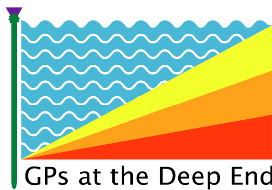

GPs at the Deep End Response to the Scottish Government Mental Health Strategy Consultation 2016

We are GPs working with communities in Scotland who experience high and often extreme socio-economic deprivation. We would like to see a future where the provision of mental health services indeed all health services in these communities are world-leading examples of excellent practice - "to ensure that good medical care is provided where it is most needed"[1].

Here we set out the key factors and ingredients needed to achieve this:

1. Context

1.1. Communities experiencing high socio-economic deprivation have to cope with disproportionately negative social determinants of health and resultant mental health difficulties despite resilience factors being present[23].

1.2. Measurable mental ill health is twice as prevalent in socio-economically deprived areas as in affluent areas. It is the commonest co-morbidity in deprived communities. The prevalence of mental ill health increases in direct proportion to the number of other problems a person has[4].

1.3. Such patients need integrated care, not the separation of the mental health component by stand-alone services.

1.4. The patients with the lowest enablement scores after seeing their GP are those with mental health problems in socio-economically deprived areas[56] - a symptom of how general practice is struggling to work effectively in this context. The high prevalence of long term antidepressant prescribing is another indicator of how general practice struggles to respond and cope[7] in the context of constrained resources[8].

1.5. Given the high prevalence of mental health conditions in deprived areas, it is a matter of continuing concern that general practices serving the most deprived 40% of the Scottish population receive less funding per capita that practices serving the most affluent 60%[8].

2. Concepts

2.1. ***Psychological distress*** is a more effective basis for the framing of patient care needs than diagnostic categories - which, from a general practice perspective, tend to screen people out rather than include people in. This is especially true of crisis, out of hours and community mental health services, which are experienced by many patients and their GPs as trying to find ways not to provide support.

2.2. This takes account of many patients' experience. People experience ***symptoms*** rather than a diagnostic label.

2.3. Greater recognition should be given to the effect that complex trauma and adverse childhood experiences have on mental ill health across the whole Scottish population[910] but especially in communities with higher levels of adversity.

2.4. This should be recognised and responded to by:

2.4.1. A continued focus on prevention in the early years and with families

2.4.2. By embedding trauma informed practice[11] and mentalizing skills[12] in all mental health services- rather than in pockets of good practice (e.g. Tomorrow's Women Glasgow, Homeless Trauma and PD team in Glasgow).

2.4.3. Problem substance use (including alcohol) should be reframed as "escape coping" (using substances to block memories, emotions or manage symptoms) rather than a problem separate for patients who experience mental health difficulties.

2.5. Service design and evaluation should be culturally sensitive[13] especially for people with ***low engagement patterns with care***, including specific consideration for people who are marginalised such as being homeless or a recent migrant.

2.6. There should be a focus on better understanding of resilience and vulnerability, in the short and longer terms, over a person's life course. This is in order to ***target episodic versus ongoing support needs*** so that patients experience continuity of care from the professionals around them.

3. **Service structure**

3.1. Solutions need to pay attention to the current large gaps experienced by patients and primary care professionals seeking to support patients with problem substance use and mental health symptoms. Both systems provide good quality care - but in silos - and this leads to patients with complex needs falling between the cracks and often experiencing very poor outcomes[14].

3.2. Recognition is needed that mental health functioning has an impact on patients ability to engage with all health care including physical health concerns. ***Multi-morbidity is the norm for most patients with mental health difficulties.*** The health service should be structured around patients' needs rather than the need of the health service to work in professional and disciplinary silos.

3.3. A reframing of services around ***complexity of needs*** (including physical needs) would be an effective way of re-organising mental health services away from diagnostic categories (see for example work on supporting patients who experience severe and multiple disadvantage[15]).

3.4. A key way to support this would be to co-locate mental health services within general practice clusters and provide attached mental health workers to work flexibly within practices. This works better not only for patients but also for professionals – better relationships, communication, continuity, and better use of community resources[16].

3.5. Shared records between mental health services, general practice and social work should support this development.

4. **Attached complex needs mental health workers**

4.1 Attached complex needs MH workers should engage and collaborate with community and specialist mental health services in adult and children's services to improve communication and joint working (this is a specific request for an attached MH worker, not necessarily a CPN)[17]. The MH worker would attend primary care/GP MDT meetings to discuss caseloads and patients' unmet needs with the extended primary care team, matching mental health care at the right level based on their needs. This may involve statutory mental health services or 3rd sector agencies[18].

5. Patient and community focus

5.1 Without detracting from the important contribution that mental health professionals make towards the support of patients experiencing mental distress, the role that other public sector organisations and community based organisations have in supporting patients when in crisis, when recovering, and when thriving should be recognised and supported.

5.2 We would like to see shared learning opportunities across mental health services, general practice and third sector based organisations to promote shared decision making and inter professional collaboration[19]. This would enhance everyone's professional practice[20]

5.3 A useful way to broker more effective community involvement would be the rolling out of the ***link worker model***[21][22] to include mental health services within primary care clusters.

5.4 Mental health services would then be better placed to support patients to access public sector and voluntary sector support for other needs such as housing and benefits.

5.5 Finally, ***at the centre*** of the new mental health strategy should be the ***people who use*** the services.

5.6 Much progress has been made – however, mental health services could learn from recent efforts to have peer support leads embedded in community addiction teams.

5.7 We support moves towards a human rights based approach to care for all service users across the health service - mental health services are in a strong position to lead the way in this.

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