Overview of mental health services

EMBARGOED UNTIL 00.01 HOURS THURSDAY 14 MAY

AUDIT SCOTLAND

Prepared for the Auditor General for Scotland and the Accounts Commission
May 2009

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Acknowledgements:

Audit Scotland would like to thank the members of the project advisory group for their input and advice throughout the study (Appendix 1).

We are also grateful to everyone who provided us with information and assisted us with this study, including the participants of our focus groups.

Thanks also to Alan Ross of Ross Consulting for carrying out the service user and carer focus groups.

Jillian Matthew managed the project with support from Christopher Spratt, Lynn Conway, John Simmons (consultant) and John Jackson (Scottish Development Centre for Mental Health), under the general direction of Claire Sweeney.

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Contents

Summary

Mental health problems cause considerable poor health in Scotland and more services are being provided in the community instead of institutions.

Background

1. It is estimated that there are up to 850,000 people with mental health problems at any one time in Scotland.[1] Mental health problems can affect anyone but some people have a higher risk of developing them, including people living in deprived areas, people with drug or alcohol problems, people with physical illnesses and black and minority ethnic groups.[2]

2. People with mental health problems may require different services depending on their condition. A wide range of mental health services are provided by: the NHS, in hospital and community settings; councils through social work, education, leisure, housing and employment services; and voluntary and private organisations. The police and prison service also have an important role. In addition to formal care, family and friends provide a considerable amount of unpaid care.

3. There have been significant developments over the last ten years in the way that mental health services are delivered, with a focus on shifting resources and care into the community and a move away from large, long-stay institutions. The Mental Health (Care and Treatment) (Scotland) Act 2003 has created a new legislative framework for Scotland, with a greater focus on advocacy and the rights of the individual. There is also a greater focus on recovery, which involves supporting people to be active in managing their own healthcare and to carry out everyday activities even with ongoing symptoms.

About the study

4. This report provides an overview of mental health services across Scotland and is the first in a series of planned reports in this area. We have carried out an overview to highlight areas for improvement and to identify priorities for future audit work. We looked at mental health services provided by the NHS, councils, prisons, the police and the voluntary sector across Scotland for people of all ages. Our study examines the accessibility and availability of services and how much is spent on them. We have not looked at the implementation of the new Mental Health Act as the Scottish Government is currently reviewing this. In this study, we:

- analysed published data and research on mental health, using information relating to Scotland where available. Where information relates to the United Kingdom as a whole we highlight this in the text. There are gaps and quality issues around some of the national data available which is highlighted throughout the report but we have used these in the absence of better information
- reviewed documents and interviewed staff at the Scottish Government, special NHS boards, the Scottish Prison Service and the Association of Chief Police Officers in Scotland (ACPOS)
- carried out detailed fieldwork in three areas across Scotland – Glasgow, Highland and Tayside – which included interviews with local councils and NHS boards and reviewing available local data[3]
- held focus groups with, and interviewed staff from, various voluntary organisations
- held focus groups with people who have used mental health services and their carers (see *Report on user and carer views* available on our website at www.audit-scotland.gov.uk)
- received several good practice examples from NHS boards and councils across Scotland (see *Summary of good practice* on our website)
- highlight issues for non-executive NHS board members to raise within their boards (see *Issues for non-executive NHS board members* on our website)
- make recommendations for the Scottish Government and local partners. Local partners include NHS boards, councils, the police, the prison service and the voluntary sector.

5. This report is structured into four main parts:

- Contextual information on the scale of mental health problems and services in scotland (Part 1).
- Accessibility of mental health services (Part 2).
- Delivery of mental health services (Part 3).
- Expenditure on mental health services (Part 4).

1 *The World Health Report 2001 – Mental Health: New Understanding, New Hope*, World Health Organisation, 2001.
2 *National Service Framework for Mental Health: Modern Standards and Service Models*, Department of Health, London, September 1999.
3 NHS Greater Glasgow and Clyde, Glasgow City Council and Renfrewshire Council; NHS Tayside and Dundee City Council; NHS Highland and Highland Council.

Key messages

- Mental health problems cause considerable poor health in Scotland. Rates of suicide in Scotland are higher than in England and Wales. Mental health problems can affect anyone but people who are likely to be socially excluded, such as people living in deprived areas, are at higher risk.

- Basic management information on waiting times, staffing levels, vacancies and caseloads is needed for agencies to plan and manage mental health services more effectively. In areas where we carried out fieldwork, we found evidence of children and adolescents waiting a long time to access services. This is likely to reflect the picture across Scotland.

- There have been significant developments in the way that mental health services are delivered, with a focus on shifting resources from hospitals to the community. Community services have developed in the last ten years but there is insufficient information about how well resources are being used and what difference they are making to assess how well they are working.

- People with mental health problems often receive services from more than one agency. Strong partnership working is essential to plan and deliver effective mental health services. Different information systems are used by NHS boards and councils and this limits their ability to deliver joined-up, responsive services. Services out of hours and at times of crisis are not well developed in all areas.

- The wider costs of mental health problems are over £8 billion a year. The NHS spent £928 million on mental health services in Scotland in 2007/08 but this is likely to be an underestimate as there is limited information on the spend on mental health services in the community. The total amount spent by councils on mental health services is unknown.

Key recommendations

The Scottish Government and local partners should:

- ensure that they work together to deliver services for people with mental health problems which are joined up and that appropriate services are provided on the basis of need

- collect information about services in the community to enable better planning and development of services.

Local partners should:

- work together to identify and address any gaps in services, including services for children adolescents and older people and the availability of psychological therapies

- continue to monitor and develop the move from hospital to community services, ensuring that the resources to support this change are transferred as necessary

- ensure that data on waiting times for mental health services are collected routinely. Action should be taken to address services with long waiting times

- use the Audit Scotland checklist detailed in Appendix 3 to help improve the delivery and impact of mental health services through a joined-up, consistent approach.

6. External auditors will be following up progress against the recommendations made throughout our report based on the self-assessment checklist for local partners in Appendix 3.

Part 1. Mental health in Scotland

One in four people will experience a mental health problem at some point in their lives.

Key messages

- Mental health problems cause considerable poor health in Scotland and one in four people will experience mental health problems at some time. Levels of most mental health problems are comparable to those in England and Wales but suicide rates in Scotland are higher.
- People who are likely to be socially excluded have a higher risk of developing mental health problems. This includes people living in deprived areas, children in care, people with drug or alcohol problems, black and minority ethnic groups, homeless people and prisoners.
- Many public sector bodies are involved in providing mental health services. In addition, voluntary agencies and unpaid carers provide a significant amount of support to people with mental health problems.
- There is a lot of support among mental health professionals for recent mental health policy and improvement initiatives.

Mental health problems cause considerable poor health in Scotland

7. The World Health Organisation estimates that one in four people will have a mental health problem at some point in their lives and one in six experiences this at any given time.

8. There is a wide range of mental health conditions with varying symptoms and severity, for example depression, eating disorders, bipolar disorder and schizophrenia. We use the term mental health problems to describe the full range of conditions. Mental illness refers to severe and enduring problems, such as schizophrenia, bipolar disorder and clinical depression. The misuse of drugs and alcohol is associated with mental health problems, either as the cause or to relieve symptoms.[4] Children can have emotional, behavioural and hyperactivity disorders.[5] Conditions such as eating disorders, self-harm, depression and early onset psychosis can start in childhood and continue into adulthood.[6]

9. People can have mental health problems for a short period of time, can relapse repeatedly over long periods of time or have severe mental illness for most of their lives. It can be difficult to identify people with mental health problems if they do not seek professional advice or are reluctant to reveal their condition to those around them due to a perceived stigma.

Depression and anxiety combined is the most common mental health problem

10. The most common mental health problem is depression and anxiety together, with 108 women per 1,000 and 68 men per 1,000 reporting this condition.[7] Nine per cent of the Scottish population aged 15 and over (more than 300,000 people) are estimated to take antidepressant drugs on a daily basis.[8]

11. Anxiety, depression and phobias affect people of all ages. However, depression is the most common mental health problem for older people living in the UK and it is estimated that one in four people aged 65 or over have depression severe enough to impair their quality of life.[9] Depression and anxiety are also common in people with long-term medical conditions, such as diabetes.[10]

Dementia is under-reported and is likely to be a growing problem

12. Dementia is more common in older people but can also affect younger adults. Alzheimer Scotland estimates that, in 2008, up to 66,000 people in Scotland had dementia and that up to 1,600 of these people were under the age of 65.[11] Health service data, based on contacts with general practice, show significantly lower numbers but these are likely to be an underestimate of the number of people with dementia. In Scotland, 30,846 people were registered by their GP as having a diagnosis of dementia in 2007/08, and it is estimated that 20,586 people consulted a GP or practice nurse in relation to their dementia.[12]

13. Alzheimer Scotland predicts that, due to the ageing population, the number of people with dementia will increase by 75 per cent to up to 114,000 by 2031.

Severe and enduring mental illness affects over 40,000 people

14. Data from GP registers in 2007/08 show that there are 43,135 people in Scotland recorded as having severe and enduring mental illness, such as schizophrenia or bipolar disorder. Figures on individual conditions are not available from GP registers, although in 2004 NHS boards identified over 12,000 individuals with schizophrenia who were in contact with their services.[13] Schizophrenia affects men and women equally and seems to be more common in urban areas and in some minority ethnic

4 Mental health information on Royal College of Psychiatrists' website: http://www.rcpsych.ac.uk
5 *Needs Assessment Report on Child and Adolescent Mental Health*, Public Health Institute of Scotland, 2003.
6 *Children and Young People's Mental Health: A Framework for Promotion, Prevention and Care*, Scottish Executive, 2005.
7 *Psychiatric morbidity among adults living in private households*, Office of National Statistics, 2000. This was a UK-wide survey.
8 Practice Team Information on Information Services Division Scotland website: http://www.isdscotland.org/isd/1044.html
9 *Promoting mental health and well-being in later life*, Age Concern and the Mental Health Foundation, June 2006.
10 *Managing long-term conditions*, Audit Scotland, 2007.
11 *Dementia factsheet*, Alzheimer Scotland, 2008. http://www.alzscot.org
12 Quality and Outcomes Framework and Practice Team information on Information Services Division Scotland website: http://www.isdscotland.org/isd/
13 *A review of schizophrenia services in Scotland*, NHS Quality Improvement Scotland, 2004.

Exhibit 1

Mental health problems in children aged 5-16 years in Scotland in 2004
One in 12 children and adolescents are estimated to have a mental health problem.

Type of disorder	Percentage of population	Number affected
Emotional disorder	2.5	16,724
Behaviour disorder	5.5	36,793
Hyperactivity disorder	1.6	10,703
All disorders	8.3	55,524

Note: Emotional disorders include anxiety, depression and obsessions; hyperactivity (also known as hyperkinetic) disorders are those involving inattention and overactivity; and behavioural (also known as conduct) disorders are characterised by awkward, troublesome, aggressive and antisocial behaviours.
Source: *The mental health of children and adolescents in Great Britain*, Office of National Statistics, 2004

groups. It is rare before the age of 15, but can start at any time after this, most often between the ages of 15 and 35.[14]

Suicide rates are higher than in England and Wales

15. Rates of suicide in Scotland are among the highest in Western Europe and higher than those in England and Wales, at 18.7 per 100,000 population compared to 10.2 in England and Wales.[15] The reasons for such high rates of suicide in Scotland compared to England and Wales are not known but it is likely that there are a number of factors, including differences in how deaths are investigated, how cause of death is determined, and Scotland's higher levels of deprivation and of alcohol and drug misuse. Not all people who take their own lives have been diagnosed with a mental health problem.

16. In 2007, there were 838 deaths from suicide in Scotland and the suicide rate for men was almost three times that for women.[16] The rate of suicides has reduced by 13 per cent since 2002 but suicide remains a leading cause of death for people aged under 35, particularly men. An investigation into suicides in Scotland found that there were 5,054 suicides between 2000 and 2005 and that only 28 per cent of people who had taken their own lives (1,396) had recently been in contact with mental health services.[17]

One child or adolescent in 12 has a mental health problem

17. In 2003, the most common problems of children and adolescents who were referred to child and adolescent mental health services were attention deficit hyperactivity disorder, behavioural problems, anxiety problems and mood disorders.[18] In 2004, the level of mental health problems identified in Scottish children aged 5-16 years was estimated at just over eight per cent of the population, which is over 55,000 children (Exhibit 1).

18. In 2006/07, a survey of around 2,000 school pupils in Scotland aged 15-16 found that 13 per cent reported they had self-harmed, the majority of whom had done so in the last 12 months.[19] Girls were over three times more likely to report self-harm than boys. A number of factors were associated with self-harm including bullying, worries about sexual orientation, other people they know self-harming, anxiety, drug use, physical abuse and relationship problems.

Socially excluded people are at greater risk of developing mental health problems

19. Mental health problems are a greater problem for people who are socially excluded compared to the rest of society, and their access to services can be more difficult. For example:

- There are higher levels of mental health problems in deprived areas. The number of deaths from suicide for people living in Scotland's most deprived areas is four times the number living in least deprived areas (755 compared to 178 people).[20]
- Nearly half (45 per cent) of all children looked after by councils, for example those living in care homes, have mental health problems.[21]
- Up to three in four people using drugs have mental health problems and up to one in two people with alcohol problems may have a mental health problem.[22] People who misuse drugs or alcohol and have mental health

14 Royal College of Psychiatrists information, http://www.rcpsych.ac.uk
15 *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Lessons for Mental Health Care in Scotland*, University of Manchester, June 2008.
16 Scottish Public Health Observatory, http://www.scotpho.org.uk
17 *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Lessons for Mental Health Care in Scotland*, University of Manchester, June 2008.
18 *Needs Assessment Report on Child and Adolescent Mental Health*, Public Health Institute of Scotland, 2003.
19 *Self-harm in adolescents: self-report survey in schools in Scotland*, R O'Connor, S Rasmussen, J Miles and K Hawton, The British Journal of Psychiatry, 194: 68-72, 2009.
20 *Suicide statistics*, Scottish Public Health Observatory, 2008. http://www.scotpho.org.uk
21 *The mental health of young people looked after by local authorities in Scotland*, Office of National Statistics, May 2004.
22 *Mind the Gaps: Meeting the needs of people with co-occurring substance misuse and mental health problems*, Scottish Executive, 2003.

problems tend to experience difficulties in accessing either mental health or drug and alcohol services.

- In England, it has been shown that rates of mental health problems are higher for black and minority ethnic groups than for the rest of the population but there is insufficient evidence to know if the same is true for Scotland.[23] A number of factors can make black and minority ethnic people living in Scotland more at risk of developing mental health problems, including difficulties in securing employment and housing, the stress of being in a different country, racism, discrimination, and social isolation.[24]

- Approximately half a million people living in Scotland are lesbian, gay, bisexual or transgender (LGBT).[25] There are higher rates of mental health problems among LGBT people than in the general population, particularly depression, anxiety, suicide and self-harm.[26]

- People living in bed and breakfast accommodation or hostels are eight times more likely than the general population to experience mental health problems, and those sleeping rough are 11 times more likely.[27]

- Seven in ten prisoners have been identified as having mental health problems.[28] Recently Her Majesty's Chief Inspector of Prisons for Scotland found that 4.5 per cent of adult prisoners had severe and enduring mental illness compared to around 2.5 per cent in the general population. The majority of prisoners with mental health problems also misuse drugs.[29]

Organisations must work together to provide a range of mental health services

20. People with mental health problems, particularly those with severe and enduring mental illness, may need a range of services from treatment through to support with daily living and housing. It is important that the NHS, councils and voluntary and private organisations work together in partnership to deliver joined-up services to meet the needs of their local population.

21. NHS boards provide mental health services in both hospital and in the community. Councils are responsible for putting in place social care and support services in the community as well as providing a range of other services to support people with mental health problems, such as help to get back into employment. Education services are involved in providing care and support to children and adolescents. Wider services are also important for promoting well-being, including leisure, recreation and community regeneration.

22. Access to the majority of mental health services is generally through a GP, although referral processes may vary in some areas. Specialist mental health services, such as those provided by community mental health teams (CMHTs) and hospital psychiatry services, should be targeted at people who need the most support, including people with mood disorders, such as depression and anxiety, and severe and enduring mental illness.

23. Specialist services aimed at particular mental health problems may be provided on a regional basis, for example the North of Scotland regional planning group has set up a managed clinical network for eating disorders. Forensic services are in place for the care of mentally disordered offenders and can be provided in hospital, prison or the community. The State Hospital, a high secure forensic facility, is a national service for both Scotland and Northern Ireland and there are a number of medium secure forensic units across Scotland. Other services, such as NHS 24 (a 24-hour helpline which provides health advice and refers people to appropriate services as necessary) and the Scottish Ambulance Service, can provide out-of-hours and emergency care for people with mental health problems.

24. The voluntary and private sectors provide a wide variety of mental health services which are either commissioned by statutory agencies or provided independently by the organisations themselves. Examples of services range from advocacy, advice and support, through to care at home and the provision of supported accommodation. In addition to formal services, family and friends provide a considerable amount of unpaid care.

A wide range of professionals are involved in delivering mental health services

25. People with mental health problems can come into contact with a variety of staff. People may be diagnosed and treated by their GP or other members of the practice team. GPs may refer people to a CMHT, which usually consists of community psychiatric nurses. CMHTs may also include a number of other professionals within or linked to the team from the NHS and other agencies, including psychiatrists, clinical psychologists, pharmacists, allied health professionals (eg, occupational therapists), support workers and social workers. GPs may

23 *Equal Services? Report of Race Equality Assessment of Mental Health in NHS boards*, National Resource Centre for Ethnic Minority Health, October 2007.
24 *Equal minds*, Scottish Development Centre for Mental Health and Scottish Executive, October 2005.
25 *Ibid.*
26 *LGBT Community Needs Assessment*, LGBT Centre for Health and Wellbeing, September 2007.
27 *Homelessness: A primary care response*, N Wright, Royal College of General Practitioners, 2002.
28 *Annual Report 2005-06*, Her Majesty's Chief Inspector of Prisons for Scotland, November 2006.
29 *Out of Sight: Severe and Enduring Mental Health Problems in Scotland's Prisons*, Her Majesty's Chief Inspector of Prisons for Scotland, December 2008.

refer people with severe or complex symptoms to a psychiatrist for diagnosis and initial treatment.

26. Social workers should ensure that appropriate services are provided to support people with mental health problems, including social, housing, employment and benefit advice services. Mental Health Officers (MHOs) are social workers with specialist training in mental health. They have a range of statutory duties under the Mental Health Act and other legislation, for example a person cannot be detained in hospital without the consent of a MHO, except in an emergency.

There is strong support for recent policy and improvement initiatives

27. There have been significant developments in mental health policy over the last ten years building on the *Framework for Mental Health Services in Scotland* in 1997 (Appendix 2). *Delivering for Mental Health* is the current national plan for improving mental health services and covers the prevention and treatment of mental health problems. It sets out the key services that should be available across Scotland and identifies targets for NHS boards and priorities for local partners. The plan covers all ages but there is also a separate mental health strategy for children and adolescents.

28. The Mental Health Act has made significant changes to the existing legislation, with the aim of ensuring that the rights of those affected by the Act are protected and that they receive the most effective care and treatment. The Act introduced community-based compulsory treatment orders as an alternative to hospital detention and, from May 2006, gave patients detained in the State Hospital the right to appeal against the level of security in which they are held. Up to March 2008, 39 patients successfully appealed against being held in the State Hospital and were transferred to forensic units with lower levels of security.

29. There is strong support across all professional groups within the NHS, councils and the voluntary sector for recent mental health policy developments, particularly in relation to the principles of the new Mental Health Act, *Delivering for Mental Health* and the development of standards for integrating services.

People are being supported to recover from mental health problems

30. There is now a greater focus on recovery within mental health services. This involves supporting people to be active in managing their own healthcare and to carry out everyday activities, even with ongoing symptoms. The Scottish Recovery Network, with Scottish Government support, is developing a tool, known as the Scottish Recovery Indicator, to help service providers to develop their services in a way that supports people to recover from long-term mental health problems.[30]

31. The Scottish Recovery Indicator was piloted in five NHS boards during 2007. An evaluation of the tool showed it could help services make changes to strengthen their approach to recovery.[31] The tool is currently being further developed and the Scottish Government has committed to roll it out across Scotland by 2010.[32]

32. As part of promoting recovery within mental health services, peer support workers were employed to work within teams in inpatient wards and community mental health teams in five NHS boards in 2008 (Forth Valley, Grampian, Greater Glasgow and Clyde, Lothian and Tayside). Peer support workers will themselves be in recovery from a mental health problem and have been trained to support other people using their own experiences and knowledge. This approach will be evaluated to see if it should be rolled out across Scotland.

30 Scottish Recovery Network website: http://www.scottishrecovery.net/content/
31 *Evaluation of the Scottish Recovery Indicator Pilot in Five Health Board Areas in Scotland*, Scottish Government Social Research, 2008.
32 *Delivering for Mental Health*, Scottish Executive, 2006.

Part 2. Accessibility of mental health services

Staffing levels are affecting the availability of some mental health services and can lead to long waiting times.

Key messages

- There is limited information on mental health staffing, vacancy levels and caseloads. Available data show that there are high vacancy rates for certain professional groups and particular problems in recruiting staff in some areas. This affects the availability of services and can lead to long waiting times for services.
- Basic management information on waiting times is needed for agencies to plan and manage mental health services more effectively. In areas where we carried out fieldwork, we found evidence of children and adolescents waiting a long time to access services. This is likely to reflect the picture across Scotland.
- People who are likely to be socially excluded find it more difficult to access mental health services than the rest of the population. People from minority ethnic groups, those with sensory impairment, homeless people, prisoners and people with drug or alcohol problems find it harder than most people to access the mental health services they need.

Staffing levels are affecting the availability of services

33. A lack of information on mental health staffing and waiting times makes it difficult to plan and target resources effectively. Different professionals are involved in providing mental health services but there are gaps in information on staffing, such as information on caseloads and vacancy levels for some staff groups.

Exhibit 2

Number of doctors in medical and psychiatry specialties, 2001-2008

There has been an increase in the number of doctors in most mental health specialties.

	2001 (WTE)	2008 (WTE)	Change between 2001 and 2008 (%)
All medical specialties	8,004.7	10,752.6	34
All psychiatric specialties	875.1	989.7	13
General psychiatry	569.4	651.8	14
Old age psychiatry	100.8	109.0	8
Child and adolescent psychiatry	92.2	91.5	-1
Forensic psychiatry	37.6	49.4	31
Psychiatry of learning disability	46.2	49.3	7
Community psychiatry	10.1	23.3	130
Psychotherapy	18.8	15.5	-17

Notes:
1. Whole-time equivalent (WTE) adjusts headcount staff figures to take account of part-time staff and is calculated by dividing the number of hours worked by the number of staff to give the equivalent number of staff working full-time hours.
2. Forensic psychiatry includes doctors working in the State Hospital and medium secure units and community settings across Scotland.
3. Community psychiatry is listed as a separate sub-specialty but psychiatrists in other sub-specialties also work in the community.
Source: NHS Scotland Workforce Statistics: Hospital, community and public health service medical and dental staff by specialty over time, Information Services Division Scotland, 2008

Information on waiting times is not collected nationally, but where this information is available we found significant variations in how long it takes to access services in some areas.

The number of psychiatrists has increased but some areas have high consultant vacancies

34. Since 2001, there has been a 13 per cent rise in the number of whole time equivalent (WTE) doctors (consultants, career and training grades) working in psychiatry, from 875 to 990 (Exhibit 2). This compares with a 34 per cent rise in all medical specialties. The increase in psychiatrists disguises a small drop in the number of child and adolescent psychiatrists and psychotherapists.

35. Vacancy rates are not available for all doctors working in psychiatry but the vacancy rate for consultants is higher than that for all medical specialties (7.8 per cent compared to 4.2 per cent).[33] In 2008, there were 40.3 WTE consultant vacancies within all psychiatry specialties, half of which were in general psychiatry.

36. Vacancy problems are concentrated in a relatively small number of NHS boards. For example, NHS Dumfries and Galloway has a consultant psychiatry vacancy rate of 15 per cent (2.5 WTE), Lanarkshire 22 per cent (12 WTE), Highland 23 per cent (6 WTE) and Ayrshire and Arran 25 per cent (7.6 WTE). Many of these posts have been vacant for several years.

Access to psychologists varies across Scotland

37. In 2008, there were 581.9 WTE clinical and other applied psychologists working in the NHS in Scotland.[34]

33 NHS Scotland Workforce Statistics: Hospital, community and public health service medical and dental staff by specialty over time on Information Services Division Scotland website: http://www.isdscotland.org/isd/5390.html
34 Clinical psychologists include staff whose professional group is clinical psychology, clinical health psychology, clinical forensic psychology or clinical neuropsychology. Other applied psychologists include staff from counselling psychology, health psychology, forensic psychology and neuropsychology.

Of these, just over half (322.6 WTE) were working in mental health, which was an increase of 17 per cent compared to 2007.[35] Vacancy data for psychologists are not available nationally. Access to psychology services is important as the Scottish Government aims to reduce the rate of antidepressant prescribing, which is likely to lead to more people needing access to treatments such as psychological therapies (see Part 3).

38. There are differences in staffing levels depending on the age of the service user. Across Scotland as a whole, the staffing ratio of mental health psychologists for specific age groups varies:

- 8.0 WTE psychologist per 100,000 population for those aged under 20
- 6.7 WTE psychologist per 100,000 for those aged 20-64 years
- 0.6 WTE psychologist per 100,000 for those aged 65 and over.

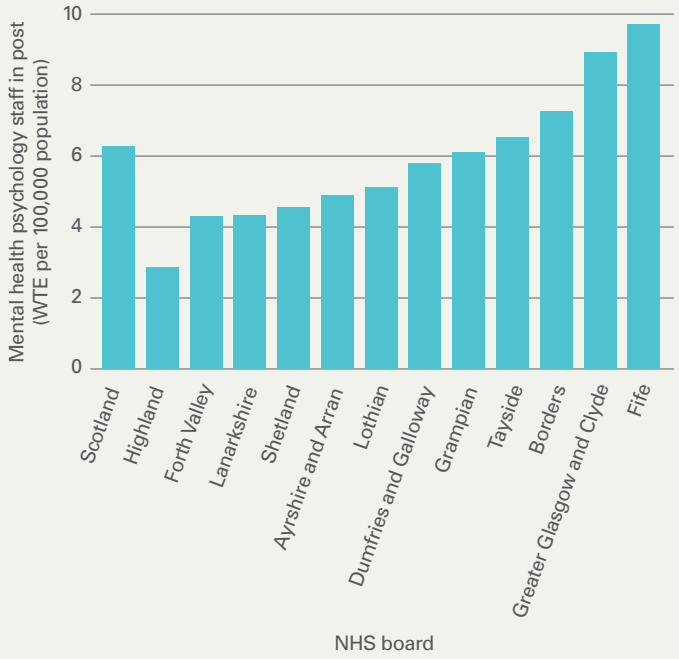
39. As well as age-related differences there are also geographical differences with significant variation in psychology staffing levels among NHS boards in Scotland. For example, of the mainland NHS boards, Highland, Forth Valley and Lanarkshire have the lowest number of mental health psychologists per head of population (2.85, 4.30 and 4.32 WTE per 100,000 population respectively). This compares to NHS Greater Glasgow and Clyde with 8.92 WTE per 100,000 population and NHS Fife with 9.71 WTE (Exhibit 3). National data on waiting times are not available therefore it is not possible to identify the effect that vacancy levels are having. However, it is widely recognised that waiting times for psychology services can be too long.

40. Our fieldwork sites provided information which is likely to be indicative of the situation across Scotland. In July 2008, 40 per cent of people referred to psychology services were waiting over 18 weeks in one Community Health Partnership (CHP) area in NHS Tayside, with the longest wait almost one year. NHS Tayside has recently addressed vacancy and sickness problems and waiting times have improved after July 2008. In January 2009, no one was waiting over 18 weeks for adult psychological therapies in any of Tayside's three CHPs, however, 40 per cent of those referred to older people psychology services were waiting over 18 weeks. In NHS Highland, there were very long waiting times to access psychological therapies in two out of its four CHPs with average waiting times of 58 and 77 weeks. In NHS Greater Glasgow and Clyde, waiting times ranged from less than a week to 20 weeks across four local areas. The majority of people referred to psychology services in NHS Greater Glasgow and Clyde will have already been assessed by a CMHT.

Exhibit 3

Staff working in mental health psychology services in the NHS per 100,000 population, 2008

Staffing levels for mental health psychology services vary across NHS boards.



Note: NHS Orkney and Western Isles do not have any psychology staff working in mental health.
Source: *Characteristics of the Workforce Supply in 2008, Workforce Planning for Psychology Services in NHSScotland*, NHS National Services Scotland, 2008

41. In addition to psychology staff, there are a number of other professionals across Scotland (including nurses and occupational therapists) who have been trained to provide some psychological therapies, such as cognitive behaviour therapy. The Information Services Division (ISD) of NHS National Services Scotland plans to start collecting data about the availability of psychological therapies later this year but these are not currently available. The Scottish Government and NHS Education Scotland are also looking at referral pathways which will link to this work and inform how waiting times should be measured for psychology services.

There is likely to be a shortage of MHOs to cope with recent legislative changes.

42. In 2008, a Scottish Government survey identified that 622 WTE social workers were employed as MHOs in Scotland. The majority of MHOs (around

35 *Characteristics of the Workforce Supply in 2008, Workforce Planning for Psychology Services in NHSScotland*, NHS National Services Scotland, 2008.

70 per cent) also carry out a general social work role. Around half of MHOs (325 WTE) work in specialist mental health teams, including 168 WTE working in multidisciplinary CMHTs. The survey report identified that those not working within specialist mental health teams spend an average of six hours per week on MHO-related work.[36]

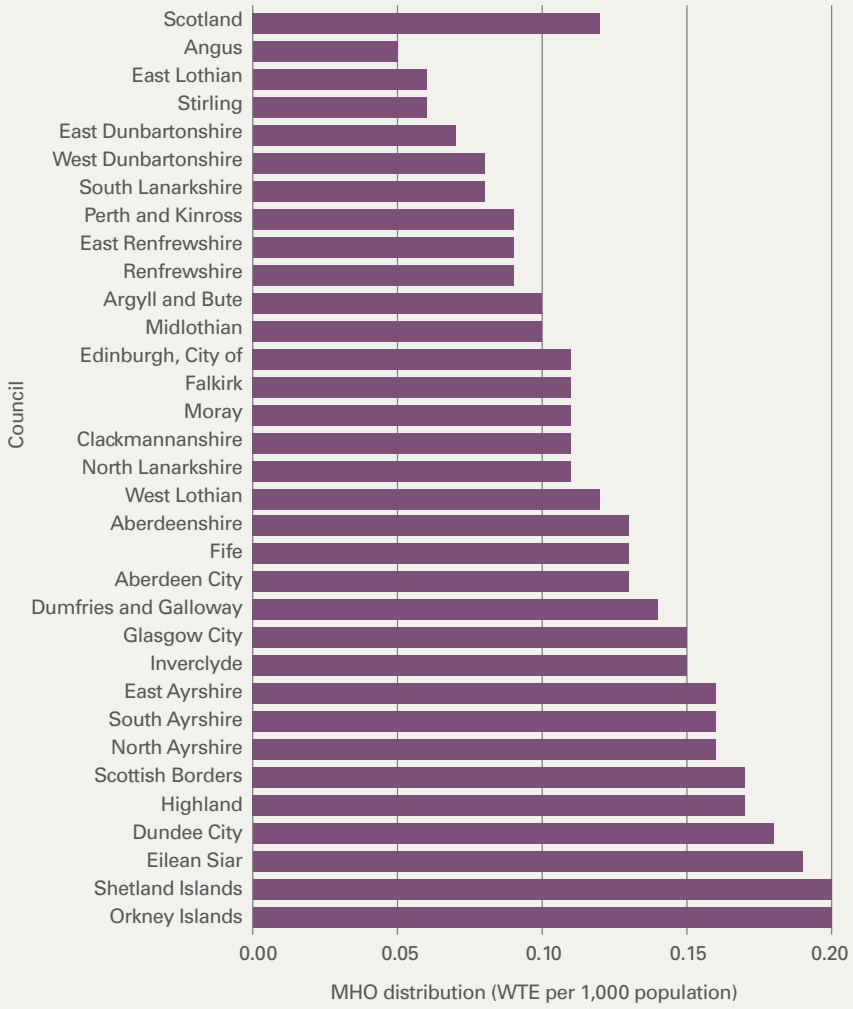
43. There is considerable variation across councils in the numbers of MHOs in post. Excluding the islands, this ranges from just over 0.05 MHO per 1,000 population in Angus Council to 0.18 in Dundee City Council (Exhibit 4). There are limitations in comparing the numbers of MHOs in post as there are no routine data on how much time MHOs spend specifically on mental health work.

44. There are no national vacancy data for MHOs but 14 councils identified a shortfall of MHOs in their area, which amounted to an estimated total of nearly 1,000 hours (25.6 WTE posts) per week across Scotland.[37] North Ayrshire and North Lanarkshire had the highest estimated shortfalls at 140 and 105 MHO hours per week respectively. The most common areas where shortfalls were identified were in services for older people, children, people with learning disabilities and forensic services. General social workers are likely to have people on their caseloads with mental health problems but this is not quantified.

Exhibit 4

Mental Health Officers per 1,000 population by council, 2007/08

There is significant variation in the number of MHOs working in councils across Scotland.



Note: Around 70 per cent of MHOs carry out general social work roles in addition to MHO-related work and the amount of time spent on MHO work will vary considerably.
Source: *Mental health officers staffing,* Scottish Government, 2008

There are long waiting times for services for children and adolescents

45. The provision of specialist child and adolescent mental health (CAMH) services across Scotland varies considerably. Children and adolescents can experience long waiting times or gaps in specialist care. Waiting times have been recognised as a problem in these services along with a lack of early intervention and prevention work.[38, 39]

46. Our fieldwork sites showed that waiting times continue to be a problem for children and adolescent services. In July 2008, 27 per cent of children and adolescents in NHS Tayside and 40 per cent in NHS Highland were waiting over 18 weeks for a first assessment by a CMHT and some had been waiting for outpatient appointments for over a year. NHS Greater Glasgow and Clyde were unable to provide figures for July 2008 but in February 2009 they reported that 59 per cent of children and adolescents in Greater Glasgow were waiting over 18 weeks to see a CMHT and 16 per cent had been

36 *Mental health officers staffing*, Scottish Government, 2008.
37 *Ibid.*
38 *Only connect: Addressing the emotional needs of Scotland's children and young people*, NHS Health Scotland, 2006.
39 *Needs Assessment Report on Child and Adolescent Mental Health*, Public Health Institute of Scotland, 2003.

waiting for over a year. The Scottish Government is developing an NHS target on delivering faster access to mental health services for children and adolescents during 2009/10. The specific requirements and timescales for the target have yet to be agreed.

47. National guidance states that CAMH services should be provided up to 18 years of age but this has not been implemented by all NHS boards.[40] Around half of NHS boards provide a specialist service to young people up to the age of 18. In other NHS boards CAMH services vary: some only provide services up to the age of 16 and others provide services to 16-17-year-olds still attending school. In the areas not providing CAMH services to 16-17-year-olds they are seen as part of adult services.[41]

48. The Mental Welfare Commission for Scotland is a statutory, independent organisation which ensures that the rights and welfare of everyone with a mental illness, learning disability or other mental disorder are protected.[42] Mental Welfare Commission guidance and the Mental Health Act state that age-appropriate mental health treatment should be available.[43] The Mental Welfare Commission has stated that, where possible, children and adolescents under 18 should not be placed in adult wards but, when this is the only option, there should be access to additional age-appropriate services such as clinical input from a CAMH specialist and access to a social worker. In 2007/08, there were 142 admissions of children and adolescents under 18 to adult wards, which represented an overall 24 per cent reduction from the previous year.[44] However, in six NHS boards the number of admissions increased (Borders, Dumfries and Galloway, Fife, Forth Valley, Lanarkshire and Lothian). See Part 3 for further information on the availability of adolescent beds.

49. *Delivering for Mental Health* made a commitment to halve the number of admissions of children and adolescents to adult hospital beds by 2009 (from 186 admissions in 2006/07 to 93 in 2009/10). A further reduction of around 24 per cent is required during 2009/10 to meet this commitment.

Staff shortages are a barrier to providing a comprehensive child and adolescent service

50. In 2005, a review of the child and adolescent mental health workforce in Scotland estimated that double the number of staff are needed to provide a comprehensive service and to deliver government policies (from 555 to between 1,200 and 1,450 WTE).[45] This estimate was calculated on the information available on the workforce at that time. Work has been carried out to improve information about the CAMH workforce which should enable agencies to better plan specialist services over the next few years.[46]

51. In 2007, there were 559.4 WTE staff working as part of CAMH teams in Scotland.[47] Of these, just under half (45 per cent) were nurses; a fifth were psychologists, including qualified clinical psychologists and unqualified assistant psychologists; just over one in ten were medical staff; and less than three per cent were social workers.

52. Some areas of the country have more CAMH staff than others. Excluding staff who tend to work in hospitals providing regional or national services (tier 4 staff), the number of CAMH staff ranges from 4.2 WTE worker per 100,000 population in NHS Lanarkshire to 14.2 WTE in NHS Greater Glasgow and Clyde (Exhibit 5).

Older people find it difficult to access services in some areas

53. In the areas where we carried out detailed fieldwork, we found gaps in mental health services for older people, particularly in psychology and crisis services. For example, there were no psychology services for older people in Clyde and services in Highland and Tayside were limited. There were no crisis services for older people in Clyde or Highland. In England, a recent National Audit Office report found a lack of priority for dementia services, high levels of under-diagnosis and late diagnosis, and not enough use of early interventions known to be cost-effective.[48]

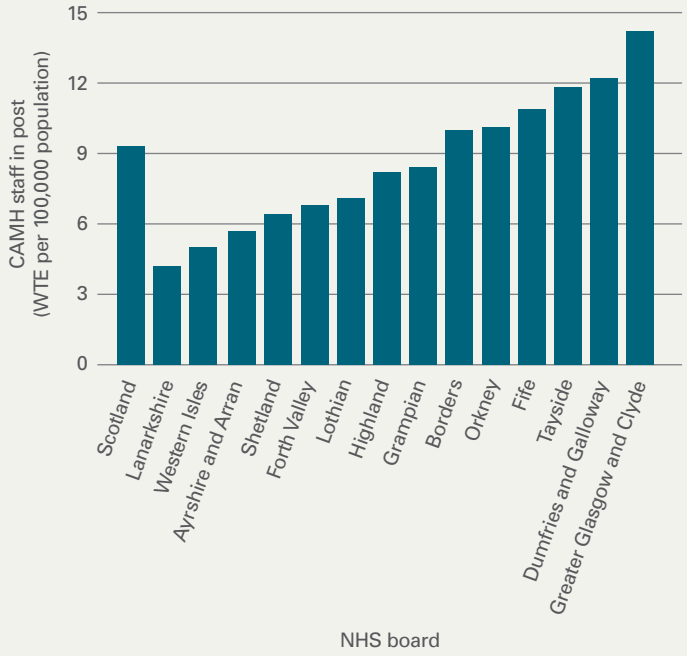
54. As well as gaps in particular services for older people, staff vacancies in some areas limit the provision of services. In September 2008, two NHS boards had long-term vacancies for consultants in old age psychiatry (Highland since 2004 and Lanarkshire since 2005) and Grampian had been successful in filling posts which had been vacant since 2004.[49] ISD data show that there are 11 WTE consultant vacancies in old age psychiatry across Scotland (14 per cent of the specialty establishment). Highland has three WTE longstanding vacant posts in old age psychiatry. The

40 *Children and Young People's Mental Health: A Framework for Promotion, Prevention and Care*, Scottish Executive, 2005.
41 *Our overview of mental welfare in Scotland 2006-07*, Mental Welfare Commission for Scotland, October 2007.
42 Most of the Mental Welfare Commission's work is concerned with safeguarding the rights and welfare of people being cared for under two Acts: the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2000. http://www.mwcscot.org.uk
43 *Guidance on the admission of young people to adult mental health wards*, Mental Welfare Commission for Scotland, 2006.
44 *Our overview of mental welfare in Scotland 2007-08*, Mental Welfare Commission for Scotland, October 2008.
45 *Getting the Right Workforce, Getting the Workforce Right: A strategic review of the child and adolescent mental health workforce*, Scottish Executive, 2005.
46 Child and Adolescent Mental Health Services Workforce Project on Information Services Division Scotland website: http://www.isdscotland.org/isd/4160.html
47 *Child and Adolescent Mental Health Services (CAMHS) in NHS Scotland: Characteristics of the Workforce Supply in 2007*, Information Services Division Scotland, 2009.
48 *Improving services and support for people with dementia*, National Audit Office, 2007.
49 *NHS Scotland Workforce Statistics: Hospital, community and public health service medical and dental staff by specialty over time*, Information Services Division Scotland, 2008.

Exhibit 5

Staff working in child and adolescent mental health services in the NHS per 100,000 population, 2007

Staffing levels for child and adolescent mental health services vary across NHS boards.



Note: The numbers of CAMH staff in this chart excludes staff who tend to work in hospitals and provide regional or national services (tier 4 staff).
Source: *Child and Adolescent Mental Health Services (CAMHS) in NHS Scotland: Characteristics of the workforce supply in 2007*, Information Services Division Scotland, 2009

Case study 1

Improving dementia services in Forth Valley

Starting in 2007, 120 staff involved in providing care for people with dementia in Forth Valley took part in a 12-month project to identify ways to improve services and help meet local and national objectives for dementia care. Almost 200 proposals for change were identified, ranging from producing easy to understand literature to increase awareness of dementia to developing rehabilitation services in people's homes.

The Scottish Government provided £200,000 to support the project and the main resource provided locally was staff time. An evaluation of the project was unable to measure impact, such as reduced length of stay in hospital, but a staff survey highlighted more confidence in their capacity to deliver dementia-related services. Others involved in the project, such as the police, churches, libraries, voluntary organisations and members of the public, also reported better knowledge of how to support people with dementia.

Source: *Forth Valley Dementia Project*, Dementia Services Development Centre, University of Stirling and Scottish Government, 2008

board has used locums for the past five years, which has limited its ability to develop mental health services for older people in the area. In Forth Valley, work to improve dementia services has been carried out locally and other areas are starting to carry out similar projects (Case study 1).

Better information is needed about socially excluded people to help plan and deliver services

55. NHS boards and councils in our fieldwork sites consult with service users and carers but this is not always carried out routinely or consistently for all groups of people using mental health services. Routine attempts are not made to identify unmet need or people not already in contact with services. The voluntary sector often works with socially excluded people who require services that work together to address their needs. Although a key player in the provision of mental health services, the voluntary sector is not always included in planning services.

56. Statutory bodies are required to collect information on ethnicity to demonstrate they are meeting their legal obligations under the Race Relations Amendment Act 2000. The Act requires that they do not allow racial discrimination and that they promote equal opportunity and good relations among people of different racial groups. There is a lack of up-to-date ethnicity information and most public bodies rely on figures from the last census in 2001, at which time two per cent of the Scottish population were from black and minority ethnic groups.[50]

57. We found little evidence of local equality and diversity monitoring within mental health services. Other national studies have also found a lack of understanding of

50 *Equal minds*, Scottish Development Centre for Mental Health and Scottish Executive, October 2005.

equalities and diversity issues among professionals providing mental health services, and a lack of management information relating to ethnicity and diversity to support service planning and delivery.[51] This information is needed to ensure that services are appropriately targeted and sensitively delivered.

People with sensory impairments face particular challenges in accessing services

58. The Scottish Parliament Health and Sport Committee inquiry into mental health services for people with sensory impairments highlighted a number of gaps, including a lack of support in psychiatric inpatient services and few appropriately trained mental health staff.[52] The Scottish Council on Deafness estimates that 65-130 deaf people have severe mental illness and that levels of mental health problems in deaf and deafblind people could be four times greater than in the general population.[53]

59. There is a lack of specialist services across Scotland for deaf and deafblind people with mental health problems across Scotland, including the availability of skilled interpreters. Currently patients with sensory impairment requiring specialist psychiatric inpatient care are referred to a specialist unit in Manchester which also provides outpatient services to deaf people in Scotland. In light of the Parliamentary inquiry the Scottish Government is currently reviewing mental health services for deaf and deafblind people.

60. There is an example in NHS Lothian of specialist services being provided in the community for deaf people. A community mental health service for deaf people has been developed in partnership with Deaf Action. The service is provided by a mental health nurse and an occupational therapist who work collaboratively with CMHTs and other agencies. A range of services are provided including assessment, group therapy, support for people admitted to hospital and advice and support to professionals, families and carers.

Recommendations

The Scottish Government and local partners should:

- collect national comparable data on mental health services staff, including details about caseload and vacancies. These data should be used to benchmark staffing levels across Scotland and identify where staffing levels are affecting service availability.

Local partners should:

- work together to identify and address any gaps in services, including services for children, adolescents and older people and the availability of psychological therapies
- ensure that data on waiting times for mental health services are collected and reported routinely. Action should be taken to address services with long waiting times
- ensure that the views and needs of service users and carers, including people who are likely to be socially excluded, are considered as part of service development
- involve the voluntary sector in developing and planning mental health services to meet the needs of the local population
- ensure that child and adolescent mental health services are provided up to the age of 18, in line with national guidance
- collect information on personal characteristics of people using mental health services, such as age, gender, ethnicity and sexual orientation, to allow monitoring of equality and diversity and to develop services to meet their needs.

51 *Equal Services? Report of Race Equality Assessment of Mental Health in NHS Boards*, National Resource Centre for Ethnic Minority Health and Scottish Executive, 2006.
52 Official reports of meetings of the Health and Sport Committee, Scottish Parliament, June 2008: http://www.scottish.parliament.uk/s3/committees/hs/2008.htm
53 Petition PE808 by Lilian Lawson on behalf of the Scottish Council on Deafness, Health and Sport Committee briefing paper, Scottish Parliament, June 2008: http://www.scottish.parliament.uk/s3/committees/hs/papers-08/hep08-16.pdf

Part 3. Delivery of mental health services

Agencies involved in delivering mental health services need to provide more joined-up care and improve how they share information.

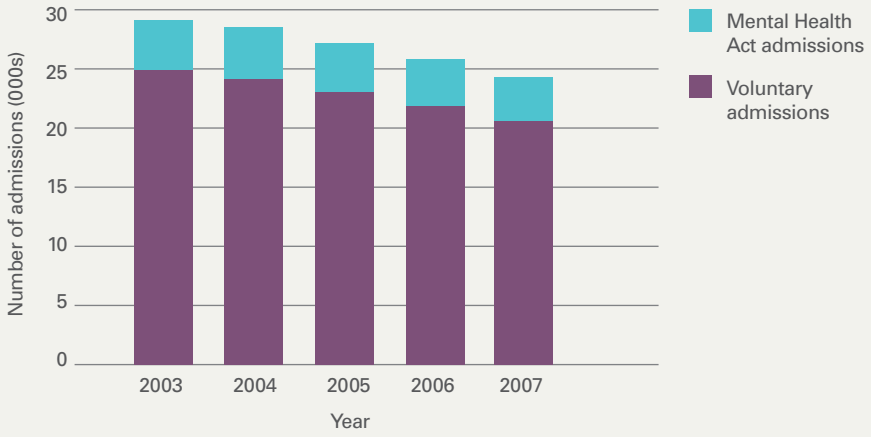
Key messages

- The number of psychiatric inpatient beds has reduced over time. There is evidence of variation in bed occupancy rates across Scotland, and high occupancy levels in some specific services, including services for adolescents.
- Community services have developed in the last ten years but there is insufficient information about how well resources are being used and what difference they are making, to assess how well they are working.
- People with mental health problems often receive services from more than one agency. Strong partnership working is essential to plan and deliver effective mental health services. Different information systems are used by NHS boards and councils and this limits their ability to deliver joined-up, responsive services. Services out-of-hours and at times of crisis are not well developed in all areas.
- There are currently few outcome measures for mental health. Single Outcome Agreements (SOAs) are now being used to measure improvements but as yet they do not focus on outcomes for mental health. Quality standards have been developed for mental health services and work is under way to align the different performance targets and priorities across the public sector. It is unclear whether the NHS will achieve its existing mental health targets.

Exhibit 6

Number of admissions to psychiatric inpatient units, 2003-2007

The number of admissions has reduced since 2003.



Source: Mental Health Summary Statistics, Information Services Division Scotland, 2008

Psychiatric hospital beds and admissions have reduced over time

Hospitals treat people with a range of mental health problems

61. In 2006/07, the most common diagnoses for men admitted to a psychiatric ward were drug and alcohol abuse and schizophrenia (23 per cent and 21 per cent respectively of all psychiatric admissions). The most common diagnoses for women were mood disorders, including depression and bipolar disorder, and dementia (33 per cent and 16 per cent respectively).

62. People with mental health problems may be admitted to hospital either voluntarily or under the Mental Health Act (about 15 per cent of all admissions over the last five years) (Exhibit 6).

The availability of beds varies by psychiatric specialty and by NHS board

63. The total number of psychiatry beds varies across Scotland, from 0.96 beds per 1,000 population in NHS Grampian to 1.39 beds per 1,000 population in NHS Greater Glasgow and Clyde. NHS Western Isles has the lowest number of general psychiatry beds per population and NHS Greater Glasgow and Clyde has the highest (0.22 and 0.67 per 1,000 population). Psychiatry beds designated for older people range from 0.45 beds per 1,000 population in NHS Highland to 1.09 beds per 1,000 population in NHS Western Isles (Exhibit 7).

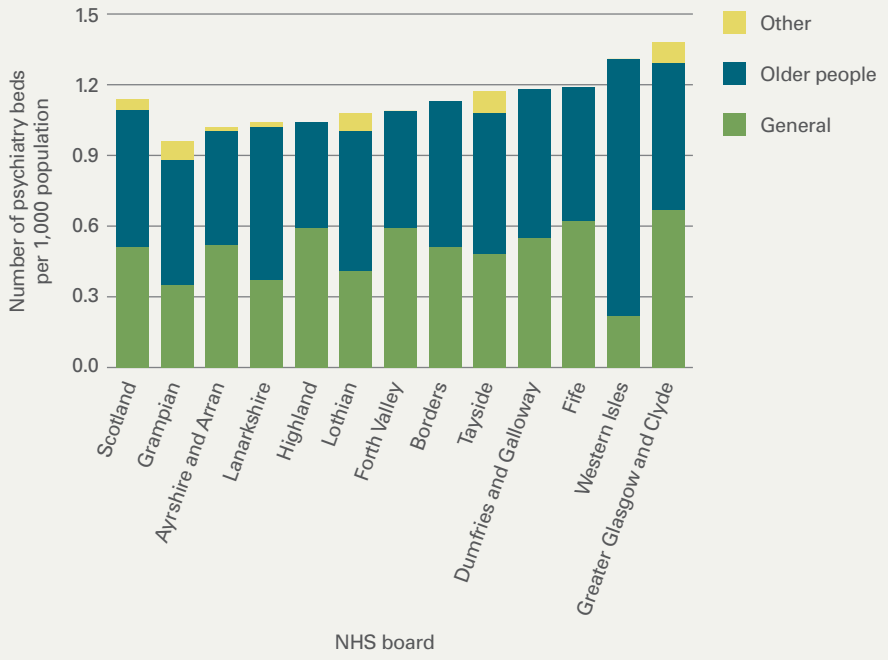
64. The Royal College of Psychiatrists recommends that bed occupancy levels should be no higher than 85 per cent for both adults and young people to ensure effective and safe care. The Royal College reported that while national statistics showed an average adult bed occupancy level of around 84 per cent in 2005/06, the Mental Welfare Commission had found an average bed occupancy of 92 per cent on inpatient wards, and 42 per cent of wards with occupancy rates of 100 per cent or more.[54] In 2007/08, the average bed occupancy reported for mental health services was 79 per cent although an average figure will disguise pockets of high and low occupancy levels (Exhibit 8, page 20).

54 *Fair deal for mental health*, Royal College of Psychiatrists, 2008.

Exhibit 7

Number of psychiatry beds per 1,000 population, 2008

The availability of psychiatry beds varies across Scotland.



Note: NHS Orkney and Shetland do not have psychiatry beds. 'Other' includes child, adolescent and forensic beds which are not provided in all NHS boards.
Source: Inpatient facilities by NHS board and specialty, Information Services Division Scotland, 2009

65. Managing inpatient beds within different psychiatric specialties is complex, particularly in remote and rural areas and where beds are for small numbers of people, such as those for children and adolescents. In 2008, a total of 36 adolescent beds were available in three NHS boards (Greater Glasgow and Clyde, Lothian and Tayside).[55] This is not in line with Scottish Executive proposals in 2005 to have 47 adolescent beds available by 2008 and 56 beds by 2010.[56]

66. In the majority of NHS boards providing forensic beds, there are occupancy rates of over 85 per cent, which may affect the quality of care provided. In seven NHS boards, the occupancy of beds for older people is 70 per cent or less which suggests not all of these beds are required. In NHS Fife, the occupancy rate for general psychiatry is also around 70 per cent.

67. A significant percentage of patients admitted to psychiatric inpatient units will stay for long periods of time due to the nature of their illness. Older people with long-term, degenerative conditions such as dementia will require more long-term care. In March 2007, 76 per cent of patients aged 15-44 were discharged from psychiatric beds within four weeks of admission compared to just 30 per cent of patients aged 75 and over.

68. There are insufficient data on length of stay and bed occupancy rates to look in further detail at trends in hospital care. A breakdown by NHS board area of short-stay and long-stay beds, diagnosis, age, and specialty is not routinely provided. This would give a clearer picture of the use of psychiatric beds across Scotland and help inform effective planning of services within each specialty for all groups of people.

The number of inpatient beds has reduced by a third

69. Over the last ten years there has been a gradual reduction in hospital care and an increase in community services for people with mental health problems. Between 1997/98 and 2006/07, the total number of psychiatric inpatient beds reduced by around a third, from 9,076 to 6,114 beds. The average length of stay also reduced over the same period from 85.7 to 66.5 days.[57]

70. There has been a continuous reduction in the number of female psychiatric first admissions since the 1980s (from around 6,000 to 4,000 a year), while male psychiatric first admissions have remained relatively stable at around 4,000 a year.[58] This reduction in hospital admissions suggests that more people are being treated in the community instead of hospital. However, there are no comparable figures for the number of people receiving treatment in the community.

More community-based services have been established but there is a lack of information about how they work

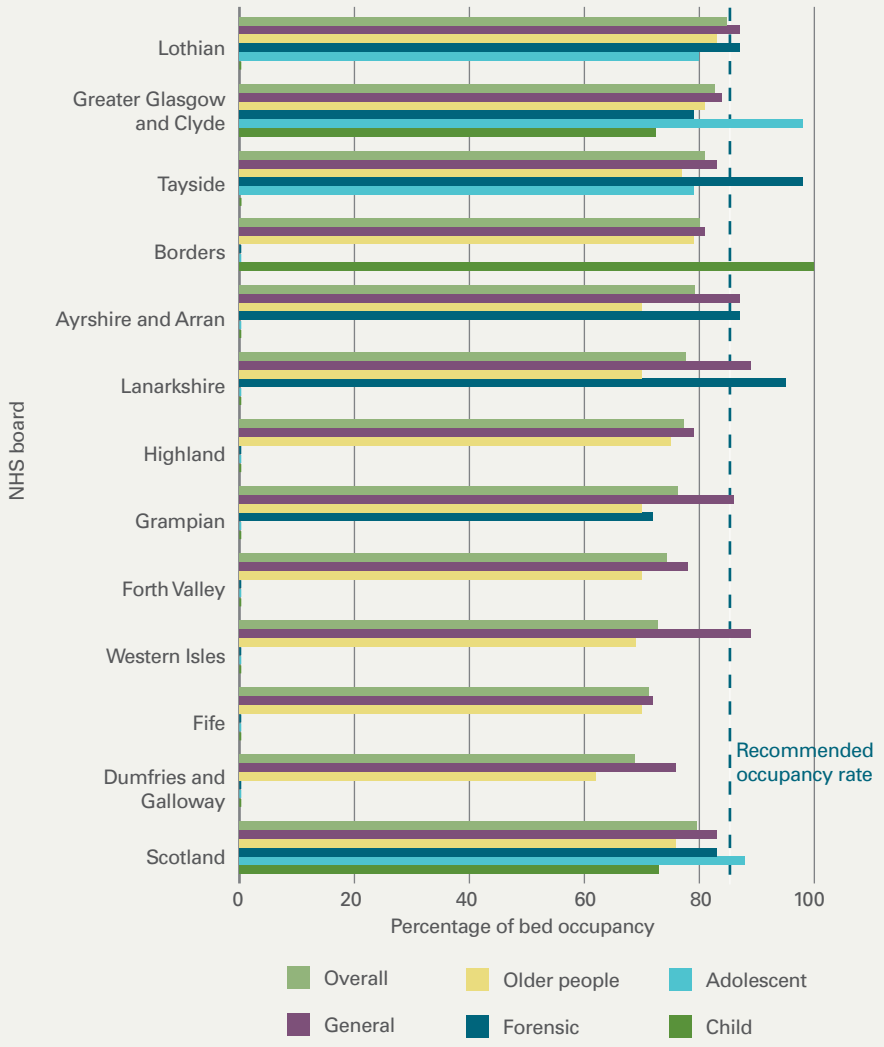
71. There has been a large increase in the number of mental health nurses working in the community since 2001, from around 700 to nearly 1,800, and over 400 nurses are working in posts which span both hospital and community services.[59, 60] This reflects a significant shift in the way that nursing services are being delivered

55 Inpatient facilities by NHS board and specialty on Information Services Division Scotland website: http://www.isdscotland.org/isd/4150.html
56 *Delivering for Health*, Scottish Executive, 2005.
57 Mental Health Summary Statistics on Information Services Division Scotland website: http://www.isdscotland.org/isd/962.html
58 *Ibid.*
59 Agenda for Change, a major review of NHS employees' pay, terms and conditions (excluding doctors), has changed the way nurses are categorised within different specialties from 2004. The numbers of mental health nurses working in hospitals under the new categories are still to be finalised and around 1.2 per cent of all current nursing and midwifery posts are still to be included in the Agenda for Change scales.
60 *NHS Scotland Workforce Statistics*, Information Services Division Scotland, 2008.

Exhibit 8

Bed occupancy rates for mental health services by NHS board, 2007

Bed occupancy rates vary across Scotland.



Notes:
1. The 100 per cent occupancy rate in Borders for child psychiatry relates to one bed. NHS Orkney and Shetland do not have psychiatry beds.
2. The recommended 85 per cent bed occupancy rate was made by the Royal College of Psychiatrists.
Source: Inpatient facilities by NHS board and specialty, Information Services Division Scotland, 2009

due to the reduction in hospital inpatient beds. The data on mental health nurses are not robust and ISD is working with NHS boards during 2009/10 to improve the quality of the data.

72. Many of these nurses work as part of multidisciplinary CMHTs. These teams bring together staff from councils and NHS boards to deliver care in the community for people with mental health problems and to provide a link with psychiatric wards to smooth the transition during admission to and discharge from hospital.

73. The composition of CMHTs varies across Scotland – in addition to nurses, membership can include occupational therapists; social workers, particularly in teams working with adults; psychologists; pharmacists; psychiatrists; and, in some cases, voluntary sector workers.

74. The services provided by CMHTs also vary, for example in NHS Greater Glasgow and Clyde there are several specialist mental health teams. As well as separate CMHTs for children and adolescents, adults and older people in Greater Glasgow and Clyde, there are specialist teams for early intervention and eating disorders. Teams providing services for homeless people and asylum seekers also provide support for mental health problems.

75. From our fieldwork we found gaps in CMHT provision in some more rural parts of Highland but these areas are working to find other solutions. For example, in Skye, where there are high levels of alcohol misuse in people with mental health problems, a detox clinic provides treatment in the community whereas previously people would have been admitted to hospital.

76. There are good examples of joint working between statutory and voluntary organisations. For example, Glasgow Association for Mental Health (GAMH) service centres are located within each of the Community Health and Care Partnerships (CHCPs) in NHS Greater Glasgow and Clyde. These link with local NHS and council services and local voluntary agencies to provide additional support for people with mental health problems. Each GAMH centre provides community outreach, home support, day activities and housing support services. Also in Glasgow, a charity, Carr-Gomm Scotland, has a number of staff working within integrated community mental health services in each of the CHCPs. The Carr-Gomm staff provide social care support to people with moderate to severe mental illness which includes outreach and crisis services.

77. There is a lack of information on community mental health services. This gap was highlighted in the Accounts Commission report on adult mental health services in 1999.[61] Better information needs to be available to examine the use of resources and what works best for people, including:

- number of people receiving treatment
- what treatment is being provided, to whom and for how long
- outcomes for people being treated
- size of mental health staff caseloads
- staffing levels and vacancies
- the amount of joint funding by the NHS, councils and other partners.

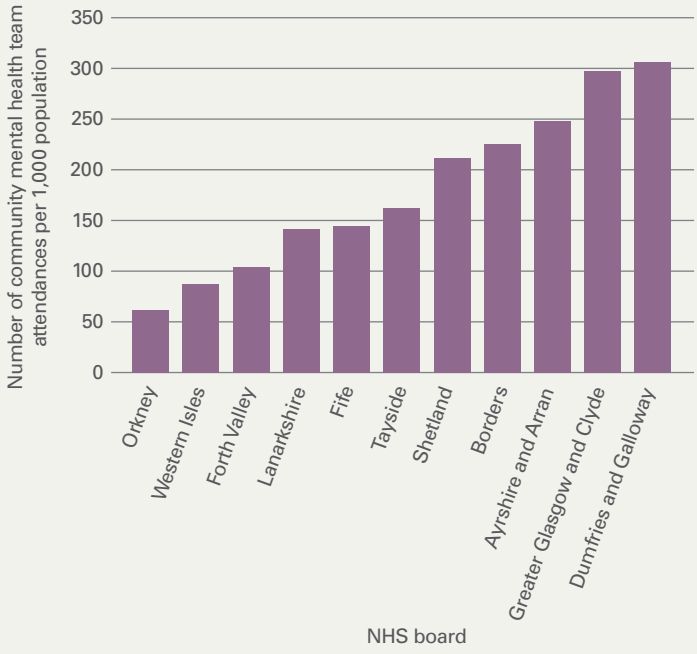
78. Limited information on CMHT activity is available from ISD but not all NHS boards complete the returns, the data are collected differently, levels of accuracy vary and not all boards are able to break down the information by different age groups. This makes comparisons difficult. However, in the absence of better information, the data returns show that in 2008 the number of contacts with CMHTs varied from around 60 contacts per 1,000 population in NHS Orkney to over 300 per 1,000 population in NHS Dumfries and Galloway (Exhibit 9).

79. ISD is currently piloting a costing project for adult mental health services which aims to collect a detailed breakdown of costs in the community and hospitals. Scotland-wide data should be available by the end of 2010.

Exhibit 9

Community mental health team contacts per 1,000 population, 2008

The rate of contacts with CMHTs varies widely across Scotland.



Note: Not all boards provide a breakdown for different CMHTs (CAMH, adults, elderly and clinical psychology), therefore the total contacts are shown for all CMHTs in each NHS board. The chart excludes NHS Highland as it did not provide the number of contacts and NHS Grampian and Lothian, which were outliers.
Source: Scottish Health Services Costs, Information Services Division Scotland, 2008

Services need to be more joined up

Organisations need to get better at sharing information

80. People with mental health problems often get care and support from more than one professional or organisation. They may also need access to care outside normal working hours if they require urgent treatment. This means that staff and organisations providing services need to easily share information so that appropriate care and support is given when it is needed. Many service users in our focus groups said that their care, and information about their care, was not always coordinated between different agencies or within different parts of the same organisation. One of their main frustrations was having to recount their treatment history to each professional they came into contact with.

81. A number of different information systems are used in the NHS, including those for mental health services, and NHS boards and councils collect information differently. NHS boards and councils in Scotland do not have a completely integrated system for caring for people with mental health problems, which would include shared electronic records and streamlined admission, referral and patient monitoring systems.[62] This limits the scope to routinely monitor and evaluate services and patient care, and share information across different organisations. Some records for service users are still paper-based.

82. NHS Quality Improvement Scotland (NHS QIS) provides guidance and advice to NHS boards, including standards, and measures and reports on the quality of patient care. NHS

61 *A shared approach: Developing adult mental health services*, Accounts Commission for Scotland, 1999.
62 *Mental Health Project Final Report: National Benchmarking Project*, Scottish Government, December 2007.

QIS standards for integrated mental health services recommend that NHS boards have information systems in place to record the provision of care, measure how well this is meeting needs and enable sharing of information among stakeholders.[63] Although the standards only apply to the NHS, the Social Work Inspection Agency (SWIA), which carries out inspections of social work services in all councils, is following up how well the standards have been implemented by councils as part of its routine inspections.

The availability of crisis and out-of-hours services varies across Scotland

83. Crisis and out-of-hours services can be provided solely or jointly by the NHS, councils and the voluntary sector.[64] National standards were issued in 2006 to encourage the development of crisis response and crisis services across Scotland.[65] The Scottish Government is monitoring whether the quality standards for crisis services have been implemented across Scotland and is due to report on this during 2009.

84. Crisis services differ across Scotland in how they are provided and when they are available. Not all services provide out-of-hours cover. Crisis services are predominantly provided for adults and few include dedicated provision for children and adolescents and older people. An out-of-hours mental health service for all age groups in NHS Tayside had 1,758 contacts during 2007/08. Two-thirds of contacts were between 6pm and midnight. The most common reason for contact was suicidal thoughts and a third of all people were not currently in contact with mental health services.

85. Our focus group participants cited out-of-hours access to services as a major problem. Often their first point of contact was with NHS 24 or hospital accident and emergency departments and they felt that non-specialist staff did not always understand how best to deal with mental health problems. Many focus group participants said that staff did not have the skills to recognise that their mental health problem was getting worse and therefore did not provide the treatment they needed. Just over a quarter of people with mental health problems using social work services, who responded to a SWIA survey, said they did not get a helpful response from social work services when they contacted them in the evening or at weekends.[66] It is important that staff working in all out-of-hours services have the skills to recognise people with mental health problems and are able to provide initial treatment or referral to appropriate services. In Edinburgh, a crisis centre for people with mental health problems and their carers has been established (Case study 2).

The police are sometimes the only service available in crisis situations during the out-of-hours period

86. Both the Association for Chief Police Officers in Scotland (ACPOS) and participants in our focus groups described cases where the police were the only service available to someone experiencing a crisis during out-of-hours periods. Many focus group participants commended the response by the police and said they had a good knowledge and understanding

Case study 2

Edinburgh Crisis Centre

Edinburgh Crisis Centre was established in August 2006 to provide support to people who are using, or have used, mental health services in Edinburgh and their carers. The service is community-based and can be accessed 24 hours a day, 365 days a year. The Centre provides crisis support through a free telephone helpline, face-to-face support and also has facilities for people who need to stay overnight. In the last 12 months to March 2009, there have been 600 Centre users, with the number of calls received each week ranging from 92 (in February and December 2007) to 344 (in June 2007). Recently the Centre has been receiving in excess of 60 new callers each month and there are a significant number of callers who contact the Centre more than once. Monitoring data show that people contact the Centre about a range of issues, including experiencing suicidal thoughts, experiencing anxiety and thoughts of self-harm.

The Centre is based on an innovative approach to partnership working. The Partnership Group oversees the work of the Centre and is made up of the commissioners and main funders of the Centre (NHS Lothian and City of Edinburgh Council), the service provider (Penumbra) and service users and carers represented by Edinburgh Users Forum and Edinburgh Carers Council. The Centre focuses on involving users and carers, through their involvement in the Partnership Group and also through routinely asking users and carers for their views on the service. The Centre also takes action to ensure the service is accessible to all who need it and works with other statutory and non-statutory services in Edinburgh. Monitoring data based on 78 callers show that 23 per cent of Centre users define themselves as lesbian, gay, bisexual or transgender and 46 per cent identified themselves as disabled.

Source: Audit Scotland fieldwork, 2009

63 *Standards for integrated care pathways for mental health*, NHS Quality Improvement Scotland, December 2007.
64 Crisis services provide a short intervention to help individuals going through a particularly difficult time, for example individuals having an acute episode, relapse or mental distress, and are aimed at preventing unnecessary admission and readmission to psychiatric inpatient facilities.
65 *Delivering for Health: Delivering for Mental Health National Standards for Crisis Services*, Scottish Executive Health Department, November 2006.
66 Service Users Survey (from 24 council inspections), Social Work Inspection Agency, 2009. Website: http://www.swia.gov.uk/swia/591.147.html

Case study 3

Joint working in Tayside to ensure prompt access to psychiatric services for people in custody with mental health problems

Tayside Police, the Crown Office, the Procurator Fiscal service and NHS Tayside have a joint protocol which allows the police to refer people in custody who they believe have mental health problems to psychiatric services for an assessment at any time, seven days a week. The protocol requires psychiatric services to attend all police referrals as promptly as possible. Once assessed, if an individual is not admitted to hospital then they will be referred where appropriate to other services for support or advice.

Tayside Police believes that this approach is providing a better service to people with mental health problems and is resulting in fewer people being held inappropriately in a police cell. HMICS has recommended that similar approaches should be rolled out across Scotland.

Source: *Medical Services for People in Police Custody,* Her Majesty's Inspectorate of Constabulary for Scotland, October 2008

of mental health problems. The police college trains new recruits about mental health issues and ACPOS has a strategy to ensure that ongoing training is provided to police officers, including their obligations under the Mental Health Act.

87. A place of safety is defined under the Mental Health Act as 'a hospital; premises which are used for the purpose of providing a care home service; or any other suitable place (other than a police station) the occupier of which is willing temporarily to receive mentally disordered persons'. In 2006/07, the Mental Welfare Commission reported that there were 130 place of safety orders and in two of these cases a police station was used as a place of safety. In England, over 11,500 people out of a total of 17,500 place of safety orders were detained in a police cell.[67]

88. ACPOS raised concerns during our fieldwork about getting people to a place of safety, particularly in remote and rural areas, and poor access to psychiatric services to have someone assessed. A 2008 report by Her Majesty's Inspectorate of Constabulary for Scotland also highlighted this in its review of medical services for people in police custody.[68] Tayside has developed a joint protocol to ensure quick access to psychiatric services for people in custody with mental health problems (Case study 3).

There can be problems in the transition between services

89. Mental health services tend to be organised around three age groups: children and adolescent mental health services (up to the age of 16 or 18), adult services (for people aged 17 or 19 up to 64) and older people's services (aged 65 and above).[69]

90. Adult services have been a focus for development and tend to have a wider range of services than those for children, adolescents and older people. For example:

- Crisis services and psychological therapies are often developed within adult services but there is limited or no service for children and older people.
- New ways of providing services are commonly piloted in adult services and not always rolled out to children and older people's services.

91. There can be problems in the transition between services. Some specialist services are available within children and adolescent services but are not provided within adult services, such as services for adults with autistic spectrum disorder and attention deficit hyperactivity disorder. Some areas have no specialist community mental health services for older people. This means that there is a lack of continuity of care for some younger and older people.

Prisoners with mental health problems can have difficulty accessing services when released

92. Healthcare in prisons is currently delivered by a number of different providers: a private company provides GP services; the Scottish Prison Service provides the nursing service; and the NHS provides other services, such as hospital care. There is no consistent process for referring people with mental health problems being released from prisons to community mental health services.[70] In June 2008, the Scottish Government confirmed that the provision of primary healthcare services in prisons would be transferred to NHS boards. It is estimated that the preparatory work and necessary changes to legislation will take around three years for this transfer to take place.[71]

93. Her Majesty's Chief Inspector of Prisons (HMCIP) has identified a number of problems for prisoners with severe and enduring mental health problems accessing services.[72]

67 *Police Custody as a Place of Safety: Examining the Use of Section 136 of the Mental Health Act 1983*, Independent Police Complaints Commission, 2008.
68 *Medical Services for People in Police Custody,* Her Majesty's Inspectorate of Constabulary for Scotland, October 2008.
69 The age limit for accessing children's services varies across Scotland (see Part 2).
70 *Out of Sight: Severe and Enduring Mental Health Problems in Scotland's Prisons*, Her Majesty's Chief Inspector of Prisons for Scotland, December 2008.
71 *Transfer of Enhanced Primary Healthcare Services to the NHS*, Scottish Government, July 2008.
72 *Out of Sight: Severe and Enduring Mental Health Problems in Scotland's Prisons*, Her Majesty's Chief Inspector of Prisons for Scotland, December 2008.

These include longer waits for transfer to a psychiatric inpatient bed compared to people in the community and evidence of few links to continuing support in the community following release from prison. HMCIP also found that a lack of information transferred between courts, community services and prisons, and a lack of skills among prison staff to recognise serious mental illness, are leading to problems with diagnosis and getting the right treatment.

Quality standards have been developed for a range of mental health problems

94. A number of quality standards are available, including those relating to schizophrenia, depression and anxiety, dementia and attention deficit hyperactivity disorder.[73] NHS QIS launched standards for integrated care pathways (ICPs) for mental health services in December 2007.[74] NHS boards were required to implement these standards with partners during 2008 and will be assessed against the standards from 2009. The ICP standards aim to address some key issues highlighted in previous work by NHS QIS which found that mental health services can lack coordination, do not always deliver evidence-based interventions, do not record outcomes and often do not meet assessed needs.

95. During 2008/09, the Mental Welfare Commission is monitoring care provided for: children and young people under the age of 18; individuals who have been detained for three years or more; and individuals who are on short-term detention certificates.[75]

96. The Mental Welfare Commission, SWIA and NHS QIS all have a role in scrutinising mental health services. Audit Scotland also looks at the performance of mental health services through national reports such as this one. It is important for all the scrutiny bodies to work together and share information. In February 2008, the Cabinet Secretary for Finance and Sustainable Growth invited the Accounts Commission to take on a gate-keeping role for scrutiny activity in local government. This development will support scrutiny agencies to work together to provide assurance about the performance of councils to support improvement as efficiently and effectively as possible.

There are few national outcome measures for mental health services

SOAs are now used to measure improvements in services provided by councils and their partners

97. In April 2008, following agreement of a concordat between the Scottish Government and COSLA, SOAs were introduced across Scotland. SOAs set out how each council and its partners, including the local NHS board, will address their priorities and improve services for the local population. They are intended to encourage councils and their partners to focus on outcomes rather than on measuring process. However, detailed management information on services, quality and cost is still needed to underpin work on outcomes to assess how well needs are being met.

98. The first round of SOAs for 2008/09 all mentioned mental health services but this was usually in connection with national targets for the NHS and there was little in the way of real outcome measures. The majority of SOAs (27 out of 32) mentioned suicide prevention work; two-thirds included a NHS target of reducing the use of antidepressants; and less than half included anything on reducing psychiatric admissions or dementia. Around half of SOAs mentioned improving mental well-being.

99. A recent report by the Parliamentary Health and Sport Committee raised concerns about the lack of guidance for councils to ensure monitoring of health outcomes and asked the Scottish Government to prepare guidance for councils on SOAs in 2009/10.[76] The Scottish Government published guidance on governance and accountability for SOAs in February 2009.

100. Councils, NHS boards and their partners should work together to establish systems to monitor and review the services they are delivering to meet local needs. Work is under way by the Scottish Government Health Directorates to align NHS targets with performance priorities for the rest of the public sector, including councils.

It is unclear whether the NHS will achieve its four national targets

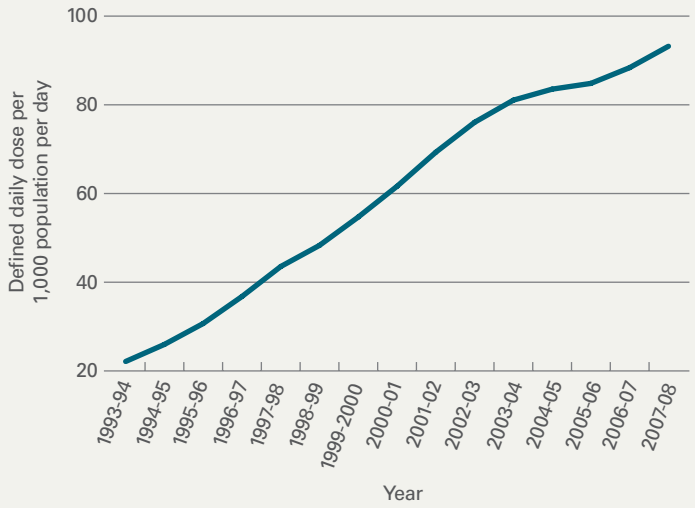
101. The Scottish Government has developed four key targets for mental health services, but these targets are not clear measures of improvement or fully supported by robust data. It is also not clear yet whether the NHS will achieve them. In April 2008, the Scottish Government set up a national mental health collaborative programme to support NHS boards achieve the mental health targets. The programme will run for three years with a team from the Scottish Government helping NHS boards to improve mental health services and with staff training.

73 NHS QIS Schizophrenia clinical standards: http://www.nhshealthquality.org/nhsqis/files/Schizophrenia%20jan%2001.pdf
SIGN guidelines: http://www.sign.ac.uk/guidelines/published/index.html
NICE guidelines: http://www.nice.org.uk/guidance/index.jsp?action=byTopic&o=7281&set=true
74 *Standards for integrated care pathways for mental health*, NHS Quality Improvement Scotland, December 2007.
75 *Our Annual Report: Key messages and challenges 2007-08*, Mental Welfare Commission for Scotland, 2008.
76 *Report on the Scottish Government's Draft Budget 2009-10*, Scottish Parliament Health and Sport Committee, 2008.

Exhibit 10

Levels of antidepressant prescribing, 1993/94 to 2007/08

The level of antidepressant prescribing has been steadily increasing since 1993/94.



Note: The prescribing rate is based on a defined daily dose (DDD) per 1,000 population per day. DDD is the average maintenance dose per day for a drug used in its main purpose in adults.
Source: Prescribing and Dispensing Information, Information Services Division Scotland, 2008

NHS boards are working to reduce psychiatric readmissions

102. The Scottish Government aims to reduce the number of psychiatric readmissions (within one year) for people who have had a hospital admission of over seven days by ten per cent by the end of 2009 (baseline year 2004). The total number of readmissions fell from 4,550 to 3,841 between 2004 and 2006 (a 16 per cent reduction). In December 2006, three NHS boards were not meeting the target (NHS Orkney, Tayside and Shetland) but data after March 2006 are provisional and may change in the future.[77] NHS boards will have to maintain efforts to prevent psychiatric readmissions in order to meet the target at the end of 2009.

103. ISD has developed a risk prediction tool to assist NHS boards to identify patients aged 15 years and over at greatest risk of psychiatric admission in a particular year.[78] Information on patients at risk of psychiatric admission has been provided to boards by ISD since February 2009.

The NHS is not on track to meet its target for reducing antidepressants

104. The NHS aims to stop the rate of antidepressant prescribing from increasing.[79] This target was set as a proxy to improve care for people with depression as reducing antidepressant prescribing should lead to an increase in the number of people receiving other non-drug treatments, such as psychological therapies. However, the target does not take account of initial prescribing levels in each NHS board. It is also unclear what the correct rate of prescribing should be and whether reducing the rate of prescribing is always appropriate. Patients may require both antidepressants and psychological therapies rather than one or the other. The overall volume of antidepressants prescribed per head of population has continually increased since 1993/94. Unless levels of prescribing remain static or reduce then the target will not be met (Exhibit 10).

105. A review of antidepressant prescribing by 98 per cent of general practices in Scotland found that variation in the rates of prescribing can be associated with a number of different factors, including the number of patients with long-term illness, a higher proportion of ethnic minority patients, size and location of practices (urban or rural) and the availability of psychology services.[80]

106. The planned reduction in antidepressant prescribing is intended to be linked to an increase in the number of people receiving other treatment such as psychological therapy. The availability and variety of non-drug therapies differs across Scotland and there are long waiting times for access to psychological therapies across the country (information on waiting times for psychology services is provided in Part 2). However, there are good examples of how this is being addressed in some areas (Case study 4, overleaf).

The overall suicide rate is reducing but there has been little change in some NHS boards

107. The NHS in Scotland has a target to reduce the suicide rate between 2002 and 2013 by 20 per cent; and train 50 per cent of key front-line staff, such as ambulance and accident and emergency staff, to use suicide assessment tools and receive suicide prevention training by 2010. The Scottish Public Health

77 To meet the readmissions target NHS Orkney needs to reduce readmissions to six by 2009 and in December 2006 they had seven people who had been readmitted; NHS Tayside needs to reduce readmissions to 254 and at the end of 2006 they had 303; NHS Shetland needs to reduce readmissions to five and at the end of 2006 they had eight.

78 *SPARRA Mental Disorder: Scottish Patients at Risk of Readmission and Admission (to psychiatric hospitals or units)*, Mental Health Programme, Information Services Division Scotland, October 2008.

79 The full description of the target is: to reduce the annual rate of increase of defined daily dose of antidepressants per head of population to zero by 2009/10, and put in place the required support framework to achieve a ten per cent reduction in future years.

80 *Factors influencing variation in prescribing of antidepressants by general practices in Scotland*, J Morrison, MJ Anderson, M Sutton, R Munoz-Arroyo, S McDonald, M Maxwell, A Power, M Smith, P Wilson, British Journal of General Practice, Vol. 59 No. 559 p.e25-e31, February 2009.

Case study 4

Providing psychological and other therapies to people with depression and anxiety

A CMHT in Glasgow provides a service called STEPS. This delivers a wide range of services for people over the age of 16 with depression and/or anxiety. Some services require referral through a GP but many are open referral and include group therapy classes, exercise classes, an advice clinic, and information leaflets (including translations for ethnic communities). Between April and September 2008, 4,464 people were seen by the STEPS team for all the services they provide, including 1,183 people receiving individual therapy such as cognitive behaviour therapy and 2,170 attending stress control classes. A third were GP referrals and the rest were open referrals. The majority of people using STEPS live in areas of high deprivation but are less likely to complete treatment compared to people living in less deprived areas. The STEPS team recently introduced a system where it follows up people receiving treatment to increase attendance and completion rates for those living in more deprived areas.

In August 2008, NHS 24 launched NHS Living Life as a pilot for two years in five NHS boards (Borders, Lothian, Greater Glasgow and Clyde, Shetland and Western Isles). It is a telephone-based service providing psychological therapies for people over the age of 16 with depression. It provides behavioural therapy and access to guided self-help to people referred by their GP. NHS 24 estimates that up to 3,000 people will use this service during each year of the pilot and will evaluate the service in 2009. In the first four months of the pilot up to the end of December 2008, the service received a total of 185 referrals from the five NHS boards.

Source: Audit Scotland fieldwork, 2009

Observatory reported that the suicide rate in Scotland fell by 13 per cent between 2000-02 and 2005-07 (14 per cent for men and ten per cent for women). However, these rates have shown little change since 2003-05 and levels vary across NHS boards. In 2007, seven NHS boards had reduced suicide rates by 20 per cent since 2002 and are currently meeting the target.[81] The total number of staff across Scotland who have been educated and trained in using suicide assessment tools and suicide prevention training programmes is not available.

It is not possible to assess whether the health target for dementia will be achieved

108. The fourth health target is to achieve agreed improvements in the early diagnosis and management of patients with dementia by March 2011 (baseline 2008). The number of people with dementia registered with GPs will be used to help assess improvements against this target. The Scottish Government approach to increase the number of people on dementia registers aims to encourage earlier diagnosis and facilitate better management as it may provide access to other GP services for people with dementia and their carers. It is not possible to comment on whether the target will be achieved as it is not clear how earlier diagnosis and management of people with dementia will be recorded or how improvement will be measured. The target is vague and clearer definitions and guidance are required to ensure that the NHS can work towards improving services for patients.

A benchmarking system has been set up to enable NHS boards to compare their performance in delivering mental health services

109. The Scottish Government is leading a national mental health benchmarking project aimed at improving mental health services by providing comparable information about individual NHS boards. Key elements of this work are the development of a 'balanced scorecard' of measures required to manage mental health services effectively and linking costing information to outcomes.[82] This work is being developed over a period of three years up to 2010. This is an important development as the amount and accuracy of national data on mental health services vary and many current performance measures, including the existing health targets, are not comprehensive. Mental health benchmarking work has begun in the NHS and social care benchmarking in councils is starting to be developed during 2009.

81 NHS boards currently meeting the suicide target are: Borders, Fife, Forth Valley, Grampian, Lanarkshire, Lothian and Orkney. Suicide rates have reduced by 20 per cent or more in 11 councils: Aberdeen City, Clackmannanshire, East Dunbartonshire, East Lothian, Falkirk, Fife, Inverclyde, Midlothian, Orkney Islands, Scottish Borders and Stirling.

82 *Mental Health Project Final Report: National Benchmarking Project*, Scottish Government, December 2007.

Recommendations

The Scottish Government and local partners should:

- develop systems across NHS boards and councils to allow them to share information about people with mental health needs and ensure that they receive coordinated and joined-up care
- monitor whether national standards for crisis services have been implemented and ensure that the services provided meet local demand
- ensure that they work together to deliver services for people with mental health problems which are joined up and that appropriate services are provided on the basis of need
- collect information about services in the community to enable better planning and development of services.

The Scottish Government and NHS boards should:

- review the number and location of inpatient beds for adolescents and ensure that provision meets demand.

NHS boards should:

- review bed occupancy levels and identify how to make best use of available resources.

Local partners should:

- address gaps in crisis and out-of-hours services in all areas.

Part 4. Expenditure on mental health services

Better information is required on how much is spent on mental health services.

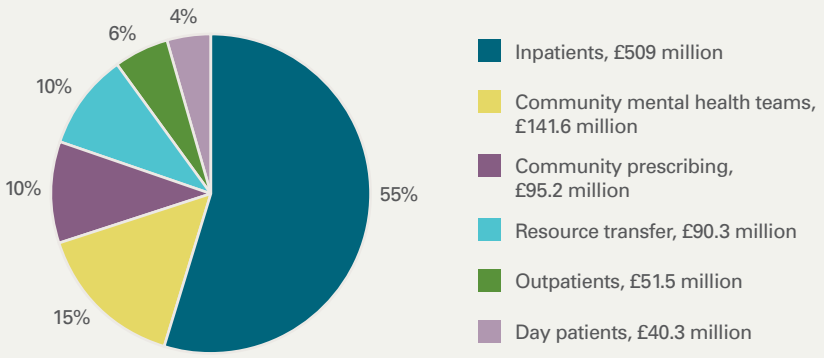
Key messages

- The wider costs of mental health problems are over £8 billion a year. Mental health problems have a significant impact on the economy and over £337 million is paid in incapacity benefits per year. Unpaid carers save society around £376 million each year.
- The NHS spent £928 million on mental health services in Scotland in 2007/08 but this is likely to be an underestimate as there is limited information on the spend in the community. The total amount spent by councils on mental health services is unknown.
- Resources have shifted over time from hospitals to community care, although the majority of expenditure on mental health is still on hospital services. In 2007/08, the NHS transferred over £90 million to councils to support community mental health services. The shift from hospital to community care is more developed in some areas.
- It is too early to assess the impact of changes to council funding on mental health services. Certain funds are no longer ring-fenced and councils will review these funds as part of their single outcome agreements.

Exhibit 11

Breakdown of spend by NHS boards, 2007/08

The NHS spent £928 million on mental health services in Scotland in 2007/08.



Note: Resource transfer is money transferred to councils by NHS boards to support community mental health services.
Source: R200 and R300 series, Scottish Health Service Costs and Prescribing and Dispensing Information, Information Services Division Scotland, 2008

The wider costs of mental health problems are estimated at over £8 billion per year

110. The full cost of mental health problems in Scotland in 2004/05 is estimated at around £8.6 billion a year. This includes costs to society of people not being able to work and an estimate of the human costs from the impact on quality of life, such as people not being able to perform their usual activities.[83, 84] In 2000, a European study found that mental health problems were the second largest category of ill-health in the UK resulting in five to six million working days lost annually.[85]

111. Just under two in five people receiving incapacity benefits have a mental or behavioural disorder, costing over £337 million in Scotland in 2007/08.[86]

Carers save society a significant amount of money

112. Unpaid carers provide a significant amount of care to people with mental health problems. In the UK, people with mental health problems receive about 21 million hours a week of unpaid care from family and friends. In Scotland, this would cost an estimated £376 million if undertaken as paid work by a third party.[87]

The total spend on mental health services is unknown

113. It is difficult to calculate the exact amount spent on mental health services due to the lack of information about NHS spend on hospital prescribing, community health services and general practice, and spend by councils.

The NHS spent around £928 million on mental health services in 2007/08

114. From available information the NHS spent at least £928 million on mental health services in Scotland in 2007/08. This is an underestimate due to a lack of information on spend on hospital prescribing and general practice. Around two-thirds of this spend (£600.8 million) is on hospital inpatients, outpatients and day patients (Exhibit 11).

115. The NHS spend of almost £928 million on mental health services in 2007/08 is nine per cent of its

83 The £8.6 billion can be broken down into three categories: health and social care costs of £1.5 billion (including NHS and council services and informal care provided by family and friends); costs of output losses of £2.4 billion (relating to costs in the Scottish economy that result from the adverse effects of mental health problems on people's ability to work); and human costs of £4.7 billion representing the impact of mental health problems on quality of life.
84 *What's it Worth? The Social and Economic Costs of Mental Health Problems in Scotland*, Scottish Association for Mental Health, December 2006.
85 *Mental Health in the Workplace: Introduction*, P Gabriel and MR Liimatainen, International Labour Office Switzerland, 2000.
86 Nomis Official Labour Market Statistics on Office for National Statistics website: https://www.nomisweb.co.uk/
87 *What's it Worth? The Social and Economic Costs of Mental Health Problems in Scotland*, Scottish Association for Mental Health, December 2006.

total expenditure. This figure includes money transferred to councils to support community mental health services (over £90 million). It also includes costs associated with the State Hospital (£39 million) and prescribing medicines in the community (£95 million). It is not possible to identify the cost of prescribing for mental health in hospitals as information is not collected in this way.

116. There are insufficient data on the costs of mental health in general practice. GPs and other staff working in general practice provide a considerable amount of care for people with mental health problems although the full extent of this is unknown. Information on contacts with GPs and practice nurses provide an estimate of the number of contacts with patients with depression, anxiety and dementia.[88, 89] In 2007/08, there were an estimated total of 886,853 contacts with GPs for depression, anxiety and dementia and 35,019 contacts with practice nurses. Using standard unit costs for a consultation with a GP and a practice nurse (£30 and £8 respectively), the estimated total cost for general practice contacts for these three conditions is £26.9 million.[90]

117. The average spend on mental health services per head of population for Scotland is £173. This varies by NHS board, from £55 per head of population in NHS Shetland to £220 in NHS Greater Glasgow and Clyde. Levels of mental health problems tend to be higher in more deprived areas but spending does not always appear to be related to levels of need (Exhibit 12).

118. In Scotland, the amount NHS boards spent on mental health services (including resource transfer and excluding the State Hospital costs) increased in cash terms from £641.2 million in 2002/03 to £888.7 million in 2007/08. Spend on mental health services as a percentage of overall NHS spend has reduced slightly from 11.1 per cent in 2002/03 to 10.7 per cent in 2007/08.

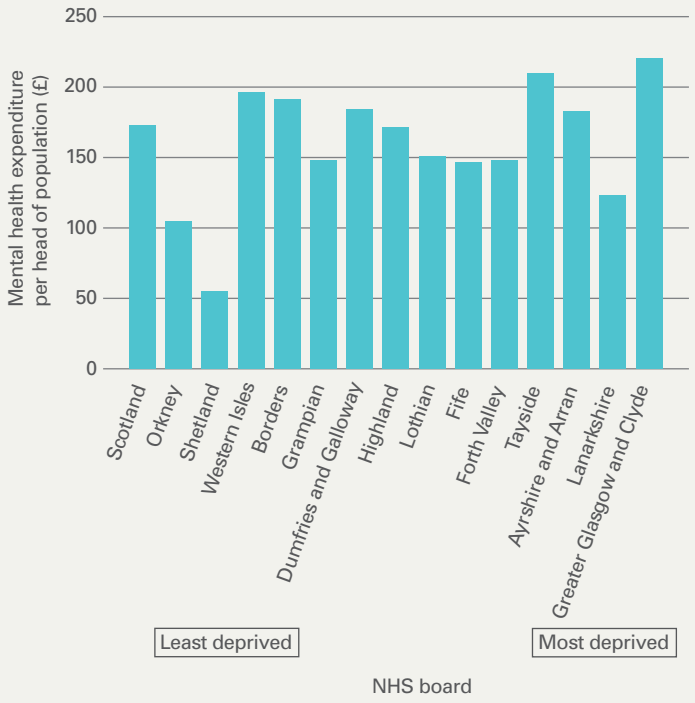
119. In 2007/08, only four NHS boards spent more than the average of 10.7 per cent of overall NHS board spend on mental health services – NHS Borders (11.4 per cent, £21.3 million), Greater Glasgow and Clyde (12.3 per cent, £262.7 million), Lothian (10.9 per cent, £122.2 million) and Tayside (12.8 per cent, £82.8 million). Three NHS boards increased the percentage of their spend between 2006/07 and 2007/08 on mental health services – Lothian (9.3 to 10.9 per cent), Tayside (12.2 to 12.8 per cent) and Western Isles (7.3 to 8.3 per cent). In the remaining boards there has been a levelling off or reduction in the percentage of money spent on mental health services.

120. Mental health services are increasingly being provided in the community although the majority of money is still spent on hospital services. However, there is variation across Scotland in the balance of spend on specialist mental health services provided in hospitals and the community and the amount of resources transferred to councils (Exhibit 13).

Exhibit 12

NHS spend on mental health services per head of population, 2007/08

Spend on mental health services is not related to levels of deprivation.



Source: R200 series, Scottish Health Service Costs and Prescribing and Dispensing Information, Information Services Division Scotland, 2008

88 People with depression, anxiety and dementia may also have contact with district nurses and health visitors but data on contacts with these staff have not been collected since 2005/06.

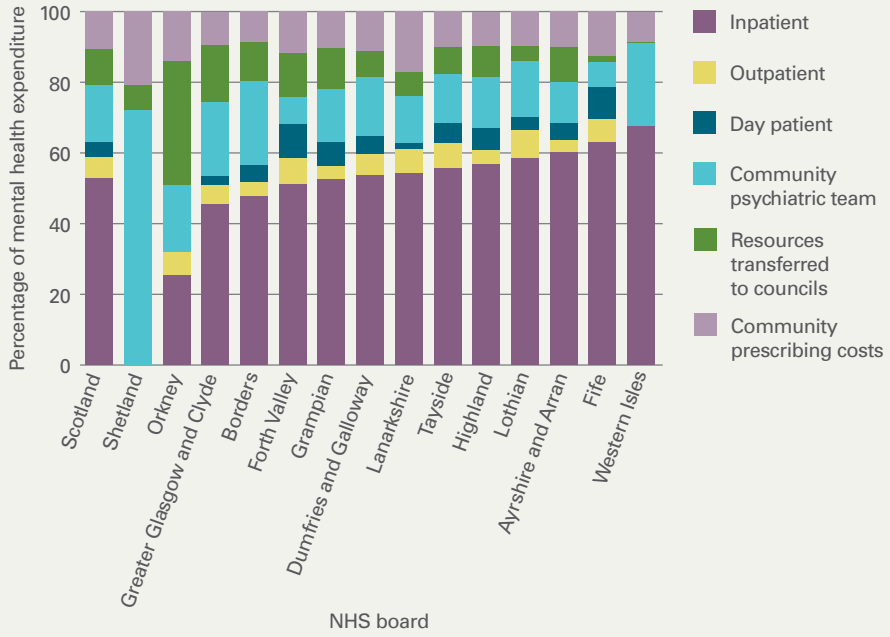
89 Practice Team Information on Information Services Division Scotland website: http://www.isdscotland.org/isd/1044.html

90 *Unit Costs of Health and Social Care 2008*, Personal Social Services Research Unit, University of Kent, 2008.

Exhibit 13

Spend on psychiatric services by NHS board, 2007/08

Spend on different mental health services varies across Scotland, with most expenditure on psychiatric inpatient beds.



Source: R200 series, Scottish Health Service Costs and Prescribing and Dispensing Information, Information Services Division Scotland, 2008

The shift of resources to community mental health services is more developed in some areas

121. NHS boards transfer money to councils to support community mental health services. These are mainly provided by social work departments and services commissioned from the voluntary and private sectors. In the absence of more detailed data, the amount of money that NHS boards transfer to councils is a proxy indicator for the progress in shifting care from hospitals to the community. In Scotland in 2007/08, an average of ten per cent of NHS expenditure on mental health was transferred to councils (£90.3 million). In mainland NHS boards, this ranges from £2.72 per head of population in NHS Fife to £35.33 in NHS Greater Glasgow and Clyde (Exhibit 14). This suggests that community services are further developed in Glasgow than in some other areas, which is supported by our fieldwork.

Exhibit 14

Resource transfer from NHS boards to councils to support community mental health services, 2007/08

The amount of money transferred from the NHS to councils varies across Scotland.

NHS board	Resource transfer as % of total mental health expenditure (%)	Resource transfer amount (£000)	Resource transfer per head of population (£)
Scotland	**10.2**	**90,315**	**17.56**
Western Isles	0.4	21	0.81
Fife	1.8	979	2.72
Lothian	4.3	5,310	6.56
Lanarkshire	6.7	4,648	8.30
Shetland	7.2	88	3.99
Dumfries and Galloway	7.5	2,061	13.89
Tayside	7.5	6,224	15.79
Highland	8.5	4,482	14.52
Ayrshire and Arran	9.8	6,575	17.92
Borders	11.0	2,353	21.11
Grampian	11.8	9,356	17.48
Forth Valley	12.5	5,359	18.58
Greater Glasgow and Clyde	16.0	42,133	35.33
Orkney	35.0	727	36.59

Note: NHS Orkney's resource transfer is particularly high due to closure of a hospital and the majority of the mental health spend is on the community mental health team and resource transfer rather than inpatients.
Source: R200 series, Scottish Health Service Costs and Prescribing and Dispensing Information, Information Services Division Scotland, 2008

It is difficult to quantify how much councils spend on mental health services

122. It is more difficult to quantify the amount of expenditure by council services on mental health due to the lack of information on care for people with mental health needs, the way services are structured and budgets are recorded, and the cross-cutting nature of the work. Only the amount spent on adults with mental health needs is shown separately in council budgets. Services provided to children and older people with mental health needs are not separately identified within the general social work budgets for children and families and for older people (which are just under a quarter and a half of all social work spend respectively).

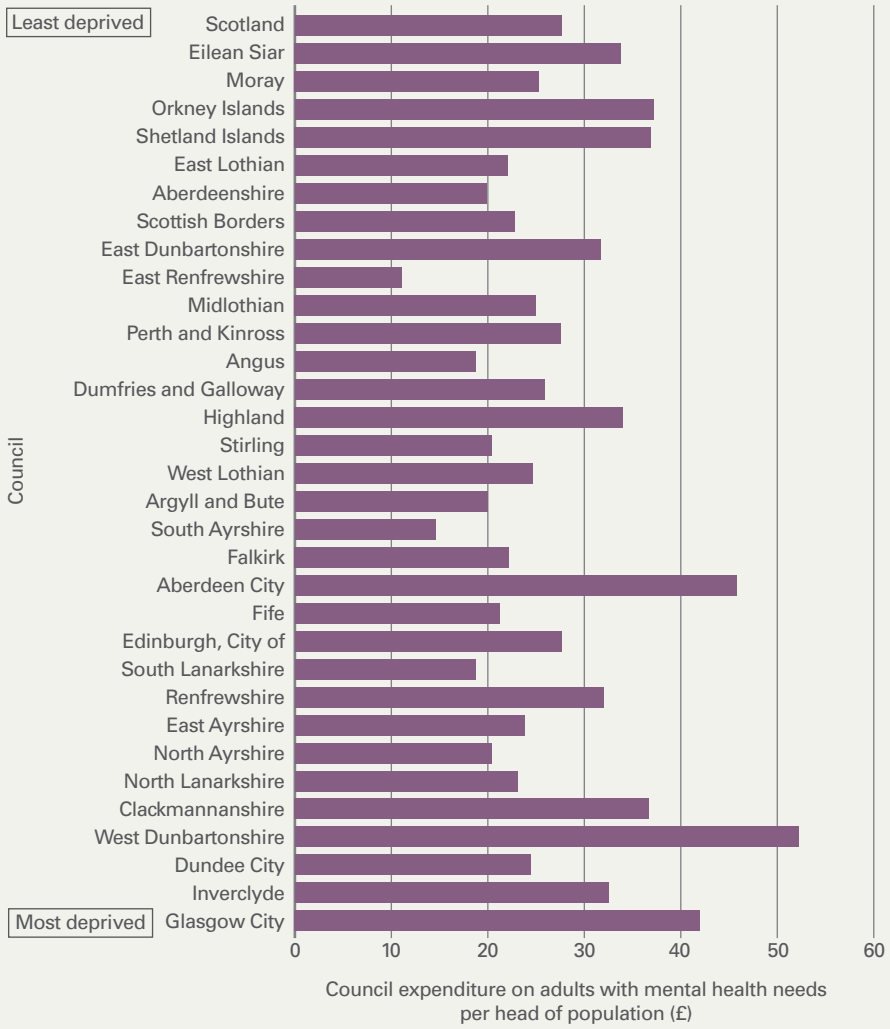
Council spend on adults with mental health problems has increased significantly since 2000/01

123. In 2007/08, £141.9 million of the total social work spend in Scotland of £3.2 billion was on adults with mental health needs. This has increased four-fold in cash terms from £35.1 million in 1995/96.[91] The full cost of council services for people with mental health problems is unknown. Many people may receive general support from social workers, for example, and these costs are not available. Transfer of resources from the NHS is included in the overall £141.9 million but a breakdown of how much is transferred to each council is not recorded at a national level. From local information provided in our fieldwork we know that in 2008/09 Glasgow City Council spent £22 million on adults with mental health needs, £11 million of which was transferred from NHS Greater Glasgow and Clyde.

Exhibit 15

Council spend on adults with mental health needs in Scotland per head of population, 2007/08

Spend on adults with mental health needs is not related to levels of deprivation.



Note: Adults with mental health needs includes people aged 18 to 64.
Source: Local Government Finance Statistics, Scottish Government, 2009

124. The average council spend on adults with mental health needs per head of population for Scotland is £28. This varies by council, from £11 per head of population in East Renfrewshire to £52 per head of population West Dunbartonshire. Levels of mental health problems tend to be higher in more deprived areas but spending does not always appear to be related to levels of need (Exhibit 15).

It is too early to assess the affect of funding changes on councils' mental health spend

125. With the introduction of the concordat between the Scottish Government and COSLA in 2008, certain council funds are no longer ring-fenced.[92] This means that funds previously used fully or partly for supporting people with mental health needs (eg, Mental Health

91 Local Government Finance Statistics on the Scottish Government website: http://www.scotland.gov.uk/Topics/Statistics/Browse/Local-Government-Finance
92 The Convention of Scottish Local Authorities (COSLA) is the representative voice of Scottish local government and also acts as the employers' association on behalf of all Scottish councils.

Specific Grant, Choose Life, Changing Children's Services Fund (CCSF) and Supporting People) are now part of a council's general allocation and councils decide what these funds should be spent on.

126. The Mental Health Specific Grant (MHSG) was paid to councils to help them to work with their partners to develop local, community-based services for people with mental health problems and their carers. Up to 2006/07, the Scottish Executive provided 70 per cent of MHSG funding (about £20 million) and councils were required to provide the remaining 30 per cent from their general allocation. From 2007/08, the Scottish Government provided a similar amount but councils now have discretion over how to use this and whether to add any more to their indicative allocation.

127. It is too early to assess the impact of funding changes for councils on mental health services. The councils in our fieldwork have made no major changes to the levels of funding previously ring-fenced (MHSG, Choose Life, Supporting People and CCSF). These funds are currently under review and some councils in our fieldwork reported that they expect to make changes in the second year of SOAs.

128. Through our focus groups, voluntary organisations highlighted some projects which have had cuts in funding and have received warnings from councils of future cuts. They are also finding it increasingly difficult to get continued funding from councils.

The uptake of self-directed support for people with mental health problems is low

129. Self-directed support, previously called direct payments, has been available since 2001. This enables people to buy services to meet their community care needs in addition to, or instead of, the council arranging services on their behalf.[93] In 2006/07, the number of people with mental health problems using self-directed support was low (three per cent) compared to other client groups such as people with physical disabilities (51.7 per cent) and people with learning disabilities (26.4 per cent).[94] This suggests that councils and the NHS could do more to promote self-directed payments to people with mental health problems.

Recommendations

The Scottish Government and local partners should:

- promote self-directed payments and improve the referral system to increase uptake by people with mental health problems so they can take a more active role in their recovery.

Local partners should:

- continue to monitor and develop the move from hospital to community services, ensuring that the resources to support this change are transferred as necessary
- monitor the funding for mental health services following the removal of ring-fenced funding so this can be matched to outcomes and ensure that services are delivered based on local need.

93 *National guidance on self-directed support*, Scottish Executive, July 2007.
94 *Statistics Release Direct Payments Scotland 2007*, Scottish Government, September 2007.

Appendix 1.

Project advisory group membership

Member	Organisation
Paul Barton	Head of Equalities Development, NHS Health Scotland
Raymond Bell	Head of Service for Mental Health, East Glasgow Community Health and Care Partnership
Geraldine Bienkowski	Lead for Psychological Therapies, NHS Education for Scotland
Dr Tom Brown	Chair of the Scottish Division, The Royal College of Psychiatrists/Consultant Psychiatrist, NHS Greater Glasgow and Clyde
Dr Graham Bryce	Consultant Psychiatrist in Child and Adolescent Services, NHS Greater Glasgow and Clyde
Dr Denise Coia	Principal Medical Officer for Psychiatry, Scottish Government
Lee Davies	Programme Principal – Improving Mental Health Information Programme, Information Services Division Scotland, NHS National Services Scotland
Sean Docherty	Mental Health Team Lead, NHS Quality Improvement Scotland
Dr James Hendry	Consultant Psychiatrist, NHS Lothian
Geoff Huggins	Deputy Director of Primary and Community Care/Head of Mental Health, Scottish Government
Jan Killeen	Information and General Policy Director, Alzheimer Scotland
Carolyn Little	Carer
Dr Donald Lyons	Director, Mental Welfare Commission for Scotland
Wendy McAuslan	National Development Coordinator, Voices of Experience
Anne McLaughlin	Service user
Professor Alex McMahon	Deputy Director, Strategic Planning and Modernisation, NHS Lothian
Charlie McMillan	Director of Research, Influence and Change, Scottish Association for Mental Health
Dale Meller	Programme Manager, Mental Health and Race Equality, NHS Health Scotland
Christina Naismith	Inspector, Social Work Inspection Agency
Eileen Ross	Community Psychiatric Nurse, NHS Lanarkshire
Dr Philip Wilson	GP, NHS Greater Glasgow and Clyde/Senior Research Fellow in General Practice, University of Glasgow

Note: Members of the project advisory group sat in a personal capacity only. The content and conclusions of this report are the sole responsibility of Audit Scotland.

Appendix 2.

Mental health policy

Year	Health policy	Main issues
1997	The Framework for Mental Health Services in Scotland	Issued by the Scottish Office and taken forward by the Scottish Executive, the framework provided a basis for subsequent policy development in mental health. It set out the essential features of a local mental health strategy and provided a matrix showing the key elements of a comprehensive service.
2000	Our National Health: A plan for action, a plan for change	Stated that mental health would be a clinical priority, along with coronary heart disease and cancer, and made a commitment to accelerate the implementation of the Framework for Mental Health Services and to develop high-quality services.
2002	Choose Life: A National Strategy and Action Plan to Prevent Suicide in Scotland	A ten-year plan aimed at reducing suicides in Scotland by 20 per cent by 2013 through a combination of strategies including early prevention and intervention, dealing with crises, providing support, awareness raising and sharing good practice.
2003	National Programme for Improving Mental Health and Well-Being action plan 2003-06	The National Programme was launched in October 2001 and the plan set out key priorities for 2003-06: raising awareness and promoting mental health and well-being; eliminating stigma and discrimination; preventing suicide; and promoting and supporting recovery.
2005	Mental Health (Care and Treatment) (Scotland) Act 2003	Implemented from October 2005, the new Act made significant changes to the 1984 Act including strengthening the rights of those detained under the Act.
2005	Children and Young People's Mental Health: A Framework for Promotion, Prevention and Care	Expands on the 1997 Framework and outlines the elements of an integrated approach to children's and young people's mental health and well-being across a range of settings.
2005	Delivering for Health	Made a commitment to publish a delivery plan for improving mental health services by the end of 2006.
2006	Delivering for Mental Health	National mental health delivery plan with three targets supported by 14 commitments aimed at improving a range of services provided by the NHS and partners.
2007	All Our Futures: Planning for a Scotland with an Ageing Population	Highlights the importance of improving mental health and well-being in later life. Covers a range of factors contributing to good mental and physical health in later life, such as physical activity, diet, support networks, mental stimulation and security.
2007	Towards a Mentally Flourishing Scotland: The Future of Mental Health Improvement in Scotland 2008-11	A consultation paper outlining the proposed future direction for mental health improvement and population mental health for the coming three years. The consultation period ended in March 2008.

Year	Health policy	Main issues
2007	Mental Health in Scotland: Closing the Gaps – Making a Difference: Commitment 13	Guidance on care and support for people with co-occurring substance misuse and mental health problems. There are six recommendations aimed at improving coordination of care.
2007	Better Health, Better Care: Action Plan	Sets out a five-year programme of work for the NHS with an emphasis on more public involvement and targeting disadvantaged communities. It includes ten commitments directly related to mental health and several others which will also impact on mental health.
2007	Mental Health Project Final Report: National Benchmarking Project	Aims to improve mental health services by using benchmarking to understand and compare services and their outcomes and to promote best practice. A balanced scorecard has been developed with a number of performance measures which will be used to gauge if NHS boards are managing mental health services effectively.
2007	Establishing a core set of national, sustainable mental health indicators for adults in Scotland: Final report	NHS Scotland established a set of 55 mental health indicators to monitor the state of mental health at a national level to support the Scottish Government's drive on mental health improvement. The majority of indicators use data already collected in the Scottish Health Survey and the Scottish Household Survey, with some questions added in 2007 and 2008 to inform the indicators.
2007	NHS QIS Standards for Integrated Care Pathways for Mental Health	NHS QIS developed integrated care pathways for the NHS and partner organisations delivering mental health services to improve the coordination of services provided by various agencies.
2008	Improving the Physical Health of those with a Mental Illness	A consultation paper which focuses on the need to improve the physical health of people with mental health problems and sets out six recommendations for change and improvement. The consultation period ended in May 2008.

Appendix 3.

Self-assessment checklist for local partners

The checklist on the next few pages sets out some of the high-level practical issues around mental health services raised in this report. NHS boards and councils, and other partners where relevant, should assess themselves against each statement as appropriate and consider which statement most accurately reflects their current situation. This will enable NHS boards and councils to identify what actions need to be taken forward.

Self-assessment for improving mental health services

The last column in the checklist can be used to record sources of evidence, supplementary comments to support your assessment or to highlight areas of interest.

	Assessment of current position					Comments
	No – action needed	No – but action in hand	Yes – in place but needs improving	Yes – in place and working well	Not applicable	
We collect and monitor data on mental health services staff, including details about caseloads and vacancies. This information is comparable and shared across the NHS and councils for benchmarking staffing levels and to help to identify service planning.						
We collect data and monitor waiting times for mental health services. We are taking action to address services with long waiting times.						
We have identified any gaps in services, including services for children and young people and older people and the availability of psychological therapies. We have an action plan in place to address these gaps.						
We routinely consider the views and needs of service users and carers, including people who are likely to be excluded from society, as part of service development.						
We involve the voluntary sector in the development and planning of mental health services to ensure the needs of the local population are met.						
We provide child and adolescent services up to the age of 18, in line with national guidance.						

	Assessment of current position					Comments
	No – action needed	No – but action in hand	Yes – in place but needs improving	Yes – in place and working well	Not applicable	
We collect information on personal characteristics of people using mental health services, such as age, gender, ethnicity and sexual orientation, to allow monitoring of equality and diversity and to develop services to meet their needs.						
We have systems in place to allow the sharing of information about people with mental health needs to ensure they receive coordinated and joined-up care.						
We have crisis services in place which meet local demand for all age groups, in line with national guidance.						
We work with partners, including prisons and the police, to deliver joined-up services with clear referral processes for people with mental health problems.						
We collect information about community mental health services for the planning and development of services, including: • the number of people receiving treatment • what treatment is being provided, for whom and for how long • outcomes for people being treated • size of caseloads • staffing levels and vacancies • the amount of joint funding by the NHS, councils and other partners.						
We have reviewed crisis and out-of-hours services and plans are in place to address any gaps.						

	Assessment of current position					Comments
	No – action needed	No – but action in hand	Yes – in place but needs improving	Yes – in place and working well	Not applicable	
We have reviewed the number of adolescent inpatient beds and taken action to ensure that provision meets demand.						
We have reviewed bed numbers and occupancy levels to ensure that resources are being put to best use (eg, we have reviewed if there is scope to reduce the number of beds and develop more community services).						
We have financial information, monitoring and planning processes in place for mental health services. In particular, we: • identify and analyse costs across all key mental health services • have clear links between budgets and mental health strategies and service plans • involve key staff providing mental health services in the financial planning process • are able to provide evidence of effective use of resources and demonstrate value for money.						
We promote self-directed payments to ensure people with mental health problems can take a more active role in their recovery.						
We are monitoring the shift in the balance of care from hospital to community mental health services to ensure that resources to support this change are transferred as necessary.						
We are monitoring council funding for services for people with mental health problems to assess the impact of the removal of ring-fenced funding and to ensure it is matched to outcomes and that services are based on local need.						

Overview of mental health services

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ISBN 978 1 906752 48 4 AGS/2009/5