Preliminary Notes for DHSC Mental Health Plan

How can we support different sectors within local areas to work together, and with people within their local communities, to improve population wellbeing? (Chapter 1)

It is promising to see that the strategy discourages ‘over-medicalised’ options to improve population wellbeing. There is considerable scope to enable people to practise effective self-care in their local communities without clinical or specialist intervention.

The NHS Long Term Plan has committed to building the infrastructure for social prescribing, a key part of which will expand the number of social prescribing link workers installed in primary care networks (PCNs) by 2023/24. As a method of non-clinical intervention, social prescribing can promote self-care and mental wellbeing by connecting patients to services and local agencies.

There is evidence to suggest that a model of social prescribing via community pharmacy could offer key benefits to patients. Pharmacy teams operate at the heart of their communities and have a robust understanding of their local populations. A review into community pharmacy’s potential role notes that it would be a “missed opportunity” to overlook the sector in social prescribing policy and practice frameworks (Lindsey et al, 2021).

There are good practice examples showing strong cross-sector collaboration between community pharmacy and local agencies to promote mental wellbeing. In Manchester, for instance, Well Pharmacy partnered with the charity Mind in May 2022 to fundraise for awareness and support for mental health conditions.

For an effective social prescribing model with community pharmacy engaged as a key actor, incentivising pathways for better partnership working – particularly across the primary care and the VSCO sector – is essential. NHSE&I should consider extending its social prescriber connector programme to formalise community pharmacy participation as part of the referral process to local services and agencies.

Additionally, there is some (if slightly limited) evidence that proposes social prescribing’s potential to reduce demand on NHS services (Taylor, 2019). A mental health strategy that is serious about prevention should prioritise and invest in frontline solutions that have dual benefits to both the patient, the local community and the wider health service.

What needs to happen to ensure the best care and treatment is more widely available within the NHS? (Chapter 4)

Our response below is predominantly concerned with medicines optimisation for people with serious mental health conditions (such as schizophrenia or bipolar affective disorder). For more common conditions such as depression or anxiety, there may be an opportunity to expand the scope of health screening questionnaires available via community pharmacy to screen for symptoms.

Patients with serious mental illnesses (SMIs) may present with complex and enduring needs. They are often service users supported by more than one provider across varied sectors. Siloed service provision across multiple providers will not deliver the best and bespoke level of care.

Underpinning this requires a patient ‘flow’ approach that incorporates community pharmacy within a multi-disciplinary network of providers. Integrated models of care should use the clinical expertise and knowledge of community pharmacy teams to deliver wraparound support for patients.

Commissioning community pharmacy-led interventions could reduce the risk of co-morbidities, minimise the risk of psychotropic medicines-related harm for people with SMIs, and support stabilisation in the community.

Crucially, there must be considerable improvements to two-way communication systems between prescribers and community pharmacy. Whilst specialist psychiatric medication are typically initiated in secondary care, a focus on monitoring and adherence in primary care settings may reduce relapse rates and improve compliance.

Research suggests that between 30 to 50% of medicines prescribed for long term conditions are not taken correctly. As experts in medicines, community pharmacy teams are ideally placed to support people with SMIs to manage and understand their medication. Teams can better support patients' medicine literacy and minimise the risk of harm.

Cheshire and Wirral Partnership Mental Health Trust has worked with their Local Professional Network to develop a system which notifies community pharmacies when the antipsychotic clozapine is prescribed and dispensed in secondary care.

To that end, better data sharing infrastructure and more effective commissioning efforts at system-level could improve care for patients. The Discharge Medicines Service, launched as an essential community pharmacy service in 2021, is designed around improving patient outcomes across care settings. Better promotion of the service amongst NHS mental health trusts would drive consistency and improved communication rates between providers so that patients receive sustained care across settings.

What more can we do to improve the physical health of people living with mental health conditions? (Chapter 5)

As the strategy observes, people with serious mental illness/es (SMIs) are more likely to experience co-morbid physical health problems. Community-led intervention is central to minimising risks, and can be offered as lifestyle advice, health checks or medicines adherence support.

However, the risk factors for poor physical health for this cohort are often multiple and complex. Side effects from treatment, poor lifestyle factors and co-occurring mental or neurological conditions can all impact the physical wellbeing of people living with SMIs. Patients may present with one or more risk factors, or have existing physical health conditions.

In the first instance, the prevention or reduction of physical ill health conditions may be offered through medicines monitoring and health checks. Importantly, psychiatric medication can carry a number of potential side effects, such as cardiovascular complications or increased risk of diabetes. People taking medicines such as antipsychotics and mood stabilisers may be offered ECGs and/or blood tests prior to or during treatment to identify psychotropic medicine-related harm.

A joint initiative in 2018 between the North East London LPC (Local Pharmaceutical Committee), North East London NHS Foundation Trust and University College London, presents a successful collaboration between secondary, primary and community pharmacy sector providers to reduce medicines-related harm.

This community pharmacy-led service offered physical health checks to patients with a psychotic illness. Participating local pharmacies delivered ECGs, blood pressure checks, cholesterol and glucose testing, in addition to advice on physical health self-management. 71% of patients who attended a participating pharmacy had all five Lester cardiometabolic risk factors monitored, a much higher rate than the standard care in Barking and Dagenham (36% in 2018-19).

Further, the NHS has identified SMI as one of its five clinical areas of focus to reduce health inequalities in England. Modifiable risk factors which contribute to disparities in health outcomes, such as smoking, are more prevalent for people with SMI. For example, people with bipolar disorder or schizophrenia are three times more likely to smoke than the wider population (Gilboody et al, 2019).

Triangulating models of communication between community pharmacy, primary care and community mental health teams could further support patients with co-morbid physical and mental health conditions. This could prevent a gap in care but also avoids unnecessary duplication across care settings. As we have already explored, local examples of notification between secondary care and pharmacies are in place to avoid medicine-related harm. Scope exists to provide pharmacy-led healthcare checks for people with complex mental health needs.

At the other end of the spectrum, the strategy is also concerned with early mental health intervention for people with wider (physical) health problems. Midlands and Lancashire Commissioning Support

Unit proposes a physical health-mental health segmentation model to consider the interaction between physical and mental health conditions.

Patients with long-term health conditions may visit their pharmacy more often; equally, those who have experienced acute episodes of serious illness may require intervention form their local pharmacy team. In both instances patients may be more susceptible to developing a mental health condition. For instance, a person who may have recently had a heart attack is subsequently experiencing symptoms of anxiety and/or depression, or loneliness.

We refer to our earlier proposal on increasing the accessibility of social prescribing programmes through community pharmacy as a starting point. Equally, greater training and upskilling for pharmacy teams will aid earlier detection of common mental health symptoms within pharmacy settings.

What can we do at system-level to ensure that individuals with co-occurring mental health and drug and alcohol issues encounter 'no wrong door' in their access to all relevant treatment and support? (Chapter 5)

Dame Carol Black's independent review into drugs points to the scale of addiction and substance abuse problems heightened by the pandemic. The review suggests that austerity over the past decade has prevented a whole systems-approach with a lack of appropriate treatment or aftercare options.

Substance or alcohol abuse disorders and mental health conditions are often heavily linked yet services for people with a dual diagnosis is typically uncoordinated or separated. As such, wraparound support must engage with different providers with expertise in different areas and levels of care across substance, alcohol and mental health support.

For example, pharmacy teams' effective stewardship of opioids could help to address the negative impacts these drugs can have on patients' lives and prevent death and misuse. Pharmacists have an important part to play as part of a systems-wide approach to appropriate prescribing and safe management of controlled drugs.

Whilst people who use drugs often fall into hard-to-reach categories, pharmacy teams are likely to already have professional relationships with individuals being treated for substance misuse who attend the pharmacy for supervised consumption services. It is not uncommon for community pharmacists to be the only health care professional a patient has seen for many months, making them well known and trusted. Further, there is a greater concentration of community pharmacies in areas of deprivation – this is particularly important given drug related deaths are significantly higher in areas of higher deprivation.

It is worth noting that the best interventions are those that are long-term and built on rapport between trusted professionals and patients – this requires times and funding, but community pharmacists are well placed to deliver this support in collaboration with the wider health care team. There are number of other factors relating to training, safeguarding, funding and mechanism of supply which will need to be addressed, which we have outlined in our response below.

Concerted and multi-pronged efforts are necessary to reduce drug and alcohol related deaths. We support reactive harm reduction measures (such as expanded access to naloxone), and also strongly recommend nationally led programmes to address the root cause of dependence to prescribed and non-prescribed opiates. Again, community pharmacy must be engaged within a network of providers to reduce deaths and ensure no one with a dual diagnosis falls through the cracks.