Public Audit Committee
Overview of Mental Health Services
Submission from NHS Lanarkshire

1. Purpose of Report

Further to the correspondence issued by Jason Nairn on July 22\textsuperscript{nd} in respect of the Scottish Parliament Public Audit Committee Inquiry into Mental Health Services, the following report has been prepared to:

- Provide background information on how mental health services are delivered across Lanarkshire.
- Answer the specific questions posed in the attachments to the correspondence.

2. Background

2.1 Strategic Planning

Mental health services in Lanarkshire have been progressed using a service strategy developed in partnership between the NHS; North and South Lanarkshire Councils; and service users and carers. The original strategy was developed in 1999 but has been updated in 2004 and again in 2006 to reflect changes in both national policy and mental health legislation. The principle aim of the strategy is to re-balance care away from institutional settings to community based provision. This has necessitated reviews of the existing service models; the in-patient and community based accommodation; as well as the workforce requirements both in terms of numbers of staff and in the levels and range of skills and competencies needed to deliver contemporary care and treatment.

2.2 Service Modernisation and Workforce Developments

Much has been achieved since the original framework was prepared, with the development of community mental health teams designed to better meet the needs of people with enduring mental health problems as well as improving capacity and capability to provide focussed interventions for people with mild to moderate mental illness. These community based developments have been essential to support the rationalisation of in-patient accommodation by lessening dependence on institutional care. This has freed up resources for direct investment into improvements in community based services, some of which are set out below:
- Psychiatric Assessment Team £254K 5.0 WTE
- Old Age Psychiatry £575K 12.5 WTE
- Child and Adolescent Mental Health £637K 14.9 WTE
- Psychological Therapies £120K 2.5 WTE
- Forensic Services £34K 1.0 WTE
- Adult In –patient £316K 14.1 WTE
- Resource Networks £374K 13.0 WTE
- Eating Disorders £250K 5.2 WTE
- ICP £100K 2.0 WTE
- Psychological Therapies Prescribing Project £352K 10.0 WTE
- Crisis Resolution Home Treatment £550K 14.06 WTE
- MH Collaborative £191K 2.0 WTE
- In-patient Forum £ 40K 0 WTE

TOTAL £3.793m 96.26 WTE

2.3 Capital Developments

At the same time as these service developments were being implemented a detailed review of the existing estate was completed. This has resulted in a substantial capital development programme being prepared and implemented. For mental health services this involves investment of £55m capital and around £6m of revenue funding. Work is at an advanced stage on 2 new units to provide in-patient care for those with complex mental health needs at Coathill Hospital, Coatbridge (opening March 2010) and Caird House in Hamilton (opening December 2010). Plans are also being prepared for a new 130 bed psychiatry unit in North Lanarkshire. It is expected that this facility will open in Spring 2013. This unit will provide dedicated facilities for adults; older people; substance misuse services and those who require intensive psychiatric care.

2.4 Current Position

Whilst these developments represent considerable progress it is recognised that the level of investment currently available needs to increase if the NHS Board and its partners are to deliver on all of the targets and commitments set out in “Delivering for Mental Health" (SEHD 2006). The Lanarkshire mental health strategy clearly sets out our intended service models; the workforce requirements; the capital developments and the attendant financial requirements if these goals are to be met. The overall strategy is supported by more detailed plans for each of the sub-specialty areas including Child and Adolescent Mental Health services; Psychological Therapies; Old Age Psychiatry and Substance Misuse services. This approach has enabled priorities to be identified for future investment. These plans have been developed by and implementation is monitored via a Service Improvement Board with representation from NHS; both Local Authorities and service users and carers.
3. Service Delivery

It is clearly recognised by all stakeholders that strong partnership working is critical if we are to succeed with our aims of delivering treatment and care services locally and within people's own homes. Whilst NHS Lanarkshire and its community planning partners have a single mental health service strategy, delivery is through two community health partnerships (CHP's) which are co-terminus with local authority boundaries. In recognition that comprehensive support, treatment and care for those with mental health problems needs effective co-operation amongst community planning partners, both council areas have structures in place to facilitate service planning; delivery and evaluation for each of the community care groups including mental health. Below this, the CHP's are divided into 10 operational localities, 6 in North Lanarkshire and 4 in South Lanarkshire. This approach enables local needs to be considered alongside corporate and national targets. A copy of the organisational structures for North Lanarkshire is attached as appendix 1. Similar arrangements are in place within South Lanarkshire Council area.

4. Specific Points to be addressed

The correspondence issued to NHS Boards and Local Authorities on behalf of the Public Audit Committee requested that a number of issues relative to mental health services are addressed. These are responded to in turn in the following section:

4.1 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 CHP’s have set out waiting times trajectories for assessment in all of our mental health services. Whilst the ultimate aim is to develop the systems and capacity to achieve similar 18 week referral to treatment targets set for Acute Service areas we need to take a realistic view based on the current level of need and the relatively low resource base.

Within NHS Lanarkshire we have a Capacity Planning and Waiting Times Group that reviews levels of demand and the capacity to supply. Predictive tools have been developed to scenario plan future waiting times and the models and resources that will be required to address these. This approach considers referral rates; caseload capacity for new and return appointments and takes account of the evidence base on expected number of clinical sessions that a patient will required to be on the caseload for. This enables us to set improvement trajectories for each sub-specialty. Some examples of the impact that this system has had are set out below:

Old Age Psychiatry Service – Longest wait in 2006 was 46 weeks now at 26 weeks. CAMHS Services have reduced longest waits by 21 weeks, from 73 to 52 weeks, since 2008.
From a quality perspective service models reflect contemporary evidence based practice and NHS QIS Standards where these exist. Considerable work is also ongoing in the development of the NHS QIS generic and condition specific care pathways approach.

**b) What action are you taking to address services with long waiting times?**

Considerable work has been taken forward in terms of clinical re-design; review of referral, assessment and appointment procedures and in restructuring the available workforce to improve the use of existing resources and to enable a more effective match between service users' needs and the most appropriate clinician. The above noted capacity planning programme has also supported the prioritisation of additional resource allocations as set out in section 2.2 of this paper.

Where there has been non-recurring funding available and appropriate clinical staff can be recruited, additional clinics to clear longest waits have been implemented. These measures bring only short term benefit as recurring funding is not available to sustain these. Where possible, patients are also offered appointments outwith their own locality where waiting times are lower.

Considerable work has also been progressed with Community Planning Partners to address mental wellbeing within the population. This work seeks to encourage people to use existing community provision to improve socialisation, exercise, education and employment opportunities, all of which contribute to improvements in mood and self esteem.

**c) What are the current issues affecting vulnerable groups in your area – children and adolescents; minority ethnic groups; prisoners and ex-offenders; older people with dementia?**

The issues affecting vulnerable groups in Lanarkshire would be the same as any other comparable board area i.e. ensuring fair and appropriate access to opportunities such as health improvement, employment and to services when required.

Specific issues exist in relation to high levels of deprivation; alcohol misuse; substance misuse; poor parenting; childhood developmental issues; rising unemployment; rehabilitation of offenders; community safety; incidence of Long Term Conditions; and numbers of people on incapacity benefit. This can lead to a vicious circle where children grow up in households where some or all of these issues are present and where living off benefits is the norm and therefore they are ill equipped in relation to having the life skills and abilities to break out of that cycle. This situation requires strong partnership working between social work; education; substance misuse; public health and mental health services to provide integrated support packages. The Single Outcome Agreements for the Council areas reflect these issues and improvement targets have been set to support better outcomes in Early Years; Educational Attainment; Improve Employability; Reduce Impact of Substance Misuse and Enhance Community Safety including reduction of the incidence of domestic violence. The
partnership structures are designed to support effective assessment of need and the delivery of care packages to community care groups including Older People; People with Mental Health and Learning Disabilities and people with substance misuse problems.

Work is ongoing with the Scottish Prison Service to support effective transition of offenders as they move between the community and the prison system.

d) Are current levels of service for vulnerable groups adequate and what improvements, if any, are being planned?

It is perhaps worth stating that NHS Lanarkshire continues to be funded below the levels set out within the Arbuthnott Formula and we are known to be in excess of £21.5m revenue below the “fair shares” level set out in the National Resource Allocation Committee Formula. This does impact on our potential to provide all of the services for our communities that we would desire. Despite this position, within NHS Lanarkshire, detailed work has been carried out looking at the profile of communities including the use of data zone information. This data is then used to adjust the levels of resource available to each community adjusting population share for age; gender and deprivation. In essence those areas with the greatest levels of need receive a higher proportion of resource to support fairer access to services.

Improvements in access to services are a key feature of care strategies for homeless; older people; people with mental health problems or a learning disability and for people with substance misuse problems however much of the planned developments beyond those already achieved are dependent on improved resource allocation.

4.2 Delivery of Mental Health Service

e) What is your performance against the 4 national health targets for mental health?

<table>
<thead>
<tr>
<th>Target</th>
<th>Description</th>
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<tbody>
<tr>
<td>Target 1 - T3</td>
<td>“Reduce the annual rate of increase of defined daily doses per capita of anti-depressants to zero by 2009/10 and put in place the required support framework to achieve a 10% reduction in future years”</td>
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Table 1

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<tbody>
<tr>
<td>Trajectory</td>
<td>32.9</td>
<td>35.2</td>
<td>37.3</td>
<td>39.7</td>
<td>38.9</td>
<td></td>
</tr>
<tr>
<td>Actual</td>
<td>30.7</td>
<td>32.91</td>
<td>34.65</td>
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The trajectory to June 09 sets out what the rate of growth would be if current trends continued. Beyond that the trajectory begins to work towards the target 10% reduction. Actual performance measures the impact that local actions are having in slowing the rate of growth to zero by the due date.

Performance trajectories have been agreed with the Scottish Government Health Department within the NHS Lanarkshire Local Delivery Plan. Currently the Board has slowed the rate of growth and is ahead of the agreed trajectory (see table 1). This has been achieved largely by two specific actions. Firstly
the review of prescribing rates per GP practice and CHP locality and by setting targets within the prescribing action plan to reduce these where appropriate.

The second has been the introduction of a psychological therapies pilot project in the two localities with the highest prescribing rates. This model offers faster access to a programme of psychological therapies and by using Gateway Workers supports people to use existing community services to improve socialisation; access to educational opportunities and increased use of leisure facilities in accordance with the community prescribing model. This approach is known to enhance self esteem; improve mood and reduce anxieties.

An Information Prescribing Programme has been developed in partnership with local council libraries. This service will ensure easy sign posting and accessibility to mental health self help, biblio-therapy, and supported self help approaches.

At a more strategic level a full service review of psychological therapies based on the national work ‘The Matrix’, has also been concluded. This will result in a programme of re-design to improve assessment and match patients to appropriate clinicians. This re-modelling work will see a more efficient use of resources and speed up access to appropriate care.

Target 2 - H5 “Reduce Suicide Rates between 2002 and 2013 by 20% supported by 50% of key frontline staff in mental health and substance misuse services, primary care and accident and emergency being educated and trained using suicide assessment tools/suicide prevention training programmes by 2010”.

Once again trajectories have been set for staff training programmes as part of the Local Delivery Plan. To date NHS Lanarkshire is ahead of these trajectories and has plans in place to support training of GP’s; A & E staff and consultant psychiatrists.

**Staff to be Trained by 2010**

<table>
<thead>
<tr>
<th>Year</th>
<th>DEC 2007</th>
<th>DEC 2008</th>
<th>DEC 2009</th>
<th>DEC 2010</th>
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<tr>
<td>Trajectory</td>
<td>Base line</td>
<td>20% (n= 467)</td>
<td>35% (n= 811)</td>
<td>50% (n= 1159)</td>
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<tr>
<td>Actual</td>
<td>22% (n= 500)</td>
<td>31% (n= 722)</td>
<td>38.7% (n= 918) (as at June 09)</td>
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Reduction in suicide by 20% by 2002 to 2013.

<table>
<thead>
<tr>
<th>Year</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
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<td>16.3</td>
<td>15.9</td>
<td>15.6</td>
<td>15.5</td>
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<tr>
<td>Actual</td>
<td>15.8</td>
<td>16.6</td>
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Suicide rates in Lanarkshire remain largely in line with the Scottish average. Multi-agency partnership steering groups, led by North and South Lanarkshire
Councils with partnership from NHS Lanarkshire, and support from Choose Life coordinators have been formed in response to the Choose Life national strategy. This includes representatives of addiction services. Each group has developed local action plans in order to deliver on the priority areas and objectives of the strategy, with funding provided by local authorities through the Single Outcome Agreement. Action Plans are now closely linked to mainstream health improvement activity to strengthen the Choose Life message.

NHS Lanarkshire has funded the release of staff to support the implementation of the training strategy and undertake training for trainers courses. They are supported thereafter to deliver the suicide prevention training programme.

Trainers for suicide prevention training:
- 5 people trained as trainers in ASIST
- 5 trained in safeTALK
- 12 people trained as trainers in STORM

Target 3- T4 Reduce the number of readmissions (within 1 year for those that have had a psychiatric hospital admission of over 7 days) by 10% by end December 2010

Trajectory:

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<tbody>
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<td>411</td>
<td>436</td>
<td>436</td>
<td>436</td>
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<tr>
<td>Actual</td>
<td>414</td>
<td>375</td>
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The baseline of 484 for this target has been taken as December 2004 (the original baseline of 483 was recalculated by ISD). We are currently ahead of target trajectory.

NHS Lanarkshire has several initiatives underway which are relevant to the achievement of this target and associated commitments from “Delivering for Mental Health” (SGHD 2006).
- Crisis Resolution & Home Treatment Service development;
- Review of Psychiatric Assessment Team.
- Development and implementation of NHSQIS standards for ICPs
- Mental Health Collaborative Programme being implemented

Target 4 -T9 Each NHS Board will achieve agreed improvement in the early diagnosis and management of patients with dementia by March 2011.
Trajectory year ending 2007 – 2011
Target 64% of prevalence

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<tbody>
<tr>
<td>Trajectory</td>
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<td>3072</td>
<td>3306</td>
<td>3540</td>
<td>3774</td>
</tr>
<tr>
<td>Actual on Register</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>% of prevalence</td>
<td></td>
<td></td>
<td>50.4%</td>
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Work is ongoing between Lead GP’s and the Lead Clinician for Old Age Psychiatry to improve rates of diagnosis and registration. This also features as a key work stream within the Mental Health Collaborative Programme. With this increased focus it is expected that we will achieve the 2010 trajectory level.

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

The targets do add value in respect of the fact they have led to reviews of existing services and the provision of improvement strategies through the Mental Health Collaborative which have enabled teams to reflect on how service provision can be remodelled to improve efficiency and effectiveness. They have also highlighted gaps in service provision that will require further investment if waiting times are to be reduced. However whilst the targets are aimed at quantitative measures they are not in themselves good measures of service quality or clinical outcomes e.g. reducing admissions is only a good thing if safe and effective community based alternatives are in place.

g) The suicide rate in Scotland is almost double the rate in England and Wales - What is the situation in your board area and what measures do you think will be effective in reducing the rate?

Suicide in Lanarkshire - current position

Suicides in NHS Lanarkshire Board area have decreased in the period 2007-2008 from 104 to 102 completed suicides, and remain largely in line with the Scottish average. Whilst numbers in South Lanarkshire have fallen from 48 to 41 in that period, the same period in North Lanarkshire has shown an increase from 56 to 61. This may be explained by the high levels of deprivation in North Lanarkshire. Risk increases with increasing deciles of deprivation, and those living in areas in the three most deprived deciles of Scotland have a significantly increased risk of suicide compared to Scotland generally. North Lanarkshire is currently the second most deprived local authority area of Scotland.

Performance of NHSL is only one contributing factor to the local population suicide rate. Although we are committed to reaching the training target, this alone will not necessarily result in a fall in the suicide rates. Other key factors are social deprivation; the local and national economy; multi-agency partnerships; the performance of local authorities; and wider cultural
influences. Greater national consideration and information as to how we should measure the impact of training on practice and on reducing suicide would be welcomed. Whilst we know how many completed suicides occur, it is harder to estimate how many lives are saved through early identification of risk and the delivery of suitable supports.

Measures being taken by NHS Lanarkshire aimed at reducing suicide rates

(i) Suicide Assessment and Intervention Pathway

A multi-agency suicide assessment and treatment pathway has been developed. The focus at this stage is embedding the pathway in existing training and agreeing evaluation and outcome measures, exploring involvement of academic establishments in the process. The relevant recommendations within the National Confidential Inquiry into Suicide and Homicide by people with mental illness (2008) have been included within the pathway. The pathway has been printed onto pocket sized ‘Z – cards’ which are currently being distributed to key frontline staff. It is envisaged that in conjunction with the training, these guides will enable staff to be better equipped to identify people at risk and ensure they are offered the appropriate level of care and treatment for their needs.

(ii) Multi agency approach to mental health improvement and wellbeing

We remain committed to partnership working to maximize the contribution of all parties to address the health and socio economic issues that are known to be factors which affect suicide rates. The Choose Life agenda is also closely linked with the wider mental health improvement agenda that has a focus on the prevention of mental ill-health and the promotion of well-being. A multi-agency Lanarkshire Mental Health Improvement Partnership Group has been established and has developed a local Action plan in response to the national action plan Towards a Mentally Flourishing Scotland.

(iii) Mental Health Awareness

100,000 information cards have been printed for distribution at point of contact with GP, targeted at those people with mental health or emotional problems. These cards were produced in May 2009 and contain information on telephone and web support for mental health. They also provide information in relation to welfare, debt and money advice in view of the current economic climate.

A high profile social marketing campaign was implemented across Lanarkshire in September 2008, with good media coverage through linking with Motherwell and Celtic Football Clubs. In addition, road shows were taken around Lanarkshire. Excellent media coverage was achieved with 4 national and 6 local newspapers covering the work that was going on in relation to mental health awareness, anti stigma and suicide prevention.
Work with two local taxi companies on an initiative for suicide prevention week seen a taxi branded to advertise awareness of suicide prevention. 30,000 cards were distributed by 250 taxi drivers who were briefed and driver and call centre staff participated in safeTALK.

As well as these high profile initiatives suicide prevention activity continues to build capacity, increasing suicide awareness and sustainability through links with existing programmes such as health promoting schools, healthy working lives, health promoting health service and health promotion training programmes, and existing networks such as housing, education, looked after and accommodated young people and the police.

An on-line mental health awareness-training programme (northlanmindset), including suicide awareness has been developed through the North Lanarkshire Choose Life Steering Group and is promoted across organisations and communities element within NHS Lanarkshire’s on-line Mental Health Information Resource has been redeveloped and launched in June 2008: www.lanarkshirementalhealth.org.uk

(iv) Crisis Resolution and Home Treatment Service Development

A crisis resolution and home treatment service has been developed and is available on a 24hr / 365 day basis to provide urgent assessment and intervention for people experiencing mental health crisis. The service is currently available in the East Kilbride / Hairmyres area with plans to roll out to the remaining areas of Lanarkshire over the next 18 months

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

Antidepressant prescribing has increased in response to better primary care identification and screening of depression in General Practice in the past fifteen years.

Initiatives such as “Defeat Depression” and the increasing adoption of validated depression screening tools to identify postnatal depression and depression related to chronic illness have culminated in the inclusion of a Depression clinical domain within the General Medical Services Quality and Outcomes Framework. While initially focused on identification of depression related to chronic illness, this now requires interval assessment of depression symptoms using a validated tool. It is clear that not all patients with a diagnosis of depression require pharmacotherapy. Alternatives such as watchful waiting, where clinically appropriate and use of alternative treatment modalities including counseling to address life issues and Cognitive Behavioural Therapy provide evidence based alternatives. As part of a Care Pathway these alternatives are increasingly offered within NHS(L) and significant investment into non-pharmacological therapiess has occurred in recent years. Policy on antidepressant prescribing is part of the Formulary function of the Area Drug and Therapeutics Committee.
Monitoring of antidepressant prescribing takes place at a number of levels. Use of 1st and 2nd choice formulary antidepressants is encouraged in the Prescribing Action Plan (PAP 6) process.

The level of prescribing by practice, locality, CHP and Board is recorded quarterly as part of the PAP 6 template and this is used to feed back to prescribers at local level using Locality Pharmacists to discuss prescribing and encourage reflection on practice both in the volume and range of antidepressants prescribed. Discussions also take place at Locality Clinical Fora and at Locality Quarterly Reviews with senior CHP Management staff present. Finally the overall Board picture on antidepressant prescribing forms part of the discussions held on Primary Care Prescribing within the Prescribing Management Board. This in turn reports to the Board’s Corporate Management Team.

i) What work are you doing locally looking at prescribing patterns to determine whether antidepressants are being prescribed appropriately and what other treatments are available to people with depression, such as psychological therapies, increased social support etc?

A detailed analysis of antidepressant, anxiolitic and hypnotic prescribing per GP practice and locality has been carried out. This has been used to a) set targets at locality level around prescribing rates which are monitored operationally via the Performance Review system (described in section h) and b) prioritise two locality areas (highest prescribers) to pilot a Mild to Moderate Mental Health Pilot project designed to provide speedier access to both Counselling Services and Gateway Worker to facilitate changes in lifestyle; socialisation; and use of community services.

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?

A full mental health needs assessment was carried out by the Public Health Department of NHS Lanarkshire. This level of need was considered against “Defining a Good Mental Health Service”, produced by the Sainsbury Centre for Mental Health (2005). This document presented calculations on the specifications and workforce requirements for the level of mental health services required to achieve all of the standards from the National Service Framework for Mental Health. Taken together with service users and professional views this was used as the foundation for the Lanarkshire Mental Health Strategy and the attendant Modernisation Plan. In this way services have been designed to meet local needs using nationally recognised service models.

Currently we are utilising those targets and commitments from a range of policy and performance management documents issued by the Scottish Government Health Department to measure service quality. These include HEAT targets; “Delivering for Mental Health”; “Delivering a Healthy Future” and “Towards a
Mentally Flourishing Scotland”. In addition community planning partners have agreed joint priorities for community care groups including mental health. These are included within Single Outcome Agreements. The targets are designed to have a positive impact on both the wider SOA agenda on poverty; inequalities; employment; lifelong learning; mental and physical wellbeing and substance misuse and more directly on mental health targets such as improved emotional wellbeing; reductions in deaths by suicide and reduced prescribing of anti-depressants linked to improved utilisation of “social prescribing” options. The SOA’s also include measures linked to the National Community Care Outcomes including:

- numbers of Single Shared Assessments completed
- numbers of Carers Assessments carried out
- numbers of people living at home with intensive home care support packages

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

There is very close partnership working within Lanarkshire at all levels. As described above, implementation of Mental Health services is overseen by Joint Community Care structures such as the Health & Care Partnerships; Partnership Boards and Locality Planning Groups. Service delivery is carried out by Resource Networks in localities which comprise health and local authority staff. There is also a very strong ethos of working in partnership with service users and carers who have a real voice in how services are designed and delivered, through organisations such as Lanarkshire Links and Partnership 4 Change.

There is an evolutionary process of integration of services in North Lanarkshire where we have Integrated Day Services for Older People; Integrated Addiction Services and we are now exploring the feasibility of integrating our Mental Health Services.

We have an excellent foundation on which to build better mental health services. Our current services have been praised by external scrutiny bodies for what they are able to deliver within current resources. There are clearly issues related to the relatively low levels of funding available to us.

l) What mechanisms do you have to deliver joined-up services with clear referral processes for people with mental health problems?

Individuals can access mental health services in various ways. The majority of people access services through their GP and many have their care completely managed through these primary care services.

There are a number of routes of referral to mental health services, some of which are detailed below:-

- Community Mental Health Teams
Community Mental Health Services include a range of clinical services that provide support to a range of care groups and have a specific remit within these teams. These include:
Outreach Services providing services to people suffering severe and enduring mental health problems:
Focus Intervention providing short term interventions for first episode Psychosis and mild/moderate mental health problem
Early Onset Dementia
Care Home Liaison
Discharge Liaison
Old Age Psychiatry.

Mental health referrals can be made to Community Mental Health Teams by a range of professionals both internal and external to NHSL Mental Health Services, i.e. General Practitioners: Primary Care Teams: Psychiatric Assessment Teams; Local Authorities’: Mental Health Admission Wards.

Allocation meetings are conducted weekly to manage and review all referral to the teams. Where urgent referrals are received allocation will take place on receipt of referral. Meetings generally consist of psychiatry, psychology, community mental health nurses, social work, dietetics and occupational therapy staff. Local variation may be noted in some localities however these general principles are in place across mental health services.

**Psychiatric Assessment Team**
Urgent referrals can be seen by Psychiatric Assessment Team based in general hospital sites in Monklands and Wishaw. Sources of referral are GP Out of Hours services: on call psychiatrists: self referral via Accident & Emergency. These teams work in close partnership with police, ambulance services, NHS 24 and local authorities.

The team see all age and care groups providing psychiatric nursing assessment and psychiatric clinical support to a variety of services within the Monklands and Wishaw hospitals. This support is provided to Accident & Emergency Services, Emergency Receiving Units and all hospital in-patient wards. Written referrals with supporting clinical assessments will be made to the relevant/appropriate mental health service/teams where necessary.

**Crisis Resolution Team**
Urgent referrals can be made to the team where an individual is in acute mental health crisis and who would previously have required hospital admission. Individuals referred to this service must be willing to receive treatment in their own home. Referrals are accepted from Accident & Emergency Department: Acute In-patient Services: Community Mental Health Services: Consultant Psychiatrists: General Practitioners.

The team will provide an initial assessment and where required people between the age of 16 and 64 will be offered a follow up service from the team. Any person out with this age range will be referred to the appropriate
service for follow up. This service is delivered by Nurses: Occupational Therapy: Psychiatry: Social Worker: Pharmacy and offers interventions in Community Living Skills: Crisis Resolution: Medication Review: Psychosocial Interventions: Relapse Minimisation. The team will provide intensive services for up to six weeks allowing frequent visits through the acute phase of illness and during resolution, care will be transferred to existing services or other appropriate supports that ensure ongoing care and appropriate social supports.

- **Eating Disorder Specialist Service**
  This is a Lanarkshire wide service. Referrals are generally received through Community Mental Health Teams: General Practitioners: CAMHS: Psychiatry supported by written information on the Eating Disorder Indicator Referral Form.

  Eating Disorder Specialist service sees individuals’ placed at the highest risk from their eating disorder that can benefit from intensive community care. In addition, this service will provide consultation, training and advice to other professionals as requested.

- **Antenatal and Postnatal Mental Health and Wellbeing Protocol**
  A pathway is currently in place which details prevention, care and treatment of women in Lanarkshire who may experience mental health problems throughout and after pregnancy. This pathway provides guidance on liaison with community mental health services and identifies formal links with the Specialist Mother and Baby Unit at Southern General Hospital.

- **Integrated Care Pathway for referral to Adult Learning Disabilities Service**
  The Integrated Care Pathway is locally agreed, multi-disciplinary practice. It is inclusive to all disciplines within the Adult Learning Disabilities service. It forms all parts of the clinical record, documents the care given and facilitates evaluation of outcomes for continuous quality improvement.

  An open referral system supports referral to the service. Referral forms and guidance notes can be obtained from any member of the Adult Learning Disabilities service/GP Practices/ Schools/ Social Work Departments.

  The ICP focuses on the patient journey and the pathway supports and records the whole episode of care for the individual with a learning disability from the point of referral to discharge. The pathway takes into account the different professionals the patient may be allocated to, i.e. Psychiatry; Community Nursing; Psychology; Physiotherapy; Speech & Language; Occupational Therapy; Dietetics. Members of staff from various departments or professions work together with the service user and carers to agree what the best journey for the patient should be. An ICP document is completed for each patient with input from the staff involved in their episode of care.

  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
The Forensic Mental Health Team provides a Lanarkshire wide service covering a population of approximately 560,000. The team provides assessment (risk and mental health), consultation and treatment for Mentally Disordered Offenders both in the community and in an eleven bedded low secure inpatient facility. It provides a specialist service to those referred by other professionals within NHS and with partner agencies which include the State Hospital, Rowanbank Clinic (West of Scotland Medium Secure Unit) Criminal Justice Social Work, Criminal Justice Services (Procurator Fiscal, Sheriffs and Prisons) Police and Community Care Social Work who meet the agreed criteria. The services are designed to work with offenders from the time of arrest; through the court proceedings and through custody where this is required.

- **Court Liaison**
  - NHS Lanarkshire provides a mental health court liaison service to the three sheriff courts in the area. The primary purpose of the service is to carry out mental health assessments on individuals who are identified by the Procurator Fiscal (PF) held in custody prior to their appearance in court. Information is gathered from a variety of sources if available prior to the assessment. The primarily nurse led service sees all individuals referred by the PF where concern has been raised over their mental health. This service enables early assessment and where mental health care and treatment under criminal procedures or mental health legislation is considered appropriate, advice can be given to the court to aid decision making at the point of sentencing.

- **Patients known to Forensic Mental Health Service remanded to prison**
  - The appropriate clinician within the team liaises with the mental health team in prison and provides information on current risk factors, medication regimes and contact names and numbers. Regular contact is made with the prisoner throughout their sentence and the prison staff are encouraged to utilise the Care Programme Approach to plan for their release. The use of this in the prison service is sporadic and not consistent which can make follow up arrangements difficult. This is particularly evident when the prisoner is having home leave.

- **Through Care Justice Team**
  - Lanarkshire’s Through Care Justice Team provide continuity in relation to their progress through the prison estate for prisoners who have been sentenced to 4 years or more. The Forensic Service works closely with the throughcare team and work in collaboration on high risk offenders who have had contact with mental health services prior to prison, who experience mental health difficulties whilst in
prison or where reports indicated further mental health service follow-up is necessary. The through care team and the forensic team advocate the use of the Care Programme Approach for prisoners with severe and enduring mental health illness.

- **Psychiatry sessions to Prison**
  NHSL currently have 1 full time consultant and 3 consultants who work part time in NHSL and part time in The State Hospital. We provide 2 psychiatric sessions to HMP Shotts. Addiewell Prison is a community facing prison for Lanarkshire prisoners. It currently has 1 psychiatric session provided by The State Hospital although this is under review. Each prison in Scotland has a visiting psychiatrist who will liaise with local services when required.

- **Care Programme Approach (CPA)**
  CPA has been recognised as the process for planning, co-ordinating and agreeing care packages for individuals who present with severing and enduring mental health problems. The prison service should embrace this those prisoners who meet the criteria but its use is limited.

- **Addiction Services**
  Addiction services have close working relationships with local prisons which include HMP Shotts and HMP Barlinnie. This has also been introduced to HMP Addiewell. The liaison process allows addiction services to identify key workers within Lanarkshire to take on individuals’ cases on their release and prepare prescribing appropriately. Addiction Services routinely receive lists of prisoners being released into Lanarkshire.

- **Prison Liaison Services**
  The Learning Disabilities Service has well established formal Prison Liaison arrangements with six prisons in Scotland who are likely to accommodate people with learning disabilities who come from Lanarkshire. These prisons are HMP Barlinnie: HMP Cortonvale: HMP Glenochil: MHM YOI Polmont: HMP Shotts: HMP Addiewell. This arrangement enables the Community Learning Disability Team to work closely with staff from these prisons in identifying and supporting people with Learning Disabilities who are remanded to or given a custodial sentence.

- **Criminal Justice Social Work/Throughcare**
  Formal links are established with and a supporting pathway is in place to ensure where appropriate access to the Learning Disabilities service. Teams have access to Learning Disability Resource packs and have received awareness raising training.
• **Learning Disability Court Liaison Service**
  This liaison service is dependant on the Court Liaison Nurse from the Forensic Community Team alerting the Learning Disability Service that an individual may have a learning disability and may require further information and guidance to support the Procurator fiscal in decision making with regards the person in custody.

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

NHSL is represented on North and South Lanarkshire Council’s Children’s Services Strategy Groups which also include representation from Education Officers and Principle Educational Psychologists. In addition NHSL ensure a partnership approach to integrated service strategy and development through participation of Educational Psychology in the NHS Lanarkshire’s Children and Maternity Service Improvement Board. Further engagement and partnership working is ensured through multi-agency participation in the Sub-Group structures of both Local Authority and Health Services.

NHSL has invested £250k in an early intervention CAMHS Primary Mental Health Service based in Lanarkshire schools. This team works closely with education staff including psychologists. The services are working together to develop an integrated pathway ensuring rapid and flexible access to mental health services whilst avoiding duplication of work. The services are developing and rolling out a joint model of screening referrals and are working with Youth Counselling Services to develop a model of targeted and staged interventions for children presenting with a range of mental health needs.

The CAMHS Primary Mental Health Team are working jointly with Educational Psychology to provide the following services to young people and schools:

- Professional liaison and Consultation Service
- Training of School based staff in aspects of identification and appropriate less complex intervention for children with mental health needs
- Delivery with Education staff of psycho-educational elements of mental health and well-being to children.
- Direct clinical assessment and intervention service for children based in schools and where appropriate working jointly with Educational Psychology on therapeutic interventions.
- Jointly with Educational Psychology Services provided a range of information and advice for parents who may be concerned about their child’s mental well-being on a range of issues and conditions.

Where more intensive or specialised care is required Child and Family Clinic Teams in Lanarkshire work closely with Educational Psychology Services on a case by case basis.

The clinical staff and Educational Psychologists will regularly work together sharing information where appropriate, participating in the assessment processes and the formation of jointly agreed intervention plans. These
arrangements take place where appropriate as part of the Education (Additional Support for Learning) (Scotland) Act or on an informal “by consent” basis without a statutory framework. On occasions CAMHS clinicians and Educational Psychologists will work together under the legislative framework of the Children’s (Scotland) Act or The Mental Health (Care & Treatment) (Scotland) Act.

**Expenditure on Mental Health Services**

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

The strategic financial framework had been agreed through the two Funding and Resources Committee’s set up between NHS Lanarkshire and North and South Lanarkshire Councils. Mental health development plans are discussed at the Mental Health service Improvement Boards of which the councils are members. The starting point is the previously approved budget and the pace at which developments can be taken forward is largely dependent on the Board itself receiving development funds.

**p)** Do you use pooled or aligned budgets to jointly manage mental health services in your area?

The NHS and Councils have participated in an exercise to identify the overall combined resources devoted to mental health. Some services, such as the substances misuse services, have well established aligned budgets. The integrated day services are moving to a similar model. Others work together in an integrated way at service level but manage the finances separately.

**q)** Are there barriers in the accountability or financial procedures that you feel prevent you from delivering better joined-up services?

There are not believed to be any insurmountable barriers. The timing of budget agreement, approvals through committees with elected member input and differing local priorities may increase the time taken but where there is a will to work together financial procedures can be adapted.

Both the councils and the NHS are complex organisations delivering care to several, overlapping client groups. In year variations will occur and it is normal for budgets to be balanced off within the organisations. Clarity about the deployment or solution to underspends and overspends is needed between the organisations when joint working. If the budgets are segmented into too small portions and ring fenced under joint agreements the normal capacity to manage risk and variation is diminished.

**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 local council, such as education or housing?
Traditionally resource transfer was linked to long stay bed closures. An agreement was reached around the sum to be transferred for each bed or patient. Where the group was diverse and patient needs complex, such as in Learning Disabilities, the more the resource transfer would relate to an assessment of the care package needed to support that individual in the new community accommodation. Where the needs of the patient group were lower and more uniform a generic sum per bed would be agreed.

The scaling down of large institutions and the attendant significant bed closures has now largely been accomplished. Any further, smaller, movements in bed numbers should be subject to joint discussion.

The NHS holds records of why and for whom resource was transferred originally. However as time passes, the individuals change and models of care evolve. Client groups are typically classified in different way between councils and the NHS with the councils reporting finances for over 65’s with mental health needs in the older peoples grouping with the NHS considering them under Mental health. The NHS Resource transfer is only one part of a much larger social services budget which has multiple strands of funding. All these factors mean that as time passes from the original resource transfer event any monitoring can only happen at a higher level.

Locally the councils confirm on a quarterly basis that the agreed level of funding is still needed for that client group. Reassurance is then taken from the fact that the overall budget for the community care client groups is growing rather than diminishing.

The debate about the future of resource transfer is happening through a formal process of engagement between the NHS, COSLA and the Scottish Government Health Department which will report to the ministerial strategic group on Health and Community Care chaired by Shona Robison and due to report in Spring 2010.

There is a view that as resource transfer is only one part of a much larger budget the mechanism to ensure funding is not diverted by either party should be the principle that there should be no unilateral decisions on community care budgets or services that impact on the other. This will become increasingly important as public finances tighten.

s) The Audit Scotland report highlighted that the total amount councils spend on mental health services is unknown. How do you know if you are meeting the needs of people with mental health problems if you do not know how much you are spending on these services? [councils]

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 you monitoring the shift in the balance of care?
The local mental health strategy is accompanied by a detailed 10 year framework which clearly tracks the movement of financial resource from institutional care to community delivery and greater therapeutic input. This translates into annual budgets contained in a financial ledger which can report on all the different elements of mental health provision and clearly identify the cost of community services.