REPORT OF THE SHORT LIFE WORKING GROUP FOR MENTAL HEALTH IN PRIMARY CARE

January 2022

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Introduction

1. The Scottish Government Mobilisation and Recovery Group (MRG) was established to support our 'Remobilise, Recover, Redesign Framework for Scotland'. Its aim is to ensure key expert, stakeholder and system-wide input into decisions on resuming and supporting healthcare service provision, in the context of the COVID-19 pandemic. The MRG sub group on Primary and Community Care highlighted the provision of mental health support as a key issue for primary and community services, supporting the parity of esteem between mental and physical health, as we emerge from the Covid-19 pandemic.

2. In response to this, the Short Life Working Group (SLWG) for Mental Health in Primary Care was commissioned and Terms of Reference can be found in Annex A. Its purpose was to consider "what good might look like" in terms of provision of mental health support within Primary and Community care settings.

3. Membership of the SLWG drew on a variety of geographical areas and specialisms and can be found in Annex A. At the outset of the group, a statement of intent (Annex B) was agreed between the Scottish Government, Royal College of General Practitioners and Royal College of Psychiatrists in Scotland, with input from the Royal College of Nursing. This described the ambition of the group – to agree principles and consider clinical models to deliver improved mental health capacity in Primary and Community care.

4. The Group agreed the following principles which should underpin service delivery for mental health in Primary and Community Care:

   - All parts of the system should enable support and care that is person centred, looking to access the most appropriate information, intervention and support in partnership with the individual through shared decision making. Trauma Informed Practice will be the norm. Wherever a person is in touch with the system they will be listened to and helped to reach the most appropriate place for them - there is no wrong door.

   - Primary Care mental health services should have no age or condition/care group boundaries, and meet the needs of all equalities groups.

   - Local systems will positively seek to address health inequalities, proactively engaging those that are less likely to access support.

   - Digital approaches to self and supported management of distress and mental health conditions will be an integral part of the service with the caveat that those who are digitally excluded need to be engaged positively in different ways.

   - Where support can be accessed to help an individual within the Primary Care setting in their own local area this should be the default. If referral to specialist services is required, then this should be straightforward and timely.

- People presenting in the Out of Hours period should have access to the full range of options available in hours, accepting some options may not be available immediately.

- The Primary Care Mental Health Services (PCMHSs) linked to a group of practices or a locality to serve a population needs to be developed and resourced to provide appropriate levels of mental health assessment, treatment and support within that Primary Care setting.

- Staffing levels within PCMHSs will be subject to, and compliant with, safe staffing legislation.

- Evidence based psychological therapies need to be offered, with appropriate supervision and stepping up seamlessly to secondary care mental health services where appropriate.

- The use of screening and clinical measures pre and post intervention is encouraged, as this can indicate efficacy of intervention as well as assist with triage to ensure people are seen in the right service as quickly as possible.

5. The group collated examples of Mental Health models that are in place across various board areas in Scotland, which demonstrate good practice – the evidence paper alongside this report. This gave the group an understanding of current mental health service provision in Primary Care settings, highlighted potential gaps and helped to inform recommendations setting out how services can be improved.

6. The group met four times between September and December 2020 and this report reflects its discussions.

7. In the context of this report “Primary and Community care” is defined as all services that provide healthcare in a local area. These are services that are usually the first points of access for people in the community who are seeking advice or help with a health concern. “Primary and Community care” is linked closely to the wider services and assets within the community such as social care and support, education, community groups, leisure opportunities, workplaces etc. All of which may have roles to play in supporting the wellbeing of the local population.

8. “Mental Health in Primary Care” or “Primary Care Mental Health” (PCMH) in this report refers to a community based response to the following issues:

- stress and distress, including the outcome of socioeconomic pressures and the consequences of complex trauma and adversity;
- emotional and relational difficulties;
- anxiety and depression;
- wellbeing; and
- mental illness.

9. Presentation with such issues is often multifactorial and frequently requires a biopsychosocial formulation and can include the following three factors:

    - A stressor (commonly relational, financial, or social difficulties) which the patient cannot manage within their usual resources.
    - A background history of exposure to adversity and trauma, often in childhood.
    - Limited availability of immediate, confiding social support.

10. Responding to these issues require a multifactorial approach, with the person at the centre. Early intervention especially with first line depression and anxiety can prevent difficulties escalating.

11. There is a considerable evidence base for psychological therapy in relation to presenting issues in mental health.

Discussion

Mental Health in Primary Care

12. General Practice are long-standing anchor institutions of their communities providing ongoing care for the mental and physical health across the whole lifespan. Practices provide universal, comprehensive and accessible care to all individuals offering continuity of care, particularly important for those who are socioeconomically disadvantaged, and oversee care from a range of service providers.

13. GPs are increasingly working as part of Multidisciplinary Teams (MDT) within their practice, based in the community or alongside specialist colleagues. The vast majority of patients are cared for in Primary and Community Care close to their homes, especially when supported by an MDT. To reduce stigma and encourage the creation of mental health communities, there has to be acceptance that the responsibility for Mental Health is for everyone and not only for specialist services.

14. GPs are usually the first port of call for people seeking professional help for mental health issues and the vast majority of mental health consultations occur in Primary Care, covering a diverse range of needs. Approximately 1/3 of GP consultations (c8million / year) have a mental health component. GPs may diagnose, treat and monitor the individual themselves or they may refer the individual to specialist services for further investigation, and / or treatment. People can present with mental health issues to other members of the General Practice team, however, this data is less formally captured.

15. The management of people who present with mental health problems in the Out of Hours (OOHs) period varies across health boards and their associated partnerships. A study has shown that people who present with mental health concerns have on average five contacts before they reach the most appropriate person in the OOHs period compared to physical health concerns which have on average two contacts. As OOHs is an urgent care service, the majority of these presentations will be in crisis. This means that timely and easy access to

secondary care services for all age groups is essential. It is imperative therefore that when considering people who present with mental health concerns in Primary Care, a 24/7 view is taken of service delivery.

Current Challenges in Service Provision

16. The range and complexity of mental health presentations in Primary Care do not all fit existing pathways of care. While GPs can refer to specialist services, those services may reject that referral on the basis that the condition does not meet the criteria for specialist care, or where people require mental health and substance misuse support, resulting in a referral back to the GP. This means GPs become the primary clinical support for individuals with complex needs that they are not always trained to deal with. Having only general practice involvement in this range of complex needs is unsatisfactory for the person and can have a high impact on GP workload, therefore looking to a multidisciplinary response will ensure the best outcomes for people. It is also important to have strong connections with secondary care mental health services in order to be able to "step up" treatment if needed, as seamlessly as possible.

17. Another concern for GPs is management of less complex mental health issues, often associated with other social stressors. This may require little clinical input and while that is important, it will not address the underlying issues. Links to alternative supports in the community, including social services, community groups and those services delivered by third sector organisations is vital for this group.

18. Patients with severe and enduring symptoms of mental illness need referral to specialist services for diagnosis, treatment and for advice about managing risk including those whose presentation is complex or for whom there is diagnostic uncertainty. They may also require ongoing access to support in Primary Care.

19. GPs are often satisfied with the response such patients receive once they have an established place in secondary care services. But any delay in assessment and care planning may lead to a significant reliance on unscheduled presentations, including to crisis and out of hours' services. Improved access to prompt scheduled care therefore has the potential not only to improve the patient experience, but also to reduce the overall resource burden on the system.

20. Specialist services also have an important role to play in providing peer-to-peer decision support for the care of people with complex illnesses in the community. This works best in areas that are able to invest in relationships between clinicians across the health and social care interfaces and where access is available to the electronic patient records such as Clinical Dialogue.

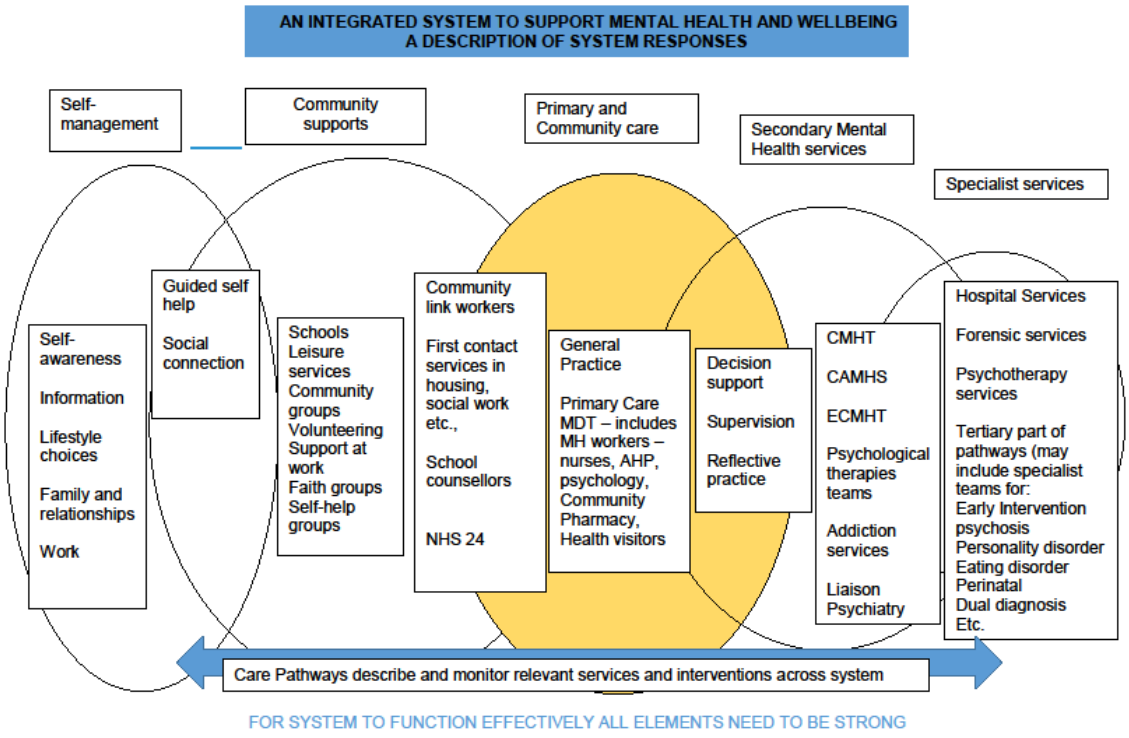
21. There are significant challenges with obtaining access to mental health specialist service provision for children and adolescents. Contributing factors to this include long waiting times and high levels of rejected referrals. Primary Care mental health teams that are able to offer crisis intervention and support to young people early in their journey, significantly limit potential future damage for young people and their families.

Where Primary and Community care fits into an integrated mental health care system

22. Primary and Community Care Teams have a pivotal role within an integrated mental health system and are key in developing and sustaining a system that supports the population with improved mental health and wellbeing. The services provided by such teams is necessary, but not sufficient: they depend on a wider system of care to function optimally. The Scottish Government Mental Health Transition and Recovery[1] plan sets out the range of areas where improvements are required to deliver an improved mental health and wellbeing service to the wider population.

23. An integrated system requires strength across all components, including public health messaging for the whole population, provision of information to assist self-management, third sector provision of community services and Primary and Community care as well as highly specialised aspects of care and treatment.

24. The role of Primary and Community care is central to this system, as illustrated in the diagram below:



[1] https://www.gov.scot/publications/mental-health-scotlands-transition-recovery/

25. Primary Care provides support and care to the majority of those that seek help but also provides the link into secondary and more specialist services where required.

26. There is widespread recognition that the Primary Care part of the Mental Health system requires attention and development. A range of local initiatives have been supported through recent Primary Care Improvement Funding and/or funding via Action 15 of the Mental Health Strategy for Scotland[2]. Many of these initiatives to date are described in the evidence paper that accompanies this report. Further evidence can be found in '*Exploring Distress & Psychological Trauma'* research commissioned by NHS Greater Glasgow and Clyde[3] and '*Mental health and Primary Care networks - Understanding the opportunities'* a report published jointly by the King's Fund and the Centre for Mental Health[4]. These reports highlight both the concerns and the opportunities that exist to improve this aspect of the system.

27. Whist the distress/crisis response element within mental health is very important, it is part of the wider multi-disciplinary system and at the moment services are being developed in silos, without the overview of how different aspects of care and treatment will connect with each other. For the Primary Care team, it is really important that they can understand the system to navigate appropriately on behalf of their patients, with whatever form of mental health problems/symptoms they are experiencing.

28. This report and its recommendations focus on early clinical intervention by MDTs, supporting 'key priority 5' in the Memorandum of Understanding (MoU) between Scottish Government, British Medical Association, Integration Authorities and NHS Boards.[5] This priority requires that additional professional roles will provide services for groups of patients with specific needs that can be delivered by other professionals as first point of contact in the practice and/or community setting. These additional roles should include community clinical mental health professionals (e.g. nurses, occupational therapists, psychological therapists and enhanced practitioners) based in general practice. The MoU envisages that "by 2021 specialist professionals will work within the local MDT to see patients at the first point of contact, as well as assessing, diagnosing and delivering treatment, as agreed with GPs and within an agreed model or system of care. In line with the recommendations in this report, it provides for service configuration to vary dependent upon local geography, demographics and demand." Current system configuration/demands present significant challenges to implementation. This report seeks to describe the kind of system changes which would be required to make this possible.

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[2] Mental Health Strategy for Scotland

[3] Exploring Distress & Psychological Trauma - NHS GG&C Report

[4] Mental health and Primary Care networks - Understanding the opportunities

[5] Memorandum of Understanding between SG, BMA, Integration Authorities and NHS Boards

29. Below are examples of existing models demonstrating how mental health support services are integrated in Primary Care settings:

30. In Lanarkshire, Occupational Therapists (OTs) are working in Primary Care settings offering open access appointments to patients requiring prevention and early intervention solutions. This enables patients to self-manage their condition and build resilience. OTs are skilled in assessing components of everyday occupations and roles that matter to people, identifying the impact of development, physical and mental health conditions on these occupations and devising intervention plans to enable people to overcome such impacts and engage fully in their day to day lives. OTs use scientific bases, and a holistic perspective to promote a person's ability to fulfill their daily routines and roles.

31. Mental Health Liaison Nurses are also used in Lanarkshire, providing triage, assessment and short term intervention to people experiencing mild to moderate mental health problems of a short term nature.

32. In Lothian, Dumfries & Galloway and Lanarkshire, Mental Health Nurses have been recruited to meet the needs of patients with mild to moderate mental health difficulties. Their interventions consist largely of clinical advice/triage, crisis management, case management of those with complex mental health needs, general psychological support, brief intervention, treatment for addiction, independent prescribing and signposting to local services. In Lanarkshire, they have built on this to develop a stepped/matched Mental Health & Wellbeing Service model, using Action 15 funding. It has continued to expand, with the service being rolled out to 40 GP practices.

33. In Ayrshire and Arran, they are increasing mental health provision within Primary Care Teams/Clusters by embedding Community Link Workers and Mental Health Practitioners within Primary Care Teams to assist with sign-posting, access, and provision of time limited interventions. They have seen great value in having Mental Health and Psychological Therapy aligned with Primary Care.

34. In Grampian and Lanarkshire, the Accessible Depressions & Anxiety Psychological Therapies model increases access to psychological therapies and interventions in Primary Care adult mental health and develops the specialist mental health workforce in secondary care. This is achieved through expanding the competencies of the existing workforce to deliver the most effective treatments, developing Primary Care Teams with multiple disciplines and providing guidance and support on the model of service delivery. This enables cost-effective stepped care, patient choice, quality assurance and increases capacity.

35. In Fife, a comprehensive matched care model offers a wide and flexible range of early intervention, self-help, groups and one to one psychological therapy including integrating web based, remote and face to face interventions.

36. In Scottish Borders, a recent development is a partnership between GPs/Primary Care and Mental Health utilising funding from PCIP and Action 15.

This is a collaborative Primary Care service that is currently operating completely remotely, offering a wide range of interventions.

37. The most important common factor is that each of these approaches are moving towards a reframing of the 'task' for Mental Health and support workers in Primary Care settings. The traditional model prioritises triage and diagnosis, with a view to identifying people who will be accepted for care by specialist Mental Health services on the basis of 'mental illness'.

38. A more useful model in Primary Care settings is a prompt and compassionate response to all forms of distress, which is provided at a local level using community assets and peer networks wherever possible. Specialist Mental Health input must be available whenever indicated, but should not be the default response for all presentations.

39. Other common factors in the success of these services are:

- Where available, regular reflective practice (or other wellbeing support) to deliver a sustainable, timely and compassionate mental health service.
- Taking a person centred approach to meet the needs of the person in a timely way.
- Integration with digital/remote Primary Care mental health and wellbeing resources, increasing access to resources such as NHS inform, interactive self-care guides, NHS 24's 24/7 mental health hub, Breathing Space crisis line and computerised CBT.
- Alignment with Primary Care and the use of the wider multi-agency team.
- Close linkage with Social Work and addiction services in the locality.
- Raising GP Awareness about the role and availability of the wider multi-agency team.
- Providing continuity of care.
- Highlighting the importance of providing training, standardised operational procedures and opportunities for feedback.
- Increased GP cluster working.
- Integration of psychological therapy pathways, reflective practice, training and supervision.
- Utilising a stepped/matched care model of evidence based treatment. Fidelity to an evidence based model has been shown to consistently improve outcomes.
- Access is available to the electronic patient records.

40. These factors have resulted in people accessing the correct support quickly, leading to better outcomes for them. This in turn leads to a reduction in GP, GP Practice and clinical attendance rates.

Proposals, Recommendations and Principles

Proposed Model

41. Within an area served by a group of GP practices (this could be a locality, part of a locality or a cluster area) there should be a multi-agency team providing assessment, advice, support and some levels of treatment for people who have mental health, distress or wellbeing problems. The multi-agency team may include Occupational Therapists, Mental Health Nurses, Psychologists, Enhanced Practitioners, Link Workers as well as others such as those providing financial advice, exercise coaches, family support and peer networks.

42. That team would provide assessment and support to the individual to access appropriate levels of advice, community engagement treatment or care – some of which would be delivered within the Primary Care setting, depending on the skills and capacity of the team.

43. The team would work closely with and / or be part of the wider community team in that area, engaging with the wider assets of the community, health and social work staff and with other agencies as appropriate.

44. Although the team would be aligned to a group of GP practices, there should be named members of that team that work closely with each individual practice to provide continuity and allow the development of effective clinical or multidisciplinary team relationships.

45. Practice systems should allow patients to be directed to an appointment with the appropriate members of the MDT based on self-directed care, including self-referral. This option should be publicised and communicated to the practice population.

46. The team would provide timely support and treatment for people in that setting with the GP providing clinical leadership and expert general medical advice where needed. Where more specialist input is required the resources of Community Mental Health Team or other appropriate secondary care Mental Health service would be accessed and work in partnership with the Primary Care team where appropriate (e.g. shared care around medication).

47. The team should have members that are trained in mental health and may be drawn from mental health nursing, clinical psychology or Allied Health Professional (AHP) disciplines. The team should also have members or close links with other staff with relevant expertise and experience e.g. Community Link Workers, Addiction Services, Health Visitors, Health Improvement staff and financial inclusion teams.

48. The SLWG recognises that the use of terminology can be a source of confusion about what we are trying to achieve. The terms Primary Care multidisciplinary team or locality multidisciplinary team have different connotations for different professional and geographic groups. Rather than seek to ‘name this model’, the SLWG has sought to describe the function which local areas can name as appropriate.

49. A critical part of this approach will be a local communications strategy to inform local populations about how they can access services. Tools may range from social media channels, website updates and local newsletters, posters, flyers.

Proposed benefits

50. The Group suggest that this approach would realise a number of improvements that would benefit both individuals and practitioners. An enhanced range of service provision, embedded within a range of wider community assets would mean individuals can be better, and more quickly, connected to the support that meets their needs in the right settings. This will also support more efficient and targeted use of resources across a local area. Better communication across service providers will improve early intervention, continuity of care and better support self-management. The Group also considers that such a model would potentially reduce referrals to specialist services while also improving support for those who do and ensuring it is delivered promptly.

Proposed next steps

51. To further develop this approach, initial work should be undertaken to establish the baseline by identifying the level of support currently available in teams across Scotland, however, they are currently named and described. Posts in the Primary Care setting funded through Action 15 or the Primary Care Improvement Fund should be considered, and any opportunities to further expand capacity through those funds should be supported and encouraged.

52. A needs analysis should be conducted to scope the need for expansion of such a team/service. The expansions should be funded through a proposed Primary Care Mental Health (PCMH) development fund that will be jointly managed through the mental health and Primary Care planning processes within Health and Social Care Partnerships (HSCPs).

53. The development of an asset-based community development should be a collaborative one, led by HSCPs as part of Integration Joint Boards (IJBs) strategic commissioning plans. Local communities and 'experts by experience' should be fully engaged in this. As a minimum, local GP sub-committees, HSCPs, locality management, mental health service leads, psychology leads, interfaces with schools and third sector interface structures should be part of this collaborative approach.

Recommendations

54. To support the implementation of 'the model' described in this paper, the SLWG recommends the following:

- **Recognise the central role of Primary Care** within the Mental Health system and of MH & WB within Primary Care. This should be a priority for development within the MH Services Renewal Plan and also the revision of the GP Contract MoU (through further definition of MH as an "additional role"

for expansion and development). In developing PCMH capacity to deliver a 24/7 service, the principles that we have set out above should be followed.

- **Review existing additional role developments** in PCMH, such as those funded under Action 15 of the Scottish Government's Mental Health Strategy or through Primary Care Improvement Plans (PCIP). This work should be led by a newly established **Development Group**. There should be a partnership between the MoU/PCIP process and the MH planning process at local level with objective of maximising PCMH capacity along the lines of the model described in this paper.

- The same Development Group also undertake a "**gap analysis**" to scope workforce and resource requirements associated with providing a 24/7 service with a view to implementing a **funded PCMH development programme** in 22/23 and thereafter. This should include a plan for monitoring impact of this approach going forward.

- The Development Group would also promote implementation of robust systems to deliver **peer-to-peer decision support between community and specialist services and within Primary Care mental health services** to ensure patients are receiving the best care, from the most appropriate staff, irrespective of where they present in the service.

Annex A

Mental Health in Primary Care Short Life Working Group

Terms of Reference and Membership

1. **Background**

Approximately 1 in 4 people experience a mental health problem at some point in their lifetime and at any one time approximately 1 in 6 people have a mental health problem. Early evidence suggests mental health problems will increase following the Covid pandemic with a disproportionate effect on younger people, women and that a widening of already existing inequalities is likely.

The vast majority of mental health and wellbeing issues can be managed appropriately in the community with self-management, community assets, third sector, primary, community care and specialist mental health services all having a part to play. This can only happen if there is capacity across all parts of the system to support management of problems in a timely way

Approximately 1/3 of GP consultations have a mental health component and this constitutes a significant workload within practice settings. While some people need to access secondary care mental health services, many do not and the limited capacity of specialist services can lead to limits on access through waiting times and rejected referrals.

The Short Life Working Group (SLWG) will set out to describe what an improved range of options in the Primary and Community care settings might look like and how these could be achieved

2. **Purpose**

These guidelines are intended to provide clarity and direction to the activities of the SLWG. They can be revised and amended as necessary once the work is underway.

The overall purpose of the SLWG is to improve outcomes for people with mental health problems and distress within the Primary and Community Care setting.

The expectation is that the final document will be issued within four meetings.

3. **Working Group**

Remit

The SLWG will provide a vision of how mental health care could be delivered better in Primary Care and in localities.

The SLWG will review the models currently in place, identify commonalities/success factors and produce a report with actions, suggesting

how these models could be implemented by health and care systems across Scotland.

Membership

Name	Organisation	Email Address
Andrew Cowie	SGPC	acowie@nhs.net
Carey Lunan	RCGP	carey.lunan@rcgp.org.uk
Laura Hudson	RCPS	laura.hudson@rcpsych.ac.uk
Theresa Fyffe	RCN	theresa.fyffe@rcn.org.uk
Linda Findlay	RCPS	linda.Findlay@lanarkshire.scot.nhs.uk
Alastair Cook	Scottish Government	alastair.cook@gov.scot
Amy Dalrymple	RCN	Amy.Dalrymple@rcn.org.uk
Katriona Paterson	NHS Lothian	Katriona.Paterson@nhslothian.scot.nhs.uk
Grecy Bell	NHS	g.bell@nhs.net
Jan Beattie	Scottish Government	Jan.Beattie@gov.scot
Michael Smith	NHS GG&C	Michael.Smith2@ggc.scot.nhs.uk
Jim Hume	Support in Mind	JHume@supportinmindscotland.org.uk
Judy Thomson	NES	judy.thomson@nes.scot.nhs.uk
Miles Mack	RCGP	Miles.Mack@rcgp.org.uk
Caroline Cochrane	NHS Borders, Representing Heads of Psychology Services	Caroline.Cochrane@borders.scot.nhs.uk
Val de Souza	HSCP	Val.deSouza@southlanarkshire.gov.uk
Ross McGuffie	HSCP	Ross.McGuffie@lanarkshire.scot.nhs.uk
Katrina Cowie	Scottish Government	Katrina.Cowie@gov.scot
Naureen Ahmad	Scottish Government	Naureen.Ahmad@gov.scot
Gordon Mason	Scottish Government	Gordon.Mason@gov.scot
Siobhan Mackay	Scottish Government	Siobhan.Mackay@gov.scot
Heather Campbell	Scottish Government	Heather.Campbell2@gov.scot
Justin McNicholl	Social Work Scotland	JMcNicholl@clacks.gov.uk
Sian Tucker	NHS Out of Hours	sian.tucker@nhslothian.scot.nhs.uk
Anna Armitage	Scottish Government	Anna.Armitage@gov.scot
Niall Kearney	Scottish Government	Niall.Kearney@gov.scot

Sonia Cottom	Patient Representation	scottom@painassociation.com
Eileen McKenna	RCN	eileen.mckenna@rcn.org.uk
Claire McDermott	Scottish Government	Claire.McDermott@gov.scot

4. Method

- **Meeting 1**
  Discuss consensus statement and invite comments by next meeting.
  Discuss evidence paper and strengths/gaps in evidence.

- **Between meeting 1&2**
  Shape consensus statement into a vision.
  Collate additional evidence submitted around models.
  Skeleton report of output.
  Brief Ministers and other relevant stakeholders.

- **Meeting 2**
  Discuss and if possible agree vision.
  Discussion of evidence and describe an agreed model or models.

- **Between 2 & 3**
  Adjust vision.
  First draft of a report with vision, what works and initial estimates of workforce/resource requirements.

- **Meeting 3**
  Discussion of first draft report.
  Discussion about implementation and how that might be managed.

- **Between 3&4**
  Redraft of report to reflect group inputs.
  Draft implementation plan.

- **Meeting 4**
  Final report signs off.
  Discuss implementation plan and agree any next steps.
  Sign off the work of the group and hand over to those tasked with implementation.

5. Timescale

The SLWG will meet monthly or as necessary and agreed by the membership. The first meeting of the group will be Thursday 24th September 2020.

6. Communications

The Scottish Government will co-ordinate communications. There will be a formal minute recorded of each meeting which will be circulated to the members of the group. In this regard, progress updates on the activities of the Working Group will be translated into lines for communication and cleared by Scottish Government and issued to stakeholders for further dissemination.

Public Mental Health and Primary Care
Scottish Government
10 September 2020

Annex B

Mental Health in Primary Care Short Life Working Group

Statement of Intent

1. Background

   Approximately 1 in 4 people experience a mental health problem at some point in their lifetime and at any one time approximately 1 in 6 people have a mental health problem. Early evidence suggests mental health problems will increase following the Covid pandemic with a disproportionate effect on younger people, women and that a widening of already existing inequalities is likely.

   The vast majority of mental health and wellbeing issues can be managed appropriately in the community with self-management, community assets, third sector, primary, community care and specialist mental health services all having a part to play. This can only happen if there is capacity across all parts of the system to support management of problems in a timely way

   Approximately 1/3 of GP consultations (c8million/year) have a mental health component and this constitutes a significant workload within practice settings. While some need to access secondary care mental health services, many do not and the limited capacity of specialist services can lead to limits on access through waiting times and rejected referrals.

   The Short Life Working Group (SLWG) will set out to describe what an improved range of options in the Primary and Community care settings might look like and how these could be achieved.

2. Aim

   To improve outcomes for people with mental health problems and distress within the Primary and Community Care setting.

   By

   Providing a vision of how mental health care could be delivered better in Primary Care and in localities, suggesting models that could be implemented by health and care systems across Scotland.

   Possible elements of that vision:

   That enhanced services within Primary and Community care sit within a wider system that emphasises the value of self-management, access to community assets and linkage to specialist services where required

   That by enhancing access to mental health expertise and resources within the Primary Care setting we will:

- Improve the experience of support and care for those currently already managed in Primary Care through more rapid access to support, within a team that they know and trust, using a shared Primary Care clinical record.
- Reduce the referral burden to specialist services, allowing quicker access to specialist help for those that need it.
- Improve the outcomes for patients through earlier intervention and support.
- Raise awareness and confidence within the wider Primary Care team to support people with their emotional needs.
- Build interfaces with local specialist mental health services (for example, to offer clinical decision support, to plan discharges).
- Build interfaces with local schools, and work collaboratively to support the mental health needs of young people with a common approach and language.
- Support and enable 'reflective practice' for all clinicians managing mental health issues, to sustain compassionate practice and reduce professional burnout.
- Ensure that there is capacity to deliver CBT and other initial talking therapies to support patients with mental health conditions such as anxiety, depression and adverse trauma experience and that this can be accessed directly (face to face or digitally) from Primary and Community care or through self-referral.

This will be achieved by embedding mental health professionals, support workers and others with appropriate skills into Primary Care multidisciplinary teams within clusters or localities. Their role will be to directly assess and support people presenting with mental health problems and distress but also to support the wider Primary Care team in managing mental health problems.

Assessment, advice, support or intervention needs to be tailored as appropriate to the person and a range of skills, expertise and knowledge should be available within the team (or easily accessed by the team) to maximise the options available for individuals and facilitate person-centred care.

Mental health workers in the Primary Care team need to be able to directly access advice, support or make referrals to specialist community mental health teams (CMHTs), psychological therapies (virtual and face to face, individual and group), and Distress Brief Interventions (DBI).

Mental health workers within the Primary Care team would work closely with community link workers (CLWs), peer support workers and third sector and voluntary groups to maximise the assets of their local community.

Depending on the mental health resource and expertise available in the team, there would be the potential for training opportunities for practice based staff, community pharmacists and for all others within the cluster or locality (for example case-based discussion, PLT sessions).

Mental Health workers would support GP practices in the management of acute and ongoing mental health and addiction issues and engage with other community resources to achieve this.

The SLWG is tasked with using the expertise of those on the group to agree the vision and illustrate how this could be implemented by citing examples of good practice, and sharing the available evidence base. The group will also make recommendations about workforce that would be required to support implementation of these models and how that might be deployed.

Drafted with input and comments from Carey Lunan and Miles Mack, RCGP, Linda Findlay, RCPsychiS and Alastair Cook, PMO Mental Health

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Any enquiries regarding this publication should be sent to us at

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

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