Impact of the Proposed Closure of the NHS Practitioner Mental Health Programme for Doctors and Managers in Secondary Care

Editorial

Abstract

To reduce its financial deficit, NHS England decided to cull the Practitioner Health Programme (PHP) funding, which has been providing confidential mental health services to 110,000 NHS doctors/ senior managers since 2011. This decision was announced when NHS doctors were in a dispute over pay and conditions AND coincided with the increasing prevalence of mental illness, stress and burnout.

This decision raised concerns among doctors' unions, medical royal colleges, and doctors through social media. An open letter asked the Health Secretary to reconsider this decision. Access to primary care doctors was maintained. What appears not to have been considered is that around 50,000 junior doctors, including locally employed doctors and international medical graduates who are in short-term contracts or rotational attachments, are unlikely to meet the waiting time for such 'secondary care OH services'. In addition, the elephant in the room of a massive challenge of the professional stigma that prevents doctors from accessing mental health support early seems to have been missed.

This editorial briefly explores the causes of a high prevalence of stress and work-related mental illness amongst HCPs, the consequences on their overall health, employing organisations and their patients.

Keywords
Mental health, healthcare professionals, workplace stress,

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Background

The global migration of healthcare professionals (HCPs) or students is well-established. It has many advantages and challenges, both personally and for institutions and societies. Health economies such as the UK, USA, Australia, and New Zealand are often net importers of HCPs. International HCPs are vital in delivering care and cannot be economically or effectively replaced by 'home-grown' professionals. Like other migrants, HCPs also face many challenges of acculturation, social exclusion, bias and discrimination, along with the upheaval from their families and familiar home environments, which can lead to lower mental well-being and undermine their contributions to clinical care. International HCPs can often be positioned in socioeconomically disadvantaged areas or remote communities, which are unpopular amongst locally trained doctors, mainly due to broader policy priorities rather than through personal interest or choice. There is a clear link between a lack of autonomy about geographical areas of practice and susceptibility to anxiety, depression, and other psychiatric disorders.

Rates of stress and burnout are generally high for all HCPs, particularly for migrant HCPs. There are many factors, some individual - such as family background, personality traits (neuroticism and self-criticism), and coping by wishful thinking, and contextual factors, including work-related stress, overwork, emotional pressures, working in an intensive-care setting, and stresses born from societal interactions outside of work, which is often predictive of mental health problems.[1] This is not helped by the existing stigma associated with mental health issues in all societies. Hence, access to and engagement with mental health services can be particularly challenging for HCPs, especially international HCPs. However, irrespective of immigration status, medical students, junior doctors and general practitioners report some of the highest rates of having a formally diagnosed mental health condition in the previous twelve months in most surveys. Junior doctors are less likely to know how to access help or support. Senior doctors on permanent or long-term contracts, those working as SAS (Staff, Associate Specialists and Specialty) doctors and international medical graduates (IMGs) are more likely to have unsuccessfully asked for support from their employer in managing a problem. [2] Several improvements for future NHS mental health services have been identified regarding reduced waiting times, better access to alternative treatments and facilitating more patient-centred communication.[3] Since the COVID-19 pandemic, there has been a sharp increase in the incidence of mental health disorders among HCPs and new medical graduates. [4–6]

Consequences

The consequences of increased stress and an inhospitable work environment in healthcare are moderate or severe depression (68%), anxiety (53%) and burnout (49%).[7] High levels of mental pressure may lead to further problems, including drug abuse, smoking, alcohol use, academic failure, sleep disorders and suicide. [8] Depression and anxiety can be associated with self-harm, suicidal ideation, and suicide. [9] This leads to challenges in recruitment and retention.

Societal stigma has a significant impact on many people with mental illness, especially if it leads to reduced self-esteem and interference with various aspects of life, including work, housing, health care, and social life. Stigma towards mental illness does not help the situation and is compounded for HCPs, where it can act as a formidable barrier to using health services. [10] Avoidance of appropriate help-seeking starts early and is linked to perceived societal or professional norms, which dictate that experiencing a mental health problem may be viewed as a form of weakness and has

implications for subsequent successful career progression. [11] For international HCPs, discrimination, or the unjust treatment of different categories of people, is one of the most powerful social determinants of mental health, leading to increases in rates of depression, generalised anxiety disorder, post-traumatic stress disorder, alcohol use disorder, and mentally unhealthy days. [12]

Solutions

Many preventive measures can reduce stress levels, and easy access to professional mental health services is a crucial component. [13] Coping strategies are vital for mental well-being and include emotional and behavioural actions to tackle a troubled person-environment association. [14] These strategies also include seeking support, active coping, acceptance, avoidance/denial, substance abuse, faith/religion, and sports or exercise.

In a recent inaugural speech at the Royal College of Physicians of London, the newly re-elected President extolled the virtues of '*resilience*' learnt from celebrated role models such as from ultra-marathon running in helping junior colleagues manage the stresses of working in a health service (that was reaching a nadir of financial and workforce resource availability against sky-rocketing demands). Such attitudes to resilience building or sink-or-swim strategy as an option to reduce mental health disorders among HCPs working in a challenged environment are unfortunately widely held by the senior leaders and demonstrate a disconnect from the frontline. Such attitudes also add to the stigma of mental illness as a sign of individual weakness and stress burden for not only juniors but all HCPs. Some institutional strategies and guidelines also emphasise individual mental health and psychological support rather than a systems approach to tackling the underlying causes.

In contrast, healthcare workers emphasise structural conditions at work, responsibilities outside the hospital and the invaluable support of the community as the major influences on their mental wellbeing. The well-being support interventions proposed in institutional guidelines very rarely take cognisance of or respond to the lived experiences of staff. Even when mental health support is made available, staff report being unable to participate in these interventions due to understaffing, exhaustion or clashing schedules.[2]

Resilience or coping strategies can offer a way out with multi-institutional interventions that promote *approach-based coping* styles (rather than avoidance-based styles) combined with social support, which may lead to decreased rates of mental health issues. The development of these interventions needs to be multifaceted, including promoting care-taking behaviours and focusing on institutional cultural change to empower HCPs to participate in these resiliency strategies.[15] A commission set up to explore the mental health and well-being of HCPs by the World Psychiatric Association and the Asian Journal of Psychiatry in October 2022 made several recommendations, including the need for institutions to provide well-resourced, exclusive and bespoke services for support and well-being targetted to the specific needs and challenges of HCPs. [16]

International HCPs

However, international HCPs are even less likely to talk about their hardships in unfamiliar settings and experience exclusion in the community as well as the workplace. Providing culturally adapted support that considers ethnolinguistic differences, religious practice, and mental health literacy is more likely to meet the needs of international HCPs.[17]

Mindfulness-based interventions may decrease stress, anxiety, and depression and improve

mood, self-efficacy, and empathy. Due to the range of presentation options, mindfulness training can be relatively easily adapted and integrated into health professional training programs.[18] Although theoretically holding promise and being provided by NHS England post-pandemic, there is often little evidence of the effectiveness of online mindfulness interventions on depression, anxiety and burnout. This might also be due to low program usage and diminishing participation near the conclusion of the interventions.[19]

Strategies to overcome these barriers for international HCPs include comprehensive and broad-ranging onboarding. Interventions that build an open and supportive culture address individual needs and include ongoing support from all staff beyond the initial intervention. [20] Some successful options include increased coordination and communication between voluntary organisations, social services and mental health services; training on cross-cultural issues; integration with primary care; psychoeducational initiatives that include families and broader socio-community groups; and technology-based ones. [21]

Physician-directed interventions are usually expensive, have limited access due to a mismatch of capacity vs demand and are associated with only minor reductions in symptoms of common mental health disorders among physicians. Hence, alternative strategies or organisational interventions aimed at improving mental health via modification of the work environment are needed. [22] Changing work environments is also required to reduce unnecessary stressors and create more positive care settings.

An essential component of any intervention is the ongoing measurement of mental health outcomes. HCP leaders must have the courage to measure outcomes to spur change and track the efficacy of programs. [23] Interventions emphasising relationships and belonging are more likely to promote well-being. Interventions that create a people-focused working culture balance positive/negative performance and acknowledge positive/negative aspects of a career to help doctors thrive. The way that interventions are implemented is also critically important. HCPs need to have confidence in an intervention to be effective. [24]

Conclusion

More support is required to support doctors and HCPs from recruitment to retirement. [25] HCPs frequently experience difficulties in finding appropriate treatment thus, problems become often severe by the time specialised agencies such as PHP receive the referrals. Concerns about confidentiality, judgement, and impact on career are obstacles to seeking help and essential issues during treatment. [26] In the NHS People Plan, support for HCPs is a key component. Providing systemic solutions to the causes of stress and mental illness is as essential as discrete, bespoke specialist MH support services in which HCPs can have confidence is crucial. The authors call on the government and NHS leaders to ensure that such services are commissioned and adequately resourced to ensure the health of this vital workforce.

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