

A FRAMEWORK FOR MENTAL HEALTH SERVICES IN SCOTLAND
SECTION 1. PROCESS ELEMENTS

THE INTERFACE BETWEEN PRIMARY CARE, SECONDARY CARE AND SOCIAL WORK¹

Service Element	Description of Needs	Ways in Which Services May Respond
<p>The delivery of community care to people with mental health problems by the primary health care team (PHCT) to a suitable standard.</p>	<p>Clarification of the expectations of the role of the PHCT.</p> <p>The PHCT provides skills which are not normally developed in the mental health service</p> <p>Assessment of the training and development needs of the PHCT to provide care for people with mental health problems.</p> <p>General Practitioners are seen by people who receive mental health services as:</p> <ul style="list-style-type: none"> • the most important gatekeeper to mental health services; • less stigmatising; • having a more positive attitude; • providing continuity of care; • accessible and flexible; <p>but</p> <ul style="list-style-type: none"> • may be too ready to discount physical symptoms co-existing with mental health problems; • may lack information on diagnosis, available treatments and support services. <p>Psychiatric teams provide the following skills not normally available in the PHCT:</p> <ul style="list-style-type: none"> • experience in the diagnosis of psychiatric disorders; • detailed knowledge of drugs, mainly used for psychosis; • specialised psychotherapies; • experience in the use of the mental health legislation; • management of conditions which are rare in primary care. 	<ul style="list-style-type: none"> • Named individuals in the mental health and social work services responsible for PHCT liaison, and regular visits to practice premises. • PHCT attendance is important at assessment, discharge and care planning meetings in complex or contentious cases, or where arrangements are at risk of breakdown. • The PHCT should notify social work of significant changes in an individual's medical condition with implications for social care. • It should be the remit of a named member of the PHCT to identify local resources and liaise with mental health and social work. • The PHCT should notify the mental health services or the local social work team, and, if necessary, the joint commissioning team, of problems or gaps in the local community care arrangements. • The PHCT should examine the potential its various members - district nurses, health visitors, practice nurses and reception staff - have to contribute to the care of people with mental health problems who belong to the practice. • The PHCT should work with mental health service and social work staff to identify the training and support needed by PHCT members, especially in: <ul style="list-style-type: none"> - the early identification of mental health problems²; - understanding available treatments and interventions; - minimising confrontation; - managing aggression; - preventing suicide - operating the legal framework, eg Mental Health Act, CPA, etc. • Training for the specific skills required in the community care of people with mental health problems should be provided jointly for the PHCT, social work, housing and mental health service staff .

¹ "The Role of Primary Care in Community Care Services" (1996) Report CRAG/SCOTMEG Working Group on Mental Illness
"Review of the Literature Relevant to the Development of a Primary Care Strategy for Mental Health" (1993) PRiSM Research Unit, London

² Report of the CRAG/SCOTMEG Framework For Action Working Group on Maternity Services on Detection and early Intervention in Postnatal Depression (1996)

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<p>Input from Mental Health Services</p>	<p>Identification of the resources needed to support the PHCT to allow it to deliver adequate care in the community.</p> <p>This will include:</p> <ul style="list-style-type: none"> - an awareness of vulnerable individuals in the practice; - good practice guidelines jointly developed for common treatable conditions; - specific training requirements identified and met; - clear definition of the roles and responsibilities of the PHCT; - immediate access to specialist mental health services for people who are acutely ill; - access to community-based mental health services; - regular audit and evaluation of services and joint working. 	<ul style="list-style-type: none"> • A 24 hour availability of all essential services to provide back-up to the PHCT, with guaranteed access to emergency specialist care. • A wide range of facilities and services provided in the community near to the individual's home. • Special help provided in areas of high deprivation or high caseload to ensure adequate support for the PHCT. • Improved support for isolated GPs in remote rural areas and Islands, including joint training with the relevant social work department. • Sectorised mental health services, relating to a defined group of PHCTs (second opinions should be available, if required). • Adequate provision of facilities for acute and continuing care. • Reduction in continuing care bed numbers paralleled by adequate community support and crisis/emergency provision. • Full and proper implementation of the Care Programme Approach, involving the PHCT at all stages.
<p>Communication between Primary and Secondary Services.</p>	<p>Timely, accurate and informed communication is required to ensure the provision of "seamless" care to an individual by all the partners in mental health care.</p> <p>To promote "seamless" care of people with mental health problems in the community, close working relationships should be established between the PHCT and social work department assessment and care management services.</p>	<ul style="list-style-type: none"> • Provision of care plans before discharge and prompt transmission of immediate discharge letters (within 5 days) and full discharge summaries (10 days). • Regular face to face PHCT and mental health service liaison. • The mental health service should keep GPs and social work fully informed of any significant withdrawal from a care programme or changes to that programme. • GPs should inform the local mental health service, social workers and/or Mental Health Officer if an individual has become violent or threatening. • When GPs consider the removal of someone with a mental health problem from their list they should inform the local mental health service so it can assist the person find a new GP. • GPs, given adequate notice, will normally attend aftercare meetings for vulnerable people.

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Service Element	Description of Needs	Ways in Which Services May Respond
The PHCT and Social Work	A flexible and responsive working relationship.	<ul style="list-style-type: none"> • Social work departments establish and publicise assessment and care management procedures and eligibility criteria for services. • Social work departments and primary care team work together to develop good working relationships to deliver services. • Care managers attached to PHCTs. • Co-terminous social work team and PHCT boundaries. • Priority is afforded to vulnerable groups (the homeless and roofless, those discharged from hospital, those with a mental health problem living alone, and those with a history of violence or self harm). • Allowance made for variation in need in localities (eg inner city or rural areas) in allocation of resources. • A 24 hour provision of a Mental Health Officer service in each locality, with clear information available to the PHCT about access to the service. • A rapid response to requests for assessments for social care needs in response to social crises or breakdowns in existing care packages (including crisis accommodation and support). • Identification in every individual care plan of a contact telephone number, for use in a crisis within or without normal working hours. • Support for joint training initiatives for the PHCT, mental health service staff and social work assessment and care staff. • Follow up arrangements of people subject to individual CPAs, who move out of the social work team's area, must be carefully arranged.

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This table demonstrates how the care needs of people with mental health problems of different complexity and severity might be addressed.

Level	Type of disorder	Likely course without treatment	Treatment available	Who best provides it	Likelihood of recurrence
1	Disordered reactions to loss and bereavement (prevalence is increasing)	Spontaneous remission	Proven treatments are lacking. Therefore support, practical help, time limited counselling is all that can be given	Members of PHCT, self-help groups, voluntary sector counselling services.	Low
2	Phobic disorder chronic fatigue syndrome, Post Traumatic Stress Disorders (variable prevalence), Post partum depressive illness	Variable remission rates	Talking treatments based on cognitive methods give a fair to good response	Members of PHCT, with support from a member of CMHT from time to time Self-help groups	Some relapses will recur
3	Depressive or panic disorders (high prevalence - may take up a 1/3 of GP's time) and eating disorders	Low spontaneous remission rate	Medication and therapies based on cognitive methods - give a good response	PHCT, but referral to CMHT if no response to first line treatment or if case is complex	High risk of relapse but some prophylactic treatments available
4	Severe and/or enduring mental health problems (low prevalence)	Very unlikely to remit spontaneously	Medication and psycho therapies (especially cognitive and support for carers). Fair to good response but treatment needed in long term. CPA likely to apply and Mental Health (Scotland) Act 1984 to be used	Care shared between PHCT and CMHT. Mental Health Officers will be involved when the 1984 Act is used or is considered. Special housing needs possible.	High risk of self harm, relapses and/or chronicity without continued input by CMHT in liaison with PHCT

PHCT - Primary Health Care Team
CMHT - Community Mental Health Team
CPA - Care Programme Approach