GP SUBCOMMITTEE

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NHS Greater Glasgow and Clyde GP Subcommittee of the Area Medical Committee Response to SGHD Mental Health Strategy Document

The GP Subcommittee of Greater Glasgow and Clyde Area Medical Committee welcome the opportunity to comment on the Mental Health Strategy Document. Members noted that there was little mention in the consultation document of poverty and alcohol which are the two main drivers of mental health problems in Scotland.

- **There should be improved timeous access to psychological therapies.**

  GPs want access to be easy, equitable, geographically close to patients, and reliable, which means there needs to be an adequate workforce to cover sickness and maternity leave etc.

- **Dementia Strategy:**
  i) There should be adequate support & information for dementia patients and their carers.
  ii) There should be an improved response by hospitals to dementia, including better provision of alternatives to admission and better discharge planning.

  But there needs to be adequate funding for same. Hospitals are often the only place to admit dementia patients in a crisis due to lack of e.g., OOH or APH cover. The ever-ageing population means there needs to be more community accommodation to provide for dementia patients. Respite for carers is a major workload too. How is this to be catered for? If more patients are to remain in the community, GP workload will increase at a time when there is little added capacity or funding for same.

- **Preventing Suicide & Self Harm.**

  Good to see suicide rates dropping, but unfortunately there is a significant minority of suicides which are unpredictable and unforeseen.

- **Removing the Stigma of Mental Health Problems.**

  Laudable work already going on. But can always be improved.

- **Promoting Mental Wellbeing.**

  The document alludes to improving early recognition of mental distress and prevention of illness. GPs spend a large amount of their time dealing with non-psychotic mental health problems at source already. There needs to be better counselling provision offered by community-based mental health services in poorly resourced areas, with adequate workforce planning to avoid long waiting times due to poor backfill caused by sickness etc.

- **Child & Adolescent MH Services (CAMHS).**

  Unfortunately, 26 weeks' access is still too long. Taking health visitors away from being practice-based will not help communication between CAMHS and mainline general practice.

- **Enabling People to Take Control of their own Mental Health.**

  This is easier said than done. By definition, people with major mental health problems withdraw from society, are socially isolated from friends and family and often itinerant. How is this overcome?
  We do not have confidence in NHS24 being able to offer e.g., telephone-based CBT.

- **Patients Seeking Help in a Crisis Situation.**

  GPs have worked hard to produce depression registers, but these do not contain all patients. GPs and their staff are not offered training in suicide awareness training as per HEAT target.

- **Reducing Antidepressant Prescribing.**

  This is laudable, but until there are adequate, 24 hour-a-day psychological and talking services (which are expensive to staff and maintain), then antidepressant prescribing is often the only tool GPs have at their immediate disposal.

- **Integrated Care Pathways.**

  GPs feel strongly they should be fully involved in the design of same from the start.

- **The Balance of Community and In-Patient Services.**

  Shifting the balance of care towards the community needs to be matched by adequate resourcing and funding of services devolved to the community. The money needs to follow the patient. This includes timeous and adequate communication amongst hospitals, community psychiatric services and general practices. IT integration is very important here (e.g., PsyCys), taking into account the problems of confidentiality regarding level of access of information for health professionals.

- **Barriers to Accessing MH Services.**

  Minority groups, taking into account disability, ethnicity, race, culture, gender, sexual orientation, sensory impairment, etc experience real or perceived barriers to access MH services, as they do with GMS. GPs are well aware of this.

- **Training of Health Professionals Involved in the Care of Patients with Dementia.**

  There appear from the document to be sound measures in place to meet the demands of training Health Professionals who are employees, but what about Independent Contractors to the NHS? What mechanisms are in place to provide up-to-date training for them and are there mechanisms to provide backfill to allow training?

- **The Physical Health of Patients with MH Problems.**

  Though QOF and Enhanced services, GPs are more involved in managing the physical health needs of MH problem patients who have a disproportionately high burden of same.

Yours sincerely,

Dr John Ip