1. Mental Health Services in Highland

Introduction

The Highland Council area is co-terminous with NHS Highland but it should be noted that the Council’s submission covers the Council area only. The NHS Highland submission will include Argyll and Bute which is in the Argyll and Bute Council area.

The current population of the Highland Council area is 219,000. Recent estimates suggest that between 40,000 and 50,000 adults within Highland are likely to experience mental health difficulties at some point in their lives, about three-quarters of whom will consult their GP. About 15,000 will be identified as having a mental health problem. In any one year, around 3,000 people will be seen by specialist mental health services.

Hospital Services

There is one psychiatric hospital, New Craigs Hospital in Inverness, to serve the whole Highland area. The Hospital has 72 acute beds, with a 12-bedded Intensive Psychiatric Care Unit. It accepts patients over the age of 16. There are 32 beds for older people and a 4-bedded assessment and treatment unit for people with learning disabilities. There are 34 rehabilitation and long-stay beds.

Specialist in-patient services for mothers with post-natal depression and people with eating disorders are provided in Livingston and Aberdeen respectively. There is no Medium Secure Unit (MSU) for mentally disordered offenders but a North of Scotland MSU is due to be completed in 2012.

Some local community hospitals have psychiatry of old age units, but there is no acute younger adult provision in the localities.

Community Mental Health Services

The Community Mental Health Service is provided through ten locality-based Community Mental Health Teams (CMHTs). CMHTs in Highland generally consist of psychiatrists, community psychiatric nurses (CPNs), social workers (most of whom are Mental Health Officers), occupational therapists and support workers. Some teams have an attached clinical psychologist. CMHTs are funded by the NHS and the Highland Council. The management and budgets of Teams are not integrated. However, staff are co-located and there is a significant level of joint working. The total caseload of the ten teams is 2,300, of which around 25% are people with a schizophrenic illness and 40% with depression and anxiety. Older
adults with dementia are seen by CPNs from the CMHTs and by social workers located in the Older Adult Teams in the Council’s community care service.

The priority for the Community Mental Health Service is the care and support of people with severe and enduring mental health problems.

**Child and Adolescent Mental Health Services**

A range of staff across agencies in children’s services have responsibilities to promote mental health, including as part of the mental health link worker role around schools.

Specialist services are provided by Integrated Child and Adolescent Mental Health Services, which now incorporates the former Department of Child and Family Psychiatry, Clinical Child Psychology, and Clinical Child Psychology - Learning Disabilities. This is a multi-agency and multi-disciplinary team. While most of these staff are based centrally at Raigmore Hospital, there is one post in the North CHP and an associated post of Forensic Psychologist based in the Social Work Service. There are also locality-based Primary Mental Health Workers in each CHP.

**Highland Council Services**

Highland Council employs 39 MHOs of whom 19 work in mental health services and 13 in community care services. The remainder are spread amongst Criminal Justice Services, Children and Families Teams and in the Out of Hours Emergency Team.

The Council also employs support workers in CMHTs, two accommodation officers and some admin staff. All other CMHT staff are employed by the NHS.

The Council manages one mental health day centre based in Inverness and funds drop-in centres in each local area that are run by voluntary agencies.

Supported accommodation is provided in four localities by Birchwood Highland, which also manages a residential Recovery Centre.

There are three other independent sector care homes which specialise in mental health, two of which are located in the Inverness area and one in Easter Ross.

The Training and Guidance Unit (TAG) funded jointly by Highland Council and NHS Highland provides guidance and training towards employment and meaningful activity in nine localities. Two social firms employ a number of people with mental health problems. The Council is currently reviewing supported employment services and there is a corporate short-term working group tasked with this.

2. Issues to be addressed

2.1 Accessibility of mental health services
(a) What targets have you set for accessibility to services (including waiting times) and the quality of services in your area?

The Council has established mental health services in each of its three geographical areas and with staff located to provide more local access. A 15-day target has been set for the completion of assessments. These will be addressed by Scottish Government waiting times for psychology services and by the implementation of Integrated Care Pathways (ICPs) for five conditions: schizophrenia; depression; dementia; personality disorder and bi-polar affective disorder. ICPs are likely to be implemented in 2010.

(b) Action taken to address services with long waiting times

The longest waiting times have been in psychology services but these have been significantly reduced in the last two years.

This includes a steep rise in the numbers of private welfare and financial guardianship applications being made. These largely relate to young people moving into adulthood. As a result of the increased number of guardianship applications, the Service now has a waiting list for allocation to MHOs. In Inverness, Nairn, Badenoch and Strathspey, the most populated area, this waiting list varies between 20 and 30 cases and the CMHT Manager is continuously assessing risk and determining the priority for dealing with applications. The lowest priority group is that of young adults who are being supported at home.

(c) Current issues affecting vulnerable groups – children and adolescents; minority ethnic groups; prisoners and ex-offenders; older people with dementia

There are no specialist in-patient facilities for young people under 18 years and the target to reduce such admissions to adult wards has not yet been met. The Child and Adolescent Mental Health Service has recently reviewed its services and extra staff have been recruited.

The Integrated Child and Adolescent Mental Health Service has recently reviewed its services and additional staff have been recruited. New processes have been introduced to streamline systems, and achieve more seamless provision as part of ‘Getting it Right for Every child’.

Highland has a low number of people from minority ethnic groups. However, there are an increasing number of referrals to mental health services of people from Eastern European countries. Access to interpreters is normally through NHS Highland as the individuals tend to be in-patients. Payment for interpretation services are therefore borne by health colleagues. However, finding interpreters can on occasion be problematic.

Highland has implemented a protocol with the Sheriff Court Service in the use of the Criminal Procedures Act with mentally disordered offenders which has improved the way the Courts deal with people with mental health problems. There
is a small forensic mental health team which provides inreach to Inverness Prison enabling prisoners with major mental health problems to receive treatment.

The numbers of people with dementia has increased significantly and will continue to rise.

The Community Care Service in Highland Council was recently re-organised into specialist Older Adults Teams in order to provide an improved service. There is however a major challenge to meet the future needs of people with dementia given increasing numbers of older people and a corresponding decrease in the numbers of young people to provide the care.

(d) Adequacy of levels of service for vulnerable groups

Please see above.

2.2 Delivery of mental health services

(e) Performance against the four national health targets for mental health

Please see the NHS Highland submission

(f) How helpful do you think these four targets are?

The suicide target was in place for two years before the Mental Health Delivery Plan was published and is essential given the concerning suicide rate in Scotland and in Highland in particular. The associated training target is useful to ensure that services have sufficient awareness of suicide and its warning signs.

The target relating to the prescribing of anti-depressants is designed to ensure that more alternative psychological therapies are available and as such is useful, but it has coincided with GPs being trained to be more aware of depression and anxiety and as a result more people have been identified as needing help. This makes it a more challenging target to meet.

The re-admission target has encouraged services to look at how people with severe and enduring mental illness are cared for in the community and at strategies for preventing admission. It should also assist in designing new services. This is especially an issue in Highland given the remoteness of some communities, with some populations over 100 miles from the nearest in-patient facility.

The dementia target is helpful in identifying numbers and in assisting in early intervention. However a key challenge is to ensure that those people identified with dementia receive a good service from health and social care.

The HEAT targets have been reflected in the Single Outcome Agreements. This underlines the partnership approach and joint ownership.
(g) The suicide rate in Scotland is almost double that of England and Wales. What is the situation in your Board area and what measures do you think will be effective in reducing the rate?

Highland has one of the highest suicide rates in Scotland, especially among young men. In 2007, 38 men and 7 women committed suicide in Highland and in 2008, 38 men and 10 women. The rate has therefore increased slightly after a period of decline. The Highland Choose Life Group has done a lot of work in the last five years to increase awareness of suicide and the factors leading to suicide, including the funding of a number of local groups and an advertising campaign in football clubs, shinty clubs and local communities. Vulnerable groups such as farmers have been identified and offered support and self-help activities are available on the Group’s web-site.

Volume training through STORM and ASIST courses was delivered from 2004 until 2007. A part-time training administrator is being appointed to ensure training is continued. A course specifically for Children’s Service workers has been developed together with Children First and is currently being delivered.

There is, however, insufficient evidence of the difference all the Choose Life activity makes to the suicide rate and it is apparent that the stigma of mental illness still plays a part in local communities in creating a barrier to people seeking help when they most need it. Research will be carried out into the prevalence of self-harm and a Scotland-wide research project into the reasons why Scotland has a higher suicide rate than other European countries is planned.

(h) There has been a fourfold increase in prescribing of anti-depressants since 1993-94. What is the prescribing policy in your area and how is it monitored?

As above, please see the NHS Highland submission.

(i) What are you doing locally looking at prescribing patterns?

As above, please see the NHS Highland submission.

(j) There are currently few national outcome measures for mental health services. How are you monitoring and reviewing mental health services to ensure that your services are meeting local needs and have you included mental health issues in your single outcome agreement?

We are planning to use the Scottish Recovery Indicator to evaluate the work of the Community Mental Health Service and in-patient services. One CMHT and one hospital ward will act as pilot sites for this.

The Delivery Plan targets of suicide prevention, early diagnosis of dementia, prescribing of anti-depressants and reducing re-admission rates to psychiatric hospitals have been included in the Single Outcome Agreement.
Also included in the SOA: ‘Attitudes & behaviours towards alcohol and other drugs are changed and those in need are supported by better prevention and treatment services.’

Mental health services will form part of our Joint Community Care Plan, 2009 – 12, currently in draft.

(k) How does partnership working in your area operate in practice and how effective is it?

CMHTs have been in existence in the Highlands since 1995 and have proved effective at providing a joint service for people with severe and enduring mental illness in the community. The sharing of tasks and roles as well as a ‘one-stop shop’ approach to referrals has resulted in fewer hospital admissions and a better quality of life for service users and better liaison with families.

There is a multi-agency approach to the overall operational and strategic management of the mental health service. The IRF project is likely to promote closer engagement and joint commissioning across community care. It operates at pan-Highland CHP and team service delivery level. There is a Mental Health Strategic Group which has the responsibility for strategic review and planning. There is a Joint Community Care Management Team and Joint Mental Health Teams.

Child and Adolescent Mental Health Services are managed through the Child Health Network, which involves managers from across agencies, seeking to ensure that decision-making is joined up.

(l) Mechanisms to deliver joined-up services

As mentioned above, CMHTs provide a joined-up service in the community, with one referral point and a team approach to the allocation of cases. Referral criteria are being aligned as part of the Integrated Care Pathway development process which will result in greater consistency in the future and clearer guidelines for referrers. This will make it easier for teams to concentrate on their core business of care for people with severe and enduring mental disorder.

‘Getting it Right for Every Child’ and associated pathways and systems have been introduced in children’s services.

(m) How do you work with prisons to ensure that prisoners with mental health problems in your areas receive the support they need while in prison and appropriate referral to community services once they are released?

There are two forensic CPNs and a consultant psychiatrist who provide a service to the prison. Two criminal justice social workers are also MHOs and two others have been MHOs. There is evidence of increasing levels of mental health problems and substance misuse in prison. The forensic mental health service provides advice, guidance and support to prison staff. Prisoners who exhibit acute
symptoms of mental disorder are usually transferred to New Craigs Hospital for assessment and treatment.

(n) How do you work with educational psychology services to ensure that issues with children's mental health are picked up in schools?

The approach has involved the redesigning of services and streamlining of processes to promote more effective integrated working. Positive partnership with parents and effective early intervention is at the heart of GIRFEC. We are working with colleagues in CHPs and associated school groups locally to ensure the optimum relationships and combination of roles locally, including that of educational psychology, and as part of the mental health link worker role.

2.3 Expenditure on mental health services

(o) How do you decide how much will jointly be spent on mental health services by the NHS Boards and local authorities in your area?

Decisions about spending on mental health services are made by each organisation. Joint priorities are identified through the community care planning processes.

(p) Use of pooled or aligned budgets

Some budgets are aligned to mental health services, and CMHT managers have some flexibility in managing the local service.

(q) Are there barriers in the accountability or financial procedures to prevent delivery of better joined-up services?

There are no perceived accountability or financial barriers to the delivery of such services.

(r) How do you decide how much NHS resources will be transferred to councils in your partnership and how do you know that such money is being spent on mental health services rather than being diverted to other services provided by the Council, such as education or housing?

The major decision about resource transfer in Highland was made in 1995 and aside from inflation the amount has not changed in the intervening period. Resource transfer has been used for the provision of mental health services in the community including the social work, support work and administration staff in CMHTs. A very detailed annual report is provided to the Chief Executive of NHS Highland to account for expenditure.

(s) Knowledge of total amount of council spending on mental health

Community Care Teams (including MHOs) CMHT and Older Adults - £2.4m
Community Support Services, including commissioned services - £4.7m
Direct Payments        - £4,000
Care homes are more difficult to estimate but likely to be - £4m
(the independent sector budget is not differentiated)

(t) Over recent years more resources have been directed into community services. What information do you have on the cost of community services and the effectiveness of these services? How are monitoring the shift in the balance of care?

As mentioned above, there is accurate information on the cost of community services. Up until now, outcome measures have not been used to evaluate the effectiveness of community services, although in the last 15 years there has been a significant decrease in the number of hospital beds and average length of stay. We intend to measure the effectiveness of community services by using the recently-introduced Scottish Recovery Indicator (SRI) as a tool to see whether CMHTs are providing the right kind of service. The SRI is one of the Scottish Government’s Delivery Plan Commitments.