to face, plus a number of telephone interviews. Some participants had very tight availability so discussions were very focussed on key question areas. Others were very generous with their time, which enabled more in-depth and wide-ranging discussions.

The fieldwork with general practices was conducted January – March 2020. When lockdown loomed, a couple of telephone interviews which were already in the diary were completed if the interviewees were willing and able to do so but other practices who had agreed to participate were not pursued further obviously given other priorities at this time. The following profile of participants was achieved:

31 GPs (plus 3 steering group GPs)
7 Practice Managers
7 Practice Nurses (plus discussion with 25 PNs at NE, NW and South PN network meetings)
7 Receptionists
6 Community Links Practitioners
2 Pharmacists (covering multiple practices)
1 Secretary/Administrator
1 Phlebotomist
1 Money Advice Worker (embedded in 1 practice)

2.6 Validation discussions with people with lived experience

The original intention had been to conduct three validation events with people with lived experience, to share findings to date and seek their views. As Covid-19 lockdown came into play towards the end of the fieldwork period, this had an impact on what was possible (as face to face discussions were no longer possible) and on timescales. GCHSCP and FMR reached out to a number of organisations to establish whether their group members/clients would be willing and able to participate in validation discussions, and the best means to do that. Contacts worked hard to make that happen and the following validation discussions were achieved:

5 Zoom discussions (30 participants) and 12 individual telephone interviews with people with lived experience from NE & NW Locality Engagement Forums, NE Recovery Network volunteers, The Women's Centre, Homeless Network Scotland peers, Moira Anderson Foundation, Tomorrow's Women and Community Justice.

Participants received a £20 voucher for a supermarket to thank them for their inputs.

3 Literature and desk research

3.1 Introduction

As outlined in the previous section, time was spent to conduct a brief and very focussed literature review and desk research. Much of this was ‘around’ rather than directly relevant to the issues of distress in general practice and trauma informed practice, or outwith the UK, so is not reported here.

The majority of this element of the budget was spent on desk research, interviews and meetings:

- with steering group members (to gain a sense of current practice and help develop appropriate research tools for the primary research with GP teams);
- with those seen to be doing things differently (Craigmillar Medical Group and the national Distress Brief Intervention Pilot are reported later in this section); and
- trying to gather (unsuccessfully) hard data on the scale of distress in Glasgow city (we discovered that this was not logged by GPs and any codes used on EMIS are used inconsistently, plus it is challenging to access this data, and access to proxy measures like prescribing data and referrals to mental health services by GPs were not accessible as Covid-19 hit at this point).

This section gives further national, local and emerging practice context to help interpret the primary research findings and move actions forward.

3.2 National context

3.2.1 Scottish strategies

The NES Framework and Psychological Trauma Training Plan cited in Section 1 are not the only national documents of relevance to this work. The Scottish Government published The Mental Health Strategy for Scotland 2017–2027 in 2017, which highlights that poverty is the biggest driver of poor mental health – a key point made by participants of this research – and commits to increasing access to joined-up services, including dedicated mental health professionals to all GP practices (as well as A&Es, police stations and prisons) citing additional investment of £35million for 800 additional mental health workers in those settings.[6] This investment is understood to be ongoing, although the detail on where it has been made to date – and whether GP practices have benefited so far – has not been accessed for this study.

It also makes the commitment to test and evaluate the most effective and sustainable models of supporting mental health in primary care by 2019. According to the November 2019 update, this action has been completed via the 2019 Scottish School of Primary Care publishing its National Evaluation of New Models of Primary Care in Scotland report (looking at models such as a listening service for service users, training service users on self-management, improved support for self-directed support for mental health service users, wellbeing services for NHS staff and locating welfare rights advisors in GP practices – all of which are sound approaches given the discussions for the current research) and the Scottish Government’s ten year Primary Care: National Monitoring and Evaluation Strategy in March 2019, which informs the evaluation of these models.[7]

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[6] https://www.gov.scot/publications/mental-health-strategy-2017-2027/ last accessed 9/9/20

[7] https://www.gov.scot/publications/mental-health-strategy-second-annual-progress-report/pages/10/ last accessed 9/9/20

Every Life Matters: Scotland's Suicide Prevention Action Plan (2018) also makes a number of commitments or actions to support people in distress and ensure appropriate services are in place for those at risk of suicide or affected by suicide.[8]

3.2.2 The bigger picture

The primary research highlighted the need for change in the way mental health services are delivered. This emerging paradigm shift to the way we support mental health was also reflected in the literature. This was not explored fully given the specific focus of this project, but some examples are given below.

The scale of poor mental health, its links to health, social and economic inequalities and the need for prevention and early intervention are highlighted in various ways, including NHS Health Scotland's inequality briefing series.[9] Their issue on mental health sees key actions being:

- the integration of mental health into all national and local policies;
- reducing mental health inequalities by avoiding opt-in approaches, maximising income and using universal services for those with greatest needs; and
- tackling the social and health inequalities of those with mental health conditions, including those with long-term physical health conditions.

The need to approach mental health models of care differently are highlighted in other literature, such as the King's Fund (2017), which stresses how disconnected mental health care often is from wider health and social care systems *"institutionally, professionally, clinically and culturally".*[10] This disconnected and fragmented system translates to disconnected and fragmented care, rather than looking at an individual and their care needs in a holistic way. This was perceived to particularly disadvantage those with multiple physical and mental health conditions - including those with long-term physical health conditions which can impact on mental health and those with mental health conditions experiencing poor physical health as a result - plus those experiencing chronic pain.

Whilst the vanguard sites trialled different approaches which were viewed positively, they were generally not seen to have gone far enough in integrating mental and physical health and care services. A number of learning points and recommendations were made, including making new forms of mental health support a core component of enhanced models of primary care so that general practice is better placed to meet the mental health needs of patients and those with long-term mental health problems have their physical health and care needs met more effectively.

Shifting from a medicalised model of psychiatric diagnosis - which sees distress (albeit inconsistently) as a disease to be medicated for rather than a response to what is going on in a patient's life - to a more collaborative approach has also been mooted in the literature, such as by Byng, Groos and Dowrick.[11] The authors suggest an individualised causal model, administered via empathic discussion possibly over more than one session, is more beneficial for patients and practitioners. They identify three steps: prioritising key issues facing the patient (including looking at self-harm and risk taking behaviour), explicit causal links between the distress and the issues to develop a shared understanding and developing a shared action plan (considering what approaches and support may be helpful). This sounds much like the approach taken by Community Links Practitioners, but would require a culture shift for some GPs.

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[8] https://www.gov.scot/publications/scotlands-suicide-prevention-action-plan-life-matters/pages/1/ last accessed 9/9/20

[9] NHS Health Scotland (Nov 2017) *Inequality Briefing 10: Mental Health*

[10] Naylor, Taggart and Charles (May 2017) *Mental health and new models of care: Lessons from the vanguards* The King's Fund, Royal College of Psychiatrists

[11] Byng, Groos and Dowrick, *From mental disorder to shared understanding: a non-categorical approach to support individuals with distress in primary care* British Journal of General Practice, March 2019

3.3 Local context

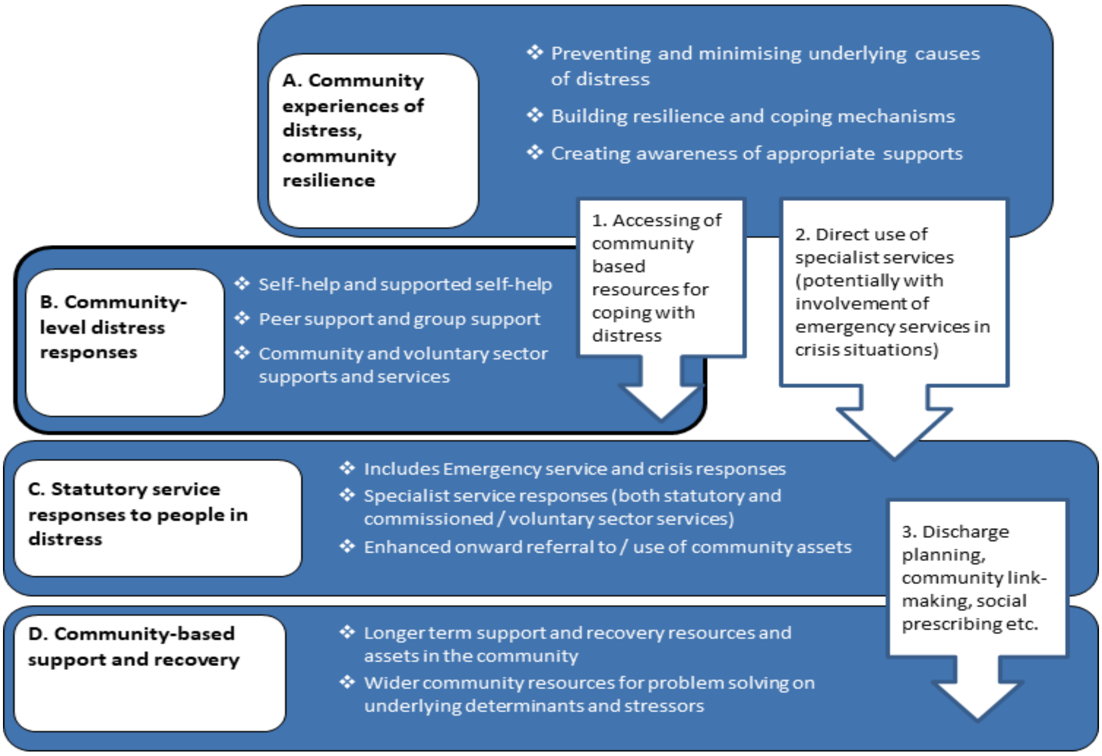
Trauma, distress or mental health issues more generally are recognised in a number of studies and strategies within Glasgow City, beyond the Primary Care Improvement Plan and Mental Wellbeing Model highlighted earlier in this report. This is an area of increasing priority for action as there is a consistent message that mental health support for patients within the city is not currently provided in sufficient quantity and consistent quality for citizens.

3.3.1 NHSGGC Multiagency Distress Collaborative

In 2016, NHS Greater Glasgow and Clyde (NHSGGC) established a Multiagency Distress Collaborative, a three year programme to identify and improve the response given to people in emotional distress which was funded by the Scottish Government Mental Health Innovation Funding.[12] A variety of partners were represented: Health and Social Care, Primary Care, Police Scotland, Scottish Ambulance Service, Scottish Fire and Rescue, NHS24, Health Acute Services and Third Sector organisations. The Collaborative defined distress as follows:

> *"Distress is an emotional state, not an illness, which is expressed and comes to our attention when a person's internal capacities and external supports cannot contain something."*
> (Expert Reference Group, September 2016)

A key recommendation from the Collaborative was to develop an alternative distress response service, as part of the overall Distress Response Framework. It was intended that this would be an integrated community response model where access is equitable, clear and understandable; the response is person-centred, safe, effective and compassionate; and interfaces and transitions are managed carefully. The Distress Response Framework is as follows:



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[12] F McMahon (2019) *Together Delivering Care and Compassion: NHS Greater Glasgow and Clyde Multiagency Distress Collaborative April 2016 until March 2019 Report on Outcomes*

The Collaborative conducted a literature review and primary research which highlighted a number of factors:

- the importance of understanding the context of distress (leading to a more compassionate response);
- the importance of organisational culture and how it views compassionate care (versus process and systems);
- traditional pathways usually lead to traditional responses to distress and some individuals and services seek greater choice in the support provided;
- the fact that staff need to be supported to provide compassionate care;
- there need to be clear and accessible pathways to support; and
- communities want to see a safe, non-clinical space provided where staff have the time, knowledge and skills to support people in distress.

The Collaborative also looked at how best to manage repeat presentations at Emergency Departments by individuals in distress who are known to Community Mental Health Teams (CMHTs). A Standard Service Response Pathway across Adult and Older Adult Community Mental Health Teams was developed and implemented, to ensure consistency of care and communications to those involved in delivering ongoing care.

The Collaborative mapped current pathways to respond to distress, which involved some signposting and referral to out-of-hours services, but the majority of distressed individuals were channelled via Emergency Departments where they would be assessed and deemed medically fit or not. If not medically fit, they would be admitted for treatment but otherwise they may be referred on to other mental health services for assessment and/or referred to Community or Primary Care Mental Health Teams, Third Sector or specialist services. If in-hours, presentation to primary care then referrals to Community or Primary Care Mental Health Teams, Third Sector or specialist services could also be made.

All of this work informed the development of an Alternative Distress Response Service (now called the Compassionate Distress Response Service) and its key service principles (We Care, We Listen and We Support). Associated support such as the Emergency Pocket Information Card (EPIC), raising awareness of other resources available, testing SAGE and THYME distress response training with a multiagency group and scoping the support currently provided to staff (leading to the establishment of a Mental Health and Wellbeing Group) were also moved forward by the Collaborative.

3.3.2 Compassionate Distress Response Service

The Compassionate Distress Response Service was commissioned late 2019/early 2020 from Glasgow Association for Mental Health (GAMH) which started providing an out-of-hours (5pm – 2am, 7 days) service by telephone during Covid-19 lockdown from late May 2020. The service is for people aged 18+ resident in Glasgow City who are emotionally distressed and require support but do not require medical or specialist psychiatric assessment.

Distressed people are referred to the service from statutory services, including first responders (especially Police Scotland/British Transport Police and Ambulance), GP Out of Hours, Out of Hours CPNs, NHS24, A&E and Mental Health Assessment Units, Urgent Care Resource Hub, etc., provided they have capacity to engage and consent to doing so. The service gives ‘listening’ support to each individual via telephone (this will also be face to face and outreach when appropriate post-Covid), provides support to develop a plan of action to alleviate their distress and onward referral to appropriate support services for each person accessing the service. People who are referred to the service should receive a call within an hour of referral for immediate support and receive a follow up phone call the following day. The case is kept open for a month, or more in some circumstances.

This service was commissioned with scope to extend the contract to include an in-hours service, as outlined in the introduction. Initial feedback from this research supported the need for in-hours provision for general practice referrals and this service commenced in September 2020.

3.3.3 The Jigsaw Project 2017-19 and follow up work

The Jigsaw Project was established in the Drumchapel & Yoker GP Cluster by Dr Peter Cawston, the Cluster Quality Lead, and Hilda Campbell of local Third Sector provider COPE, funded as part of the NHSGGC Primary Care Mental Health Transformation Fund bid to the Scottish Government.[13][14] The name arose from the perception that existing mental health provision was fragmented and its use as a visual tool for the learning process. This fragmentation was perceived to make mental health services difficult to negotiate, particularly as they were perceived to use barriers to manage demand and focus too heavily on assessment rather than solutions.

The project aimed to consider, better understand and help find solutions for people who experience longer term mental health difficulties who were not well-served by existing arrangements. This involved some difficult conversations between general practice and mental health services, but illustrated the need for further discussions to better understand each perspective and move forward to improve the relationships, systems and service for patients. The project also helped to raise awareness of other community supports which help improve mental health and a directory of these was produced for each locality to assist GPs to direct patients to these.

The voice of people with lived experience ran throughout the project, alongside those of GPs and their teams (regarding managing their own mental wellbeing as well as that of their patients). A Jigsaw tool kit was developed to engage with the community to identify problems and solutions, and these 'jigsaw lids' helped illuminate wider perspectives on the issues. The project also provided seed funding to local groups to develop solutions to poor mental health.

Mental health services were seen to rely too heavily on GP practices to support those whose needs were not being met, which impacted on their stress levels and mental wellbeing. The study found some evidence of GPs negatively affected by their workload around mental health and the challenges of negotiating the system and, although preserving non-clinical space within the diary was one of the successful approaches to avoiding burn out, most felt they were operating at the full extent of their resilience. Mutual support has improved across the cluster and active support such as Mindfulness Based Stress Reduction training and yoga practice have supported this within primary care.

The project highlighted the different ways of working amongst the public and Third Sectors but also the importance of continuing the dialogue and looking at solutions to improve communications, understanding and service delivery to better meet the needs of local people.

The North-West GP clusters, led by Dr Cawston, are also currently gathering learning and observations about the interface between CMHTs and GPs, building on the Jigsaw Project's work. This started pre-lockdown so some GPs attended CMHT allocations meetings and there will also be some reflection on referrals made to mental health services. This work is not yet complete but initial feedback suggests that patients referred to mental health services were less likely to be accepted if they were experiencing environmental stressors (financial or social issues are usually referred to Third Sector providers) or drugs or alcohol issues (these are referred to addiction services). GPs are not experts in mental health and it would be unrealistic to diagnose what support is required in a ten minute consultation in any case, but there is a perception that there is an increasing expectation from mental health services that GPs will do just that.

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[13] Cawston (2019) *Drumchapel & Yoker GP Cluster View of the Jigsaw Project 2017-2019*

[14] Campbell (2019) *Cope Scotland's View of the Jigsaw Project 2017–2019*

This initial data - and feedback from our primary research - suggests that a significant proportion of those referred to mental health services are not accepted for treatment by the CMHT, but are directed to the PCMHT, Third Sector providers or back to the GP. This may be due to inappropriate referrals, lack of capacity or other issues but this perhaps suggests that better communications between GPs and mental health services (around what is and is not an appropriate referral) and a single point of entry to mental health support – of all kinds – would assist in ensuring patients receive the support they need (specific interventions, practical or emotional support and harm reduction/risk minimisation) and make the process more effective and less frustrating for all concerned.

3.3.4 The Govan SHIP Project (Social & Health Integration Partnership)

The Govan SHIP Project was established in 2015 to provide additional resources within primary care to enable a more effective response to the challenges faced by health and social care professionals in deprived areas.[15] The project was prompted by work of the Deep End Group and funded by the Scottish Government Primary Care Transformation Fund.

The project focussed on person-centred care delivered by multi-disciplinary teams, creating capacity for GPs to support more complex patients and understanding demand for health and care services at GP practice level. One part of the project focussed on mental health as more deprived areas have a higher incidence of mental health issues and there was a professional perception that mental health support services were not being accessed by those most affected and in need of support. This work strand also contributed to the development of the Primary Care Improvement Plan. The work involved consultation with a variety of key players: GPs, CLPs, wider primary care team, social work, PCMHTs, CMHTs, Lifelink, SAMH, GAMH, the Health and Social Care Alliance amongst others. Work was done to develop a better understanding of the type of mental health concerns presenting to primary care and the prevalence of these from existing data and literature. Fresh data was gathered by reviewing GP consultations which had substantive mental health components and an audit of outcomes of referrals to mental health support services.

It was found that 20% of patients attended with a mental health issue, primarily (74%) with depression, anxiety, low mood or stress - a significant proportion (72%) were on medication (mainly antidepressants) to assist with this but were not linked into additional support services, although most had been referred/engaged previously. Overall, less than 20% of patients referred to PCMHTs and CMHTs received treatment, raising questions around processes. The study found that the way in which mental health concerns were responded to by different practitioners was inconsistent, there was not a shared understanding around the definition of mental health needs, and current support services were challenging for both referrers and patients. This suggested a need for clearer pathways, guidance and consistent practice. The group made a variety of suggestions:

- further analysis of referral outcomes to mental health teams (particularly those which are rejected or redirected, as this was a high proportion – which is consistent with the work currently ongoing in the NW cluster);
- consultation with patients about their experiences of help for mental health issues;
- the need to develop a protocol for the routine mental health screening of all primary care patients with long term conditions (who often develop mental health issues);
- continued mental health input to the development of the CLP role;
- GP input to mental health service planning, such as the proposals for a single point of access for services;
- better links with NHS 24, Scottish Ambulance Service and Police Scotland to co-ordinate local and national efforts;
- updating online HSCP/GCC website mental health information;
- online referral guidance for GPs; and

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[15] McGarry (2019) *The Govan SHIP Project (Social & Health Integration Partnership) Report and Evaluation*

- create a visible leadership team to be accountable at a strategic level for mental health, to support joined up, collaborative partnership working.

The above is very consistent with the findings of this research, which echoes many of the above points for improvement.

3.3.5 Trauma Informed Practice Training Needs Assessment

Rocket Science and the University of St Andrews conducted a literature review and trauma informed practice training needs analysis of a range of services (health, community justice, homelessness, addictions, prison and police custody health care services) in different HSCPs in the NHSGGC area in late 2017/early 2018.[16] This highlighted a need to be clear on what TIP is/is not so that it is consistently applied, and to boost staff confidence in implementation.

This study highlighted similar issues to our own research, for example the lack of time with service users, the inflexibility of service structures, challenges in being able to find appropriate services for service users and long waiting times for these, physical environmental limitations around waiting areas, privacy and formality of space and the need to support staff, encouraging self-care. Recommendations for making a service trauma informed revolved around the physical environment (removing barriers and reducing re-traumatisation), how staff behave and respond to service users, and how the service is designed (criteria and eligibility, paperwork, waiting processes, female staff and flexibility around processes).

The study identified four drivers of staff behaviour: gaining buy-in to the importance of TIP, ensuring staff are knowledgeable about TIP, building staff confidence to use their TIP skills and providing realistic actions for staff which are possible within the constraints of the service. Specific training topics were suggested as follows:

- Awareness and understanding of trauma
- Managing conversations and disclosure
- Identifying triggers and avoiding (re)traumatisation
- Body language and effective communication
- Referral processes
- Effects of trauma on practitioners and vicarious trauma
- Recognising and understanding trauma related behaviours
- Managing crises in trauma-informed way
- Making clients feel safe
- Self-care

3.3.6 Trauma informed practice training pilot

A TIP training pilot was planned in the North East of Glasgow just as the Covid-19 pandemic hit. The Trauma Informed Practice Implementation Co-ordinator and Steering Group have proposed a route map for TIP, drawing on learning and resources available nationally and locally which will form a useful structure for TIP in primary care if adopted by the Mental Health Programme Board.

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[16] Hammond and Gardner (2018) *NHS Greater Glasgow and Clyde Trauma Informed Training Needs Assessment Final report and supporting action plan*

3.4 Progress to note from elsewhere

3.4.1 Aldershot Safe Haven

The researchers considered other distress response services such as the Aldershot Safe Haven out-of-hours drop-in service, staffed by NHS and Third Sector staff, which has been running since 2014 and has been copied in other areas. The service is centrally based so is easily accessible by public transport and is open 365 days a year. It aims to support people in/approaching crisis by listening and signposting to relevant services, helping them to maintain their mental health and reduce the need for NHS intervention.

Whilst the service is out-of-hours and the key focus of this research was in-hours, it is perhaps worth highlighting that the Safe Haven evaluation highlights reduced ED attendances (by 46% for a cohort of service users), fewer mental health related police deployments, fewer Section 136 detentions, positive feedback from service users and (85% said the service had prevented them reaching crisis and 94% felt it was a safe place to go).

3.4.2 Guidance for enhancing trauma-informed care in Scotland

Researchers at the Rivers Centre, a psychological trauma centre in Edinburgh, have been conducting research during the same timescale as this study, funded by the Scottish Government, to develop guidance around trauma-informed care for services in Scotland. This study acknowledges the prevalence of trauma and Adverse Childhood Experiences (ACEs) within the population and the fact that people who have experienced trauma are significant users of health (physical and mental), addictions and criminal justice services. If services are trauma-informed, people who have experienced trauma are more likely to engage positively. Services therefore need to become more trauma-informed so that they are accessible and appropriate for those who have experienced trauma – trauma survivors – without actually addressing the trauma, as that is the role of trauma-specific services.

When FMR spoke to the researchers, they were reviewing the literature around trauma-informed care and looking for examples of good practice to share from a number of different services. These included primary care and other health services but also various elements of the justice system, education, services which support substance misuse, a variety of care services, homelessness services and various Third Sector organisations. FMR's research also highlighted the need for practical examples to help services bridge the gap between the theoretical principles of trauma-informed care or practice and what that could mean for them in reality, so this work will be welcomed.

3.4.3 Mental health and wellbeing support within General Practice

Tayside

There has been significant focus on mental health services in Tayside. An independent inquiry into mental health services was published in February 2020, which highlighted five cross-cutting themes which needed to be addressed to improve mental health services (strategic service design, clarity of governance and leadership responsibility, engaging with people, learning culture and communication) and made 51 recommendations including low-intensity provision which impacts positively on primary care.[17] This was followed by an action plan in July 2020, which responds to each of the recommendations made by the inquiry, structured around the five cross-cutting themes.[18]

Much is therefore planned and some actions have been taken forward already. For example, FMR noted that a significant tender (£4.4million over 3 years) was issued by Tayside Procurement Consortium on Public Contracts Scotland in February 2020 for the provision of Mental Health Peer Workers in GP surgeries to provide 'a sustainable model of

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[17] https://independentinquiry.org/final-report-of-the-independent-inquiry-into-mental-health-services-in-tayside/ last accessed 21/9/20

[18] https://www.nhstaysidecdn.scot.nhs.uk/NHSTaysideWeb/idcplg?IdcService=GET_SECURE_FILE&Rendition=web&RevisionSelectionMethod=LatestReleased&noSaveAs=1&dDocName=prod_340030 last accessed 21/9/20

peer support at practice or cluster level', principally for the Angus Health and Social Care Partnership but with scope for this to be extended to the Dundee, Perth & Kinross HSCPs.

England
Whilst the focus of the desk research was meant to be in the last 5 years in Scotland, it is perhaps useful to note that the use of mental health nurses, therapists or other practitioners within GP surgeries has been promoted by NHS England for the last couple of years.[19] The guidance recognises that by co-locating talking therapies within GP surgeries – which can be referred to or patients can self-refer - this enables earlier intervention, reduces potential stigma/increases attendance and closer team working, which all help provide an improved service to patients and reduce the burden on GPs and the wider health care system.

There are examples of mental health practitioners based in GP surgeries in England, such as Dr Sophie Kilmartin's in a South Gloucestershire practice, which has reduced GP workload and cut prescription rates for anti-depressants – both concerns expressed during the primary research for this study.[20] This practice also reports significantly increased consulting time for mental health issues and reduced referrals to secondary care, so their mental health practitioner has become a valued member of the team from both staff and patient perspectives. Suzanne Glennie's paper in May 2019 also highlights a number of other approaches in England, so there is no need to duplicate them here.

A key GP player in trauma informed practice development is Dr Jonathon Tomlinson, based in Hackney, East London.[21] Dr Tomlinson is also a researcher, has written a number of blog posts and is a regular Twitter contributor to explore the narrative around trauma and trauma informed practice, including the concept of salutogensis (the inter-related factors that support health and wellbeing, rather than looking at disease).[22] His work highlights the need for greater understanding around trauma and its impact on physical and mental health, and the important role of the relationship between GPs and their patients.

3.5 Examples of doing things differently

3.5.1 Craigmillar Medical Group

The Craigmillar Medical Group is a large practice serving one of the more deprived areas of Edinburgh. A couple of years ago, it radically changed how the practice worked to move towards a more relational model of caring for patients, based on the Nuka system of care developed in Alaska.[23] This is a relationship-based approach to transforming health care, designed to improve outcomes and provide greater value for money. The system aims to understand each individual patient in a holistic way, and work with them to maintain and improve their health and wellbeing and it has had a transformational effect on both the health care system and the health and wellbeing of residents.

This is still a new way of working and is continuing to change but Craigmillar Medical Group has developed a new approach around patient care, the environment and systems. Changes include the following:

- The practice has three Mental Health Nurses, including one who has been made a Partner in the practice, to help provide immediate and ongoing support to those in distress, for example by introducing coping skills and techniques. They have 30 minute appointments. Counselling was planned to be introduced within the practice,

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[19] https://www.england.nhs.uk/2018/08/mental-health-therapists-in-gp-practices-could-be-the-norm/ last accessed 13/2/20

[20] http://www.pulsetoday.co.uk/clinical/clinical-specialties/mental-health/how-our-mental-health-nurse-reduced-gp-workload-and-cut-prescription-costs/20037635.article, last accessed 10/9/20

[21] https://abetternhs.net/2017/10/15/we-need-to-talk-about-trauma/ last accessed 1/9/20

[22] https://abetternhs.net/2018/10/17/hope-and-salutogensis/ last accessed 1/9/20

[23] https://www.southcentralfoundation.com/nuka-system-of-care/ last accessed 1/9/20

because of the high level of need and in part because of the long waiting times for access to psychotherapy and CAMHS locally.

- The practice uses a triage system to meet needs, including having a care plan with a named clinician (GP, PN or MHN) for those in the top tier of need. Trauma informed discussions take place to discuss care needs with patients in a proactive way and there are 4-weekly meetings to discuss cases.
- Reception staff are now called Care Co-ordinators and they all look after a cohort of patients so they develop relationships and know them well, The shift in role is indicated by them wearing uniforms (tunics like clinicians) and simple things like the way the phone is answered – ‘ Good morning, you’re speaking to X, one of our Care Co-ordinators, how can I help today?’ – also reinforces this. This was not a smooth process, however, as there has been some churn where existing staff did not wish to take on this role as it is a very different way of working.
- The whole team has undergone team building and profiling so they know and respect each other’s ‘type’, particularly helpful when having difficult conversations as it makes it less personal. They also use team types to identify who needs to be involved in projects, which helps keep the focus on the task rather than personalities.
- Clinicians only use consulting rooms when consulting. The remainder of the time, all staff are located in a central open plan ‘hub’, which allows everyone to have a better understanding of each other’s role and contribution. It also facilitates communications and enables quick, informal discussions between different roles and support to be provided around patient care. The physical environment had to be adapted to accommodate this change, so physical files are now located off-site, for example.
- Staff try to make the environment less clinical, with fresh flowers, keeping décor light and bright, etc.
- There is an informal ‘catch up’ at 11.30 each day.
- Supervision of staff is also provided to support staff to keep well.
- The waiting area has videos for patients to watch, colour photos of each staff member so they know who they will be seeing (everyone wears a name badge too), community organisations have stands to share what they do, there is carol singing at Christmas, and so on.

Anecdotally, the new approach has reviewed well via internal evaluation. For example, the new approach has had an impact on referrals (referrals to CMHT reduced by 60%) and reduced attendance at A&E for some patients who were regulars. Covid-19 interrupted sharing of any further evaluation or other relevant data, unfortunately.

3.5.2 Distress Brief Intervention Pilot

The Scottish Government funded a pilot Distress Brief Intervention (DBI) programme 2016-2021 as a new way to respond to people in distress, as a result of work on the Suicide Prevention and Mental Health Strategies. This was established incrementally in four areas – Aberdeen, Inverness, Lanarkshire and Scottish Borders – following a competitive bid process, where 22 HSCPs applied for funding. Glasgow City HSCP was also awarded funding for a DBI but withdrew from the pilot programme shortly after the award was announced.

The programme operates at two levels, providing both emotional and practical support. Level 1 involves a trained member of frontline staff giving a quick compassionate response to a person in distress, with the offer of ongoing referral for further support. Level 2 provides this support within 24 hours for a period of up to 14 days, with trained Third Sector staff helping people to plan/cope with their distress and the issue(s) which prompted it. There is a simple leaflet outlining the service and referral is by secure electronic means (Third Sector partners have nhs.net emails to facilitate this). The programme involves health and social care (including primary care), Police Scotland, Scottish Ambulance Service, Emergency Departments, NHS24 and the Third Sector.

The majority of Level 2 support is provided during the standard working day (9-5), with the first call not usually made before 11am. People who have been referred the previous evening may be asleep and a text is usually sent first to increase the likelihood of a call being answered, although the referral asks people about their preferred method of contact. The first call then checks in to see how people are, if they understand what the DBI is and when/where they would prefer to be seen if they would like further support. The majority of cases have a mix of phone, text and face to face contact.

An independent evaluation of the DBI pilots has reported positively at the interim stage, in January 2020, as follows:[24]

- As of end May 2019, more than 1,350 frontline staff had been trained at DBI level 1 (e-learning or classroom based, using the training package developed by University of Glasgow) and 78 staff in 6 organisations had been trained at Level 2.
- Of those referred to Level 2, attempts had been made to contact all of them, with 60% successful contacts achieved within 24 hours and 85% contacted at some point. Nearly half (46%) received Level 2 support until they achieved a planned exit (38% had support for 14+ days) but 19% had only one supportive contact.
- Jan – April 209 there were 902 referrals to Level 2. 56% were women and 44% were men, with 71% aged under 45.
- Most referrals came from A&E (34%), followed by primary care in hours (30%) and Police (16%).
- Feeling depressed/low mood (60%) was the most common presenting issue, followed by stress/anxiety for women and suicidal thoughts for men. This was consistent across geographic areas regardless of deprivation or being urban/rural in nature.
- Service users who gave a view, rated the level of compassion highly (8.1 out of 10 at Level 1 and 9.7 at Level 2). 87% agreed the DBI helped them make plans to manage distress and 95% that it gave them tools and skills to manage distress. Most people experienced a reduction in distress levels (a mean overall distress CORE-OM 5 score of 27 on entry to 17 on exit). Most did not know what they would have done without the DBI intervention, but some said they could have attempted suicide.
- Learning to date includes the need for:
  - enhanced risk assessment processes at first contact;
  - equitable levels of psychological and emotional support for Level 2 staff (all have access to a clinical psychologist and additional support where needed);
  - improved feedback loops between Level 2 and Level 1 staff;
  - Level 2 intervention duration to be kept under review; and
  - regular review of training to ensure it meets staff needs.

Other feedback suggests Level 1 staff felt empowered to be (more) compassionate and less frustrated as there was a service to which they could refer distressed people for appropriate support. It was interesting to note that in-hours primary care were the strongest referrers (34%) and referrals from primary care were reported to be more likely to be female, not involve alcohol and come from areas of greater deprivation. By February 2020, there had been 7,000 referrals to the programme. The DBI programme developed slowly and different approaches have been trialled in different areas, with different Third Sector partners providing Level 2 support to suit the local context. Twice yearly reflective sessions have been built in to ensure the process has been formative. There have been modifications to the approach, for example the service was originally restricted to those aged 18+, it has been reduced to 16+ and there are plans to extend this further to under 16s.

Since Covid-19, the Scottish Government allocated additional funding to establish new DBIs so a DBI is now operational in Glasgow.

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[24] Scottish Government, January 2020 *Evaluation of the Distress Brief Intervention Programme: Interim Report*

4 Key findings

4.1 Introduction

This section summarises the key points to emerge from the qualitative discussions with staff based in general practice in Glasgow City. Discussions focussed on two clear tranches of enquiry:

- the scale of patients presenting in distress; and
- their/the practice's awareness, understanding and practice when dealing with patients experiencing psychological trauma.

The findings regarding the scale of distress have been used to estimate the cost of such presentations. This will be used to inform discussions around extending the new out of hours alternative distress response service to general practice staff during normal working hours.

DISTRESS

4.2 Is distress an issue in general practice?

Most participants spoke of significant levels of distress within their practice and were very quick to agree that it was a huge issue for general practice, in terms of patients and staff plus impacts on other patients and the practice generally. Whilst it is recognised that practices were self-selecting which may introduce bias towards those experiencing higher levels of distress or with a particular interest in distress/trauma informed practice, participants did not generally view their practice as being particularly unusual in the levels of distress displayed. During ancillary discussions around the project, it was suggested that trauma and distress are high on the agenda for GPs *"as they don't know how to deal with it"*, so it was perceived to be an issue across the city and not restricted to some postcodes/SIMD areas (although it may present in different ways or people may have different coping skills).

> *"…as a rough guide, I'd say that more than half of my consultations are related to distress."* GP
>
> *"It can be very disruptive to the practice. It adds at least half an hour on to a consultation."* GP
>
> *"It affects a lot of younger people and men, those with poor coping strategies."* GP
>
> *"There's distress in all cases, just different levels of distress at different times depending on how the case is progressing. The first appointment usually has the most significant distress levels."* Money Advice Worker (MAW)
>
> *"It's a daily issue. It take at least half of my day on a bad day*." GP
>
> *"It's unusual to have a day when we don't need the tissues."* GP

This feedback would suggest that the anecdotal reports of high levels of distress in general practice which prompted this research are correct. It is anticipated that these issues will only increase with the added impacts of Covid-19 and lockdown.

4.3 Scale of distress

There was general agreement that distress was a significant (and increasing) issue in general practice, and for patients' lives generally, but quantifying it was more challenging. The estimates of time spent on distress varied, for a number of reasons such as:

- people's interpretation of the term distress and what 'counted' will have varied;
- distress may not have been the only reason for contact;
- some participants counted the 'extra' time distress caused but did not necessarily take into account whether the consultation was required at all;
- GPs and other practice staff felt they have become *"hardened"* to distress as they see it so often;
- some reported they have become better at *"shutting down*" conversations and moving people on when there was nothing they could do for them and they did not have time to be 'a listening ear'; and
- because it appears to be such a common issue, there may be a tendency to under or over report it.

Some participants gave an estimate of time spent on distressed patients at the time of interview, others wished to think about it and came back to the researcher with an estimate at a later date and a few practices committed to completing a log over the course of a week (noting all distressed patient encounters, the time taken to deal with them, whether this could have been handled/better suited to another role, and so on). This was based on a 'week of care audit' format so it was familiar to staff. A few participants declined to give an estimate of time spent on distressed patients as they found this too challenging or time consuming to do (particularly if they had never considered this before or found the term distress too vague).

All of this data was considered and 'low', 'average' and 'high' amounts of time spent on distressed patients by each role were calculated, erring on the conservative side to avoid over-claiming whilst also accepting that participants may be including/excluding different things. Estimates were as follows:

Table 1: Monthly estimate of time spent on distress by role (hours)

Role	Estimated no. in city	Time spent on distress (monthly estimated hours)		
		Low	Average	High
GP	600	5	9.8	20
Practice Nurse	340	1	2	3.8
Health Care Support Worker	150	1	3	5
Pharmacist/pharmacy technician	70	0.25	2.1	4
Community Links Practitioner	40	4	12.2	44
Practice Manager	125	0.5	1	1.7
Administrator/receptionists	450	1	2.6	5
Money Advice Worker[25]	30	3	3	3

4.4 Variation by role

As can be seen from the figure above, distressed patients affected some roles more than others. It was particularly an issue for GPs and Community Links Practitioners. Patients become distressed during the GP consultation as their main point of contact with the practice but other staff members also refer distressed patients to a GP for support, as they often feel

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[25] There are 30 Money Advice Workers embedded within general practice in Glasgow City (1 advisor per practice: 17 in the NE, 12 in the NW and 1 in the South).

they do not have an alternative to offer and want to do something (or feel they need to offer something to move the patient on). This particularly applied to practice nurses or reception/administrative staff.

> *"People in the community don't know where to go for help, so they go to the GP as they feel bad and don't have another option."* GP

It was also a direct issue for receptionists (as reported by them and their colleagues), where distress can manifest itself as aggression/anger as well as tears, but each encounter tended to be for a shorter period of time unless it escalated into a more serious issue. The relatively low 'high' and other figures above for administrator/receptionist reflects the fact that few felt able to produce a figure – often as it was seen as a daily part of the job – and this role may not be patient-facing full-time in some practices as staff take turns to work at reception.

Community Links Practitioners (CLPs) and the Embedded Money Advice Worker interviewed reported high levels of distress during their working week, as might be expected given their roles. Whilst the CLP role has brought welcome relief to practices (several participants referred to them as *"a godsend"*), one noted that the level of need was such that only the most urgent cases are being supported and they are operating a waiting list for CLP appointments (which are longer – usually an hour). This in turn impacts on the GP as people still need to see someone.

The individual CLP workload will be impacted by the patient profile and the number of patients on the list as the list size varied significantly by practice. CLPs are aligned to individual practices rather than being a pooled resource, even within health centres. CLPs reported that, whilst patients were not distressed at every appointment, the majority (50%+ and some reported nearly all/all) were at some point and nearly all at the first appointment. Practices without CLPs were keen to have one, mentioned in relation to assisting distressed patients and other needs.

> *"We don't have a Links Worker, OT, pharmacist or physio – no extra support for patients. We would love to have a Links Worker."* GP

> *"There are 40 CLPs working in practices across Glasgow and it would be good to extend this so every practice had one, even if they weren't based there full-time."* CLP

Practice Nurses (PNs) and pharmacists usually see patients at planned appointments booked well in advance, e.g. to review long term conditions. Distress was not perceived to be a frequent issue by some, but the question 'How are you?' can bring things to the fore. Most PNs, pharmacists and other staff refer a distressed patient to the GP unless they know of a local service which may be of assistance. Few participants (apart from CLPs or those with CLPs in the practice) felt they were well informed about local services they could refer patients to for support.

4.5 Reasons for distress

Distress was seen to be caused by many different things but poverty and benefits-related issues were perceived to be a huge cause of distress, as were debt, housing, work, relationships, bereavement, and "*life generally*". Whilst some patients were reported to have mental health issues – personality disorder was frequently mentioned by GPs – the majority were perceived to have social support needs as they often face multiple challenges.

> *"Benefits are a huge issue and I don't know how many years of my working life I've spent talking to people who are distressed because of benefits."* GP

> *"Asylum seeking is a big issue. It generates a lot of stress which can bring people to our door presenting as mental health."* GP

> *"Many of the issues around trauma and distress are rooted in poverty and societal issues and these problems won't be resolved until these bigger issues are addressed*." CLP
>
> *"There's a clear link to childhood trauma."* GP

The GP surgery was perceived to be the *"first port of call"* for people when they don't know where else to go and *"feel bad".* For example, one GP realised that they had not needed to go into their bag for their stethoscope until the last appointment of the day as all their previous appointments had related to social or mental health issues rather than medical ones.

CLPs see a lot of distressed patients, with distress commonly presenting in the first appointment. The CLP works with them to address their challenges and their distress reduces. The lives of some patients in more deprived areas are so precarious that it does not take much to tip them into distress again, however. They may have gained some knowledge and skills from the support of the CLP the first time around but that does not mean they will not need support in the future. People are not one-dimensional and discussions suggest that often it is the number of issues, the inter-related nature of them and the (lack of) support from friends and families which make it difficult for people to move forward positively (and continue to do so).

A lack of adequate mental health support (in the public and Third Sector) was also seen as a reason for the scale of (especially repeated) distress presenting to general practice. This was raised as an issue particularly in terms of:

- the stringent referral criteria (and the way these were applied in some areas) for accessing some services (it is noted that lack of capacity particularly within statutory mental health services will have made criteria stricter and services will not take referrals if they do not believe their intervention would have a positive impact);
- the limited-time support (3-6 weeks) available in more accessible services like Lifelink and PCMHTs (so patients then rebound to the GP as they still need support, particularly if they have more complex issues or more than one issue to address, e.g. ACEs, trauma, bereavement and chaotic lifestyles are not unusual to see in one person in some parts of the city, and can impact generations of families);
- the waiting time for counselling/psychological therapy (people reported patients waiting for months but still needing support in the meantime);
- the lack of choice (so patients may be offered solutions such as group work which they are not willing or do not feel ready to take up);
- non-response from services following referral; and
- the impact of lack of capacity in mental health services:

> *"If the CPN is off there's a patient in every day."* (Receptionist)

4.6 Is there a pattern to distress presentations?

Whilst some participants felt there was greater incidence of distress on Fridays and Mondays (because of anticipation of/no access to surgery over the weekend and weekend events) and most distress presented in the afternoon, the majority felt that it was either too regular an occurrence throughout their days/weeks and/or that it just depended on the individual and what was happening to them, in addition to whenever they could get an appointment. Collectively, Christmas can be a challenging time as can summer holidays for some families, but otherwise it will vary according to the individual.

The age of patients was raised by some participants as a point of differentiation. Several practices noted a rise in distress particularly in younger age groups. Whilst some practices did service a higher number of students because of their location, this observation was not restricted to those practices. The current pressure on CAMHS was also highlighted, so the need for any service to be open to young people was stressed (the national Distress Brief Intervention (DBI) project has reduced its age criteria from 18 to 16).

However, other practices reported a mix of ages with presentations perhaps varying by age and issue more than age alone. For example, participants reported that:

- younger people display more anxiety/depression and *"existential"* distress;
- those in middle age are more affected by the complexities of coping with life (relationships, families, working life and managing income);
- whilst older people are more affected by bereavement, loneliness and sometimes wishing to *"get things off their chest"* before they died or after someone close to them died (who they didn't want to be affected by them disclosing past trauma, for example).

Other aspects which arose in discussions frequently were the perceptions that some patients have poor coping skills and do not know where to go for help. The GP is the first and only place many patients feel they have to go, so it will be hard to change that culture. However, participants made it clear that distressed patients need more time than general practice has to give.

> *"A lot of people are just overwhelmed by life and need help."* GP

If distress is caused by a number of factors, including poverty, then it must be acknowledged that patients may be facing extreme challenges that anyone would find it difficult to cope with. Practical support around these specific challenges, such as a CLP will provide, may be more appropriate than mental health support (which may help in some ways but will not change their circumstances) in addition to the wider issues of systemic and policy change to alleviate poverty.

4.7 Degree of distress

Participants found it challenging to quantify the degree of distress and felt this was quite a *"woolly"* and subjective area. For some, urgent clinical attention (at A&E, immediate mental health clinician support, addictions services, etc.) was required for patients on a regular basis, for example fortnightly. This can take up a significant amount of GP and other staff time, trying to access support for them once they had calmed them and been able to ascertain the issues. This could be an hour or two, which can have a significant impact on the GP practice, professional and patients. Others have become adept at managing interactions to reduce the time spent, regardless of distress. The vast majority of distress was perceived to fall between these two extremes, however, where some time was invested in distressed patients which was more than 'budgeted' for - they empathised with patients and wanted to help but did not have the means to do so, particularly if they did not have a CLP in the practice.

> *"We generally have low level anxiety issues but also a lot of suicidal intent. Suicide ideation seems to be a bit of a trend, we probably get one a day. People now know the language and talk about it openly… this is social media [driven] not Google and I think it will get worse, not better. It's younger people, so some students but people in work too. People often have no underlying mental health issues."* GP
>
> *"I would say less than 5% of our distressed patients require psychological assessment, so we have to manage the risk of 95%. The CMHT rarely take referrals so we refer many of our patients to Lifelink. It doesn't really fix things, so people often return to us."* GP

> *"I think we're good at signposting and getting to the nub of the issue at the start. We don't have time for anything else."* GP

> *"People accept it's not necessary to go to A&E but a GP appointment is easy and it is an emergency in their eyes."* GP

> *"They may have talked to someone or called NHS24 and they've told them to see their doctor."* GP

> *"Probably not so often. I tend to see people in pre-arranged appointments about their medication and long term conditions so if they're in a state they are less likely to see me."* Pharmacist

Any delays to surgeries due to distress impacts on other patients due to see the clinician. It also impacts on staff as it can be stressful to deal with these situations as well as frustrating if there isn't appropriate support available for patients. Staff, especially GPs, also reported finding their own stress levels rising from keeping other patients waiting and/or dealing with patients annoyed at being kept waiting.

The differentiation between genuine distress and that which is expressed in order to gain an appointment was also highlighted, by administrative and clinical staff. Three or four practices highlighted that increasingly (in the last 5 years or so) some patients phone the surgery for an appointment and if they cannot get one that day they *"threaten suicide*". Staff felt this has contributed to them becoming more hardened to patients expressing distress. However, others clearly took time to call patients later to check they were alright.

The intersection between distress, trauma and pain management was also raised by a number of participants. Firstly, that pain can make people very distressed (upset and angry) but also that the links between trauma and physical as well as mental health are strong. It was suggested that awareness of this could be much improved amongst health professionals and patients, to enable better understanding and treatment of people's health in a more holistic and effective way.

4.8 Need for an In-hours Alternative Distress Response Service

The majority of participants were very quick to say that there is definitely a need for an Alternative Distress Response in the city in-hours as well as out-of-hours, such is the amount of distress they see and their frustrations at not being able to do enough to help.

> *"It could be very beneficial and take the pressure off us."* GP

> *"I think it will definitely be very good for people to have access to something like this. Mental health is such a big issue."* CLP

> *"At present, we signpost a lot of people to Breathing Space or the Samaritans or religious organisations for people with faith because we don't have the time and resources to listen to people. In primary care, we also see a lot of people who are dealing with bereavement and they're just looking for somebody to talk to and – in a normal conversation – that takes up a lot of time… so an in-hours service would be very welcome."* GP

> *"There are a lot more mental health issues, more anxiety, especially for younger people – girls and boys. The GPs are all dealing with a lot more mental health issues than they used to."* PM

> *"We're the first point of contact and that's part of the problem. We need to educate people to go elsewhere – like we are with pharmacists, opticians and so on – if we are not the right people to help. If they have*

> *to come here first that could actually give us more work, especially at the start. Could they self-refer after they've been once? That would help."* GP
>
> *"They need more time than we can give them. Someone else needs to do that, but it needs to be done in the right way so people are genuinely helped to move on."* GP
>
> *"Bereavement is a big issue for people – they need time to talk."* PN

However, a few were more cautious and had questions about what such a service would be like. They wanted to be assured, for example, that any additional funding would prioritise making a positive difference to people in the longer term rather than just signposting or adding *"another layer which doesn't help really"* in the short term. There was a concern that if the bigger picture is missed then any new service could actually incur a higher time input for GPs and their teams (if they still need to see people, calm them down, see what support is required then go through the process of referral, etc.) rather than save them time in the long run (as they would return to the GP anyway).

> *"We already have quite robust pathways. If somebody comes in and is super-distressed and wants to kill themselves, I can get them seen by the Community Mental Health Team directly that day, an urgent on the day referral. Otherwise, if it's distress because of benefits or housing, I'll send them to [CLP] so for me – if the new service is in-hours – I don't know what other things would be useful. If somebody has in-hours needs today, you just contact the relevant agency like a Housing Association or Scottish Gas. We currently have Breathing Space if people need someone to talk to, and people can also access the Crisis Team if they have mental health issues so there wouldn't be much need for an in-hours service which just duplicated those things."* Trainee GP
>
> *"It all depends on what this new service might offer. If I'm going to signpost someone and they're just going to be given a mindfulness course, that's a joke but if they're able to access some sort of meaningful suicide intervention, that would be much more worthwhile."* CLP
>
> *"What will the age group be? Can they take teenagers too? There's a big issue with lack of capacity and waiting times for CAMHS."* GP
>
> *"The challenge is we don't know what's coming through the door. People don't book in with distress."* PN

Whilst participants were keen to reduce the number and frequency of distressed patients presenting to them, it was not necessarily seen to be an easy issue to solve well. The main issues raised – for the Alternative Distress Response Service and services more widely - were:

1. The need for **clarity** around who should or should not be referred and what they can expect. Plus a couple of participants highlighted the potential impacts of referral criteria on other services.

   > *"What counts as distress? Does it include those on anti-depressants too? Or those seeing mental health teams?"* GP
   >
   > *"There is a risk that a distress service can be used as exclusive criteria for other services. In other words, if we have a distress service then other services [CMHT, PCMHTs, etc.] won't take patients who are distressed. It could reduce access to services, not increase it."* GP

2. The need for **1:1 support**. Several participants commented on the need for support to be provided on a 1:1 basis, certainly in the first instance, as they felt most patients

would not be keen to go straight into a group setting. This may be something that some patients would wish to move on to, if appropriate. An element of choice was seen to be critical so that patients feel in control of what is happening.

"I also notice that when people are referred for counselling, they're often pushed into groups because that's more cost-effective but not everybody feels comfortable in groups. If you have severe anxiety, you're not going to open up about your problems in a group." CLP

3. The need for support to be **as open-ended as possible** so that people get to a healthier place and fewer re-enter the system.

"A rapid response is absolutely vital for someone who is experiencing acute distress and you also need time to ensure a patient can walk out the door in a better shape than when they came in." GP

"Access to a long-term counselling option would be helpful but it would have to be locally based…short term counselling services aren't really enough for deep trauma or ACEs. People might need 30-odd sessions." CLP

"There's also the question of the waiting list because the Sandyford waiting list is 2.5 years and that's for six sessions of sexual counselling… if you're in distress and have to wait 2.5 years to see someone, that's not really much help. The thing that's really missing is access to long-term counselling and it has to be locally-based." CLP

4. **Mixed contact modes**. There was a view that it would be beneficial if the service could be responsive to people's needs and preferences (online, telephone, face to face or a mix). Most participants championed the need for face to face support as they know some patients will not phone Breathing Space, for example. Given the recent changes to ways of working since lockdown, greater use of virtual or online mechanisms to engage and also to access self-help tools, training and approaches may now be possible. This may not require new resources to be designed but it is critical to ensure as many people as possible know where they can be found. The recent funding announcement by the Scottish Government included online resources, so may be a good starting point.

5. The service needs to be **responsive** and **accessible**: *"not an answerphone!"*.

"Accessibility is a big issue because if there are any barriers, they'll come back to us." GP

"Quick access is really important because if you're living with trauma or distress, fast intervention is definitely the best…[trauma] isn't the sort of issue you can park for months on end. And the other issue is how often can [patients] access the service because distress and trauma aren't issues which can be quickly resolved , you need prolonged access to these services as well as being able to access them quickly." GP

6. **Physical (local) location of services**. Accessibility in terms of location was raised by most participants as an important issue for any new service to consider. Those in practices in different parts of the city all raised the need for local access for at least some of their patients based on their experience of whether or not patients are willing or able to travel to access services. This can be due to lack of funds to get to a different location, lack of transport options, territoriality or anxiety about going to an unknown place with unknown people. This would obviously not be the case for all potential users of a new service, but it was consistently raised as an issue for a significant proportion of patients across the board. This was perceived to be less of an issue for younger patients, particularly students who had less 'loyalty' to one specific area of the city. The fact that residents of some areas of the city are more

amenable to travelling whilst others are less likely, was highlighted, with different dynamics being perceived in different communities. Residents of Govan, Easterhouse, Possilpark, Govanhill and Pollok, for example, were perceived to have smaller orbits and less propensity to travel elsewhere.

"Many of the people I work with don't leave [local area] and that can be for financial reasons – they can't afford the bus fare – and it's also quite often due to the anxiety that comes with trauma. They won't leave their house, they won't use public transport, they won't even get in a car with me whom they know. It's all these barriers, there's no point wasting time referring people to a service outside [local area] when I know they won't go." CLP

"The city centre is a big barrier to a lot of people here. They just won't or don't go there and transport issues [cost and availability] don't help. Is there an option to have different locations or smaller satellite services? Or even a mobile unit?" GP

There was also some comment around where the service should be located in terms of proximity to other services and the degree of 'openness' about it being a mental health service, with mixed views on whether it should be a stand alone facility independent of the NHS (therefore non-medicalised support which can provide talking therapies and practical support, for example around benefits or housing) or be integrated with other facilities in a 'hub' so attendance at an overt mental health service is not a barrier to attendance. There are pros and cons of each approach.

"Something custom-made for mental health services might be a potential barrier." GP

7. **Trust**. It was suggested that patients' willingness to travel to another service can be influenced by how referral is approached. If a service is suggested by a trusted person as being useful and providing expert advice/support which they think will help the patient, it may have an impact on uptake.

   "It depends how you sell something too. If you say it's helpful to them or suitable for them, they're more likely to go with it. It makes a difference if the doctor recommends it to them." PN

8. **Minimising form filling and re-telling the story**. However, participants were keen that referral/self-referral is not a bureaucratic process which involves extensive form filling and re-telling of a person's story as this would be a barrier to use (for patients and busy staff). This relates to the referral and assessment processes – i.e. take the details once rather than repeatedly – but also who is able to make a referral. It was recognised that some patients may prefer to self-refer (particularly if they have used the service before and know that similar support is required again) but that others needed to be referred by the practice (as they trust their GP, in particular, to know what would be helpful for them).

On the matter of who can refer a patient to the Alternative Distress Response Service, above, it would be helpful if this could be as wide as possible. It is understood that at present it is only GPs who can refer to Community Mental Health Teams so if another staff member, such as a CLP or reception staff (particularly if the patient has previous experience of a service and knows what they need, but also if staff members are trained to make appropriate referrals) is the first point of contact and feels they would benefit from support from a specific service, they have to first refer them to a GP. This is not necessarily the best use of everyone's time, creates additional steps for the patient and practice and can be distressing in itself if re-telling their story is required.

"We do ask people when they call why they want to make an appointment and people say 'it's for my mental health' but we don't ask beyond that. However, 'mental health' could mean they just want to discuss their medication with their doctor or they could be in a really bad place and we

> *don't know because we've not been trained to ask further…we'd need more training so we know we're asking the right questions and not making things worse… it's more than just signposting."* Reception Manager

The option of self-referral was also raised, for those who preferred to access a service directly, for those who had used it before and wished further support and to remove the need for patients to see a GP at all:

> *"Any in-hours service should be a self-referral service and we can tell people, give them the number when they phone in."* GP

Reassuringly, GAMH, the successful contractor for the out-of-hours Compassionate Distress Response Service, was well-rated by participants who knew their work, so there was confidence that they would know how to provide a service that meets people's needs and links in to the wider network of support they and others provide.

Discussion highlighted other questions which need to be considered, such as:

How long will support be provided for?
Will there be continuity of contact person?
What follow up service will it provide?
What will it provide that current services are not doing? What makes it different?

4.9 What are the financial implications?

Whilst it was difficult to quantify distress presentations, part of the task was to do exactly that in order to assess whether there was a financial case for extending greater support to distressed patients in general practice. An initial consideration of costs, shows that given the scale of general practice even a small amount of time spent per month on distress can add up to a significant cost collectively for the city:

The **lowest** time estimates suggest the total estimated cost is **£1.9million**.[26]
The **mean** estimates suggest the total estimated cost is **£3.9million**.
The **highest** estimates suggest the total estimated cost is **£8.0million**.
Even estimating just half an hour per month per member of staff is spent on distress – and we know for some it is significantly more - the estimated cost would be **£290k**.

This suggests there is a financial, as well as moral, case for effective, holistic, person-centred approaches to respond to distress in a non-medical way to help patients and reduce the burden on general practice, particularly as the highest paid members of staff – GPs – are ones who appear to be bearing the brunt of distressed patients. This may be via an Alternative Distress Response service, by increasing the number of/access to CLPs, easier access to (longer term if required) counselling and other support, other options or, most likely, a mix of *different but co-ordinated* options.

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[26] Using average salary rates with 13% employer's NIC added only, not full cost of employment (pension, share of overheads, etc.)

PSYCHOLOGICAL TRAUMA

The second part of each discussion focussed on understanding and awareness of trauma and its impacts, the current trauma-informed practice in play and whether/how this needs to change.

4.10 Understanding of psychological trauma

Once we were clear that we were talking about psychological trauma, not physical trauma, the majority of participants had at least a basic working knowledge of what that meant. It should be highlighted that any understanding was not generally gained through training or professional development, however, but more likely to be gained on the job, through the media and/or life experience (so may not align with current best practice and NES guidance). Staff other than GPs or CLPs (the latter had received recent Safe to Say trauma training) were less likely to be able to say much about what it meant in any detail and were less clear on the distinctions between trauma and complex trauma, for example. Participants felt that other staff in the practice were, if anything, less informed than they were about what trauma entailed, its prevalence and impacts on people. The term trauma informed practice, for those who were familiar with it, was flagged as a relatively new term.

> *"I think it [trauma] is widespread, especially with asylum seekers who often come with a very significant history of trauma. It means long consultations."* GP
>
> *"I definitely think trauma has become more prevalent over the last few years, sometimes in a good way because people are not encouraged to go and speak to somebody and… primary care is the front line so if a crisis happens at work or at home … the normal response is: 'Oh, you better go and see your doctor' and [primary care] is the front line, which I don't think it should be."* GP
>
> *"We see psychological trauma on a daily basis here…psychological trauma is fairly prevalent in this community and there's physical trauma as well – we had a patient in a month ago who'd been stabbed and developed PTSD from that… you can't work in this surgery and not have an understanding of trauma."* Trainee GP
>
> *"I think trauma is very widespread in the local community. I think there's quite a lot of poverty-related trauma which impacts on people in later life. Even if they have the right benefits and are able to live, the impact of not having enough as kids and what they might have done to get by lives with them. Obviously, there is sexual trauma as well and also people who've maybe not had the best NHS experience, people who've undergone major surgery and haven't really recovered mentally from that, that lack of power over their own body. And I think that growing up in [local area] and Glasgow generally means that many males in their late 40s/50s experience high levels of anxiety from growing up around gangs and violence – they might not know they're traumatised but they've got anger issues or have just totally withdrawn from life. Also, whenever people have chronic pain, I always try and ask how they were growing up because there's such a link – I don't think I've ever met a fibromyalgia patient who hasn't had some sort of childhood trauma. The impact is always there."* CLP

A number of GPs highlighted that patients confide in them about trauma they have experienced. For some, this is a source of 'active' distress but others wanted their GP to be aware of it but do not wish any further action to be taken.

CLPs also reported that they were often the first person a patient disclosed trauma to - often childhood sexual abuse - as they had time to build up a relationship with hour-long appointments, giving patients the opportunity to talk at their own pace and affording the CLP time to listen. It should be noted that the CLPs do not seek disclosure of trauma and if it is disclosed they acknowledge it, reassure the patient and refer them to an appropriate service if the patient wishes to receive support around this. Where mentioned by CLPs, the scale of trauma disclosed was more significant than they had anticipated prior to coming into the role.

> *"People don't come to me because they've got trauma, they see me because they've got damp in their house or it's overcrowded or they've got benefits issues but I say 'You've got an hour so you can talk to me' and this often opens up a can of worms. Off the top of my head, I'd say about 60-70% of the people I see have some form of trauma or they're living with major distress but that's the nature of the Community Links Worker role."* CLP

4.11 Awareness/understanding of Trauma Informed Practice (TIP)

Whilst there was a reasonable stated level of understanding and awareness of trauma per se, fewer participants were aware of, or understood what was meant by Trauma Informed Practice (TIP) and some just worked it out from the words used. Understanding was largely restricted to CLPs, some GPs and those who had an interest or more experience in this area.

> *"I'm not aware of that term. It's not something we've ever discussed as a practice."* PM
>
> *"We're probably doing it, we just don't call it that. I'm sure we could do it better, but we just don't have the time people need."* GP
>
> *"All GPs deal with trauma from Day 1 on the job."* GP
>
> *"It's not something I'm aware of at all. It makes me think of physical trauma, A&E."* PN
>
> *"It's nothing new, just a different name. There's no GP training on trauma, you just have to learn on the job."* GP
>
> *"I think it's an intuitive way of doing things rather than a 'set programme' as such*." GP
>
> *"It's a shift from thinking about what is wrong with a patient to asking them 'what happened to you?' and listening to them… and validating that it should not have happened to them and it wasn't their fault. Then discussing with them if and what they need to support them."* GP

Even where participants felt they understood what it meant, they found it harder to explain what that actually meant in reality. Only a few participants were aware of the NES National Trauma Framework, Training Plan and associated tools such as videos on the NES website. Most were unaware of the fact that Scotland has committed to becoming a Trauma Informed Nation and the four levels outlined by NES (Trauma Informed, Trauma Skilled, Trauma Enhanced and Trauma Specialist), prior to seeing the research information sheet and taking part in discussions. The topic did appear to be of interest to most participants, however, with several intimating that they were keen to find out more about it, having taken part in the research. The sheer volume of information GPs and their staff receive was cited a challenge to read and feel up to date, as they have to prioritise what to read fully.

4.12 What TIP looks like in general practice currently

Interestingly, when asked what TIP looks like in general practice, despite largely not being able to articulate what that meant in reality, many GPs recognised it as what they currently do. It was perceived to be about the 'softer' skills such as being compassionate/sympathetic/empathetic toward patients, being more aware of body language, spending more time to enable more talking/listening led by the patient, for example, and also thinking about what might lie behind unusual behaviour or repeated presentation for minor issues.

> *"It's difficult to quantify what I do or the way people are different. Body language maybe? I know if they're recently bereaved, for example, so have that in the back of my mind when I see them and tailor my approach accordingly. A lot of it is human nature, as well as years of experience… Sometimes you just need to spend extra time with people to build rapport and find out what matters to them."* Pharmacist
>
> *"My natural way of working is side by side, person-centred. I ask people if they are comfortable with each course of action proposed and check in with them all the way through, asking if they're happy with things and if there is anything else they need to talk about/help with."* CLP
>
> *"Be kind. Acknowledge their trauma and that it is not their fault."* GP
>
> *"Trauma informed practice is about understanding how common psychological trauma is, what it means (the experiences it refers to), the effect it has on the brain, behaviour, development and emotional regulation. We need to think how the practice and environment takes all that into account and responds to that appropriately as it's different for different people… It probably sounds quite vague but it's about listening, not judging, believing patients if they disclose trauma or thinking about how when and how you ask if you believe trauma is in the patient's background."* GP
>
> *"If patients keep coming back, it's trauma-informed to ask what happened to them."* GP

This (trauma informed) practice was seen to have been honed through years of experience individually rather than something that has been discussed overtly or developed in any formal sense with colleagues. GPs and their staff, particularly in small practices or those with a more settled population and low staff turnover, know their families' history well, build a rapport and understand their issues.

> *"People [patients] don't see it as trauma. They had a difficult childhood, a tough life, a terrible time, they're a poor wee soul… Trauma [as a term] is not on the agenda in here."* CLP
>
> *"Trauma informed practice [as a term] is not on the radar for us, we just get on and deal with it."* PM
>
> *"We don't have any coordinated approach as a practice towards trauma… we've just learned as we went along."* PN

However, not all felt confident or comfortable dealing with patients with experience of trauma.

> *"You try and be sensible and sympathetic and non-judgmental but beyond that I don't know that I feel particularly well-equipped to help people with trauma."* GP

> *"You're worried about asking too many questions because it might open up a Pandora's Box that you don't have time to deal with and you're not really trained to deal with their issues anyway."* GP

At the same time, however, there was a view that there is a limit to how much trauma informed practice can really be enacted within general practice. As one GP said *"we see 38 people a day".* CLPs have time to spend with patients (an hour per appointment) so they have time to build relationships, for people to get upset and for them to make progress past this. They clearly work in a trauma informed way. There is a very fast pace elsewhere within practices, however, such as the front desk (which is also often not a private space) and appointments are generally 10 – 15 minutes.

Several practices visited operated from new health centres which are attractive, modern environments in which to work. Another had tried hard to make their environment more welcoming or trauma informed, with colourful murals, providing an art exhibition space for local groups, stalls for Third Sector organisations to engage with local people each week and information on local organisations on display. Having a TV for distraction (not tuned to news, as this could make people more anxious) and more space in waiting areas so patients had sufficient space were also cited as actions taken to improve the environment. This has made a safer, more welcoming space for patients to come into rather than an environment which could have made patients more miserable or anxious. Another participant spoke about changing their room around so it is now less clinical. Other practices felt restricted by a lack of space, particularly those in older health centres where space is at a premium.

4.13 Perceived need for TIP expertise in primary care

Once understanding and practice of TIP was established, discussions explored how much TIP expertise participants felt was required in general practice. Given the number of people living with trauma, participants were quite clear that it is important to be aware of trauma, to understand what it is and how it affects people – and that it is important to 'do no harm' – but many respondents found it hard to see in what ways it needed to be present any more than it currently is in practice.

Participants who were more familiar with TIP felt it was incredibly important that general practice is more practically trauma informed, particularly in terms of attitudes towards patients and the way in which they are treated. For example, they felt it was important that staff took a step back and thought about why people behaved in the way they did rather than reacting to the way in which patients sometimes present themselves. The suggestion was made that TIP training should be in the core training for staff, which all general practice staff should be expected to undertake.

Many reception staff were praised for their abilities to de-escalate situations, build positive relationships with patients and work together as a team to deal with issues as they arose but there is still room for improvement with some staff. The key areas for improvement were perceived to be around changing attitudes towards trauma, helping all practice staff to relate it to real life situations and embedding TIP to be the norm.

However, some reception staff reported that they understand *"as much as I want to*" about trauma and did not want to take on more of a role around that. They reported that they already have to know/deal with a lot of difficult circumstances patients face and it is tough. Whilst colleagues were perceived to be supportive, everyone is busy and they are not able to talk to friends and family about it because of patient confidentiality. That can make it hard to leave work behind at the end of a day.

> *"There is definitely a place for TIP in primary care and both sides – patients and staff – need to be aware of it. We see a lot of people who come in repeatedly for many things and there may well be an underlying trauma that wasn't addressed years ago… childhood abuse or somebody who's been in a war zone and they've never come to terms with it and it's*

> *only when you delve into their issues that you really understand why they've been attending the surgery all those times… having awareness of trauma and knowledge of the services that are available would be invaluable because – in the longer term – [those patients] will use up less resources both in terms of healthcare and social resources because – if something becomes PTSD – it ends up using more resources than if someone reacted helpfully at the beginning."* GP

> *"Primary care staff do need to have a better understanding and awareness of trauma informed practice but no matter how much they understand it, we still don't have the time to respond appropriately*." GP

4.14 Existing good practice in primary care

No-one could suggest practices which were exhibiting particularly good practice currently around trauma informed practice at present, other than CLPs or colleagues whose skills they particularly rated, but most were able to cite examples where it could be improved! Those who were more aware of TIP felt there was a lot of work to be done on attitudes in particular.

One practice was praised by a Practice Nurse for its positive work in promoting staff awareness of human trafficking and its implications.

The role of allied health professionals such as Community Links Practitioners was also highlighted as a positive move, as it enhances practices' ability to address distress and trauma issues.

One Prescribing Support Pharmacist runs a pain clinic – where a lot of distress and trauma presents - as well as a yoga class (they are a qualified yoga teacher) to help people manage their pain/health more holistically.

The culture within each practice visited varied considerably in terms of how collegiate an approach was taken, how flat or hierarchical the team was, how bureaucratic it was and how open/closed it was in terms of new ways of working. One practice visited came across as a welcoming and less hierarchical structure, for example, with an open door policy (unless consulting), room rotas issued a month in advance so staff could plan ahead and regular coffee mornings/informal lunch time sessions/meetings where team members could share experiences, hear from others and were interested in what each other is doing and how that can be supported.

4.15 TIP training

Few participants reported undertaking TIP training or being aware of any discussions about how to respond to this agenda better as a practice. All CLPs had received TIP training (for some it was a refresher) but they were the only ones to have received any specific TIP training apart from one pharmacist who had completed the trauma module on TURAS (NHS learning platform). Other staff mentioned training on specific aspects of trauma such as recognising domestic violence, childhood sexual abuse, child protection issues, ASIST suicide prevention training or female genital mutilation (FGM), for example. Most felt that there was some level of awareness of trauma within the practice team, gained through experience but this was neither formally trained nor consistently applied.

> *"None of the staff have had any formal TIP or trauma training, but I think they've developed a sensitivity to know how to respond to people who seem to be in deep distress. The staff have got quite good at picking up on people exhibiting distress when they call in… staff have picked up the rudiments of [TIP] through experience though I think some are better than others."* GP

Several practices reported challenges around staff training, with no protected learning time and operational challenges of providing cover to allow staff to attend or undertake training. There was, however, some interest in training on TIP (Levels 1 & 2 on the NES Framework), with participants reporting that it would be worthwhile in particular for those in reception and the 'front line' so that they had a better understanding of what might lie behind patients presenting in an aggressive/angry manner and how best to deal with this. Some GPs and nurses were also interested in building their understanding and professional development. Not every participant saw TIP as a priority, however, with some feeling they knew as much as they needed to in order to perform their role.

> *"We need training that would help us within the existing confines of our appointments. We couldn't be expected to replace experienced counsellors but anything that helps us consult better would be good, but we won't have any more time available to do extensive work around trauma."* GP
>
> *"I'd be delighted to have some training on this."* GP
>
> *"Everybody in primary care should have some basic awareness around trauma – to know what signs to look out for – but we don't have time in primary care to adequately treat and assess people with trauma… People only need basic Trauma Awareness… so we don't inadvertently re-traumatise people."* GP
>
> *"[the practice] doesn't have the tools right now to recognise trauma if someone was experiencing it…if we had some trauma training, we could recognise it in our patients and provide a better service. I absolutely think trauma training is essential."* PM
>
> *"Improved understanding of trauma and a compassionate response is critical. Changing attitudes is key. There should be mandatory training and protocols in place to make sure it is consistently applied. People may think they give a compassionate response but...perhaps we need to recognise that some people are better or worse at uncomfortable conversations?"* Pharmacist
>
> *"We can't close, not even for lunch. We can't get everyone together. There's no protected learning, that stopped years ago. There never any backfill to free up staff and there's not enough locums anyway."* PM
>
> *"The Practice Nurse network meetings are good for training as a group. It's a good forum to speak about this sort of thing."* PN

One practice which served asylum seeker and refugee populations highlighted the need for training specifically around FGM:

> *"How do I speak to them [if I discover they've experienced FGM]? Where do we go from here? Do they want anything done? These are very difficult conversations so if we had more training, raising those issues would be a whole lot easier."* PN

The Practice Manager was perceived to be a key 'gatekeeper' role in terms of staff being able to access training. A Learn Pro type online module was considered to be helpful in the first instance for staff to become familiar with the concept but some staff highlighted the importance of prioritising face to face training for this topic as this is more likely to have a positive impact on attitudes, for example, which participants felt was particularly critical. CLPs, who had undertaken recent training, echoed the added value this brought to understanding the issues more fully and how they could adapt their practice.

It was also suggested that training as a team would be beneficial for practices. This could illuminate what others are facing/doing – some participants suggested staff are often too busy doing their own work to realise what others are doing. This could also lead on to discussions around how the practice could be more responsive to distress and trauma in practical terms, for example environmental changes, more flexibility over/variety of appointment lengths, etc., and how staff could work together on this more effectively.

> *“Face to face is more beneficial, especially if you’re trying to change attitudes and understand what difference [what seems like] small things can make to people.”* CLP

The key thing many participants highlighted with regard to rolling out TIP more widely was to make it as easy as possible for staff. For some this meant consistent corporate messaging so everyone uses the same language, understands the issues and their importance. Most importantly, it meant giving staff easy to use resources, checklists and tools to implement change to their practice and examples of how, when and why these might be useful. In a time-poor environment, clear examples of potential issues and how best to prevent these and provide appropriate support would be appreciated, so that it is easier for people to take things on board and effect change - both encouraging and enabling a consistently high level of service to be provided.

> *“Having some examples would be good. It’s easier to take on if you can see the benefits.”* CLP

However, several participants highlighted the need to educate patients so they do not take up GP/practice time with issues they cannot really help with, but there may be other places they can go to receive the support they need.

> *“I feel it’s not us that needs training, it’s the patients! They need to be informed what to do and how to deal with things. They don’t have good coping skills and the GP can’t help them develop those but other people can. They come here because they don’t know where else to go. We need to change that thinking.”* PM

4.16 Beyond the practice

However, staff were very clear that being trauma informed will make little difference to patients or the load on general practice if sufficiently good services are not available to refer patients on to for effective support. The CMHTs were perceived not to accept many referrals and the PCMHTs are inundated and providing short term support, if anything, so patients return to the GP.

> *“Mental health services are by far the most frustrating services we have to deal with and they take a lot of our time. The criteria [for referral] are incoherent and if they get refused or sent back to us we then have to start again to see who can help.”* GP

> *“Ping ponging between us and services is traumatic for the patient. That needs to be recognised, acknowledged and sorted. It’s traumatic for us too as advocates for our patients. No other services provide so much angst [as mental health services] and it needs to stop. It’s wrong.”* GP

GPs reported that psychological services do not tend to deal with alcohol or addictions cases and alcohol/addictions services do not tend to deal with psychological cases, which puts them in a difficult ‘Catch 22’ position. Waiting lists for counselling were perceived to be long (although this may relate to historical or second hand experience for some) but generally services provided by Wellbeing Scotland and the Moira Anderson Foundation, for example, were rated highly.

> *"Even if you refer someone for mental health support, there's often… a long waiting list before they can access services so you end up giving them additional appointments while they're waiting to see other services."* GP
>
> *"I know what trauma is and I can recognise it in people and I know the right questions to ask to get that information, but what do I do with it? I'm sat with this person and sometimes that's therapeutic because they just want someone to talk to but that's where it stops. We have the Anchor Project, it's where to go with them after that if there's not a local support service."* CLP
>
> *"There's a real need for trauma-specific counselling."* CLP
>
> *"We're not experts or specialists but we're meant to be able to diagnose mental health issues in 10 minutes. Community Mental Health Teams increasingly expect us to make diagnoses but we're not in a position to do that."* GP
>
> *"GPs can only do so much with short appointments. Patients do need additional support but mental health services need a revamp. People have to be in crisis before they're seen by mental health teams and then they just deal with that, not what got them there in the first place… There's no early intervention. It's all reactive, not proactive. A more preventative approach is needed. There needs to be more resources for distress and trauma as there is a huge, unmet need out there."* GP
>
> *"We need something between us and the CMHTs [not PCMHT as seen to rebound to GP as patients say the PCMHT don't return their calls]."* GP
>
> *"A lot of refugees and asylum seekers live here and there's nowhere to send people. The Anchor is only for the most serious trauma, they get turned down if it's not bad enough and not referred elsewhere. The system is not working."* GP

The need for access to meaningful therapeutic work was also stressed to stop medicalising distress and trauma unnecessarily (as GPs want to help and they are the only service people can access).

> *"We need to stop medicalising trauma and distress issues and this is inevitably what happens if people come to see me. People might need psychological help or intervention but I'm not the best person to see for those issues but unfortunately – because we feel obliged to help our patients – GPs can end up prescribing unnecessarily because we feel we have to do something, and what we know is prescriptions and medicines and I think we sometimes prescribe inappropriately."* GP
>
> *"Continuing access to ongoing talking therapies is really important because if patients have access to this, it'll reduce their reliance on medication and cut down the incidence of self-harm."* GP
>
> *"Dealing with trauma is not the role of primary care staff – they might be good at spotting trauma but what they really need is the ability to refer people to specialist services elsewhere."* CLP
>
> *"It's all very well recognising trauma and appreciating that something needs to be done but… if the resources aren't there to help patients, what do you do? You can have a run of days when your entire surgery is full of people presenting with trauma-related issues, it's mentally draining and it can be really frustrating… you feel like you're running around in circles*

> *'Yes, I appreciate your situation is terrible and I'm doing my best to help you in the 10 mins I've got' but you don't and they just keep coming back because there's no specific service to refer them to."* GP
>
> *"A public awareness/public health campaign around trauma could be helpful – people need to know that if they have back pain, it could be a result of how they've lived their life over the last 40 years. But it could also be a double-edged sword because if you make people more aware of trauma and how it affects them but don't provide resources to address the issue, it'll just create massive frustration."* CLP
>
> *"The mental health services we do have are wholly inadequate - we have to do this better."* GP

The point was also made that GPs and their teams do not know what services exist, particularly in the Third Sector, to support people who need it. The researchers were aware of the ALISS (A Local Information System in Scotland) database, which was meant to help connect services to beneficiaries but few participants were aware of this and those who were did not use it (they felt it was not updated well so used Google instead, in addition to word of mouth recommendations). Some GPs and their staff, particularly those with CLPs, know what is available in their area or centrally to support people, but many felt they did not have the time to find this information. It can be easy to refer people to specific organisations, like Cruse for bereavement, but harder to know where to refer Muslim women, for example, or where might be a supportive and engaging environment whilst not necessarily directly addressing a specific 'need' as such. These kinds of organisations were seen to be particularly helpful - often *"by osmosis"* - for those who are lonely, isolated or bereaved.

4.17 Additional comments

A number of other points were raised by participants which need to be considered, as follows.

Support for staff

There is no formal and consistent support for all staff in general practice (some professionals such as nurses, pharmacists and CLPs will have supervision) – there is no clinical supervision for GPs as would usually be the case for counsellors/psychiatric staff, yet GPs are also dealing with disclosure of trauma, etc. At best, staff support each other when they have a tough day or a challenging patient. However, some GPs and other staff reported becoming hardened to the issues as they are present so frequently, which they found difficult to square with their caring role but felt was both inevitable and necessary from a self-care perspective. This 'empathy fatigue' is unlikely to be helpful to patients and suggests the need for greater support for staff working with these issues.

> *"Having …[the new service] would reduce some of the distress I suffer as a GP because you want to help people but your time is limited. If someone comes in and they're suffering from bereavement, it may take up a lot of time and I won't do very much, I won't necessarily prescribe anything but listening is what they want and that takes up a lot of time… the consultations inevitably over-run and that puts me under pressure so I have to start managing my own distress because I've then got patients waiting but I equally need to give this patient time because they are distressed."* GP
>
> *"It can be really intense, all staff need support."* CLP
>
> *"I think there's a lot of distress among healthcare workers…and… a lack of access to services where we can discuss our concerns and our worries… I know that some of my colleagues have experienced a lot of trauma in practice with patients and colleagues and you're just expected*

> *to get on with it… it's never adequately addressed so I think there needs to be some sort of [distress] service for healthcare professionals as well."* GP
>
> *"It affects us, upsets us. We're all very aware of what's going on so share the load and step in and support each other when we need to."* Administrator
>
> *"Staff also have to be mindful of the mental impact of dealing repeatedly with trauma. From personal experience, I know that if I get back to back disclosures of childhood sexual abuse or suicidal ideation or any sort of trauma it can be really draining and a lot of my Community Links Worker colleagues experience that as well, it's demanding, it's difficult to avoid getting burned out because – as much as you can practice self-care – that only gives you the resources to sit with that person but it's not solving the problem and they'll just keep coming back."* CLP
>
> *"We have massage for stress here once a month, for staff, and a healthy walking group, which both help staff manage stress levels." CLP*

Equalities issues
Throughout discussions around both managing distress and trauma equalities issues were raised. Any provision needs to consider the different challenges people may face in accessing services and staff need to be reminded not to make assumptions but to clarify what people's access needs are. For example, the challenges of working with people who require interpreters (re verbal/written information and being able to discuss trauma appropriately/at the right time) or have literacy issues.

> *"Asylum seekers… come here and it's sometimes difficult to get them to speak about [trauma], they often need 2-3 appointments before they start opening up so some sort of interpreting service would be essential."* GP
>
> *"There's always the language barrier – if you're going to deal with trauma issues, you need to be able to talk openly about things but if a patient's English isn't great and you can't speak their language, you need to get a translator in and the moment's gone."* PN

This relates to non-response to written communications and non-attendance, but the wider point about people being refused services because of non-response/non-attendance was also made with respect to distress and trauma – some people may not feel able to access services at the allocated time because of their distress/trauma and services should not be withdrawn without ascertaining what barriers people are facing (as was perceived to happen at the moment).

It was also highlighted that counselling is not always culturally appropriate and men can be reluctant to undertake talking therapies, so alternatives need to be considered. Staff felt at a loss to know where to refer people otherwise at present.

Context information is important
There is quite a range of views and interpretations of what distress and trauma are, and how these intersect with physical health, particularly around pain. Greater clarity around this is required in any awareness raising/training for staff and patients.

Managing access to GPs better
It is difficult for practices to manage the number of people wishing to see a GP – it is a universal service, patients do not cite distress as a reason for visiting and reception staff only feel able to ask limited questions.

Impact of other roles and need for wider training

The impact of other agencies, including Police and Social Work, was also highlighted – these need to be trauma informed as they currently risk re-traumatising patients.

Streamlining the process to minimise further distress and re-traumatisation

It was also highlighted that having to repeatedly tell 'your story' causes further distress and the system needs to consider how to reduce this. For example, if a patient discloses trauma to a CLP the CLP cannot directly refer them to mental health services. The CLP has to ask the patient to re-tell their story to a GP who can then refer them to the mental health team, where they have to tell their story again. Can this process be streamlined, with the CLP's account of the trauma experienced and the need to refer is trusted, so that people only have to tell it once?

5 Validation discussions

5.1 Introduction

Validation discussions were undertaken with people with lived experience of distress and trauma, plus regular NHS engagement networks, to ensure the patient voice was heard alongside the views of those working in general practice. These were conducted during Covid-19 lockdown, so were a mix of Zoom group and individual telephone discussions. The focus of the research was outlined and topline findings from the primary research shared with participants before exploring their views on these, the concept of the new service and their experience of barriers to accessing GP services, how well or otherwise GP services respond to their needs and what they would like to see improved.

It was made clear to all participants that they did not need to share anything personal and they could stop the discussion at any point. Participants were recruited via trusted organisations such as Tomorrow's Women and the NE Recovery Network so were selected on the basis that they were in a good position to participate and staff were able to provide support if required.

5.2 Barriers to accessing GP services

The majority of participants had been able to access GP services, but it had been an issue for one who had been homeless and for another with addiction and criminal justice issues because of territorial concerns given the location of the surgery.

> *"I've not used a GP for 13 years. I was turned away years ago because I had to show them photo ID but I didn't have any photo ID. I felt a level of hostility towards me."*
>
> *"I feel I'm constantly repeating mysel' o'er and o'er. I tend not to go to the doctor a lot of the time 'cos there's no point. I have to repeat it all as they've no time to read the records back and it's never the same one. They all have their own opinions, I've been told very different things."*

Accessing a service when they needed it – sufficient time face to face or on the phone – was an issue for a variety of participants.

A couple of participants highlighted that their GP receptionist can be a barrier to accessing services: *"you can't get past them!"*

For some participants – and reports from workers regarding other service users – a negative experience at their GP can be the barrier to further use at all or *"unless they absolutely have to"*. If they have supportive professionals via other services/projects, they would tend to go to them in the first instance instead. These comments primarily related to the attitudes of staff – primarily GPs and receptionists. Interestingly, few had changed their GP – or really considered it - other than because they had moved or been told they had to switch, even if they reported negative experiences and a poor service from their point of view.

For some other participants, it was more about barriers to accessing good GP services. For example, one participant who has been on methadone for twenty years has found it challenging to gain the support of her GP to reduce her reliance on that. Another had been told she was *"too young for depression"* so became much more ill before she/that was taken seriously as an issue.

Others went on to talk about barriers to mental health services, specifically the need for quick assessment and support to be provided sooner rather than later, catching people before they deteriorate further.

5.3 The importance of people

The way in which GPs and their staff treat people was highlighted to be far more important than the physical environment of a practice, although this could also have an impact on how welcome and comfortable patients feel. Both positive and more challenging experiences were recounted to highlight this point.

5.3.1 Positive feedback

Many participants rated their GP receptionists very highly. This was because they knew their situation and were perceived to *"look after"* them when they attended the surgery, for example by making sure they were in and out quickly (if they became stressed sitting in the waiting room) and helping them get quick access to the GP (such as an appointment the same day and/or in to see the GP promptly once they arrive) or prescriptions required.

> *"The receptionists know my voice, it's great."*
>
> *"The lassies know me, know I'm anxious so they get me in and out quick."*

Some GPs were also rated very highly, particularly where they knew their patient's history, were able to give them time to talk, listened to them and supported them through whatever they were facing. Participants consistently said that they would wait (sometimes two or three weeks) to see this compassionate GP about mental health issues or specific challenges they faced that the GP knew about and was helping them with. It was worth waiting to save repeating their story and to increase their chances of having a positive outcome.

> *"My GP now is great – compassionate and understanding. She's directed me to different services."*
>
> *"I don't mind who I see if it's something straightforward I need but I'll wait [for preferred GP] if it's not. They know me, they understand."*
>
> *"My GP now has done more for me than any other doctor ever has. It's as if I've been heard for the first time in my life. It only happened last year."*
>
> *"My GP made eye contact, turned to face me and asked questions to make sure he understood. He went the extra mile because he listened, asked questions and tried to help. He asked me to tell him if the meds worked and to keep in contact. It was good. So I do go back. I always felt I was bothering them before."*

Other staff, such as practice nurses and CLPs (where present), were also cited positively but to a lesser degree. The receptionists and GPs were the two key players for participants.

> *"[the CLP] caught me like a net. She was brilliant. I talked things through with her and she linked me in to the appropriate services."*

Not all participants with experience of trauma had shared their full story with their GP, however.

> *"I've not told them my full story yet. They know there's some trauma there but they don't know all of it… They've picked up well on it, though."*

Positive feedback was not restricted to GPs and their teams, however, as other public and Third Sector organisations – particularly those which had recruited the participants for the validation process – were rated very highly indeed. Participants spoke about being treated with respect, being listened to, staff following through on promises to do things and a genuine will to help them. This seemed to be a more holistic approach where people were seen as individuals that mattered, rather than a one-dimensional problem or issue.

There was also recognition from participants that mental health and wellbeing is not just down to the GP or mental health services, but individuals and communities impact on health:

> *"A lot of it is about being good neighbours as much as counselling. Take depression, we need to take care of ourselves and our neighbours, the GP can't do everything."*

5.3.2 Challenges

A number of participants spoke about having to re-tell their story to different people on their journey to gain the help they needed. This was a challenge if they did not see the same GP and time was tight so notes were not read in advance.

> *"There's always a different doctor. I don't know them - it's confusing and frustrating. I try to stick to two GPs now."*

The amount of time with GPs was highlighted as a challenge, as it impacted on what they felt able to raise, what could be achieved and the approach of the GP.

> *"Some don't even lift their head to look at you and are typing the prescription before you say anything."*
>
> *"It just feels like they're trying to get you out the door as fast as they can."*

The apparent willingness of GPs to continue to medicate, even when patients have wanted to reduce/come off medication, was also raised as an issue around methadone and anti-depressants in particular. Locums were also highlighted by a couple of participants as more likely to be quick to prescribe rather than listen to the patient, in contrast to their usual GP.

> *"GPs just hit you with tablets - they're too quick to gie you anti-depressants, not deal with the issues."*

For some who need particular prescriptions, it can be challenging to find a GP to provide these however. Others feel scared when doctors suggest coming off their medication, so don't return.

> *"I've been chased oot my old GP [by a locum] for asking for diazepam but it's the only thing that calms me doon an' I still get it [for 30+years, since 14]."*
>
> *"The doctors say I should be coming off my meds so I don't go back. I'm scared to come off them. How am I gonna cope? I don't like being on meds but I struggle if I've not got it, if I forget to order it and have a weekend without it I'm distraught so it has a really fast impact…They're more concerned about the meds than what the problem is."*

First impressions count. We know this from other aspects of our lives but when people are distressed or have experienced trauma, the wrong look or tone of voice can make all the difference between a positive engagement with a service and non-engagement or a poor experience.

> *"You know as soon as they look up. It's that look. It can just rip you to pieces and you just want to get out of there."*
>
> *"There is a need for training on this, especially for receptionists. They need the right personality – caring, understanding, have empathy. A lot of them don't show that, it's just a job. There was a man at my doctor's*

> *recently who just said ‘all I need is your help, please help me’ and they didn’t respond as well as they should have.”*
>
> *“The immediate response needs to be positive or you’ll lose people, so there needs to be much better awareness of that.”*
>
> *“How the receptionist is that first moment has a big impact on you. It can set you back and make you feel really uncomfortable in the waiting room. Makes you think ‘Should I be here? Am I wasting their time? Do other people deserve it more?’ The receptionists at my doctor are usually awright but it just takes one, for any service.”*
>
> *“Staff need to be trained on their attitude, it’s so important.”*
>
> *“They never even ask you how you are. We’re still human.”*
>
> *“They don’t ask how I’m coping with my anxiety and depression. All they have to say is ‘how are you doing?’ but they don’t ask. They don’t ask the right questions. You’re trying to tell them but before you finish they’re printing off your prescription so you think you need to go. You feel rushed off.”*

Another participant highlighted that their mental health condition means they can get agitated quickly and speak in a loud voice, so the GP receptionists have become aggressive and threatened not to engage with them as a result. If there was greater awareness of the ways in which people can be affected by their mental health conditions, they felt this would not have happened.

Several participants also highlighted that patients’ attitudes and behaviour also needs to improve: *“it’s a two way street”.* Several people highlighted that they are polite or friendly to receptionists and they are polite or friendly in return.

GPs and their staff making the wrong assumptions were also highlighted as a challenge. One participant who has been clean for a number of years visited their GP – one they hadn’t seen for years – but without looking up the GP asked if they were still on drugs (not in a very nice way). Others who had drug addiction issues all reported that GPs and other staff automatically assume that they are there to get whatever drugs they can, even when they are actually looking for help to get clean. Also, when addicts/recovered addicts felt they had other genuine health issues, they felt they were often not believed or treated for them, as they were perceived to be telling lies in order to obtain pain relief, for example, or told they could not be treated because of their addiction history. This made them feel worthless. Others reported feeling that GPs or their teams judged them as a person just because they live in a poorer area and are out of work/on benefits.

> *“Don’t [people like us] get a second chance?”*
>
> *“When I registered at the health centre I was told I had to take a drugs test. I hadn’t heard about that before. I felt really uncomfortable and it raised my anxiety and depression. I had to do a urine test. It was compulsory to do it but it wasn’t a condition to taking me on as a patient, apparently. They told me I had taken codeine and of course I had – I get it on prescription.”*
>
> *“You can genuinely be in pain but they assume you’re chasing medication.”*

Examples were also given of GPs being unaware of the links between trauma and physical health. One participant suspected they had fibromyalgia because of the information provided by their Third Sector counsellor but their GP had not considered that as an option until they asked about it. Another said:

> *"It took my GP 44 years to realise my trauma [in childhood] was the cause of everything else... but they still didn't want to look at it. It was too hard. They [or someone] needs to be ready to unpack Pandora's Box, they need to be comfortable to unpack trauma to deal with it... 10% of my life is what happened to me, 90% is how I reacted to it."*

Many participants spoke of GP appointments running late. As the majority felt they did not have sufficient time with their GP they understood this, but they felt this highlighted the need for longer appointments, or different length appointments on different days/times of day (one GP interviewed in the primary research actually has 15 minute appointments in one half of the day and 10 minute appointments in the other half). Participants also asked why they were not told if appointments were running late. This was perceived to be common courtesy at the very least and then they could decide if they stayed (and relax more knowing that it would not be for x minutes, or pop out to get something they needed as they had time to do so) or changed it to another day. Many GPs apologise for keeping people waiting when they are seen, which is good, but an indication of when they will be seen would be helpful.

One disabled participant highlighted how timing and punctuality of appointments can have a significant impact on them. They rely on a taxi to take them to and from a GP appointment. If the appointment time is close to school-run time, traffic is busier, parking can be harder and taxis are harder to get in the first place (as many are booked for schools) so the patient is worried that they will be late and may not be seen by their GP at all. If the GP is late, they may miss their taxi home, have to pay more or have a long wait for one (if this pushes them into school/rush hour time). This makes for a stressful, long and potentially expensive visit to the GP, which GPs and their staff may not be aware of.

5.4 The physical environment of GP surgeries

The physical environment of GP surgeries was perceived by participants to be much less important than the attitudes of staff. However, there were a few issues raised during the validation sessions. It was recognised that the physical constraints of some GP surgeries make these challenging to instigate, but it is still important for practices to be aware of the issues and to consider how they might be able to address them, now and in the future.

Having a quiet space to sit and wait – some waiting rooms were perceived to be small, busy and cramped so a couple of participants suggested that having a quieter space to sit would be helpful for them.

> *"If there's lots of kids and noise sometimes it would be good to have somewhere else to sit. A quiet space, without the fear that you're putting them out."*

Having a quiet space to talk - a few participants particularly found the open nature of the reception area in their GP surgery challenging, particularly when they needed – or receptionists expected them – to talk about issues regarding their care. This perhaps highlights that different people will have different views on what is 'personal' information. Receptionists and other staff may be used to discussing things on a day to day basis but this may be new to the patient, and they may be embarrassed. They would appreciate it if there was a quieter space where they could discuss issues, similar to approach taken in pharmacies now.

> *"There needs to be a private space. You shouldn't have to give more personal information in front of everybody [in the waiting room]."*

Being more discreet – relates to not discussing private issues in front of others in the waiting room, as above, but also how other things are done, like giving a sample bottle for a urine test. Some patients felt they are being judged for having to do this and suggested they could perhaps be given in a paper bag or given by the GP directly, rather than reception, so the patient can then go directly to the toilet and it is less obvious.

Making it less clinical – whilst some participants expected their GP surgery to be ‘clinical’ as it is a clinic, others felt that more effort could be made to make it more welcoming, colourful and *“softer”* than is currently the case. It needs to feel comfortable. This applied to the reception area – *“it all needs to start at the reception”* – but also within consulting space:

> *“Having a big desk is already intimidating… And it looks like they’re just googling the answer when you’re talking to them! You want their input and expertise [tailored to you]... A good GP is away from their desk, sitting next to you.”*
>
> *“Settings are really important. Having soft furnishings and somewhere for children to play helps people [relax and talk about what they need to talk about].”*
>
> *“Our GP employed a counsellor, which was really good, but the atmosphere wasn’t right – it was like going to speak to the teacher.”*
>
> *“My old GP was like a cowp, the new one is like a hotel. You need to be reassured, cheerful, welcomed, it needs to be tidy and for you to feel safe.”*
>
> *“Having a screen or something to watch helps, it takes your mind off things. Or play the radio?”*
>
> *“What about a fish tank? That’s meant to be relaxing…and more plants.”*

5.5 Rating of GP services

We had intended to ask all those involved in validation discussions to rate their GP service in terms of being trauma-informed, as a mark out of 10 (where 0 was low and 10 was high). Some participants were quite disclosive and it did not feel appropriate to ask this question of them. Where it was asked (of 17 participants), the mean score was 6.35 although this varied from 2 for a GP to 10 (although someone gave their GP a 12, it was scored as a 10).

It should be noted that some participants giving a score highlighted that they were scoring their current GP service but this would not have been such a positive score in the past.

5.6 Views on the new Compassionate Distress Response Service

All participants welcomed the new out-of-hours Compassionate Distress Response Service and felt that it would be helpful to people. The liked the fact that it would be run by a Third Sector organisation and felt that a non-medical approach would be positive and help put people at ease. As participants felt there were significant levels of distress in the community, there was also strong support for the service to be provided in-hours.

Suggestions for the kind of support which need to be provided – either by the Compassionate Distress Response Service or elsewhere – included peer group support, cognitive behaviour therapy (CBT) and trauma counselling.

> *“That’s exactly what’s needed… to know there’ll be some follow up is fantastic.”*

The need for individual support rather than group support was reiterated by the validation discussions.

> *“I’m not good in a group. It feels like I’m giving people bullets to shoot me with.”*

5.7 Trauma Informed Practice

Participants highlighted the need for general practice (and other) staff to have more compassion and empathy, recognising that it takes time to listen and understand. Having respect for each patient as a human being/individual rather than *"a set of symptoms"* or a label was also highlighted as making the difference between good and bad care.

> *"The approach taken and people's attitudes are the key things really. People need to be more mindful of other people's circumstances."*

Participants also felt that being trauma informed meant looking at the whole person:

> *"Actually trying to understand more [about people's situations and experiences], instead of saying you understand and you don't understand at all! They've never been in your shoes and know how you feel. They [GPs, their teams and other services, including mental health services] need more training so they understand how you feel. It's just trial and error with tablets like you're a guinea pig or somethin'."*
>
> *"Perhaps 10 minute appointments are not enough for people?"*
>
> *"Services need to look at the whole person. Addictions and health are not separate."*

Having to re-tell their story was challenging for people in different ways, as was also highlighted in the staff research:

> *"You get sick of telling your story. By the time people are asking you about it, it's just another story, it doesn't affect you any more. You become Teflon. You've had to detach to deal with it. I had to dissociate to cope with what happened to me."*

One participant highlighted starkly that having to re-tell her story impacted negatively on the PTSD she was experiencing but there was no proactive support:

> *"No-one contacted me to see how I was coping… they need to look at the whole [mental health] system."*

As with GPs and their teams, participants also highlighted …

> *"There's no point being trauma informed if there are no trauma reducing pathways to help people come to terms with their life."*
>
> *"I've always said we need a mental health nurse in every GP practice. To catch things before they take hold."*
>
> *"There's not enough mental health services out there for adults or teenagers… and they need advertising so the doctor knows it's not a bad thing to go get help."*

The services which did seem to be treating people in a trauma informed way were those in the Third Sector or those providing more intensive support, such as the Moira Anderson Foundation, Wellbeing Scotland, COPE, Tomorrow's Women, 218 Project, Homeless Network, NE Recovery Network, Thriving Survivors, The Anchor (Glasgow Psychological Trauma Service) and the Drug Court at Norfolk Street. There were many, many positive comments about the support provided by all of these teams, and more, but the following quote perhaps illustrates the contrast in approaches:

> *"My GP gives me the feeling she thinks I'm looking for something and I'm no'. I've never asked for meds… I've always taken care of my appearance, do my hair and have make up on, that's just me, but she*

> *always says ‘you’re looking great, you’re doing well’ as if that means something. She’s known me all my life, she must know that… It’s my inside that’s important, not my outside… I keep asking her to reduce my meds – I’ve been on methadone for 20 years. It’s like I’ve just been put on pause and nobody listens or cares. I’ve suggested Suboxone… But she puts me off and says we’ll discuss it next time... but next time it’s not her or she seems to have forgotten about it even if we’ve made a plan. It’s really hard to get her to listen and help me… It’s like groundhog day but you have to keep trying. That’s why so many people give up and accept that’s their life now. If they’d had proper support they wouldn’t be on drugs all those years. There’s not enough support for dry addicts in doctors’ surgeries…*
>
> *I’ve got 2 kids and my 12 year old is going to start wondering why I have to go to the chemist every day. She [GP] doesn’t care about that, she just says leave them with someone else. I’ve been going to that chemist longer than all the workers there, it’s scary! I feel embarrassed… There’s no point going to the GP even if I feel unwell.*
>
> *…I don’t go near the doctor now I’m under the Drug Courts at Norfolk Street. What a difference! It’s much better. They interact with you a lot better, it feels like it’s genuinely all about your wellbeing. They want to know if you’re okay and if you’re not what they can do to help… My worker had to contact my GP because I needed an emergency mental health appointment but my GP didn’t do anything. When I’ve seen her since, she’s never even asked me how I am, just ‘you’re looking good, smashing that’s what I like to see’!”*

5.8 Other points made

5.8.1 Mental health support services

Some participants had been referred to CMHTs, PCMHTs, and other public and Third Sector organisations for mental health support. Where this was embedded within other supports to help people move on from addiction/criminal justice issues, for example, this was rated very highly and the turning point for them moving forward with their lives.

However, the lack of time to make any real progress – particularly if there were multiple issues to address – was highlighted as a significant drawback of short-term mental health support. Participants felt a short period of support, with assessment taking up one valuable session, meant that only immediate issues were considered but these may just be ‘symptoms’ of more long-standing issues particularly those relating to trauma.

> *“It just wasn’t worth bringing up half the things I needed to deal with. You can’t start going back to your childhood at session 5 of 6!”*
>
> *“I had all different things. Childhood abuse, grief and more recent traumas. Where do you start with that? You cannae do it in 6 sessions, that’s for sure.”*
>
> *“It takes you 3 sessions to get into it and then it’s nearly over.”*
>
> *“I was referred to the PCMHT and had to wait 5 or 6 months then only had 3 or 4 weeks with Lifelink. It was good, but not nearly enough.”*
>
> *“We need long term not short term counselling. Three weeks is not good practice or effective. If it takes 18 months, it takes 18 months, and you don’t need to come back.”*

The fact that mental health services are a *"complicated landscape"* was not lost on participants. This was perceived to be both confusing and ineffective, with participants feeling they were not being looked after, particularly if they were not accepted for a service but no (suitable) alternative was proposed.

> *"The psychologist declined me for treatment even though they had never met me and was apparently basing the decision on the decision of another psychologist more than a decade before - who had also never met me and referred me for CBT which was no good for long term depression anyway….There's no continuous contact with mental health services and there are lots of bad experiences out there. You need to make people aware of what services there are."*

There was limited comment on Mental Health Resource Centres (Community Mental Health Teams), but one was identified by a participant with a waiting time of months, poor communications and limited contact:

> *"You're in less than 5 minutes, 'how are you?' - not a good day – you get your tablets upped, sleeping tablets for two weeks and it's 'see you in a month'. They don't get to the bottom of what's wrong with you, you're just dismissed and back out the door…I was meant to see a psychologist but they moved [to a different service] so I never saw one. I only had a few sessions then they sent a letter to my GP …but my GP can't give me those tablets, I need to see a psychologist. But I've been taken off the list… Mental health services are not great."*

There was also a view that GPs do not know where to refer patients with mental health support needs.

> *"[GP] didn't know where to refer me to. I begged them for a referral, but they didn't know what to do with me. I had to keep repeating my story, so I had to learn to distance myself from that as it was exhausting. It took years to get the support I needed. [when young] I was told I was wasting their time, I was called stupid and selfish and not to do it [suicide attempt] again. That was it. When I eventually got a CPN who helped, listened and was genuinely interested, it made all the difference. The GP just didn't get it."*

Participants also perceived mental health support in the city to be disjointed and inadequate, as primary care staff had highlighted. There was a view that mental health challenges are not being supported well enough at the moment – there are not enough services, it is too hard and takes too long to access support and when support is provided it is *"tokenistic",* too short and was perceived to only address crisis or superficial issues rather than supporting people properly.

> *"The Third Sector and statutory sector need to come together to help people. It's not working for people at the moment – we have to do better."*

Some Third Sector organisations were rated very highly by participants, but the fact that these are not accessible consistently city-wide was raised as a concern.

> *"Some organisations, like COPE, do a very good job. It's what people want – it's one to one, they listen, they understand and they tailor their service to what you need. But there are borders. Unless you're in G13 or 15 you can't access it."*

> *"We definitely need more community-based workers to help people with their problems."*

Flexible services, which people could *"dip in or out of"* whenever they needed support/ wanted to give support to others, were also highlighted as a possible way forward in future.

Participants recognised that mental health changes over time so it would be helpful to have easy access (local, relaxed, no need to refer – just turn up) options to access support when it is needed.

The issue of referral/self-referral to services was also raised by a couple of participants. Whilst some would like to be able to self-refer, especially if they have attended a service before and know they need more support at a particular time, others reported that they would not self-refer but if the GP referred them and the appointment came in the post, they were more likely to attend.

> *"It easy for the doctor to give you a leaflet, but a lot harder for me to follow it up."*

5.8.2 Waiting lists and lack of support whilst waiting to access services

Those who had been referred to mental health services spoke of having to wait a long time – months – before they were invited to attend. As general practice staff also highlighted, participants in the validation discussions spoke of the lack of support whilst waiting to access services (mental health services but also other services like addictions). They felt forgotten about as there was often no communication in the interim.

5.8.3 Criteria for accessing services

A few participants gave examples of their own or friends' experiences of knowing they were on a downward spiral (because they had been there before) but not being able to access services until they were in crisis. This applied to both mental health services and addiction support. For example, one participant's friend felt compelled to take drugs, despite not being an active user at the time, in order to gain access to a rehabilitation facility as they could not access this support any other way. One participant highlighted the lack of interface between criminal justice and GPs, reporting being put in jail for three months after attempting to hang himself. Another was charged with breach of the peace for threatening to cut his own throat. None of these experiences are joined up, holistic or trauma informed.

5.8.4 Medical assessments for benefits

A couple of participants highlighted their poor experiences of medical assessments conducted with regard to a benefits review. These were viewed very negatively with participants reporting that assessors said things like *"you look fine to me"* despite detailed information on their mental and physical health from their GP.

It should be noted that a number of GPs and CLPs in particular had also raised this issue when talking of the distress caused by poverty and benefits applications/reviews.

5.8.5 The impacts of lockdown

Several participants spoke about how their mental health had deteriorated with lockdown. Part of this was anxiety about the virus and what would happen to them/those they were close to, but it was also because there had been some reduction or loss of mental health support because of the virus and because they were surprised and disappointed that their GP surgery had not checked they were alright during lockdown, knowing the challenges they faced.

> *"Because of Covid, a lot of people have had their cases reviewed and they've now got no CPN [Community Psychiatric Nurse]. They were just told by letter, that was it!"*

One person (aged early 60s) was phoned and asked if he wanted to be resuscitated … but he had recently become a father, was sober and very much wanted to live his life. This person did not consider the call to be trauma informed practice.

5.8.6 Proactive and peer support

Proactive checking on patients' mental health and wellbeing was flagged in several validation discussions as being something participants felt would make a big difference – both to know that someone cared about them but also to help them tap into support more quickly and become/stay mentally healthier.

The use of peer support was also rated highly as a means of doing this. This was suggested by those who have experienced that support, such as those in active networks or groups, but also by others. This was perceived to be an opportunity to tap into volunteer/befriending/ mentoring networks as well as people who have experienced or are experiencing mental health issues providing support to others in a similar situation. The value of giving support and being useful to others was cited as helping individuals feel better about themselves so it was perceived to be a win:win opportunity.

5.8.7 One stop shop v different locations

Participants expressed different views on where mental health services should be located. For example, some felt that a variety of services should be under one roof to help avoid them *"being passed from pillar to post"* but others felt this could be challenging for other patients. For example, one cited older people finding it stressful having to give bloods next to a drugs clinic, which made them not want to get their bloods done. Participants felt that the needs of different service users should be taken into account when designing services, such as the new Health and Social Care Hub in Parkhead.

Another participant highlighted that mental health issues can also make it challenging to attend any service:

> *"A lot of people are agoraphobic, stuck in our own heads and don't like to go out. It doesn't matter where the service is, the biggie is getting there… but once you're there it can be life changing."*

6 Conclusions & recommendations

6.1 Introduction

There were two principal tasks for this research. One was to explore the scale of patients presenting in distress, to inform potential expansion of the out-of-hours compassionate distress response service to in-hours. The other was to investigate the current state of play around trauma informed practice in general practice within Glasgow City, to inform improvements in this area. These are two very distinct issues, but both were perceived to be a priority for service improvement amongst health professionals and people with lived experience who participated in the research.

During discussions, much comment was also made on the wider issues which relate to distress and psychological trauma, particularly around provision of mental health services and supports within the city. This section therefore makes conclusions and recommendations for consideration around all three of these areas. These recommendations aim to move service improvement forward for patients and also help GPs and their teams in practical ways, reducing the burden of care currently on their shoulders.

That said, the current situation with regards to the resurgence of Covid-19 as we enter the winter months (an already busy time for respiratory illness) cannot be ignored. GPs and the wider HSCP and NHS may feel that they are already at breaking point and now is not the time to pursue new initiatives. However, it may be that is exactly the reason to roll out trauma informed practice – provided it is made as easy as possible for general practice to implement – at least to some degree. Trauma informed practice is beneficial for everyone, not just trauma survivors, and in the current climate a more compassionate approach to care sounds like a positive move.

6.2 Scale of distress

The research confirmed that distress is perceived to be a significant and growing issue in general practice. It is acknowledged that this may not necessarily be the case across all practices[27], those with greater challenges in this regard may have been pre-disposed to volunteer their time to participate and the term ‘distress’ may indeed have been interpreted differently by different respondents. Nonetheless, the majority of participating practices felt that it was a very significant and growing issue within the city for a variety of reasons across the population.

‘Distress’ is not something which is recorded in any formal or consistent way at present by general practice so the researchers asked participants to estimate how much time they spent dealing with distressed patients. GPs, Community Links Practitioners and Reception staff were most likely to experience distressed patients on a regular basis, although other roles did to a lesser degree too. Some participants reported that distress was encountered daily, others that half of their patients became distressed at some point or that much of their day is spent dealing with social rather than medical issues.

In addition, a few practices were willing and able to provide a log of distressed patients encountered within one week so different staff roles estimated how often they encountered

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[27] Although all were invited to participate and we endeavoured to achieve a spread of participating practices across the 3 city localities and size/SIMD of practice.

distressed patients and the (additional) time required to deal with this. We used all of this data to estimate low, average and high cost of distress[28] as follows:

Using the **lowest** estimates provided by participants, the total cost is **£1.9million**.
Using the **mean** of estimates provided, the total cost is **£3.9million**.
Using the **highest** estimates provided, the total cost is **£8.0million**.

Even estimating just half an hour per month per member of staff is spent on distress, the estimated cost would be £290k. These figures are sufficiently significant to clearly justify investment in support for general practice and their distressed patients.

It might also be assumed that the scale of distress has not reduced during lockdown, but increased further. Some of the main reasons cited for distress include challenges around poverty, benefits, housing, relationships, work and trauma – which may well all have been heightened by lockdown - in addition to overt concerns around the impacts on mental health of social isolation, bereavement and other fears relating to the global pandemic. Whilst benefit reviews may currently be on hold due to the pandemic and uptick in applications for Universal Credit, the impacts of the current economic recession are likely to be further accentuated as government support dwindles, unemployment rises and benefits reviews return.

There is not just an economic case for investment in better support for distressed patients, of course, it would also have a positive impact on both patients and GP teams. There was a real sense of staff being at or close to breaking point, with such high need for patient support and the willingness to help them… but limited resources within practices, without access to sufficient and/or appropriate meaningful referral services. The current ‘sticking plaster’ approach with short-term inputs is not considered to be working for patients, who return seeking help at a later date or, worse, do not seek help as they do not think it will be worthwhile from their previous experience - further compounding their mental health issues. It is also not working for health care professionals, who find the interface with mental health services the most frustrating and time-consuming referrals they make, with little positive return for them or their patients.

Recommendation 1:
This suggests that there is a need for the new out-of-hours compassionate distress response service operated by GAMH to be extended in-hours for primary care. It is understood that this is already being actioned, as there was provision for this within the out-of-hours contract to enable GAMH to provide in-hours support. This needs to have:

- *clarity around who it is for and what to expect;*
- *mixed contact modes (online, face to face when possible, telephone);*
- *a responsive and accessible approach;*
- *local access points where possible;*
- *a hand over of the ‘baton of trust’ from a trusted health professional or self-referral, as appropriate; and*
- *minimal form-filling and re-telling of people’s stories.*

It has been challenging to find any data of relevance, because it doesn’t exist (because codes used in general practice have evolved over time so are not exhaustive/helpful - particularly for social issues/mental health - and there is variation in which codes are used, if any) or because there has been a reticence to share data around referrals to mental health services and acceptance to/uptake of those services. It is difficult to address the issue properly if the scope and scale is not clear.

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[28] Using average salary rates with 13% employer’s NIC added only, not full cost of employment (pension, share of overheads, etc.)

Recommendation 2:
We need better data on distress and trauma. This is not intended to be a data-gathering exercise for the sake of it. It is understood that a new IT system is being developed so it would be helpful if the design could take a more consistent and comprehensive approach to coding from the outset (SNOMED is the new coding framework to replace Read codes).

6.3 Trauma informed practice

6.3.1 Awareness and understanding

Trauma informed practice (TIP) was not a term that was familiar to many participants, albeit that some de-coded what it meant to some degree, so there is work to be done in raising its profile and taking forward the aspiration for general practice staff to be more trauma informed. Community Links Practitioners were all aware of it, as they had recently received training on TIP. Being trauma informed has gained prominence in their role as the additional time they have to spend with patients has resulted in frequent disclosure of trauma[29], often for the first time, while supporting patients around long term health conditions or other issues.

Many GPs felt that, whilst they may not call it that, they have always been trauma-informed and some of their staff do it very well, intuitively. There was recognition that this is not the case across the board, however. This was echoed by people with lived experience, who highlighted that a positive relationship with their GP and practice receptionist can make all the difference – knowing their history so they do not have to repeat it, getting them in and out quickly if appropriate, giving them time, listening to them and supporting them through crises.

Interestingly, even those who were familiar with trauma informed practice found it challenging to describe what that meant in the context of service delivery within general practice, so this needs to be made more tangible. There was general agreement that it was good to be able to understand patients' behaviour and be aware that trauma may play a role in both physical and mental health issues which would help GPs and their teams do their jobs better, but they should not be dealing with trauma directly as specialist services are better suited to that if the patient wishes to pursue that route (not all do).

Very few participants were aware of the NES National Trauma Framework, associated Training Plan or tools which aim to support the national aim of becoming a Trauma Informed Nation so have not accessed these. There is support and interest to become better at trauma informed practice within general practice, but caution around this too. It needs to build on learning and good practice to date rather than be parachuted in as 'the next big thing'. For example, there has been recent focus on person-centred care and any guidance or training around distress and trauma informed practice should recognise that and build on it. Shifting priorities and silo thinking were seen to be the norm, with little 'corporate memory' of positive aspects of approaches which have gone before in the NHS. This suggests there is a need to develop the narrative around TIP as a natural evolution of what has gone before, so that staff appreciate its relevance to previous work, recognise the overlapping principles plus its distinctive characteristics. There needs to be a clear corporate context for TIP and a whole systems approach taken to embed this as good and consistent practice within the organisation.

6.3.2 TIP training

Changing the attitudes of some staff were perceived to be the biggest challenge in moving forward trauma informed practice. Helping staff to understand the importance of the language they use, the assumptions they make and ways in which they may be consciously

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[29] CLPs listen to patients and refer on to appropriate services, where the patient wants that next step.

or unconsciously biased are critical to changing attitudes, culture and the equity of service provided to patients. It may be easier to address environmental factors (if buildings allow) but this should not become a distraction or a tick box exercise. Participants with lived experience very clearly said that whilst environmental factors can make a difference, it is more important that they are heard and supported appropriately, so attitudes are key.

Recommendation 3:
Whoever takes forward the trauma informed practice agenda needs to make it as easy as possible for busy staff in general practice to grasp the relevance, importance and practicalities of trauma informed practice so that it becomes embedded. This means:

- *spelling out what it means;*
- *what difference it can make to patients, staff and colleagues; and*
- *providing practical tips, checklists and tools which can be quickly implemented. This does not mean dealing with a person's trauma but asking the right questions in the right way, acknowledging/validating and managing trauma disclosures safely and helping patients to access support where required and wanted, in a positive, meaningful and collaborative way.*

A mix of approaches is required. Opportunities for online training would be the minimum provision, but face to face training would be welcomed and seen to be beneficial by some practices. For example, they could look at TIP in teams – smaller practices could mix with other practices to share experiences, ideas, etc. - and have space to actively consider what they need to change and do to become more trauma informed.

TIP could be included as core training for all staff, like equalities issues, so it is embedded within the organisation and presented in a coherent, joined up way rather than as an 'add on' which staff do not see applying to them. There may also be merit in each practice having HSCP support to devise and implement a TIP plan. Templates could be provided to assist with this in the first instance.

The NES resources have been developed nationally and make a good start at explaining this work stream. There is perhaps a need to tailor these to both the Glasgow and general practice contexts, however, to deliver an appropriate response to this agenda and meet the City's aspirations around TIP. This might include a scoping review of what would work to support practices, including other stakeholders like the Local Medical Committee, Royal College of General Practitioners and postgraduate training to become more 'TIP'd'.

6.3.3 Shifting culture and practice

During the course of the research, the variation in provision and culture of general practice across the city has become evident… as has the difference this can make to both staff and patients. It is recognised that GPs are effectively small businesses and there are limits to how prescriptive GCHSCP can be in terms of how things are delivered. However, it would appear that there is such a heavy workload that it is difficult for practice teams to deliver a service, respond to everything they need to respond to and consider improvement and best practice on every front.

Recommendation 4:
Again, if this can be made easier for practices then that might help shift culture and practice. Working collaboratively and sharing examples of practices which are doing things differently, which are trauma informed, could be helpful to busy practices. For example, the different approach taken at Craigmillar Medical Group could be shared with practices as an exemplar of managing patients more proactively. Craigmillar Medical Group have 3 mental health nurses on the team (including a partner) and have pursued a more patient-driven approach where more proactive patient management by care co-ordinators has been introduced to

positive effect. This has worked alongside physical changes to the environment, increased communications and visibility by staff working in open-plan unless consulting, for example.

There are elements of that already happening in Glasgow (some practices have an 'open door' approach, more collaborative working, and the new health centres are welcoming environments, etc.) but this could be built upon to respond to patient distress and practice trauma informed care more effectively in these more receptive practices, and to start to effect change in those which have not currently considered this way of working.

6.3.4 Patients reaching the right support quicker, reducing the burden on GPs

There is a need to manage access to GPs better – if people feel bad they go to the GP but they may not be the best person to help a patient in distress, as they do not have much time to actively listen to them. The PCIP and the primary research recognise that GPs' workload needs to be reduced and distress is increasing so patients in distress need to be directed elsewhere if possible.

Recommendation 5:
As receptionists and recorded messages encourage patients to go to the optician for eye issues, the pharmacist for minor ailments, etc., can patients with low level distress also be directed to somewhere more appropriate to free up GP time? Strong messaging from the Scottish Government and HSCP may also help to change the current culture of attending the GP as a first point of contact.

6.3.5 Staff wellbeing

There is little in the way of support for staff dealing with patients who are distressed or have experienced trauma, but the mental wellbeing of staff, including GPs, is a component of TIP. GP teams support each other to some degree, but they also reported having become hardened to, for example, people threatening to kill themselves.

Recommendation 6:
Consider how best to provide mental wellbeing support for GPs and practice staff at HSCP and individual practice level and encourage staff to access this.

6.3.6 Equalities and accessing services

As with everything else, the full range of equalities and access issues need to be considered. For example where people require interpreters or where there are literacy issues it can be challenging to disclose trauma as it is often a question of timing. Also, counselling or talking therapies are not for everyone so clarity is required on what the alternatives are for men, for example. Is counselling or other support available culturally appropriate?

Recommendation 7:
Active consideration needs to be given to equalities and access issues for all of Glasgow's citizens to make sure barriers are removed to disclosure of trauma or distress and that support solutions are appropriate for all.

GPs, CLPs and people with lived experience all highlighted that services can be challenging for people to access because of the trauma they have experienced. It does not mean that they do not want or need the service, but they can have additional barriers which need to be taken into account. Other services can seem to also stack things against patients' engagement, for example having to travel to the first office in which they were declared homeless even if they have been housed two bus rides away or recovering addicts needing to steer clear of old associates to stay safe but having to access the same service locations.

Recommendation 8:
General practice and other statutory services need to follow up non-response or non-attendance to explore the reasons for that – in a different format, as there is no point sending another letter to someone with literacy issues, for example – and consider whether trauma is a factor and provide appropriate support to access services if so.

6.4 The bigger picture

6.4.1 Introduction

Practices can become trauma informed but if there is no meaningful therapeutic support for patients who have experienced trauma or are distressed, this does not go far enough. Patients need to be identified and heard, but they need to then access the right support to help them get to and stay in a more positive mental space.

This has been an engaging research project, producing rich findings around a subject health professionals and patients alike clearly wish to see improved. It was commissioned at a key moment in time. The commissioning was prompted by anecdotal feedback which suggested that general practice was spending significant amounts of time to support distressed patients and the imperative to reduce the burden of care on general practice. If so, there was an opportunity to augment the out-of-hours compassionate distress response service with an in-hours service specifically for primary care referrals to assist this issue.

6.4.2 The need to review mental health support services

However, the feedback from stakeholders was more wide-ranging than this. The impacts of Covid-19 and lockdown have also sharpened the focus on mental health support services more broadly within the city – how they are structured, accessed and whether they meet the needs of Glasgow's residents and GP teams in supporting distress and trauma. It will no doubt have been useful to have had the additional capacity of the mental health assessment hubs which were introduced after lockdown to assist first responders dealing with people in distress alongside the new out-of-hours GAMH-run Compassionate Distress Response Service, however, these join an already cluttered yet fragmented landscape of mental health support within the city.

Recommendation 9:
Whilst the research was commissioned to look at the case for in-hours distress support for general practice, the views and experiences expressed would suggest that wider consideration of how people are supported through distress and mental ill health is required as existing services and structures are not serving us well.

It is understood that an exploration of the interface between general practice and mental health services is being taken forward, but discussions whilst researching and presenting the interim findings of this research would suggest that a full review of mental health services – the scope, scale, structure plus how they connect to each other and allied services like GPs and Addictions – is required.

This is not intended to be critical of mental health services in the city but to help move provision forward to better meet the needs of patients, referrers and assist mental health professionals do their job more effectively too. The research suggests that mental health services are under-resourced and this will have impacted on how they assess, structure and respond to need in the city – the balance needs to tip from an apparent emphasis on assessment/refusal of service given strict acceptance criteria to ensuring there is capacity for people to be supported during their time of need.

It is hoped that the insights from professionals and people with lived experience gathered during this research will inform any review of services, without the need to gather further views unless or until there is consultation on proposed changes to services and/or general practice staff or people with lived experience are part of that review group.

6.4.3 A paradigm shift?

Presentations of mental illness and poor health are complex with GPs varying in their expertise and what they consider as part of their GP role, so this does suggest that a single point of entry for mental health support – major or minor – would be helpful, or a 'no wrong door' joined up, flexible person-centred approach. At the moment it appears to be very much about what can be delivered, not what people need. There is much talk of a mental health 'ticking time bomb' given lockdown and the forthcoming recession, so the more that can be done to respond to this now the better. Some of this is about more generic practical and emotional support as people deal with challenges in their lives, such as bereavement, relationship breakdown, money advice, etc. but it is also about minimising risk of harm.

The model at present appears to treat only those worst affected and the majority of patients only receive short-term support as it is a deficit-based model. Many patients then rebound to their GP.

Recommendation 10:
Can this be turned around to consider positive mental health (not simply management of mental illness) and how this can best be supported and achieved? A preventative model focusing on improved coping skills, practical support to help people face the challenges which cause distress and longer term co-ordinated support from mental health, addictions and other services for people to properly improve their mental health would require a paradigm shift from where services currently stand, but that initial investment and proactive approach to managing mental health could make all the difference and be more cost-effective than the current system which stakeholders referred to as a 'revolving door'

Recommendation 11:
Future mental health support is likely to be delivered via a mix of statutory and Third Sector services, but these need to be co-ordinated so that people are ***only assessed once*** *before then receiving the support they need rather than being stuck in a cycle of repeated assessment, short-term support, no support at all or accessing their GP for support in lieu of/while waiting for specialist support (waiting times for specialist support such as counselling for childhood sexual abuse can be years, not months).*

Covid-19 lockdown has significantly changed the ways in which GPs and other services engage with patients and this may continue to evolve in future. Could there also be scope to actively triage patients seeking support at all levels and respond flexibly? For example:

- *Initial triage by reception staff could be expanded to include distress, as suggested above.*
- *Referrals work best for some people, but self-referral may also be useful to reduce the burden on GPs.*
- *Having a choice of options so people actually take it up – groups may work for some but often 1:1 support is required first.*

- *Looking holistically at people, and their short and longer term needs, so for example providing coping skills in the short term whilst waiting for longer term counselling.*
- *Enabling people to self-refer back into a support service they have found useful when they know they need it, rather than them having to deteriorate further before they can access help.*
- *There are many resources online, but people need links to specific ones that will help them.*

6.4.4 Improving the interface between GPs and mental health services

Feedback during this research suggests that there is a tension between GPs referring to mental health services, particularly Community Mental Health Teams, and the number of patients accepted for support. There is an apparent distinction between 'medical' mental health issues – which may be accepted for support - and environmental or social issues which are causing distress, which are not accepted. Patients with the latter are often referred to Primary Care Mental Health Teams or the Third Sector, such as Lifelink. However, funding of Third Sector services has to be considered alongside this to ensure they have sufficient resources to provide the quality and quantity of service required. This is particularly pertinent given recent grant funding cuts to the Third Sector.

Recommendation 12:
There is a need for better communications between Mental Health services and GPs so there is greater clarity around what support is needed for different people/circumstances and what can make a difference to them – rather than wasting everyone's time – plus a route map of support for those who don't fit into the clinical categories.

6.4.5 The need for more 'lower level' support

Distress may be a natural response to environmental or social issues such as poor living conditions, poverty, poor health, relationship or employment issues or bereavement. However, people still need support to deal with the issues they are facing, even if it is just having someone to talk to, who listens and allows them to be heard and their feelings to be validated.

It would appear that the current system is best at responding to those with mental illness and the new service will help with those who are very distressed, whether or not mental illness or addictions are also present. However, feedback suggests there is a large cohort of patients at any one time who do not need that rapid response, but are experiencing significant ongoing distress who need better practical support. Going to a GP may result in medication they do not need or really want as that is in the gift of the GP who wants to help, but it does not necessarily help them in the longer-term. Patients wishing to come off long-term use of methadone, anti-depressants or alcohol dependence to deal with past traumas also need to be supported in a co-ordinated way. There are examples of this happening in the city, but it is not sufficiently wide-spread.

There is a need for additional support or at least different ways of dealing with patients in lower level distress – not all may need or want to be referred to the new compassionate distress response service but wish to see the GP. However, this is not necessarily the best use of a GP's time and a GP's time costs more than many other staff in statutory or Third sectors. The perceived impacts of the CLPs in this regard have been seen to be significant by GPs who have them, but not all practices have access to a CLP. It is understood that others have called for an increase in the number of CLPs recently and that needs to be considered at national level.

Recommendation 13:
This research suggests there is a case for increasing both the number of CLPs and access to whatever CLPs there are (as they were allocated by SIMD rather than list size so have varying workloads). GPs currently feel they have a lack of options to support patients with non-urgent mental health support needs but the patients keep returning when they feel bad, so there needs to be a route to less cost-intensive staff who can support patients in a practical, longer term way. There is a clear role for greater Third Sector input here - increased access to talking therapies, Money Advice Workers, etc. - in addition to other options like peer support. These may also help whilst patients are on the waiting list for more complex issues.

But it needs to be provided in a joined up way, which again suggests either a single point of entry or a 'no wrong door', person-centred approach is required. This would avoid patients having to re-tell their story and ensure that once they have been referred to/have entered mental health support services (in the widest sense, be that statutory or Third Sector provision) they will receive support until – with discussion and their consent – they no longer need mental health input. Responsibility then lies with mental health services to ensure the patient is recovering within the different tiers of support, rather than the patient and/or GP having to diagnose and navigate the services on offer on a one-by-one basis.

6.5 Feedback to participants

Many people have given their time to input to this project and are keen to see change happen. For any research or consultation it is also important for people to know they have been heard and some participants asked if they would see the findings, but it is even more important for GCHSCP to show the participants that they have heard their views, they wish to see services improve and the specific changes proposed.

Recommendation 14:
The final recommendation is that the findings of the research are communicated to research participants, alongside GCHSCP's response to these (in the short term and more detailed proposals at a later date).